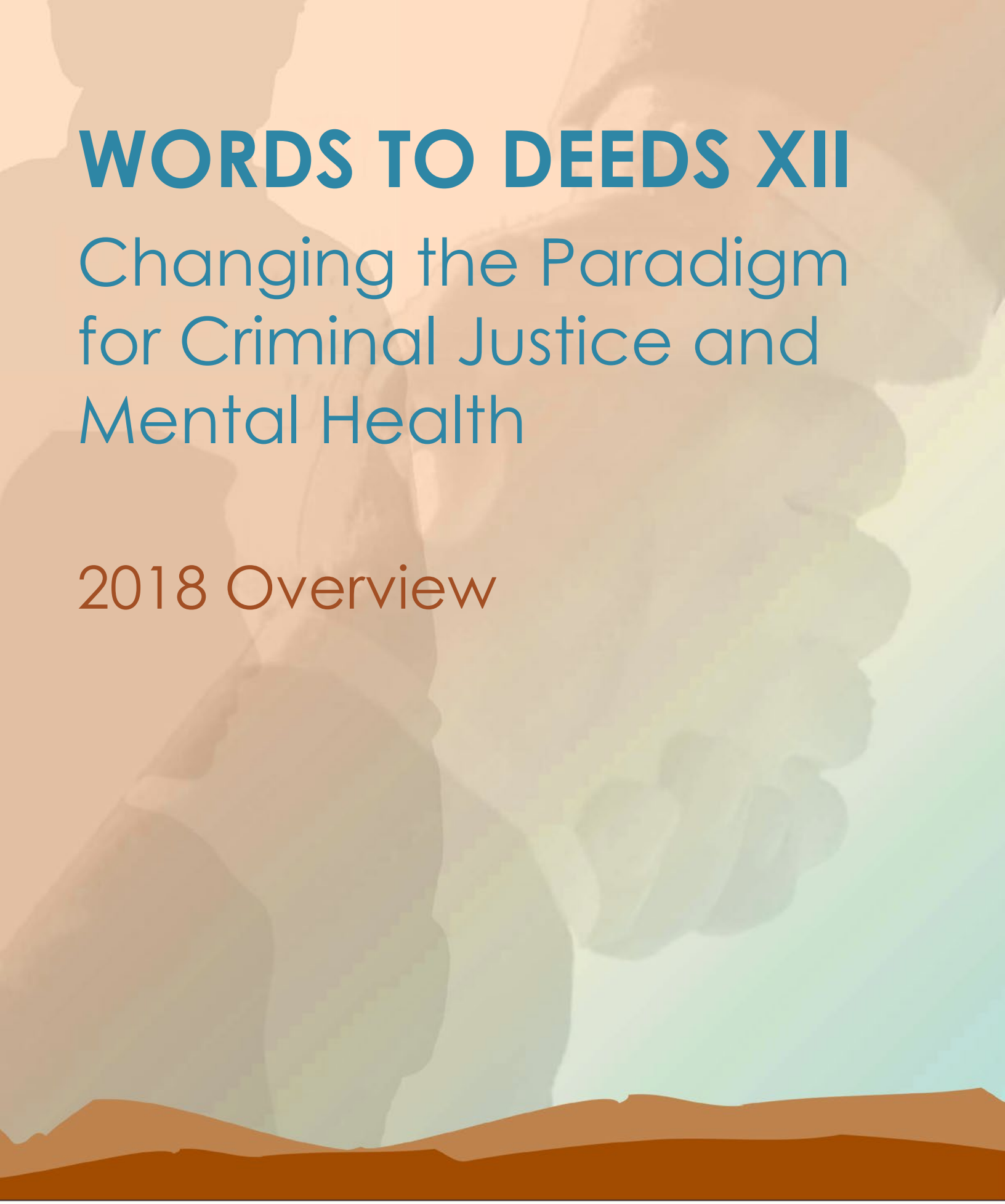
WORDS TO DEEDS XII

Changing the Paradigm for Criminal Justice and Mental Health

2018 Overview



W2D

FORENSIC MENTAL HEALTH Association of California

Words to Deeds

Bringing together behavioral health and criminal justice leaders and stakeholders with the goal of ending the criminalization of individuals with mental health needs

2018 Conference Overview

Policy and decision-makers from across California participated in *Words to Deeds XII* in partnership with the Los Angeles County Department of Mental Health (LACDMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC), November 15 - 16, 2018. This year's conference focused on behavioral health and wellness for first responders and custody officials, reducing the Incompetent to Stand Trial population, integrated service initiatives in Los Angeles County, best practices from Riverside and San Francisco Counties, and the launch of the MHSOAC Innovation Incubator.

"You are the thought leaders, the doers, the people making us a better county and making sure that we can keep people in the community and in treatment instead of behind bars and incarcerated."

- Curley Bonds, MD
Chief Deputy Director, Clinical Operations,
Los Angeles County Department
of Mental Health

Serving Those Who Serve: The Behavioral Health Needs of Our First Responders and the Consequences When Needs Go Unmet

Ashley Mills, MS - Senior Researcher, Mental Health Services Oversight and Accountability Commission
Kristal Antonicelli - Health Program Specialist, Mental Health Services Oversight and Accountability Commission

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is developing a suicide prevention plan for California that, in part, will address the behavioral health needs of first responders and custody officials who experience trauma as part of their jobs. While researching mental health needs and suicidality in the state, Senior Researcher Ashley Mills found that there is great need for enhanced services, both proactive and reactive, for individuals who respond to emergencies and natural disasters. First responders include emergency medical services (EMS) personnel, police officers, fire fighters, search and rescue personnel, and paramedics, among others.

Data About First Responders

While studies on the behavioral health of emergency responders and custody personnel are limited, existing data and surveys using representative samples show:

- Correctional officers have a 39% higher risk of suicide than other professions.
- 27% of correctional officers experience Post-Traumatic Stress Disorder (PTSD), similar to the rate among military personnel and veterans.
- One study of large urban police departments reported an average of 170 critical incidents over an officer's career and 188 in small/medium-sized departments.
- First responders and custody officers are at increased risk of depression, suicide and substance use disorders.
- 30% of first responders develop behavioral health challenges, likely underreported.
- EMS personnel and fire fighters were reported to be more likely than the general population to think about and attempt suicide.
- Being both EMS and a fire fighter is associated with a 6-fold increased likelihood of reporting a suicide attempt.
- Between 125-300 law enforcement officers die by suicide each year, likely underreported.

Types of exposure first responders experience:

- Life-threatening natural or manmade disasters,
- Witnessing death and dying,
- Witnessing adults and/or children who have been physically and/or sexually assaulted,
- Threats to responders' families,
- In addition to witnessing traumatic events in the field, there can be stress related to the occupation including the pace of the job, the need to be constantly vigilant, and a lack of down time after a traumatic incident to assess personal impact before needing to respond to another incident.

About Suicide

A mental health crisis is a state of mind when an individual is no longer able to cope with and adjust to recurrent stress in a functional way. It may include extreme, erratic behavior that is easily recognizable, but not necessarily. Symptoms can be mostly internal and may include fatigue, restlessness, anxiety, racing thoughts, intrusive thoughts, and social withdrawal.

Suicidality is a continuum of behaviors that range from thoughts, which vary in severity, passivity and persistance; to planning, which might involve giving away possessions, visiting the site of potential suicide, or purchasing the means of the suicide; to attempts and completion, which is statistically rare. What makes someone move from having suicidal thoughts to action?

Interpersonal Theory of Suicide

These attitudes have the strongest relationship to suicidal thoughts:

- Thwarted belongingness - the extent to which someone believes their need for belonging is being met.
- Perceived Burdensomeness - the extent to which someone believes they are a burden on someone or one's family.

Thoughts move to action through "Acquired Capability," which is the increased tolerance of pain and decreased fears around death. Suicidal individuals develop "Acquired Capability" through abortive suicide attempts, self-injury and other forms of violence or risk-taking behavior.

Risk factors:

- Prior suicide attempt(s)
- Misuse/abuse of alcohol or other drugs
- Unaddressed mental health needs
- Access to lethal means
- Knowing someone who has died by suicide, particularly a family member
- Social isolation
- Chronic disease/disability
- Lack of access to behavioral health care

Improvements

Protective factors include:

- Effective behavioral health care
- Connectedness to people, family, community and social institutions
- Life skills
- Problem-solving skills
- Self-esteem
- Sense of a purpose in life
- Cultural/religious/personal beliefs that discourage suicide
- Training on mental health and wellbeing, including resiliency when exposed to trauma.

In addition to encouraging and supporting adaptation of each protective factor, agencies can improve the education that they offer their employees. Many law enforcement officers in California receive Crisis Intervention Team (CIT) training, which provides information about how to respond to someone in a mental health crisis. However, not all first responders receive this training and, further, they need education about how to take care of their own mental health as well. Resiliency training provides tools to adapt to stresses while maintaining psychological wellbeing in the face of adversity. This helps responders cope with trauma they witness and has been shown to increase job satisfaction.

Audience Comments

- Public defenders also need services and resiliency training for the vicarious trauma they experience in their jobs, resulting high rates of substance abuse.
- People in these types of jobs who don't have a set of self-care skills are at much higher risk of developing stress-related symptoms. It does not seem to be common practice for employers to provide assistance.
- Some counties have used MHSOAC grant money for training. Police get CIT and de-escalation training but fire fighters and EMTs respond to a significant portion of calls even though they don't get that same training.
- Culturally-competent treatment is important. When first responders seek support only to find mental health professionals who do not have a basis for understanding their feelings and the situations they've been in, it creates a barrier to trust and undermines their confidence that treatment will help.
- When job-related, Worker's Compensation and/or Employee Assistance Programs (EAP) should be utilized. Particularly if you can demonstrate that a particular program reduces costs related to disability claims and stress leave, you'll get departments on board and be able to get insurance to pay. Is it not being utilized because employees are not seeking help or are the assistance programs not working?

Resources:

- MHSOAC plans on releasing a draft report on suicide prevention for public comment in Spring 2019, available at www.mhsoac.ca.gov.

On the Road to Mental Readiness (R2MR)*

Introduction:

Stephanie Welch - Executive Officer, Council on Criminal Justice and Behavioral Health

Speakers:

Beth Milliard - Sergeant, York Regional Police, Ontario, Canada

Jennifer Thompson - Early Intervention Analyst, York Regional Police, Ontario, Canada

The Road to Mental Readiness (R2MR)* is a peer-driven program in Ontario, Canada, that provides resiliency training to law enforcement officers. Its goal is to reduce stigma, increase awareness of mental health, and offer tools to help officers recognize and manage the signs and symptoms of mental distress in themselves and their colleagues. The program has been adapted for paramedics, fire fighters and correctional officers.

R2MR strives to normalize discussion of mental health among law enforcement officers so that individuals who experience distress recognize the signs early, feel comfortable seeking help and know how to connect with a support system. The program also promotes positive mental health in the workplace by discussing policies, cultures and behaviors that might dissuade employees from disclosing mental distress.

Since this program began, the number of personnel who started privately to see a therapist increased by 400%.

Training Elements

The Mental Health Continuum Model, a self-assessment tool to help officers identify the status of their own mental health, is an important component used in the R2MR training. The Continuum reminds participants that people move back and forth between healthy (green) and ill (red) over time. As resilience increases, each person moves more quickly to green from yellow/orange/red.

Clues that a person or his/her peers might need mental health assistance include:

- Changes in behavior/performance
- Changes in thinking/attitude
- Changes in mood
- Physical changes

The Big 4 is a set of evidence-based techniques that can help individuals cope with stress and improve mental resiliency:

- SMART goal setting
- Mental rehearsal/visualization
- Positive self-talk
- Arousal Control

Additional Comments

- Supervisors need to be trained as well, so that mental distress is not considered a performance issue. Agency leadership needs to prioritize employee well-being and integrate it into the culture.
- Make sure the EAP includes sufficient behavioral health services and that they are the right services for your employees.

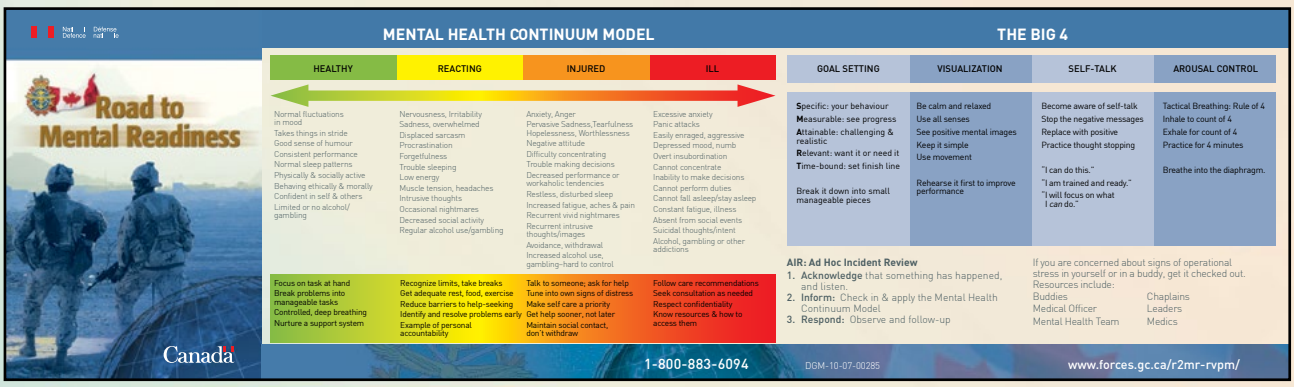
Other employee mental health support offered at York Regional Police:

- The peer support team includes support specifically for families.
- Traumatic incidents are reviewed so that the responders involved can be proactively contacted about potential symptoms and support options.
- A supplemental training provides interactive scenarios where officers can practice difficult situations.
- A list of culturally-competent therapists is maintained.

Resources:

- About R2MR - theworkingmind.ca/working-mind-first-responders
- York Regional Police - www.yorkbeyondtheblue.com/
- Summary of Road To Mental Readiness (R2MR) Evaluation Results - www.oapc.ca/wp-content/uploads/2016/09/Appendix-A-R2MR-April-2016.pdf

*The program name was changed to The Working Mind First Responders on December 12, 2018.



Mental Health Continuum Model pocket card, Road to Mental Readiness Program - theworkingmind.ca/working-mind-first-responders

Challenges and Opportunities for Supporting First Responders and Custody Officials

Moderator:

Ashley Mills, MS - Senior Researcher, Mental Health Services Oversight and Accountability Commission

Panelists:

Charles Dempsey - Detective III, Officer in Charge, Admin-Training Detail, Mental Evaluation Unit; Crisis Response Support Section, Los Angeles Police Department

Matt Garcia - Officer, Sacramento Police Department; Commissioner, Council on Criminal Justice and Behavioral Health

Steven Sultan, PhD, ABPP - Director of Bureau Operations, Psychological Services Bureau, Personnel Command, Los Angeles County Sheriff's Department

Dean Borders - Warden, California Institution for Men, California Department of Corrections and Rehabilitation

Katherine Minnich - Deputy Director, Human Resources, California Department of Corrections and Rehabilitation

Pat Green - Executive Director, First Responders Support Network; California Highway Patrol (Retired)

What causes stress for your staff today?

Matt Garcia - Technology, such as video, worries our officers because an action we may take that is moral and appropriate for the situation could be misconstrued by society and distributed on social media. The result might be that the department then would be unable to protect the officer because it must respond to the community. Additionally, the officer's friends and family could be impacted by fallout in social media. Law enforcement officers want transparency but the level of exposure and risk they might endure if they're involved in a critical incident that becomes viral is a source of stress. Officers may start to have problems earlier in their careers today because of animosity from society.

Charles Dempsey - There are some generational differences but there are still a lot of common fears between the older and younger generations. The difference is that the younger generation is more open about those fears. Officers need to feel that their departments support them and that responses to their actions are fair. The younger generation more often asks why when they are given a task or order. This can be seen as entitled but many of them have good ideas. For example, the openness to talking about mental health is a positive change the younger generation is bringing about.

Katherine Minnich - California Department of Corrections and Rehabilitation (CDCR) deputies are isolated during the day and not thanked very often. Most have very long commutes, which allows some to decompress, but does not work for others because it makes their days longer and prevents them from seeing their families. Also, younger staff communicates in a different way than the older generation - for example, they text more often than using other forms of communication.

Steve Sultan - It is interesting to see how the generations view mental health differently. The younger generation finds mental health care to be an entitlement, not something to be hidden.

Pat Green - The First Responder Support Network (FRSN) is seeing younger people come in for help earlier in their careers. If departments can help them be more resilient early on, they're more likely to be able to stay on the job to a healthy retirement. Besides taking better care of their employees, this would save money for departments in the long run.

What is your organization doing (or what should they be doing) to assist your staff after they experience a traumatic event?

Katherine Minnich - CDCR health and wellness initiatives have both physical and mental components. Improvements for physical health include increased availability of affordable and easily accessible healthy food, and gym equipment and massage chairs in many facilities. For mental health, staff receives stress resiliency and suicide awareness training in the Block training and in the academy. CDCR added an 8-hour correctional fatigue component to the Block training, which has been helpful in reducing stigma around mental health. To provide support after retirement, CDCR is looking to increase the involvement of retired staff in their peer support teams. CDCR is working closely with its EAP, CALPERs, State Fund and health plans to increase the availability of mental health care. CDCR is also vetting certain substance abuse programs specifically for first responders; emailing wellness tips; and working on a digital display that will push out wellness information.

Dean Borders - First responders experience an adrenaline rush with each call and they need to learn how to deal with that

stress and how to transition down. CDCR also holds a Staff Support Day, bringing together family members to teach them about what deputies go through and why they might react to normal daily things the way they do. It also helps the staff members understand that they've changed and that it's ok to talk to someone, such as a therapist, about what they've experienced on the job.

We have been talking about the role of the employer in promoting a healthy workplace and environment. How does your agency build resiliency?

Charles Dempsey - After 18 months on the job, the Los Angeles Police Department (LAPD) brings officers back for training, which includes additional police skills, mental health information and resiliency tools. Now that we're giving this training to new staff, we need to think about how to better support officers who were hired before it was implemented.

Matt Garcia - We have peer support, work out time and a fitness coordinator. We're good at dealing with officers who experience a critical incident but we are just starting to recognize that support is needed for staff who are burned out or have a moral injury. We also encourage healthy ways to decompress by organizing staff outings.

Steve Sultan - We have a unit dedicated to psychological health and welfare for staff including 21 psychologists and 2 deputies. It provides 24-hour emergency services for staff and their families. Our department offers treatment services in clinic settings, the organizational development unit provides trainings, and the operational support unit offers information and training regarding how officers can do their jobs better and affect better outcomes. Psychologists are required to spend time in the units and in operational support so that staff sees them as part of the team. We use a 3-tier approach: prevention, intervention, and treatment. You can reach more people in the intervention phase, starting with the high-functioning group after traumatic events, than the treatment phase, which will be just one person. Prevention reaches the largest amount of people and includes trainings about early warning signs. We also integrate information about officers' own mental health into trainings about other topics related to their work.

Q & A

Q - What metrics are you using to determine the effectiveness of your initiatives?

Katherine Minnich - We are careful about tracking information so we don't get resistance from staff. Regarding peer support, we have a system where call-outs are tracked and categorized into types, such as stress or substance abuse. These are reviewed annually to determine what changes are needed in trainings. However, the initiatives are fairly new so there is not yet a lot of data to draw upon.

Dean Borders - Although anecdotal, I have seen results first hand as to how well peer support has worked.

Q - Are suicides increasing or decreasing? What about absenteeism, worker's compensation claims, calls to assistance lines?

Katherine Minnich - We have collected completed/attempted suicide numbers for the department but it is difficult to know whether the numbers are accurate. We can pull numbers from worker's compensation records but things aren't defined as we think they would be in the system. For absenteeism, it's hard to know if someone is out for illness or vacation. But, if the rate decreases over time, it might be an indication that the initiatives are working.

Pat Green - Suicides can be significantly underreported. It might be because a department decides to rule it an accident for the benefit of the family. This may be compassionate but makes suicide seem like much less of a problem than it really is.

Q - Will what we know now about wellness influence who and how you recruit?

Katherine Minnich - We will integrate it in training new recruits but we haven't yet determined if it will change who is recruited.

Charles Dempsey - We have changed who we recruit from the warrior mindset to the guardian mindset. That being said, recruitment is down and has been difficult due to a strong economy in other fields.

Q - Regarding metrics, have you thought about using something like the Maslach Burnout Inventory? You could compare scores to people in other units who have more routine work.

Katherine Minnich - I'd be interested to learn more.

Charles Dempsey - The LAPD recently did a survey with union backing but officer participation was very low so it was skewed as to those who were willing to share.

Q - Pat, you're seeing people in severe distress at FRSN. What type of things come up for the first responders attending your program? What should we focus on upstream that eventually becomes a problem later?

Pat Green - This would be difficult for agencies to address but we see a high percentage of first responders who experienced physical and sexual abuse as children. We're also seeing complex trauma with many critical incidents, which is harder to treat, and might be something agencies could work to reduce. Or perhaps increased resiliency would mitigate some of the impact of so many traumatic experiences.

Any final comments or recommendations?

Pat Green - We would like agencies to front-load training about resiliency and continue it throughout employees' entire careers as they have traumatic experiences and differing needs. We want Post-Traumatic Stress Injury (PTSI) to be a presumptive injury and we'd like privilege for peer support members.*

Charles Dempsey - We need to normalize the conversation about mental illness and distress. Those of us who have experienced mental illness need to talk about it. At the LAPD, we start right away in our trainings by modeling it ourselves. It sets the tone of the conversation and makes it normal to talk about. This helps build resiliency.

We don't do a good enough job taking care of retired first responders, particularly when they've been injured on the job. They need access to behavioral health services and support systems that are more robust than we have now.

Dean Borders - At some point, officers became social workers as well as law enforcement officers. It would be good for officers to know that from the beginning. It's hard for new officers to switch gears when they don't even know they're supposed to be doing something different.

Katherine Minnich - Watch what other states are doing, listen to your staff to find out what's working, what isn't and what's needed. Know that this will evolve over time and will improve as changes are made.

Steve Sultan - Stigma around mental health is not specific to first responders. Eighteen percent of the general population would qualify for a diagnosis of a mental illness but only 6% seek mental health assistance. These are similar to the rates we see in the first responder population.

Resources:

- Code 9 - Officers Need Assistance - www.youtube.com/watch?v=jO01Qeg15KU

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*There was extended conversation about privilege, what it means legally, what it means for law enforcement officers and what is required within agencies. The following is a summary of the discussion.

In a healthcare setting, privilege belongs to the patient, not the doctor, according to state and federal law. Psychotherapist-client privilege is in statute but is not as all-encompassing as attorney-client privilege. Attorneys cannot be compelled to testify about thier clients but healthcare practitioners can be compelled to testify in a variety of proceedings by court order. If there is a subpoena from an attorney, psychotherapists do have to respond but do not necessarily have to comply. If a judge orders a psychotherapist to appear in court or produce client records in court, compliance may be required.

Peer support members act in a quasi-mental health professional role but they are not protected in statute from having to disclose information received as a peer support member. Recently, some states have passed legislation giving peer support a higher level of confidentiality. A recent California bill on peer support privilege was vetoed. Importantly, a statute defines what peer support is and that it is more than simply when two staff members are socializing.

Peer support members are volunteers and most departments have a confidentiality clause in their policies regarding peer support disclosure. However, there are certain limits because of what peace officers are legally bound to disclose and act upon. Departments may also use "informed consent" regarding what is and is not covered under privileged confidentiality. Especially if a peer support member is a supervisor, there are certain things they must disclose, such as misconduct or criminal behavior. Furthermore, if a peer support person is accused of breaking confidentiality, it could impact their ability to testify.

Call to Action: Words INTO Deeds - Next Steps!

Moderator:

William Arroyo, MD - Medical Director, Children's System of Care, Los Angeles County Department of Mental Health; Professor, USC Keck School of Medicine

We know that many emergency responders will become depressed, have severe anxiety problems, develop Post-Traumatic Stress Disorder (PTSD), and develop substance abuse issues as a result of the work they do for our communities. This session was an opportunity for *Words to Deeds* participants to brainstorm strategies to better support the wellness of emergency responders.

To identify those in need, would it help to mandate the use of assessment tools to screen responders for these problems and proactively get them assistance? There would certainly be pushback from unions, and likely other complications.

- In correctional settings, having a mandate to do something is very important. But, mandates aren't always helpful, there must be incentives. First, it's hard to sell making improvements in human services without data. For example, if we have data about a baseline suicide rate, we can apply that to our departments and work on improving our rate compared to the baseline. Second, having a policy statement from the highest leadership level that wellness is valued will make a difference and may have more impact than a mandate.

Would a policy statement from all of the organizations represented in the *Words to Deeds* Leadership Group make a difference?

- That would help, as well as something from policy makers, the Department of Finance, and others. Is there a model policy for peer support that organizations can use and that can be used to inform legislators? We also need financing to support the recommended increase in training and programs such as R2MR.
- Pillar #6 in the federal report on 21st Century policing is Officer Wellness and Safety. It states that this is critical to officers themselves, their colleagues, their agencies and their communities. Many of the major agencies around the country are striving to implement these pillars. Most recently, the Law Enforcement Mental Health and Wellness Act was signed into law, awarding Community Oriented Policing Services (COPS) Grants to counties.
- Do we need a state statute, with funding, to implement a wellness model for emergency responders statewide?

Has the LAPD measured the effectiveness of its wellness initiatives?

- The Behavioral Science Unit would know more but, yes, they do report back on strategic goals.
- Independent evaluation is best practice and perhaps a local university could assist.
- Chris Cotton from Every Day Matters might have ideas about what could be done, particularly about getting an independent evaluation done. The Los Angeles District Attorney's Office is doing some work regarding what could be done policy-wise. Some of the people involved in *Words to Deeds* do legislative heavy lifting and might have ideas about what could be done. We should reconvene when we can have the right people in the room who would know what is needed legislatively.
- There will likely be a piece of legislation with funding proposed at the beginning of the year by our new Governor to deal with our forest fire situation. Part of that money should be used for the health and wellness of our first responders. What I've heard today is that EAPs and managed care plans aren't equipped to deal with this problem. Perhaps people who have jobs where they are exposed to trauma should get an additional mental health benefit. This should be an urgent issue to be discussed with the Governor so it can be part of the legislation proposal.
- This legislation is in Newsom's Behavioral Health Platform. It is very comprehensive and covers much of what we've been discussing. The Prevention and Early Intervention section discusses treating brain illness in Stage 1 rather than waiting until Stage 4. It specifically states, "integral to this push we will launch a campaign to train our teachers, counselors, first responders, and pediatricians on how to recognize early signs of mental illness."

Maybe we need to have a hearing in Sacramento. How do we make some of these recommendations real?

- There is always a desire to introduce legislation and then a program is created that misses the mark because the analysis of the problem wasn't done at the beginning. What struck me from the panel earlier was how little data we have to even

define what the problem is. If you're not able to measure it, it's hard to manage it, and it's hard to get any money for it. The numbers are there, perhaps underreported, but you need to utilize them to make a case that there is a problem that needs funding and prioritization. Second, there is assistance available to support employees. Are they not being utilized or are they not working? We need evidence to determine where the problem is. Third, in terms of what kinds of policy changes are needed – do we create a new program, do we adapt what's working already, do we even know what kinds of programs are already being implemented? It's not the first time we're seeing this type of situation - but we need the data to inform a policy discussion.

- What if we approach the mental health caucus?
- If you are going to do an ask – you need to be very careful and specific about what you want, otherwise they will use it to cover what they want and other issues will be brought in. Be very targeted.
- Regarding data, one of the measures we used when we first implemented Employee Assistance Programs were penetration rates into the employee population. That meant we needed to have someone working on getting the resource out to employees and monitoring the response. You could take that rate from department to department to measure implementation effectiveness. It can also be used as a success measure in a grant to incentivize good implementation.
- It is a good idea to recruit supportive family members and educate them about what are common reactions to stress, given that someone close to them has been exposed, so they can support the first responder at home and find professional help. If there's a wellness program that includes family members, that may go a long way.
- We could recommend the next round of MHSOAC funding be given to this population for this purpose. Further, some departments or types of agencies, such as fire, might have greater need for additional funding because they are set up differently from police departments.
- Support is needed for families and, specifically, the children of first responders – not only because of traumatic incidents but the potential for them to be targeted after a viral critical incident. It would be good to include them in the funding from Governor Newsom's legislation. We need to identify the right people to speak to the Governor about this.

- The MHSOAC is involved in an effort to develop a voluntary workplace mental health standard.
- I urge us in our work to speak specifically to substance use disorders because there is a lot of stigma around it. Behavioral health isn't always understood to include substance abuse.
- We can explore a work group for this subject area and solicit participation from attendees today and our *Words to Deeds* list in general, upon release of the *Words to Deeds XII Report*.

Resources:

- Getting Serious About Mental Health, Gavin Newsom - https://medium.com/@GavinNewsom/getting-serious-about-mental-health-8c09ad95a5ae
- 21st Century Policing Report - https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf

Pre-Trial Felony Mental Health Diversion Programs

Moderator:

Brenda Grealish - Acting Director, California Department of Health Care Services, Mental Health and Substance Use Disorders Services

Speakers:

Stephanie Clendenin - Acting Director, California Department of State Hospitals

Katherine Warburton, MD - Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals

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In 2012, the Department of State Hospitals (DSH) began seeing a precipitous rise of Incompetent to Stand Trial (IST) referrals, soon realizing it was a statewide problem. Since then, the rate of increase has not slowed. At that time, DSH was receiving an average of 232 referrals per month with 348 individuals pending placement. Last year, it was receiving 372 referrals per month and had an average of 819 individuals on the waitlist.

Improvements

To deal with the problem, Acting Director Stephanie Clendenin reported that DSH has implemented many changes over the past 6 years, including increasing capacity, improving system efficiency, and working to understand what is driving the increase. These changes have helped grow the number of patients being treated for IST from 4,000 to over 5,800 per year.

Capacity

- Activated 411 beds for IST referrals in the state hospitals.
- Opened 249 beds for competency restoration in county jails throughout the state. Continuing to expand capacity in this area.
- Established an admission, evaluation and stabilization center operating out of Kern County with 60 beds.
- Increased the number of forensic beds by 236 at Metro State Hospital, expected to be completed in spring/early summer.
- Initiated a partnership with Los Angeles (LA) County to establish community-based restoration opportunities for up to 150 individuals.

System Improvement

- Centralized the referral process to the Patient Management Unit where referrals are reviewed and the best location for treatment is determined.
- Developed a patient reservation tracking system which manages bed reservations and the statewide waitlist.
- Reduced average length of stays for IST patients – it is now 152 days, down from over 200. Jail-based competency restoration programs are designed for short stays, the average being 69 days. Those who need a longer stay are sent to DSH.

Legislative Changes

- AB 2186 - Involuntary medication orders and court reports.
- AB 2625 - Those who cannot be restored to competency are returned to court within 10 days. This ensures beds open up for new patients more quickly.
- AB 1187 - Reduced the maximum IST commitment from 3 years to 2 years.
- AB 1810 - A budget trailer bill included language to allow the court to order the reevaluation of a person who has been referred to DSH for restoration and for that person to be deemed restored without going to DSH.
- $100 million has been allocated for mental health jail diversion programs designed to redirect individuals with mental illness into treatment.

Understanding the Demand

A longitudinal national research institute study released in 2017 documented a 72% increase of IST individuals in state hospitals since 1999. Surveying 52 jurisdictions across the country, DSH Medical Director Katherine Warburton found that the steep increase in the IST population also was happening in many other states.

Combining all the different ways that IST patients can be admitted to a state hospital, more than 80% of respondents to the survey reported an increase in the IST population in their jurisdictions. Of the respondents, 69% had a waitlist and 41% were facing litigation as a result of that waitlist. Reasons for the increase given by respondants included: inadequate number of acute care mental health beds in the community, inadequate general mental health services, inadequate crisis services and inadequate assertive community treatment.

Dr. Warburton then analyzed data DSH has gathered for more than 10 years about the IST population regarding: demographic profile, clinical profile, treatment needs, and housing status at the time of offense. Forty-seven percent of IST admissions were people who had been unsheltered homeless at the time of their arrest. Presuming this population would be eligible, the data show that 47% didn't access any Medi-Cal reimbursable mental health services in the 6 months prior to the arrest.

The data showed that the prevalence of schizophrenia spectrum disorders is not increasing. Nor can population growth explain the level of increase of IST referrals. There was no appreciable difference in the diagnostic profile of this population, including no difference in substance abuse diagnosis. What did change, however, is the number of people being admitted with 15 or more arrests, which grew from 15% of admissions to over 45% of admissions in the last 10 years. Looking at arrest records, it does not seem to be related to realignment. Instead, many of the arrests seem to be related to untreated mental illness or to conditions of homelessness. The data paint a picture of people with serious mental illnesses being arrested on many misdemeanors over time and eventually being arrested on a felony.

Dr. Warburton and her staff hypothesize that individuals with schizophrenic spectrum disorders are drifting into untreated, unsheltered conditions due to a lack of mental health and social services. These conditions are then leading to increased contact with police and, consequently, criminal charges and the surge of IST referrals to DSH.

Further compounding the problem, litigation may result in very hefty fines that exacerbate already underfunded services or in mandated admission of IST patients to DSH. The result can be unsafe and inhumane conditions.

Jail Diversion

Although capacity and efficiency improvements have been made in attempting to treat the large numbers of referrals, IST restoration is not a substitute for mental health treatment and comprehensive care. Instead, the long-term solution is to provide mental health services to this population in the community.

As part of that solution, $100 million was allocated in the 2019 state budget to be used over three years for pre-trial, post-booking diversion programs with the goal of increasing diversion opportunities for those likely to be found or have been found IST on felony charges. In partnership with counties, these programs will provide evidence-based community mental health treatment with the wraparound services these individuals need to be safely treated in the community.

The target population has a history of arrests, homelessnesss, and often not accessing Medi-Cal services, primarily with diagnoses of schizophrenia, schizoaffective disorder, and bipolar disorder. Because there is a correlation in this population between the symptoms of mental illness and/or conditions of homelessness and incident offense, these people do not pose a significant safety risk if treated in the community. Some can be safely treated in unlocked residential programs while others might need more secure housing. For those being treated in the community,

services might include Forensic Assertive Community Treatment, intensive case management, criminal justice coordination, crisis residential services, peer support, supportive housing, substance use disorder treatment, vocational support and whatever else is needed.

The statute allows funding to be used for post-booking assessments to identify individuals who may be appropriately treated in a diversion program along with up to 15 days of treatment in jail pending transfer to a community program. Outcomes of the programs will be tracked.

Ninety-one million dollars of the funding has already been awarded to the 15 counties with the most number of IST referrals to DSH. The remaining $8.5 million will go to other counties. There is a 10% matching requirement, depending on county size.

Q & A and Audience Comments

Comment - In the past, defense attorneys were averse to utilizing competency procedures for a variety of ethical and practical reasons, especially for a misdemeanor. They now see the declaration of doubt as a mechanism for diverting mentally ill individuals away from the criminal justice system and into the mental health system. This trend will probably continue to increase and many providers are not ready for it.

Comment - Incompetency commitment itself does not have a mechanism to attach individuals to long-term care. The objective that everyone has - whether a defense attorney, prosecutor or

judge - is to keep people from returning to the criminal justice system after the conclusion of the immediate case. That presupposes the availability of long-term care and engagement with an individual who has been diagnosed with chronic mental illness. No one yet has proposed a solution to that because there is no connection to long-term care or housing after the conclusion of the criminal case, with the exception of Hoffenberg and Murphy conservatorships, which are very small populations. I believe the next challenge is figuring that out. We simply don't have enough long-term care capacity, whether it is facilities, providers or housing.

Comment - Clarification: in discussing IST diversion, it is penal code 1001.36. So, even with funding new diversion programs, an IST patient would have to meet the eligibility requirements of 1001.36 to be admitted into a diversion program and diversion would still be discretionary, meaning judicial officers would have to agree to let individuals into the program.

Q - This diversion funding represents an opportunity to start to knit together short-term and long-term care. Hopefully that's what counties are trying to work out. The rub is getting this population appropriately treated in the community. It will be interesting to hear LA's experience with the IST outpatient program in the next presentation. There are people concerned about allowing those charged with a felony to move into a community program. Do you have any thoughts on that?

Katherine Warburton - I think that's a legitimate fear in a general sense. As we talk to counties, what we're hearing from across disciplines, including officers of the court and district attorneys, is that they often know who the IST individuals are. They know that if these people were treated with antipsychotic medication, had housing and intensive case management, they wouldn't pose a significant safety risk. We're targeting 20% of the IST population who aren't violent offenders and whose offenses were related to untreated psychosis and unsheltered homelessness, not a criminogenic drive to hurt people.

Q - One of the statistics you gave is that 47% of ISTs didn't access mental health services 6 months prior to arrest and that was based on Medi-Cal usage. What about people who are 5150'd and being put in acute inpatient facilities? They wouldn't be accessing Medi-Cal because of the IMD exclusion. Were all of those people not 5150'd during the 6 months prior to their arrest?

Stephanie Clendenin - We didn't look at 5150's specifically but we did look at emergency room services, which can be considered a proxy if someone went to the ER with a psychiatric issue. We are not seeing people who have been going into acute treatment facilities.

Comment - I believe the IST explosion and the increase in the number of people with mental illness in jails and prisons is due to the lack of access to and lack of capacity of acute care, subacute care and IMD care. If someone with mental illness is being released from a facility after 2 or 3 days, they're not really getting treatment and this is at the root of the criminalization problem. Thank you for your research on this.

Comment - Jail diversion is reactive, not proactive, and it's not enough. We need adequate acute and subacute care and enough capacity. Funding from the Mental Health Services Act (MHSA) is up probably 50% and mental health realignment funding, when it's not being cut, is flat at best. The recent announcement by Centers for Medicare & Medicaid Services (CMS) was about waivers of the IMD exclusion so we could build enough care that is acute, subacute and IMD. I'm not talking about reinstitutionalizing people with mental illness. But what I am saying is that we need a minimum capacity of acute care. We've starved the preventative services and we must increase that capacity. We also should bring recovery into hospitals, IMDs and subacute settings while we're expanding it.

Katherine Warburton - You're absolutely right, the answer to the problem needs to be proactive and preventative. My point is that the answer to the acute IST waitlist crisis is diversion. The answer to preventing the criminalization of individuals with mental illness must be, as you say, much more proactive. Maybe jail diversion happens at that first intercept. We did look at the issue of acute patient hospital bed capacity because this was cited in our survey as the number one reason for the problem. We found in Organization for Economic Cooperation and Development (OECD) economic data that the average number of psychiatric beds internationally is 71 per 100,000 people. The

Treatment Advocacy Center expert consensus recommendation is 50 beds per 100,000. We found that in the US, there are 22 beds per 100,000 and, in California, there are 17 beds per 100,000. We also found a paper on police discretion that notes the single most important factor in a police decision about whether to take someone to the emergency room or the jail had to do with whether the officer thought the person would get a hospital bed if they went to the ER.

Brenda Grealish - We need to get people who are newly diagnosed directed to a totally different path. One opportunity I see with the diversion program is in bringing people together who haven't worked together before. Also, I'm hearing that people are staying in jail because there's no step down in care in the community. From the county perspective, why would a county want to spend so much money for this population in their jail system and not reorient the funding to community-based services? Even with Federal Financial Participation (FFP) not available, community services have shrunk over the years. Why aren't counties thinking that they're spending way too much keeping people with mental illness in the criminal justice system?

Comment - There is a disconnect in Sacramento. We need people like you to educate our legislators. Also, we need to stop the arguments between recovery and intervention with higher levels of care for people who are more seriously mentally ill.

Brenda Grealish - I understand the fear about intervention because of some things people have experienced. But people do want to be healthy, cared for and part of our communities. How do we develop a system that does that? As we move into our waiver discussion, with the 1915B waiver being renewed in 2020, this is the kind of stakeholder input we'll be seeking.

Comment - Regarding how officers make decisions about where to take someone, in rural areas, a hospital may be 2 hours away and the jail is just a lot closer. Even if they would like to take them to a place for treatment, sometimes it makes more sense to go to the jail. In your research, I would encourage you to look at where the pockets are regarding either a lack of resources or a lack of training. Each agency has a unique identifier on the arrest or criminal justice reports so you can find where services are inadequate in particular communities.

Comment - We definitely need more beds but I also want to point out what Assertive Community Treatment can do. A lot of people won't meet the criteria or it will be a stretch to meet criteria, and they will be admitted to the hospital and maybe get somewhat well in a week or 10 days. Then they may be released in the community where all the progress may be frittered away. Working with someone in the community, often under circumstances you wouldn't choose for them but they have chosen, and moving them toward a different idea for themselves, may be slow and difficult work. However, I have an overwhelming sense that this is where the bulk of the work will have to take place. People who require locked psychiatric placement, I contend, will be a relative minority. Finding a way to work effectively with people in the community, who are reluctant and resistant to treatment for any of a number of reasons, is really essential. And if we can demonstrate to our judges and district attorneys that we can manage people safely and effectively in the community, then it will ease the fear. There will be setbacks with cases when we try to intervene and it doesn't go the way we want but over time we will hopefully engender that confidence and make the system work a little better.

Meeting the Challenge: Los Angeles County

Introduction:

Dave Meyer, JD - Clinical Professor, Institute of Psychiatry, Law and Behavioral Sciences, USC Keck School of Medicine

Speakers:

Hon. James Bianco - Site Judge, Los Angeles Superior Court Mental Health Court

Peter Espinoza - Director, Los Angeles County Office of Diversion and Reentry

Kristen Ochoa, MD, MPH - Medical Director, Los Angeles County Office of Diversion and Reentry; Associate Clinical Professor, UCLA David Geffen School of Medicine

Having started with existing funding and personnel, the Los Angeles County Office of Diversion and Reentry (ODR) is an illustrative example of the *Words to Deeds* ethos. Seeing that the status quo of jailing people with mental illness and trying to treat them there was not working, the members of this panel presentation, along with others, decided to make a change. Los Angeles County District Attorney Jackie Lacey's Mental Health Advisory Board developed a *Blueprint for Change*, which included a recommendation for a county office to divert people with mental illness from the criminal justice system. The Board of Supervisors was supportive of the idea and the ODR was created in 2015. It opened with a program to provide community-based restoration for misdemeanor defendants who are Incompetent to Stand Trial (MIST). It now also includes programs which divert pregnant women, provide permanent supportive housing for people charged with felonies, provide

community-based restoration treatment for felony defendants, and perform competency evaluations and restoration treatment while people are on the DSH waitlist.

The success of the ODR and its MIST program was due to recruiting the right people to be in the room with the attitude that the status quo was unacceptable. There were hurdles, and changes were needed along the way but they were always met with finding solutions. The Los Angeles Police Department (LAPD) made changes to its data system, the Los Angeles County Department of Mental Health (LACDMH) provided housing, and Special Services for Groups (SSG) proved that Full Service Partnership (FSP) providers would work with the justice-involved population. LACDMH provided competency training and initially provided all of the FSP slots. The jail mental health treatment team identified about 40% of the MIST population in the LA County Jail who could be released immediately for community treatment. All the partners, including attorneys, the National Alliance on Mental Illness (NAMI) and court clerks worked together to achieve success. Sometimes roadblocks were most easily overcome by working with an agency's line staff.

ODR programs provide services to clients depending on their individual needs, ranging from very structured care with many services to services within clients' homes, though that is a rare occurrence. For the most part, people go into the ODR housing programs, which are structured with clinical services, and many are on long-acting injectable anti-psychotic medications. Some first need to go to the acute inpatient hospital for stabilization. When clients reach the maximum commitment time in the IST programs, they are transferred to permanent supportive housing, which does not have a time limit.

Although the ODR has diverted 2,539 people since its inception, the number of jail inmates with mental illness continues to be a problem and the IST population continues to rise.

- In 2015, 130 people were being treated in the jail for misdemeanor competency restoration.
- Today, there are approximately 130 people in community treatment and approximately 250 people being treated in the jail.
- There are currently over 5,000 people in mental health housing in the LA County jail.

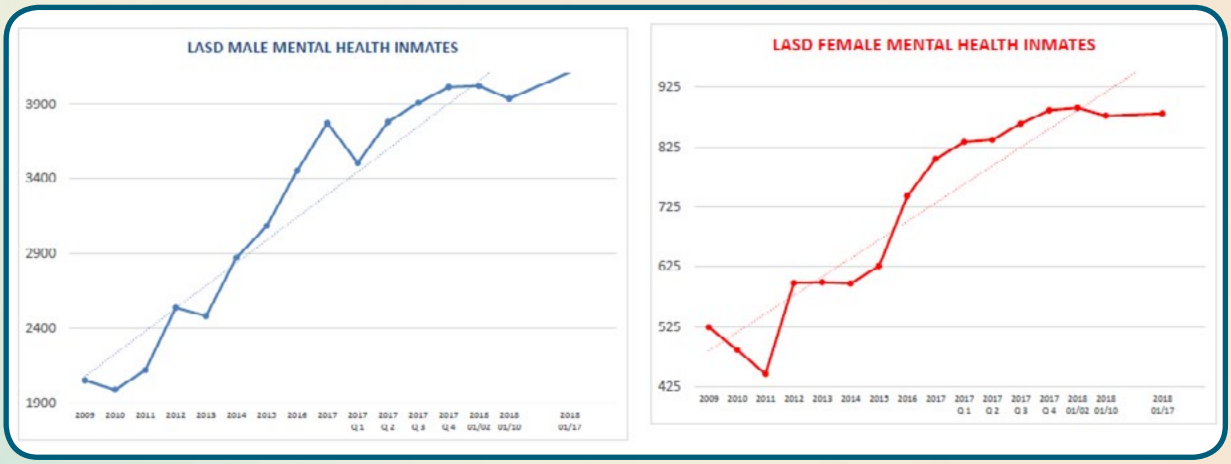
ODR is working on increasing capacity to accommodate the need but they have a very lean staff, as does one of their main partners, Housing for Health. Hoping that more funding can be appropriated, the ODR is partnering with RAND and UCLA to determine how many people in the jail are divertible. They plan to present their findings to the County Board of Supervisors.

Q & A and Audience Comments

Comment - This is a partnership among public agencies, private individuals and private entities of various kinds. We were lucky in LA to have available resources and the force of will to use them. Involved in this program is the experienced provider agency, SSG, who was able to provide services with existing resources and eventually was able to utilize Medi-Cal. SSG also had a good deal of experience with another reentry court operated by Judge Tynan so they knew what was needed with this population. This program is managing to get people into long-term care after their IST commitment is done.

Q - Can you speak to the relationships you've developed with probation or other supervising entities? Are your patients in a mental health court diversion program with community supervision? Has anything made that relationship stronger and more effective?

Kristen Ochoa - The majority of our clients are on formal probation and that is an important component of the permanent supportive housing program. Supervision is what makes everyone feel comfortable about releasing people for community treatment and allows us to take more serious cases. ODR Probation is very collaborative and understands the different approach needed for this population.



www.fmhac.net/uploads/1/2/3/9/123913996/community-based-restoration.pdf

Q - What is the flow and timeline for someone going through your program's levels of care?

Kristen Ochoa -Typically, if they don't need to go to an acute hospital setting first, clients go to interim housing for some period of time until they are stable enough and housing is available. This is usually about 6 months to a year at which time a case manager will help them look for supportive housing or apartments for those who are high-functioning. We have a new partner called Brilliant Corners who is working with us to establish new housing and find apartments.

Q - Are there any inspections happening to verify that the housing units you're using are healthy environments?

Kristen Ochoa - Yes, ODR and Housing for Health have very high standards. We are present at the sites very frequently. Case managers also feel comfortable calling ODR if there are any problems. We control the contracts and we hold them to high standards.

Q - Can you share any of your outcome data?

Kristen Ochoa – I can share some data but these are not official numbers. We compared our first 100 MISTs to people who went through that program before our services existed. It was found that the program is cost-neutral, meaning taking people out of custody and putting them in services didn't save money but it also didn't cost additional money. The difference is that the costs for people not in the program were associated with ER visits and inpatient hospitalizations whereas the costs for people in the program were outpatient services. From a public health perspective, this is a positive effect.

We have about a 75% housing retention rate in our pretrial permanent supportive housing program. The rate of new felonies in that program is 11%. Rearrests are part of this process, such as being violated for walking away from housing, but new offenses are concerning.

Peter Espinosa - One thing that has been important to the success of this program is the progressive and supportive Board of Supervisors, which is always looking for ways to improve our ability to do our work. Second, the partnership with Probation has been incredibly important. It makes our justice partners more comfortable with the work we do, which is mostly in the criminal courts not the mental health court. Our Probation partners understand their duty to inform the court when people violate their probation but they rarely ask that people go back into custody as long as we can keep them stabilized and in housing. Third, Dr. Ochoa has been very successful at educating our justice partners on the importance of the harm reduction model, which informs all of the work we do. The court's goal now is to stabilize this population in housing and it understands that clients may still use substances because of their behavioral health needs. We work closely with our sobering center so when people get a little out of control in the housing units, they don't have to go back to jail. This education of our justice partners is one of the most important contributions to the success of this program.

We recognize that community-based restoration is not a long-term solution but our permanent supportive housing is a long-term solution, with intensive case management, to reduce the rate at which this population recidivates. We continue to look for ways to expand the program and expand the collaboration with LACDMH.

Q - In what ways are the practices of Public Defender's Offices counter-productive to the goals of ODR? In what ways could Public Defender's Offices engage in practices that would be more supportive of the goals of ODR but still be consistent with ethical obligations to our clients?

Hon. James Bianco - The one thing that could be improved, though it's probably in part due to understaffing, is the sense of urgency about getting a client into treatment and out of jail. The more people feel that urgency and do not accept the status quo, even with just one individual, the faster this problem will be alleviated on a bigger scale.

Dave Meyer - I appreciate the anxiety that all lawyers in this role have with respect to dealing with the constitutional rights of individuals who have mental illness and are caught up in the criminal justice system. Ethically speaking, it is really tough because there is no flexibility in the rules related to professional conduct for lawyers representing individuals who have serious mental illnesses and shouldn't be in the system at all. What I can tell you is there is a responsibility to get the right thing done for the client. To its great credit, the California Supreme Court has

approved a new set of rules of professional conduct that are based on the American Bar Association (ABA) model rules, just now going into effect. They have always had a nationwide perspective and you would think that because of the impact of collaborative courts and the various community-based practices that public defenders have created in the last few years, that the new model rules would provide some comfort to public defenders. In fact, the Supreme Court of California approved this set of rules based on the ABA model rules with one exception – that was the rule related to representing people with mental disabilities, rule 1.14. The version of rule 1.14 that had been proposed to the Supreme Court had flexibility in approaching the attorney-mentally disabled client relationship. But, for unknown reasons, the Court deleted the language and left the issue unclear. So, it's not there in the California rules and that presents an ethical conundrum for an attorney representing a client with mental illness. I don't know what a complete answer is, but I know it's worth working out because I've seen things like this MIST program work out to the benefit of individuals to keep them out of the criminal justice system and in treatment.

Kristen Ochoa - There is absolutely a tension here but I think there is a culture shift happening among defense lawyers that is going to change that. You can see it more in the mental health court where there's an understanding that getting your client the lowest possible sentencing terms and getting them out of jail with no strings attached is actually not helping in the long run.

Kit Wall - We've talked about doing a *Words to Deeds* conference focused on attorneys and judges. Los Angeles County District Attorney Jackie Lacey has organized a mental health committee for district attorneys and we've discussed doing something with a state organization.

Comment - As a provider of long-term care, I'm glad to hear that supervision is part of your program and I think more people and providers need to get that information. My question is, what is the plan for outside providers? What are you going to look for? Right now I get calls for permanent housing. In the future is there going to be something else? I think not knowing is what's causing some fear for us in the Veteran's Administration (VA).

Hon. James Bianco - The more integration there can be among service providers, for example the VA and ODR, the better. Long-term outcomes are dependent on getting someone quickly into a healthy, productive situation of their own choosing. I also think supervision is a key piece that we haven't completely built yet. At the moment, we rely on the court to provide supervision but, in a perfect world, it may be served by some other entity.

Kristen Ochoa - Some providers in the county won't take veterans because they think vets have other service options available. That is not our approach. We take veterans, put them in our services, get them settled out of jail and then attempt to access VA services. We try to be the office of "yes" and not turn anyone away.

Meeting the Challenge: Information & Tools - Ask the Experts

Moderator:

William Arroyo, MD - Medical Director, Children's System of Care, Los Angeles County Department of Mental Health; Professor, USC Keck School of Medicine

Speakers:

Kathleen Lacey, LCSW - Program Director, UCSF/Citywide Case Management

Mary Marx, LCSW - Clinical District Chief, Countywide Resource Management, Los Angeles County Department of Mental Health

Judi Nightingale - Director, Population Health, Riverside University Health System

Countywide Resource Management, Los Angeles

Countywide Resource Management (CRM) manages urgent care programs, enriched residential programs, and Full Service Partnerships (FSPs) for justice-involved individuals with mental illness in Los Angeles (LA).

Urgent care programs are an important component of caring for individuals with mental illness, particularly those coming out of jails or prisons, who have acute needs. The CRM urgent care programs identify people in jail who need their services upon release. Patients are then evaluated for an acute inpatient bed and, if a bed is not available, the patient may be moved to a county hospital inpatient unit. CRM urgent care programs have locked units as well as a unit for registered sex offenders.

CRM enriched residential programs are set up to accept people directly from custody, the urgent care centers, or the probation hubs, which have mental health clinicians. The enriched residential programs provide intensive mental health and substance abuse treatment with augmented supervision in certain board-and-care facilities. Beverly Qualified Healthcare provides healthcare on site.

CRM's FSP programs are funded by the Mental Health Services Act (MHSA) and the Los Angeles County Department of Mental Health (LACDMH) recently developed a forensic FSP specifically for justice-involved individuals with mental illness. CRM also participated in the development and implementation of an assisted outpatient treatment program.

CRM works closely with the ODR on the MIST community restoration program with a streamlined process for referring people to FSPs and enriched residentals, sub-acute and acute inpatient units.

CRM collects data, including the number of people served, homeless status, service referrals, ongoing patterns of linkage and support, custody release dates, and recidivism information. Data is collected centrally and sent to programs where a client is referred so that patient information is passed on to where it is needed.

Important Elements

- It is necessary to take a holistic approach. Successful patient care must address mental health needs, medical needs, social needs and substance abuse needs.
- Basic needs must be met first. Patients in this population often initially require intensive treatment for the first few months. After that, case managers can work on reintegration into various systems, such as work and school.
- People in this population need financial stability. The Department of Public Social Services (DPSS) works with CRM to sign people up for benefits.
- It is necessary to train staff specifically about this population. CRM holds a minimum of 6 trainings annually on topics such as Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Moral Reconation Therapy, substance abuse treatment, trauma-focused CBT, and family therapy.
- Peer support is very helpful. CRM encourages its providers to use peers in its programs because they help sustain the client as they make progress in their recovery and stabilize in the community.
- Especially in later stages of community reintegration, it is important to help individuals identify natural support systems with meaningful activities, such as vocational, educational and employment opportunities, and groups to help prevent relapse and recidivism. All of CRM's providers are required to involve family, if appropriate, and connect clients to faith-based support in the community.

Barriers and Ineffective Approaches

The least effective approach for this population is to provide services on a piecemeal basis. Although they each have different tasks, it is very important for agencies to collaborate.

The main barrier in treating this population is housing. Treatment will not be successful if a patient does not have stable housing. In some cases in LA County, ODR provides housing and a CRM program provides the services. Alternatively, the Probation Department can provide housing through AB109 with services provided on an outpatient basis. CRM's housing funding is now being turned over to Housing for Health to achieve integration. They have better access to housing in the community with a lower bureaucratic burden.

Words of Wisdom

- A critical element of treatment for this population is encouraging empowerment. Clients need to restore their sense of self-respect and be encouraged to have self-compassion for their mistakes.
- Maintain collaborative partnerships with county departments, agencies and the courts.
- Reintegration needs to be a focus at all levels, including service providers.
- Not all clients can sustain treatment on an outpatient basis. Crises do not generally occur at a clinic; they occur in the community. It is important that providers and systems have the ability to respond to crises 24 hours a day.

Population Health, Riverside County

After surveying directors around the county, including the Probation Department, Sheriff's Office, behavioral health agencies, DPSS, and the Department of Public Health, Population Health determined that there was an unmet need for physical health care for people being released from custody. They sought and received $35 million over 5 years from the 2020 1115 Waiver for whole person care, providing the required match from MHSA Prevention and Early Intervention (PEI) funding. The grant allowed Population Health to hire 8 nurses for Probation sites throughout the county to provide health screenings for people recently released from custody.

Population Health has screened about 4,000 probationers and over 60% were referred to physical healthcare. Forty-five percent were referred for substance use treatment, 45% were referred to behavioral healthcare, and 25-30% were referred for housing. This demonstrates that physical health care in custody continues to be inadequate and it seems that many of those in custody do not know that they have a right to access physical health care.

In the Population Health program, probationers are screened for mental health and substance abuse needs, offered a variety of health tests, and their medication supply is evaluated. Nurses also assess probationers' housing situations and route anyone without stable housing to a housing outreach team. The team helps

clients apply for social services such as Medi-Cal, CalFresh and cash aid as well as arranging housing. Referrals from Probation centers are tracked to ensure a successful hand-off. Probation is notified when clients do not attend referral appointments and uses a non-punitive model with this population to help keep them from returning to jail.

With Department of Health Care Services (DHCS) funding, the main goals are to get this population into healthy homes so they can avoid using emergency rooms (ERs) as their source of primary care and to reduce recidivism. To achieve these goals, it is important to identify needs early. The most effective element of this program is persistence with clients and making them feel that they are being supported.

Outcomes are measured in terms of referral success, referral barriers, recidivism, and ER visits, among other data.

Barriers and Ineffective Approaches

The least effective method Population Health found is to dictate to clients what they have to do.

The most challenging barriers involved sharing information and HIPAA. There was both the difficulty in determining if information could be shared legally as well as the logistics of sharing between data systems. There were additional barriers including a lack of housing and the 5-month Probation background checks which were required in addition to the county background checks. One thing that is particularly frustrating is that before clients are signed up for Medi-Cal, which can take 30-60 days, they can have appointments to address behavioral health needs but they cannot get treatment.

Citywide Case Management, San Francisco

Citywide Case Management (CWCM) is a multi-disciplinary forensic FSP using an Assertive Community Treatment (ACT) model focused on high utilizers of the criminal justice system. It employs psychiatrists, nurses, Master's Level clinicians, and peer staff, which is very important to its model, as well as a supported employment program.

CWCM is the primary community service provider for the San Francisco Behavioral Health Court, providing behavioral health clinicians for the Sheriff's Department's case management program and the Probation Department's Community Assessment Service Center. This center is truly a community hub with people on site from a charter school, Goodwill, and case managers to process benefit applications.

Using the Sequential Intercept Model to identify service gaps, CWCM creates partnerships with agencies so that gaps in the county system can be filled without the need for additional funding. Many of the champions who make these initiatives successful have come from the criminal justice system.

Recently, CWCM found that because the Behavioral Health Court is for felonies, there was a gap in services for the pre-trial population and those who quickly cycle in and out of jail. With behavioral health partners, CWCM opened a court program for misdemeanants. Without the legal leverage of a felony, the program found people responded best to housing as an incentive to participate. The Sheriff's Department was able to secure funding from the last round of Mentally Ill Offender Crime Reduction (MIOCR) grants to bolster the program, along with matching grant funding from a local private social club.

CWCM was surprised at the high level of impairment they encountered with the misdemeanor population. It illuminates the fact that it is all the same population simply with different legal charges and they need to connect these individuals with services wherever they are.

San Francisco uses a tool from the Arnold Foundation to determine pre-trial release, which removes the interview piece. This has resulted in people being released and sent to the pre-trial offices without prior notice, many with serious mental illnesses. So the Sheriff's Department is funding a CWCM clinician to work on site at the pre-trial diversion offices. This clinician takes referrals from the pre-trial screening, performs a more thorough assessment, and then provides intensive case management or linkage to treatment.

Barriers and Ineffective Approaches

The most challenging barrier for CWCM is housing, so it has had to be creative in finding funding.

This population requires a spectrum of housing levels, to accommodate differing levels of functioning, often accompanied by intensive clinical case management services to ensure that clients stay in their housing. It can take 2 years or more to find permanent housing for a client in San Francisco. In the meantime, CWCM works with whatever needs the client has and whatever level of housing they can tolerate.

Flexibility has sometimes been achieved with the receipt of private grants and CWCM includes transitional housing in all of their grant requests. Realignment money is utilized through the Probation Department for housing in a number of locations. The Department of Behavioral Health's residential treatment programs are also utilized for people released from jail if they are ready for that type of setting.

CWCM has found that punishment is ineffective when it comes to reducing substance use. Instead, the program uses the recovery model and any available leverage and incentives to encourage clients to want to reduce their substance use.

Words of Wisdom

- Be creative. If you see a problem, create a solution.
- Do not wait for additional resources. Find ways to realign existing resources and collaborate effectively.
- Not every client in this population is ready to be in a treatment setting, so harm reduction is very important. Court partners must understand and support this approach.

Q & A

Q - Mary, would you tell us more about the bureaucracy in accessing housing for your clients and how you deal with it?

Mary Marx - LACDMH is required to have contracts to obtain housing. Recently, a Department of Health Services Board action allowed the creation of Housing for Health so there can be a fiscal intermediary that is not bound to contracting for housing. This allows for broader housing options and they can sign leases for individual clients.

Q - What types of certification or training do you require or provide for your peer support members?

Kathleen Lacey - We don't have a lot of educational requirements, although specialized training for peer support members is becoming more common. Instead, we look for lived experience and how they use it with clients. Then we provide weekly supervision with clinicians.

Q - What training does your staff receive to support its success with this population?

Judi Nightingale - Our nurses are trained in Motivational Interviewing, trauma-informed care, and how to not be manipulated, among other topics.

Mary Marx - We have regular trainings and one of the most popular is about treating individuals with criminogenic factors as well as mental illness.

Kathleen Lacey - Training around criminogenic risk factors and needs is very important. Research shows that simply providing mental health treatment to this population is not going to reduce recidivism. Our program uses the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment to identify criminogenic risk factors and inform client treatment plans. In addition, we are currently partnering with Jennifer Skeem to analyze the efficacy of a CBT intervention meant to address criminogenic thinking and values, adapted specifically for people with mental illnesses.

Mary Marx - We see people with high needs and it is very important to screen them into appropriate levels of care with consideration of all the risk factors. We have a forensic psychiatrist who educates our staff, provides consultation and does clinical supervision.

Q - In what ways are you helping your clients build social networks? We know that this population has burned a lot of bridges and their social networks are likely sparse.

Mary Marx - We have a peer bridging program in which peers work as part of the clinical team. They attend groups and social activities with the clients to help build natural systems of support. The important thing to know when working with peers, is that they require a lot of support themselves. We ensure they have weekly supervision with clinicians. Our FSPs and enriched residential programs utilize peers and family members. Integrating natural supports is part of our contractual agreements.

Judi Nightingale - We also use peer support in substance abuse, behavioral health and many other programs. Our Probation Department is unique in its level of engagement with community leaders. Probation holds a quarterly meeting for anyone who provides services in the community such as to the homeless, individuals who have been incarcerated, and others. These meetings have shown how important it is to develop relationships by casting the widest net possible.

Kathleen Lacey - We're trying to create a community where people can feel comfortable and welcomed at our new Probation site. Most of our clients have broken family ties and sometimes we can facilitate reconnecting to their families. Financial flexibility becomes important in achieving this.

Q - How successful have you been with policing and servicing the population of sex offenders required to register (PC 290)?

Kathleen Lacey - This has been frustrating for us because these clients can't access any of the residential dual diagnosis programs

in our county. We have to create specialized treatment for them, such as one-on-one substance abuse counseling, and find housing in the right areas. They are at an enormous disadvantage.

Mary Marx - In LA County, we are seeing a lot more "290s" and housing is a big issue for that population. We have to plan around our city ordinances to be able to place them. Most of our locked facilities are in residential areas that prohibit felony ISTs (PC 1370) and Not Guilty by Reason of Insanity (NGRI, PC 1026) so we have to move to other counties to place those clients.

Q - Would you speak to the degree to which you offer medication assisted treatment (MAT)?

Judi Nightingale - We utilize MAT clinics, which are partially funded by the Department of Behavioral Health, and recently obtained funding to license our clinicians. Our Emergency Department will also fund several physicians to become licensed so they can start patients on 72 hours of MAT treatment while getting them linked to services. We're also hiring peer support specialists in our Emergency Department to help with the transition to peer support.

Kathleen Lacey - We utilize MAT clinics around the city but I would like to see MAT for methamphetamine. This is a much bigger problem in our county than opioids.

Mary Marx - Early on, we partnered with our jail mental health services and MAT clinics so treatment of inmates would continue upon release from custody. We also recently opened a crisis residential treatment program that provides mental health and substance abuse treatment.

Q - Are you planning on pursuing the robust state funding for opioid abuse? There is a mandated prevention component that is supposed to be built into the funded programs to address prevention in youth.

Mary Marx - Our hospital Medical Director told me that they are really ramped up for the opioid crisis but they are seeing mostly methamphetamine and crack. Methamphetamine is the big issue in our urgent care centers that accept law enforcement mental health drop-offs. This is a problem that needs to be addressed.

Q - There is another $50 million in the state budget for adults being released from state prison to help with housing and warm hand-offs. It addresses the parolee and the Post-Release Community Supervision (PRCS) populations that you are already working with. The challenge will be to integrate parolees into that network of services you're already providing.

Mary Marx - We are seeing more and more parolees in our program so I think the integration is already happening naturally.

Hope on the Horizon! MHSOAC Innovation Incubator

Toby Ewing, PhD – Executive Director, California Mental Health Services Oversight and Accountability Commission (MHSOAC)

The Mental Health Services Act (MHSA) has a unique mandate to use a percentage of funding for Prevention and Early Intervention (PEI) and innovation. These mandates are crucial to improve California's mental health systems and to reduce criminal justice involvement for people who have mental health needs.

Innovation and Collaboration

Mental Health Services Oversight and Accountability Commission (MHSOAC) Executive Director Toby Ewing often sees counties doing small projects with marginal impact, which can sometimes be due to lack of funding for larger projects. In response, the Commission has been encouraging counties to co-invest in strategic opportunities to leverage funding that is available. The attitude in California is often that each county is completely unique but counties have more in common than is traditionally assumed. Additionally, it is important to collaborate in order to drive systems change and have lessons learned from innovations be taken up into the broader system of California's rules, regulations, and licensing requirements.

Recently, a group of counties co-invested over $100 million for an initiative called the Tech Sweep project. The goal of the project is to use data and mobile options to develop an innovative way of accessing care that involves multi-county learning. By pooling

Recent Mental Health Services Oversight and Accountability Commission (MHSOAC) Activities

- Online fiscal transparency tool that shows how much funding counties have received, how much they spent and how much is left.
- Demo program inventory tool which depicts 1,500 MHSA funded programs throughout California. It shows type of program, target audience, and how much money is available. In time, more information will be available, such as number of people served by race, gender, ethnicity, and sexual orientation.
- Mental Health Innovation Summit held earlier in 2018 with Google, to introduce mental health leaders, providers, consumers and family members to the tech and innovation sector in California and explore partnership opportunities. This is important as far as technical assistance but also to encourage the broader community to give support to counties for their creative initiatives.

their resources, counties can buy technical assistance more effectively, do more robust evaluation and learning, and create opportunities for systemic reform.

Innovation Incubator

Innovation is a way to drive reforms in the broader mental health system. One of the biggest challenges in accomplishing this is the need for technical assistance. The Commission sought and received funding for an Innovation Incubator to facilitate cross-county learning with a focus on reducing the number of people being referred to the Department of State Hospitals (DSH) as Incompetent to Stand Trial (IST). The goal is not to find innovative ways to restore competency but instead to find ways to reduce pressure on the state hospital system through more upstream engagement of prevention, early intervention and diversion.

The Innovation Incubator will provide the opportunity to plan and design multi-county collaboratives. There will likely be a range of approaches but all will focus on making upstream improvements to reduce incarceration and pressure on the state hospital system. The Commission is exploring models for implementing this project and will have a proposal in early 2019.

Innovation and Evaluation

The MHSOAC is concerned that evaluation of innovations is not being performed to a high enough level. To bring an innovation to scale, it is important to be confident of its effectiveness and when it should be used, and that requires robust data.

The Commission is looking at data from the Department of Justice (DOJ) and Full Service Partnerships (FSPs) to determine the extent to which FSPs are actually resulting in lower criminal justice involvement. FSPs are funded at over $700 million per year and data are not showing the kind of impact expected for that investment. It is unclear that our system is taking advantage of the data to understand what kinds of approaches with FSPs are more effective than others. Furthermore, the law requires half of Community Services and Supports (CSS) funding to be used for FSPs and that requirement is not being met at the moment in many counties. Data are showing that only around 40% of people who disenroll from an FSP have their goals met. And an equal number of people are "lost" from FSPs.

Challenges

- There is a need for technical assistance across the whole system, not just for innovation.
- It is difficult to find out what other counties are doing.
- It is difficult, given how busy everyone is, to spend time figuring out how to evolve from the system of today to an improved system of tomorrow.
- There is not a good method for shedding old programs when new ones are started.

These challenges represent an opportunity for the state to do a better job supporting counties in learning from each other, not just on innovation but across the whole behavioral health system. The MHSOAC continues to discuss how to accomplish this.

Learning From the Physical Healthcare System

1. Fiscal Incentives. There are significant fiscal incentives in the physical healthcare system. If a patient is re-hospitalized within a certain timeframe, there is a fiscal penalty. The behavioral health system does not have those same incentives between the state and counties; between community mental health and the criminal justice system; or between community mental health and DSH. How could fiscal incentives be used to improve outcomes in behavioral health?

2. Leverage Data. Physical healthcare utilizes clear strategies for systemic improvement and makes effective use of data. For example, when a mistake is made during a procedure at a hospital, there is a method to analyze what went wrong. It is done immediately and a hospital can change its practices based on what is found. On a broader scale, the physical healthcare system knows what current performance is; where gaps in care are; and what the target is. Then, this information is used to focus on closing those gaps. It is not clear that the behavioral health system has a clear understanding of current performance, gaps and goals.

3. Land-Use Strategies. Public healthcare sometimes uses land-use strategy to improve health, such as locating the bike lane between the sidewalk and the parked car lane. There have been some land-use initiatives for improving mental health but it is an opportunity often overlooked. One example is a community garden opened in Fresno to facilitate conversations about mental health with the Hmong population, which has low mental

healthcare access rates. What other land-use opportunities are there that would support mental health goals and have an upstream impact on reducing criminal justice involvement?

4. Tax Policy. Physical healthcare initiatives sometimes use tax policy to positively affect health, such as a sugar or soda tax. How might a tax policy be leveraged to support mental health?

5. School Engagement. Schools provide health screenings, physical fitness testing, and distribute information about healthy eating. How can the mental health community work with educational partners to help them set up systems for distributing mental health information and engaging people at the onset of mental illness?

6. Public Health Approach. There is a constant conversation between public health and physical health providers but that same conversation is missing between public health and mental health providers. Mental health is not approached in terms of population health and public health so as to have an upstream impact on the mental health system.

It is clear that California cannot afford to pay its way out of the problem of an increasing IST population needing treatment. The trend is national and it seems likely to increase. There is one-time $100-million funding to reduce the pressure but that money will be used very quickly. The long-term solution is upstream investment in prevention, early intervention and stronger community programs to reduce the pressure on DSH and ensure that the only people referred to that system are those who really need to be there.

Q & A and Audience Comments

Q - We identify a child's risk of hypertension and diabetes through their familial history. How can we identify children at risk of mental health problems so we can provide them education and tools to help deal with symptoms that may come up?

Toby Ewing - Not being a mental health practitioner, I can't speak to whether there are early indicators of mental illness. My sense as a lay person is that there may be social, environmental or familial risk factors and that we could support children's resiliency in the face of those factors. Additionally, some schools are seeking understanding to better deal with children who act out. For example, there are schools that are replacing disciplinary programs with mindfulness programs. PEI dollars can absolutely be used to further these goals.

Comment - I used to work at DSH and that information is there. We know that trauma and other factors that are first experienced as children are important.

Q - In the 60's, California assessed its first graders to determine how many would end up in prison and based building capacity on that estimate. Can we estimate mental health need in the same way and base prevention and early intervention service capacity on that estimate?

Toby Ewing - I might instead use the analogy of immunization. We have a strong sense of prevalence rates broken down by age, race, urban/rural, and other demographics. So, if there is a 20% prevalence rate of mental illness but only 4% penetration rate of accessing mental health services, there is an obvious gap. That points to an opportunity, informed by the public health field, to anticipate the need and get the structures in place in advance. This is happening in some communities but it is unusual.

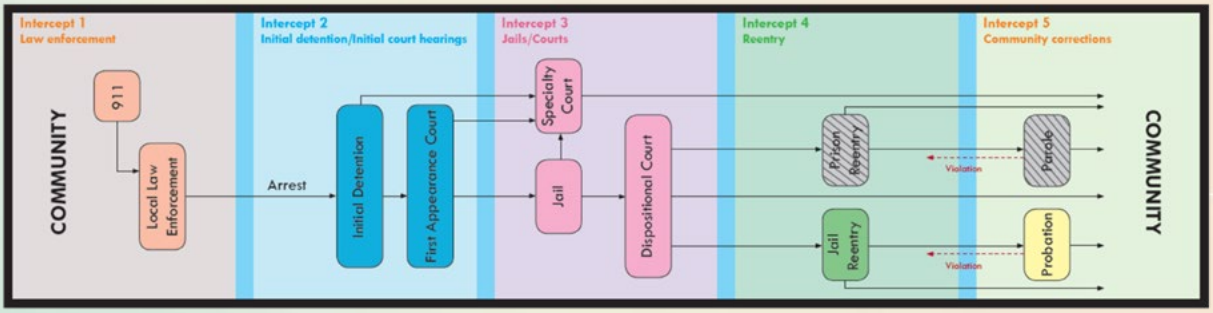
Q - When the focus is on prevention and early intervention, I am concerned that it will mean not focusing on the people in the system in crisis right now. Reentry is a very important piece of reducing criminal justice involvement.

Toby Ewing - I agree that reentry is important and MHSA by and large allows counties to determine how to invest their funds. But let's not forget the upstream work. This year's budget has $120 million to target the IST population. $115 million is for competency restoration strategies and $5 million is for more long term innovation. So the bulk of funding available is for people who have a current need. To solve this problem in the long-term, and reduce criminal justice involvement, we need to focus on prevention and upstream strategies with the small $5 million investment. We also need to recognize opportunities from throughout the sequential intercept continuum.

Q - I thought that innovation funds were both CSS and PEI funds, so wouldn't counties naturally have to focus on CSS innovation in order to get their innovation projects approved?

Toby Ewing - MHSA requires counties to set aside 5% of CSS and PEI funds for innovation but they are not required to spend those innovation dollars on CSS or PEI. Counties have tremendous flexibility in how they use their innovation funds.

Comment - Innovation should be individualized in that the needs of one county won't be necessarily what another county



Sequential Intercept Model - https://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf

needs. On the innovation subcommittee, we were concerned that developing something like a statewide screening tool for innovation would actually prevent true innovation. Innovation can be a simple change in a program if it has a positive effect. Second, we're not going to solve the behavioral health problem in the criminal justice system until we remove the barriers of systems that don't talk to each other and develop an umbrella record management system, whether that be statewide or countywide. I just know that our program is successful because information can be shared. We need to share the risk rather than be risk averse. Remember, the original intent of HIPAA was not to impede improvement.

Toby Ewing - I'm not suggesting that this is one-size-fits-all. Instead, it's an opportunity for counties to learn from each other. There are a lot of things that are unique about each county but there are also a lot of things counties share.

Q - I encourage you to look at the Police Mental Health Collaboration Toolkit, a DOJ/BJA-funded project, that outlines what practices have worked.

Toby Ewing - That is part of the conversation around technical assistance. There are wonderful models out there.

Q - Even when we identify people fairly early on, say age 20, it's often too late. We needed to have seen them at 14. How has the educational system gotten involved so far?

Toby Ewing - We have been working with the Department of Social Services and the Department of Health Care Services to determine if we can identify risk factors that could be utilized to engage families so as to avoid out-of-home placements, which is an explicit goal of the MHSA. There's a lot of interest in this but it has been difficult because of data access issues and lack of funding. In terms of schools, the Commission has a school mental health project under way. We have awarded grants to 4 counties to partner with schools to improve access to care and reduce the need for crisis services. We have agreement from the Department of Education to co-fund a multi-county, multi-school collaborative to facilitate learning.

Comment - When you don't give schools the resources they need, for example, one nurse and one psychologist each only one day per week, the outcomes are predictable.

Q - We know which kids have an Individualized Education Program (IEP) and which have a Serious Emotional Disturbance (SED) designation. We could correlate that designation with those involved in the juvenile courts. But as soon as they become adults, all of that information is removed. We've already identified kids having trouble from a mental health perspective and a criminal justice perspective. When they go from the juvenile justice system to the adult system, the mental health information doesn't follow. It is sealed due to privacy concerns, which has the effect of then not being able to identify who needs assistance. How do we reach people when they're young, before they're really sick and ending up IST? Have any studies been done to look at this list of kids to see what happened to them later and see if there are any common denominators?

Toby Ewing - This is a conversation we're having with the State Superintendent Association, the California Behavioral Health Directors Association (CBHDA), the Department of Education, and the Department of Health Care Services. You're right. Not only do we stop sharing information when juveniles becomes adults, we stop it when they walk out the door. It's a blank slate every time they enter a different door in the wider system, whether that's education, child welfare, juvenile justice, or mental health. There is recognition right now that there is a need for sharing this information. There are legal and technical challenges but part of the conversation with the Department of Education is about understanding where we need to dedicate resources. A lot of times the IEP becomes the path to mental health services rather than being used for young people who have learning disabilities. There are children who need IEPs but that shouldn't be the primary or only path to getting mental health services.

Resources:

- Police Mental Health Toolkit - https://pmhctoolkit.bja.gov/

"If we are going to be change makers, we need to be willing to take risks. We need to be willing to fail, in order to succeed."
- Jackie Lacey
Los Angeles County
District Attorney

Description

Words to Deeds is the result of a collaboration of leaders in criminal justice and mental health throughout California who joined together to identify and advance strategies to effectively divert individuals with mental illness from jail.

Since 2003, *Words to Deeds* has provided a unique forum that has evolved into a standard best practice for creating a true shift in the paradigm between criminal justice and mental health, by fostering successful and ongoing collaboration among courts, criminal justice agencies, mental health professions, and governmental and nongovernmental organizations.

Mission

The leaders in criminal justice and mental health participating in this effort strive to end the criminalization of individuals with mental illness by supporting proven strategies that promote early intervention, access to effective treatments, a planned reentry and the preservation of public safety.

Vision

A true shift in the paradigm between criminal justice and mental health will embody an effective jail diversion system that fosters a successful and ongoing exchange of information among courts, criminal justice agencies, mental health professionals, government and nongovernment organizations, to achieve a substantial positive change in the way individuals with mental illness are treated within our communities.

Words to Deeds Leadership Group

- **Deanna Adams** - Senior Policy Analyst, Council of State Governments Justice Center
- **Bill Brown** - Santa Barbara County Sheriff-Coroner
- **Hallie Fader-Towe** - Senior Policy Advisor, Council of State Governments Justice Center
- **Morgan Grabau** - Events & Communications Director, Forensic Mental Health Association of California
- **Brenda Grealish** - Acting Director, California Department of Health Care Services, Mental Health and Substance Use Disorders Services
- **Carmen Green** - Executive Director, California State Sheriffs' Association
- **Catherina Isidro** - Executive Director, Forensic Mental Health Association of California
- **Kathryn Jett** - Senior Policy Consultant, California Forward
- **Darby Kernan** - Deputy Executive Director for Legislative Services, California State Association of Counties
- **Kathleen Lacey** - Program Director, UCSF/Citywide Case Management
- **Robin Lipetzky** - Public Defender, Contra Costa County
- **Sheree Lowe** - Vice President, Behavioral Health, California Hospital Association
- **Rosie McCool** - Deputy Director, Chief Probation Officers of California
- **Farrah McDaid Ting** - Legislative Representative, Health and Behavioral Health, California State Association of Counties
- **David Meyer** - Clinical Professor, Institute of Psychiatry, Law and Behavioral Sciences, USC Keck School of Medicine
- **Ashley Mills** - Senior Researcher, Mental Health Services Oversight and Accountability Commission
- **Janna Munk** - Senior Consultant, Training Program Services Bureau, Commission on Peace Officer Standards & Training
- **Tyler Rinde** - Legislative Analyst, County Behavioral Health Directors Association
- **Patricia Ryan** - Consultant; Executive Director (Ret.), County Behavioral Health Directors Association of California
- **Linda Tomasello** - Senior Governmental Program Analyst, California Highway Patrol
- **Jolena Voorhis** - Executive Director, Urban Counties of California
- **Kit Wall** - Words to Deeds Project Director, Kit Wall Productions
- **Stephanie Welch** - Executive Officer, Council on Criminal Justice and Behavioral Health (formerly COMIO)
- **Tracey Whitney** - Deputy District Attorney, Mental Health Liaison, Los Angeles County District Attorney's Office
- **Molly Willenbring** - Chief Operating Officer/Director of Finance, First Responder Support Network
- **Helene Zentner** - Field Representative, California Board of State and Community Corrections
- **Carrie Zoller** - Supervising Attorney, Judicial Council of California, Administrative Office of the Courts

About FMHAC

For more than 40 years, the Forensic Mental Health Association of California, a nonprofit organization, has advanced the provision of mental health services to persons involved in the criminal justice system and provided educational opportunities to the professionals involved in the delivery of these services.

Paradigm Awards

Congratulations to the 2018 Paradigm Award winners! Thank you for being champions of mental health services for individuals involved in the criminal justice system.

Judicial Champion

HONORABLE JAMES BIANCO
Site Judge, Los Angeles Superior Court Mental Health Court
Presented by David Meyer - Clinical Professor, Institute of Psychiatry, Law and Behavioral Sciences, USC Keck School of Medicine

Law Enforcement Champion

CHARLES DEMPSEY
Detective III, Officer-In-Charge of the Administrative Training Detail,
Mental Evaluation Unit, Los Angeles Police Department
Presented by Linda Boyd - Clinical Program Manager II, Los Angeles County Department of Mental Health

Behavioral Health Champion

KITA CURRY, PHD
Chief Executive Officer, Didi Hirsch Mental Health Services
Presented by Stephanie Welch - Executive Officer, Council on Criminal Justice and Behavioral Health

Lifetime Achievement Champion

KIT WALL
Policy Consultant; *Words to Deeds* Project Director, Kit Wall Productions
Presented by Ken Carabello, President, Forensic Mental Health Association of California

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More Information

For more information about *Words to Deeds* and FMHAC, visit www.fmhac.net or contact:

Forensic Mental Health Association of California
fmhac@fmhac.net
415.407.1344

Kit Wall
W2D Project Director
kitwall@sprintmail.com
707.280.7133

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