Comment Received Prior to the September 29th Subcommittee Meeting

Jim Gilmer	Good afternoon, the recommendations and key findings 1-6, lacks the over arching and foundational commitment to terms like cultural competency, reducing disparities, not to mention the elephant in the room, disproportionate confinement of people of color. What is the focus of a prevention focused plan as stated in recommendation 1. Would it include a public health model that incorporates the social determinants of health which would reduce incarceration rates as mentioned in numerous reports (CRDP Phase 1 Population reports). Finding #1, states that people from diverse communities end up in jail because of unmet needs; however, this is partially correct. People from racial and ethnic communities end up in jail repeatedly for these reasons: * over policing in urban communities * disproportionate arrests * unfair sentencing * school to prison pipeline issues with younger children (suspensions, truancy, under resourced schools, lack of effective teaching, etc) The OAC's focus on robust prevention is welcomed and needed; however, without these elements the glass will be half full for people of color. Recommendation #2, deployment of services must be culturally appropriate and inclusive of community defined practices as recommended in the CRDP 1 population reports and modeled/expanded upon in Phase 2 implementation. There are many CDP's that did not get funded by OHE, frankly because CRDP is less than 1% of all MHSA funding. CRDP needs more resources! The OAC should be intentional about adequate funding of CRDP 3 and beyond if the outcome is to reduce incarceration of people of color with mental health issues. Recommendation #5 cites more technology for data collection; however, CRDP representatives and their reports articulate universally a need for culturally congruent research from design to evaluation. What good is data that does not tell the stories of our communities accurately? Consequently, if culturally appropriate research is conducted using the CRDP as a model, there will be an equivalent increase in knowledge to better serve communities of color and more specifically a reduction in mental health disparities for those populations over represented in the criminal justice system. We need more "robust prevention strategies." and community driven, culturally appropriate practices and programs---- the bottom line is to reduce incarceration of people from racial and ethnic communities.

Raja Mitry	Appropriate diversion must be prioritized to avoid that individuals taken into custody become traumatized. Vulnerable individuals are traumatized once jailed, traumatized by the treatment from law enforcement and by inmates. I speak about the real experience of a young adult female who was taken to jail in San Francisco where within a matter of hours she was "traumatized," as she put it in her own words. This terrible harm could have been avoided. All involved law enforcement and inmates must be held accountable for endangering and mistreating such a vulnerable individual. Deploying services once in jail is too late; effective services must be there, swift and able, prior to being jailed. Preventing contact with the criminal justice system was not there for this young lady. Being traumatized once jailed then beckons the need for mental health treatment, which could have been averted by those in law enforcement who must be sensitive, perceptive and decent -- and not hold a callous attitude that it's another crime committed. There was no one there to help this young lady deal with the trauma she endured in custody and upon release, there was no support nor guidance for further care. Counties need more effective in-custody options to ensure they provide appropriate and necessary services to those who cannot be diverted and to ensure immediate availability of people superbly trained to shield individuals from any traumatic mistreatment.
Mark Spencer, Co-founder HHCG	In reviewing the report I definitely agree with Jims statements. The one item that stands out to me when reading is that although many of the items deal with the community with regard to listening to what they have to say the response is still to quantify, and interpret the needs of these communities in a systems approach instead of empowering those groups to implement their own best practices. There must be a direct voice and supported line of action from the community to those within the community who need it most. Simply adjusting some of the methods currently in place within the criminal justice system may work to slightly reduce the issues faced by these populous', but in my opinion can not impact and make significant change without this key component.
Disability Rights California	DRC has reviewed MHSOAC's draft report, and are impressed with the breadth, depth, and insights of the report. In advance of Friday's public CJMHP meeting (at which we expect DRC to be present), we provide some written comments on discrete aspects of the report that DRC feels can be strengthened. · **Page 24 – Intercept One.** DRC strongly supports improved crisis intervention training and mental health/counseling providers' involvement, as discussed in the draft report. One component that is missing in the discussion is the need for law enforcement and treatment providers to have adequate *options* for immediately providing services and resources to people in crisis. There should be housing and voluntary treatment/service options available, to better facilitate resolution to a crisis situation that does not involve arrest/incarceration.

	· **Page 29 – Intercept Five.** The recommendation for specialty probation approaches has merits, but the discussion does not acknowledge the many concerns that have come out of research and policy analysis about the harms of over-reliance on community supervision (probation/parole), including collateral consequences for those who are subjected to onerous mandatory government supervision, including additional arrest/incarceration. (See, e.g., Michelle S. Phelps and Caitlin Curry, Supervision in the Community: Probation and Parole (April 2017) http://criminology.oxfordre.com/view/10.1093/acrefore/9780190264079.001.0001/acrefore-9780190264079-e-239?print=pdf). It is useful for systems to include community mental health services that are voluntary and disentangled from criminal/corrections entities, wherever possible. · **Pages 44-47 – Finding Two.** DRC suggests that it be clearly stated that jail custody staff should receive crisis intervention and mental health awareness training with the same or similar frequency and intensity as compared to law enforcement that work in the general community. Dr. Bruce Gage and other experts have provided a strong training of this kind in Los Angeles County. · **Throughout** – The report often refers to communities of color as "minority" communities. Particularly given California counties' demographics, this term is highly relative and outmoded, and distorts the issue (particular in communities where "minorities" are in the majority). We suggest that the report use more precise terminology, such as "communities of color," where appropriate.
Lynne Gibb, NAMI	Though I might have missed it, given the goal "to produce a plan for reducing the number of people with mental health needs who enter California's criminal justice system - and better serving those who do become incarcerated," I wonder as to the omission of Assisted Outpatient Treatment as a program with proven effectiveness in reducing incarcerations (by 78% in LA County; 74% in SF County; and 75% in Orange County, according to most recent reports) both from this report and from consideration of the Stepping Up initiative, thus far. In response to your request for the AOT evaluations: The 78% reduction in incarcerations in LA County came from a report on their pilot program. See https://mentalillnesspolicy.org/states/california/los-angeles-county-assisted-outpatient-treatment-program-outcomes-report-pdf.html

	The 74% reduction in San Francisco County came from San Francisco's 2-year report. See attached. To clarify, what it actually said is that "74% were successful in reducing or avoiding time spent incarcerated." The figure from Orange County (" 74.5% reduction in incarceration days") came from a presentation at the recent NAMI convention, by Jennifer Dinicola, OC Health Care Agency. I have a printed copy of the powerpoint presentation, but I can't find it online. These outcomes are remarkably similar to those from other states (see attached). And, they are so impressive, there's no way AOT is not one of the most successful, evidence-based programs to reduce recidivism. I think it should be part of our Stepping Up initiative. The interesting thing about California is that so few cases are referred to the court, as compared with other states (I asked the person in charge of Ventura County's SAMHSA- funded program why he thinks this is, and he cited CA's tradition of strongly defending civil rights). But, the studies consider all of those on whose behalf applications are judged to meet criteria, and assertive outreach ensues, whether or not their cases ever are referred to court. So, the number in other CA counties is not anywhere so small as it might seem. Even in our own county, with a 10-slot pilot, many more have been brought into treatment through assertive outreach than 10, and when someone accepts treatment, that slot opens for someone else. I hope we will see that figure when we get the 6 month report from Harder and Co. The thing is that AOT gives the BW department authorization to reach out to those who are treatment resistant, and places a mandate upon them to do so. That is the difference from the ACT program we've had for so many years with unimpressive results. Let me describe one case - a young guy who suffers from paranoid schizophrenia, was homeless for some time, and then placed at Pescadero Lofts. He wanted nothing to do with his family, or anyone else. Threw coffee on another resident he felt threatened by. The forensic team decided the only way to get him help was to ask a judge to issue a bench warrant so that he could be arrested. At the same time, his mother filed an AOT application. An outreach worker began making contact with him and gaining his trust. In the meantime, he got arrested, and the outreach worker visited him in the jail, and then at the PHF where he was transferred IST. Because of the relationship established with the outreach worker, he stuck with treatment, was able to convalesce at his mother's home (he hadn't previously been willing to have contact with his family for years), and then return to PL where he's been stable and recovering, rather than returning to the jail and criminalization. Everyone doubted AOT could work for him, but that is the power of the program.