

Questions for SMEs to Inform CFJL Recommendations

Questions regarding People with SMI/SUD/co-occurring in jail who are gravely disabled and/or are a danger to themselves or others

- These questions are intended to help further refine Recommendations in Section 8 (Increase Access to Treatment) and Section 5 (Diversion)
- Questions for Juan Taizan, Dr. Aaron Chapman and/or a jail psychiatrist (perhaps a recently retired psychiatrist- Jennifer Chaffin?, Brian's contact), Restore Oakland's health care provider group?

1. For people exiting Santa Rita jail with SMI/SUD/co-occurring disorders, are they covered by FSPs? What is the County's current approach or plan for this specific population? What types of services are provided, and what are the criteria? What is the roadmap for a person in that category who exits jail?

Instead of "people ... with SMI/SUD/etc." I'd suggest we specifically ask about the people assigned to a Therapeutic Housing Unit (THU). Or alternatively, we could ask specifically about people assessed at Level 2 or greater on the Level of Care Assessment. Asking about "people with SMI/SUD/etc." may be too vague because there's no easy way to figure out just who these people are. In other words, people are not assessed as having "SMI" or "SUD" or "a co-occurring disorder" but they are assigned to a THU and assessed at a certain Level of Care.

Instead of "covered by FSPs," I'd suggest we ask the following questions: (1) what percentage of people assigned to a THU were on an FSP caseload at the time of their arrest and incarceration?; (2) what percentage of people assigned to a THU are referred to an FSP upon discharge from jail?; (3) what percentage of people assigned to a THU are referred to an Intensive Case Management Service Team upon discharge from jail?; (4) for those people assigned to a THU who are NOT referred to either an FSP or a Service Team upon discharge, to what other kinds of treatment programs are they referred?

And then finally, we could follow up with: Who within ACBH is responsible for tracking this population (those assigned to a THU) after they leave jail to assess whether or not the treatment to which they've been referred (FSP, Service Team, or other program) is successful? (measured by a decrease in arrest, incarceration, hospitalization, etc.)

2. What is the degree of recidivism for people who have SUD/SMI or co-occurring disorders exiting SRJ?

We'd want to define recidivism, otherwise the answer may not be helpful. The state uses a 3-year definition (ie, any criminal conviction within 3 years of release is the recidivism rate). And

again, I'd suggest focusing on a specific population (those assigned to THUs or with a Level of Care at 2 or more).

3. What are the treatment expectations, scope of services, and barriers for people who are incarcerated at SRJ who have SMI/SUD/co-occurring?

4. What percentage of people at SRJ are accepting behavioral health services? In other words, of those who are deemed to have a need and are offered treatment, how many are opting into voluntary treatment options? Please sub-aggregate "treatment options" by medication and other options.

5. At the last meeting, it was shared that there were 252 people who are assigned to the Therapeutic Health Unit) at SRJ. We have also been made aware that some people at other levels of service need higher levels of services when they are in the community than when they are incarcerated. Please provide additional detail about the categorization of all levels, and the connection to services during their incarceration at SRJ, or upon their release? How often are they reassessed?

- *Note: Level 4 is 5150 level acuity and there are only an average of about 10-12 in any given month. Not all LOC 3s are in a THU, but most are. There may even be some LOC 2s who are assigned to a THU.*

6. At the last meeting, Captain Perez shared that there were currently 5 people pending state hospital commitment. Is this the sum total of IST at the jail right now? Do you have to be IST at the jail to be on the waitlist for a state hospital commitment? How long is the wait time for incarcerated people to get into a state hospital?

I reached out to Juan Tiaizan because this number seemed so low (historically, 30-40 people at any given time are in jail, having been found Incompetent to Stand Trial (IST) but waiting for a competency restoration treatment bed to open up at the State Hospital. He checked and says the number is currently 12, not 5. The number obviously fluctuates some as some people go to the state hospital while others are newly found IST and waiting. Yes, except for people found Not Guilty by Reason of Insanity (an entirely different category and a very small number of people), the only people in jail waiting for a competency restoration bed at the State Hospital are defendants who have been found IST. Historically about 85 felony defendants a year are found IST in Alameda County. Currently the waiting time to get to the State Hospital for competency restoration is 3-5 months.

7. What is the potential for opening more beds at Napa or another state hospital for the IST population?

No, the state has put in millions of dollars and tons of time to put pressure on the counties to handle their IST population through the IST Diversion program, county jail based restoration programs, the elimination of competency restoration for misdemeanor defendants, among other things. Sacramento has made it very clear that they have no intention of expanding capacity at the state hospital level. (AM—can the subject matter expert report on whether there are unused beds at Napa and/or other state hospitals even though the state has no plans to fund the staff to reopen them?)

8. What kind of communication, if any, does SRJ or affiliated case managers/etc provide to family members of people in this subpopulation who are incarcerated? In addition, when and how often is family contact facilitated with these individuals? What family services are provided for this population? What monitoring is possible for the conditions of their relatives, and how is this facilitated? What policies does ACSO or AFBH have to remove the “privilege” of communication with family members? What pathways to appeal are there for such determinations, either by incarcerated persons or their family members?

More broadly, do ACSO and AFBH have a general policy statement about the value or effectiveness of family contact for incarcerated persons in maintaining or improving their mental health and behavior? If so, please share with us any such policy statements.

9. What is the current process for addressing concerns with practices that are risky or causing harm to folks in the jail (e.g. soap in the women’s facility)? What is the process for people outside of the jail to address these issues?

10. What has been the progress on the 2020 housing plan and does that include housing for incarcerated/formerly incarcerated persons?

11. What has been articulated about how the county should reallocate the approved jail redesign funds?

Questions to refine section 2 Recommendations:

1. 2.1.A - Per the DRC settlement, Alameda County is charged with adding 100 FSP slots for adults and TAY for a total of 1,104 FSP slots for that population. Also per DRC settlement Alameda county is to complete an assessment of needs and gaps in FSP services for individuals 16 years and older that is designed to determine the number of additional FSP slots needed. Since these items are already included in the DRC settlement, does it make sense to remove this recommendation? *(AM—we might want to leave the suggestion in with a note that the analysis of the need for FSP slots is planned under another mandate. We might want to recommend that an analysis be done of other things not required by the DRC settlement: the need for Crisis Residential Treatment beds (like Jay Mahler), the need for subacute beds (like Villa), the need for acute psychiatric beds (like John George), the need for licensed medium-term residences (like CRTs but longer term, like Psynergy and Everwell facilities), and the need for licensed residences in general (board-and-cares).*

General Questions:

1. Who should be added to a potential list of subject matter experts that could inform the recommendations?