Mental Health Advisory Board

Preliminary Report on Lessening the Reliance on Incarceration for the Mentally Ill in Alameda County

Presented to the Alameda County Board of Supervisors

By
The Criminal Justice Subcommittee of the Mental Health Advisory Board (MHAB)

September 2016

Testimony from Executive Directors, Program Directors, Mental Health Clinicians, and Social Workers serving individuals involved in the Criminal Justice System with moderate to severe mental health issues in Alameda County

Introduction:

Across the nation, federal, state, and local criminal justice experts, police departments, mental health specialists, policy makers, and government officials have recognized the significant problem of the incarceration of individuals with moderate to severe mental illness. President Obama has called for extensive criminal justice reform including making the reduction of mentally ill inmates in US jails and prisons a national priority. More than 130 police chiefs, prosecutors and sheriffs have joined the movement to reduce the nation's incarceration rate and address the problem of the criminalization and incarceration of those with mental illness. (1)

There are currently a disproportionate number of people with mental illnesses, co-occurring mental health and substance use disorders and homelessness in local jails. More than two million people with serious mental illnesses enter U.S. jails each year - more than the number of people found in the nation's psychiatric hospitals. The related costs to law enforcement agencies and jails and the toll on human lives have reached crisis levels. (2)

Individuals with mental illness in jails face significant challenges, including access to psychiatric and medical treatment, longer incarceration stays, higher recidivism rates, and increased risk of bodily harm. A recent report entitled *Justice That Heals: Promoting Behavioral Health, Safeguarding the Public and Ending our Overreliance on Jails* concluded: "By virtue of their very nature - from their architectural design to the manner in which they are operated - jails and prisons tend to exacerbate mental illness."(3)

The Criminal Justice sub-committee of the Mental Health Advisory Board supported the effort of a volunteer to interview Executive Directors, Program Directors, Mental Health Clinicians, and Social Workers serving individuals with moderate to severe mental health issues in Alameda County that have been involved in the criminal justice system. The identification of gaps in service and the lack of resources in particular areas points to the increased need for strategic planning and coordination on a county level.

Many of those interviewed stressed the need for greatly improved collaboration and leadership from the Board of Supervisors to include all the stakeholders: providers, policy makers, criminal justice staff, community members, and BHCS in creating a county-wide plan to address these multi-faceted issues.

Each of those interviewed stressed the need for 'upstream' approaches that increase prevention and treatment and decrease incarceration. As one mental health provider stated, "We are always mopping up, but no one is turning off the water."

The Criminal Justice sub-committee of the MHAB is requesting that this report encourage the Board of Supervisors to hold a hearing supported by the public health

and public protection committees that addresses the need for countywide planning and coordination and implementation of a county-wide strategic plan to decrease incarceration of the mentally ill.

1. Police leaders Join Call to Cut Prison Rosters: Williams, Timothy. New York Times October 20, 2015

2. Community Policing Dispatch: Reducing the number of people with mental illness in jails: Why sheriffs are stepping up. Volume 8; Issue 9; September 2014

3. A national survey of mental health services available to offenders with mental illness: who is doing what? Bewley, M and Morgan, R. (2011) Law and Human Behavior.

Overview:
The intersection of mental illness and criminal justice system

Donald Frazier, Executive Director of Building Opportunities for Self Sufficiency

Mental health care is miserably underfunded and the criminal justice system is often the only institution that picks up the slack with the result that 15 percent of men and 30 percent of women in jails have a serious mental health condition, most of whom don't get needed care while they're in jail, according to National Alliance on Mental Health (NAMI).[1]

This is the result of decades of policy. As different levels of government slashed resources to mental health care, the justice system was left as the only institution equipped to respond. In multiple report cards[2], NAMI outlined some of the cuts that followed the Great Recession: None of the states graded by NAMI earned an A, and almost all made significant spending cuts to mental health services in the past few years. And these cuts came to a system that NAMI had already criticized for decades as being severely underfunded.

The report cites California's permanent supportive housing program for the mentally ill "the gold standard," because it provides clients with a safe, structured place to live. California cut 21% from its total general mental health budget from 2009 to 2012. Space in state hospitals for general psychiatric clients is limited, because 90% of beds are used for mentally ill suspects awaiting trial, or for sexual predators who have completed their prison sentences.[3]

The number of people with serious mental illness in prisons and jails outnumber those in state hospitals 10 to 1. It is worth noting that most people with mental illness are not violent. Many are locked up for low-level crimes — loitering, littering, criminal trespassing, and drug possession. Moreover, people with mental illness are **more likely** to be victims — not perpetrators — of violence. And only **about 3 to 5 percent** of violent acts in the

US are carried out by people with serious mental illnesses, while **about 4.2 percent** of adults in the US experience a serious mental illness in a given year that substantially interferes with or limits their major life activities.

Over a five-year period, these individuals accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. The cost to the community was conservatively estimated at $13 million with no demonstrable return on investment in terms of reducing recidivism or promoting recovery. Comprising just 5 percent of all individuals served by problem-solving courts targeting people with mental illnesses, these individuals accounted for nearly one quarter of all referrals and utilized the vast majority of available resources.

A 2013 Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications[4] by the Vera Institute of Justice, found that "it can cost two to three times more for a person with serious mental illness to be housed in the criminal justice system compared to receiving treatment in the community." The review found, some mental health programs led to fewer arrests and shorter jail stays among mentally ill populations.

1. https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness
2. http://www.usatoday.com/story/news/nation/2013/01/07/states-mental-health/1805023/
3. Source: The National Alliance on Mental Illness, Kevin A. Kepple, USA TODAY 2013 *This needs a more specific date and a page number.*
4. http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf

INTERVIEWS

Dr. Noha Aboelata, M.D.
Chief Executive Officer:
ROOTS COMMUNITY HEALTH CENTER
Interview conducted May 16, 2016

Roots Community Health Center is an East-Oakland based primary medical care medical home with a patient base of close to 10,000. Roots has expertise with the re-entry population, engaging 500+ reentry clients in services over the past 12 months; the vast majority were direct referrals from inside Santa Rita Jail. Of Roots' adult reentry population, approximately 15% are diagnosed with severe mental illness, and close to 70% have mild to moderate mental health issues such as PTSD, depression, and anxiety.

From 2001 through 2006, Dr. Aboelata was Associate Medical Officer for Tiburcio Vasquez Health Center. Beginning in 2007 Dr. Aboelata served as Consultant Chief Medical Officer for the Native American Health Center in Oakland. One of Dr. Aboelata's initiatives (2000) was to obtain the designation of the East Oakland communities of Fruitvale, Fremont, Eastmont, and Melrose as a Health Professional Shortage Area (HPSA). This designation paved the way for increasing primary care services in these communities. She went on to obtain the HPSA designation for the communities of Ashland, Brookfield Village, Castro Valley South, Elmhurst, Hayward Northeast, San Leandro North Central and San Lorenzo East.

Key Issues

No Discharge Planning - There is an absence of discharge planning when people are being released from CJMH at Santa Rita Jail. There is no plan for continuity upon release, no referral to psychiatry, and no post-release appointments made. We have people showing up to our site with a piece of paper with our name and number and the number of ACCESS. We have to help patients initiate out-patient psychiatric care when they are already going through multiple destabilizers.

No Medication – We rarely see someone that leaves CJMH with their medication. Prescriptions are called in to a pharmacy in the community, and patients are expected to arrange for their own pick up of these medications. This is another place where the continuity is often disrupted. They may not have transportation or ID, or face other barriers that prevent them from obtaining their meds in a timely manner. Also, their prescription is usually for only 10 days, so if there is an issue with their insurance coverage, or they can't get a psychiatry appointment within 10 days, the likelihood is that they will go off of their treatment and may end up right back in jail.

No Medi-Cal - We still see people getting their Medi-Cal terminated while they are incarcerated. It should be suspended and put back on as soon as they get out, but we are still seeing many who are released having a completely terminated Medi-Cal case. Our staff must restart the enrollment process, and in an effort to preserve continuity, we often need to work to get the case expedited - this takes a lot of staff time and still runs the risk that a person won't have coverage when it's time to refill their medication or be seen by the psychiatrist.

No Records - We have never been able to obtain medical records from CJMH. Obtaining even the most basic information such as diagnoses and medications is critical to the safety and continuity of patient care.

Needs

Points of Access to Appropriate Care - We need more outpatient treatment. It should be accessible where people live, it should be culturally congruent and competent, and points of access should be distributed through the community in the geographic areas

where they are needed most. If these access points were medical homes where they could receive both primary and behavioral health care, patients could receive integrated, more holistic services. And they would know where they could show up if they felt they were going into a crisis.

Timely Reassessment - People are diagnosed under duress and without support when they are in incarcerated settings. Incarceration itself is stressful, what led to incarceration was stressful, and then the person is isolated from any support they may have had – community resources, home, or anyone they call family. So naturally their symptoms are exacerbated. Things may change as soon as they are out so they need to be reevaluated. We need a more fluid continuum between inside the jail and the outside.

Services Along the Continuum - The largest gaps are for mild-moderately mentally ill people. I'm not suggesting that we have enough resources for the severely mentally ill, but at least housing and treatment are available. But for people with mild to moderate mental illness, there are simply insufficient resources dedicated to addressing the needs. It would be helpful to have a table to discuss needs of people getting out of Santa Rita along the entire continuum of mental health needs.

Preventing Incarceration and Recidivism - Resources in the community that are equipped to handle individuals along the continuum of mental health needs would go a long way to decrease incarceration and recidivism. When people begin to destabilize, particularly when they are men of color in poor communities, they are often seen as a threat by law enforcement and arrested. By investing in accessible community resources, we can work to stabilize more people and also develop critical resources for Probation and law enforcement. This will ultimately protect individuals from the criminalization of their mental illness by providing viable community alternatives.

People need to be treated, but the jail is the worst context. Our investment in treatment and supportive services in the community should far exceed any investment in these services behind bars.

John Knowles
Program Director and Social Work Administrator
East Bay Community Recovery Program
Interview conducted June 8, 2016

John has been working in the non-profit world of mental health, co-occurring substance abuse, homelessness and chronic health issues for 25+ years. He manages the **Forensic Assertive Community Treatment, FACT (est. 2007) and the Behavioral Health Court's TrACT (est. 2009) programs of the East Bay Community Recovery Project.**

Overview of Programs:

East Bay Community Recovery Project's Forensic Assertive Community Treatment Programs—FACT and Transitional ACT (TrACT) provide intensive wraparound services through Medi-cal and MHSA prop 63 funding through Alameda County Behavioral Health Care Services.

Program Eligibility: (18-59) mental health condition severe and persistent; histories of over utilization of jail, psychiatric emergency and inpatient services. A majority of participants are challenged by homelessness and substance abuse.

TrACT, the service provider for the Alameda County Behavioral Health Court, has the capacity to serve up to 29 individuals. FACT has the capacity to serve up to 79. Clients or partners (the term we use) have benefitted from partnering with staff to utilize services such as: outreach, engagement, crisis intervention, peer support, case management, housing, employment, educational, mental health, psychosocial educational, psychiatry, and medical triage. Program empowers partners to obtain and maintain housing, achieve and maintain wellness, recovery, and self-sufficiency while living independently.

The FACT and TrACT Programs have a presence in court and advocate with judges and attorneys. Team members present progress reports providing partner updates and offer recommendations, whenever possible, for community based treatment in lieu of incarceration.

Our clients/partners have a significant reduction, or elimination of episodes of incarceration, days in custody, their involvement with Alameda Superior Courts, and episodes and days of emergency and inpatient psychiatric services.

Santa Rita Jail and BHCS:

Staff visit Santa Rita Jail at least once weekly for assessment of newly referred program participants; provide continuity of care for partners in custody, and for partner discharge/release planning. We often go to Santa Rita weekly to transport newly enrolled participants to ensure a successful transition.

In the early years of the programs, we did assessments in the medical clinic where we had face to face contact. This is no longer the case. We have been meeting with the inmate in the pod where there is a small closet like space with a thick glass divider between staff and inmate. This "accommodation" makes it difficult to develop rapport with the individual and almost impossible to complete a 12-page assessment. We can request a contact visit, however, with the lack of space, we have to meet in an open area where the inmates can roam freely which is also not conducive to a 1:1 interview/assessment and does not respect the inmates right to privacy and confidentiality.

The expansion project's office spaces will make a significant and positive impact allowing us freedom to move around the mental health pod, to interview our potential

participants where their privacy can be upheld and develop therapeutic rapport. The rapport will help minimize safety concerns related to transporting an almost unknown individual in a vehicle for an approximate 45-60 minutes to their destination. We have had individuals decompensate or act out and jump out of the vehicle while in motion. This therapeutic alliance enables staff to gain their trust and respect and to be able to push our partners beyond the limits of what they think is possible for themselves and to achieve their wellness and recovery goals .

Release planning is a collaborative coordination process between a partner, a FACT/TrACT team member and a staff member of the Criminal Justice Mental Health program that includes a jail pick-up date and arranging transportation. The planning also involves a referral to a step-down co-occurring mental health and substance abuse residential program if needed. If substance use is an issue, it involves transitioning the individual to the programs' emergency housing. Release planning requires the coordination with the jail psychiatrist for a written prescription or a verbal order to our pharmacy for a minimum 10-day supply of medication. These medications last until my team psychiatrist is able to meet with the new participant within 1 week of release.

Inmates currently do not receive any substance abuse treatment or peer led self-help such as AA or NA. This could change with the expansion project as we may be able to have access to a meeting room for a relapse prevention or substance abuse educational group.

The expansion of space will support participants in taking advantage of the time in custody to attend groups and gain information and possible coping skills to increase the potential for them to be successful upon release from jail.

The increase in space will also increase the medical services available as we sometimes have trouble connecting individuals with medical services in the community. Having health-dental-obgyn services in the jail create an opportunity for us to coordinate these services while they are in custody.

We were involved with BHCS to discuss the new space. Discussions with the sheriff's dept. could have been improved. The jail needs to better prepare people coming into the community as many are getting out without adequate medication, are not stabilized and are symptomatic.

We have a good relationship with CJMH: we get a fax when one of our clients arrives so we can visit t and assure them that we will support them the courts and in jail. We provide the courts with progress reports.

Over 9 years, I have seen programs develop to provide re-entry services to inmates in Santa Rita Jail, however, nothing has changed as far as the Sherriff's department accommodating the needs of programs needing additional access to the inmates. Mental Health providers and the sheriff's department would benefit from a closer

collaboration to improve the outcomes. In some ways the jail seems to have gotten more restrictive.

Sharing data has always been a challenge. We have never had full access to medical records inside jail. I have searched for data about the cost of treatment in community vs. treatment at SF and I was not able to get that information. If I am not mistaken there is an effort within the Behavioral Health Care's system of care to begin addressing this issue along with increased coordination efforts with the sheriff's department.

Needs:

1. Co-Occurring Residential Treatment for low functioning, criminal justice involved, mentally ill, substance abusing and homeless individuals.

The primary challenge to the programs meeting outcomes continues to be pervasive and chronic substance use/addiction that plagues, 90 % (83 of 92), of the program partners. The FACT partner's substance use is more significant both in actual total number of partners served and the severity of use when compared to the TrACT partners. Partners substance use/ addictions compromise their ability to adhere to program guidelines whether it is taking medication as prescribed or following through with orders from the court. Substance use diminishes functioning capacity which in most cases keeps them from being able to utilize and benefit from MHSA funded programs.

The programs have access to the limited co-occurring residential programs as we have developed close partnerships with the programs. We refer partners to residential treatment beds available in need of a structured rehabilitation program. FACT and TrACT partners' mental health and co-occurring substance abuse treatment needs have continued to increase each year while the existence and availability of other co-occurring community resources—residential treatment programs, sober living environments (housing), intensive outpatient and self-help services—continues to fall short of the need. Most inmates could benefit from a direct transition from jail to a residential treatment program, however, there are not enough beds available and our program partners often considered too acute for these services and denied entry. We have had to refer partners to residential treatment services that are intended for individuals with substance use issues and do not have the ability to treat individuals with co-occurring severe mental health issues.

2a. We need to create a community based continuum of care for individuals that are low functioning due to years of homelessness and substance use. We need many more crisis stabilization units.

Our rate of graduating partners would be higher if there were a system of care that included: 1) co-occurring substance abuse residential programs; 2) step-down community based recovery support (Crisis Stabilization Units and true SLE's) 3) self-help programs complementing the therapeutic and rehabilitative services of FACT and TrACT. Such a system would provide longer-term comprehensive services and support individuals in their efforts to maintain their recovery and increase their sober community

network. These challenges significantly decrease the program's capacity for effectively supporting partners in achieving their wellness and recovery treatment goals.

3. We need greatly improved collaboration. A goal of an initiative developed by the National Association of Counties is getting individuals with mental health issues out of criminal justice system. I believe our county signed up to participate, but I have no idea how we can become involved. We cannot afford to duplicate services - there are not enough services to begin with.

4. We need leadership at the macro level to bring federal resources to support innovation in programming and additional programs. I would like to see the creation of an ongoing department whose mission is to bring all the players together and oversee problem solving in the criminal justice behavioral health care system. BHCS does the best they can, but they are only one arm of the county. The BOS needs to make this an important priority and include all the stakeholders: community based providers, policy makers, sheriff's department and the leadership from BHCS.

Gigi Crowder, MFT
Ethnic Services Manager & Culturally Responsiveness Coordinator: BHCS

Interviewed July 12, 2016

We need to approach the issue of incarceration and the mentally ill by improving outcomes through prevention and treatment. The juvenile justice system invested in a new building, but they supported upstream programs and the population significantly declined. We need to do that for the seriously mentally ill at the county jail.

I agree that people with mental illness in the jail should be treated in improved environments, but we need to spend as much money preventing people from ending up at Santa Rita Jail.

The bulk of our SMI patients that are incarcerated are African American. We need to use more culturally appropriate practices to identify interventions that could prevent behaviors that lead to them being criminalized.

It is very difficult to get data from CJMH about the numbers of SMI that are in the jail. CJMH staff have told me that deputies often treat the SMI horribly. Their behavior often decompensates because they are incarcerated and they are often not adequately treated with medication.

We need crisis stabilization units throughout the county. I do not fault John George for having overflow most of the time - I fault a system that doesn't plan for services at lower levels. We need places that are culturally appropriate where people get counseling reflective of their community.

We need more transitional housing with supportive independent living opportunities. Some individuals have the coping skills to live independently with a check-in from a case manager, but the SMI need more support to stay out of John George and Santa Rita.

Many individuals need programs that have better assessments, counseling, and help getting prescriptions filled. People with severe mental illness decompensate with 3-4 days of no medication, so they often wind up with behaviors that put them in Santa Rita. We need to stop seeing psychotic people that make bad choices as criminals.

I know of a young man with SMI who died in the backseat of a police car. He had over 60 noted episodes: visits to John George then released, visits to CJMH them released. We don't keep track of these individuals. There is not the data and if there is, it is often not shared.

We have many community-based organizations that do excellent work and are already engaged with re-entry population, but they do not have the capacity to bill Medi-Cal. None of our providers that specialize in working with the SMI African American community have long-tern funding. That is some of why we continue to see so many cycle in and out of jail.

We need a grassroots effort supported by the Board of Supervisors. It should not just be BHCS: it needs to include housing, substance abuse treatment, CJMH, the community, and law enforcement. We need a mandated meeting that is staffed and supported by the BOS to address these upstream problems.

Interview with Officer Doria Neff
Oakland Police Department Mental Health Liaison and Alameda County Crisis Intervention Training (CIT) Coordinator.
Interviewed July 25, 2016

CIT is a partnership between law enforcement, behavioral mental health, consumers, and family members. It is a jail diversion program where officers are trained to de-escalate situations. We have trained 700+ officers in Alameda County to conduct better evaluations in an effort to divert consumers from jails. In Oakland, if a dispatcher indicates a call is related to mental health or a suicide risk, they attempt to get a CIT trained officer to respond.

Officers current options are: jail (if arrest is applicable) or John George Psychiatric Pavilion if they meet the 5150 WIC criteria. There is a segment of the SMI that have been traumatized by hospitalizations; others have a secondary motive to go to John George: they get food, temporary respite from the streets, etc; and are subjects who are under arrest and will malinger in an effort to get out of going to jail.

For 5 years, local law enforcement agencies have advocated for crisis stabilization units throughout the county. If an individual does not meet the criteria for an involuntary hold, and no crime has been committed, officers are left with no other options for intervention.

Law enforcements goal would be for individuals seeking services, instead of having to walk into a police department, consumers, could walk into a community based crisis stabilization units which are warm and welcoming and does not feel like a jail or a hospital. Ideally Alameda County would have 4 – one in each different area of the county.

The ideal crisis stabilization center needs a security element so it does not become a hang out that attracts unwanted activity, but the preference would be to keep law enforcement out of it. In some situations, law enforcements presence can escalate the situation. Officers are able to provide structure and calms things down, but often people become more distressed when officers are involved.

The Oakland Police Department piloted a Mobile Evaluation Team [M.E.T.] that partners a CIT officer and a licensed clinician who respond to crises in the field, while riding in the same vehicle, primarily in East Oakland. The relationship allows the clinician to have access to the consumer's history on scene and can assist with diversion from the hospital and maybe jail. OPD also partners with BHCS and has a dual clinical team in downtown/West Oakland who respond to mental health calls at the request of officers in the field.

One of the struggles officers report facing John George is the dual diagnosis population who often time end up at their facility. PES often times does not have enough space or time to allow an individual fully de-tox in an effort to truly assess their needs; is the root, substance abuse or a mental health issues. John George is not a dual diagnosis treatment program… therefore this complicates those folks treatment. In PES, once that individual no longer meets the criteria for an involuntary detention, JGPP can no longer legally hold them. PES is not a treatment facility – just stabilization with some medication if applicable.

One of the most challenging populations are those with thought disorders. Officers interact with individuals who lack the insight into their illness and are most often un-medicated at the time of contact. When the person does not meet the criteria to be on a hold, they are left in the community, with little assistance. Many are homeless and struggle with follow up services. These folks are vulnerable to their environment and lack the means to advocate for their needs.

Law enforcement has to constantly evaluate and balance public safety and an individual's rights. When public safety or an individual's safety is in jeopardy, officers are expected to prevent injury in the safest way possible. With a population that can be unpredictable and lack impulse control while delusional or hallucinating it becomes a challenge to communicate, de-escalate and resolve sometimes very dangerous situations. Law enforcement agencies throughout Alameda County are doing more and more to connect

with and learn from the mental health community. We also need education for families about mental illness and when to call for help.

Tom Gorham
Program Director
Options for Recovery
Interview conducted June 23, 2016

"Options" was founded in 1996 as the case manager for the Berkeley Misdemeanor Treatment Court. Options expanded its collaboration with the courts, district attorneys, police, and probation department to promote an alternative sentencing approach addressing any substance abuse-related offense in the courtroom. We serve more than 1600 clients annually.

Overview:

The biggest problem is that many people don't get treatment for substance abuse and mental health disorders until they have committed a criminal act. I have seen many people get out of the state prisons and Santa Rita County Jail that have not had any substance abuse treatment.

Most first and second time offenders coming out of Santa Rita are not eligible for AB109 services so they are not adequately supported. We have to wait until people are in and out of the system 4-5 times before they are correctly diagnosed. We have 165 clean and sober beds and we are at 95% capacity at all times, but only 13 of those 165 beds are AB109 clients.

As a provider of AB109 services, I have watched million of dollars come into the system. However, I have also watched hundreds of people get out of jail and prisons without any substance abuse treatment and with inadequate hand-off into community care to help them stabilize.

Problems:

The DEUCE program at Santa Rita reaches about 10% of the population, but many of those with mental health issues are not eligible. We know that the vast majority of those with mental health issues in the jail also have substance abuse problems. The DEUCE program and BHCS mental health providers do not seem to work together with co-occurring disorders.

We frequently see people coming out of Santa Rita Jail with no medication so we often have to rush them out to Sausal Creek. We need a 30-day supply that takes them from the jail to providers.

Treatment in a jail setting should happen, but if the follow-up is weak or non-existent, the individual will fail. There has to be more continuity between what happens in the jail and

what happens when they get out. We created a program at San Quentin where we have case managers that meet them during treatment; we have a car waiting and pick them up on their release date and bring them directly to the program.

Alternative Solutions:
I would like to see the half of the money that was put into the jail expansion go into new facilities. It would have been better to build an addition onto John George or another facility for co-occurring substance abuse/mental health disorder treatment. People should be diverted there instead of going to jail.

We need to ask ourselves why are many mentally ill are there in the first place? The criminal justice system should not be one of the biggest providers of mental health in the county.

Rudolph Smith, LCSW
Clinical social worker for BHCS. Past president of National Association of Black Social Workers.

Mr. Smith has worked clinically and administratively in SF Community Mental health Services as deputy director and with Kaiser Permanente Department of Psychiatry as chief psychiatric social worker. Healthy Communities - formerly Healthy Oakland
Interview conducted June 24th, 2016

Healthy Communities serves the community residents including the formerly incarcerated in West Oakland. Healthy Oakland is a social service agency that provides a variety of wrap-around services including connecting to individuals while they are in prison. They provide Public Benefit Enrollment Assistance, an on-Site Barber Shop, Mental Health Services, Anger Management, Domestic Violence Classes, and Alcohol & Drug Counseling

Overview:
“A common diagnostic thread with most of the clients is that they have PTSD and other diagnosis including depressive diagnoses, bi-polar diagnoses, and substance abuse, but having experienced trauma is what they often share. Women have had both physical and sexual abuse in their youth and have acted that out in various ways including criminal behavior. Men have experienced some sexual trauma, but mostly violence and violent confrontations that has had a negative impact on their thinking and behavior.

Not having income is the biggest factor that contributes to why people go back to jail. When people come out labeled as sexual offender, they are limited significantly as to where they can live. I have clients living in their car because they can’t get adequate housing because of the label.

Getting people with serious mental health issues on disability is extremely difficult. It often takes 2-3 times before they are approved. They get discouraged when it could take over a year and then can go back to some of the same pathological behaviors.

The people that I see returning from prison have had contact with a psychiatrist in prison that may have given them some medication or maybe a group, but nothing that gets more in-depth with personal issues and their unique history.

It is crucial that the reentry clients have counselors that are culturally appropriate and ethnically similar to them ethnically and understand their language so they can relate. They need individual and group counseling from someone that they can genuinely trust and there is not enough of that available.

Needs:
We never have enough places to refer people to. We often refer to West Oakland Health Center for mental health care and sometimes there is an extended waiting list. Sausal Creek will see our clients, but the daily wait is lengthy and they will get only a 2-week supply of medication and be referred elsewhere. There are not nearly enough programs to get people seen quickly and to maintain them.

There is a need for residential treatment programs that allow people to stay past the first few months. The more seriously mentally ill people need ongoing support, not just transitional support. ACBHS has a housing component that locates housing for some clients, but many do not meet the eligibility requirements or are too unstable to follow through without support.

Arthur Shanks: Executive Director
Cypress Mandela Training Center
Interview July 13, 2016

Cypress Mandela offers a 16-week pre-apprenticeship program for men and women over 18 years old. Training prepares students for skilled trades jobs for the construction industry. Approximately 25-50% of the student population has been involved in the criminal justice system.

Many of our students come in with PTSD: they have often served in the military; they are from public housing; single parent families; and have witnessed violence and drug abuse in their homes and neighborhoods. They frequently self medicate with marijuana and sometimes cocaine.

About 25-50% of our clients have been involved with the criminal justice system. The people with moderate mental health issues and are often underserved. They need life skills, trauma centered therapy and cognitive and behavioral structuring.

Wellness is far more than just dealing with PTSD. After clients leave the program in the afternoon, some start the drinking and self- medicating and that is when they need to have someone to talk with. We work on wellness issue, but we could use much more support to help us do that. Exercise, helping in the community, establishing rapport with their family – that is all a part of wellness and adds up to preventing recidivism.

We need more referrals and resources for those with PTSD and moderate mental health issues. John George is not appropriate for meeting these skills training to deal with the high level of stress in their lives.

From 82-85th on International Blvd. there are many homeless people with serious mental illness that impacts on the entire neighborhood: it impacts on businesses, stifles the community, and is a negative impact on our young people.

This is a countywide issue – not just one city's issue. We have a county office for mental health. Why isn't it working? We need more support from the BOS so we can collaborate and map out a strategy for a countywide strategy.

Douglas Butler: Program Manager/Instructor Cypress Mandela
Formerly Program Director at Men of Valor
Interview conducted July 13, 2016

The biggest problem seems to be lack of adequate staff to provide services. At Santa Rita, they just try to stabilize with medication, but there does not seem to be any long-range treatment plan. This is a grave public safety issue for the residents of Alameda Count having so many seriously mentally ill on the streets. Both John George and Santa Rita are discharging people to the streets who are mentally unstable with no place to stay and no money.

We need more accountability and communication coming from the jail. We have to start all over when clients get out of Santa Rita, as we receive no records or history. John George is overcrowded and the behavior and attitudes of the staff towards the patients and their families needs to be improved.

I know people who are so afraid of their mentally ill adult children that they lock themselves in their rooms to avoid calling the police because they know they will go back to Santa Rita or risk being badly treated by the police. There is a lot of reluctance to call the police on people with mental health issues.

We have inadequate housing programs for people that are in recovery with mental illness. They need supervision – not just a place to stay. Some of the programs that are run by local churches have 4 people in a bedroom that was made for one: it is like the prisons. Some of those places don't have proper permits or experience to run programs. They might have an NA meeting, but that is not adequate treatment.

We need more oversight from the BOS about who is getting money for these programs. We need a long range plan that incudes crisis housing, and long-term treatment program. We need to take pressure off of John George with additional satellite programs thought the county. We also need more holistic programs that include nutrition and fitness – a wellness approach not just medication.

Recommended readings:

1. "New Efforts To Keep the Mentally Ill Out of Jail," http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/19/new-efforts-to-keep-the-mentally-ill-out-of-jail

2. "Conditions at John George Contributing to mentally ill ending up at Santa Rita," http://www.eastbayexpress.com/oakland/overwhelmed/Content?oid=4705660&showFullText=true

3. Public Safety and Justice: Miami's Model for Decriminalizing Mental illness in America: http://www.governing.com/topics/health-human-services/gov-miami-mental-health-jail.html

4. "A Way Forward: Diverting People with mental Illness from inhumane and expensive jails into community based treatment that works" https://www.aclusocal.org/wp-content/uploads/2014/06/MENTAL-HEALTH-JAILS-REPORT.pdf

5."Decriminalizing mental Illness: the Miami Model," http://www.nejm.org/doi/full/10.1056/NEJMp1602959

6.Stanford Law School: When did prisons become acceptable mental health facilities? http://law.stanford.edu/wpcontent/uploads/sites/default/files/child-page/632655/doc/slspublic/Report_v12.pdf

Interviews conducted, transcribed and edited by Micky Duxbury, MFT.
Project Coordinator of the Welcome Home Project, a project of Community Works made possible by CAL Humanities and the Alameda County Probation Department. Duxbury received a USC Annenberg Health Journalism Fellowship for her 10 part series on Lessening the Impact of Incarceration on Oakland.