# FORENSIC MENTAL HEALTH Association of California

# Newsletter

Fall 2007


Dear Member,

I'm happy to present to you our first e-newsletter! The Board of Directors and I have been working hard this summer to improve the benefits you receive from being a member of the Association and we hope you find the articles here interesting, informative and helpful.

**Save the Date!** Our 2008 conference will be held at the Embassy Suites, Seaside, March 19th-21st. The theme is *Moving Ahead: Building a Better Continuum of Care* with an emphasis on better integration of mental health care and substance abuse treatment. Please visit our website in the coming months for more information.

Molly Willenbring
Executive Director

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## Featured Member

Congratulations to past FMHAC president **Joel Fay, PsyD**, for receiving the California Psychological Association's Distinguished Humanitarian Contribution Award this year! This award honors a person whose voluntary and career efforts have directly and significantly improved the quality of life for a broad range and large number of persons in our society.

## Council on Mentally Ill Offenders Best Practices Award

*What are the best practices our mental health providers and law enforcement officials have devised? What barriers were overcome in gaining these successes? How can we measure and publicize those successes? Which of these interventions can be replicated?*

The Council on Mentally Ill Offenders is conducting a survey for the best forensic mental health practices in California and will be giving out awards in Spring 2008. Nominations are due November 9, 2007. See the COMIO website for more information. www.cdcr.ca.gov/comio.

# The Best Forensic Mental Health System in the Country

Ken Carabello, LCSW
President

I had the opportunity to attend the National Association of State Mental Health Program Directors, Forensic Division Annual Meeting in September. Relating to the issues that other states are facing was certainly no problem, since there are many common themes: the "competency crisis" with waiting lists to get into state institutions, analyzing the effects of civil commitment of sex offenders, the struggles to build a continuum of care, substance abuse treatment integration with mental health treatment, staffing shortages. However, in addition to sharing some struggles, we also shared some positive developments and successes: implementation of the recovery model is becoming more comfortable and we have made strides in reducing restraints and seclusion.

The State of New York laid informal claim to having the best forensic mental health system in the country. I haven't received the answer yet, but I have asked its director what the criteria is for being the best. You know why? Because I want the title for us. His answer will certainly will be something along the lines of having a full array of services that are delivered well and are in full collaboration with one another. As for assessing where we are in relation to these criteria, I am most worried about our collaboration abilities.

Recent events, including the federal court takeover of CA Department of Corrections and Rehabilitation's (CDCR) health services, disputes on Proposition 63 money, and ongoing tension and conflict in relation to county and state responsibilities seem to forebode a continued lack of coordination. However, conversely, I think there is a unique opportunity in the dialogues brought on by these events to rally around meaningful systemic changes. To be certain, there are political realities, grievances, and complexities that must be overcome. But if disparate interests will engage and focus on common values such as public safety and humane treatment, we can build solutions.

For all of us, fighting on behalf of those needs that only we can fully appreciate because of our unique point of view is a fundamental duty in a democracy. So is working with others in crafting long term solutions that better our society. Simply guarding our own turf is not enough. For us to change, it will take a conscientious effort to increase good will, decrease apathy, and counteract mistrust that often contributes to our failure to work together.

An eye to the needs of other agencies will not bring about the extinction of our own, rather the enhancement of its place as a leader in a system desperate for coordination. Find a way to help other agencies accomplish their goals, and the reciprocal efforts will help you and lift us all.

I was heartened to attend in August a summit between county mental health directors and Department of Developmental Services' regional center directors and staff. In this meeting the defensive postures broke down. There was focus on problems, not turf. Joint solutions were being explored. I felt a thrill when in a small break out session, for a moment, each side began to explore how they could improve things for the other, instead of simply listing how the other side could improve things for them. It was a small step, but it was in the right direction. It's the direction we need to take as a state.

## CME Committee Members Needed

FMHAC would like to become a provider of CMEs and we need a few doctors to help us by serving on our CME Committee!

It's a great way to contribute to the forensic mental health community while networking with other professionals in the field!

If you are a medical doctor (MD) and would like to be involved in this project, please contact us.

# Public Policy Update: SB 851 and SB 568

Mark Grabau, PhD
Vice President

Hello Association members. I am pleased to chair the FMHAC Public Policy Committee and be able to present here a discussion of two important pieces of legislation regarding forensic mental health services, SB 851 and SB 568, reviewed by two of our Committee members. Our mission is to review the forensic mental health landscape for opportunities to improve services to mentally disabled patients by improving their access to a full range of services and ensuring these services are provided in environments which are safe and secure for patients, employees, and the public. Through review of legislation, research, and service delivery outcome data, it is hoped the public policy committee will chart a conceptual framework for the Association that will guide future educational, policy, and political efforts. One important aspect of our efforts is to keep members of the Association in touch with key policy and legislative events that most affect your ability carry out your work in the vast and diverse field that is forensic mental health.

I have served on the Board of Directors of the Forensic Mental Health Association of California for over two years. I have enjoyed meeting so many knowledgeable and energetic peers, and have had the pleasure of working with many of you in my role as Community Program Director of the Central Valley Conditional Release Program. Since my election as Vice President and chair of the Public Policy Committee, I believe we have slowly laid a foundation to resume our rightful place as leaders in the review and formation of effective, timely, and sound public policy.

If you are an association member, and would like to become involved with the public policy committee, or would like to voice your opinion about policy issues, contact me through our website. Please continue reading for a discussion of two current legislative bills and a brief introduction to the FMHAC Public Policy Committee.

## SB 851 and SB 568

On top of the public policy agenda is Senate Bill 851*, introduced by Senators Steinburg and Romero. This bill would authorize superior courts to develop and implement mental health courts, as specified, which may operate as a pre-guilty plea program and deferred entry of judgment program. This bill would also allow parolees to participate in mental health courts, as specified. Because it would change the punishment for commission of various crimes and would require local officials to provide a higher level of service, this bill would impose a state-mandated local program. In addition, it would require the Department of Corrections and Rehabilitation, in consultation with the State Department of Mental Health, to establish, to the extent funding is available, mental health service standards.

SB 851 has the ability to rectify what some have described as the criminalization of the mentally ill that began when the deinstitutionalization efforts were sabotaged by failing to provide adequate community-based care and housing. While SB 851 appears to be a move in the right direction by placing treatment first, the public policy committee hopes the bill will ensure community-based supports are adequately conceived and funded. Basic needs such as reliable transportation to mandated appointments, assistance with accessing social services, and resources needed to obtain safe, long-term housing are keys to ensuring the large investment SB 851 requires would not be in vain. Mental health courts are a wonderful idea, but they work only in so far as they allow caring mental health professional to intensively case manage those in need.

Another area affecting many of our members is the state-wide problem of the mentally ill being housed in county jails, many of whom are waiting to be placed in state hospital for competency to stand trial or restoration of sanity services. The state Senate voted 36-0 on September 7, 2007 to approve Senate Bill 568* which would allow county jail facilities to provide medications to defendants with mental illnesses so the defendants could stand trial. Due to the shortage

of state hospital beds, some patients have had to wait over six months for adequate treatment. Under the language of SB 568, counties would be allowed (after a required court hearing) to medicate defendants diagnosed as mentally ill and found to be incompetent to stand trial by a judge or jury, in concurrence with the county board of supervisors, the county mental health director, sheriff and chief of corrections.

Clearly SB 568 is addressing a severe problem in our continuum of care but giving counties the option to medicate inmates in county jails does not a treatment facility make. In other words, treatment facilities are more than physical places where medication is dispersed. Forensic treatment facilities provide group and individual therapy, limit confinement as much as possible, and provide a treatment plan dedicated to the overall wellness of the individual. The public policy committee is concerned that SB 568 would have very limited effect as most counties do not have the infrastructure or personnel to become a 'treatment facility'. As it may face legal challenges, we will continue to monitor SB 568 closely as it heads to Governor Schwarzenegger's desk for consideration.

The public policy committee will continue to monitor these bills as well as the fate of Mentally Ill Offender Crime Reduction Grant Program funding, the application and ramifications of Proposition 83 (Jessica's Law), and issues related to mental health treatment parity.

*UPDATE: SB 851 has been vetoed and SB 568 was signed.

## The Public Policy Committee

I would like to introduce the bright, energetic and dedicated members of the public policy committee who volunteer their time and effort to monitor and deliberate on matters of public policy that greatly affect the field of forensic mental health in the state of California:

**Mark Grabau, PhD**, is the Community Program Director of the Central Valley Conditional Release Program in Sacramento, California and is also a psychologist in private practice. He is Vice President of the Forensic Mental Health Association of California and the Chair of the public policy committee.

**Kelley Babinau, JD**, is Assistant Public Defender for the Sacramento County Public Defender. Ms. Babinau has played a leading role in litigation ensuring Sacramento County patients deemed incompetent to stand trial are admitted to the state hospital system expediently.

**Christina Barasch, LCSW**, is the Community Program Director of the Sonoma County Conditional Release Services. She has also served as the Forensic Coordinator at Napa State Hospital.

**Jane Johnson, LCSW**, works with Telecare Corporation in Oakland, California.

**Ronald Kaufman, PsyD**, is a psychologist with Sylmar Health and Rehabilitation Center in Sylmar, California.

**Peter Kalmar, MFT**, is the Mental Health Services Coordinator of the Placer County Jail in Auburn, California.

**Brian Nelson, MFTI**, is a Forensic Mental Health Specialist with the Central Valley Conditional Release Program in Sacramento, California.

**Jennifer Orthwein, PhD**, is a psychological intern with Anka Behavioral Health, Inc., Golden Gate Regional Conditional Release Program in San Francisco, California.

**Justine Schmollinger, PhD**, is a psychological intern with Anka Behavioral Health, Inc., Golden Gate Regional Conditional Release Program in San Francisco, California.

**Rene Wilkinson, PhD**, is a psychologist in private practice in Los Angeles, California.

**Martha Wilson, PhD**, is a Forensic Community Liaison with Contra Costa Detention Facilities Mental Health Program in Martinez, California.

# Where To Go With Laura's Law

Munir A. Sewani, PhD
Director of Conference

*The following article is a summary of a research project submitted by three psychology interns (Shana Garcia, Megan Lowery and Kathryn Steffenson, 2006/2007) to San Bernardino County Department of Behavioral Health. Permission to use their research data for the current article was granted to Munir A. Sewani, PhD. The writer is responsible for the information and opinions expressed in the following article. Readers are directed to contact Munir A. Sewani for comments, questions and information.*

Governor Gray Davis signed Assembly Bill 1421, written by Assembly Member Helen Thomson, in September 2002 with a sunset date of 2008. Last year, Governor Arnold Schwarzenegger extended the bill via AB 2357, now set to expire in 2013. AB 1421, known as Laura's Law, allows court-ordered assisted outpatient treatment for individuals with severe mental illness who refuse treatment, whose mental illness impairs their ability to make rational treatment decisions for themselves, and who constitute a danger to self and others. The law advocates involuntary treatment for those mentally ill individuals who have not benefited from voluntary treatment. Furthermore, it allows each county to choose if they want to implement the provisions of the law and initially Nevada, Sacramento, and San Francisco counties expressed interest. As of 2004, however, Los Angeles is the only county to have implemented this law and only on a very limited basis.

Laura's Law is an attempt to fill the gaps left by the Lanterman-Petris-Short Act (LPS), which established a provision for involuntary treatment of mentally ill individuals found to be gravely disabled, danger to self or danger to others. Though involuntary treatment under LPS is limited to short hospitalization for these criteria, it does have a provision for extended involuntary treatment for those mentally ill individuals that are found gravely disabled. But there are no provisions for long-term involuntary treatment for those individuals who are a danger to self or others. The provision for long term involuntary treatment for danger to others in the LPS Act, known as Murphy conservatorship, is rarely used and then only for cases where an individual has committed a serious felonious act. This has left clinicians without legal standing to provide involuntary treatment to segment of mentally ill individuals who decline continued treatment on a voluntary basis in an outpatient setting.

Laura's Law was named in the memory of Laura Wilcox, a nineteen year old high school valedictorian shot and killed in 2001 by Scott Harlan Thorpe, a 41-year-old man with a history of mental illness who had repeatedly refused voluntary medications and treatment. Laura, on break from Haverford College, was working as a temporary receptionist at a public mental health clinic in Nevada City, California, when Mr. Thorpe walked into the clinic and opened fire. Laura and another clinic employee were killed. From the clinic, Mr. Thorpe drove to a restaurant and killed the 24-year-old restaurant manager and a 68-year-old customer. Mr. Thorpe was found to be mentally incompetent to stand trial and sent to a state hospital. Prior to the crime, Mr. Thorpe had suffered from paranoid delusions but his family and the mental health providers did not have any legal authority to mandate mental health treatment for him.

Laura's Law parallels a similar law enacted in New York State called Kendra's Law, passed in the memory of Kendra Webdale who was killed in 1999 after being pushed in front of a New York subway train by a man who was not receiving treatment for his mental illness. Successfully implemented statewide, Kendra's law established outpatient treatment programs in New York for mentally ill individuals deemed incapable of safely surviving in the community without supervision. Because of its success, the law was renewed in 2005.

The success of Kendra's law has been measured by a 74% decrease in homelessness, 77% decrease in psychiatric hospitalizations, 83% fewer arrests, 55% decrease in suicide attempts and self harm. The number of hospitalization days decreased by 56% and drug, alcohol and substance use decreased by over 40%. Similarly, the percentage of patients reporting improvement in quality of life, greater sense of control, stability in life, medication compliance and utilization of mental health services exceeded 60% in most cases.

Despite the positive results associated with Kendra's Law, implementation of Laura's Law remains controversial in California. The controversy revolves around issues of coerced care, denial of rights and involuntary medications. Furthermore, the

legislature did not provide a funding stream to finance the implementation and the counties were left to fund their own programs if they chose hence, providing a very weak and tepid support. The foremost argument against court-ordered treatment relates to the meaning of dangerousness, which opponents say is subjective and left to interpretation by law enforcement and mental health professionals. Proponents of the law see an opportunity to stop the revolving door of involuntary inpatient admissions and discharges commonly experienced by persistently mentally ill individuals in California.

Moreover, proponents of Laura's Law believe that its implementation, like Kendra's Law, would decrease relapse rates, frequent hospitalizations, homelessness, victimization, suicides, and episodes of violence. Above all, there is a significant possibility that fewer mentally ill individuals would be incarcerated, thus helping to ease overcrowding in California criminal justice and prison systems. The success of mandated outpatient programs can be seen in Conditional Release Programs here in California and across the nation. Mental health service providers in these programs act proactively to monitor compliance with treatment and negotiate various services that provide the required level and type of treatment to help individuals become independent and functioning members of the community.

Many states have recently adopted the Assertive Community Treatment (ACT) model that proposes to provide comprehensive outpatient mental health services. Similar models have recently been adopted by California counties using Proposition 63 (the Mental Health Services Act) money to develop mandated mental health services program through mental health courts.

Opponents of mandated outpatient services believe that coerced treatment would drive individuals away from treatment. Yet there are studies that show individuals in mandated treatment acknowledge the treatment favorably in retrospect. Furthermore, mandated treatment in California already exists in the form of mental health courts. Though voluntary in nature and, by definition, giving the individual the choice of treatment over incarceration, failure to comply with the terms of the mental health court results in returning to jail. Laura's Law, on the other hand, provides only for increased treatment services (if necessary, in an inpatient hospital setting) upon failure to participate in the mandated outpatient treatment.

Like the LPS Act, Laura's Law has embedded several procedural safeguards to protect individual freedom and liberties. The law specifies under what circumstances a petition may be filed for involuntary outpatient treatment. The ultimate authority to file this petition with the court lies with the local county mental health director. The law is specific about the required information, timeline and independent information that must be used to file a petition with the local superior court. The superior court is required to hold hearings on the petition, cannot order treatment longer than 180 days and the individual has the right to challenge the petition at the time of the hearing and also later, if in mandated treatment for at least 60 days. Furthermore, the county mental health director is required to submit a progress report every 60 days detailing the individuals progress and need for continued treatment.

The legislature's failure to provide a funding stream for Laura's Law is the biggest hurdle for county mental health directors to support the implementation of Laura's Law. The cost for each county is estimated to be about $35 million but, in the long run, implementation of the law would save money by reducing the intensity and frequent use of high end services such as involuntary hospitalizations and other law enforcement resources. The savings for New York state, after implementing Kendra's law, has been significant and one can only imagine the relief to the community and families of the mentally ill served by the program.

Yet one can understate the concerns of families that worry about one more trend in the mental health services system in California. Not only that the memories remain fresh of the 1960's deinstitutionalization of the mentally ill and the subsequent failure to provide adequate community services but the continued inability of local mental health systems to provide services to individuals unable/unwilling to accept services is clear. Laura's Law is not an answer to the long standing failures of mental health delivery system in California but it is one avenue to address the needs of the community, families and the individuals who, because of their illness, are not able to make rational decisions about their care and continue to be a danger to self and others.

Hope remains that the extension of the law through AB 2357 will encourage county mental health directors to implement the provisions of Laura's Law. The bill asks that counties justify their decision if they decline to implement the law, so we are sure to see in the near future a good number of counties putting Laura's Law into practice.

# The Current Status of the Mentally Ill Offender Crime Reduction Grant

David Polak, LCSW
Director of Education

When the funding allocations for the Mentally Ill Offender Crime Reduction (MIOCR) grants were reinstated in 2006, the Forensic Mental Health Association of California (FMHAC) and a number of partners that participated in the initial projects (1999 to 2002) enthusiastically supported it. Unfortunately, the celebration has been short-lived.

Supported by the Governor and the California State Sheriff's Association but scrutinized by the Senate and the state legislature Conference Committee, MIOCR funding was uncertain for 2007-08. Ultimately, the budget was signed with MIOCR funds intact for the current fiscal year but it is sure to be contentious again next year. In addition, as a result of the lag time involved in passing the budget and uncertainty of funding, many of the MIOCR programs slowed and are now running behind schedule.

We must view MIOCR as a multi-stage proposition. Most of these programs use an "intercept model" to prevent mentally ill offenders from re-entry into expensive systems such as hospitals and correctional facilities. In order to successfully implement their plans, these programs need a long-term investment and continued state funding. They also must create a partnership between mental health and criminal justice. There should be a blending of finances and human resources to address this problem. As the previous MIOCR programs were proven to be cost effective and efficient in serving the needs of individuals with mental illness by reducing recidivism, diverting individuals with mental illness out of the criminal justice system, and reducing reliance on local health and human services, successful implementation of these programs benefits both law enforcement and mental health agencies.

Besides the fate of direct funding for MIOCR programs, there are also issues regarding whether Mental Health Services Act (MHSA, Prop 63) money can be used to supplement MIOCR, particularly to enhance the partnership between mental health and law enforcement agencies. The division between the Department of Mental Health and law enforcement agencies by restricting use of MHSA funds solely for mental health care is an obstacle preventing smooth functioning of these programs. In fact, there is contradictory language in the MHSA legislation. One statement recommends that modeling previous MIOCR programs (which partnered with law enforcement agencies) shows evidence-based practice while another statement restricts the funding specifically to mental health care with no funding allowed to partner with law enforcement or probation.

The California Mental Health Directors Association has made a strong case for this restrictive language, stating that there can be no supplementation of existing programs with MHSA funds. The language in AB 2034 (funding for homeless mentally ill individuals) is a clear example of restricting specific funding to the target population, but MIOCR language remains vague. This could become a huge obstacle to continuing these programs in the coming year. At this point, the Department of Mental Health has not clarified the use of MHSA funds to include funding for law enforcement and/or probation agencies.

Many Californians believe that MHSA is a "honey pot" of funds and groups from community services, as well as legislators, are expecting more services. Unfortunately, the reality is that the mental health system is recovering from years of major budget cuts and Prop 63 is really only the "lipstick on the pig" of a mental health system that has been under-funded and in disrepair for many years. In fact, local governments want to withdraw county realignment funds to reduce their costs as a result of MHSA.

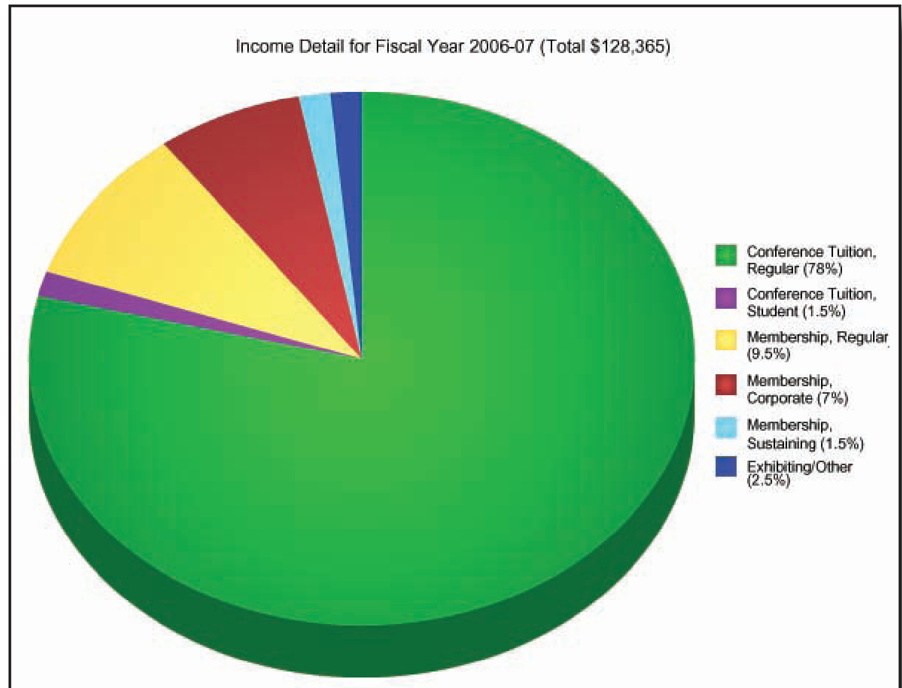
Ultimately, this population costs the taxpayer regardless of what we do or don't do. It makes neither policy nor fiscal sense to compromise a very successful program that has demonstrated improved outcomes for mentally ill offenders. Reducing or eliminating funding for these programs will only contribute to further pressures on our criminal justice and treatment systems, at a far greater cost than could be invested in the existing MIOCR programs. This is a time when California is devoting extraordinary resources to reforming our corrections system to address the twin problems of recidivism and over-crowding. As advocates for forensic treatment services, we need to become politically active to educate our legislators and prevent deletion of MIOCR funding in the coming budget year.

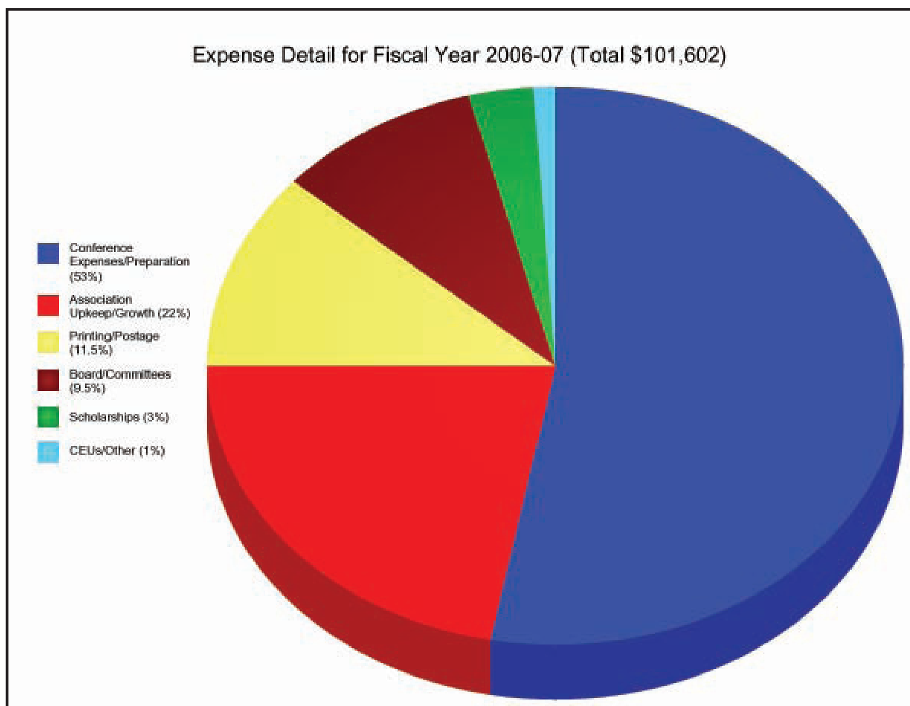
# FMHAC Financial Report: Fiscal Year 2006-07

Carrie Gustafson
Treasurer

The following charts show the Forensic Mental Health Association's income (top) and expenses (bottom) for the past fiscal year.

As you can see, our income for the entire year largely rests on tuition from our annual conference. We earn less than a quarter of our annual income from other sources. Although our total income changes from year to year, the percentages generally stay static.




In this chart, you can see how the Association spent money last year. Conference expenses are always a large part of our annual spending, particularly since printing and postage expenses are almost completely for advertising the conference. Along with expenses related to upkeep of the organization, these three categories represent well over three quarters of our annual expenses.

## CORPORATE MEMBERS

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