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>> Good afternoon. And we apologize for the short delay. Welcome to today's webinar titled Solutions to Improving Access to Care for Individuals with Serious Mental Illness in Prisons and Jails, sponsored by SAMHSA and presented by the National Disability Rights Network, also known as NDRN.

My name is Kelle Masten from the National Association of State Mental Health Program Directors, and I would like to thank you all for joining us today. Before we introduce today's presenters, I would like to go over a few housekeeping items. Today's webinar is being recorded. The recording along with the PowerPoint presentation slides will be sent via e-mail within 3 to 5 days to all those who registered. However, you may download -- I'm sorry -- the PowerPoint presentation slides for your convenience at the top of the screen where it says "PowerPoint presentation." Please click on upload file to download the slides.

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I would like to thank SAMHSA for allowing us to share this information with you today, and, again, thank you for joining us. I will now turn this over to Eric Buehlmann, Deputy Director Executive for Public Policy for NDRN, who will introduce today's presenters. Eric.

>> Thank you very much, Kelle. I'm glad today to have Phil Fornaci and Stuart Simms with us. Phil Fornaci is the staff attorney for the National Disability Rights Network, NDRN, as Kelle said. Mr. Fornaci provides training and technical assistance on adult criminal justice issues for persons with disability, as well as on abuse or neglect on person with disabilities who reside in institutional settings.

Prior to joining in NDRN in March of 2020, right during the pandemic, Mr. Fornaci spent more than 12 years as an advocate and litigator in Washington, D.C. on behalf of prisoners and formerly incarcerated people.

For five years, Mr. Fornaci served as the executive director for

Maryland Protection and Advocacy Agency, now called Disability Rights Maryland and later as the executive director for a legal services program providing employment advocacy for low income workers. He received his BA in philosophy from Columbia University and a JD from George Washington School of Law.

Stu Simms is a partner at Brown, Goldstein and Levy, with nearly 20 years experience as a trial lawyer and respected prosecutor as well as more than a decade heading large government agencies. Prior to his current position as a partner Mr. Simms was a secretary for Maryland Department of Public Safety and correctional services from 1997 to 2003; the secretary for the Maryland Department of Juvenile Services from 1995 to 1997; and elected States Attorney for Baltimore City from 1990 to 1995, and appointed Assistant U.S. Attorney from 1978 to 1982. In 2012, Mr. Simms was awarded Baltimore Child Abuse Center's first founders award. In 2013, the American Bar Association appointed Mr. Simms as the member of the special committee on bioeffects and law. Also in 2013, he was selected by the NAACP as a Thurgood Marshall honoree. In 2015, Mr. Simms was selected as one of the Pro Bono Resource Center of Maryland honorees for exemplifying the best in the legal profession for unwavering commitment to creating a more just and accessible legal system in Maryland. And most recently, Mr. Simms was nominated to the American Bar Association standing committee on substance abuse.

Mr. Simms graduated from Harvard Law School with a juris doctorate in in 1975 and a bachelor in arts from the Dartmouth College in 1972.

I'm happy to have both these guys speaking on this important topic today and I'm turning it over to Phil to start the presentation.

>> Thank you Eric. This is Phil Fornaci from NDRM. I was going through some of these introductory slides. As Eric mentioned my background is both in the P and A world as protection and advocacy system, but also as a litigator on behalf of prisoners, primarily prisoners with disabilities and people with mental illness. So a lot of what I have to say today is based on negative lessons, that is what does not work. But I do have some ideas to offer about how to do it better. And most of the things I want to talk about will be mostly in the prison environment as opposed to a jail but a lot of the issues are very similar. And of course you have some questions later if you want to clarify any of that. I want to fist of course acknowledge that we're sitting in a situation now with the COVID epidemic and the subsequent government measures in response, we know that COVID of course is airborne that causes problem in a prison environment with overcrowding, staff are in close contact with prisoners as prisoners with each other. So these are very closed environments. COVID has taken a fairly high toll on prisoners and staff as you can see, about 400 prisoners have died with COVID and 23 staff. So it's a situation that people have very much aware of and dealing with and trying to survive. The intersection of a large number of people with serious mental illness in prisons and jails, it creates enormous problems for correction staff and for prisoners. We talked with -- we'll go through some of this today, but staffing is very short now both because of the epidemic itself and because of the fear involved with that and because many people have gotten sick. It's caused many shut downs and limitations. Another issue has been the shutdown of programming because of the intent to avoid program activities, so there are very few situations where prisoners and staff or prisoners with each other are meeting in groups that is for educational programs or counseling and

other programs. So when we're talking about mental illness in prisons, it's a little bit of a squishy topic. That is mental illness even a serious mental illness is based on behavior. There's no blood test for identifying somebody who has a serious mental illness, only behaviors and their life history can result in that kind of diagnosis. The symptoms and the impact of mental illness are very real but it's very difficult to classify and treat appropriately. When we talk about serious mental illness which is a term that is prominently used in the corrections setting, those typically are people are talking about what used to be called Axis I diagnoses, major depression, bipolar disorders, schizophrenia, borderline personality disorder among others. But a big issue with working with prisoners with mental illness is who has a mental illness and what wants or needs treatment which requires a diagnosis that is often not available. So in this slide we're showing estimated 30 percent of California prison no, sir, 21, percent in New York and Texas have a mental illness. The bureau of prisons reports only 3 percent with serious mental illness which is not accurate but more how they count that number and acknowledge people with mental illness. One of the difficulties when it's -- with mental illness being a challenge to diagnose and identify is that certain behaviors are recognized not as illness but malingering, that is simply faking the disorder, not really having an illness but pretending otherwise. People are accused of having this antisocial disorder, that is strictly oppositional behavior or simple refusal to comply with the rules and being punished and sometimes it's not recognized that people are unable to understand or obey orders as a result of their disability. I think it's also one way or the other pointing out that issues like racial tensions, most staff in most prisons are white, prisoners are disproportionately people of color, there's tension there. There's tensions around gay prisoner, transgender prisoners, and staff who may not be used to dealing with a variety of people. And staff also tend to perceive all prisoners as criminals and have certain perceptions that go along with that. The challenges in terms of the inherent tension between staff and prisoners, there are also resource limitations which have been worsened during the COVID pandemic. But also there have been difficulties in general with hiring, recruiting, retaining mental health staff both case managers, et cetera. And finally a prison is not exactly a therapeutic setting so it's generally not an appropriate setting to get mental health treatment but that's where a lot of people with mental illness are and they need to be treated. So the most common treatments for mental illness in jails and prisons in particular is psychotropic drugs and outside of prison, drugs are usually combined with counsel or preferably are combined with counseling but again with resource limitations and the other challenges of COVID, many facilities are relying primarily on drugs alone, which causes some significant challenges as well. For one, it prioritizes the drugs over other avenues like group and individual counseling which might be more effective in addressing the behavioral issues. Many prisons and jails have limited formularies, that is they have limited number of drugs available which forces them to use perhaps older medications or medications which have serious side effects. More commonly, drugs anxiety psychotropic drugged are prescribed by internal medicine doctors or non-psychiatrists to due to a shortage of psychiatric services available in prison. So sometimes diagnoses are not correct, drugs are not right. And finally people are transferred to other prisons and their drug regimen will be disrupted. So what happens is when treatment fails, there's discipline. When treatment fails or it's unavailable, people act out and they're punished.

Unfortunately, this is pretty much the worst outcome for people with a serious mental illness because the disciplinary actions that are taken, that is, for instance, revocation of phone or visitation privileges will tend to isolate people further. It removes the moderating impact of family and friends, who might help somebody with a mental illness survive a very challenges experience in prison. Solitary confinement I'll make mention that is the most common disciplinary action taken against prisoners and has very serious implications for people with mental illness in prison, particularly serious mental illness. I'll talk about that a moment. Another factor is prisoners are transferred frequently to different facilities, certainly every couple of years and sometimes more often, and often as a result of a disciplinary action. That also is disruptive to people with mental illness. Finally, if prisoners act out in a violent way, they assault a staff member, for instance, they can be brought up on criminal charges, which extends their sentences and makes the whole thing worse.

So there's certainly alternatives to disciplining prisoners in that way. The strongest and the most important alternative would be for better staff training so staff know how to deal with behaviors that may look oppositional, but maybe are not. It may be that people are not understanding the orders. Fostering better relationship between staff and prisoner is certainly helpful. But there's also things like using different kinds of incentives. I had a client several years ago who had repeatedly attempted to kill herself, she was a transgender person. And what they found was when they moved her to less restrictive prison environment among them was that she could use the commissary more often and could secure things that she felt she really needed, that was a reward for better behavior. Similarly, a lower security status is a reward for better behavior. So there are things you can do a little bit better. But unfortunately with disciplining people with mental illness in prisons, is that. So in particular high security interaction is one way of calling it, many of you are familiar with cell extractions where they come in with the use of force team to remove someone from their cell. That's a pretty serious impact on people with mental illness and certainly on anyone who experiences that. And in the course of those kinds of violent interactions that happen in the course of discipline, there are racial issues as I mentioned before as well as trauma that prisoners may have experienced prior gets a retraumatizing impact of these disciplinary actions. Sorry if I'm running along too quickly, but I want to cover as much as possible.

Under issue the suicide risk, of course. Suicide is a threat to all people involved in corrections that is with prisoners. The incidents of suicide are extremely high, multiple times higher than the national average suicide. And the way prisoners generally feel about it when it becomes a critical moment. There are these things that are called safe cells which means that a person who threatens suicide or indicates they might be planning to commit suicide put in a cell that is stripped down, often the prisoner is stripped down as well and lights are off and on 24 hours a day. They're monitored constantly or at least to on a regular a basis. They're put on a suicide watch. That is not generally something that prisoners like. Obviously, other than interventions are possible, among them counseling and direct one-on-one therapy with people who are suicidal, obviously going through a crisis. As we mentioned, such options are less and less available because of resource issues and because of COVID there are fewer one-on-one conversations between staff and prisoners.

I want to talk a minute about solitary confinement. Solitary

confinement is simply the worst thing to be done to a prisoner with a serious mental illness or any mental illness and personally I'd say the worst thing to do to any person. But it is the primary means of discipline in most federal systems. For small infractions or large infractions. I've none of prisoners who wore the wrong shirt than they were required to do in their Freddie Mac and they're put in solitary confinement for two weeks. It's kind of a knee jerk automatic response to violations of rules. The problem is when you have people that cannot follow rules effectively, may not understand the rules or they simply have difficulty controlling their behavior, they end up in solitary confinement. That of course causes longer term psychological damage to people who are already damaged. But it also excludes them from programming, from mental health treatment and from other services that they might be getting were that not in the solitary confinement cell. It causes a kind of a retraumatization, makes things much worse, they relive what happened prior and it can lead to prisoners acting out further leading to the use of restraints and other more serious interventions. Also has an impact on recidivism. And any prisoner, particularly those with anxiety 14 years, and various psychotic disorders will have huge escalation and voices and delusions because unexpectedly locked in a room by oneself 24 hours a day with half an hour for recreation is challenging for anyone. There are some categorical exclusions from solitary confinement. Several district court decisions have excluded people from serious mental illness from being put in extended solitary confinement. The federal bureau of prisons has mental health care level and those at the most serious care level are not permitted to be put in solitary confinement. A situation I wanted to comment on was in the supermax prisons, which is an area where I've done a lot of litigation prior to joining NDRN. In a case called Cunningham versus the the Federal Bureau of Prisons, and I could send information on the site after this presentation. It was in Colorado, a rather of the notorious place called the ADX. Some of the prisoners held there were held in a control unit, not only held in their cells pretty much 24 hours a day with a couple hours a week out for recreation, but they were also barred from any psychotropic medication. So that created quite a terrible situation, a lot of self harm, people have committed suicide but also really incredibly and I won't go into but fairly terrible things that people did to themselves in that environment. So we take people that are already damaged and putting them the in that kind of situation of except stream isolation and the results from predictable. The Cunningham case filed in 2012, fairly quickly within a couple of years, this most of the prisoners who were first named in that suit were removed from that facility entirely, interestingly many went to mentally lower prisons and managed quite fine, so went to medical facilities. But all did better removed out of that environment. Unfortunately many people with serious mental illness remained in that facility after the conclusion of the lawsuit in 2016. The most prisoners however what was done in that situation what the BOP did is they created a different kind of programming option. So all prisoners had at least 20 hours of out of cell time which meant they were brought out to do programming, for individual counseling, their treatment was overseen by psychiatrists who were appointed to monitors and they got extended privileges, things like being automobile to call home, have greater access to communication and also have the ability to step down from that level of isolation. So I think even in that kind of environment where people were put in solitary confinement with a serious mental illness, there are steps that can be made to I won't say make it better, to make it

a little less terrible. Unfortunately those lessons learned by the federal government were not learned by the state systems. One other thing that the bureau of prisons did is create what they called the stages program and that was create small units one outside of Atlanta, one in Pennsylvania, one in Colorado, which are under 50 prisoners with a large number of dedicated mental health staff and other services. And the idea was to provide mental health services to prisoners in a less confined environment. That experiment has got mixed reviews, but I want to commend them for at least moving in that direction, for recognizing that people with serious mental illness have specific needs. So in conclusion, I'll say that the challenges to providing mental health treatment are significant. Typical mental health treatment practices are very difficult, if not impossible to replicate in a correctional environment while also maintaining order where discipline is pretty much the order of the day. Additionally staff are difficult to recruit to prisons they're usual any in rural areas where people perhaps don't want to work. Particularly psychiatrists are hard to hire, but also psychologists, senior mental health staff. It's an ongoing challenge and now with COVID it's even worse because they're just fewer people willing to work in that environment. The high cost of providing these entire inventions, there's no two ways around it if you're going to deal with people with disabilities with mental illness in a very rigid, harsh environment like a prison sob is going to have to put some resources into it. But typically most prisons do not put the resources in, instead they treat people with serious mental illness like everywhere else and they bear the costs for that. Thank you. I'm going to turn this over to Stu now, thank you for you attention.

>> Thank you, for the outstanding overview that you provided. And I think what I'm going to try to do is set is the stage because left off in the résumé discussion was the fact that I've been a defendant in some of the very actions that Phil has described. I've also been a plaintiff on behalf of individuals and I've also represented individuals with serious mental illnesses. So my remarks come in some respect as a reflection of what is possible, even though the context that we're talking about in a society where we have almost 2 million inmates across the country, on almost 50 percent of them have some type of mental illness with a significant number of them being in state and local institutions. The reaction of COVID has certainly come challenges for the mental health population. The states, just to simply put things in context as we look for answers, the states have gone as a result of the COVID trends, to looking at particularly at inmates who are close to completing their sentences, the very elderly, and those that are near the end of life, and are low risk and have been convicted of minor crimes to try to get them to exit state institutions. And the federal government has acted under recent legislation which was the first step back in 2018 in which federal prison inmates and persons and their loved ones can get an opportunity for sentence reduction. Initially that was solely within the discretion of the Bureau of Prisons, it's now been expanded so the courts have been involved and so petitions in federal courts have certainly sky rocketed since April, as individuals who have certain conditions have attempted to get released from custody. The challenge has been is that most of the prisons have really not thought about look at -- none of the policy makers have thought about looking at the mental health population. They're focused on merely keeping run and scrub, keeping the facilities clean or screening clean, or at the very worst by the Bureau of Prisons simply I allowing people to remain in custody until they're at death's door. So as Phil points out

with these daunting numbers and challenges in terms of mission training, prescription, medications and so forth, do you just tweak the current model and leave as is or do you sort of make a slight move and particularly at the local level try to develop mental health courts as either a diversionary program or a moderate size program. Some of you, as you know those courts have met with some success, there are about 350 across the country and there's certainly some evidence by the American Psychiatric Association that they've been effective. But that doesn't give your prisons necessarily enough relief and certainly not the state at the state or federal level. Phil has mentioned the litigation and certain federal litigation for cruel and inhumane treatment, an ADA or Americans with Disabilities Act claim and other types of claims can be done. They're labor intensive and certainly you've got to assemble the information. And one time in another life being a defendant, certainly there are things that you want to avoid. I think the COVID environment environment may be another opportunity to be aggressive and to -- do what I'm calling a aggressive consultation with state and federal partners. And what I'm talking about on that is really building an alliance, if you will. And the network that you have that others have both courts, non-profit, health provider, state and local agencies, and advocates. And most importantly I think trying to raise the level of two factors that are important to the bureaucratic type, and they are first lowering the length of stay and second, lowering costs. Those two things are your entry points. I think to really sort of get into some discussions that can be very substantive and hopefully lead to some further successful discussions. The other opportunity is if you're able to point out of those things based on either the diversion model or other types of models that lower cost by putting the mental health population in different settings or diversion, they may lead to discussions about putting together study committees to identify gaps in services and perhaps to put together the ultimate situation is that people would know and that is a continuing of services. And what I'm referring to is a continuum is really a spectrum of treatment of modalities that you can probably -- that you can excuse me possibly put together with the criminal justice partners. And that means to the extent that they have the resources, trying to determine whether they can put together assessment at the entry points to their particular system, particularly in local detention centers where visit can be adequately assessed. Second, giving and this is particularly at the local jail and state institution, giving prisoner access to mental health care and discussion. And third, certainly making that access confidential because I think it's important to try to gather some trust and meet people in some way. And fourth, something that Phil mentioned, that is trying to adequately train a sufficient staff. Fifth, developing internally your inpatient capability. Six, certainly having a methodology for documentation. And 7th, some kind of inpatient crisis intervention modality. And certainly I'll mention training again, case management, and certainly the informed consent in consultation of the very population you're treating. With all of that I want to try to encapsulate and conclude, I guess with four guiding principles that will be important I think in the discussions with the criminal justice and hopefully maybe social service and psychological partners that you can go their. The first is inclusion -- gather. The first is inclusion and that's trying to bring some cultural competence, trying to bring some broad based support to the discussions in terms of building a community sort of foundation to help both the criminal justice partners and those who are coming in and out of the penal institutions. The second is certainly some

law enforcement a backup, that is law enforcement even before the George -- the most recent incidents causing racial strife in this country, you need partners. And certainly correctional and police types. Sometimes feel isolated themselves. And to that extent the addition of other partners, social work, psychological -- psychology students, others, other advocates that can come into the discussion will be important I think this trying to build both a community support and confidence, particularly on the correctional side. The importance of housing cannot be overstressed. It's very interesting that one of the initiatives certainly in most large cities and communities in response to COVID was to certainly go and try to assist the homeless population. We should be giving and certainly in any kind of a -- be it a mental health diversion court or a full scale system with all the components that I mentioned, the importance of housing cannot be overstressed, it is very important. And to that end I think it's important to bring state housing representatives and others into the discussion to try to build capacity with regard to housing options and how those options can be offered and put together. The fourth component with regard to certainly look at a guiding principle is the gathering of data so that any path that one pursues, you got to get a sense of what the trends are and particularly looking at the issue of lower costs and particularly looking at the issue of recidivism. And trying to come away, whether it be a pilot or full scale program with something that is -- that works, something that is usable and something that can be trustworthy for your public and civic partners. Having addressed that very quickly, I want to again thank the moderators and Eric and others who are allowing us to participate and then open it up as directed by Eric for any questions or additional comments. Thank you.

>> Thank you, too. I really appreciate it. One question that came up pretty early on was the numbers that came early on about death and infection rates, are they nationwide. They're from the website. They will be on the side. They're nationwide number, four four jurisdictions around the country, it was a fairly swath of the country and I would suggest it's a pretty good website with a lot of data. So if you get an opportunity and a chance I would dig around on that website a little bit. It's constantly updating and it's got some pretty good data there.

We were then asked, one question came in and said what steps can loved ones of those in jail in prison we're going to be specific in California think to advocate for the human rights they are looked in their cells with 24 hours a day with no mental health services. Secondly when recourse do people have when mental health diversion court is denied in California. I don't know if Phil or Stu wants to take the first crack at that

>> The one thing that I've seen both in my home state and in jurisdictions across the country and it's an unlikely ally, when you initially think about it, but they have certainly come to the rescue in many instances and that was continued discussion within the judiciary, that is, finding a way to find an advocate among judges, active judges who are sitting particularly in cities and large jurisdictions. Just as with the whole war against controlled dangerous substances, I have found in the past that with regard to the sensitive issues of domestic violence, drugs, as well as mental health, you can find among any bench at least 1 or 2 judicial allies who are willing to marshal the discussion and move in certain ways to change the perspectives. Now, judges don't have money and they don't have a budget necessarily, but they can become pivotal, become pivotal importance with regard to any state funding, federal funding, with regard

to any grant funding that can assist in the establishment of diversionary issue. In a sense a judge himself or herself can be a diversion court on their own. And to that end many have acted and have spawned the system. Phil.

>> I think you covered it. I don't know anything about the California system so I'm not sure how to answer the issue about being turned down for diversion.

>> Thanks, guys. Then there was a question that came in whether there was a difference or there was some new other steps that needed to be taken for aging populations. So especially sort I guess the aging population that needs treatment for serious mental illness, also and are there some steps that need for taken to help address both the aging and the mental health side?

>> Go ahead, Phil.

>> I was just going to say I've been --

>> Phil, you go first.

>> I was going to say there are been efforts through litigation to oppress the release of compassionate release for holder individuals and largely but not hugely effective and the prison population overall nationally has gone down something like 12 percent, which is not real significant given those number of elderly prisoners there. I'm not sure that's responsive but that's the best I know.

>> I think you've covered it.

>> Okay. I then got a question about sort of what mental health training are correctional officers receiving annually? Stu, you'll go first this time if you know.

>> Insufficient number of hours. And there is a national association, the American Correctional Association which is sort of a trade association for the American prison equipment provider so to speak. And they offer some nominal training, but enough training is -- there's an insufficient amount of in service training for correctional staff. There's an insufficient amount of psychologists for particularly for state correctional institutions. And there's an insufficient amount of psychiatrists and analysts who are of state institutions which makes it especially difficult in these days and times. The very issue of a paroleability in states is being backed up because of insufficient number of psychologists. Phil.

>> I think that covers it. I think it's a major resource issue and related issues.

>> The next question that came in said is there any data that supports the efficacy of solitary confinement for inmates. And I'm going to let Phil go with that one.

>> I'm going to say no. But I guess I would add to that, I had -- I referenced an interesting study on the slides from Cornell that actually came out of Denmark where they found that any period of solitary confinement increases the risk of death within five years after release from prison. In European situations we're talking about 3, 4, 5 days of solitary confinement, they found that dramatically increased the risk of death not only from suicide but from silence and other matters. Solitary confinement has been banned in virtually all the European countries and much of the world. And unfortunately it is still practiced here in the because it is a relatively simple thing to do, that is you move the problem into a corner and shut the door. It's not unlike used for see conclusion and discipline in schools. In my opinion, it's never appropriate.

>> Stu, do you want to add anything to that?

>> No, simply if they're concerned in their state about that, they should go to their local state legislator and attempt to try to craft state regulations after that are evasive and require reporting in order to keep that issue alive within the public debate. Because, you know, folks are behind the walls and things may not be documented the way they ought to be and reported the way they ought to be. But that may help in the road to try to minimize and hopefully on the road to eliminate solitary confinement, which is an about an abomination? The next question if there's a prior dig notice before incarceration does the prison ever research out for continuity of care and medication.

>> Yes. And no. My experience as a legal practitioner is from what I've seen, if it is a unfortunately, if it is a non-violent offense, and if you put together the case in an appropriate way, you have a better opportunity to try to put together continuity of care. And if the family has resources, you have a better opportunity to put together continuity of care. If the individual does not have resources, and if the individual has completed committed some kind of invasive crime, property or personal, it just becomes a lot more difficult. And particularly when they don't have resources.

>> Thank you.

>> I respond to this in chat. One of the things that even short of continuity of care is we had a lot of engagement with certain facilities to try at least acknowledge the person's prior diagnosis before they came into prison, provide records prior to being in prison and in most cases we found that this was the first officials had even seen of the prior preincarceration mental health records which is both up setting but not surprising. So there's very -- when you talk about continuity of care which I think is sort of another level I think the challenges Stu identified are exactly right.

>> One quick story I've certainly suggested to some families even if they can't go hire counsel they've hired social workers to put together documentation of certain issues and literally done the work of the probation officer or parole officer in order to try to move things continue a continuity of care. In other words, on occasion sometimes embarrassing those in the criminal justice arena in terms of not doing their jobs or looking individually to the problems, to try to get either the court or others to about act in a way that's consistent with goods health.

>> Got a comment and question the simple fact that with people what kinds of systems reforms can we implement to keep people with serve use mental illness out of jails and prisons? Stu, why don't you go first.

>> Well, I think the key, I mentioned at a continuum of care for penal institutions, I think there's a continuum of care that should occur for anyone entering the charging arena. In fact, I had an extensive argument with prosecutive types to simply say there are certainly instances where we're not talking about a plea of insanity, we're not talking about a plea of mental defect, we may be talking about a plea based on the individual's challenges of having a serious mental illness. And in some instances, that discussion, what I call the sort of the prearrestment or post arrestment discussion of health issues has worked. And essentially, you know, if you're able to get counsel, whether it's expensive private counsel or even a well trained and seasoned public defender, you have the possibility of doing that, but again, it depends on the circumstances of the crime, the public prosecutor's perception and at that particular stage. It's a great opportunity to try to get some things done.

>> And I think that's all exactly right. And you know it's a really big challenge. And the American correctional system there's this tension between what we used to call rehabilitation and punishment and certainly punishment has carried the day for the last, I don't know, 30 years. 30 years. People with serious mental illnesses have been implicated in very serious offenses, sometimes there are steps you want to do to remove that person from the general population to get them what they need if possible to treat their situation so it doesn't happen again, but mostly to remove them from society. And that's a pretty big challenge, to say the least. But I think one of the answers is that a prison is never going to be the right environment. There's been a little time in prison hospitals where they have people with serious mental illness and that makes something like one flew over the cuckoo's nest like like a delightful fantasy. It's a bad situation. So we're doing exactly the wrong thing. Even somebody who is the most violent person with mental illness, to be put in a place that's absolutely a negative environment, that is punishing, it's just going to end up torturing them and not do anything at all. I guess I make the point they should not be in a prison environment at all if possible.

>> Because I'm not totally sure if some of Phil's answers were to all or individually, what practical steps can you take advocating for an individual client to be granted access to mental health care and?

>> Okay. I'm sorry. I may have messed that up. Yeah, most facility there a mental health -- if someone is already incarcerated or in a jail you can identify who the mental health director is, who the appropriate staff is and communicate with that person in terms of getting information about their loved one or friend or client to those officials. They just want to try to figure out the structure of the facility, who's in charge of what and get this touch with that person directly. Advocacy itself is going to be very challenges as Stu has already mentioned. They may not listen to you but may listen and have very little they can do. But that's how I would go is go to the mental health services in that facility.

>> Any thoughts Stu?

>> Yeah. The only thing I would add is really if you're doing it on your own without the benefit of counsel, you're sending letters to bureaucrats, I would also find the legislative advocate. It's important sometimes to have external eyes that are watching and to the extent that the local state representative, the local state senator, the local committee person, some local elected official or local basis or state basis who's at least looking at the record of correspondence and whether or not the institution is reacting in some way, with regard to the person's care. Now, it's a difficult bridge because you're dealing with privacy issues and other kinds of issues which is a bit tricky, but it is something where you can sort of lay a pathway to move the needle in terms of care.

>> Great, thanks. We also got a good comment I have a friend who has nephew in jail system and the problem is there's nowhere to place him for discharge. So he remains in jail afterwards. That's something I know both of you talked about in your discussions and the importance of housing and don't know if you want to opine on that a little bit more or just leave the comment out there as a truth.

>> The only thing I would say is it's extremely unfortunate that he's remaining in jail and in fact should not be in jail. The only reason he's being there is because of his mental health diagnosis it creates a is certain urgency to solve

that. You can't leave someone in jail because of their mental illness.

>> As an emergency, I would say that the person should run to the local health department and try to get an advocate. An advocate just in terms of providing them information, guidance, capacity, in terms of trying -- in other words, you're doing the work again for the institution to try to find options, if there are options for housing or options for care.

>> Great. Thank you. We had a question on how do you get an inmate identified as someone who qualifies for the BOP cares level and they also wanted to know what BOP stands for. That one I can answer, which is the bureau of prison sons.

>> I'm sorry. I probably should not have even referred to it but the care levels are what used in terms of the Bureau of Prisons and state systems often have similar. So they rang from 1 to 4 the level of care that is required to take care of that person in the facility and it's done by the facility. I don't know if you have any ability to affect what care level that set it ought. It's done by the treating mental health professionals there. I've seen a man go from one to four in a period of year and has less to do with their actual mental illness as to how much resources they require, that is how much resources the facility needs to put into them. If they can be managed on psychotropic medications and no behavioral incidents, they're a level one even if they have a serious mental illness. So it has to do with resources and the amount of care they need in the facility.

>> Okay. Probably do two more questions. Is it legal for jails to hold inmates in their cages for 23 hours a day, citing due to COVID 24 hours every single day and no mental health treatment? I think it answers itself but I'll let you guys.

>> Well, there's no absolute, when you say legal, quote-unquote, I don't know that unless the facts can show it that there's a criminal offense that can be charged or whether or not the facts would lead to a civil rights claim that would be successful. Having litigated lots of different things and seen them litigated I certainly am not going to suggest that nothing's impossible and certainly you could. It was announced today, for example, in the local jurisdiction where I live that the inmates were locked up for 20 hours and a sewage issue arose and it was unattended for ten hours. And that was filed in federal court. So it certainly conceivable that one could make that claim. How quickly there would be a response and how quickly there would be corrective action certainly is another matter. Phil?

>> I think that's exactly right.

>> And for the last question, we got and the other ones as Kelle said earlier on we will pull the questions that we didn't get to at this point and get you responses to those. But who can community based volunteers contact in jail for continuity of care? Phil, you want to --

>> Well, I think we kind of already addressed that. It really depends where you are, that is what jail you're in, what prison you're in in terms of continuity of care. And as Stu has eloquently described it's hard to get continuity of care. But your only option if they're already in jail is to try to deal with the mental health staff that is in that facility and communicate with them in the ways we've already described.

>> Any thoughts, Stu?

>> I think that's exactly right. I think, again, if you are in the advocacy

area and you're looking a programmatically, I say yes, you go to all the usual suspects, the local health department, a local community hospital, advocates and so forth to try to get some programmatic relief. And if you're an individual citizen to either try to get some resources or look for resources in a particular way to try to probe or embarrass the institution into some kind of -- some kinds of action.

>> Great. Thanks, appreciate it. There's a couple other questions that we'll pull down, given the time we'll pull down and get answers to those that are sending. But I really want to thank Phil and SAMHSA for sponsoring the webinar today and I'll also like to thank for speakers, Phil Fornaci and Stuart Simms for all the information they provided. Feel free to reach out to us if you've got additional questions. And appreciate your time today. I'll turn it over to Kelle I think for conclusion

>> Thanks, thank you, Eric, and to our speakers for a wonderful presentation and again thank you to SAMHSA for allowing us to share this information with you today. I will now switch the screen to a sort evaluation and ask that you take a few moments to fill this out for us. Again, thank you for joining us this afternoon and enjoy the rest of your day an your weekends. Stay well, everybody.

(Time ending: 3:05 p.m.)