

Centerforce



Safe Transitions



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Our Story

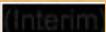
The mental health of all citizens affects the well-being not only of these individuals, but also that of the families and communities of which they are a part. African American men returning to society from incarceration face many challenges to their mental well-being.

In addition to the serious mental illness experienced by a small percentage of this population, most have faced multiple layers of trauma, historically, in their families and communities, and during their incarceration. Engaging and retaining this population in mental health services requires a culturally appropriate approach, many aspects of which are unique to this population.

Centerforce's Safe Transitions program designed, pilot tested, and refined materials and methods for addressing the mental well-being of African American men returning home from incarceration. It is our sincere hope that the lessons learned from our experience in this program will be helpful to others and will influence policies and practices in the field moving forward.

Sincerely,

Larry D. Hill, MPA

Executive Director 

Centerforce

Date: May 30, 2013

Project Name: Safe Transitions

Your Name, Role on the Project:

Carol F. Burton, Report Co-Author / Former Executive Director

Julie Lifshay, Report Co-Author / Health & Special Projects Manager

Jason Walsh, Project Coordinator

What Did We Learn?

The Innovation Round II projects were designed to answer “Learning Questions” and address “BHCS Desired Outcomes.” Your answers to these questions will be used to increase access to culturally informed and responsive services for the African American community. BHCS looks forward to receiving your description of project outcomes and learnings and will incorporate your findings in ways that improve the quality of services, reduce overutilization in involuntary settings, and increase positive outcomes..

Learning Question #4

“What are effective strategies and supports for medically underserved African American adult males with serious mental illness, including those with co-occurring conditions, which will improve their engagement in behavioral health and primary care services?”

BHCS Desired Outcome: Development of a set of specific strategies, supports and recommendations that will improve the engagement of African American adult males in behavioral health and primary care services that have been ‘field tested’ with BHCS African-American participants/consumers and County and contracted community-based providers and primary care providers.

I. YOUR PROJECT SUMMARY

A) Describe your project and its strategies. Indicate if your strategy was “adopt,” “adapt,” or “new.”

In order to explore the learning question, Centerforce (CF) implemented the newly designed Safe Transitions (ST) Program for African American men leaving San Quentin State Prison (SQSP) and the California Medical Facility (CMF) who are returning to Alameda County. The Safe Transitions Program is a two pronged approach that includes a group level intervention (Circle of Knowledge) and one-on-one meetings pre and post release to help build trust with participants and engage them into mental health services and primary health care upon returning to the community after incarceration. By engaging participants in casual counseling sessions and building a safe and trusting relationship between participants and staff, Safe Transitions works to strengthen the effort to ensure that program participants receive linkages to mental health services and primary health care upon leaving prison and returning to the community. To this end, participants in Safe Transitions are referred to organizations staffed with Alameda County Behavioral Health Care Services (BHCS) mental health providers, primary care physicians, and social workers that offer traditional wrap-around services.

Recruitment and Outreach: CF implemented a multi-faceted recruitment and outreach methodology for the ST program. Recruitment efforts include: 1) word of mouth outreach, 2) direct referrals from CF staff working in other prison-based programs, 3) direct referrals from prison social workers working with individuals with mental health diagnoses in San Quentin’s Pre-Release Unit (PRU), 4) lists of men soon to be released to Alameda County from prison Community Resource Managers, and 5) voluntary participant sign-up. During outreach and recruitment, ST staff provides potential participants with a 4x6 card advertisement (see Appendix A: Safe Transitions Recruitment Postcard) that invites them to join the program and participate in “Circle of Knowledge” re-entry groups as a means to discuss the stresses and challenges that individuals may face when returning home and how to get the support they need for a successful transition.

Individualized Assessment and Planning: ST staff works with participants one-on-one to assess their individual behavioral and primary health care needs. A “non-invasive” assessment

tool was developed specifically to gather the basic information necessary to determine program eligibility and assess mental health and primary health care needs. This tool was purposely shortened from more traditional intake and assessment tools in order to be less invasive or “stigmatizing” for participants and thus not “turn off” participants from the program at onset. The assessment tool includes a validated Post Traumatic Diagnostic Scale that helps staff to identify a history of trauma and inform individualized transitional mental health services and primary health care plans post release (see Appendix B: Safe Transitions Enrollment and Assessment Tool).

One-on-One Meetings: ST staff meets one-on-one with participants both prior to release and in the community after release to help participants better identify and understand their transitional and counseling needs. These “casual counseling” sessions help to build trust and rapport between staff and participants. This relationship helps staff to best support participants in identifying appropriate community services to address their individual needs. One-on-one meetings are documented in participant files and on the ST Participant Log (See Appendix C: Sample Participant Log).

Circle of Knowledge: In addition to the one-on-one meetings, participants in ST are invited to participate in a group level intervention, “Circle of Knowledge.” The primary focus of the “Circle of Knowledge” is to explore re-entry issues as they relate to primary and mental health concerns, gauge participants interest or openness to counseling services, address their hopes, hardships, stresses and fears about returning home, and develop peer support inside and once released. The group utilizes a talking circle format that has been effectively used in correctional facilities across America. As Kay Pranis, former Restorative Justice Planner for the Minnesota Department of Corrections states, circles “call forth potentials for understanding, compassion, and transformation.” Circles are effective in correctional settings because they create a safe and open atmosphere that equalizes relationships among participants, honors and respects all voices, generates a shared responsibility for the common good, and encourages the self-reflection necessary for successful reentry. Additionally, the format lends itself to relationship and friendship building beyond the confines of the circle. It is the intention of the ST program to facilitate Circle of Knowledge groups in the community after release to foster continued support and collective accountability to participants’ re-entry plans, mental health and primary health care needs.

Post Release Care Engagement: Based on their individual assessments and planning, ST staff actively work with participants to refer them to organizations within Alameda County that are staffed with BHCS mental health providers, primary care physicians, and social workers who offer traditional wrap-around services after release. This active “facilitated” referral process may include: 1) making appointments with or for participants; 2) providing transportation to appointments; 3) and/or calling or texting participants to remind them of upcoming appointments. By coordinating their mental health needs on the outside, Safe Transitions staff works with program participants to strengthen the odds that they receive seamless mental health care upon reentry into the community after incarceration. The ST program’s primary BHCS community agency referral is Healthy Communities, Inc. (HCI) for primary medical care and counseling services. ST participants are directly referred to a specific staff member at HCI (Rudy Smith) who is aware of the ST Program and the unique needs of this community. By having an actual direct staff person as a referral point, participants are more apt to feel a connection to the referral and follow through with services. ST also provides referrals to a variety of other community services. For a complete list of community referrals, please see Appendix D: Safe Transitions Provider and Referral Resource List.

Incentives: Participants in ST are paid a small incentive for their participation in the Circle of Knowledge re-entry groups. Safe Transitions offers a series of incentives post-release (such as Clipper cards, store gift cards, and a bicycle) totaling a maximum of \$150 per participant for continuing with the Circle of Knowledge and meeting with the BHCS provider in the community after release.

Participant Involvement/Peer Advisory: ST enlisted the support and knowledge of Peer Advisors in the ST program. All of the ST Peer Advisors are currently incarcerated men at one of the two prisons where the program was established. Many of these men are serving long sentences and have been involved in helping to plan and implement other Centerforce programs. The ST Peer Advisors have contributed to the overall planning and design of ST. Specifically, they have helped to determine what language to use when discussing mental health issues with men inside, how best to recruit participants, how not to duplicate other services that may already exist, and provide insight into the workings of the prison and yard politics. They know how to best work with the prison bureaucracy and have directed CF to Correctional staff that may be most supportive of the program. In addition, the ST Peer Advisors have advertised the “Circle of Knowledge” class through word-of-mouth and have

signed people up to participate. Input from the ST Peer Advisors was also instrumental in determining which questions were asked (or removed) and the general tone of the ST Enrollment and Assessment Tool. Finally, the ST Program Coordinator met with the ST Peer Advisors multiple times per month throughout the program to continue to inform the program’s approach and learning regarding which strategies and supports would be effective with the target population. The similar background and experiences of the ST Peer Advisors to the program’s target population has helped CF to understand the needs and mindset of the target population as they relate to mental health, prison culture, and re-entry to the community. The efforts of the ST Peer Advisors to help support the program in very substantial ways has reinforced CF’s belief that incarcerated individuals themselves have excellent ideas about what they need when it comes to effective programming and issues of re-entry.

B) Description Project Participants

- **Age Group:** Average age 38
- **Number of participants:** 25
- **Which BHCS organizations participants were recruited from:** none
- **Other organizations participants were recruited from:** San Quentin State Prison and California Medical Facility (both state prisons)

C) Results (measurement):

A total of 34 individuals participated in the project. Of the 34 participants, 25 men were enrolled in the intervention and 9 men served as ST Peer Advisors to the program.

Safe Transitions Program Participants: The 25 participants enrolled in the intervention were all African American men who were incarcerated at either San Quentin State Prison (SQSP) or the California Medical Facility (CMF) in Vacaville, CA at the time of their recruitment into the program. They were all planning to return to Alameda County after release from prison. Their average age is 38 years old and 6 of the 25 participants self-reported a formal mental health diagnosis given to them sometime during their incarceration.

Safe Transitions Peer Advisors: The 9 advisors were also all incarcerated men at either SQSP or CMF. Many of the peer advisors are serving long sentences and have been involved with many other programs within the prisons. They were specifically recruited as peer advisors through their involvement in Centerforce’s other programs in the prisons including the CF Hepatitis Peer Education Program and CF’s Positive Health Class.

Many of the men in prison have previously been victims of violence and neglect. Of the 10 ST participants that completed the Post Traumatic Diagnostic Scale as part of their intake process, 90% self-reported that they had ever been physically abused. Additionally, 90% of participants witnessed acts of violence that had been extremely upsetting to them. Every participant who completed the trauma scale assessed at a high level for presence of Post Traumatic Stress Syndrome (PTSD). The table below presents trauma data for all participants assessed.

Prevalence of Trauma in ST Participants

Trauma Related Symptom	%
Ever been physically abused	90%
Witnessed acts of violence that were extremely upsetting	90%
Ever been emotionally abused or neglected	70%
Felt intense fear or fear for life	70%
Ever been physically neglected	40%
Ever been touched or made to touch someone in a sexual way because you felt forced in some way	10%

Seven of the participants had been diagnosed with a serious mental health illness while incarcerated. Eight of the participants (two of whom had been diagnosed with a serious mental illness while incarcerated), stated in the assessment meeting done prior to release that they needed mental health services or that mental health services would be helpful to them when they are released. Centerforce was successful in linking 3 ST participants each with one mental health service meeting with a BHCS provider.

II. WHAT DID YOU LEARN?

A) Answer the Learning Question.

“What are effective strategies and supports for medically underserved African American adult males with serious mental illness, including those with co-occurring conditions, which will improve their engagement in behavioral health and primary care services?”

Please use data from your project’s measurement tools to help you answer the questions below.

(i) **Name strategies and supports that were essential in engaging this population in**

Their desire to receive help:

Strategy 1: Successful recruitment strategies include the utilization of key staff within the correctional facility to help identify potentially eligible participants in the most confidential manner possible and/or by word of mouth. Examples of key staff that can help with recruitment are staff that work with individuals preparing for release such as the social worker within the San Quentin Pre-Release Unit (PRU) who refers participants receiving mental health services in the prison. Another key resource for recruitment may be the prison’s Community Programs Resource Manager (CPRM) who can provide an on-going list of men returning to a certain county, such as Alameda County. Given the sensitive nature of this program and the stigma related to mental health support, word of mouth may be an even more successful and important recruitment strategy. Word of mouth was overwhelmingly the preferred method of recruitment as reported by both ST participants and in interviews with the target population. This word of mouth can come from staff but the most helpful and reliable is word of mouth outreach from peer advisors and/or the program participants themselves.

Strategy 2: Develop intake and assessment tools that have minimally invasive questions.

Because incarcerated individuals already have a level of mistrust with mental health services, it is important to not overwhelm potential participants with paperwork upon meeting them. Incarcerated individuals are tired of being assessed and labeled. Lengthy assessment tools create distance and break trust between the service provider and participant right from the beginning. Instead, prioritize talking and engaging with the participant in meaningful dialogue about their lives. ST developed a modified Enrollment and Assessment Tool (Appendix B) which includes a brief assessment for trauma and post traumatic stress disorder. Be deliberate in developing intake paperwork that incorporates a smaller number of non-invasive questions but still collects critical information to verify eligibility and identify mental health and physical health histories and needs.

Strategy 3: Promote the program to participants as a more general reentry program that addresses a wider range of needs and planning instead of as a “Mental Health Program.”

Because of the stigma associated with mental health and the need for incarcerated men to maintain a "tough" exterior in the face of all they experience, if the program is promoted strictly as a mental services program, it will have difficulty recruiting and engaging participants within a correctional facility. Participants are willing to engage in a reentry program that is presented in terms of successful transitions and the realities that individuals will face once leaving prison. Programs can discuss the stresses of prison and life outside and then encourage participation and provide referrals to BHCS providers.

Their ability to trust the people offering help:

Strategy 1: Develop relationships built on mutual respect, trust and honesty while participants are still incarcerated. Building this type of relationship while the participant is incarcerated is essential to ensure participants continue to engage in the program after release and are open and willing to consider engagement in formal community mental health services and primary health services after release.

(ii) Name the strategies and supports you used in your project that were effective in engaging this population to access and receive behavioral health services.

Strategy 1: Utilize a Trauma-Informed Approach. Given the large degree of trauma found in this community, it is vital to utilize a trauma informed and culturally appropriate approach in any mental health services or primary health care engagement program. This type of approach helps staff and participants address issues of safety, trustworthiness and transparency, collaboration and mutuality, empowerment, resiliency, inclusiveness, and cultural, historical and gender issues. ST utilized a trauma informed approach in the development of the Enrollment and Assessment tool, implementation of Circles of Knowledge, utilization of “warm hand-offs” to community care practices, substantive reliance on ST Peer Advisors for program planning and implementation, and in staff interactions and conversations during one-on-one meetings and sessions with participants.

Strategy 2: Offer incentives to released participants to strengthen program retention and help participants meet basic life needs upon release. Not only will these incentives help to better encourage participants to meet with BHCS counselors after release, but they provide concrete

resources and money to help participants with basic life needs upon reentry. ST provides Clipper cards and store gift cards and provides transportation for participants for their first meeting with the BHCS provider. One ST participant was able to use program incentives to help purchase a business license and equipment for his new sandwich shop. He felt that not only did this type of incentive help him feel better about the program but provided concrete and important resources he needed to get back on his feet and establish quality and sustainable employment for himself. See Appendix E: “The Blue Store Sandwich Shop” Grand Opening Flyer.

Strategy 3: Offer case management and facilitated referrals for additional needs beyond medical and mental health care. The lives of participants are very complicated after release. Thus if participants are truly going to engage and remain in primary health care and mental health services after released, they need to have support, referrals and case management in other sometimes more pressing life needs (e.g. transitional housing, employment, parenting.)

Strategy 4: Make access to county-level behavioral health services more user friendly and develop a warm handoff referral process. Understanding the various criteria for different BHCS community service providers can be very challenging for anyone, let alone an individual who is juggling the many different stressors and challenges of community reentry after incarceration. In addition, ACCESS, the primary portal for entry into the BHCS, relies on an automated telephone service designating a future appointment at an unfamiliar location with unknown people. This system can be overwhelming, particularly for men who may have missed the technological revolution the outside world has undergone while imprisoned. Thus the likelihood of ST participants successfully navigating the ACCESS system is low. A much more realistic and positive process is for these men to be introduced by a familiar person to a “friendly face” within the BHCS system shortly after leaving prison; a “warm handoff referral process.”

Strategy 5: Utilize non-traditional settings and strategies for post release meetings. Being creative and “non-traditional” in scheduling post release meetings can be a successful strategy to help keep participants engaged in the program. Such settings include meeting at local cafes where staff can provide lunch or coffee in addition to the participant meeting. Additionally, staff from ST met participants at a park or Lake Merritt and took walks with participants during the session. Participants greatly enjoy these “less traditional” meetings while still engaging in deep and meaningful counseling sessions.

Strategy 6: Routine post-release meetings are a key method for retaining participants through the first 6 weeks after release from prison. Having established a relationship inside prison enables ST to provide a seamless emotional support system for participants coming back to the community after release. ST staff successfully maintained the rapport established with the men while they were incarcerated by providing a large number of ongoing one-on-one “check-in” and casual counseling sessions after release. ST staff provided 57 pre-release meetings with participants and 40 post-release meetings with participants. Meeting up with participants on an individual basis provides small doses of support as they navigate re-entry. Having lunch with the men on the outside and lending a supportive ear as they work through their issues can be a major support for them. In addition, phone calls, texts, and reminders of appointments as well as scheduling appointments for more traditional mental health services with participants during these sessions can be of great assistance.

(iii) Name the strategies and supports you used in your project that were effective in engaging this population to access and receive primary care services.

Strategy 1: Enroll participants into HealthPAC. Insurance coverage is essential toward ensuring that participants have access to and receive primary care services. Thus ST participants were enrolled into the Health Program of Alameda County (HealthPAC). This enrollment process was usually completed with participants at Highland Hospital.

Strategy 2: Link clients to multi-service agencies. It is challenging enough to try to connect men coming out of prison to one health care provider, let alone multiple providers. Thus, it is best to try to link clients to providers that have the capacity to provide both mental health care and primary care services on site. By utilizing this strategy, it may also provide a more “back door” entrance for participants into traditional mental health services. In other words, clients are referred to community providers for primary health care issues that may more easily be identified by either the client or staff. While an individual is receiving primary care treatment, he may learn of additional mental health services that may be on site and be more open to these services because he is already enrolled in the agency’s service system and has access to both types of services at one location. For ST clients, Centerforce worked with Healthy Communities as its primary community referral for both mental health and primary health care.

B) Your Response to the BHCS Desired Outcome.

The last section described what you did in your project. In this section you let BHCS know which engagement strategies you would recommend. In this section, we ask for what you have learned.

“Develop a set of specific strategies, supports and recommendations that will improve the engagement of African American adult males in behavioral health and primary care services.”

- (i) Name the Strategies. Based on what you learned in this project, describe strategies that will improve the engagement of African American adult males in behavioral health and primary care services. Please use data from your project’s measurement tools to help you answer this question.

Name strategies to improve engagement of African American men with behavioral health services	Details important to effectively implement this strategy.
1. Make connections with key prison personnel	<p>In order to develop and implement a successful program within a correctional facility, agencies must make connections and develop relationships with key correctional personal who have the ability to “sponsor” or support the program within the facility. Examples of key personnel for the ST program include:</p> <p>Landon Bravo, Community Resources Manager (CRM), California Medical Facility Provides lists of incarcerated individuals with upcoming release dates who were returning to Alameda County. Mr. Landon also provides bicycles from the prison's bicycle recycling program for ST program participants as an incentive to maintain participation in the program post release.</p> <p>Mr. Dunn, Social Worker, California Medical Facility Provides "ducats" for participants for Safe Transitions. A ducat is a written “pass” that gives incarcerated individuals permission to move within the prison for appointments and programs.</p> <p>Steve Emrick, Community Resources Manager (SQSP), San Quentin State Prison Provides lists of incarcerated individuals with upcoming release dates who were returning to Alameda County.</p> <p>Vita Callari, Social Worker, Pre-release Unit (PRS) at San Quentin State Prison Provides referrals of participants to the program who have upcoming release dates and have been diagnosed with a mental health illness while incarcerated.</p>
2. Establish trust: by collaborating with an organization or an individual who is trusted by the	This population has seen services come and go. They are very reticent to engage with any organization or individual unless they have been “endorsed” in some way. An organization or individual cannot walk into a prison environment, offer services, and expect

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for Alameda County Behavioral Health Care Services

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participant.	people to enroll in the program. To be successful at recruitment, an individual needs to be affiliated with an organization and/or other people who have proven themselves to be in the prison “for the right reasons”.
3. Establish trust: be culturally aware.	Individuals working as case managers or mental health or primary health care providers need to be aware of, trained in, and able to provide appropriate services for those who are incarcerated and recently released. Also, the more providers look like and come from the same communities as the participants, the more likely the participants are to trust them. Hiring case managers, mental health, or primary care providers that are from communities that are highly impacted by incarceration and who are African American, is a strategy that is likely to increase the engagement of this community in these services.
4. Build trust: by engaging with them prior to release.	These men have had a lifetime of disappointment and people not following through. To engage them in services, the provider has to establish a trusting relationship prior to release.
5. Build trust: be consistent and reliable.	This population has had a lifetime of broken promises. They are often assessing and “testing” the interventionist/case manager to see if he/she follows through on what they say. To build trust, reliability, honesty, and consistency are essential. This applies to every aspect of service provision – if you say you are going to do an interview at the next meeting, then do the interview; if you say you are going to provide a list of resources in the community, then bring that list. Each commitment is a test and if you are not true to your word, the participant will disengage.
6. Intervention sessions should be both 1:1 and in Group Setting.	To assess and respond to individual needs, 1:1 meetings are necessary. However, participants also respond well to group meetings where individuals have an opportunity to hear from their peers about their common needs and, at times, to offer advice to each other.
7. Once basic needs are met, secondary needs can be addressed.	Only after their basic needs are met with consistency can these men focus on whether they are in need of, or willing to engage in, mental health or primary care needs.
8. Improve access to county-level behavioral health services: train providers on cultural considerations of working with criminal justice involved populations.	Individuals working as case managers or mental health or primary health care providers need to be aware of, trained in, and able to provide appropriate services for those who are incarcerated and recently released. Prison is truly its own world, with its own language, cultural practices, methods and approaches. To be trusted by this population, providers need to have training in this culture and to be able to change their practices to meet the needs of the population. This means all levels of service – case managers, BHCS service providers, people who answer incoming calls, primary care providers, everyone. Only those agencies who have been working in the system and/or with this population for a long time are qualified to provide this training.
9. Improve access to county-level behavioral health services: make services more user friendly.	The BHCS 1-800 number is extremely off putting to participants. If they call, they want to be able to talk with a real person who understands their situation and is able to talk with them about what they need and how to most effectively link them to services. Participants coming out of prison will not engage with a 1-800 voicemail/call back system.
10. Improve access to county-	Given the large degree of trauma found in this community, it is vital

level behavioral health services: provide trauma-informed care.	to utilize a trauma informed and culturally appropriate approach in any mental health services or primary health care engagement program. This type of approach helps staff and clients address issues of safety, trustworthiness and transparency, collaboration and mutuality, empowerment, resiliency, inclusiveness, and cultural, historical and gender issues. ST utilized a trauma informed approach in the development of the Enrollment and Assessment tool, implementation of Circles of Knowledge, utilization of “warm hand-offs” to community care practices, substantive reliance on ST Peer Advisors for program planning and implementation, and in staff interactions and conversations during one-on-one meetings and sessions with clients.
11. Utilize non-traditional settings and strategies for post release meetings.	The model of providing services at the service agency will often not work for this population. The service provider needs to be flexible and to, literally, “meet the participant where they are at” – be it a park, a café, fast food restaurant, their house, etc.

Name strategies to improve engagement of African American men with primary care services	Details important to effectively implement this strategy.
1. Enroll in HealthPAC	Ensure participants have insurance coverage. This is best done by enrolling participants into the Health Program of Alameda County (HealthPAC).

(ii) *Name the Supports.* Based on what you learned in this project, name a list of supports that will improve the engagement of African American adult males with behavioral health and primary care services. Please use data from your project’s measurement tools to help you answer this question.

Supports to improve engagement of African American men with behavioral health services	Details important to effectively implement this support.
1. Offer participants linkages to the immediate help they need.	People coming out of prison need housing, food security, substance abuse treatment, and employment. These are fundamental to survival. Without these supports, they will immediately be caught up back into the system. These men want to stay out and they want to be successful for their families. Mental health and primary health care are not on their immediate radar for what needs to be addressed. Without meeting these basic needs, they cannot attend to their secondary needs (including mental health care and primary health care services)
2. Build trust: provide them with the help they need.	An important factor in building trust, establishing a relationship, and engaging this population in services is to listen to them and respond accordingly. If those needs are not responded to, the participant will feel like they are not being heard and the services are focused only on what the service provider is interested in. If this happens, the participant will disengage.

<p>3. Build Trust: consider the use of a “Circle of Knowledge”.</p>	<p>Centerforce successfully used "Circle of Knowledge" re-entry groups as a means to discuss the stresses and challenges that individuals may face when returning home and how to get the support they need for a successful transition. The primary focus of the “Circle of Knowledge” is to explore re-entry issues as they relate to primary and mental health concerns, gauge participants interest or openness to counseling services, address their hopes, hardships, stresses and fears about returning home, and develop peer support inside and once released. The group utilizes a talking circle format that has been effectively used in correctional facilities across America. As Kay Pranis, former Restorative Justice Planner for the Minnesota Department of Corrections states, circles “call forth potentials for understanding, compassion, and transformation.” Circles are effective in correctional settings because they create a safe and open atmosphere that equalizes relationships among participants, honors and respects all voices, generates a shared responsibility for the common good, and encourages the self-reflection necessary for successful reentry. Additionally, the format lends itself to relationship and friendship building beyond the confines of the circle. It is the intention of the ST program to facilitate Circle of Knowledge groups in the community after release to foster continued support and collective accountability to participants’ re-entry plans, mental health and primary health care needs.</p>
<p>4. Build trust: Routine post-release meetings are a key method for retaining participants through the first 6 weeks after release from prison.</p>	<p>Besides meeting basic needs, participants most need someone to talk to who will listen. To support participants in being successful and to build their trust, the interventionist/case manager should routinely meet with the participant, at places that are convenient to the participant (e.g., the park, a café, fast food restaurant, etc.) to check in with them and to see if there are other immediate referrals or incentives that the interventionist/case manager can provide.</p>
<p>5. Offer incentives.</p>	<p>Offer incentives to released participants to strengthen program retention and help participants meet life basic needs upon release.</p>
<p>6. Improve access to county-level behavioral health services: provide warm hand off.</p>	<p>Since participants who have stayed engaged with the interventionist/case manager likely trust him/her, there should be a warm handoff system between this person and the person that will be providing mental health services to the participant. The case manager/interventionist should DIRECTLY introduce the participant to the service provider to “validate” his/her as a reliable person.</p>

<p>Supports to improve engagement of African American men with primary care services</p>	<p>Details important to effectively implement this support.</p>
<p>1. Link clients to a multiple service agency</p>	<p>Utilize a primary care community referral agency that provides both mental health and primary health care. In doing so, clients are able to access a more comprehensive wrap around service package within one agency and thus decrease the amount of effort it takes to</p>

	access services.
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(iii) Recommendations. Based on what you learned in this project, offer recommendations that will improve the engagement of African American adult males with behavioral health and primary care services.

Recommended Program Elements To Support Engagement Strategies for African American Males with Severe Mental Health issues (including Co-Occurring Conditions):
<p>Description of what services or supports the engagement strategy will offer:</p> <ul style="list-style-type: none"> • Developing connections with key prison personnel. • Building and establishing trust between client and staff. • Providing both 1-on-1 and group sessions. • Meeting immediate and basic needs first. • Improving and simplifying access to county-level behavioral health services. • Providing a “warm hand-off” to community providers. • Training for BCHS providers on the cultural considerations of working with criminal justice involved populations. • Providing trauma-informed care. • Utilizing non-traditional settings and strategies for post release meetings. • Providing program incentives that help clients meet basic life needs.
<p>Description of how the engagement strategy will work: All of the key program elements listed above help to address the issues of trust and stigma associated with mental health services among the incarcerated African American male population. These strategies also address the realities of the complexities of these men’s lives as they leave prison and reenter their home communities. By focusing on building trust and developing a program that is tailored to their unique needs, the program will have much more success in engaging these men into mental health services.</p>
<p>Recommended BHCS Partners: Healthy Communities, Inc. (HCI), Center Point, Alameda County Parolee Day Reporting Center, Options Recovery- Berkeley, Rubicon Programs.</p>
<p>Recommended AA faith based and spiritual community partners: NA</p>

Recommended Program Elements To Support Engagement Strategies for African American Males with Primary Care Conditions.
<p>Description of what services or supports the engagement strategy will offer: All of the program elements listed above plus enrollment into health insurance (HealthPAC) and linkage with primary health care providers who also provide mental health services.</p>
<p>Description of how the engagement strategy will work: Similar to the discussion above, by utilizing these strategies, the program will have more connection to the reality of these men’s lives and provide a</p>

more trusting vehicle into primary health care.

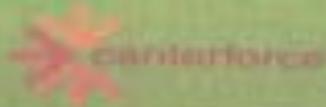
Recommended BHCS Partners: Healthy Communities, Inc. (HCI), East Bay AIDS Center, Alta Bates Summit Medical Center, Highland Hospital.

Recommended AA faith based and spiritual community partners: NA

Short to the House?
Going home to Alameda County?
Need a Game Plan?

“Circle of Knowledge”

Wednesdays from 11 – 1pm in the U wing Clinic





—SAFE TRANSITIONS—

First Name: _____ Last Name: _____

Safe Transitions Enrollment Date: _____

CDCR# _____ Age: _____

SQSP CMF Dorm#: _____

Number of times in prison or jail:

1) 2) 3) 4) 5) 5+

Most recent Incarceration start date: (*month/year*) _____

Date of Release: _____ County: _____

I don't have a release date yet:

Is there a hold on your release: Yes No Not sure

I will be on parole I will be on probation Not sure

Name of officer: _____

PO contact information: _____

Post-release housing: I have an outside address I need transitional housing support

Address returning to: _____

City: _____ Zip: _____

Your phone# _____ email _____



—SAFE TRANSITIONS—

Outside contacts:

1) Name/Relationship: _____

- May we contact them to reach you? Yes No
- Do they know you are/were in prison? Yes No
- Can we tell them who we are? Yes No

Contact's Address: _____

City: _____ Zip _____

Contact's phone number: _____

2) Name/Relationship: _____

- May we contact them to reach you? Yes No
- Do they know you are/were in prison? Yes No
- Can we tell them who we are? Yes No

Contact's Address: _____

City: _____ Zip _____

Contact's phone number: _____

Education/Employment:

Highest education completed _____

I want to continue my education: Yes No

Put me in touch with an education counselor Yes No

Past types of work: _____

Longest time at one job _____

Put me in touch with an employment specialist: Yes No

I would like training/education for: _____ not sure



—SAFE TRANSITIONS—

Medical:

Do you have immediate medical needs?

Yes, I have immediate medical needs and need to see a doctor after release.

No, I don't have medical needs.

Please describe condition(s) and any medications you take:

Condition: _____ Medication: _____

Condition: _____ Medication: _____

Condition: _____ Medication: _____

While in prison I met with a counselor or someone from mental health. Yes No

Did you receive a diagnosis from them? Yes No

Classification? EOP CCCMS None

I was diagnosed with _____

Medications?: _____

Do you think this is a right diagnosis for you? Yes No

Have your medications helped you? Yes No

Continued mental health services are a condition of my parole. Yes No

History of substance abuse? Yes No

Trauma-Related Symptoms: Post traumatic Diagnostic Scale

(This section is adapted from the Post-traumatic Stress Diagnostic Scale [PDS] developed by Foa [1995])

Many people have lived through or have witnessed a very stressful or traumatic event at some point in their lives. Now I am going to read to you a list of stressful or traumatic events. Some of these questions may not apply to you, but I have to ask them as is. Please think back over your whole life when you answer these questions.

		NO	YES
16A	Have you ever experienced any type of serious accident or have you been exposed to any situation in which you felt intense fear or fear for your life?	0	1
16B	Have you ever witnessed any acts of violence that were extremely upsetting to you?	0	1
16C	Have you ever been emotionally abused or neglected? (For example being frequently shamed, embarrassed, ignored, or repeatedly told you were no good)?	0	1
16D	Have you ever been physically neglected? (For example not fed, not properly clothed, or left to take care of yourself or your siblings when you were too young)?	0	1
16E	Have you ever been physically abused, attacked with a weapon, or severely punished?	0	1
16F	Have you ever been touched or made to touch someone in a sexual way because you felt forced in some way?	0	1

total: _____

Needs Assessment:

Immediate needs/stresses upon release:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____



—SAFE TRANSITIONS—

Referral source to Safe Transitions:

- San Quentin Pre- Release Unit Circle of Knowledge sign-up at CMF
- Circle of Knowledge sign-up at San Quentin
- word-of-mouth, SQSP word-of-mouth, CMF
- yard/dorm recruitment SQSP yard/dorm recruitment CMF

Do you need a ride from SQSP to the gate back to Oakland? Yes No

Pre-release meetings: *(circle one)* one-to-one w/ Jason Circle of Knowledge

1) 2) 3) 4) 5) 5+

Have you ever seen a counselor on the outside Yes No

Was it helpful? Yes No Not sure

Why or why not? _____

How did you get there? Referred Walk-in Mandated

Who was the service provider: _____

Do you think a counselor on the outside would be helpful for your transition back to community?
 Yes No Maybe



—SAFE TRANSITIONS—

Incentives:

Post-release - Circle of Knowledge - Oakland

- Meet 1: \$25 Clipper card received initial _____ date _____
- Meet 2: \$50 Ross card received initial _____ date _____
- Meet 3: \$25 Clipper card received initial _____ date _____
- Meet 4: \$25 AMC movie card received initial _____ date _____
- Meet 5: \$25 dinner card received initial _____ date _____

- * Meet 6: Bicycle received initial _____ date _____

**** If all 6 meetings and 4 BHCS provider meetings have been completed and there is a bicycle available, you will get one.***

BHCS service provider meetings:

- 1st meeting completed date _____
- 2nd meeting completed date _____
- 3rd meeting completed date _____
- 4th meeting completed date _____