November 17, 2021

Via Electronic Mail

IST Solutions Workgroup
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To the IST Solutions Workgroup:

California's prison system has systematically failed to adequately treat incarcerated people with significant psychiatric disabilities. Despite decades of effort, the State has not managed to provide constitutionally sufficient care to the tens of thousands of people with significant psychiatric disabilities languishing in California prison cells. People wait many months for treatment, only to be cycled through the criminal legal system. Experts have repeatedly recognized that the incarceration of people with significant psychiatric disabilities does a disservice to both the individuals and the public.

At this critical juncture, we call on the State and counties to center and dramatically expand decarcerative approaches in responding to the IST crisis. As further elaborated in the attached recommendations, we call on the State and counties to:

1) Sharply expand access to mental health diversion;
2) Expand access to community-based restoration and treatment through increased funding, technical assistance, and political commitment;
3) Place a moratorium on new jail-based competency restoration (JBCT) beds and end its reliance on jail-based programming;
4) Reform the State's outdated competency scheme;

5) Avoid harm to people conserved pursuant to the Lanterman-Petris-Short Act;
6) Prioritize discharging from DSH custody long-term patients who do not present a substantial risk of danger of physical harm to others; and
7) Invest in a robust array of community-based behavioral health care services to meet the needs of people with mental health disabilities before, during, and after involvement with the criminal legal system.

Real solutions will require strong political commitment and significant resources to build county infrastructure and capacity for an effective response.

Sincerely,

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RECOMMENDATIONS FOR RESPONDING TO CALIFORNIA'S FELONY INCOMPETENT TO STAND TRIAL CRISIS AND FOR THE DECARCERATION OF PEOPLE WITH MENTAL ILLNESS

> "The most tragic aspect of [the IST] crisis is that the massive efforts to admit and restore patients are ultimately a waste of expensive clinical resources without improving the trajectory of a person's life. After returning to jail and standing trial, they are most likely worse off: either released without resources to the same circumstances that precipitated the arrest or incarcerated."
>
> - Dr. Katherine Warburton, Medical Director, California State Hospitals

California's prison system has systematically failed to adequately treat incarcerated people with significant psychiatric disabilities.[1] Despite decades of effort, the State has not managed to provide constitutionally sufficient care to the tens of thousands of people with significant psychiatric disabilities languishing in California prison cells.[2] There is currently a waitlist of approximately 1700 people deemed incompetent to stand trial (IST) languishing in jails with neither treatment nor due process.[3] People wait many months for treatment, only to be cycled through the criminal legal system. Experts have repeatedly recognized that the incarceration of people with significant psychiatric disabilities does a disservice to both the individuals and the public.[4]

Diversion and community-based treatment should be the primary means of responding to people with significant psychiatric disabilities in the criminal legal system, including those deemed IST. The State's response to the crisis of over-incarceration of people with mental illness, including people deemed IST, should be centered on an urgent and dramatic expansion of county mental health diversion and community-based treatment options (including community-based restoration programs, or CBR). Both the California Department of State Hospitals (DSH) and

independent researchers have concluded that the majority of individuals found IST are suitable for diversion,[5] yet diversion programs are severely under-resourced.

At the same time, the State should avoid expanding institutional and incarcerative remedies – including jail-based competency restoration (JBCT) – which do more harm than good. Because people of color are more likely to be arrested and less likely to be diverted, jail-based treatment also exacerbates existing disparities by excluding minority groups from receiving meaningful treatment.[6] In recent years, there has been a dramatic expansion of JBCT beds. This should stop.

DSH should also not direct its focus narrowly on competency restoration to facilitate prosecution. If individuals found IST are restored to competency and subsequently prosecuted, the effect will be to continue—and exacerbate—California's longstanding over-incarceration of people with significant psychiatric disabilities.

Real solutions will require strong political commitment—from the state and counties—and significant resources to build county infrastructure and capacity for an effective response. In many cases, county resources are either inadequate or nonexistent, and this must be addressed. Legislative reform and financial commitments should center decarcerative approaches, including diversion and community-based restoration, as well as enhancing access to an array of mental health care and permanent supportive housing for people with serious mental illness outside of the criminal legal system.

A. <u>California Should Sharply Expand Access to Mental Health Diversion.</u>

Informal or formal diversion is both better for patients and less expensive than restoration services provided in jail or inpatient settings such as DSH.[7] Devoting resources to diversion (as well as dismissal of cases) will therefore provide better treatment to more people than if those same resources were put into the types of custodial treatment that now form the bulk of the State's treatment options.

In 2018, with the passage of AB 1810, California established a new mental health diversion process. As codified in Penal Code § 1001.36, most individuals with significant psychiatric disabilities may be diverted from prosecution to a behavioral health treatment program. This program could have a substantial impact on limiting the number of people with significant psychiatric disabilities in criminal custody, including the IST population. DSH acknowledges this. But despite the potential presented by this law, mental health diversion programs have been severely limited in reach and impact. A dramatic expansion of mental health diversion—and the requisite funding—is essential to effectively respond to the crisis of extensive IST waitlists and the over-incarceration of people with significant psychiatric disabilities in California's jail and prison system.

The State has not provided the funding and leadership sufficient to implement AB 1810 effectively and scale up diversion statewide. To facilitate the implementation of AB 1810, the 2018-19 budget provided $100 million in one-time funds to DSH to award contracts to counties to help create diversion programs. DSH used $93 million of those funds to help twenty-four counties with high IST referral numbers set up felony diversion programs.[8] These programs have been inadequate, diverting only 424 people across the whole state in the first three years of the

program despite available funding for 820 diversion slots—and a far greater need.[9] Indeed, DSH acknowledges that, upon a review of diversion eligibility for those on the IST waitlist, *approximately half* are diversion eligible. Yet very few of these are diverted. This is due to myriad factors including inadequate state funding, inadequate housing to support the diversion program, disagreement about who is suitable for diversion, and insufficient implementation of the program at the county level.[10]

Even the target goals of these programs are far too modest given the need: the existing programs aimed to divert only 820 people over their three-year lifespan.[11] Given that the pre-COVID statewide IST referral rate was 350 people per month (and the current monthly IST referral rate is more than 450 per month),[12] DSH's diversion programs were slated to divert fewer than *seven percent* of potential ISTs. This would make barely a dent. Many others who have a significant psychiatric disability but are not deemed IST are also unable to benefit from the law because of this slow scale-up.

The State's planned expansion of diversion in this year's budget is similarly modest. In this budget cycle, DSH has allocated only $46.4 million to expand and create DSH Diversion programs.[13] Furthermore, the budget does not specifically set aside funds for resources – like supported housing for participants – that are necessary to ensure that diversion is a feasible and effective option for individuals and counties.

To meaningfully expand mental health diversion ("MHD," including but not limited to AB 1810 diversion), the State should implement the following reforms:

1. Early Access to Dismissal and Diversion: The State should increase access to pre-filing and informal diversion to limit unnecessary involvement with the criminal legal system. This should include dismissal of cases or other pre-trial release into treatment and services.

    a) There should be early intervention programs where the district attorney and public defender stipulate—either before or at the time that a complaint is filed—to dismissal, pre-trial release into treatment, or diversion. This should include the identification by law enforcement of cases where an arrestee has a known mental health condition, to expedite the dismissal of charges, or referral to mental health court and access to diversion or community-based treatment options.
    b) There should be early intervention programs where the district attorney and public defender stipulate—either before or at the time that a complaint is filed—to dismissal, pre-trial release into treatment, or diversion.
    c) Mental health assessments should be conducted upon booking.
    d) Detention mental health staff should conduct early discharge planning.

2. Legislative Reform to Expand Diversion Access: The Legislature should amend the laws governing mental health diversion to expand access and eliminate obstacles to eligibility. This should include in particular:

    a) Eliminating the requirement of a nexus between the defendant's mental disorder and the charged offense, or at a minimum establishing a rebuttable presumption that for

anyone diagnosed with a serious mental illness the mental illness was a significant factor in the commission of the charged offense (see PC 1001.36(b)(1)(B));

b) Modifying language concerning permissible public safety risk for diversion eligibility (from the more vague "unreasonable risk to public safety" to "clear and present risk to public safety") (see PC 100.36(b)((1)(F));
c) Requiring an evaluation of eligibility for diversion at the earliest possible opportunity, including by requiring that the initial evaluation of competency (by an "alienist"—a person assigned to provide forensic evaluations of an individual's competency to stand trial) include an evaluation of eligibility for diversion;
d) Establishing a presumption of diversion eligibility if a person charged with a crime is declared incompetent to stand trial; and
e) Establishing community-based treatment as appropriate in lieu of restoration for low-level felonies and not just misdemeanors (by expanding SB 317 (2021) to include PC 1170(h) felonies for which the maximum penalty is county jail rather than prison).

3. Earlier and Expanded Evaluation for Diversion Eligibility: More entities—including CONREP, county behavioral health systems, and DSH (when it evaluates in the jail or admits to a DSH facility)—should have the obligation to evaluate and recommend candidates for mental health diversion. Such entities should have adequate resources and capacity to do so. The State should also direct funding to county public defender offices to ensure they have capacity to evaluate candidates for mental health diversion programs.

4. Increased Statewide MHD Funding: The State should provide at least double its current funding to county agencies to expand their AB 1810 diversion programs. The State should also eliminate any match-funding requirement for MHD programs.

5. Regional Diversion Programs: The State should implement regional AB 1810 diversion programs to increase access to diversion and community-based treatment. By creating regional programs, the State can begin to bridge the gap between its estimate for the number of individuals eligible for diversion and the number of those actually placed in diversion. Regional programs will also eliminate the impediment to granting diversion to out of county residents.

6. Funding for Housing for MHD Participants: The State should provide funding to counties explicitly directed for housing individuals who are participating in MHD. This is critical in light of the fact that approximately half of people found IST were unhoused prior to their incarceration.[14]

7. Continued Access to MHD Funding Despite DSH Placement: The State should permit individuals placed in DSH facilities to access funding for mental health diversion. This is currently prohibited as the grant does not permit funding for individuals who have been in State Hospital custody.

8. Data: The State should require counties to provide regular data on diversion programs. Such data should be made publicly available. Currently, publicly available diversion data provides only the number of diverted individuals (including the number of attempted

diversion motions and the number of diverted individuals deemed likely to become IST) without any county-level breakdowns or point-in-time tracking. Publicly-available data should include, at minimum, a disaggregated and anonymized list of the diversion motions made per county program per month, including whether the person was successfully diverted, the race/ethnicity of the person, and criminal charge(s) of the case in question. Similar data should also be maintained showing the number of completed diversion periods and the number of aborted diversion periods.

B. California Should Expand Access to Community-Based Restoration Through Increased Funding, Technical Assistance, and Political Commitment by State and County Entities.

Diverting people from the criminal legal system should be the state's first priority. However, for individuals deemed IST and charged with felonies, but ineligible for diversion, the state should ensure broad access to community-based restoration (CBR) and treatment. This is both better for patients and less expensive than restoration services provided in jail or inpatient settings such as DSH.[15]

Currently the only county with a CBR program is Los Angeles County, which has capacity for 415 people.[16] In contrast, in FY 2020-21, there were 437 beds for JBCT programming across the state.[17] LA County's CBR program diverts people found IST and facing felony charges into community-based settings to be restored to competency. The LA County FIST-CBR program commits to a continuity of care and has a far better recidivism rate than other county or state programs—including county programs for people *without* serious mental illness.[18] This program should be expanded in Los Angeles and other counties should also implement CBR.

1. Adequate CBR Funding: The State should allocate adequate funds to ensure the expansion of CBR to meet the needs. The 2021-22 State Budget Act allocates $208.3 million over this and the next three fiscal years, plus ongoing funding, to expand the only currently-existing CBR program in Los Angeles County and establish new programs in 17 additional counties.[19] DSH's estimate is that this will increase DSH-funded CBR capacity by 552 beds over a three-year period.

2. Adequate Technical Assistance: The State should provide adequate technical assistance and other support to incentivize the effective development and expansion of county CBR programs. DSH should be mindful of the challenges encountered by its diversion partner counties when scaling up CBR, as many of the same challenges will likely exist when placing CBR participants in community settings, making significant technical assistance and other support essential.

3. Incentivizing County CBR Programming: State funding must actively incentivize - and avoid disincentivizing - the development and expansion of CBR programs. Specifically, the State should ensure additional funding for counties that are initiating new CBR programming without pre-existing infrastructure. The State should also not add onerous requirements to the acceptance of CBR funding (for instance, a requirement that counties

assume responsibility of all people designated FIST or that counties with CBR programs pay more than other counties for access to state hospital beds).[20]

4. Earlier and Expanded Evaluation for CBR Eligibility: More entities—including CONREP, county behavioral health systems, and DSH (when it evaluates in the jail or admits to a DSH facility)—should have the obligation and any necessary resources to evaluate and recommend candidates for community-based restoration.

5. Incentivizing Individual access to CBR Programming: Currently, individuals being evaluated for community-based restoration or mental health diversion lose their place on the waitlist for DSH placement, meaning that if they are denied community placement following evaluation, they go to the end of the DSH line. DSH should eliminate disincentives to community-based restoration (and mental health diversion) by maintaining an individual's place on the waitlist for DSH placement while they are being evaluated for, or participating in, community-based restoration (or mental health diversion).

6. Mandated Consideration of CBR Eligibility: The State should require consideration of community-based restoration, with a presumption that such placement is appropriate, including for individuals who have been found ineligible for diversion (or for whom diversion is not otherwise appropriate).

7. Data: The State should require public data tracking of CBR programs so that the public can evaluate their effectiveness. At a minimum, the State should mandate (and make publicly available) data tracking that includes a disaggregated and anonymized list of people restored per month per program, the length of stay in the program, the race/ethnicity of the person in the program, the charge(s) of the criminal case in question, and whether the individual returned to the program after the resolution of their criminal case.

C. DSH Should Place a Moratorium on New JBCT Beds and End its Reliance on Jail-Based Programming.

Recent years have seen an exponential increase of the JBCT beds in California—with an increase in referrals from zero in 2014 to 1604 in 2020—with JBCT referrals accounting for 50 percent of all IST referrals and JBCT programs in twenty counties.[21] DSH should not continue to prioritize the scaling up of jail-based competency treatment units, which are designed to restore individuals found IST to competency for subsequent prosecution.

In this year's and next year's budgets, DSH has allocated $13.1 million and $20.1 million, respectively, to expand JBCT counties to 11 additional counties and increase the number of JBCT slots by up to 123 beds in 2021-22.[22] This is a mistake. These beds are costly, provide poor care, and do nothing to end the incarceration of people with significant psychiatric disabilities.[23] As experts have found, diverting IST patients from jail-based treatment to community-based treatment saves $60,000 per person.[24] JBCTs keep people with significant psychiatric disabilities in austere, traumatizing, inhumane environments, shortchanging their well-being for a purported quick restoration.

DSH should discontinue JBCT funding and redirect the planned JBCT funding requests towards diversion programs. As the California Legislature declared with the passage of AB 720 (Eggman) in 2017: "Jails are not therapeutic environments and were not intended or designed to be mental health facilities."[25] California should not provide any further funding for these programs.

D. The State Must Reform its Outdated Competency Scheme.

The current waitlist for a DSH bed is approximately 1700 people. Individuals found incompetent to stand trial and committed to DSH wait an average of six months after commitment and prior to placement. However, the delays in treatment begin long before the time of commitment. The existing statutory scheme that has remained largely unchanged since the 1970's creates pre-commitment delays of at least six to eight weeks. Post-commitment delays are three to four times longer. Overall, competency proceedings can span a period of nine months to a year before an incompetent and seriously mentally ill individual receives any treatment. Given court backlog and the lack of priority for mental-health cases, the delay in getting a case to trial can range from months to years.

To reform the statutory scheme, the State should implement the following recommendations:

1. Statutory Timelines Pre-competency Evaluation: The Legislature should establish timelines for appointment of court appointed evaluators and receipt of reports to avoid delays prior to a finding of incompetency.

2. Funding for Expert Reports: The State must also provide funding so that courts can maintain a panel of experts with sufficient experience and ability to provide timely and competent reports. Relying exclusively on counties to fund experts contributes to inequity and further delay as less resourced counties are unable to adequately compensate experts.

3. Shifting the burden to demonstrate competency: The Legislature should place the burden on the prosecution to establish competency, rather than (as is the case now) on the defense to establish incompetency. Currently, fifteen other states place this burden on the state, and California should do the same. This legislative reform would avoid due process violations, and needless delays from contested competency hearings where there is clear evidence of incompetence.

4. Limiting Improper Competency Hearings: The State must limit the prosecution's ability to re-litigate competency or keep a person in custody once an individual has reached the maximum commitment or been found unlikely to be restored to competency.

5. Reforms to CONREP: The State must reform CONREP to eliminate placement delays and to increase the number of referrals to outpatient treatment. Pursuant to PC 1370(a)(2)(A), the CONREP community program director must evaluate and submit a placement recommendation report within 15 days as to whether an individual deemed IST should be committed to a state hospital or receive community-based treatment. The placement recommendation report delays access to treatment by three weeks and rarely recommends outpatient referrals.

6. Competency Evaluations: DSH should re-evaluate its methods of assessing competency. While DSH reports that 25 percent of individuals committed to DSH are already competent, its restoration of individuals based on rote knowledge of basic court processes does not comport with legal definitions of what it means for an individual to be competent to stand trial. Defense counsel often find that although the client has memorized a curriculum packet and overt symptoms of psychosis have improved, the client is in no better position to make informed decisions regarding the criminal case then prior to hospitalization.

E. California Must Implement Solutions to the DSH IST Waitlist Crisis in a Manner Which Does Not Harm People Conserved Pursuant to the Lanterman-Petris-Short Act.

If DSH cannot complete the recommendations of the IST Solutions Workgroup, or it cannot make sufficient progress towards providing timely access to restoration for felony IST defendants on the waitlist, WIC 4147(f), which mandates the creation of the IST Solutions Workgroup, provides that DSH may discontinue admitting Lanterman-Petris-Short (LPS) conservatees and/or reduce the number of them committed to state hospitals.[26] If DSH elects to take either of these actions, it must do so in a way that does not place LPS conservatees at risk of future involvement in the criminal legal system or re-institutionalization in psychiatric hospitals.

California already faces a shortage of non-hospital placements for LPS conservatees and counties are not equipped to handle an exodus of hundreds of LPS conservatees from DSH. If LPS conservatees are discharged from DSH or other locked settings without adequate supports to transition into less-restrictive placements, there is a real possibility that many of them will fall back into the cycle of homelessness, disengagement from services, law enforcement contact, and subsequent criminal legal system involvement that the State intends to curtail. As such, county Public Guardians and Behavioral Health Departments must prioritize successfully transitioning LPS conservatees to unlocked settings, including linking them with intensive FSP services, and allocating existing locked beds to people who cannot be placed at a lower level of care.

F. To Increase Forensic Capacity in State Hospitals, DSH and CONREP Should Prioritize Discharging Long-Term Patients Who Do Not Present a Substantial Risk of Danger of Physical Harm to Others.

Many people committed to DSH on Not Guilty by Reason of Insanity (NGRI) and Offender with Mental Health Disorder (OMHD) commitments have been institutionalized for decades and would not be a substantial risk of danger of physical harm to others if released to the community with the appropriate structure and supports. This is particularly true of people committed on the extensions of these commitments pursuant to Penal Code sections 1026.5 and 2972, respectively, as well as people who permanently require a skilled nursing level of care. As such, DSH and CONREP should evaluate every patient committed under Penal Code sections 1026.5 and 2972, as well as every patient who permanently requires a skilled nursing level of care, and determine whether placement outside of DSH is appropriate.

G. California Must Invest in a Robust Array of Community-Based Behavioral Health Care Services to Meet the Needs of People with Mental Health Disabilities Before, During, and After Involvement with the Criminal Legal System.

A recent study conducted by DSH's Medical Director Katherine Warburton and others found that three of the top four factors for the nationwide increase in IST referrals are directly related to deficits in community behavioral health systems: (1) inadequate general mental health services in the community; (2) inadequate crisis services in the community; and (3) inadequate Assertive Community Treatment (ACT) services in the community.[27] Dr. Warburton and her co-authors opined that "the current response to the IST crisis does nothing to address the complex long-term biopsychosocial needs of individuals living with serious mental illness…[O]nce [IST] proceedings have concluded, the patient is released to the same circumstances that precipitated the arrest, institutionalized, or incarcerated, no better off for the state hospital stay."[28]

Dr. Warburton and her co-authors suggest that, rather than incentivizing costly state hospital stays or incarceration, public mental health dollars should focus on creating robust, long-term community systems of care.[29] We agree. To this end, California should take the following steps to make meaningful investments in building every county's capacity to prevent needless involvement of people with serious mental illness (SMI) in the criminal legal system. Needed services should be available *before* arrest, *during* involvement in diversion or community-based restoration services, and *after* re-entry following exit from the criminal legal system.

1. Infrastructure Funding: The Behavioral Health Continuum Infrastructure Program (BHCIP) is a state program that authorizes the Department of Health Care Services (DHCS) to award $2.2 billion in competitive grants over three years to construct, acquire, and rehabilitate real estate for the purpose of expanding access to community-based treatment, and to invest in mobile crisis infrastructure. When evaluating applications for funding under BHCIP, the State should prioritize infrastructure projects that benefit people involved in the criminal legal system.

2. Program Funding and Technical Assistance: The State should provide counties with program funding and technical assistance—and not just the infrastructure support referenced above—to develop behavioral health crisis response systems that include meaningful alternatives to the criminal legal system. This should include, among other things, regional crisis call centers, mobile crisis teams, and crisis receiving and stabilization services.

3. Access to Community-Based Treatment: The State should ensure access to high-engagement community-based behavioral health treatment services before, during, and after involvement with the criminal legal system. This should include funding and incentives for expanding Full-Service Partnerships (FSPs) and Assertive Community Treatment (ACT). In addition, the State should ensure that people dually diagnosed with serious mental illness (SMI) and substance use disorder have access to appropriate services to treat both conditions simultaneously.

4. Housing First: The State should use a housing first approach to create pathways to permanent supportive housing for all unhoused people with SMI involved with the criminal legal system. Between 2018-20, approximately two-thirds of those admitted as IST in California were homeless, including nearly half whom were unsheltered.[30]

Unhoused people with significant mental illness cycle through the criminal legal system. Without a serious political and financial commitment to permanent supportive housing to people with SMI, this will not change.

5. Cal-AIM: The State should ensure the effective implementation of Cal-AIM (California Advancing & Innovating Medi-Cal) components relevant to individuals involved with the criminal legal system. These components include mandatory pre-release application for Medi-Cal, enhanced care management, and in lieu of services.

6. Peer Specialists: Counties should increase the delivery of services through peer specialists, including forensic peer specialists, in diversion and CBR programs and at all points in the criminal process

[1] Despite 25 years of court supervision and scores of court orders in the *Coleman* litigation regarding mental health treatment for people incarcerated by the California Department of Corrections and Rehabilitation ("CDCR"), the *Coleman* Special Master recently reported that CDCR had the second highest suicide rate of the nation's ten largest prison systems for the most recent period, 2001-16. *See* January 28, 2021 Special Master Report on 2016 Suicides, ECF No. 7038 at 23.

[2] For instance, the *Coleman* Special Master recently found in a report on CDCR inpatient programs that incarcerated people in CDCR's programs "uniformly receive less treatment than would be expected in functioning inpatient programs," partially due to "the lack of a sufficient number of inpatient beds" in CDCR. *See* January 28, 2021 Special Master Report on CDCR Inpatient Programs, ECF No. 7039 at 21. These problems will only increase if DSH takes a narrow approach to the IST crisis.

[3] Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 8, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf. People with intellectual/developmental disabilities who have been found IST on felony charges and committed to the Department of Developmental Services (DDS) may also face unnecessary and detrimental incarceration, and wait for long periods in county jails. While this is not the focus of this Workgroup—or this set of recommendations—we urge California to expand diversion opportunities and timely meet the needs of IST defendants committed to DDS.

[4] *See. e.g.*, Darrell Steinberg *et al*., "When Did Prisons Become Acceptable Mental Healthcare Facilities?," Stanford Law School Three Strikes Project (Feb. 19, 2015), *available at* https://law.stanford.edu/publications/when-did-prisons-become-acceptable-mental-healthcare-facilities/.

[5] DSH May Budget Revision at 234 ("As of March 2020, DSH found that little more than half of IST cases on the waitlist reviewed may be eligible for diversion based on the diagnosis and/or the condition of homelessness in relation to the charged offense. These individuals are not likely to pose a safety risk to the community with appropriate medication and treatment and are not charged with one of the exclusionary crimes listed in Penal Code (PC) 1001.36."). *See, e.g.*, Stephanie Brooks Holliday *et al.,* "Estimating the Size of the Los Angeles County Jail Mental Health Population Appropriate for Release into Community Services," RAND Corporation (Jan. 7, 2020), *available at* https://www.rand.org/pubs/research_reports/RR4328.html.

[6] Leah Pope, "Racial Disparities in Mental Health and Criminal Justice," NAMI Blog (July 2019), *available at* https://www.nami.org/Blogs/NAMI-Blog/July-2019/Racial-Disparities-in-Mental-Health-and-Criminal-Justice.

[7] For instance, one study found that states spend nearly $400 less per day per patient by using outpatient programs over inpatient treatment. *See* W. Neil Gowensmith, *et al*., "Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges," Psychology, Public Policy, and Law (June 6, 2016), *available at* http://dx.doi.org/10.1037/law0000088, at 9.

[8] *See* May Revise, 228-230, *at* https://dsh.ca.gov/About_Us/docs/2021-22_May_Revision_Estimate.pdf.

[9] *See* Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 16, 18, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.

[10] Stephanie Welch & Kate Warburton, The Case for IST Diversion (presentation), 27, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/The-Case-for-IST-Diversion.pdf; Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 15, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.

[11] *See* May Revise, 228-230, *at* https://dsh.ca.gov/About_Us/docs/2021-22_May_Revision_Estimate.pdf.

[12] *See* Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 8, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.

[13] 2021-2022 State Budget, Department of State Hospitals, 2, *at* https://www.ebudget.ca.gov/2021-22/pdf/Enacted/GovernorsBudget/4000/4440.pdf.

[14] 2018 DSH Annual Report at 10 (noting that their "research indicates that almost half of the IST patient referrals were unsheltered homeless individuals at the time of their arrest.").

[15] *See* W. Neil Gowensmith, *et al*., "Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges," Psychology, Public Policy, and Law (June 6, 2016), *available at* http://dx.doi.org/10.1037/law0000088, at 9.

[16] The LA Office of Diversion and Reentry Program is currently the *only* CBR program in the state. ODR has been operational since 2015, initially for individuals deemed IST and charged with misdemeanors (MIST-CBR) and expanding in 2018 for those charged with felonies (FIST-CBR). *See* Kristen Ochoa, "Decriminalization in Action: Lessons from the Los Angeles Model," Cambridge University Press, Nov. 5, 2019, at

https://www.cambridge.org/core/journals/cns-spectrums/article/decriminalization-in-action-lessons-from-the-los-angeles-model/9D6707735699A466C1950C5DDDCFD15D.

[17] *See* Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 6-7, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.

[18] The LA ODR FIST-CBR recidivism rate (here, rate of arrest for a new offense) is 17%, compared to 39% for other county supervised release programs, 44% for LA County felony pretrial releases, 49% for LA County people with serious mental illness, and 70% for people deemed IST and committed to a state hospital for treatment. *See*, LA County Health Services, Office of Diversion and Reentry (presentation), 12, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/08/ODR_CBR_Presentation_08312021_Accessible.pdf.

[19] 2021-2022 State Budget, Department of State Hospitals, 2, *at* https://www.ebudget.ca.gov/2021-22/pdf/Enacted/GovernorsBudget/4000/4440.pdf.

[20] *See, e.g.*, California Legislative Analyst Office, "Behavioral Health: Community Care Demonstration Project," Feb. 19, 2021, *at* https://lao.ca.gov/Publications/Report/4382.

[21] *See* Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 5, 8, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.

[22] 2021-2022 State Budget, Department of State Hospitals, 2, *at* https://www.ebudget.ca.gov/2021-22/pdf/Enacted/GovernorsBudget/4000/4440.pdf.

[23] *See, e.g.*, Alexandra Douglas, "Caging the Incompetent: Why Jail-Based Competency Restoration Programs Violate the Americans with Disabilities Act under Olmstead v. LC.," Georgetown Journal of Legal Ethics, 32 (2019), 525– 575.

[24] *See* Gowensmith at 9.

[25] AB 720 section 1(c) (2017).

[26] Welf. & Inst. Code § 4147(f).

[27] Katherine Warburton, *et al.*, *A Survey of National Trends in Psychiatric Patients Found Incompetent to Stand Trial: Reasons for the Reinstitutionalization of People with Serious Mental Illness in the United States*, CNS Spectrums, 245, 248 (2020).

[28] *Id*. at 249.

[29] *Id*.

[30] *See* Melanie Scott & Kate Warburton, The Case for Early Access to Treatment (presentation), 10, *at* https://www.chhs.ca.gov/wp-content/uploads/2021/09/DSH-Early-Access.pdf.