



## Individuals Who Are Incompetent to Stand Trial (IST)

### 2021-22 PRIORITIES

NAMI California (NAMI-CA) brings more voices of people with lived experience of mental illness and their families than any other organization in our state. With over 110,000 active advocates and 62 affiliate organizations, NAMI-CA advocates for lives of quality and respect, without discrimination and stigma, for all our constituents. We provide leadership in advocacy, legislation, policy development, education, and support throughout California.

#### I. Do No Harm Must be the Standard of Care

People who have committed offenses due to states of mind or behavior caused by a serious mental illness do not belong in penal or correctional institutions. Such persons require treatment, not punishment. A prison or jail is never an optimal therapeutic setting. **NAMI-CA opposes efforts to expand the use of jail-based competency restoration for non-violent individuals with serious mental illness.**

Jails are designed for punishment and are not resourced to provide robust mental health care and medications to individuals with serious mental illness, including those facing criminal charges who need competency restoration. While maintaining individuals in jails is less expensive than state hospitals, the human costs are irreversible. **Jail inmates with serious mental illness are highly vulnerable to becoming victims of violence and abuse, and self-mutilation and suicide are both sadly widespread in jails and prisons.** Inmates with serious mental illness are disproportionately segregated or held in solitary confinement, which often contributes to further mental suffering and distressing symptoms.

It is inhumane to subject seriously mentally ill individuals who are arrested and referred for IST services to unnecessary incarceration when we know that **about half have not even been receiving mental health care in the community over the prior 6 months.**<sup>1</sup> Additionally, once competency is restored, individuals in jail are often held many months more before their criminal case concludes. NAMI-CA supports expansion of efforts to divert individuals upon law enforcement contact to treatment instead of jail. California must avoid using jails for competency restoration and instead expand the number and types of community-based facilities.

#### II. Prioritize Diversion and Community-Based Restoration

NAMI-CA urges diversion and community-based restoration to become the rule in California, not the exception, for individuals with serious mental illness who come into contact with law enforcement. According to data analyzed by Department of State Hospitals, close to half of individuals in jail awaiting competency restoration services facing felony charges are eligible for diversion. While we appreciate the current capacity challenges for alternatives in the community, we urge the dedication of new state funds

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<sup>1</sup> California Department of State Hospitals, "The Case for IST Diversion," September 2021. Available online at: <https://www.chhs.ca.gov/wp-content/uploads/2021/09/The-Case-for-IST-Diversion.pdf>

to expand acute and subacute facilities and social rehabilitation programs as quickly as practicable. Luckily, California has an existing framework from which to build and does not need to create new types of alternatives out of whole cloth, nor wait for implementation of CalAIM. Specifically, California can *immediately* expand utilization of the following **existing programs and services** as alternatives to or step-down from incarceration for this population:

- **Full-Service Partnerships (FSPs):** Required in each county and funded with (growing) revenues from the Mental Health Services Act, FSPs provide a “whatever it takes” approach to keep clients out of jail, out of the hospital, and in safe and permanent housing. With many of the treatment and case management services covered as existing Medi-Cal Specialty Mental Health services, most of the funds expended to support FSPs are 50% Medicaid reimbursable. Additionally, FSP participants may receive direct supports to address needs – namely housing and board and care costs – not covered by Medi-Cal.
- **Assertive Outpatient Treatment (AOT):** Under the Bronzan-McCorquodale Act, each county must now offer an AOT program (unless the county Board of Supervisors opts out) for court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement. Most counties have implemented their AOT programs as part of their Mental Health Mental Health Services Act FSP programs, mentioned above, and many of the services provided are 50% Medicaid reimbursable. According to the most recent report to the legislature, California’s 20 AOT programs significantly reduce involvement with the criminal justice system, homelessness, and psychiatric and non-psychiatric hospitalizations.<sup>2</sup>
- **Psychiatric Health Facility (PHF) Services:** As covered Medi-Cal Specialty Mental Health benefits, the services provided in PHFs are 50% reimbursable. Clients receive acute inpatient care outside of a traditional hospital, as well as rehabilitation and support with basic needs, while treated in a PHF. Additionally, PHFs may be designated by the county for involuntary mental health evaluation and treatment under the Lanterman-Petris-Short Act. Unfortunately, since PHF services are not required to be available in every county, and we only have 31 PHFs in California at this time.<sup>3</sup>
- **Mental Health Rehabilitation Centers (MHRCs):** Under the Bronzan-McCorquodale Act, MHRCs provide 24-hour intensive support and rehabilitation to individuals who would have otherwise been placed in a state hospital or another mental health facility. While MHRCs are not a Medi-Cal Specialty Mental Health covered benefit, MHRC services are Medi-Cal billable as “Adult Residential Treatment Services” when certified by the county Mental Health Plan. Like PHFs, MHRCs are not required to be available in every county, and we only have 32 MHRCs in California at this time.<sup>4</sup>
- **Transitional Residential Treatment:** Transitional residential treatment programs provide a range of mental health treatment services and activities and are an effective alternative to psychiatric hospitalization and involuntary, institutional placements. Licensed by the California Department of Social Services (CDSS) as “Social Rehabilitation Facilities” these programs may participate in Medi-Cal if they are certified by the California Department of Health Care Services (DHCS). Like PHFs and MHRCs, Social Rehabilitation programs are not required to be available in every county. We currently have 192 Social Rehabilitation Facilities in 30 of California’s 58 counties at this time.<sup>5</sup>

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<sup>2</sup> Source: California Department of Health Care Services, “Laura’s Law: Assisted Outpatient Treatment Demonstration Project Act of 2002, Report to the Legislature, May 2021.” Online at: <https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf>

<sup>3</sup> Source: California Health and Human Services Agency Open Data Portal. Online at: <https://data.chhs.ca.gov/dataset/licensed-mental-health-rehabilitation-centers-mhrc-and-psychiatric-health-facilities-phf>, accessed on October 28, 2021.

<sup>4</sup> Ibid.

<sup>5</sup> Source: California Health and Human Services Agency Open Data Portal. Online at: <https://data.chhs.ca.gov/dataset/community-care-licensing-adult-residential-facility-locations>, accessed on October 28, 2021.

### III. Family Members' Voices Must be Sought and Utilized

NAMI-CA urges the California Department of State Hospitals (DSH), county mental health agencies, and county Sheriffs' departments to actively seek the involvement of family members in **designing and implementing treatment and diversion solutions** for people living with a serious mental illness who need competency restoration services. In survey responses we received from about 100 family members last month who have had experience with state hospitals and a loved one found IST, a sad theme was woven throughout: "Families are HELPLESS." As collateral informants, family members and other loved ones can provide **treatment and medication history** that can shorten the treatment planning process and help get individuals back into the community as soon as possible. Obtaining the client's medication and treatment history from family members can be particularly useful when health information exchange systems are not in place between health and law enforcement agencies. Consider this NAMI-CA member's story about her son:

*"Once (at a state hospital) he did well at first and then it all fell apart due to a lack of coordinating medication history with his county conservator and his family who knew that the medications he was on at (the state hospital) would lead to disaster. Sadly, once the treating psychiatrist started listening to us, it was too late. My son's behavior was out of control. He was placed in seclusion and restraints five times in a handful of days and after being released, he acted out. That resulted in his arrest and his first felony charge. He was determined to be Incompetent to State Trial and sent back to (the hospital) for "competency training." I went into warrior mom mode to save him from state prison. He picked up two more felony charges while in jail. He was sent to Atascadero which was a better program for him, and they were better at partnering with our family. But it was 5 hours away from us which meant that we could not visit him as often as we wanted.*

Unfortunately, many service providers and law enforcement staff erroneously believe privacy laws prevent them from engaging with an individual's family. To counter this common misunderstanding, **DSH should provide clear guidelines** to all parties and providers involved in the treatment of clients deemed IST about how to **maximize involvement** of family members and other loved ones throughout the process. After all, even absent a client release to share information with family, treatment providers and public safety **staff can receive health information from family members** and other collateral informants. NAMI-CA can provide resources on information-sharing related to family members, including the value of **Psychiatric Advance Directives**. As one NAMI-CA member told us:

*"The family role in the process is to provide support to our loved ones, their treatment team, and attorney. It is almost an impossible role to navigate. I was fortunate to have resources, relationships, and knowledge that allowed me to help the public defender, the judge and the DA understand how we could keep both the community and (our son) safe and achieve justice. ... (T)here are solutions and alternatives to state hospitals, jails, and prisons for families like mine. I will spend the rest of my life fighting for a system of solutions that will prevent the suffering and solitary that my son and family survived. The one size fits all system approach, fails many in California. It is time to focus on funding a full continuum of care for all and all means all.*