Dan Gillison:

Good afternoon to all, and thank you for joining us, and I want to say hello to all of you all from our national board, all the leaders and volunteers across the country and our staff. Special thanks to our staff that's here today, and want to take the time to also mention our chief advocacy officer, Hannah Wesolowski and Shannon Scully, our director of justice policy and initiatives. Many of you know Shannon and Hannah, but there's several that don't, and what I want to mention to you is that this work that Shannon is doing as a director of justice policy and initiatives on behalf of NAMI is very comprehensive, and she provides strategic guidance and leadership on the organization's work at the intersection of mental illness and the criminal justice system, and she joined us after she began her career advocating for victims of crime in the court system in Cook County, Illinois. So that's Shannon.

To the staff that's here, I just want to thank the staff, because they're going to be navigating quite a bit of this, and as we are looking at and listening to our outstanding speakers on today, they will be managing the questions and the content. So with that said, let me start out by giving you a little background in terms of why we're here and what this conversation is going to be about. Pathways to Healing: Insights from a Cop, a Client and a Counselor, and we're very excited to have our guest share their insights and perspectives. What do we know? We know people with mental illness and substance use disorders are overrepresented in our nation's criminal justice system. The NAMI Alliance at the local, state, and national level has long engaged in finding ways to divert people with behavioral health conditions away from the justice system and connect them to the services and supports they need.

What we have found is that we are most successful when stakeholders from across the criminal justice system come together to talk to each other and create solutions. So it's very fitting that in today's webinar, we will be hearing from a police officer, a person in recovery, and a psychiatrist that will each be sharing their perspectives on the underlying public health concerns that result in so many with mental illness and substance use disorder becoming involved in the criminal justice system, and how we can make improvements to reduce re-arrest and strengthen communities. Again, how we can make improvements to reduce re-arrest and strengthen communities. So it's very important on this next part, as I introduce the panelists, that I share with you that their bodies of work are very comprehensive, and I want to do them justice and make sure I do that for you as you look at who are our speakers on today, our panelists.

So I have the honor of working with each of them most recently, as they have all given of their time and talent to serve on NAMI's National Board of Directors. Starting with Vanessa Matthews, she is the division director of the Treatment Court Institute, a division of All Rise, which is formerly known as the National Association of Drug Court Professionals. Vanessa was employed as a police officer with Oklahoma City from 1990 to 2012, working with the Oklahoma County Drug Court from May of 1998 to September 2009. She has served as a defensive tactics and field training officer, amongst other training assignments with the police department.

She was instrumental in the development of the drug court program, including policy manual development, budgeting, and staff training. Her training presentations and curriculum development include recognizing the signs of mental illness, identifying a subject under the influence of drugs, effectively communicating with consumers, strengths based interviewing, team building, drug testing, program planning and development, grant writing, community supervision, cultural proficiency for consumers served, and ethics and confidentiality in treatment programs, psychopharmacology of drugs for first responders, and community resource identification and development.

In 2014, she was appointed by the governor of Oklahoma to serve on the Oklahoma Pardon and Parole board, and was reappointed to a four-year term in elected chair of the organization in 2015. She joined the staff of All Rise in 2016, and serves as the director of TCI. Ms Matthews has an associate degree from Oklahoma State University in applied police science, and a bachelor's degree from the University of Central Oklahoma and Criminal Justice. In July of 2020, Ms Matthews was elected to serve as a member

of the NAMI National Board of Directors, and in May of 2023, Ms Matthews was elected to serve as part of the IACP Mental Health Work Group. IACP, International Association of Chiefs of Police.

Now to Amy Brinkley. Amy Brinkley is a NAMI National Board member and a senior recovery support system coordinator at NASMHPD, which I'll tell you more about in a second. Amy is a nationally recognized advocate for mental health and substance use recovery, drawing from 15 years of direct lived experience. Motivated by personal struggles, including the loss of three brothers to suicide and her mother's overdose, she is dedicated to catalyzing change through peer support, recovery focused care systems, and robust data collection policies. Her mission centers on enhancing the quality of life and sustained recovery for individuals with substance use disorders and mental illness, championing person-centered recovery oriented outcomes.

In her professional journey, Amy spent five years with the Indiana Division of Mental Health and Addiction, where she played a pivotal role in expanding peer support services statewide. She contributed to multiple publications for the American Psychiatric Association Journals and served on the APA policy advisory board, leveraging her expertise in peer support. Currently serving as the first ever senior recovery support services coordinator for, and I gave you the acronym earlier, National Association of State Mental Health Program Directors, and she's been there since January of 2022.

Amy provides crucial leadership in bolstering recovery support services nationwide. Her extensive experience in developing recovery data collection practices, particularly in Indiana, informs her work in supporting states and territories. Amy's dedication extends beyond her professional role. She serves on the boards of NAMI National, the SERF Center, the Recovery Cafe Lafayette, and leads locally in Lafayette, Indiana as CEO and founder for Paul's Plan Ministries. Amy is fully committed to fostering and bolstering mental health and substance use recovery at the local, state and national levels.

And last but not least is Dr. Glenda Wrenn Gordon. Also a national NAMI board member, Glenda Wrenn is a member of the national board for her second term, and is an associate professor of clinical psychiatry at the Morehouse School of Medicine. She also serves as the medical director of clinical integration at Mindula, and lives in Decatur, Georgia as a member of NAMI Georgia. She brings both medical expertise and a passion for building community and individual empowerment to address mental health needs.

Glenda was the founding director of the Kennedy Satcher Center for Mental Health Equity, where she developed mental health policy and research initiatives. She is a board certified adult psychiatrist and a nationally recognized leader of efforts to advance mental health equity. She has authored or co-authored many published works, most recently Racial and Ethnic Disparities in Treatment and Treatment Type for Depression in a National Dample for Medicaid Recipients. In 2020, Glenda received the NAMI Psychiatrist of the Year Award. I will now hand off the webinar to Vanessa, Vanessa Matthews.

Vanessa Matthews:

Thank you so much, Dan, for this opportunity and for all the folks at NAMI that helped make this a reality for us. I've always been told that if you are the smartest person in the room, you are in the wrong room. I can definitely tell you I'm in the right room because of my esteemed colleagues that I have an opportunity to work with. If you'll advance it to the next slide, let's talk a little bit about what we're going to talk about today. I'm not a reader of slides word for word, so I hope you'll go along with me and extend me some grace as it relates to that. But we're really going to talk about looking at the co-responder model and how that looks. Understanding trauma as folks transition through the mental health services that they need, and roadblocks to reintegration.

You're going to hear some fabulous things about that, and then most importantly to me is to talk about the benefits of really true collaborations, because the ultimate goal here is to have safer communities that we work in. And the key to it is that we all truly do play an important part in that happening in all three areas you see bullet pointed here. These individuals need our support, and some folks, Dan referred to them as lived experiences, and I always say when I'm talking with folks locally, it's lived expertise. Because we

all have the expertise of our particular lens that we look through to be able to really navigate the system and help people do what they need to do. On the next slide, we talk about target population. Here's the thing I want to say about target population.

When we talk about risk in treatment courts, we really focus on looking at high risk, high need individuals. And when someone hears this in layman's terms, they automatically think danger. Here's an important teaching point I want you all to take away from this. When we talk about risk, what we're simply talking about is, if that person were on traditional probation, they would not be successful, because a lot of needs go unmet. All rise has what is called the best practice standards. There are 10 standards where courts can operate and have the best outcomes if they adhere to these standards. And the very first standard is the target population. Within there we talk about risk, we talk about need. And when we say risk, what we're talking about is, do you have a validated assessment for risk? And risk looks at criminogenic factors for that individual.

Now the question you're probably asking is, why are those criminogenic factors important? We got to know what they need in order to know what they need. And the same is true when we take a look at behavioral health. We need to do clinical assessments as well. I think I read one of the questions was asked, "What do you do with someone that has a co-occurring disorder if they're coming into a treatment court?" Up front, if we do those correct assessments that are evidence-based practices, then we know up front what those needs are going to be and how to help that person navigate through the system. And so what we really want to do is to be aware of what risks truly means as it relates to substance use disorder and mental health issues. We're talking about looking at how we can best fill the gaps to meet the needs of those individuals. And law enforcement plays a huge part in that. When I show you the sequential intercept model, you will see that, because we are the first intercept point for anybody that ever enters criminal justice, and many times get referral to services as a result of a law enforcement officer being called.

So here's what we want to do. We want to really understand and take away from this that when we talk about risk, we're talking about the risk that that person is probably not going to succeed on traditional probation, because there are going to be some unmet needs, just because traditional probation is typically ran a little bit different than what treatment courts look like. On the next slide, you'll see a true rendition of what law enforcement really looks at when it comes to this population and these identified needs. Honestly, in my 22 years of service as a police officer with Oklahoma City, the most rewarding part of my career was when I had the opportunity to work in treatment courts. And honestly, when we take a look at treatment courts, I saw a different opportunity to do something and have better outcomes.

This is a issue that's very near and dear to me. When we talk about substance use disorder and mental health issues, I have folks that I love that have struggled through these issues for a number of years, but when we take a look at law enforcement being that first intercept point, we can understand how that, together with treatment courts, is really a way out of that revolving door, how we can have an opportunity to change. Traditionally, we think about things like treatment court or reintegration programs, and we automatically think, "Oh, we've become soft on crime." I can promise you this, I was never a person to be soft on crime, but what I do understand, and what was really important to me early on in my career, is the humanity that we need to stay in touch with as we help folks navigate through their challenges in life. And I always remind folks that the difference between me and the person that I may be providing services to is a circumstance.

And quite honestly, I reflected back as I was preparing for this session, I got a text message on Sunday, and the text message from the young lady said, "I just ran across somebody in the center median on one of our main thoroughfares. She was completely unclothed and she was clearly having a crisis moment." And this individual dialed 988 first. Dan mentioned that earlier, and I think Hagan mentioned it when he first started. But she knew to call 988, and she knew to call the police and explain to them what was going on. Now, why is that important? Because she is a 15-year graduate of a local treatment court program here in

Oklahoma County, and I talk about her all the time and the great tremendous work that she's done. So I give you that example to say that if we can make the difference in one person's life...

I'm probably going to tell you how old I am now, because if you think back to remember, if you can, there was a commercial by a shampoo company, and it said, "It started with one person, and then they told two friends, and then they told two friends," and then it goes so on and so on, until you have this TV screen that's full of people that get the message. That is exactly what we're trying to do with these collaborative efforts between All Rise, NAMI, and other organizations that we work collaboratively with to get the message out there. And the greatest advocate for that is the person that's in that community each and every day, and that's law enforcement. And we have really taken a strong hold in understanding this from a training perspective, because we don't know what we don't know. And so we want to train law enforcement to really understand that this is not about just clapping and applauding somebody, but this is about real life struggles and meeting unmet needs.

And so let's talk in the next slide about how we truly do make that case. When you take a look at what is the target population's needs, when we talk about folks that are dealing with substance use disorder and mental health issues, and at the end of the day we want to look at community connectedness, well, guess who's the most connected person when you hear about the sequential intercept model later? It's law enforcement. And the other great thing is that we're there 24/7. And so All Rise has really taken the position that if we can train law enforcement on the front end in how to manage and interact with individuals, we have better outcomes on the back end with this. And so that means putting those resources together to identify gaps. We're not just talking about identifying gaps for the target population that we're looking at, but we're also talking about training gaps.

There has been a wonderful collaboration that has been developed between All Rise and NAMI, and Hannah has really led the force on that to make sure some things are happening. Shannon has been working really hardly with that. The goal is that together we can share with the community, and we want to always remain solution focused as we approach these issues. And that's where this is absolutely my favorite saying in the whole wide world. It is keep the main thing the main thing. When I get confused and I get frustrated, I have to go back and ask myself, "Is this about the main thing, or is this about me?" And as long as we can go back and center ourselves on it being the main thing, the needs of those folks with lived experiences and lived expertise and meeting those needs, the better we're going to be, whether you're law enforcement, a clinician, a peer, a judge that's interacting with those folks. And that happens by law enforcement being able to come to the table with the knowledge base.

On the next slide we take a look at, really, what does research say about it? And what we know through All Rise and the research that we've done is that treatment courts are the number one research response to the issue of substance use disorder at the intersect of criminal justice and mental health disorders or diagnosises. So if that's the case, and we know that just having law enforcement involved, you can see an 83% reduction in cost savings in that community, so what does that mean? It means dollars back in the community. And that's really what the ultimate goal is here, is that not only do we put dollars back into the community, but we give these folks with lived expertise an opportunity to have a fulfilled life, just like each and every one of us want to have each day. And so we'll take a look at the next slide when we talk about, what are some of the common goals that we really want to take a look at in this?

And key to it... I mean, there are a lot of things listed on these bullet points, but here's the most important part of it. Improve lives of folks that live in our community. Our neighbors matter. We matter. But what matters the most is if we can come to the table together and really develop something. We know that we ask the question all the time, "What does this look like? How we work together look like?" But we have to really understand this from a perspective of all intercept points that become involved in this. On this next slide, I'm going to show you a quick video. It's about three minutes, three and a half minutes long, but it talks about why we need to have treatment courts and how they work. So you have a little bit better understanding of this as we lean on toward hearing from someone that has the lived expertise in Amy. So go ahead and play the video, and let's take a look at this.

Video:

Drug addiction has become an unprecedented public health crisis. We cannot solve this with incarceration. Drug courts are part of the solution. Drug courts, also called treatment courts, are specialized court programs for persons with substance use disorders. Instead of simply going to jail, the programs give people the opportunity to enter long-term treatment and agree to court supervision. Drug courts address the root causes of drug use and criminal behavior, like poverty, mental health issues, physical health, and unemployment. Participants in drug court maintain recovery from drugs, take on responsibilities, and work towards lifestyle changes. Members of the court help participants in their progress towards these goals, and hold them accountable for lapses in improvement. Unlike traditional court, drug courts take a collaborative approach to justice. The judge, prosecutor, defense attorney, and probation official work collaboratively as a team. They use their individual expertise in partnership with public health professionals such as treatment providers, social services, and mental health specialists. Together they seek solutions that benefit the participant. Ultimately, drug courts reduce crime and affect real change in lives.

To be eligible for drug court, a person must be charged with or convicted of criminal drug or related charges, be likely to re-offend, and are experiencing serious substance use disorders. There is no universal model for drug court programs, but there are two common ways in which people enter drug court. One, in which defendants who meet eligibility requirements are diverted from traditional court proceedings into drug court prior to pleading to a charge. The other, in which defendants who meet eligibility requirements plead guilty to their charges and their sentences are deferred or suspended while they participate in drug court. In many cases, participants who successfully complete the drug court program may have their underlying criminal offenses dismissed or expunged. If a participant fails to complete the program, their case will be processed as it normally would in the traditional criminal justice system. Drug court is an intensive program. It requires immense commitment from participants, and dedicated case supervision from the drug court team. The program often includes participation over a series of months or years. This establishes and helps maintain long-term recovery strategies.

Frequent and random drug tests. Drug tests are a way to establish accountability and integrity in the effort to stay sober. Treatment for substance use disorders. These treatment programs are grounded in the science of addiction and evidence-based models. Required frequent appearances in court. This gives structure to participants' lives and integrates them into a community of recovery. Immediate rewards for maintaining treatment plans and sanctions for failure to meet obligations. Individualized case management services. Connecting participants to employment opportunities. Community service, pro-social activities, and education, and support and encouragement from the drug court team. Drug courts can be tailored for specific populations. There are courts specifically for DUI, DWI violations, courts for opioid use disorders, courts for juveniles with drug dependency, and courts for veterans.

Vanessa Matthews:

Thank you for that. Now I want to talk about it from the court model. So you heard in this video talk about how folks get involved in treatment courts. Here's the takeaway, though, that I want you to have, and that leads us right into the sequential intercept model. I shouldn't have to be charged with the crime. The whole goal is not to criminalize your diagnosis, right? And so when we take a look at this, we have to understand that there are other intercept points that a person can be introduced into services and to have those needs met. The drug court model is one model, but as we take a look at the sequential intercept model, which basically looks at a spectrum of interaction with individuals in the community at different decision points along this spectrum, and what we really want to do is we really want to take a look at that collaborative approach that is community-based for those folks that may have some diagnosis around mental health or substance use disorder that do become involved in the criminal justice system.

On this next slide, you'll see basically what the sequential intercept model looks like. I'm not going to go into a whole lot of detail about it, but I will recommend that you go to SAMHSA's GAINS Center and

take a look at this. They've got some extensive information that really talks about different decision points along the sequential intercept model. But really to talk about and understand experiences that a person has throughout this journey on the sequential intercept model, I want to hand it over to our person with lived experiences and expertise, and that's Amy Brinkley. So I'll go ahead and turn it over to Amy.

Amy Brinkley:

Thank you Vanessa. Good afternoon and hello everybody. You can go ahead and go to the next slide, please. So as I was sitting there and I was watching the video that Vanessa just played... Oh, I forgot to turn my video on. I apologize. As I was sitting here listening to the video, watching the video that Vanessa played, I was struck by the fact that I wish I had had access to a drug treatment court during my time, but I didn't. And so I'm so thankful for the people that get access, but let me back up a little bit and just start with introducing myself. So my name is Amy Brinkley, and I'm a person with direct lived experience in both mental health and substance use recovery. By the grace of God, I've been in recovery now since April 3rd of 2009, which is just over 15 years.

And I was watching the video and I was having all of these memories coming back, and I wished I had had access to that, because I can remember sitting in the jail cell thinking to myself and praying and just evaluating life, and wishing that I had had help. I couldn't quite understand why I was being incarcerated when I just needed help. I just couldn't seem to stop, and I didn't know why or how. And I think, well I know, there's a misnomer. People think that people who use substances, that it's a choice, and it's not a choice, and I just couldn't stop and I just needed help, and I didn't know where to go for help. I already disclosed I spent some time incarcerated, and my journey to where I'm at today was a very long journey that I'm not going to get too far into the weeds on, but I am a firm believer that people don't care how much you know until they know how much you care.

And so as Dan had shared during the bio reading, I've lost three brothers to suicide and my mother to an overdose, so this is a topic very near and dear to my heart. When my second brother passed away, we were both actually incarcerated at the same time. Completely different charges. He was incarcerated way before I landed in a jail cell, but he was released just before I was. And we had communicated via snail mail. We had been writing letters back and forth to each other for a few years, and I know how scared he was to be released. And growing up, he had had a diagnosis of ADHD, and so he had been on a medication for that growing up. And then following a divorce, he fell into a substance use disorder in order to try to help deal with his divorce, and then that landed him in a jail cell.

My own process was, I had a shoulder surgery that required physical therapy, and I became addicted to the pain medications that were prescribed from the doctor, and then I ended up incarcerated shortly thereafter him. And he had ADHD growing up, but by the time he was released, he was diagnosed with paranoid schizophrenia. He had had multiple diagnosises and had been on and off dozens of medications, and had had several suicide attempts prior to being released from the criminal justice system. And I remember his letters towards the end, right before his release, he was scared to death. He was scared to death to be released because he felt like he had lost his mind being incarcerated. And because the criminal justice system, the Department of Corrections, doesn't really have mental health treatment that folks really need, he was kept in total isolation for the duration of his sentencing.

And I think his... Well, it doesn't matter what his charge was, but he was in incarcerated for several years on a drug-related charge, and the majority of that time was spent in isolation. And so he quite literally said that he lost his mind, and then five days post-release he took his life. And so that had a huge impact on my own journey, and that burned this fire inside of my gut to want to advocate, because I became angry. Angry that the community did not help him come out of the criminal justice system in a way that he could have thrived the way that I have. So when I came out of the criminal justice system, one of the first things that I found out from a case manager is that I could use my recovery experience to help other people, and so he told me about a peer certification training.

And so I signed up for this peer certification training, which turned into meeting somebody from the NAMI state chapter. And so the person was telling us what NAMI is and what NAMI does, and I was like, "Okay, I want to get involved and I want to advocate, because less than a year before that my brother had passed away, and I wanted to advocate on behalf of people with mental health challenges and substance use challenges who go to the criminal justice system." So as soon as I landed back on home turf, because at that point I was still in the state capital, Indianapolis, when I got back home in Lafayette, Indiana, I signed up for my local NAMI chapter. I got plugged into our peer-to-peer classes and peer-to-peer trainings, and I started becoming a facilitator and becoming a trained trainer. I learned about our family-to-family programs, and I just got significantly plugged in with NAMI.

And I was already certified by the time I landed back in Lafayette, but what I found is that nobody wanted to hire me. Prior to being arrested, I had been in corporate level management, overseeing staff of up to a hundred and fifty people on any given shift, and I was quite successful in the workplace. When I came out of incarceration, however, nobody wanted to hire me. So I worked at a local pizza restaurant for a while, and then I just volunteered for my local NAMI for about two years... well, it was about 18 months to two years, before I landed my first peer job. And so my first professionally paid peer position, I actually had to leave my hometown to even get that job, because nobody would hire me. The background check kept screening me out. And so I ended up leaving...

I didn't leave the state, but I left the city, and I went to Gary, Indiana, where I became a youth peer support wraparound provider. And it was there that I got plugged into my local NAMI, and I worked for about a year, and then I took a position with the state. And so that was part of my bio too. I oversaw all of our peer and recovery support services for the state of Indiana. And I was there for about five years, and I had about $750,000 in three or four contracts when I started in state government, and then when I left in January of 2022, we had just over $10 million invested into our state recovery infrastructure, and almost 30 peer-run organizations were being funded, providing recovery support services across the state. So we significantly increased our recovery infrastructure development during my time at the state. And then that led to the position that I'm in now, which is the senior recovery support assistance coordinator for NASMHPD.

And so my role now is really providing peer support to other state peer recovery leaders across the country who oversee peer and recovery support services in their state. And so I feel like I really do have my dream job at this point, and I focus primarily on recovery infrastructure development because I feel like, well, I think, we would all agree that we've just got to do better. And I've lost three brothers to suicide, my mother to an overdose, but so have a lot of other people, and we've just got to do better. Our system just needs to do better. And especially for people coming out of the criminal justice system, it's interesting, because SAMHSA, our federal behavioral health authority, released a report a couple years ago saying that we need a million peers across the country, but recently they released a report that says we only have about 750,000. So there's still this huge gap in what we need across the behavioral health workforce and what we actually have.

And so my last role here that I'll talk about is my NAMI national board member role. I'm two years into my NAMI National board member position, and that is actually where I got to meet Dr. Wrenn and Vanessa Matthews, who are two women that I will consider friends until the day that I die. I would follow them to the ends of the earth. I just have so much respect and awe and inspiration from both of these women. And so I've enjoyed my time on NAMI National, and if you can go to the next slide, I think I want to do some level setting now, and just talk about... We're going to play a short video here that talks about what recovery is, and then we're going to talk about what a peer support role is as well, just to level set the conversation. So go ahead and play the video.

Video:

The goal of treatment courts is recovery. But what does that mean? What is recovery? Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives,

and strive to reach their potential. Let's dig deeper. Recovery is a process. Recovery is not a singular event. It has a beginning, but no end. Recovery is a way of life that must be sustained. There are many pathways to recovery. Some find it on their own. Others are referred through the justice system or nudged by friends and family. But there are also many pathways of recovery. These are the practices, beliefs, and programs people use to maintain and sustain their new lives. Recovery is not defined by abstinence. Relapse is not the end of recovery. It is often a part of the process, and it presents a renewed opportunity for intervention. Recovery is change.

Recovery is more than the physical transformation of no longer using illicit drugs or alcohol. Recovery is an ongoing change that affects all aspects of life. Recovery is physical and emotional health, because filling your best will help you retain recovery skills. Stable and supportive housing, because your environment outside of treatments plays a role in reinforcing healthy habits. Living with purpose, finding employment or volunteerism, service, family caretaking. Community and connectedness. Recovery thrives through positive relationships of love, friendship, and most importantly, hope. 25 million people are currently thriving in recovery. Each one is living proof that every person is capable of finding a path to and of recovery, and when they do, recovery is beautiful.

Amy Brinkley:

Thank you. And you can go ahead and go to the next slide. So as you could tell from the video, recovery is different for each person. It's very much a self-directed, self-identified path. And for each person, it's going to look different, which is why nationally there's been a huge push, and you've probably all heard about the multiple pathways to recovery. So it's not for any other person to tell me or anybody else what our recovery should look like. It's very much a self-determined process, and it looks different for each of us. And I would also argue that each person's recovery needs are different at different points in their life. And so SAMHSA, they have the definition of recovery, which we just saw played a little bit in the video, but they also have what they call dimensions of recovery. And it focuses on health, home, community, and purpose.

So I would argue that each of us, to achieve our full recovery and to be thriving in our own self-determined recovery, we all need access to resources and services within health, home, purpose, and community dimensions. So that being said, I'm going to talk a little bit about this SAMHSA resource that focuses on the peer support roles in the criminal justice system. So to level set here, the term recovery can be defined as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. In addition, peer support is a highly effective way of supporting the recovery of individuals with behavioral health challenges who are involved in the criminal justice system. And if you can go to the next slide, this is from the same resource.

Peer support has been defined as offering help based on the shared understanding, respect, and mutual empowerment between people in similar situations. And this resource, I will put a link in the chat as soon as I stop talking, I will share the resource, but in addition to what I'm not going to cover here, but what is also in the resource is lists of roles and responsibilities of peers within different settings across the sequential intercept model, as well as key characteristics of what the peer role is and should look like within the settings across the criminal justice system and the sequential intercept mapping. So if you can go to the next slide.

So here's where I'm going to kind of park here for a few minutes, and then will pass to Dr. Wrenn. But what I wanted to share from here, so here's the sequential intercept mapping, and what I can tell you from my role, both at the local level as well as at the national level, is that there's a lot of stuff happening within the entire sequential intercept model and peers across the sequential intercept model. So what we do know is that SAMHSA has released a report, or actually a national toolkit, on best practices for the crisis delivery system, and they encourage that peers be involved across all three layers of the crisis delivery system. So in someone to call, someone to respond, and somewhere to go, ideally peers will have a role within each of those three domains, as well as a requirement for access to recovery support

services. So ideally, if you have a peer working within those three domains of someone to call, someone to respond, and somewhere to go, they will know what the local resources are.

I do know that New Mexico is the only state that actually has peers not answering [inaudible 00:38:50] but actually in New Mexico, that's the only state that allows for the caller to make the choice on whether they want to talk to a peer or a licensed clinician at the time of the call. So when you call in, you're not getting triaged. They're not making the determination on who you need to get referred to, but rather you as the caller have the choice on, "Do I think I need to speak to a clinician, or do I think I want to speak to a peer?" So the caller actually gets the choice to do that. And we know that states are rapidly implementing peers into crisis lines, but I would say that it's not the standard practice across the country, but we are seeing that number increase.

In addition to that, mobile crisis teams, the majority of states, NRI, the [inaudible 00:39:38] Research Institute... And I'll put all these links in the chat. The [inaudible 00:39:41] Research Institute did a workforce report using the state profiles that we get from all the state mental health authorities. And they found that 75% of states said that they were hiring peers at the time of the state profile survey, and I believe it was twenty-some states have peers working in mobile crisis teams, but they were reporting a shortage of peers within that space. And the same thing with the crisis stabilization. There were I think 15... And I'll put the links in the chat. There was 15 or 16 states that reported shortages of peers within crisis stabilization centers. In the intercept one, we see a increase, and my colleague who's actually on today's call, Justin Volpe, and I worked on a SAMHSA-funded TAC paper titled Peers Across the Crisis Services Delivery System.

And what we found in that is that co-responder models, which are a crisis response, including a law enforcement and a behavioral health professional, there's not any evidence saying that the co-responder model is any better than alternatives, and that alternative responder models are any better than co-responder models. I don't think that came out the way I originally intended it to, but my point is that there are some states that are implementing peers with the law enforcement response to crisis responses, and it's in the paper that I'll put in the chat. Across the country I would say intercept two, the first thing that comes to mind in this intercept is here in the state of Indiana, our governor's office has funded using general revenue a peer support wraparound program that actually places peers inside the jails. And so as soon as you get arrested at intake, you meet with a peer who starts that reentry planning from the gate, and they will attend court with the person as they're going to court, even, and sometimes at that first court appearance. So we are starting to see peers involved even at intercept two.

And then for intercept three, we know that peers have largely been involved particularly in veterans' court, but we're seeing peers involved across all the specialty courts as the peer role is starting to really be adopted and taken more seriously nationally. Intercept four, for the jail reentry and the prison reentry, I will say that several states across the country are now starting to certify peers while they're still incarcerated within the prison, and they're actually allowing that person to then become a paid peer to their peers within the criminal justice system, which is unheard of. And they're saying that the culture shift that's happening with that movement is amazing, and we're hearing really positive things. So I know that Pennsylvania, Ohio, Pennsylvania, Ohio, Colorado are the three top states that come to mind that are now certifying peers while they're still incarcerated at DOC, and then paying for that person to be a peer to their peers within the system. And then in the community, corrections, probation and parole, oftentimes peer support roles, extend into that too.

The last thing I'll say before I pass it over to Glenda is that I participated in my local CIM mapping project, and we had a NAMI state facilitator who came in and guided our local community members' conversations, and we did a whole mapping of CIM, and we also did a mapping of peers across the sequential intercept model in our community. And one of the things that I'll say is that historically speaking, our local jail, our sheriff was adamant that "No peers are coming in the jail. You can have video visits, you can have phone calls, but we are not having peers inside the jail. It's a public health risk. We're

not doing it." So even though the governor's office was funding pilots of this across the state for two years, the sheriff was so adamant that it was not happening.

So day one of our CIM mapping project, everybody's talking about peers working in all of these different spaces within the CIM mapping, and the jail commander just stood up and said, "Look guys, we're not putting peers in the jail, so don't ask me about putting peers in the jails. It's not going to happen here. I know that it's happening elsewhere, but it's not going to happen here." At the end of day two of us all talking about our peers working in all these different spaces and the crisis services space in the community, and all across the board, we did a round-robin take of what everybody's key takeaway was of our two days of mapping, and the jail commander stood up and said, "My key takeaway is that we need to get peers in the jail." So I can't underscore how... And we're already talking about doing that, and what that's going to look like, and the county's approved funding for that.

So it's very, very exciting locally that this is happening, but I cannot underscore enough the intentionality of communities taking the time to actually do the mapping. Because we also learned from each other what's actually happening within this space, and there were so many gaps that nobody knew that anybody was even working on providing services in these areas related to reentry until we all got together in that meeting and started mapping it out. And we were blown away by how many things that all of us didn't know about what the other was offering. So CIM mapping, CIM mapping, CIM mapping. And I think that's my last slide, so without further ado... Oh, I take it back. So there is a conclusion and call to action, but I think I'll just leave it here, and I'll just go ahead and pass it to Dr. Wrenn, and I look forward to the conversation through the Q&A, so thank you very much.

Glenda Wrenn:

Thanks Amy. I love that we've talked about so many solutions instead of focusing on the problem. Yet it's true that there's still a lot of problems out there. It's great to hear about the innovations that are happening in your state and around the country. Have two cases here that are composite cases that highlight both the challenge as well as, "I will prompt you to think about what are the potential of how things would be different if you did introduce a peer into this space."

So the first case, if you go to the next slide, is a case of an individual... Can you advance the slide for me? Thank you [inaudible 00:46:10] Joseph, who's a 23-year-old transgender individual with a history of sexual abuse, picked up for an outstanding warrant. He was in the general holding awaiting booking, and while there, being harassed and verbally berated by a few other people in holding. So not officers, other people that were there. But he also saw a few officers that were laughing at the comments that were directed at him. He had been going through a difficult time financially due to rising credit card debt and dealing with depression.

This is a great case, because we've talked a lot about substance use disorders, but right now the only risk factor that this person's presenting with is depression and financial stress and social stress, however, being introduced into the jail system is a opportunity to either heal or harm. So right now, this case highlights the risks of traumatization. I would ask you to think about what would be the impact of introducing a peer into this space. I can tell you from the experiences with inpatient psychiatric services before peers were introduced in the space, there were a lot of climate issues and cultural issues that were instantaneously resolved as soon as there was a peer member of the team who was in the environment. So by having a peer employed and present in the jail setting will change the environment, it will change the context, it will change the way people speak around individuals and introduce an opportunity for healing.

Without that intervention, Joseph is likely to have traumatic experiences that may impact his potential for reintegration. And the key thing for any system change, for those of you that are in settings that don't have these innovations, is it's going to take a team in order to make changes. The next case is a good example of how community can respond in a positive way. So if you go to the next slide, that is a case of Kristy, who's a 21-year-old with a history of bipolar disorder and methamphetamine abuse. She's very known to

her community, and periodically lives with her elderly grandmother when she's well. When she's not doing well, usually her grandmother puts her out and she's out in the community. During an exacerbation or relapse, she also will become hostile, can be violent, mostly through destruction of property, and will verbally threaten local business owners. During one of these altercations, a shop owner called 911 to report her coming into the store in an agitated state, singing, dancing, harassing customers, and rummaging through the trash outside.

So the question here is, what response would ensure a good outcome for Kristy? This is a setting where the community can play a role in coming together. One thing we didn't mention when we talk about peers, it's not just their lived expertise and what they bring to the environment, it's the fact that they are members of the community, they're connected to resources, and they are your neighbors. And so they can do a really important work, both proactive outreach to store owners, having that co-response to be able to deescalate Kristy, and this is the early interception opportunity to where maybe someone could reach out to her grandmother, someone could help her get into a peer respite environment. She should not have to be taken into jail for disruption of property. So there's a lot of flexibility that law enforcement have to choose, whether or not they're going to go that route or provide mental health support, long before you get to mental health courts.

And so this is a good example of thinking about what types of system interventions could be a response so that a person like Kristy could have a positive response. How do you engage the family? How do you engage the community, local businesses, to be able to respond and rally to how everyone benefits when she's stable? And because we're closing on time and I want to be able to take a couple of questions, I feel like I want to stop there. The other slides really just speak about, for those of you who are interested in engaging in collaborative efforts, how you can do that, and then really the focus on reintegration. How do you reintegrate into community? It really starts at the front end. So reintegration work starts at initial booking. If you're waiting until the day that you're released, that's too late in the process.

So I would encourage each of you to think about engaging in collaborations to help improve reintegration outcomes, and also to prevent entry into the criminal justice system, especially for individuals with serious mental illness and substance use disorders that will be better served by treatment instead of legal. Okay. I will stop there and turn it over to Shannon to help field some questions for us.

Shannon Scully:

Great. First of all, I know we are not all on audio, but let's give a round of applause to our presenters here. This is such great information, and there's some really amazing questions that are coming through. Amy and Vanessa, feel free to join us back on camera. I want to start... First of all, we talked a lot about the drug court model, and we did have a couple questions coming in here. And I think this is really important for people to have an understanding, because I think often when we get questions about courts, it's like, "Well, how do I get my family member involved in a mental health court, in a drug court?" So what are some of the ways that people end up getting involved in these types of court program models? Vanessa, I'm wondering if you can start that off, and to any of our other presenters, you want to jump in as well.

Vanessa Matthews:

Absolutely. So within each state and even within the jurisdictions within a state, there are different intercepts where a person can be involved. For example, I will use Oklahoma. You can be referred by law enforcement if they interact with you and understand that there is an underlying co-occurring disorder issue, or specific to substance use and mental health, they can refer you that way. We try to train the bar association and encourage bar associations across the states to learn more about treatment courts, so they identify that role in referring that individual, and also we educate judges.

What's really important is, and Glenda mentioned a little bit about the trauma piece and Amy did as well, is making sure that judges are trained on trauma-informed approaches to this so they can identify risk and

need. It is my opinion that if every court is ran like it was a treatment court, where there's an allocation of those services through that referral process at every intercept point, that we have better outcomes. But you have to reach out to your local court to see what that process looks like. We're happy to get folks connected with that. My contact information will be available here, and you can certainly go to the website and send in an information request from that manner.

Shannon Scully:

Going to leave myself off mute here, because otherwise I'll forget. So thank you so much for that. I think that's really important to lay the foundation. If you are looking for resources, I just want to throw that out there. We have a lot of questions coming in about personal experiences and personal situations that are happening. I would really encourage you to go back up, reach out to our NAMI helpline. We can help you get connected to local services, or if you go to NAMI.org/findsupport, you can also get connected with your local NAMI, and they're going to know way better than us sitting here at the national level what the local resources are in your community. So I just want to acknowledge those questions that are coming in from our audience members, and to please reach out and connect with those services.

You guys talked a lot about sequential intercept model. We're talking about some of these reforms and changes to our system. So what are some of the biggest barriers that you guys see to advocating for mental health courts, substance use treatment courts in communities, but also other reforms that we're talking about across the sequential intercept model?

Vanessa Matthews:

I'll start off by saying because we are a training and research organization, one of the biggest things that we see is that I don't understand as a law enforcement officer exactly what Dr. Wrenn's role is and how she interacts with folks, and what information may be helpful to even put in a report that would be available to her about how when I went out to that particular consumer's home on a call for service, that I identified some other specific things. So part of it is education. Folks don't know what they don't know at each one of these intercept points, and so they continue to operate under the precept that this is a choice, that you can choose to do better. And I always use the example of being a law enforcement officer and answering the question, "Why don't you just leave?" when we're talking about domestic violence?

There are a whole lot of other factors there are at play there, and so the more we can educate people about how those factors are at play, and make sure that we're including the right information in any kind of reporting and referrals that we are doing, the first thing that's important about that is we reduce the likelihood that someone is going to be put in harm's way. Because if I don't know that there's an underlying issue, I may be responding from an officer safety perspective because I just don't know. But if I know all of that information and I'm sharing that information with other officers that ride the same district and maybe respond to that person, there are going to be better outcomes and there's a better way of doing it.

We mentioned CIT, crisis intervention teams. Having that crisis intervention training and doing... Amy mentioned, she talked about co-responding. Understanding what co-responding is and what that collaborative approach is will really help us to get connected with those individuals. But at the end of the day, it boils down to building relationships through having conversations, and go back to what I said in the very beginning, the humanity of it all, staying connected in that way.

Amy Brinkley:

I think she covered it all.

Shannon Scully:

Great, thank you so much. I also want to talk about the evidence-based support for drug courts. If we're making this argument as advocates, what is some of the evidence, the success that we're seeing coming out of this court? We specifically have some questions regarding the availability of data for this type of initiative.

Vanessa Matthews:

I don't want to hog the conversation-

Glenda Wrenn:

Go ahead [inaudible 00:57:23] you guys.

Vanessa Matthews:

... but data is our friend, I will tell you that. And at the Treatment Court Institute, our division of All Rise that really focuses on training and research, part of what that research did for us was help us develop what we call the best practice standards. We originally released those in 2016, and they are jam-packed with data. We just did an update. We've rewritten eight of the 10 standards, and then the last two are in a peer review process. So for those of you that are the data-bound folks, here's what happens. We collect the data with courts and their cohort courts that are in similar situations, and we see how those courts work. The best practice standards truly came out of a comparison of courts that applied those versus courts that did not, and what that research came from as a result of that that said, "These are the best ways to operate to have the best outcomes for those individuals."

The reason we rewrote those best practice standards was because we got new research. And so we have to look at the research as a moving target, right? Every time we get new data, we have to go back and say, "Is that data continuing to operate this way going to be effective if we insert that data into it?" And if it's not, then we have to change our approach to things. But that's the data aspect of it, but I would really like Dr. Wrenn to talk about that from a perspective of looking at how we need to apply that data when it comes to providing those services for those individuals. Because you mentioned evidence-based services. The key to it is understanding screening and assessments, and I stay in my lane, she's the expert on that. So can you talk a little bit about that, so they'll understand that a little more?

Glenda Wrenn:

Yeah. In terms of the original question about data, there's always going to be a challenge collecting data because of how it's captured. But in smaller efforts where there have been funded efforts to formally evaluate, that does provide the data to look the primary outcome of recidivism. That's the main outcome that we're trying to impact. But then you can also look at, is introduction of mental health and substance use assessments early in the process of booking... That's a way that you can help to identify whose needs those programs. So efforts that have screening and assessment that's done by a trained individual early in the process both allows you to look at prevalence as well as to properly refer people to the pathway. And then once they're engaging in services, you look at retention, you look at their outcomes in terms of clinical outcomes. Are they able to engage in treatment? Are they able to address the social needs? And then more importantly, their criminal justice outcomes. Are those positive as well?

I think there's really more evidence that this is helpful, and very little evidence that it's harmful, which is why in all 50 states you see accessibility to drug courts and mental health courts. They don't always operate perfectly, but it's definitely something that it's important for you to seek for those... There's many comments with people with experiences engaging and don't have access to drug and mental health courts, so I think being proactive to look at where are they near you, even asking about them and being proactive if it's you or a loved one that's involved, is another thing I wanted to share.

Amy Brinkley:

And can I say something too, really quick, about the data piece? It's not specific to drug courts, but I talked about how our local community did the CIM mapping. And so as part of the CIM mapping, I also sit on a legislatively mandated, I guess advisory board, if you will, that's called the Justice Reinvestment Advisory Council. And the role of that council is all of the criminal justice partners in our local community coming together and evaluating how things are going on the reentry side. And we look at data. So my point here is that the data's not really there for reentry. As we talk about building out, there's a whole national push right now, we've heard this from the White House even, around all of the money being put into reentry. But the problem is that there's not a lot of data that's informing what's happening right now.

And then the data that does exist, it's not being shared. So part of the CIM mapping, the benefits of it is that all of these things kind of got highlighted for the community to say, "Hey, this organization has this data, this organization has that data. Can we create data sharing agreements so that we can start looking and evaluating what our community really needs, looking at all of the data, and not just one organization's data, which doesn't tell the full story?" So I think that with all of the reentry work that's happening, as well as the peer role within the reentry work that's happening, there needs to be more of the collaborative piece happening between community partners, including the criminal justice partners. Sorry, not specific to the drug court, but wanted to add that piece.

Shannon Scully:

No, I think that's great, and I think the more we can be collecting information about folks who are coming in at various points, the more we can better understand how to serve communities. And Amy, since we have you, there's some questions about the availability of peers, but also some barriers peers have to gaining access to employment because of their criminal histories. Can you talk a little bit about efforts that are going on, one, to be able to expand the number of peer supports specialists we have available in communities? But also, what are some thoughts you have about ways for communities to overcome some of the barriers around having justice system involvement?

Amy Brinkley:

Yes, so you may have to help me a little bit trying to answer all of that, but the first thing that did come to mind is that we worked with, Justin Volpe and myself at NASMHPD worked together with, SMI Advisor last year on a toolkit around the best practices for hiring peers with felony backgrounds. So some of the things that we highlight throughout that toolkit is the fact that SAMHSA, the federal behavioral health authority, says that we need a million peers, but statistically we only have 750,000. But if you look at how many millions of people are coming out of the criminal justice system every single year, and you do the math on the stats of how many of those people have mental health and/or substance use backgrounds, we have millions of people coming back into the community that we could be getting certified and putting into the workforce, but quite often their felony backgrounds is excluding them.

And so there are practices that hiring organizations can put into place, such as having a peer or a person with direct lived experience be part of the onboarding process, being part of the job description development piece. Right? So sometimes people won't even apply for a job. Why? "Because I know I have a felony background, they're not going to hire me. Why even bother?" It goes all the way to the job description having a clear call out that these are things that actually make you more qualified if you have that reentry experience. And then we also talk about the use of AI in HR. Right? Sometimes the use of AI within HR automatically excludes people too in the pre-screening process. Then you have the whole onboarding process of hiring a peer, and then they get there and it's a toxic work environment. "Well, the pay's already low. I don't know if I'm going to stay, especially if it's a toxic work environment."

There's this whole national federal movement now around recovery-ready workplaces. SAMHSA's Office of Recovery worked to get their SAMHSA federal office as one of the first federally registered recovery-ready workplace certified. They're now certified. And so through SPARK, a separate initiative that I work with, we are doing a webinar on that in a couple of weeks on how organizations can move in that direction. So I would say that there's a lot of work happening on this.

The last statistic I want to point out is that in the toolkit, we also point out the fact that of the millions of people being released, 60 to 75 percent of them are unemployed one year post-release. So even taking peer support out of it, 60 to 75 percent of people being released from the criminal justice system are unemployed one year post-release, but when you look at Indiana's Department of Correction statistics, the top two predictors for recidivism, so the top two predictors for people going back into the criminal justice system, are lack of employment and lack of education. So we have a problem here. People are coming out and they can't access the very things that are keeping them stuck in the system. And so we've got to rethink how we're looking at policies and how we're welcoming people back into the community post-incarceration.

Glenda Wrenn:

Can I add one thing?

Vanessa Matthews:

[inaudible 01:06:22] Oh, go ahead.

Glenda Wrenn:

I just wanted to add one thing around peer support, because our company Mindula, when we first started, we had 60% of our workforce were peers. And it's kind of a common misconception that your criminal record is going to be a deal breaker. You will need to disclose, so definitely don't hide it, because there will be a background check and it will be identified.

However, there was a couple questions that came through. There's state codes, usually, that describe what are some disqualifying convictions, but in most cases there's discretion, and you can even ask for exemptions under extenuating circumstances, especially if the felony was a result of active addiction or an active mental health crisis in those types of situations. And I know many of the colleagues that work for our company, they have felony backgrounds 10 years ago, nine years past, they're gainfully employed, fully functioning certified peer specialists.

So I wanted to encourage people to not be feeling like there's no hope for you if you do have a felony background, because in many cases it may not limit you from getting certification or getting employment.

Vanessa Matthews:

And the thing I wanted to add about that, and I think I saw this in one of the pre-submitted questions, they talked about funding to connect. Right? And so a lot of folks think of funding and they automatically think to something around treatment courts. We have to reframe how we think about resourcing. For example, with what you've heard from Amy and Dr. Wrenn, the Department of Labor actually has grant funding that takes a look at doing exactly that reintegration piece into the community. So finding someone in the community... I mean, this grant pays for housing, it pays for workforce development, all of those things that are going to be necessary to address the statistics that Amy shared with us. And if we can find organizations that are willing to partner together to go after this money, to increase the footprint of folks reintegrating back into the community, we can do two things.

Number one, we can provide people with a source of income, because the more I can pay for myself, the better I feel about myself. And the other thing is that we build coalitions of people where peers get to see

that it is possible for them to do what they do. I don't stop talking enough about the incredible work that Amy has done and she's been able to accomplish. I've never met anyone like her before in my life. When you hear her story and you hear the passion behind her story, a lot of that is tied to resources that she was able to connect to. One of my ultimate goals as I go and train across the country and internationally is I talk about NAMI. And Hannah probably is like, "Oh my gosh, somebody else that Vanessa has referred to us," because I'm constantly putting that...

I will name drop NAMI in a heartbeat, because for me, when we started our treatment court program, that was the missing link, because a call from NAMI can get someone put at the top of the list, whereas a call from Vanessa's is just another cop calling. You know? So we want to make sure that we're looking at and utilizing and leveraging our resources in the best way possible. You're no worse off if they say no than if you never asked before, because the answer's still no. So there's no harm in asking. Develop those partnerships, develop those coalitions, so that we can engage the entire community.

Shannon Scully:

And I will just share that NAMI has been advocating this Congress for the Peer Support Act. I realize that's not super helpful because about to start another congress, but in order to stay up to date with everything that we are advocating for, you can sign up for our advocacy alerts. We will be doing a lot more of those starting in the new Congress, which starts this coming January, 2025, and that's at NAMI.org/advocacy.

Dr. Wrenn, I want to get your insights here, because there's been a lot of questions. One person specifically named anosognosia, lots of folks naming a lack of insight. Can you talk about some of the ways we know, for folks that are coming into contact with the justice system, what are we doing to help engage folks in that voluntary level of care that we know is so important, especially when maybe they might not have that insight that they need into what they're experiencing?

Glenda Wrenn:

Yeah. The first thing I'll say to that is, certainly as a loved one or a family member, anosognosia is quite frustrating, and oftentimes you bear the brunt of that frustration in trying to convince your loved one, whether that has to do with bipolar disorder, mental illness, or they're not at a stage of readiness to change their behavior with respect to a substance use disorder. It is inherent in the diagnosis that denial is a part of the diagnosis. So that can be a challenge. And I know we've talked a lot about peers today, and I'm going to offer that up here as another example of, the credibility that I have as a psychiatrist talking to someone is very different from someone who's a peer that has the same diagnosis that you have been given, that is taking medications that you may be prescribed or you have taken that same medication before.

And that is the reason why peers are so effective at engagement. Another thing is that developed wellness recovery action planning, or WRAP planning, is a common tool that peers use in engaging people. And how that's effective is it's connecting with you in the areas that you're interested in getting help with. And I use this clinically as well. We don't always take the symptoms head on. We might talk about your financial needs, your housing needs, your food insecurity. You connect at the place that the person is engagable, and then you build from there and you work from there. When the justice system is involved, when the police are involved, that's a very punitive environment that most people are trying to get out of that, so you have some motivation there to say, "Is there another pathway for me than going into general population in the jail?" Or... you know.

So in my experience, people do behave differently when they're in that type of setting. And in some respects, they can be more amenable to engaging in treatment when it's offered. And a lot of places it's not actually offered, but where you are able to get those behavioral health services in the jail system, people are grateful to have it. Same thing for the work that I've done with pre-arrest diversion. People are

welcoming of that. Usually they're not the ones calling 911 on themselves, it's other people in the community responding, and so they're willing to engage in care.

It doesn't take away from the frustration that I know people are voicing in terms of, you go through all of this to try to get your person help and then they're turned away. They're not good for this setting or they're not able to be admitted. So I don't want to discount the reality of the burden that caregivers have when it comes to that. But I will say that engaging in peer support where it's available, and then for you as a caregiver to engage in the NAMI supports and family to family, if you're not really connected with your local NAMI resource, can be a lifeline to help you have support, solidarity, and a little bit of respite as you're caring for your loved one.

Shannon Scully:

Thank you for that. And staying a little bit on the clinical side, but I think all of our panelists could probably speak to this, more and more, at least in the advocacy space, I hear us talking about co-occurring disorders, we're talking more about holistic people. But it seems on the justice side, we still have things like veterans' courts, mental health courts, and substance use courts. Can any of you speak to how you might see this progressing, and are we seeing some progress into starting to integrate more of this idea that we're treating a whole person, and co-occurring within the justice space?

Glenda Wrenn:

Vanessa, you want to start and I'll-

Vanessa Matthews:

Okay, I'll kick it off a little bit. And here's what I'll say, is that the model really speaks more specifically to, I'll start with veterans' court, unique set of circumstances that bring someone into the camaraderie of being a veteran. And that's really the only approach to it that we look at that differentiates. Because what we do is, we take a look at... It's person-centered, right? Choice and voice. We want to make sure everybody has a choice and a voice in the process, and the development, even if you go back and look at where veterans' courts were developed, it was literally a process of the same person kept coming into a court to see a judge over and over again. And as he came in, his charges kept escalating, and the judge's clerk was a Marine, yes Marine, a veteran. And he asked the guy if he'd been in the military, and they developed this battle buddy, if you will, conversation.

And so in all of the courts, regardless of what the name of the model is, every one of them has that thing that is person-centered, that is voice and choice. That's why we talk about, when we say target population, that we make sure that risk tools are put in place to see what their criminogenic risk factors are, and that need tools are utilized that tell us what their level of care is and what their needs are, to make sure that we can address all of the needs of that individual. So if you take me into your program and I have a need that is of a psychiatric level that you don't have services to meet those needs, but yet you still take me in the program, you have really accelerated my pathway to prison as opposed to helping to divert me, from the program, from prison.

And so that's why we want to make sure that each individual that comes in... Matter of fact, that was the whole basis for the rewrite of the standards, to make sure based on the research that everything was voice and choice, that we were really leaning more on what treatment said, so regardless of how I felt about what needed to happen to a person, as clinician, if Dr. Wrenn said, "No, this is what needs to happen," that's what we need to go with. Because that's person-centered. That is listening to and empowering that therapist to meet the needs of that individual, and that's really what the new content and the new context of things are, is really giving treatment that therapeutic space with the support of everybody else that's a part of the team.

Glenda Wrenn:

Just want to add for... you know, there's historical reasons why drug treatment courts have been around a lot longer than mental health courts, and they are kind of qualitatively different, in that you'll be engaged in drug court if you have a drug related offense, so there's more of a tie in terms of coercion. I don't want to use that word too strongly, but that's probably the best word to say, that there's kind of a coercion factor that I think is more characteristic of drug courts, in that if you don't comply with the treatment, then you will get the consequence that you would have gotten. Whereas that's less of a case in the mental health court. There is also a trend in terms of the types of offenses that an individual who's loitering or throwing trash around, those low-level misdemeanors in a person that has a chronic psychotic disorder, for example, it's basically criminalizing their diagnosis.

And so you'll put them in a mental health court to get them treatment and taking... It's not a coercive factor in terms of, "If you don't take your medication, then we're going to lock you up." So I think there's a historical reason, as well as the fact that mental health courts are new, and that the drug courts do tend to be tied to drug-related offenses, and provide an alternative pathway to incarceration specifically, so that adherence to the treatment plan is linked back in terms of consequence. And that's consistent with accountability that is required, which you heard in the video.

You need to have accountability as part of recovery period, both for substance use and mental health disorders, but particularly with substance use disorders. That frame of accountability is kind of the scaffolding that helps a person to stay within the boundaries when their illness makes it difficult for them to otherwise do that. Sometimes the external factors can be the way to provide that stabilization until the person can internalize and have their own why that's strong enough and they don't need those other external factors.

Amy Brinkley:

I'll just add one quick thing, is that when you add a peer to the treatment team or to the team, the mental health court team or whatever reentry team you're talking about, when you add a peer, I think that automatically brings more of a holistic view into it too, because that peer's getting to know that person on a much deeper level, so that when they're at the team meetings, they can say, "Hey, look, I recognize that they're not taking their meds or they didn't show up to their appointment. But did you know that ABC is happening? And so maybe if we can address some of these other community-based service access problems that this person's having, maybe they'll show up to their appointment next time, or maybe they wouldn't have missed their medication," or whatever the issue is. I think that having a peer on the team could automatically bring some of that more holistic... you know, the needs, into picture.

Shannon Scully:

Great. And we just have a couple more minutes, and so what I want to do is just a quick round-robin of any last minute thoughts that any of our presenters have, something you really want everyone here to walk away with. And if you can't think of that, we'll go with our CEO's favorite question, which is what gives you hope? So I'll give you the alternative question here, but also, what do you want folks to walk away with today?

Vanessa Matthews:

I'll jump in and tell mine. It's a little quick story since you said walk away, and Amy's going to know exactly where I'm going with this. We were at a conference and she wanted me to walk with her just around the corner to go to this business, and it ended up being five miles, and that five mile walk there and to wait on her and to come back ended up being our evening.

The point is that she asked me and I showed up. I didn't ask any questions, I just showed up, because she cared enough to share that space with me. And so the one thing that I would like you all to take away is

that we all come from different life experiences, and most important part of you interacting with other folks, whether it is professional or from a perspective of service delivery, is that we have to hold space for them, so until they can find what is going to be necessary for them to be successful.

I was honored that I think that really solidified my friendship with Amy, and I learned a lot about her and she learned a lot about me. So in that space, be willing to learn about people, but also let them learn a little bit about you. And I always go back to it, just be a good human.

Amy Brinkley:

You know what? I'll follow up on that and I'll follow in her footsteps, because I have another story and she's going to know which one I'm talking about. We were at a national meeting and I came down with Covid. I'll do a story. They shut down my flight. I could not fly, and Vanessa stood in the gap and drove me halfway home and my husband met us halfway. And here's where I'll go with that, is that every single one of us, no matter where we're sitting in our seats today, got where we are because somebody opened a door.

One of the main things that I've learned in my recovery is that I should always be reaching back to the person behind me on the path. And so every single step up that I take, I always have a hand back helping somebody back up behind me. And so if we could just remember that none of us got where we are alone, and so we should always be reaching back and helping, and opening a door for somebody that wouldn't be opened otherwise. That would be my hope for the key takeaway.

Glenda Wrenn:

And I guess I'll wrap it up by saying, it's important to not grow weary in the good work that you're doing, and one of the best ways to help yourself to stay strong and resilient is connecting to other people that are in the trenches on the front lines. Because it can be isolating, especially if you're in a place that doesn't have resources or you feel alone and disconnected. And so the fact that we had almost a thousand people join this webinar today suggests that this is a pretty big topic that affects people. We have some probation officers, loved ones, a very diverse group that's here today. And so my encouragement is to get connected and stay connected to other people that are doing the work. You can learn from them, but more importantly they can encourage you, they can validate you, they can help you to vent when you have a bad day.

Everybody has a right to have a bad day and be like, "It's too big of a problem. What can one person do?" And then they're also going to be calling you two weeks later, saying, "All right, it's time to dust yourself off, take your shower, tousle your hair and get back out there and fight another day." And I do think that ultimately it's something that is going to take all of us working together to see progress, and we have seen progress, and those bright spots are encouragement. So you can focus on them and say, "Hey, if we just keep the fight going, then we can see progress no matter who's in charge and who's in administration." A lot of this work is done on a local level, and there's a lot more influence on the local level to make changes, so I don't think that's something that should distract us from the work ahead.

Shannon Scully:

Thank you all so much. Again, I know we're not all in the same room, but a round of applause for Glenda, Amy, and Vanessa. This was an excellent presentation, and also happens to be, I believe it's our last virtual town hall for 2025. So way to go out on a high note, and thank you guys all for joining us for this presentation. I have nothing left, except to say, again, a big thank you to all of the folks who joined us here. Please make sure that you go to NAMI.org and sign up for our emails so you can continue to get information about any of our future town halls or virtual events that we provide through NAMI. We'll be bringing you more in 2025. Again, thank you so much to our presenters, and happy holidays, everyone.