

Care First, Jails Last

Recommendations by Intercept

-2: Prevention

1. Provide a culturally competent safe place for African Americans that has education on health and nutrition.
 - In the 70's many of the black owned businesses in their neighborhood began to shut down. In the 80's crack was rampant, drive by shootings death and trauma was the norm while their fathers were being swooped up into mass incarceration. In the 90's there was a mass exodus from their neighborhood seeking reprieve, causing a loss of family property and EQUITY. In the 21st century many little league baseball, basketball, track, and football programs suffered creating a void of activities that would normally provide opportunity to teach unity, team building, discipline and core values leading to success.
 - My suggestion is to provide a safe space in the community that give AA a place of refuge that is for them, the new buzz word today is a place that is culturally competent. It needs to be a space that is able to give back much of what I suggest was stripped from them over the past 50 years. A place that they feel a sense of belonging. A place that they know the people in the space understand them. I was watching Shark Tank yesterday and Alex Rodriguez told a contestant from Dominican Republic that he should choose to work with him because "I understand you better than any of the other sharks on this stage". I point that out because the human spirit needs to be encouraged to know they are winners and the person best able to do that as Alex pointed out on national television is someone who understand them.
 - I agree the space should have education on health and nutrition. My son was misdiagnosed as having an allergy and if I had not looked online to investigate his lab results and discover what was really going on the doctor who did not know he never had allergies all the years I raised him would not have looked any deeper. As Alex pointed out it made all the difference in the world that I knew him better than the Dr. and I was motivated to determine the appropriate treatment.
2. Invest in recreational alternatives (e.g., little league, community centers, etc.).
 - We should invest in programs that bring back to the community the recreational alternatives such as little league and community centers giving the youth a safe

space to interact and enjoy their youth prior to drug dealers and gang members recruiting them into a life of turmoil.

3. Restorative community building opportunities to reduce barriers between affected communities.
 - Restorative community building opportunities to reduce barriers between reentry population, those with SMI, and broader community. Reduce stigma/isolation and improve community reception through town halls and cross-cultural meeting opportunities related to restorative justice and community building rather than retributive and punitive responses (address fear and stigma by increasing understanding, creating commonalities, emphasizing community, and providing practical tools to the community).
4. Integrating County Initiatives and Whole Person Care resources to achieve joint goals.
 - Integration of County Initiatives and Whole Person Care resources leverage joint goals and promotion for broader community; organized community events with multiple County and community agencies to align initiatives and direct resources in high need areas (e.g., Town Nights; Ashland/Cherryland EJ Collective).
5. Outreach to promote mental health resources.
 - Informational campaigns and dedicated outreach to promote MH resources, information, and tools (e.g., May is MH Month, June is Men's Health Month).
6. Invest in recreational spaces for TAY and systems-impacted individuals.
 - Invest in recreational options for TAY and systems impacted individuals. Increase spaces for youths where their physiological, social, spiritual, and mental health needs can be met such as Wellness Centers, Trauma Recovery Centers and Mental Health Supports.
7. Conduct public information campaigns aimed at families and placed with personnel who may come into contact with affected individuals.
 - Conduct public information campaigns aimed at families and placed with school personnel, Psych Emergency Services, health care providers and mobile crisis/law enforcement personnel, on signs and symptoms of serious mental illness (SMI), substance abuse disorder (SUD) and co-occurring disorders and the importance of early treatment.
8. Conduct public information campaigns on the potential deleterious impact of marijuana and street drugs on the developing adolescent brain.

9. To prevent those who are in active phases of illness from deterioration and potential for arrest and incarceration, provide adequate acute and sub-acute beds. (also see Intercept O).
10. Increase bed space to extend treatment times to reach true stabilization for individuals.
11. Provide an inclusive environment that is safe for youth and young adults to gather for education and curriculum regarding emotional support, etc.
12. Reimagining a people-first/no-wrong-door approach to behavioral health in Alameda County-centering the patient and their family/caregiver needs, instead of eligibility criteria (at minimum requires increased navigation support as first stop).
13. Provide housing stabilization services (financial and other) to people at risk of homelessness with history of mental illness and/or criminal justice involvement.
14. Continue to fund AC Housing Secure - Eviction Defence Funding for entire County. Adopt a policy that provides guaranteed legal representations for those facing eviction
15. Adopt Just Cause Ordinance in Unincorporated Alameda County, and advocate for Cities in the County to adopt a Just Cause Ordinance.
16. Provide services for 16-17 year olds who are identified as at risk of becoming part of the criminal justice system.
17. A collaboration between ACBH and university health systems to identify and serve TAY and junior college students having acute mental health crises.
18. Expand the eligibility criteria for case management services.
19. Eviction protections.
20. Increasing bed space at psych facilities.
21. Endorsement of AA center with inclusion of clinical and psychiatric support + medical care, culturally competent. All services in-house.

-1: Early Intervention

22. Reach communities with direct intervention and grass roots door knocking.
 - a. Reach the communities through grassroots door knocking and direct intervention.

23. Provide a support liaison for under-resourced schools. Develop a job description and fund the position for multiple staff to service schools and provide resources and support.
 - a. Provide a support liaison inside the most impoverished schools to reach those most likely to need the support. Through ACBH develop a job description and fund the position for multiple people to service the schools providing resources and support to the youth and their families.
24. Identify and offer support services to children of system-involved parents.
 - a. Identify and offer enhanced support services to children of parents currently on Probation/Parole including family therapy, access to school-based supports, recreational opportunities, and other resources to mitigate ACES related to justice involvement.
25. Increase support for peers and the utilization of peers in interventions.
 - a. Increase identification, training, leadership development, job placement, and utilization of peers. Support opportunities for peer-led interventions and require supports to address vicarious trauma. Support placement of peers in key programs and areas across all intercepts.
26. Mental health outreach in key spaces
 - a. MH outreach and workshops in key spaces including de-escalation training and MH tools to on-site providers. Especially important for housing programs, reentry hubs, and spaces that support families.
27. Increase family training, respite, and peer support opportunities to mitigate potential conflicts and crises.
28. Develop outreach Teams to help support homeless individuals with forensic involvement.
29. Increase/expand sub acute and acute hospital services.
30. Expand criteria that meets 5150.
31. Increase 5150 response services.
32. Strengthen and make robust a distribution system for information and referral services.

- a. Strengthen and make robust a distribution system for information and referral services for families and other caregivers who seek guidance on treatment protocols and care for SMI.
- 33. Make accessible reading material and referral to family support groups, classes.
 - a. Make accessible reading material and referral to family support groups, classes offered by local affiliates of the National Alliance on Mental Illness, county sponsored courses such as Mental Health First Aid.
- 34. Make widely available for African American families, information on the African American Family Support Group.
 - a. Make widely available for African American families, information on the African American Family Support Group, sponsored by the Mental Health Association of Alameda County (MHAAC) and The African American Family Outreach Project which provides a free, virtual workshop five times/yr which provides interactive programs with psychiatrists and key providers. The project reaches into the African American Community in order to increase understanding of SMI and to help families navigate the complex system of care in Alameda County.
- 35. Fund and open an African American focused mental health center.
 - a. Fund and open an African American focused mental health center which includes psychiatric services , an informational outreach component and is accessible to districts with a high percentage of African Americans.
- 36. For recent substance abusers, both with and without co-occurring disorders, assess need for residential and outpatient services to meet demand.
- 37. Direct community outreach and include the community thoughts and ideas of early intervention.
- 38. Increase peer counselor positions for street outreach and jail in-reach people who can serve as advocates for clients and their family members
- 39. Create health-literate and destigmatizing materials, billboards, and communications that improve service uptake. Distribute/target where 18-35 y/o eat, live, play, pray, sleep, etc.

40. Work with transition aged youth who are homeless or at risk of homelessness on housing, workforce, and supportive services.
41. Prioritize county budget to funding of new affordable housing in order to stabilize households in crisis and ensure access for re-entry population.
42. Prioritize county budget to fund operation subsidy so that Extremely Low Income households can access housing at 30% income.
43. Look at acute hospitals for first entries to John George. Prioritize identifying and serving folks at their first mental health crisis (e.g., first entry into John George or other facility).
44. Peer supports: spaces in high-contact areas, investment. Including addressing vicarious trauma.
45. More family training, respite, peer support for families themselves.
46. Housing, employment, service providers asking for more mental health training → de-escalation. equip them to deal with mental health crises.
47. Community education around alternatives to calling 911.
48. Job readiness: trainings, employment specialists to help folks develop skills & reintegrate.
49. Homeless community: collect data on their children & how to support them.
50. School liaison: esp in most impoverished schools.
51. Supported work programs can be expanded, for emotional wellbeing & self-sufficiency.

0: Community Services

52. Add acute and subacute hospitals.

53. Have dedicated staff organize the coordination and release of clients.
 - a. The onus must be on the system to ensure discharge coordination for clients who are utilizing hospitals/crisis. Need dedicated staff/provider/position to ensure coordination and release between hospitals, Probation, listed community providers, and crisis services. Currently this responsibility falls on the client/their family.
54. Increase CRT options for 290 registrants and those active to Probation/Parole and/or being released from SRJ/CDCR.
55. Process for referral from these programs to ECM providers through managed care plans.
56. Dedicated crisis service teams that will respond to ACPD offices and other high contact points.
 - a. Dedicated crisis services team/staff that will respond to ACPD offices, contracted housing programs, Parole sites, and other high contact points. This team requires the ability to de-escalate, assess, recommend 5150 evaluation, and transport.
57. Increase coordination with ACBH and JGPH during inmate hospitalizations.
58. Improve coordinated care.
59. Expand collaboration county and agency wide.
60. Improve communication and coordination of care across agencies upon entry into a hospital and at the point of discharge.
61. For first responders to 5150 calls, CATT teams, MACRO and law enforcement, ascertain they are C.I.T. trained, culturally competent and equipped with follow-up informational materials for families.
62. Evaluate current Crisis Intervention Training (CIT) curriculum for inclusion of racial realities and cultural responsiveness.
63. Assess current demand, increase the availability of acute and sub-acute beds to meet the demand. As of 2020, ACBH psychiatry department reported that only 3 of 20 individuals brought in to John George Hospital on a 5150, were actually hospitalized.
64. Introduction of WIC 5170 and WIC 5343 Facilities.

65. Add acute and subacute hospitals
66. Develop Crisis intervention teams
67. Improved communication and linkage between hospital/crisis response and outpatient service providers. Required types of elevated service provision and linkage for frequent utilizers (e.g., prioritization of FSP or other intensive service models).
68. Ensure hospitals create a discharge plan for homeless and at risk patients that includes shelter or housing support.
69. Divert funding from Hospitals and Jails to supportive housing, which has a direct impact on their ongoing operations funding
70. Introduction of 5170 & 5343 facilities (for detox and treatment) separate from MH facilities.
71. Licensed Board & Care centers -> not excluding those with felonies
72. More community events, sponsored by PDs (grassroots level, regular, casual gathering) (also address intercepts -2 through 0) - requires funding, requires prioritization.
73. Public informational campaigns.
74. Ask that police & sheriffs prioritize these sorts of programs.

1: Law Enforcement

75. Require police interacting with individuals with mental illness to have a community liaison mental health expert involved.
 - a. Create the requirement that if a police officer is involved with a mentally ill individual he/she is required to have a community liaison mental health expert involved.
76. Create consequences for police departments that don't adhere, or violate, these protocols.
 - a. Make it a consequence to the department that does not adhere to whatever changes they agree to make. For instance, for each time they are found to violate

and ignore the protocol the department is required to take from their budget to support the effort they chose to ignore. If the person is mentally ill look for family members to support and facilitate with the decisions and care needed for their loved one. Again if a person that knows and love the person the most is involved the outcome has a much higher chance of being a success.

77. Dedicated crisis service teams that will respond to ACPD offices and other high contact points.
 - a. Dedicated crisis services team/staff that will respond to ACPD offices, contracted housing programs, Parole sites, and other high contact points. This team requires the ability to de-escalate, assess, recommend 5150 evaluation, and transport.
78. Expand mental health work component to services.
79. Mental health workers to accompany officers.
80. Increase mental health assessments for system involved individuals.
81. Refer to Brian Bloom's Forensic Recommendations.
82. Non clinical Public Safety database; LE, DA's Office, Probation / Parole communication tool.
83. Coordinated Follow up teams in the field.
84. CARES Navigation Center.
85. Accountability reports for all law enforcement agencies to reflect referrals to CARES Navigation Center.
86. Expand pre-arrest and pre-booking diversion programs.
 - a. Expand pre-arrest and pre-booking diversion programs, both for people with MH/SUD diagnosis and for those who do not have a diagnosis but are at risk of developing (e.g., juveniles or TAY with involvement with JJ/CJ system, those who are unhoused, those who are trafficked, those who are survivors of crime, etc.).
87. Build supportive services and mental health providers into emergency services call for people who are homeless.
88. Train first responders in how to handle mental health issues.

89. Non-clinical public safety database (partnership between agencies) at county level for high-contact individuals.
90. Point of arrest diversion (are all law enforcement agencies participating?) - offramps to incarceration.
 - a. shouldn't be limited to misdemeanors
 - b. shouldn't be predicated on someone's insurance
91. Law enforcement carrying information and referral materials to share with families.
92. Need additional long-term care beds.
93. Point of arrest diversion access points throughout the county (right now only in Fruitvale).

2: Initial Detention/Initial Court Hearings

94. Create consequences for discrimination in AOT process.
 - a. Remove the opportunity for discrimination in who is given AOT, Community Conservatorship, Behavioral court by creating a consequence for the numbers clearing indicating that the department is clearly being biased. In my son's case the transcript clearly shows that the judge questioned why my son was not being referred to ACBH however no one in the courtroom thought enough of him as an AA to offer him help. The D.A. was determined to convince me that my attempts to help my son were futile. The public defender dismissed the judge comments as it is not in her notes to do anything about a man that is clearly struggling. I had two personal incidents in which the D.A. refused to pick up a case for a person of non-AA person. In one case the person would get drunk in our neighborhood and drive recklessly. Everyone knew him and when he hit my car the police investigated found that he had a prior incident of reckless driving, but the D.A. chose not to prosecute. As a result of my complaint it has been nearly a year and that individual has not committed this crime again. My concern is that the unfairness of over prosecution of AA is why we are the majority of homeless the majority of the inmates in Santa Rita. It is not a coincidence it is deliberate choices of bias and discrimination. Unless there is a penalty for this bias and systemic racism it will NEVER stop!

95. Assessment of effectiveness of CARES Navigation Center. Based on assessment, invest more resources into similar programs.

- a. The C.A.R.E.S. Navigation Center, located in the Fruitvale district of Oakland and in operation since mid-2021, is currently the only point-of-arrest diversion program in Alameda County. Operated by La Familia Counseling Services, it is designed to redirect individuals arrested for "low-level" offenses into supportive services, behavioral health treatment and away from incarceration and the criminal-legal system. The task force should analyze all aspects of the Navigation Center to understand, among other things, how well it is meeting its goals; why some police departments don't use the Navigation Center, how client engagement can be improved; whether one Navigation Center for the entire county is sufficient; what are the rates of engagement with services as well as rates of recidivism; and whether limiting the program to only "low-level" offenses is sensible. Based on this assessment, investing more resources into point-of-arrest diversion programs like the Navigation Center (and LEAD [Law Enforcement Assisted Diversion] programs as well) would further the goals of Care First, Jail Last.

96. Explore using Pretrial Services as a diversionary offramp away from jail and into medically appropriate treatment.

- a. The Pretrial Services Program, managed by the Probation Department, assesses recently arrested individuals within 24 hours after booking (and before arraignment) to see if they should be released from jail, and if so, under what conditions. The program also supervises those who are released from jail during the pretrial phase. In September 2022, Alameda County Superior Court Presiding Judge Smiley and Judge Jacobson gave a presentation to the Public Protection Committee of the Board of Supervisors about the county's pretrial release program. The presentation included a brief discussion about diverting people with behavioral health challenges from jail at this juncture (post- arrest/booking but pre-arraignment). Using Pretrial Services as a diversionary offramp away from jail and into medically appropriate treatment should be explored further. Again, such an endeavor should be based on a deep dive into the data surrounding pretrial release to consider the unmet needs in this area. Incorporating an evidence-based behavioral health assessment into the pretrial release program could result in more mentally ill incarcerated individuals being released from custody and into the treatment they need and deserve.

97. Custody staff should contact community mental health providers during intake.

- a. Community MH providers contacted by custody staff upon intake and during service coordination to plan for appropriate discharge and service coordination.
98. Central coordination between entities to avoid duplicating efforts.
- a. Direct communication is needed between AFBH discharge planning and Public Defenders, Probation, community providers, etc. There needs to be a central coordination entity to reduce duplication of referrals/services and wasting resources.
99. Communication with Public Defenders about options.
- a. Communication with Public Defenders regarding realistic options including residential treatment options, referrals, and connection. Clients are being ordered and OR'd to programs that cannot accept them, which results in extended incarceration and/or release with no services.
100. Central contact point for triage and connecting clients to services.
- a. Pre-trial release, collaborative courts, and diversion courts also need to have knowledge of a central contact point to triage and support connection to referred/existing services.
101. Improve AOT capacity.
102. Some temporary non-voluntary treatment in certain circumstances.
103. Develop more Peer led staff within the court systems to work with individuals to connect and engage in services.
104. Significantly expand conservatorship options,
- a. Significantly expand conservatorship options, and improve eligibility criteria for conservatorships. Required conservatorship in lieu of incarceration wherever possible. Require family/caregiver engagement and consent for conservatorship options.
105. Give family support with an advocate
106. (re: improve AOT capacity #7) & CARE court consideration

3: Jails/Courts

107. Allow families to have more input.
 - a. Again, allow the families to have more input. Unless I complained from the supervisor to the Director of Santa Rita Forensics department the little reprieve we received would not have happened. It should not take all that. Stop purposely blocking those who love their loved one the most from being involved. It is clearly a ploy to have complete autonomy and control to do and treat those mentally ill with no dignity, respect, or regard for their wellbeing.
108. Behavioral Health Court
109. Explore expansion beyond charge-based exclusionary policies.
110. Increase the capacity of BHC community-based treatment programs and other secure settings.
 - a. Currently the Behavioral Health Court (BHC) is the main diversionary off-ramp for incarcerated individuals who have mental illness. While the BHC has successfully reduced recidivism and improved mental health outcomes for program participants, it does not come close to meeting the current demand. The BHC is underutilized due to lack of capacity in community-based treatment programs and other, more secure, settings. In addition, the task force should explore what evidence, if any, supports the program's charge-based exclusionary policy (the BHC, with some exceptions, only allows participation from defendants charged with non-serious felonies).
111. Expand the “Collaborative Courts.”
 - a. In addition to the BHC, there are eight separate “Collaborative” Courts (two drug courts, a Veterans’ court, two re-entry courts, and three treatment courts in the family dependency department of the court system). These collaborative courts, like the BHC, have proven successful in reducing recidivism, increasing positive health outcomes, and re-unifying families. The task force should learn how these courts can be expanded so that they are able to divert and treat more individuals.
112. Investigate obstacles that prevent IST defendants from getting out of jail and into medically appropriate treatment.
 - a. The I.S.T. Diversion Programs diverts in-custody felony defendants who have been found by the court to be Incompetent to Stand Trial (IST). According to data

compiled by the Department of State Hospitals (DHS) 88 felony defendants in Alameda County were found IST in FY 2021-22. These individuals currently languish in jail for six months or longer waiting for a treatment bed at the State Hospital. To help alleviate this problem, DHS has provided significant funding to Alameda County so that these individuals can be diverted into local treatment. However, very few of the in-custody defendants in Alameda County who are eligible for this program have actually been diverted. The task force needs to learn why this is so and specifically what obstacles exist to getting IST defendants out of jail and into medically appropriate treatment. The task force should consider whether additional capacity at our county's sub-acute facilities, namely Villa Fairmont, would allow the IST Diversion program to successfully treat more of these individuals.

113. Investigate the low participation rate for the Mental Health Diversion Statute.
 - a. The Mental Health Diversion statute (Penal Code section 1001.36), the primary vehicle the state has created to divert mentally ill defendants, is hardly used in Alameda County as a diversionary exit ramp. According to the California Judicial Council, from 2020 when the Mental Health Diversion statute was enacted through the first quarter of 2022, just 15 defendants in Alameda County were diverted under the statute (9 of them successfully). The task force needs to understand what accounts for such a low participation rate and what can be done about it.
114. Coordinated service assessment and connection to in custody services and referrals for community-based providers
 - a. Coordinated service assessment and connection to in custody services and referrals for community-based providers if not currently connected. This should include family coaching if the individual is likely to return home and the family is open.
115. Peer training and learning opportunities within the jails.
 - a. Peer training and learning opportunities within the jails. This could include restorative justice/practice programming similar to those available at San Quentin. Individuals should have the opportunity to earn peer support credential while in custody and opportunity to facilitate peer-led groups. Pathway to employment for these individuals once released.
116. Coordinated discharge efforts and central point of contact for CBO providers.

- a. Coordinated discharge efforts and central point of contact for CBO providers to ensure clients are connected to care prior to and upon release. This includes CBO's calling into SRJ to coordinate handoff/continuity for their clients entering custody.
- 117. Expand the offering and provision for mental health services for system involved individuals.
- 118. Facilitate communication access for families/advocates with incarcerated members to speak with jail personnel.
 - a. Facilitate communication access for families/advocates with incarcerated members to speak with jail personnel or to the forensic system of care to head off misdiagnosis, to make medical needs known and identify acts of dehumanization.
- 119. Develop communication mechanisms, such as a family liaison role for families/advocates to provide/obtain information on the detained. Situate the role within the ACBH Forensic System of Care.
- 120. Allow families to have more input
- 121. Allow more community agencies to outreach within the jail
- 122. Require and enforce minimum levels of service for people with diagnoses who are in custody and out of custody.
 - a. Require and enforce minimum levels of service for people with diagnoses who are in custody and out of custody. Add triggers for increased level of service for those with repeated instances of incarceration. Gather more diagnosis (types and severity) and clinical/service data on services provided to clients in jail.
- 123. #3 & #4 - not only investigate, but then let's do something about it → get those folks diverted
- 124. examination for AOT - ensure that the person making the determination is licensed
- 125. CalAIM - focus on justice population - one way to leverage additional funding (esp 90-day inreach)
 - a. note: many in jail are pre-trial

4: Reentry

126. Offer programs in the community.
 - a. Offer programs in the community most familiar to the person so they will have a sense of belonging and support. Give a clear direct roadmap from ACBH to direct the programs and facilities providing the treatment and reentry support. This allows for consistency and ability to measure and compare outcomes.
127. Provide a roadmap from ACBH to the programs and facilities providing the treatment and re-entry support.
128. Engage with Roots Health Center and explore how SLP can be expanded.
 - a. The Safe Landing Project (SLP), located in a recreational vehicle parked on the grounds just outside of Santa Rita Jail and operated by Roots Community Health Center, provides re-entry support services to just-released incarcerated individuals. The SLP seeks to connect individuals leaving Santa Rita with a variety of services, including transportation to appropriate treatment facilities. The task force should engage with Roots Health Center and explore how SLP can be expanded to: (1) provide services 24/7; (2) operate out of a permanent structure; and (3) have a presence inside the jail so staff have an opportunity to engage with incarcerated individuals prior to their release.
129. Give clients pre-release planning services and pre-emptive acceptance into programs.
 - a. Pre-release planning services and pre-emptive acceptance into programs whenever possible. Clients are being turned away from services due to inactive/out of County Medi-Cal. Clients need access to immediate services upon discharge regardless of insurance type, with dedicated staff to assist with Inter-County transfers.
130. Reception center for client release.
 - a. Reception center or highly resources housing program that clients can be released to. Low barrier housing with high supervision and direct onsite supports.
131. Additional residential treatment providers and dual diagnosis providers.
 - a. Additional residential treatment providers and dual diagnosis providers that can serve as a transitional housing point at release. This should also be used as an alternative to incarceration for those with active Probation/Parole.

132. Triage and outreach team.
 - a. Triage and outreach team is needed to ensure connection to referred services. This team must also help coordination across providers, Probation, and Sheriffs, as needed.
133. Develop an Interagency Re-Entry team to coordinate care across systems.
 - a. Develop an Inter-agency Re-Entry Team to help coordinate care across systems upon release from SRJ. Team not only provides support upon release but follows up post-release to ensure individual remains connected to services; and/or has continued access to healthcare, MediCal/Insurance resources, employment/vocation referrals, and housing.
134. Expand reentry services and programs county wide.
135. Fully fund the ACBH Forensic Plan with new money.
136. Assure appropriate transitional housing/services for those with SUD or co-occurring disorders.
137. Develop a hub within the communities to allow individuals to have a "one-stop shop" to connect to multiple re-entry services with onsite case management etc.
138. Required reentry plan and short-term housing placement for all with documented diagnoses who are released.
139. ACBH to expand housing stock for people who are being released from jail and have documented diagnoses-perhaps the highest focus should be on those who are at early stages of serious mental illness or SUD.
140. Provide 90/60/30 day pre-release housing counseling and connection to coordinated entry for people who were homeless on entry or who do not have a housing plan on exit.
141. Increase funding to AB109 Re-entry Housing program - housing support available to probationers leaving jail
142. Reentry Center - close to the jail, to which there can be direct transport from the jail; navigation center → direct connection from jail to nav center
143. Coordination of pre-release to reentry services in the community - work with them to create a plan with case manager + families - continuous system of service

- a. include career training/employment center to support reentry to society
 - i. supportive work, training programs → productive feeling + money
 - ii. community based reentry employment contracts - possible to have some of those start in custody (i.e. if first 100 hours are classroom-based “earn & learn”)? → could help go directly into employment after release from jail
 - b. peer specialist with lived experience
- 144. Time of release from jail → important for families/existing case managers to know when their family member is being released so they can be there
 - a. already linked to that client, so that they may be there to pick them up and reconnect/restart services.
- 145. Housing - don’t have a true housing first model house in AlCo - can we build this out, especially for those who are being released into unhoused status?
 - a. State model is HF → sometimes house ppl who aren’t ready for independent living → need to get ppl to be house-ready → connections to natural resources, case management. Also need to factor in dual-diagnosis/SUD.
 - b. Family also needs to be prepared (for behavioral support).

5: Community Supports

- 146. Encourage the chances of success for individuals returning home by providing rigorous and substantial requirements from the courts, probation, and police.
 - a. Continue to provide rigorous and substantial requirements from the courts, probation and police buy in to encourage the success of the person returning home.
- 147. Find a way to effectively evaluate service delivery and incorporate feedback.
 - a. Need ability to effectively evaluate the quality of program service delivery and mechanism to incorporate feedback and make timely program improvements/adjustments.
- 148. Cross-train between LEA and community programs.
 - a. Cross-training between LEA and community programs so there is more cohesion and hand off to services. This includes Whole Person Care initiatives.
- 149. Utilize community hubs as access points.

- a. Use of community hubs and centers to provide non-threatening access point. Use this space to provide family education and additional support to mitigate impacts of justice involvement.
- 150. Retain mental health providers who will maintain outreach with hard-to-reach populations.
 - a. MH providers who will maintain outreach with our hardest to connect population and keep them open to provide services as needed/capitalize on moments of service consent.
- 151. Use of community MH providers and clinical peers who will conduct street health and therapy in non-office settings.
- 152. Multigenerational, regionally specific, and other specialty family resources, tools, trainings, supports, etc. are also needed.
- 153. Increase community meetings and use community input for policy making.
- 154. Evaluate the Wellness Centers for inclusiveness, appropriateness of offerings to engage diverse clientele
- 155. Expand Supported Work programs.
- 156. Peer advocacy/counseling.
- 157. Specialized probation unit for people released from SR jail with an SMI/SUD diagnosis.
- 158. Increase housing navigation, harm reduction services, and direct housing support such as vouchers or supportive housing placements.
- 159. Diversify pool of therapists - have incentives for those in the process of being licensed.
- 160. CBOs - hard time competing for therapists (in compensation).
- 161. Front line work can & should be done by peers (SB803 - for billing to Medi-Cal).