Care First, Jails Last Recommendations Sent to Agencies
Last Update: April 3, 2024

Inclusion Criteria

- **Accuracy**: Is this recommendation factual and/or an accurate assessment of current practice?
- **Mission-Driven**: Will it reduce the number of people with mental illness in Santa Rita jail?
- **Racial Equity**: Will this recommendation help reduce the racial disparities in incarceration at Santa Rita jail?
- **High Utilizers**: Will this recommendation support people who are repeatedly touching the system, i.e. people who cycle between jail, homelessness, and other informal family supports?
- **Level of Effort**: How complete or effort-ful is the recommendation in its current state? Is there a fully fleshed out recommendation that we need to consider as a group, or is this a brief phrase or string of words?
- **Data-Driven:** Is the recommendation data-driven?
- **Actionable**: is the recommendation "actionable" or "implementation-ready"? Does the recommendation identify the people/agency/CBP/other entity that will do the work and be held accountable for the outcome? Does the recommendation set forth achievable and quantifiable metrics and a time table by which progress can be measured?
- **Avoid Net-widening**: Does this recommendation help "shrink the net" for the number of people who are falling into the CJ system?

Running Total: 60

Section 1: African American Resource Center (2)

Context:

An African American Resource Center, specifically targeted toward African American individuals who are justice-involved with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) or living in community with SMI/SUD, plays a crucial role in addressing unique challenges and promoting positive outcomes for this population. The importance of such centers can be analyzed through various lenses:

a. **Cultural Competency**: African American individuals often face systemic barriers and cultural stigma related to mental health and the justice system. This center can provide culturally competent care that respects and integrates the individuals' cultural, historical, and social backgrounds into their treatment plans. This approach fosters trust and improves engagement with mental health services.
b. **Addressing Disparities:** African Americans are disproportionately affected by the criminal justice system and often face significant disparities in mental health care. An African American Resource Center can actively work towards reducing these disparities by offering targeted support, advocacy, and resources that are specifically designed to meet the needs of African American justice-involved individuals.
c. **Community Support:** An African American Resource Center can serve as a vital community hub, offering a sense of belonging and support to individuals who might otherwise feel marginalized. It can provide a range of services, including mental health treatment, community reintegration programs, and legal assistance, all within a supportive and understanding environment.
d. **Holistic Approach**: An African American center can adopt a holistic approach to care, addressing not just mental illness but also the social determinants of health, such as housing, employment, education, and social support. By providing comprehensive support, a center can help individuals rebuild their lives meaningfully.

e. **Advocacy and Education:** A center can play a key role in advocating for systemic changes that address equity issues facing African American individuals and educating the public about the intersection of race, mental health, and the justice system. It may contribute to a more equitable and just society by raising awareness and challenging stereotypes.
f. **Reducing Recidivism:** By offering targeted support and services, an African American Resource Center can help reduce recidivism rates among justice-involved individuals. Access to mental health care, community resources, and rehabilitative programs can decrease the likelihood of re-offense and support long-term recovery and reintegration.
g. **Empowerment:** Providing a space that focuses on the strength and resilience of the African American community can empower justice-involved individuals. Empowerment can foster a sense of agency, encouraging individuals to actively participate in their treatment and recovery process.

In conclusion, an African American Resource Center for both justice-involved and non-justice involved individuals who have mental illness is vital for providing culturally competent care, addressing systemic disparities, offering community support, and promoting holistic well-being. A center is crucial for fostering equitable treatment outcomes and supporting the broader goals of social justice and community reintegration.

1. A Recommendation: County

1.1.B [14, 34, 48]
Create and support ongoing funding of an African American Resource Center (the Center) that provides information and culturally responsive services in the areas of education, physical health (e.g., nutrition, meal services, and medical services) and mental health services (including psychiatric support, medication management, and individual and group therapy). In order to support the Center in community responsiveness, the County should develop an African American advisory committee with minimum 50% representation of people with lived experience, including family members, with the goal of identifying necessary services, culturally responsive resources, and to support the expansion and dissemination of funds relative to the Center.

1. B Recommendation: County

1.1.A [47]
Information about the African American Resource Center should be widely available in the African American communities across Alameda County and should be shared by County and community agencies, including at every step of the criminal legal process (e.g., law enforcement, courts, probation, etc.).

Section 2: Collaboration, Case Management, and Reentry (4)

Context:

Collaboration and case management are crucial for justice-involved individuals with mental illness for several interconnected reasons:

a. **Complex Needs**: Individuals at the intersection of the criminal justice system and mental health services often have complex, multifaceted needs that include treatment for mental illness, substance abuse rehabilitation, housing, employment, and social support. Addressing these needs holistically can improve outcomes.

b. **Continuity of Care:** Collaboration ensures continuity of care as individuals transition between the justice system and community-based mental health services. This seamless transition is vital to prevent relapse, rehospitalization, or recidivism.

c. **Improved Outcomes**: Collaborative care approaches, which consider all aspects of an individual's life, are linked to better health outcomes, reduced involvement with the criminal justice system, and improved quality of life.

d. **Reduction in Systemic Burdens:** Effective case management and collaboration can reduce the burden on criminal justice and emergency health services by providing more appropriate and cost-effective interventions.

e. **Promotion of Recovery and Rehabilitation**: Focusing on rehabilitation and recovery, rather than solely on punishment, supports the individual's reintegration into society, reducing the likelihood of re-offending.

f. **Respect for Human Rights:** These practices ensure that justice-involved individuals with mental illness receive the care and support they need, respecting their dignity and human rights.

g. **Tailored Interventions**: Through case management, interventions can be tailored to meet individual needs, considering each person's specific circumstances and challenges.

In essence, collaboration and case management reflect a more enlightened approach to dealing with individuals with mental illness in the justice system, focusing on rehabilitation and support rather than punishment alone. This approach is beneficial not only for the individuals involved but also for society at large, aiming to reduce recidivism, support recovery, and promote public safety and well-being.

2.A Recommendation: ACBH

2.1.A [13]

There are several initiatives in motion to increase the number of Full Service Partnerships (FSP) in Alameda County (Disability Rights California/Department of Justice Settlement, Forensic Plan Implementation, Proposition 1/MHSA reform). The DRC settlement requires assessment of the number of FSPs by November 2024. Based on the DRC mandated assessment, the recommendation to ACBH is to:

- ensure that the **number of FSPs available in Alameda County meet the demand/needs of the community**.
- make any **unused FSP slots available to/filled by individuals who need them**.
- provide a **monthly report to the community on the number and type of available FSPs, including the number that are unused.** Need to specify the entity to which ACBH should report.

2.B Recommendation: County, ACPD, ACSO, ACBH, All others

Interagency Communication and Coordination: In the interest of non-duplication of efforts and prevention of individuals falling through the cracks of services, the Taskforce recommends the following actions to increase collaboration between agencies:

- **Each county agency to assign a delegate** to be the inter-agency communication liaison. If it is not possible to have a dedicated staff person, then establish a communication strategy. **(All Agencies)**
- **Create a central contact point for triage and communicating** to clients and Public Defenders about services so programs don't get overbooked. **(ACPD)**
- **Community MH providers contacted by custody staff upon intake** and during service coordination to plan for possible referral to service providers for collaborative courts or appropriate discharge and service coordination. **(ACSO)**

- ACBH/AFBH, ACSO/Wellpath to implement **coordinated service assessment and connection** to in custody services and referrals for CBO providers.(**ACBH**, ACSO)
- ACBH/AFBH, ACSO/Wellpath to implement **coordinated discharge efforts** and central point of contact for CBO providers.(**ACBH**, ACSO)
- Assign personnel to **family liaison roles** within ACBH FSC or Alameda County Sheriff's Office (ACSO) in order that family caregivers are able to provide what can be vital information on the medical and psychiatric history and current needs of the incarcerated person. (**ACBH**, ACSO)
- **Service roadmap**: ACBH to develop a roadmap from Santa Rita Jail (SRJ) to the programs and facilities providing treatment and re-entry support. **(ACBH)**
- **Evaluate the implementation of all elements of a No Wrong Door policy**, as required by CalAIM, in Alameda County, and determine needed next steps that ensure access to care. **(ACBH)**
- Conduct a **comprehensive assessment and redesign of ACBH ACCESS line** that ensures access to services consistent with CalAIM, No Wrong Door policy, and clinical need. **(ACBH)**
- 2.4.C [99,106] **Non-clinical public safety database at county level of high-contact individuals**; LE, DA's Office, Probation/Parole communication too. (**ACSO**)

2.C Recommendation: **ACBH,** ACSO

2.7.B [145]

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. **ACBH should engage with Roots Health Center and explore how SLP can be expanded** to:

- Provide services 24/7;
- Operate out of a permanent structure; and
- Have a presence inside the jail so staff have an opportunity to engage with incarcerated individuals prior to their release.
- Provide Emergency Medication Screening and Prescription & Physical medications

2.D Recommendation: **OHCC,** Probation, ACBH, ACSO, SSA

2.7.C [146,147,149]

The County should fund and support a low barrier interagency reception housing program that individuals can be immediately released to from SRJ regardless of Medi-Cal status. This housing program must incorporate dual diagnosis providers and allows for triage, outreach, and coordination across providers, Probation, ACSO, and family when available. This housing program must have the ability to triage individuals to a higher level of care, treatment, and/or other transitional housing.

Section 3: Community-Based Support/Outreach/Education (13)

Context:

Community-based support including family support, outreach, and education play a crucial role for those living with serious mental illness including justice-involved individuals for several compelling reasons:

a. **Reduced Stigma:** Community-based initiatives help reduce the stigma associated with mental illness and criminal justice involvement. By raising awareness and providing education, these efforts foster a more understanding and supportive environment for individuals re-entering society.

b. **Enhanced Access to Services**: Outreach programs can connect individuals with essential services, including mental health care, substance abuse treatment, housing, and employment opportunities. This accessibility is vital for those who might otherwise face barriers to receiving the help they need.

c. **Continuity of Care:** Community-based support ensures continuity of care for individuals transitioning from incarceration to community living. This seamless care can prevent relapses, reduce the risk of reoffending, and support overall health and well-being.

d. **Tailored Interventions:** Community services are often more flexible and can provide more personalized support tailored to each individual's unique needs, taking into account their specific challenges and strengths.

e. **Building Support Networks:** Community engagement helps build essential support networks of peers, healthcare providers, and mentors. These networks can offer encouragement, advice, and assistance, which are critical for successful reintegration and long-term recovery.

f. **Empowerment:** Community-based programs often emphasize empowerment, helping individuals develop the skills and confidence to manage their mental health, navigate societal challenges, and make positive life choices.

g. **Prevents Cycling Through Systems:** Providing targeted support and education in the community can prevent individuals from cycling between the criminal justice system, emergency departments, and homelessness, which is common among those with untreated mental health issues.

h. **Promotes Public Safety and Well-being:** Successful reintegration of justice-involved individuals into the community, into family and supported by mental health services, contributes to the overall safety and well-being of the community by reducing recidivism and promoting healthier lifestyles.

In sum, community-based support, outreach, and education address critical gaps in care and support for justice-involved individuals with mental illness, leading to better outcomes for these individuals and society as a whole.

3.A Recommendation: County

3.2.B; 3.3.A; 3.5.A; 3.5.C; 3.6.A; 3.8.A; 3.8.C; 4.1.E; 4.2.A; 4.2.E; 4.2.G; 4.3.A
[18,20,21,35,37,39,41,45,46,50,51,52,57,62,65,67,80,81,87,88,89,90,92,95,96,120,122,124,132,137,166,168,169,173,178]

Peers must be provided with adequate training, support, and compensation to serve in front line, promotional, decision-making, and leadership positions. Training/support should include:

- Specialty and diversion programs, resources, and outreach information to improve grassroots coordination including linkages in threshold languages (**all Agencies**);
- Court operations, legal language, and making decisions (**Court, PD/DA**);
- interventions to facilitate peer support groups, family collaboration, street outreach, and de-escalation services (**ACBH and HCSA**);
- Jail services, in-reach, and advocacy (**ACSO, ACBH**);
- access to decision-making meetings and validate (uplift?) peer expertise (**all Agencies**);
- Medi-Cal billing and other charting to expand peer tasks/positions (**ACBH and HCSA**);

- Support/subsidies to help peers obtain certifications, credentials, and on the job experience (**all Agencies**);
- Fair pay for lived expertise as equitable to professional and educational experience (**County and Agencies**).

3.B Recommendation: County

2.3.A; 3.2.A; 3.2.B; 3.5.A; 3.5.C; 3.6.A; 3.8.A; 3.8.C; 4.1.E; 4.2.A; 4.2.E; 4.2.G; 4.3.A
[18,20,21,36,37,38,39,40,41,45,46,50,51,52,57,58,62,63,64,65,67,80,81,88,90,92,95,96,120,124,132,137,166,168,169,173,178]

Expansion of peer workforce must include placement in key spaces and uplifting of their expertise in front-line and leadership roles. These positions/locations include:

- **School liaison to support families**, provide respite, and mitigate conflicts (**ACBH** and Center for Healthy Schools);
- **Family case manager/liaison for John George and Cherry Hill** to respond to early MH episode situations (**ACBH** in partnership with AHS);
- **Outreach in high-contact areas** (e.g., hospitals, respite, etc.), community, and community hubs (HCSA**, ACBH**, AHS, ACSO, ACPD);
- **Jail in-reach** inside intake, units, and releasing (**ACSO** and AFBH);
- **Peer-led interventions in housing program**s and other spaces to address vicarious trauma and practice restorative practices (**ACBH** and OHCC);
- **Placement within the court systems** to help families understand processes, navigate, and connect to service (Court and **PD**);
- **Clinical peers to conduct street health** and on first responder teams (HCSA, **ACBH**, LEA);
- **Peer inclusion at County and Agency decision-making**, policy, and funding meetings (**all Agencies**).

3.C Recommendation: **County** (Central HR)

3.8.C; 4.2.E; 4.2.G; 4.3.A
[81,90,92,95,96,178]

Modify County HR process to **increase reentry hiring and inclusion of those with lived experience** (e.g., hiring of those with past felonies and/or MH/SUD service consumers) in various roles and positions.

- **Add lived expertise (including that of family caregivers) as a criteria for evaluation** in a way that is equitable to professional and educational experience.
- **Expand Reentry Hiring Initiative** and require County agencies to hire the reentry community in relevant positions.
- **Felony is not an exclusionary factor** unless it conflicts with the position being applied for.
- **Prioritize development and reentry/peer hiring of positions** listed in "Peer Recommendations Umbrellas" above.
- **Training of HR Techs on biases** and objectively evaluating lived expertise.

3.D Recommendation: **ACBH** (PIO)

3.3.A [35,87,89]

Alameda County Public Information Campaign with loved ones, caretakers, school personnel and neighbors being the primary audience. Information must be provided about:

- Peers, the work of peers, where/how to find them, and how to become a peer;
- Community centers, local resources, and how to find them;
- Alternatives to calling police and crisis intervention teams;
- Community meeting and advisory boards.

3.E Recommendation: ACBH, County

3.4.A [108]

ACBH/HCSA to identify a **staff or team responsible for engaging with Law Enforcement Agencies regarding MH diversion** and interventions. The team will:

- Develop, update, and disseminate literature to law enforcement agency (LEA);
- Facilitate training/informational meetings with LEA about available options;
- Evaluate LEA on their crisis intervention team (CIT) training.

3.F Recommendation: SSA

3.7.A [61]

Alameda County Social Service Agency (SSA) Workforce Development to work with Agency partners, develop trainings, workshops, skill development opportunities, and employment pipelines for those in reentry and/or have lived experience.

- Look for and promote reentry employers.
- Look for and promote peer and community health worker positions/employers.
- Look for and promote positions that do not require a high school (HS) diploma and/or past work experience.
- Provide connections to on the job training, transitional, and subsidized employment.
- Provide training and connection for career and promotional positions.
- Promote living wages employment for peers and the reentry population.

3.G Recommendation: County

3.7.B [143,154]

County-wide investment in the Center of Reentry Excellence (CORE) as Alameda County's reentry center. Inter-Agency support and collective impact will:

- Ensure access to services beyond AB 109;
- Prioritize reentry population in accessing County resources;
- Increase community and improve service connection for reentry population and their supporters (e.g. families and/or caregivers);
- Expand to regional satellite location(s) through a unified model;
- Embed peers and community health workers at the CORE to conduct outreach, service connection, advocacy, etc.

3.H Recommendation: DA, ACSO

3.7.C [161]

Use the District Attorney's Daylight system to generate jail release alerts to next of kin or other approved parties.

3.J Recommendation: ACBH

9.1.A [30]

Develop a **service training program and collaboration between ACBH & local university, community college, and school-based (middle & high) health systems for early identification**

of mental illness among older youth and transitional age youth (TAY). This service training program would train school-based mental health counselors on proper family notification, expedited referral pathways from school-based health systems to ACBH programs, and awareness about early warning indicators for other campus staff (residential advisors, educators, etc).

3.K Recommendation: ACBH (with consult from BOSS, Felton, La Familia)

9.2.B [29,53]

Assess the capacity of providers who work with TAY (such as at-risk 16-17 year olds) who are homeless or at risk of homelessness on their **ability to connect youth to housing, workforce, and supportive services**, and fund them as appropriate to increase and scale services to meet any unmet needs.

3.L Recommendation: ACBH (with consult from Felton)

First Episode Psychosis: The standard of care for treatment of first episode psychosis (FEP) is Coordinated Specialty Care (CSC) – a team based, person-centered approach offering case management, recovery-oriented psychotherapy, medication management, family support and education, and supported education and employment.[1] Felton Institute runs two integrated CSC-FEP programs serving TAY-aged youth who have Alameda County MediCal or are MediCal eligible. The re(Mind) program specializes in schizophrenia-spectrum disorders, the BEAM program in bipolar and other mood disorders. Located in the City of Alameda, these programs have a combined capacity of 100 individuals. By one estimate, the need for specialty FEP care in Alameda County's MediCal-served population is 1,000 individuals per year [2] -- 10 times Felton's capacity. Felton's targeting of youth aged 15 - 25, while well-justified, misses a large number of individuals whose initial presentation of psychosis appears later. Their location in the City of Alameda likely poses barriers to potential participants.

Recommendations:

A. **Program evaluation –** Felton participates in U.C. Davis' statewide evaluation of FEP programs. Evaluation of Felton's Alameda program is expected toward the end of the year.[3] Felton and ACBH should make this evaluation public and available to the group designated to monitor the CFJL implementation.
B. **Public awareness -** Develop a public information campaign to promote awareness of Felton's FEP programs. Rationale: The program is currently under-enrolled by 50 percent and among the general groupings of experienced volunteer family advocates and family organizational leaders, there's little awareness of families who've utilized its services.
C. **Expand participation** - Age restriction and program location should be studied as limits or barriers to participation. The possibility of opening a second location, closer to areas of greatest need, should be considered .

[1] First Episode Psychosis Programs: A Guide to State Expansion. National Alliance on Mental Illness (NAMI), 2017.
[2] Radigan, Marleen, Gyojeong Gu, Eric Y. Frimpong, Rui Wang, Steven Huz, Mengxuan Li, Ilana Nossel, and Lisa Dixon. "A new method for estimating incidence of first psychotic diagnosis in a Medicaid population." Psychiatric Services 70, no. 8 (2019): 665-673. This was a retrospective population-based study of NYState Medicaid data over a period of 5 years (2013-2017). Estimate of Alameda County's population served by MediCal extracted from HCSA memo to Board of Supervisors, Apr 6 2021.
[3] Personal correspondence with Jim Christopher, Dir. Felton FEP programs and Mark Savill, Dr. Mark Savill, Qualitative and Fidelity lead of the EPI-CAL project, UC Davis, March 10, 2024.

3.M Recommendation: ACBH

ACBH should review its on-line directory of services for its accessibility to an average citizen, reading at a 6 grade level. Change language and description of services as needed for ease of navigation for both those with elementary reading skill and those who are reading proficient. Also, while ACCESS and the on-line directory are current and important services, the general public, and some providers, report being unaware of them. Initiate a public awareness campaign to make visible these critical resources.

Rationale: ACBH Services provides direct services while it also contracts with community-based organizations to offer a wider range of mental and behavioral health services. These myriad services, spread across all county regions, include services open across the board as well as those targeted, for example, by age, ethnic group, gender minorities. Beside ordinary changes in the service landscape, the ordinary citizen and even service providers, are sometimes challenged in finding the appropriate service for their needs. A directory will permit fuller utilization of county services.

Section 4: Crisis Services/5150 (3)

Context:

Mobile crisis teams (MCTs) are an integral part of an effective continuum of behavioral health care. These teams support individuals who are experiencing a mental health and/or substance use disorder crisis ("behavioral health crisis") and link them to medically appropriate treatment services, care, and support. MCTs are designed to avoid both unnecessary inpatient hospitalizations and law enforcement involvement. Most importantly, these teams provide face-to-face crisis assessment to reduce immediate risks of danger, restore stability, and provide a warm hand-off to follow-up care, as appropriate.

The Task Force is concerned that in Alameda County, mobile crisis response is fragmented and in need of integration. For instance, the County has three different types of mobile crisis response services: (1) MCTs, (2) mobile evaluation teams (METs), and (3) community assessment and transport teams (CATTs). Moreover, many cities within Alameda County offer their own mobile crisis response services (e.g., Mobile Assistance Community Responders of Oakland [MACRO] in Oakland, Community Assessment Response and Engagement [CARE] in Alameda, and Specialized Care Unit [SCU] in Berkeley). In addition, some community-based services exist, such as Mental Health First.

Mobile crisis intervention is a covered Medi-Cal benefit.[1] In other words, a significant portion of the county's spending on these services is reimbursable. However, to implement this mobile crisis service benefit and leverage federal dollars, all MCTs in the county must meet the same requirements.

The Task Force is also concerned that according to the most recent CATT Program Evaluation Report, "the lack of County resources available and places to transport individuals experiencing behavioral health crises has been cited as one of the biggest challenges of implementing the CATT Program by field employees, CATT leadership and other stakeholders such as law enforcement."[2] Notably, according to the same report, half the CATT clients reported having no active source of income, and nearly one-third (30%) were homeless. Moreover, almost half of those served who had been diagnosed with a mental health disorder were suffering from either schizophrenia or another unspecified psychotic disorder.

[1] See https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf
[2] See https://acmhsa.org/wp-content/uploads/2024/01/MHSA_ThreeYrPlan23_26_FINAL.pdf (at pp. 1085-1093).

4.A Recommendation: County, ACBH

6.2.A [90]
The Taskforce recommends **expansion of 24/7 city and county crisis response teams to all parts of Alameda County**; and to address the full range of mental health crises, substance use, and other nonviolent disputes that otherwise would only be addressed by law enforcement. The Task Force strongly encourages Alameda County to create a fully integrated approach across mental health and Substance Use Disorder (SUD) delivery systems in which a single mobile crisis service infrastructure serves the entire County, and is aggressive about police training in anti-bias behavior and de-escalation approaches. This program should include a triage system for those taking 911 calls, as well as training to assess calls on what level of intervention is needed, so that using law enforcement in mental health crisis calls is a last resort.

4.B Recommendation: County, ACBH

4.1.B [77]
The Task Force recommends that the County make the necessary investments in the types of post-crisis care services that will effectively treat these individuals and serve the unmet needs of this population.

The Task Force further recommends that Mobile Crisis Teams include the following best practices:

- **Peer involvement**: It is considered a national best practice to include individuals with lived experience (including family caregivers) as members of MCTs. Since Peer Support Services is a distinct service type under Medi-Cal, a certified Peer Support Specialist (PSS) should participate as an MCT member;
- **Follow-up check-ins**: Within 72 hours of the initial mobile crisis response, a member of the MCT should make a follow-up check-in to support continued resolution of the crisis, provide additional referrals, check on the status of appointments and support scheduling;
- **Coordination with other delivery systems:** A mobile crisis response indicates that the beneficiary needs additional services or that the current array of services is insufficient or inappropriate. Accordingly, if the MCT learns that a beneficiary is already receiving services from a provider (FSP, Case Management Team, Social Worker, etc.), a team member should alert the beneficiary's care provider within 24 hours of a mobile crisis response and provide basic information about the encounter and coordinate referrals and follow-up care;
- **Response times**: There must be sufficient mobile crisis response capacity in Alameda County so that an MCT arrives at the location where a crisis occurs within 30 minutes of the call;
- **Community engagement:** Mobile crisis response can only be successful when it is well-known throughout the community how to request mobile crisis services. Accordingly, the mobile crisis service system must conduct outreach about the availability of mobile crisis services and educate community members about how to request help when someone is in need;
- **Explicit policy on 5150 decisions**: ACBH or the appropriate agency should issue standard guidance for how teams and police responders interpret the criteria for 5150. For example, how imminent should the danger be, how should family experience be taken into account, how should the availability of beds be taken into account? Katy Polony of In Home Outreach Team (IHOT) has explained that 5150s have become

difficult for reasons that are not clear. A 5150 can be a desirable outcome because for some it is the only path to a higher level of care;

- **Law Enforcement**: Law enforcement agencies should create and publish policies to refer persons eligible for crisis response services to MCTs. Unless specified safety concerns are present, it is considered a best practice for the mobile crisis response team to respond without law enforcement accompaniment. When safety concerns are present, the police who respond should be trained in de-escalation techniques and in understanding implicit bias, as may be covered elsewhere in the Task Force recommendations;
- **Documentation:** All follow-up check-ins, alerts to the beneficiary's current care providers, and response times must be documented and included in all evaluations of the mobile crisis response system.

4.C Recommendation: County, ACBH

4.2.E [81]

Pursuant to the recent settlement of the Disability Rights California (DRC) lawsuit, Alameda County must, within one year, **complete a public-facing assessment of needs and gaps in mobile crisis coverage** that is designed to determine the amount and number of MCTs needed to effectively serve the entire county. The Task Force recommends that as soon as reasonably possible and before its completion, the Mobile Crisis Assessment be presented to the public for input and comment.

Section 4.5: Treatment Beds (2)

Context:

Acute and sub-acute residential beds are essential for meeting the needs of individuals who have a serious mental illness (SMI) and, therefore, are a crucial part of the continuum of behavioral health care. The Task Force considered the question of whether there are enough acute and sub-acute residential treatment beds in Alameda County to serve the needs of individuals with serious mental illness effectively. Answering this question was difficult because, unfortunately, Alameda County has never assessed how many acute and sub-acute beds are needed for this population. Nevertheless, it appears to the Task Force that there is a shortage of acute and subacute treatment beds in the County. The Task Force bases this view on what appears to be a consensus in the psychiatric community that a community needs 50 in-patient adult psychiatric beds per 100,000 adults in the population (26 per 100,000 at the acute level and 24 per 100,000 at the sub-acute level).[1] Alameda County has approximately 1.3 million adults, and therefore, by this metric, Alameda County needs 338 in-patient adult psychiatric beds at the acute level and 312 in-patient adult psychiatric beds at the sub-acute level. The Task Force has concluded that in light of these metrics, there is a slight shortfall of acute beds and a much larger shortfall of sub-acute beds in Alameda County.[2]

The need for more sub-acute treatment beds is exemplified by the fact that at John George, a significant number of beds are occupied by patients who no longer need acute treatment, but due to the lack of beds at Villa Fairmont and other "drop-down" facilities, they stay longer at John George than they need to. Likewise, discharge planners at Villa Fairmont have reported that the dearth of licensed Board and Cares (Adult Residential Facilities) means that people who are ready to leave a sub-acute facility like Villa Fairmont cannot be dropped down to that lower level of care in community residential treatment. Identifying the source of these bottlenecks is crucial so that wise investments can be made.

[1] See, "Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California - 2021," McBain, et. al (https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html)
[2] In the acute category, Alameda County has 69 beds at John George (not including PES); 68 beds at Herrick; 148 beds at Fremont Hospital (but many of these beds are for Minors); 18 at Kaiser Fremont; and 26 at Heritage. This is a total of 329 acute beds (a "shortfall" of at least 9 acute beds).
In the sub-acute category, Alameda County has 93 beds at Villa Fairmont; 39 beds at Gladman; 78 beds at Morton Bakar; 20 beds at Garfield; and approximately 30 beds when the new Mental Health Rehabilitation Center (MHRC) at St. Regis comes online in 2027. This is total of 260 in the sub-acute category (a "shortfall" of at least 52 beds).

4.5.A Recommendation: ACBH

4.1.A [22,23,33,42,78,91,109]
The Task Force recommends that Alameda County **create more psychiatric treatment beds**, especially at the sub-acute level, to reach the numerical levels set forth above.

4.5.B Recommendation: ACBH

4.1.A, 6.1.E [9,22,23,33,42,78,91,109,152]
The Task Force recommends that the County assess the unmet needs of individuals with serious mental illness to determine how many psychiatric treatment beds, at all levels of acuity, are needed in the County. Because the issues are so interrelated, this "Bed Assessment" should happen at the same time as the County is already doing the Full Service Partnership Assessment and the Mobile Crisis Assessment pursuant to the settlement of the Disability Rights lawsuit.

Section 5: Diversion (4)

Context:

Diversion from jail, especially for persons with mental illness or substance use disorders, is arguably the area of recommendations that is most directly responsive to the County Care First policy "to reduce the number of people with mental illness, substance use and co-occurring disorders in our jail." Such diversion can occur before arrest, between arrest and arraignment, after arraignment but before trial in collaborative or behavioral health courts, and, for persons deemed incompetent to stand trial, before hospital beds are made available. Diversion programs play a critical role for justice-involved individuals with mental illness for several reasons.

a. **Appropriate Treatment Over Incarceration:** Diversion allows individuals with mental illness to receive proper psychiatric treatment and support instead of being placed in the criminal justice system, where their conditions may worsen. This approach acknowledges that treatment and rehabilitation can be more beneficial than punishment for such individuals.
b. **Reduction of Recidivism:** Individuals who receive appropriate mental health care and support are less likely to reoffend. Diversion programs, which often include comprehensive treatment plans that address the root causes of the individual's behavior, can significantly reduce the chances of recidivism by providing necessary interventions.
c. **Relief of Overburdened Justice Systems:** The criminal justice system is often overburdened with cases, and, as a result, jails and prisons are overcrowded. Diverting individuals with mental illnesses to treatment programs can help alleviate the load on the system and ensure that resources are allocated more effectively.
d. **Promotion of Human Rights:** Diverting justice-involved individuals with mental illness into treatment programs rather than incarceration promotes the protection of human rights. It recognizes the importance of treating mental illness as a health issue rather than strictly a legal one.

e. **Cost-Effectiveness:** Treatment and support through diversion programs can be more cost-effective than incarceration. The costs associated with incarceration, particularly for individuals who require specialized mental health care, can be significantly higher than the costs for community-based treatment options.

f. **Social Reintegration:** Diversion programs often focus on holistic approaches that address mental health needs and aim to reintegrate the individual into society through education, employment support, and social services. This approach enhances the individual's chances of leading a productive life.

g. **Stigma Reduction:** Promoting mental health treatment over incarceration helps in reducing the stigma around mental illness. It supports the view that mental health conditions are treatable and that individuals suffering from them deserve care and support rather than punishment.

In conclusion, diversion programs offer a humane, effective, and economical alternative for dealing with justice-involved individuals with mental illness, addressing both their individual health needs and many community-level concerns. More data are needed to measure effectiveness and the number and demographics of people who should be served by each type of diversion, more data is needed, as described below. Currently, information-sharing across the system is poor or inconsistent, and publicly available data is lacking, especially on the impacts of collaborative courts on recidivism and the reasons for non-participation of eligible persons. Reliable data and mechanisms for accountability are needed for all diversion programs. We propose expanding diversion initiatives at the same time as data gathering and reporting occurs.

5.A Recommendation: DAO, ACSO (with consult from La Familia, BOSS)

5.1.A [110, 108, 103]

Expand Point-of-Arrest Diversion: The Board of Supervisors should commission a report by an independent body on the history and prospects of Alameda County's initiatives for diversion at the point of arrest, particularly the CARES Navigation Center. The report should gather input from the District Attorney's Office, law enforcement agencies, community-based organizations (CBOs), and others, and document and assess 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; the extent to which clients would benefit from restorative justice services from community or county agencies; and whether limiting the program to only "low-level" offenses is sensible.

In addition to this independent report, the CARES Navigation Center should provide regular public reporting, using consistent terms, on the number of people served, their demographics, outcomes (including how many completed diversion programs or were incarcerated), and numbers referred by each law enforcement agency and each law enforcement officer.
Any decision to maintain or expand the CARES Navigation Center must address obstacles to law enforcement participation and non-police means for people to receive services at the Center.

5.B Recommendation: **Probation,** Public Defender (with consult from Superior Court)

5.2.A [113]

Expand Pre-Arraignment Diversion: Support and expand on the initial Reimagining Adult Justice (RAJ) recommendation that addresses post-arrest release for the entire arrested population.[1] Implementation of this recommendation applies to all persons arrested in Alameda County, including those with mental illness or substance use disorders, since it would reduce pretrial incarceration for a broad array of persons whose release does not present any substantial risk to public safety. The Pretrial Services Program features a risk assessment by a Superior Court judge within 24 hours after booking (and before arraignment) to see if the arrested individual should be released from jail, and if so, under what conditions. The Probation Department supervises those who are released from jail during the pretrial phase.

Key points

- Alameda County should **increase its use of unsupervised and supervised pretrial release**, which is an effective method for reducing the pretrial felon population in jail systems and as a diversionary off-ramp into medically appropriate treatment and/or restorative justice services.
- The **number of people eligible** should not be determined by limits on the capacity or staffing of Probation for community supervision.
- **Community supervision** should be the least onerous for clients and present fewest barriers to their success. This can be supported with electronic reminders of upcoming court dates and, (for those without reliable housing), accompaniment to the courthouse.
- Per RAJ Final Report Recommendation #34: The Superior Court should collect data on the **current risk assessment instrument (Public Safety Assessment)** and a controlled study of its outcomes should be performed, potentially in collaboration with the Probation Department. The Court and Probation should publish data on pretrial release to consider unmet needs in this area and outcomes, including those for recidivism and client health and well-being.

[1] RAJ recommendation #34: "Expand Pretrial Release and Explore Removing Limitations: Alameda County should seek opportunities to expand the Pretrial Program to include supervised release for defendants charged with a broader array of felony crimes and who have been in custody for three days or more, regardless if arraignment occurred or not. There is strong evidence that supervised pretrial release is an effective method for reducing the pretrial felon population in jail systems. Alameda County's pretrial assessment program is currently utilizing the Arnold Foundation PSA to gauge pretrial release risk for cases. The VPRAI [Virginia Pretrial Risk Assessment Instrument] is no longer in use.

While the VPRAI is not being used, analysis has shown that, although the VPRAI recommends release for a larger number of individuals, because of pre-existing State and other procedural limitations, very few of the low risk classified individuals are being released within three days. Some low-level ranked individuals were held longer than more serious felony charged individuals who make bail. It should be determined by further study of the PSA if it is also subject to this limitation. This policy needs examination and revision at some level if it is also hampering the PSA's ability to funnel persons to pretrial supervision."

5.C Recommendation: **DAO,** ACBH, PD (with consult from Superior Court)

5.3.A, 5.3.B [126,127]

Behavioral Health Court, Collaborative Courts and a proposed Dual-Diagnosis Court: Produce data, and remove barriers and disincentives to court-based diversion.
Behavioral Health and collaborative courts present alternatives to incarceration for eligible people with behavioral health needs. Currently the Behavioral Health Court (BHC) is the main diversionary off ramp for incarcerated individuals who have serious mental illness. In addition, there are eight separate "Collaborative" Courts (two drug courts, a Veterans' court, two reentry courts, and three treatment courts in the family dependency department of the court system). These collaborative courts are nimble and have many clients with some combination of mental illness and SUD.

However, while these courts have successfully reduced recidivism and improved mental health outcomes for program participants, they do not come close to meeting the need. Many of those eligible do not participate because they are not referred to the court by county agencies, or because of perceptions that benefits are outweighed by the requirements for participation (e.g. 1 - 2 year(s) minimum participation versus shorter-term release, weekly court appearances, mandatory medication). Another reason may be an insufficient number of treatment slots or beds; increasing those could increase participation. The County also lacks a Co-Occurring Disorders Court, which could more successfully address the needs of people diagnosed with both mental illness and a substance use disorder, who may not be eligible for the BHC. It is reported that the County currently has a shortage of judges to add such a collaborative court.

The Superior Court's Office of Collaborative Courts works with an independent evaluator to collect demographic and outcomes data. However, the County does not reliably publish data on the outcomes of Behavioral Health or collaborative courts as measured by recidivism, numbers of persons offered and received services, or client health and well-being.
Key points

- ACBH, which runs the BHC, should **contract with independent evaluators** to analyze: numbers of persons who meet eligibility criteria for diversion,[2] numbers offered and received services, data on recidivism and client health and well-being, and what evidence, if any, supports BHC's policy of exclusion of persons with serious felonies.
- Both ACBH and the Office of Collaborative Court should **annually publish the results of independent evaluations**, including criteria for participation, outcomes and metrics of success.
- As close as possible to time of booking, clinical staff should **conduct a full assessment of behavioral health and eligibility for pretrial release**, for collaborative courts/BHC referral, and for statutory diversion pursuant to California's Mental Health Diversion statute, Penal Code section 1001.36. Court and behavioral health personnel also should reach out as early as possible to families of clients for full information and to support follow-up.
- Collaborative courts and BHC should **require court attendance that is the least onerous** for clients and present fewest barriers to their success.
- The County should **establish a Co-occurring Disorders Collaborative Court**, possibly by converting an under-utilized collaborative court (reentry court).
- The Mental Health Advisory Board should **analyze the reasons for non-participation of eligible persons in collaborative courts** and BHC and make recommendations that the Board of Supervisors should consider and act upon in a public meeting.

- The BHC and Collaborative Courts should **create a family liaison role**, who participates in the Court and who, with permission of the client, can explain to families what is going on and receive information from families.

[2] As set forth in California's Mental Health Diversion statute, Penal Code section 1001.36

5.D Recommendation: DAO, ACBH, ACPD (with consult from Superior Court)

5.3.C [129, 130, 140]

The Incompetent to Stand Trial (IST) Diversion Program: The Task Force recommends that mental health resources go towards diverting IST defendants from the criminal-legal system and into clinically appropriate treatment in non-jail settings rather than towards restoring them to competency so they can then be prosecuted, convicted, and (in 24% of the cases statewide) sent to prison. Restoring mentally ill defendants to competency does not promote public safety. According to the Dept. of State Hospitals (DSH), 71% of ISTs who are restored to competency, prosecuted and convicted recidivate within 3 years of release. The comparable rate for non-IST defendants is 41%.

Since the enactment of Penal Code section 1001.36 (the Mental Health Diversion Act) in 2018, most ISTs are eligible to be diverted into treatment rather than restored to competency. And unlike non-ISTs who must agree to treatment before they can be diverted, IST defendants can be diverted and treated over objection (in other words, the statute provides a non-LPS mechanism for treating ISTs who are too ill to realize they are sick). If diversion is successful (ie, if the defendant stays in treatment for the requisite amount of time), the criminal case is dismissed.

Alameda County has already received significant funding from the DSH to implement a Pilot IST Diversion Program. Unfortunately, of the approximately 80 felony IST defendants per year in Alameda County, only a handful have been diverted under the Pilot program. The Task Force recommends that the County learn why the IST Diversion Program, despite adequate funding from the state, continues to be so under-utilized and what obstacles exist to getting IST defendants out of jail and into treatment. If, as the Task Force suspects, it becomes evident that lack of capacity at the County's acute and sub-acute facilities is the cause of such under-utilization, appropriate investments should be made in these areas so that more IST defendants can be successfully treated in non-jail settings

Section 6: Funding & Financial Transparency (8)

Context:

Funding and financial transparency are foundational to the success and integrity of programs aimed at supporting justice-involved individuals with mental illness. These facets are important for several key reasons:

a. **Enhanced Program Effectiveness:** Adequate funding ensures that programs designed to support justice-involved individuals with mental illness can operate effectively. This includes having the resources to employ skilled professionals, offer comprehensive services, and maintain facilities that are conducive to rehabilitation and care;

b. **Expansion of Services:** With proper funding, organizations can expand their range of services to cover more areas of need, such as crisis intervention, long-term psychiatric care,

transitional housing, vocational training, and support services that are critical for successful reintegration into the community;

c. **Sustainability:** Funding stability is crucial for the long-term sustainability of these programs. Consistent financial support helps in planning and delivering continuous and effective intervention strategies without the interruption that can come from financial uncertainties;

d. **Financial Transparency—Building Trust:** Transparency in how funds are allocated and used is critical in building and maintaining trust among stakeholders, including donors, the public, and the individuals these programs are designed to support. Trust is essential for the success of any program that seeks to rehabilitate and support vulnerable populations;

e. **Accountability and Efficiency:** Financial transparency ensures accountability, making it possible to track whether funds are being used efficiently and for their intended purpose. This oversight can help identify areas of waste or mismanagement, thus enabling more effective redirection of resources towards areas and activities that yield the most significant benefit.

f. **Evidence-Based Programming:** Adequate funding and financial transparency allow programs to invest in research and data analysis, which can lead to the development and implementation of evidence-based practices. This approach ensures that resources are allocated towards interventions that have been proven to work rather than on untested or less effective methods;

g. **Attracting Further Investment:** Financial transparency can demonstrate the effective use of resources and attract further investment from both public and private sources. Potential donors and governmental agencies are more likely to invest in programs that clearly show how their funding contributes to positive outcomes;

h. **Promoting Equity:** Proper funding and transparent accounting practices ensure that resources are allocated in a manner that promotes equity, ensuring that all justice-involved individuals with mental illness, regardless of their background or the severity of their condition, have access to the support and services they need.

In sum, funding and financial transparency are not merely administrative concerns; they are crucial to the ethical, efficient, and effective operation of programs designed to support some of the most vulnerable individuals in the justice system. These practices ensure that resources are used wisely to make a tangible difference in the lives of those struggling with mental illness within the context of criminal justice.

6.A Recommendation: County (CAO)

6.1.A, 6.1.C, 6.1.D [4,6,7,8]

The CAO must transparently report the funds that are available, earmarked, budgeted, allocated, etc. to support the CFJL population and make this information publicly viewable by website. This includes:

- Funding source, amount of allocation, intention for funds, and Agency receiving the funding provided with all reporting
- Realignment/reentry funding that comes from and/or goes into general funds, reserves, or other pots of funding
- Tracking of CalAIM funds including PATH and other reimbursements
- Funding available for reinvestment and cost-savings must remain within CFJL population
- Unspent funds and funding balances in reported accounts
- Unspent funds in Santa Rita Jail for County and Contractor staff including Agency allocations, overtime, unfilled staff positions
- Funding allocated to address Babu settlement

- Updating the information every 6mo after initial report

6.B Recommendation: **County** (CAO)

6.1.B [5]

Increase and maintain **Alameda County advocacy to the California and federal governments for legislation that expands funds**. Continue to seek new resources as programs are created.

6.C Recommendation: **HCD,** GSA

6.3.A, 7.4.B

Remaining funds from the County's dedication of $26.6M for the Mental Health Program Services Unit in Santa Rita Jail should be reallocated for permanent supportive housing. Include a report/plan for how this money will be spent.

6.D Recommendation: **County** (CAO)

Create transparency for the Babu settlement with information accessible through Alameda County website including:

- Budget report on allocation of funds
- Spending and funding source used to address Babu settlement terms
- Outcomes and impact including reducing deaths in the jail
- Site monitor reports

6.E Recommendation: **County,** ACBH

6.1.E [9,152]

Fully fund ACBH's countywide Forensic Plan.

a. Six CATT MCTs. Estimated cost: $6.6M, general fund. Intercept 0
b. Crisis 24-hour dispatch service. Estimated cost: $2.2M, general fund. Intcpt 0.
c. Expand voluntary residential treatment beds countywide. Estimated cost: $16.5M, reserves. Intcpts 0 and 4.
d. New board and care facilities. Estimated cost: $2.2M, reserves. Intcpt -2.
e. Facility for co-occurring mental illness/substance treatment. Estimated cost:$1.05M, reserves. Intcpt 0.
f. Hospital beds (25-bed subacute facility, 16-bed acute facility). Estimated cost: $9.5M, reserves. Intcpt 0.
g. Expand satellite urgent care clinic services. Estimated cost: $2M, general fund. Intcpt -1.
h. Re-entry support teams. Estimated cost: $1.08M, general fund. Intcpt 4.
i. Peer respite for persons from Santa Rita Jail, on probation, at risk. Estimated cost: $1M, general fund. Intcpt 4.

6.F Recommendation: **County**, ACBH (with consult from BOSS, Felton, La Familia, Behavioral Health Collaborative(?))

Improve recruitment and retention for crisis and community mental health teams and ensure pay equity and parity between County, private sector, and community-based organizations. This would include:

- Writing living wage compensation into County RFP/RFQ and contracts
- Provide hazard pay
- Provide paid time off and wellness benefits

6.G Recommendation: County, (with consult from ACBH)

Produce an annual report of estimated operating and capital costs for housing and treatment of persons with different levels of behavioral health needs.

- Include the number of persons served
- Comparison of net county costs (after reimbursements and grants are considered) for persons incarcerated at Santa Rita Jail with housing and treatment
- Net county costs for non-jail placements (acute care, sub-acute care, crisis residential facilities, and supportive housing)
- The report will be submitted to the Mental Health Advisory Board and to the Board of Supervisors annually in advance of annual budget hearings

6.H Recommendation: County

Cost-savings from the jail, hospitals, and unspent funds must be earmarked for CFJL populations and the reallocation should be prioritized to address other CFJL recommendations.

Section 7: Housing & Residential Facilities (15)

Context:

Housing plays a crucial role in the rehabilitation and reintegration of justice-involved individuals with mental illness for several fundamental reasons:

a. **Stability and Security:** Secure housing provides a stable and safe environment that is critical for individuals with mental illness. This stability is a cornerstone for managing mental health conditions, reducing stress, and providing a foundation from which individuals can pursue treatment and rehabilitation;

b. **Treatment Continuity:** Housing stability improves access to consistent mental health care and support services. Individuals who have stable housing are more likely to attend regular therapy sessions, receive continuous medication management, and access community health resources. This consistency is vital for effective treatment of mental illnesses;

c. **Reduction in Recidivism:** Stability in housing has been linked to lower rates of recidivism. Without the pressures of homelessness, individuals are less likely to engage in activities that could lead them back into the criminal justice system. Stable housing allows individuals to focus on recovery and reintegration into society;

d. **Improves Quality of Life:** Beyond basic shelter, stable housing can significantly improve the quality of life for individuals with mental illness. It supports better physical health, allows for the creation of a supportive community, and fosters a sense of belonging and identity;

e. **Enables Social Reintegration:** Stable housing is a platform for broader social reintegration. It allows individuals to establish a daily routine, seek employment, and rebuild family and social connections. These activities are crucial for a person's sense of purpose and community inclusion;

f. **Economic Benefits:** Providing stable housing for justice-involved individuals with mental illness is cost-effective. It can reduce the reliance on emergency services, lower the costs associated with the criminal justice system, and decrease the need for acute psychiatric services;

g. **Promotes Autonomy and Self-determination:** Having a home can increase an individual's sense of autonomy and control over their life. This empowerment is critical for individuals with mental illness, fostering self-esteem and motivation to engage in their treatment and rehabilitation;

h. Public Health Improvement: Addressing the housing needs of individuals with mental illness can lead to broader public health benefits, including reductions in overall substance abuse levels, emergency medical service usage, and infectious disease rates.

In summary, stable and supportive housing is not just about providing a roof over one's head. For justice-involved individuals with mental illness, it is a critical element of recovery, rehabilitation, and reintegration into society. Housing is intertwined with health, safety, and the dignity of individuals, making it a fundamental human right and a necessary foundation for recovery and successful reentry into the community. To these ends, the recommendations herein fall into 4 categories: *Get People Housed, Keep People Housed, Build and Support More Adult Residential Facilities, and Build More Affordable Housing.*

Get People Housed

7.A Recommendation: Sheriff

7.7.A [153,155,156,157]

Connect People to Housing Before Reentry: The Sheriff should be required to formulate a housing-focused reentry plan, with an emphasis on supportive housing, for people leaving the jail who have a documented behavioral health diagnosis. The plan should require immediate post-release housing placement and housing navigation services. This reentry plan should begin with 90/60/30-day pre-release housing support, and should assure that people are matched to appropriate transitional housing for SMI/SUD/co-occurring populations immediately upon release.

For people who are spending less than 30 days in Santa Rita Jail, and have a documented behavioral health diagnosis, the Sheriff should ensure pre-release connection to the County's (HCSA) housing navigation services. The purpose would be for the County's housing navigators to connect with people before release to see if they have housing to go to; if not, then they should connect people to housing (including bridge housing options) and get them into the coordinated entry system to get assessed for permanent supportive housing.

7.B Recommendation: ACSO, OHCC

Coordinated Entry at Santa Rita: Alameda County should establish a coordinated entry access point at Santa Rita Jail. This would allow County navigators to get people assessed for permanent supportive housing before exit to the community.

7.C Recommendation: ACSO, Probation, County

Expand realignment supports: Alameda County should create and financially support a realignment system that supports people leaving the jails with sufficient time to gain the job training, job placement and housing navigation support to become sustainably housed at the end of their support period. At minimum, this would require expanding the length of time for realignment support services from six months to two years.

7.D Recommendation: HCD

7.1.A: [162,54,10]

Eliminate Discrimination: Ensure that the unincorporated county and County-funded affordable housing projects follow Fair Chance policies, allowing people who are formerly

incarcerated/ criminalized and their families access to housing and housing stability. This would require adoption, implementation, and monitoring of Fair Chance policies in the unincorporated areas of the County and in affordable housing financed by the County. The county should advocate for other cities in the County to adopt fair chance policies as well.

7.E Recommendation: **HCD,** OHCC, County

7.1.D:

Create Deep Subsidy for people with justice involvement: Since people with criminal histories are not eligible for Section 8 housing, the County should create operating subsidy alternatives to federally funded Section 8 Housing that will not restrict access to affordable/subsidized housing to households and families with serious mental illness and those with formerly incarcerated/criminalized backgrounds.

7.F Recommendation: **OHCC,** HCD**,** County

7.1.E: [12,158]

Deep Subsidy for SMI/SUD/Co-occurring Disorders: People with SMI/SUD/Co-occurring disorders and those who are formerly incarcerated are more likely to be Extremely Low Income (ELI) and homeless or at risk of homelessness. The County should provide more funding to support this population in permanent supportive housing programs and services. The County should financially support the Home Together Plan and the Alameda County Housing Plan (currently being drafted).

Keep People Housed

7.G Recommendation: **OHCC,** HCD

7.2.B:

Anti Displacement and Homeless Prevention System: Create and support a strong Anti Displacement and Homeless Prevention system in the County. At minimum, this should include:

- Expanding funding and availability of legal services for low income tenants who are at risk of eviction, in conflict with their landlords, etc, with a focus on those at risk of homelessness;
- Expand upstream screening and tenancy-sustaining services for individuals at highest-risk of homelessness, and deploy tenants rights education, legal services, social services, and other money management services earlier in the process to help prevent evictions and displacement;
- Ensure that the unincorporated county and County-funded affordable housing projects follow Just Cause policies, providing protection to people with SMI/SUD/ co-occurring disorders and formerly incarcerated/criminalized and their families access to housing stability.;
- Dedicate County staff and County-funded CBO staff to facilitate return to supportive housing for persons who lose access to that housing.

7.H Recommendation: OHCC

Re-fund and revive the Independent Living Association of Alameda County (ILA-AC): In 2017 Dr. Robert Ratner and Healthy Homes worked to educate and support independent living home operators, service providers and tenants to improve the general living conditions of boarding homes housing many living with mental illness in substandard and dangerous living conditions. Defunded in December 2021, as of November 2021, there were 17 active operators in the ILA-AC with 33 quality member homes and 206 quality beds. These homes improved through annual

inspections, operator resources and trainings. Identify MHSA or other funding to re-establish this housing support service within the SHCLA, an active agent in promoting quality of life for the most vulnerable citizens.

Build and Support More Adult Residential Facilities

7.I Recommendation: **OHCC,** County

4.2.F,7.1.E,7.1.F [12,86,158]

Build and support licensed board and Care: Expand licensed Board-and-Care facilities, which are designed to support highly impacted persons experiencing mental illness and/or substance use disorders. This expansion should both include the creation of more facilities as well as expanding sustainability funding for these facilities by ensuring and increasing patch funding for their reimbursement rates. The county should continue to conduct a periodic needs assessment of licensed Board & Care (B&C) beds, as well as Crisis Residential Treatment bed capacity.

To maintain and increase licensed B&C stock, state reimbursement rates will need to be increased closer to those set for facilities housing people with developmental disabilities. County and local advocacy groups should partner to advocate at the state level for increased reimbursement rates for B&Cs. In addition, as the County explores future housing bond ballot measures, B&C should be included as an eligible category for the use of funds.

7.J Recommendation:**HCD,** OHCC

Create an **RFP for County-owned land i**n the unincorporated county that would be **transferred to a land trust land bank to ensure the properties remain a board and care in perpetuity.** The land trust would assemble land for new construction development opportunities.

7.K Recommendation: **OHCC**, HCD

The County should build and support more interim housing options for people who are homeless and involved in the criminal justice system. This includes expanding non-congregate shelter options and maintaining existing shelters.

7.L Recommendation: **HCD,** OHCC, ACBH

The County should create more skilled nursing facilities (SNFs) for people with high medical needs and serious mental illness. The sole SNF in the County that serves this population—OakDays, a HomeKey program- is always full and has demonstrated the need for expansion of these types of facilities in the county.

Build More Affordable Housing

7.M Recommendation: **County**, HCD

(moved- from 7.1.E[12,158])

Invest more funding in Affordable Housing and Permanent Supportive Housing for those with SMI/SUD or co-occurring illness: Invest a minimum of $80M annually to expand supportive housing units for this population. $80 million would represent an increase from the approximately $46 million from the County's General Fund allocated in FY 2021-2022, which accounted for about one quarter of all funds dedicated to the Home Together plan. Facilitate the conversion of existing residential stock into affordable or supportive housing for those with SMI/SUD or co-occurring illness through the dedication of flexible long term operating support.

7.N Recommendation: **SSA**, HCD

7.1.F

Target County Housing Funds to SMI/SUD/Co-occurring Clients: The County needs to demonstrate that it is focused on prioritizing housing solutions for the population that has SMI/SUD/co-occurring and/or have criminal justice system involvement. Any plans that the County is creating for housing should include a specific and explicit element dedicated to how the plan will address housing shortages and placement for this population. This is specifically important for any new funding streams that the County receives related to housing or to services for this population, e.g. MHSA and/or BHSA - Behavioral Health Services Act dollars, regional housing bond dollars, etc. The County agencies that receive the funding should collaborate with the housing department to make a specific plan for how those funds will be used to create supportive housing units, B&C, supported independent living programs, and other interim housing options for this population. The plan should include a clear assessment of need and how this plan addresses that need, and an accounting of the number of dollars and number and type of housing units that will be created for this population. Furthermore, the County should provide regular annual reporting to the public on their progress towards the goals and commitments made in that plan.

7.O Recommendation: **OHCC,** HCD

(moved- from 7.1.E [12,158])

Support Innovative Models: Expand funding and support for innovative housing models, including Community Land Trust models that hold land for the purposes of maintaining permanently affordable housing for low-income renters, and where possible, with a focus on people with serious mental health challenges, e.g. the Supportive Housing Community Land Alliance. Support capital funding for OHCC's Supportive Housing Land Trust (SHCLA) in its work to stabilize the loss of licensed board and cares with purchases of available properties. With capital funding of $5 million, SHCLA proposes to leverage additional sources to make headway in increasing the dwindling licensed Board and Care stock and stabilize it with public funding.

Section 8: Increase Access to Treatment (0)

*all these recommendations have been moved to other sections

Section 9: Space & Services for Youth & TAY (0)

*all these recommendations have been moved to section 3 (Community Based Supports)

Section 10: Staff Training & Professional Development (5)

Context:

Training and professional development for staff who work with justice-involved individuals with mental illness are important for several reasons, each contributing to more effective, compassionate, and appropriate care for this vulnerable population. Here are the key reasons why such training is crucial:

a. **Enhanced Understanding of Mental Illness:** Training provides staff with a deeper understanding of mental health conditions, their symptoms, and how they can impact behavior. This knowledge helps staff to better identify the needs of people with mental illness and respond to those needs effectively;

b. **Improved Communication Skills:** Communication is critical when working with individuals with mental illness. Professional development can equip staff with the skills to

communicate more effectively, ensuring they can offer support, de-escalate potentially volatile situations, and build trusting relationships with those in their care;

c. **Use of Evidence-Based Practices:** Training gives staff access to the latest research and best practices in the management and treatment of mental health conditions within the justice system. This ensures that individuals receive care that is based on the most current understanding and methods available;

d. **Increased Safety:** Proper training can significantly enhance the safety of both staff and the individuals they work with. Understanding how to de-escalate tense situations, manage crises, and intervene effectively can prevent harm and ensure a safer environment for everyone involved;

e. **Reduced Stigma and Discrimination:** Ongoing professional development can challenge and reduce stigma and discrimination against individuals with mental illness. Training programs often include components that address personal biases, fostering a more respectful and empathetic approach to care;

f. **Legal and Ethical Compliance:** Staff must be aware of the legal and ethical considerations when working with justice-involved individuals with mental illness. Training ensures that staff understand these responsibilities, helping to protect the rights of those in their care and reduce the risk of legal issues;

g. **Adaptability and Resilience:** The landscape of mental health and criminal justice is continually evolving. Training and professional development help staff to adapt to new laws, policies, and practices, ensuring they remain effective and resilient in their roles;

h. **Improved Outcomes for Individuals:** Ultimately, the aim of all training and professional development is to improve the outcomes for justice-involved individuals with mental illness. Through better understanding, effective practices, and compassionate care, staff can play a significant role in supporting the recovery and rehabilitation of these individuals.

Investing in the training and professional development of staff is not only beneficial for the staff themselves but is also a critical component of providing the highest quality care to justice-involved individuals with mental illness.

10.A Recommendation: **County** (with consult from BOSS, Felton, La Familia)

10.1.A. & 10.4.C [3,11]

Increase the County's compensation of CBOs providing behavioral health services, so that their funding reflects **full equity between similar pay scale**s at ACBH, to allow them to recruit and retain staff and managers at competitive salaries that match county compensation.

10.B Recommendation: **County,** ACBH

10.1.B [1,2]

In order to adequately provide mental health services to the populations who are most challenging-to-engage, the **County must fund a comprehensive gap analysis to better understand the existing mental health needs of the community and the corresponding service gaps in the County**. The gap analysis should focus on the mental health workforce and its ability to meet those needs and should include recommendations for hiring and training practices that could diversify the pool of mental health workers in the sector, address compensation gaps, develop training plans, and implement incentives for individuals in the process of obtaining their licenses.

10.C Recommendation: SSA

10.2.A.

Increase opportunities for supported employment to help people get back to work who are on disability related to mental health diagnoses. This supported employment program should require regular and repeated mental health training for employment providers on early warning indicators, referral and navigation services, and other ways to support this workforce.

10.D Recommendation: SSA

8.2.A [134,139]

ACBH should **enhance the availability and delivery of mental health services for individuals who are currently or previously incarcerated at Santa Rita.** Enforce mandatory and consistent service standards for individuals with diagnoses, both during custody and after release, incorporating triggers for elevated service levels for those with recurrent incarceration instances. Strengthen the collection of diagnosis types and severity, as well as clinical and service data on clients' jail-based services, to ensure appropriate support and connection to housing, psychiatry, medical care, and other supports during reentry.

10.E Recommendation: ACBH

6.2.A**,** 10.3.A [90,111,141]

Culturally competent countywide training for first responders in MH crisis services and 5150 assessments: In order to address equity gaps and race-based discrimination in first crisis response, the Taskforce recommends multiple actions specifically for crisis and first responders countywide.

1. **Conduct an evaluation of the current Crisis Intervention Training (CIT) curriculum to identify levels of inclusivity** in regard to racial realities and cultural responsiveness. Based on this analysis, the Task force recommends:
    - Any assessment to include a criteria checklist (including a racial equity lens, a concern for decarceration, and success metrics).
    - **ACBH to make quarterly reports to the Health Committee** of the Board of Supervisors on the progress (capacity of treatment and training).
2. **Pay Equity throughout the county**
    - Align pay to staff and contractors for mobile behavioral health crisis team (CATT and MCT) staff with County compensation structures
    - Ensure fair compensation for mobile behavioral health crisis team (CATT and MCT) staff and expand 24/7 city and county crisis response teams to all parts of Alameda county.Several reports indicate that persons who staff the County’s crisis response teams are not paid adequately and work in unsustainable conditions.

Section 11: Family Supports (3)

Context:

Family support plays a crucial and multifaceted role in the lives of justice-involved individuals with mental illness. The importance of this support can be understood through several key perspectives:

a. **Emotional and Psychological Stability**: Family support provides a crucial emotional anchor for individuals facing the double challenge of mental illness and legal issues. The knowledge that one has a supportive network can significantly mitigate feelings of isolation,

stress, and anxiety, which are common in such situations. Families can offer a sense of belonging and unconditional support, which is vital for emotional and psychological stability;

b. **Advocacy and Navigation:** Navigating the justice system, along with mental health services can be overwhelmingly complex. Family members can advocate for their loved ones, ensuring they receive fair treatment and appropriate care. They can help navigate legal processes, communicate with attorneys, and ensure their relative's rights are protected. Additionally, they can assist in coordinating mental health care and advocating for services that meet the individual's specific needs;

c. **Continuity of Care:** Individuals with mental illness often require ongoing treatment and support. Families can play a significant role in maintaining continuity of care, especially when transitions occur between the justice system and community-based care. They can help manage medications, appointments, and treatments, ensuring their loved one adheres to care plans that contribute to their recovery and well-being;

d. **Reintegration Support:** Reintegrating into society after involvement with the justice system can be a daunting process for individuals with mental illness. Families can provide crucial support during this transition, offering a stable environment and assisting with practical aspects such as finding employment, continuing education, and rebuilding social connections. Their support can significantly impact the individual's ability to reintegrate successfully and reduce the likelihood of recidivism;

e. **Reduced Stigma:** Families can play a vital role in challenging the stigma associated with mental illness and involvement in the justice system. By openly supporting their loved ones, they can contribute to changing societal attitudes and fostering a more understanding and compassionate community environment;

f. **Resource Access:** Families often become the primary researchers and connectors to resources for their loved ones. They can help identify and access various supports available, including legal assistance, mental health services, financial aid, and community-based support groups. This role is especially critical when individuals might be overwhelmed or unable to seek out resources themselves;

g. **Monitoring and Early Intervention:** Family members, being closely connected to the individual, are often in a position to recognize early signs of mental health distress or relapse. This proximity allows for early intervention, preventing crises, and ensuring timely access to treatment and support.

In summary, family support is indispensable for justice-involved individuals with mental illness. It provides emotional sustenance, practical assistance, and advocacy. It enhances the likelihood of better outcomes across various legal, health, and social domains, contributing to a more compassionate and effective approach to mental illness within the justice system. Particularly for many family members without access to a private psychiatrist, the informational void is vast. Particularly in the prodromal phase of an illness, when families are mystified by behavioral changes, early diagnosis, and care can lead to far better outcomes than others face after periodic episodes of psychosis. What we learn from psychiatrists is that each psychotic episode can mean further insult to the brain and deterioration of competencies. By connecting people with timely and appropriate advice and services, it's anticipated that the number of SMI/SUD unhoused, 5150s, and incarcerations, including the high rate of recycling admissions and incarcerations, will be reduced. It should be noted that it is not uncommon for individuals to lose family member housing as the mental illness or substance use behavior deteriorates.

11.A Recommendation: ACBH

11.2.A: [31]

Assign a case manager or family navigator to any patient/family experiencing an early illness episode. This applies to anyone with Severe Mental Illness or Co-occurring Disorder (designated number 3 or 4 level of care in the jail) and/or exiting hospital on a psychiatric hold.

11.B Recommendation: ACBH (with consult from AHS)

Involve families starting with the first mental health (MH) crisis (for example, at John George or Santa Rita) by doing the following:

a. Assigning a caseworker or advocate to the family;
b. Requesting a broad HIPAA Release of Information from the client as early as possible;
c. Recruiting family advocates for crisis and outreach teams;
d. Recruiting family advocates and giving them peer certification training;
e. Having an office for family advocates (for example Bev Bergman's office at John George);
f. Providing a culturally informed advice line for families and clients;
g. Endeavoring to assign a psychiatrist and therapist to follow a client throughout their experience with the system and with medications. *This recommendation comes from Dr. Alice Feller.*

11.C Recommendation: ACBH

Implement an Advice Line, broadly available (hours to be determined) and modeled after the Kaiser Advice Nurse line, and available to family caregivers, concerned family members, friends and consumers of psychiatric and substance abuse services. Success of service will depend on well organized public introduction of its availability.

- **Site of Service**: Recommend ACBH Psychiatry Department, under Chief Medical Officer, Aaron Chapman, MD, and Department's Deputy Director, Angela Coombs, MD, an African American psychiatrist with a specialty in first episode psychosis. The ACBH Psychiatry Department also houses Mobile Crisis Services.
- **Rationale**: The Department of Psychiatry is arguably the best equipped to train and oversee an Advice Line staff, which will require a range of competencies in signs and symptoms of serious mental illness, psychiatric medications and the range of its side effects, equity issues including tendencies to over-medicate African American men and the complex service system.
- **Expected Impact**: This service should be particularly helpful in supporting a wide range of families and consumers who invariably face challenging circumstances and decisions in supporting family members or themselves in search of recovery.