Diversion and Reentry Workgroup

Friday, June 18, 2021
1:00 PM – 3:00 PM
Zoom Webinar

Workgroup Purpose: To examine the Department of State Hospitals Pre-Trial Felony Mental Health Diversion Program and Virtual Hospital, as well as formulate recommendations for CCJBH's 2021 Legislative Report.

Councilmember Advisors:

Mack Jenkins, *Chief Probation Officer, Ret. San Diego County*
Stephen Manley, *Santa Clara County Superior Court Judge*
Tony Hobson, *PhD, Behavioral Health Director, Plumas County*

Panelists:

Darci Delgado, *Psy.D., Senior Psychologist, Department of State Hospitals*
Ashley Breth, *Staff Services Manager II (Specialist), Department of State Hospitals*

CCJBH Staff:

Brenda Grealish, *Executive Officer, Council of Criminal Justice and Behavioral Health*, Elizabeth Vice, Emily Grichuhin, Angela Kranz, Jessica Camacho, Monica Campos, Paige Hoffman, Catherine Hickinbotham, Daria Quintero

I. Welcome and Introductions

Brenda Grealish, *Executive Officer, Council on Criminal Justice and Behavioral Health*

Brenda Grealish welcomed participants to the meeting and gave an overview of the agenda.

II. Department of State Hospitals (DSH): Pre-Trial Felony Mental Health Diversion Program

Darci Delgado, *Psy.D., Senior Psychologist, Department of State Hospitals*
Ashley Breth, *Staff Services Manager II (Specialist), Department of State Hospitals*

Ms. Breth introduced the Department of State Hospital's (DSH's) Pre-Trial Felony Mental Health Diversion Program, hereafter referred to as the DSH Diversion Program. The DSH Diversion Program is a part of the larger picture of mental health diversion within the State, but is focused on the felony Incompetent to Stand Trial (IST) population, with an emphasis on three mental health diagnosis: schizophrenia, schizoaffective disorder, and bipolar disorder. The program just passed the halfway point of the pilot, originally scheduled to operate from July 2018 to June 2023. Each county committed to a three-year pilot program within a five-year time frame. The five-year time frame gives each county sufficient time to operate their diversion programs for three full years.

The DSH Diversion Program identified 13 of the original 15 counties for program participation, referred to as the top 15 due to having the highest rate of referrals for felony IST to the DSH Diversion Program at the time the program was being proposed. The 15 counties were guaranteed funding to start a felony IST Diversion Program. About $8.5 million of the original allocation was made available to other counties outside of the top 15 to apply via a competitive process. Between the $8.5 million and other savings, the program was able to bring 11 more counties into the Diversion Program through two different Request for Proposals that were released over the past two years.

As of this year, there are 24 counties participating in this program: Alameda, Contra Costa, Del Norte, Fresno, Humboldt, Kern, Los Angeles, Marin, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Siskiyou, Solano, Sonoma, Ventura, and Yolo County. There have been a total of 291 participants in the DSH Diversion Program to date, but only 276 were eligible as of quarter two in Fiscal Year 2019-20. Examination of data shows that there is a 2:1 ratio of males-to-females who have been placed in the DSH Diversion Program, with diagnoses being 43 percent schizophrenia, 33 percent schizoaffective disorder and 24 percent bipolar disorder. The breakdown of ethnicity is as follows: 37.7 percent Black, 29.7 percent Hispanic, 24.6 percent White, and 8 percent Other. These data are representative of the DSH population, as a whole. The majority were charged with felony assault (69 percent), followed by theft (45 percent), and robbery (42 percent). Driving offenses (1.1 percent) and drug offenses (0.7 percent) were less common.

This information is important for stakeholders who are involved in diversion program development because there is a lot of concern about not wanting to place an individual into diversion who could be a threat to the community. There are some justice stakeholders that would rather divert an individual with a misdemeanor than a felony, but also understand that there are times when individuals, if not for their mental illness, would not have been charged with a crime. The DSH Diversion Program conveyed that, from a psychiatric standpoint, once someone successfully completes diversion, their charges may be removed from participants' records. From a psychopharmacology standpoint, once participants are prescribed and taking medication, they have a higher level of success in the community resulting in lower risk of criminal or psychiatric recidivism. Most people who become felony IST have a psychotic disorder that is untreated, and once they receive regular treatment for their illness things like the number of new crimes committed, days spent in jail, and emergency room visits for psychiatric emergencies would become fewer and far between. The DSH Diversion Program strongly believes that felony ISTs can be avoided for individuals with schizophrenia, schizoaffective disorder, and bipolar disorder if they receive and take their prescribed medications, and are provided with appropriate wrap-around services.

There is a time delay with data output because all counties are implementing diversion differently. The data shown was collected during the second quarter Fiscal Year 2021 through December 2020. Acknowledging COVID-19, these data will look different in 6 months because of the pandemic, with the anticipation that the number

of people participating in diversion will increase in the next 12 months. COVID-19 had an unfortunate impact on the DSH Diversion Program. It delayed getting programs activated, as well as getting final program planning and contracting completed. The causes of the activation delays were the court closures that happened in spring 2020 which caused a low flow of referrals and court approvals, and county leads being redirected to COVID-19 response efforts. Due to the pandemic, the programs that were initiating implementation were impacted. There was a lot of "churn" occurring in the jail systems such that mental health clinicians were unable to identify whether individuals would be applicable for diversion because potential participants were released before they could be evaluated.

Large jail releases also made it difficult for active programs to locate the individuals that they had identified who may be appropriate for the program and start the evaluation process, and there were issues with having access to jails in order to perform screenings and evaluations. Jails began offering teleconferencing and video conferencing capabilities, which helped, but it was still a slow process. Finally, a big picture impact was how the programs could operate their day-to-day operations. COVID-19 severely impacted the ability to give in-person treatment, which is very challenging in these types of programs.

The DSH Diversion Program has been successful in providing technical assistance and support to participating counties. Counties, in turn, have provided helpful feedback, communicating their needs so the DSH Diversion Program staff can provide additional services and support. Some counties held their first graduations, and a handful of graduations are planned for the summer for program participants who have successfully completed the DSH Diversion Program. All the programs that have been activated to date have begun admitting clients, except for one that has been having some problems with processing referrals. Another success has been the stakeholder partnerships and counties coming together in their community.

Challenges that have been faced with implementation of the DSH Diversion Program include:

- Housing: One of the "top 15" counties was not able to proceed with the program because of their inability to find appropriate housing for program clients. Housing is a challenge the State is dealing with, so hopefully more resources and assistance can be identified to address housing needs.
- Co-occurring substance use disorders: This is going to be a focus in the next year in terms of technical assistance and support.
- Medication in jails: Whether a jail will give involuntary medication varies, and oftentimes the defendants who are eligible or appropriate for this type of programming do not want to take their medication because the nature of their illness. When a defendant does not take their medication, they do not present as an eligible candidate for diversion even though they may be if they were on medication. Medication for these individuals in jail is important, particularly prior to release into the community for stabilization purposes.

- Dosage of services: It is not clear if clients are receiving appropriate levels of services in the communities.
- The referral process: If a county doesn't have a referral process established, it is difficult to refer participants into the program. This challenge has to do with the education of the different stakeholder groups. Many county treatment providers and behavioral health providers spent a lot of time in the beginning of their program activation working with criminal justice partners to make sure everyone has a county referral process established. Some counties have a streamlined process where all diversion referrals are processed by a mental health court, using one judge and one group of criminal justice partners. Other counties do not use that type of streamlined approach, which can make the referral process challenging.

As part of the Fiscal Year 2021-22 budget packet, the DSH requested a program expansion of the Felony Mental Health Diversion Program that, if approved, would begin in July of 2021. There are two different branches of this expansion. The first is to expand the programs by an additional 20 percent in the counties DSH has funded to date. In order to participate in this expansion, counties must commit to diverting individuals who have been deemed felony IST, and not those who are *likely* to be felony IST. Any diagnosis that is specified under the Penal Code as part of this diversion expansion will be allowed, and no additional funding match is required. The second branch of expansion is to create new county programs. The DSH Diversion Program has requested funding for all other counties that have had felony IST referrals to DSH in the past three years. This funding will be guaranteed for all counties and there will be no competitive process. For this program, the original pilot rules will apply. Depending on size of the county, the county will have to provide either a 10 or 20 percent match. The eligibility requirement will be the same as the original program, which is a felony charge, somebody who has been found IST or is likely to be found IST, and has one of the three qualifying diagnoses (schizophrenia, schizoaffective disorder or bipolar disorder). As part of this request, additional funding was included to continue and expand technical assistance efforts. They also included funding to support the increase in data collection so the program could grow, as originally proposed.

Ms. Grealish added that CCJBH received funding to support the implementation of the DSH Diversion Program by providing training and technical assistance to support the implementation. A number of contractors had provided their expertise since the program was implemented, with the last being a training by Dr. Desmarais on May 5, 2021, which provided an overview of how to conduct an evaluation. CCJBH is close to executing a contract to provide focused diversion training and technical assistance to counties. The contractors can identify what has worked well and identify any gaps or challenges. A final report will be developed to include recommendations on how to proceed with expanding diversion statewide.

Q&A with Councilmember Advisors:

Q: Chief Mack Jenkins asked, "At what point, or points, in the criminal justice case processing is the diagnosis made?"

A: Dr. Delgado stated the answer is dependent on the county and how they develop their programs. The DSH Diversion Program gives feedback on individual county programs but every county creates their program blueprint considering existing evaluative processes. Individuals who have had previous clinical evaluations may qualify using the previous diagnosis, thereby resulting in a quick placement into the Diversion Program. Others will have a longer delay before a diagnosis is rendered. Generally, referrals to the county Diversion Programs are made by either jail treatment providers or public defenders. It is possible that when a public defender is identifying a potential IST case, they will perform an eligibility assessment for IST proceedings to see if someone is competent or not instead of requesting a clinical evaluation for inclusion in a Diversion Program. If the clinical diagnosis makes someone eligible for diversion, they would be able to participate in the Diversion Program instead of waiting for the IST processes. Diversion Programs are preferred as it shortens the time that someone is in jail. Other individuals who have already been found felony IST are on the waitlist and in jail waiting for a place in the DSH system. A subsequent diversion evaluation may provide a clinical diagnosis that makes somebody eligible.

Q: Chief Jenkins asked if the prosecutor does the referral post diagnosis.

A: Dr. Delgado stated they can vary depending on the county and stakeholder's decision about who to refer.

Q: Chief Jenkins noted the low percentage of drug involved charges in the program and asked if treatment for the three diagnosis was primarily psychotropic medication with support? In regards to the data presented, are all the cohorts in custody at the time of referral?

A: Dr. Delgado responded that the treatment is primarily psychotropic medication with support and not all, but the majority, of cohorts are in custody at the time of referral. There are specific scenarios where they aren't, especially during COVID-19. Counties were in a hard situation during COVID-19 because they would be in the middle of a diversion evaluation, determining if a person would be a good candidate, but jails would release them because they were trying to keep their numbers low and, as a result, the county was unable to place them in the Diversion Program. When the individual got released, they usually had not made a good connection to a provider and didn't continue their medication, and some even decompensated to a point where they no longer were in a place where they agreed to take medication and be safely treated. This caused some individuals to fall through the cracks. Ms. Breth added that counties would have to try to locate a person who got released out in the community, which was a challenge during COVID-19.

Q: Chief Jenkins asked if the data on whether someone was in jail at the time of referral was influenced by the county's response to COVID-19?

A: Dr. Delgado stated no data was specifically presented on that, but she hypothesized that the total number of people who participated in diversion would have been much higher if COVID-19 didn't exist.

Q: Chief Jenkins asked if the housing status of the cohort and the availability of housing for the folks in the program was available. He noted that obtaining housing is a challenge.

A: Dr. Delgado stated that, looking broadly at the IST population, a deep dive was done into the 2018-19 admissions and it was found that the vast majority, almost two thirds, were unsheltered homeless at the time of entering into the felony IST system. The data fed a need to put an importance on housing in the DSH Diversion Program because the majority of people who are IST are individuals who are unsheltered homeless.

Q: Judge Manley stated he has been involved with this program since the time the bill was drafted. In the opening comments, a goal was stated to put the State Hospital out of business. That is important to understand when comparing the number of 276 people diverted individuals to the number of people currently in the State Hospital, with no room for people, and the number of people sitting in jail waiting for the State Hospital. A recent court decision came down setting a statewide cutoff date for when services from the State should begin. It is a pressing problem for the courts, community, and stakeholders. It is pressing for the courts because judges are placed in a position of having to deny people their basic and fundamental due process rights guaranteed by the Constitution because of this disaster we are in. His county alone has diverted over 80 individuals at the time they were committed to the State Hospital; not somebody who's likely to go there, but someone who is already there and has been fully evaluated and found competent, and the judge can decide whether to commit them or permit them to be diverted.

The future is moving the responsibility presently held by the State Hospital to the county level. In the court today, an individual spent six years back-and-forth to the State Hospital, and he had served his term of six years, and there is no reason to keep people in custody that long. We need to find ways to work towards increasing this program. He agrees with the challenges presented, but funding has to be transferred to the counties. This is a relapsing condition, and decompensation is very common. When someone out in the community has been charged with assault, or a serious felony robbery, they decompensate. There has to be somewhere for them to go. Currently there is only the choice between jail and a facility, locked or unlocked, but if you don't have the facilities at the local level, it puts tremendous pressure on the counties to try to do the right thing. He hopes advocates will continue to press these points with the policymakers at the State level.

He chairs a committee that advises the Judicial Council Subcommittee. We advise on mental health issues and we brought over the trailer bill. In the presentation, it was stated that there is a proposal to fund an increase up to 20 percent. He has always believed in the program of "pay for success", which means looking at how many people you have in diversion treatment and if that number is going up, or exceeds larger counties or similar sized counties, then you should give that county more funding because they are producing the desired results. The counties need the money so it will incentivize the other counties to divert more individuals. If you don't do that, counties like his are going to stop the number of people being diverted. It is a treatment capacity issue that we cannot have individuals with serious charges in

the community and have nowhere for them to go when they decompensate. It is my understanding that the Governor has proposed a substantial increase in funding for behavioral health and I hope, if that comes through, consideration is given to the need of the counties to have higher modalities of treatment, such as crisis residential, and locked facilities because we are never going to solve this problem if we don't build infrastructure at a county level.

In terms of medication in the jails, most counties agree that unless they have a full array of locked facilities, they are not going to divert people who are not compliant with medication. You then must depend on custody health because if someone who suffers from schizophrenia is charged with a serious offense, they can't decide they're not going to be in custody. At some point you need to consider funding custody mental health through the State because counties don't have the funding to do so and many counties have to contract out or depend on behavioral health. Some counties have their own system of custody health, but if you don't have a very robust system at the time of booking in jail to really start working on people before they get into the elongated, elaborate, statue-driven process in the court, you don't get anywhere.

Q: Dr. Hobson asked a question about forced medication. He stated medication seems to be the key to all of this and if you can medicate as soon as the alienist is done with their evaluation and we have a diagnosis, what's stopping the jails from medicating people involuntarily? It is done in some places and not in others, so how do we fix that? In the virtual hospitalization work in Plumas County we were able to convince an individual to start taking medication and he cleared up, was reassessed, and is now competent. That seems to be the key so what can be done to have some uniform process regarding the delivery of medication involuntarily?

A: Dr. Delgado stated that is the key, end of story. There are a lot of reasons why custody mental health does not feel comfortable providing involuntary medication. There is fear and uncertainty about what that looks like, for example, force. She worked in a prison for ten years, and know others who have worked in the custody setting, and there are many behavioral interventions such as incentive programs or sitting and talking to a person to build rapport and a relationship with your patient to enforce the potential benefit of taking medication. Rarely does it come to a situation where force has to be utilized. She thinks a lot of people are fearful of the associated liability. From a DSH Diversion Program standpoint, DSH is trying to provide as much technical assistance as possible to the prescribing providers within counties and discuss the importance of involuntary medication and long acting injectable medication. She is a psychologist, not a prescriber, but she has seen the benefits to clients when long acting injectable medications are used and it is an underutilized tool within the diversion population. We have technical assistance, such as recorded webinars for prescribers and consultation services with a specialty psychopharmacological team, for any county provider who needs assistance with more difficult to medicate patients. DSH's medical director, Dr. Kate Warburton, would say this is the key component that's missing and could be life-changing for many individuals.

Q: Dr. Hobson stated there is a health and safety code used in hospital emergency rooms, 1799.111 F, which gives hospitals the authority to medicate involuntarily if someone is a danger to themselves or others, or gravely disabled due to mental illness. It could be a matter of changing the code to include jail-based medical systems because this is an issue of parity. If someone were having a heart attack and you wanted to do CPR, do they ask permission first? No, they're just going to do it because it's a life saving measure. He sees this as the same and thinks it's time to take a hard look at this.

A: Judge Manley stated there is already a law, so we don't need a new statue. Involuntary Medication Orders (IMO) are signed all the time and are served to the sheriff and the jail departments. It's an issue of engagement, and the jails and custody health are fearful of the common misconception about how these orders are carried out. They think you have to strap people down and jab needles in them, but what really needs to be done is engagement. Do you have enough people talking to that person over and over again, trying to build a bond of trust? We have to use Zoom to talk to people in jail, but our public defender, social worker, and clinical staff are directly talking with the defendant day after day until they can engage them.

Q: Dr. Hobson stated Laura's Law is controversial, but it should be implemented in counties. The one failure to the law is the medication piece, you can't enforce it even though we know it's medically necessary.

A: Dr. Delgado stated we need more folks like Judge Manley because not all courts even order IMOs to start with.

*****PUBLIC COMMENT*****

Q: A participant stated, in reference to Judge Manley, he's absolutely right. The participant works with several judges and some are uncomfortable signing an IMO or anti-psychotropic medication authorization form that allows the inpatient facilities to give medication with no consent of the defendant who's placed there. She does misdemeanor at-risk restoration for Stanislaus County and often has to make the request based on the 1370.01 evaluation recommendation for inpatient treatment. Before she can get this individual released into the county hospital, she needs to have the form requested by the judge, then the judge makes the request to the jail psychiatrist for the anti-psychotropic medication while the defendant is still waiting for placement. The treating psychiatrist then goes to see the individual, they make recommendations, and then she goes back to court with the form and the judge signs again behind the psychiatrist. She can then go ahead and make recommendations to the county hospital where treatment begins. To start the restoration process, she oftentimes tries to get into the jail as soon as the recommendation from the 1370.01 is given and try to establish rapport and engage the defendant while in custody to see if they would be willing to entertain the idea of seeing a psychiatrist in the hospital. She is often doing a lot of early engagement before getting to the hospital. If that's unsuccessful, she continues to move forward. She has also worked in the inpatient setting for seven-and-a-half years and can say that the staff she works directly with in the inpatient setting often tries to engage with them, get rapport, and ask them to take their scheduled medications by mouth. In

the event they refuse, they have to be forced through involuntary medication, but several attempts are made to get them to take the medication before actually administering it through an injection. All of this is very on point because she does the misdemeanor restoration for Stanislaus County. She does the inpatient, outpatient, and in-custody based on recommendation of the 1370.01 from the psychologist.

A: Dr. Delgado pointed out that when a psychiatrist prescribes medication they can provide an oral version or an intramuscular version, like a shot. An IMO can be written for emergency medication, but part of the reason we are talking about long acting injectable medication actually has nothing to do with the IMO. Sometimes intramuscular medication given during an emergency medication process, but taking a step back the DSH Diversion Program has found more success with patients who receive long acting injectable medications, regardless of if it's given in an emergency or not. In general for this population, being able to give an individual in a diversion program a shot once a month, or sometimes once every six weeks, as opposed to them having to take oral medication every day gives them a greater chance for success by encouraging them to take that long acting injectable medication. Shots aren't only given in emergency situations. Their psychopharmacological experts really try to talk about the benefits of building rapport so clients agree to take a long acting injectable shot. Someone who might be in a transient living situation, changing between medical providers, or in and out of custody, would be able to take a shot once every four-to-six weeks instead of having to take medications daily, which gives the patient a greater chance for success.

Q: The participant stated she has had a lot of success for many of her restoration folks, with the Invega Sustenna being one of the main ones she gives. She has had huge success with the long acting injection medication.

Q: How do we fix the medication piece in Laura's Law? This seems key in supporting a more comprehensive community system of care that prioritizes diversion.

A: Judge Manley responded that it would require legislation. The law is very clear on what can and can't be done, and it's very limited. Even though Laura's Law, also referred to as assisted outpatient treatment (AOT), is a court process, the power and jurisdiction of the judge is extremely limited other than to order a defendant to enter treatment. It is limited in terms of when the defendant decompensates, doesn't follow through, leaves treatment, etc.

Q: Chief Jenkins asked if it is something we could include in our Legislative Report?

A: Judge Manley stated we can, but it's a highly controversial issue. The consumer groups feel very strongly that the court shouldn't be involved in forcing people to do things.

Q: Chief Jenkins stated that if we find from our evaluation and discussion that it's in the best interest of our stated mission, he wouldn't think that it would preclude its inclusion in a report that the Council debates and discusses.

A: Judge Manley stated that's always been the frustration with Laura's Law. We have the treatment available, but we don't have the tools to hold anyone accountable to stay in treatment.

Q: Ms. Grealish stated we could look into the work that the Mental Health Services Oversight and Accountability Commission is doing on psychiatric advanced directives, which could play into all this in terms of when folks are decompensating. Is there a plan that can be put in place that is driven by the consumer? She started looking into that a few months ago, so we might be able to look into what's going on in different places. Just noting the issue is a first step.

A: Judge Manley stated we may need to hold a workgroup session on this because under a law passed last year, counties have until July to opt in and implement Laura's Law. He needed to report this issue because it's going to put much more pressure on our behavioral health departments and move away from the public guardian over to behavioral health.

A: Dr. Hobson concurred and referenced Dr. Warburton's research on the IST population on the waitlist, stating she made a comment in her study that county behavioral health isn't treating these people. Which is correct because they can refuse. We know that medication is effective and our hands are tied at the county level.

Q: A participant stated they think rapport needs to come from the past history that has been created by over- and under-evaluating clients. The clinician is the one that needs to be able to build that trust, so when they evaluate the client, the client believes that the clinician has their best interest in prescribing medication. History has already depleted our conditions of failure, so the client doesn't trust that they need to take this medication, and that it will stabilize their life and incentivize them to have a normal life, no matter what they've done in the past. If trust isn't built at that level, it doesn't matter who comes along and coaches you. You have to be able to trust your doctor.

A: Ms. Grealish responded that the comment made her reflect back on some of the other work CCJBH is doing on the Forensic Peer Support Specialist. Maybe this is another area where Forensic Peers could be helpful in the space and in facilitation.

II. Department of State Hospitals (DSH) Continued: Virtual Hospital Overview

Darci Delgado, *Psy.D., Senior Psychologist, Department of State Hospitals*

Ashley Breth, *Staff Services Manager II (Specialist), Department of State Hospitals*

Dr. Delgado introduced the virtual hospital and stated it is not a formal program that DSH was authorized to do. It came out of the pandemic as an emergent need and a way to support the long waitlist of people trying to get reevaluated. Individuals have been waiting on the waitlist for so long that they have been able to become competent to stand trial because they have consented to taking medication, but are still waiting in limbo within the jail system. From a procedural standpoint, DSH reevaluates patients while they are on the waitlist, starting with the oldest commitment and working their way through the waitlist by virtually evaluating individuals. The individual's commitment packet in their record is updated electronically and provided to DSH, who then schedules a virtual evaluation with the jail. Once the evaluation is done, any changes to the individual's competency are noted.

The ten counties who have opted into the virtual hospital program are Fresno, Shasta, Stanislaus, Tulare, Solano, Contra Costa, Yolo, El Dorado, Tuolumne, and Los Angeles. DSH has taken a second look at the evaluations, clinical status, and status in terms of taking medication from those counties to inform their competency. Within the pilot project, there have been a total of 120 evaluation, and 31 of those individuals, or 25 percent, were found competent in their second evaluation. To be able to find an individual who has been taking medication and is now competent, and move them through the criminal justice process so they aren't languishing, waiting for a State Hospital bed, has been quite successful. Other recommendations are given, such as when the in-custody clinician is connected with the DSH prescribing clinician to review medication options. Specific diversion recommendations are also made to counties when an individual may be a good candidate for the Diversion Program. They are trying to offer these individuals support so they can be removed from the waitlist and placed into a situation where they can receive services and medication more quickly. It is not a formal process, but is a silver lining of COVID-19 it moves individuals through the felony IST process more quickly.

Building off what was learned over the last year, DSH developed a Budget Change Proposal for Fiscal Year 2021-22 for an IST Reevaluation Services Team to formalize the work started by the virtual hospital project. The IST Reevaluation Services Team uses a panel of forensic evaluators to go into county jails and reassess any ISTs who have been in the jail waiting for admission to DSH for more than 60 days. The goal is to identify any 1370 who can be off-ramped either because they have regained competency by taking their medication and engaging with correctional mental health services while waiting for DSH, or because they are not restorable ISTs.

Evaluators can also consider whether an individual 1370 is appropriate for other types of outpatient treatment programs, such as diversion or other county programs. The updated patient records are reviewed, a video interview with the IST defendant is conducted, all of which would be notated in a report for the courts to consider, including recommendations for outpatient diversion programs that would be coordinated with the public defender or defense attorney. One-time funding will be provided to jails to support the purchase of any technology, such as buying laptops for the virtual interviews or software purchases. A flat rate payment would be provided to the local jails for each IST defendant that is interviewed to cover the cost of staff time to escort the individual to and from interviews, and to supervise them while they are out of their cell. This is a four-year pilot project, which would be assessed at the end of year three to determine if there is still an ongoing need for the program.

Q&A with Councilmember Advisors:

Q: Judge Manley asked if the budget proposal would apply to all counties. Dr. Delgado said the virtual hospital program engaged with ten counties, but will this be for all counties or will it require counties to agree?

A: Ms. Breth responded that it will be offered to all counties, but the county jails will have to agree to participate.

Q: Judge Manley clarified whether the jail will have to agree or the Board of Supervisors? He expressed approval for the concept, and stated anything we can do to improve things is good, but wants to make sure he understands who needs to make the agreement to do it. Will it be the Board of Supervisors, county executives, the Sherriff?

A: Ms. Breth stated that she misspoke earlier and that the DSH has the authority to conduct the evaluations so it will be available to all counties.

Q: Dr. Hobson stated Plumas County wasn't one of the ten listed because they only had one case. But he feels it worked out very well, and he got to witness it from beginning to end, working with Dr. Delgado to get this individual reevaluated. Through building a therapeutic rapport with the man, they were able to get him to take medication, get him off the hospital list, and ready for trial.

A: Dr. Delgado stated she will add Plumas County.

*****PUBLIC COMMENT*****

Q: A Cal Voices ACCESS program representative stated they wanted to provide their take and input on AOT (previously referred to as Laura's Law) discussion, and support that they emphasize client choice and voice when talking about these particular supports that they are trying to put in place. We agree that if Forensic Peer Support Specialists work with individuals, they build trust, respect, and have better buy- in. Documentation and reports show that it saves money when people take personal responsibility for their own wellness and treatment. They wanted to piggyback on the statements respective to the Forensic Peer Support Specialist and understand and emphasize that when individuals are a part of the process, and they have buy in, there's long-term recovery and wellness, as opposed to following the directives of a plan created for them in their best interest. Not saying that best interests aren't the root of why some treatment plans are executed the way they are, but really getting that engagement in client voice and choice.

III. Diversion/Reentry Recommendations

Ms. Grealish stated recommendations had already been discussed in our Q&A.

IV. Report to the Governor's Office on SB 369 Veto Message

Ms. Grealish stated CCJBH has been working heavily on the SB 369 Veto Message project. The Governor's veto message mandate instructed CDCR and CCJBH to work together with stakeholders to identify barriers to reentry and strategies to overcome them. The April Council Meeting was focused on determining barriers, as well as several stakeholder meetings and research. The report has been drafted and is moving through the review process, then will be disseminated for final stakeholder review. The barriers table is the bulk of the report, and the barriers are categorized into three different levels: the individual, program/provider and system. Thirty-two barriers have been identified with strategies and ideas to address all of them, and some ideas in terms of which entities should be at the table to work collaboratively to address them. We have a good inventory of barriers that have been identified through our research

and stakeholder processes to our culminate recommendations. Our Council will be voting on the report at the end of July, then we will be submitting the report to the Governor's Office. We will cite the recommendations from the SB 369 Report in our Legislative Report in terms of what we think needs to happen for reentry. Do Councilmembers or the public have any comments in terms of our reentry recommendations from the SB 369 Report or our diversion recommendations from today's discussion? Council staff will be able to look at the record of today's recommendations.

Q&A with Councilmember Advisors:

Q: Chief Jenkins stated great dialogue occurred and a lot of work has been put into the construction of the barriers document and overcoming those barriers. A lot of the barriers aren't new to people that are impacted by reentry challenges, people that practice reentry, or our stakeholders. Consequently, a lot of the solutions aren't particularly new either. The challenge is in pulling them together in our report. As we move forward with the recommendations we need to emphasize them from a standard of known best practices, not evidence-based practices, because they are not the same thing, but effective reentry does include some practices that have been well researched and well established. With the fidelity of these practices and principles, positive outcomes for reentry can be achieved. He endorses all the work that's gone into it and as he reviews what we put together and will be presenting, he will be reviewing from that lens.

A: Ms. Grealish responded that Chief Jenkin's comment was validating because as CCJBH staff did the analysis of the barriers they came to the same conclusion that the barriers aren't new and the solutions aren't new, but there may be some gaps in terms of education and people knowing what is available and having a resource. Quality improvements could be made to certain polices that are in place, but not functioning optimally. Some new projects may come from the barriers, but for the most part not much is new and a lot of strengthening can occur on persisting barriers.

V. Announcements/Next Steps

The Juvenile Justice Workgroup will be on Friday, June 25, 2021, from 1:00-3:00 PM. We will be focusing on the impacts of COVID-19 on our youth population involved in the justice system with behavioral health needs and sharing resources that will be available. There's a lot of investments coming on the federal and State level for youth population and we want to make sure that youth involved in the justice system will also benefit from it. We will also form recommendations for our Legislative Report and share the work being done with SB 823.

The next Full Council Meeting will be Friday, July 30, 2021. We will be focusing on the housing and homelessness investments and the billions of dollars being allocated through different housing efforts. Executives from the Housing and Community Development, Homeless Coordinating and Financing Council, California Department of Social Services, and the Department of Health Care Services will be doing a panel presentation and having a dialogue between Councilmembers and the executives.

The launch of our Housing Report with the Council of State Government (CSG) will be on July 14, 2021. The same individuals presenting at our upcoming Council meeting will be making guest appearances there, as well as hearing from some folks who have lived experience perspectives. CSG will then present the Housing Report and we will talk about the next steps of where we're looking to go with the recommendations from the report.

We are awaiting the Governor's Budget being signed. The May Revision summary is on the CCJBH website and has all the information and budget related proposals that pertain to our population. It will be updated once the budget is signed and will also be put in the appendix of our Legislative Report.

The next Diversion/Reentry Workgroup will be on September 17, 2021. Possible discussion topics include deflection or discussing components of AOT (previously referred to as Laura's Law) that aren't working well, including strategies, solutions, and how to support counties and beneficiaries who receive AOT services.