alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Criminal Justice Committee APPROVED Minutes
Wednesday, April 21, 2021 ◊ 4:30 PM–6:00 PM
2000 Embarcadero Cove, Oakland, CA
Alvarado Niles Room
Video Conference Meeting

Alameda County Mental Health Advisory Board

Committee Members:	☒ **Brian Bloom** *(Co-Chair, District 4)*; ☒ **Juliet Leftwich** *(Co-Chair, District 5);* ☐ **Lee Davis** *(District 5)*
ACBH Staff:	☒ **Angelica Gums** *(Administrative Liaison)*; ☒ **Asia Jenkins** *(Administrative Liaison)*

Meeting called to order @ 4:33 PM by **Chair Juliet Leftwich**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Approval of Minutes	February and March meeting minutes approved	
Discussion topic: How should the term "seriously mentally ill" be defined for purposes of evaluating the effectiveness of programs intended to reduce the SMI population at Santa Rita Jail? **Should the definition be based on diagnoses, services, a combination of those things and/or other factors?**	**Chair Bloom introduced Dr. Aaron Chapman and showed his appreciation of him participating in the meeting.** Julie provided background regarding the Committee's data request on the number of clients with SMI conditions at Santa Rita Jail. They defined SMI as individuals with psychological illnesses such schizophrenia, schizoaffective disorder, and bipolar disorder. Then the information came back with the National Institute of Mental Health (NIMH) definition, which was not the information that was requested. The Committee needs to reach a mutually agreed upon definition of SMI in order to collect the appropriate data. **Question: How should we approach this task in order to define this concept?** Dr. Chapman responds by saying that he has no formal presentation. He came with an idea of engaging in discussion. ACBH provided a definition from NIMH to define serious mental illness. Dr. Chapman explained the various categories of mental illness. There are those with mental illness, and then there are those with no mental illness. Then there is a subset of those with SMI, which is a severe impairment. Ninety-eight	Angelica will copy the chat and provide it to Chair Leftwich and Bloom.

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Guest speaker: Dr. Aaron Chapman, Behavioral Health Medical Director and Chief Medical Officer, ACBHCS	percent of those with SMI are either schizophrenia, schizoaffective disorder, and serious bipolar disorder. Some individuals may also have major depressive disorder, which can be a serious mental illness, as the most disorder can be malignant and include psychotic systems. These SMIs present a substantial interference into daily life. This is one helpful framework. Another helpful framework might be looking at the intersection of mental illness and behavior that lands someone in jail. This is when an individual has a SMI, and the SMI is the direct cause of behavior that lead to the person's arrest and incarceration. Within their delusional framework, it was an understandable and acceptable thing to do. In this case, there is an absence of criminality/criminogenic component. In the second group, an individual with a SMI leads to psychosocial/economic distress and other psychosocial factors. If it wasn't for a mental illness, you wouldn't see this level of psychosocial and economic distress. In this case, this person has a slight mental illness, but it does not lead to arrest or incarceration. The third group has no mental illness and has engaged in criminal behavior. Chair Bloom explains that the law recognizes not guilty by reason of insanity. This leads to a commitment at Napa State Hospital. A lot of people may be in group 1, individuals with SMI, and end up at Santa Rita Jail, but cannot plead under reason of insanity. For instance, the crime committed is trespassing or violating a restraining order due to a state of delusion. This cannot be disposed or resolved by reason of insanity. It is not as serious that it can be resolved by reason of insanity. They aren't eligible for behavioral health court or be amendable to treatment. What are the diversionary strategies? Should they be on a short-term conservatorship? In group 2, the mental illness doesn't directly cause the behavior, but it causes poverty, marginalization, anti-social aspect of personality and then causes the behavior. Reason of insanity is probably not directed at this group. They have awareness of their actions. We should also find diversionary strategies for this group as well. **Question: What is the number of SMI individuals in jail? This may be hard to quantify. For group 1, how are they managed at the jail?** Chair Bloom responded that folks who come to the jail still suffering from an SMI are probably incompetent to stand trial (IST). Because of the mental illness, they cannot rationally assist their lawyer in developing a defense. In California,	

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	this leads to a commitment at Napa State Hospital for the restoration of competency program. However, the waiting lists is upwards of 1200 to 1300 individuals. In this case, the person is involuntarily medicated and return to court restored. Santa Rita cannot involuntarily medicate individuals with psychotropic medications. Committee member Joe Rose asked if Group 1 is the population we should be looking at since they are on the waitlist for Napa? Brian responded that the County has agreed to divert individuals who have committed crime who suffer from an SMI to receive treatment at Napa State Hospital. Alameda County is not the only County to send people to Napa. The entire state utilizes the hospital for restoration of competency. The policy makers in Sacramento have not put enough money in to expand space. **Question: Who are the greatest utilizers of criminal justice opportunities, or the individuals who cycle in and out of jail?** Most of the individuals you would probably find in jail will be from group 2 and 3. Group 1 engages in behavior as a response to a delusion. Group 2 engages in behavior because they are cold, hungry, and maybe craving drugs which brings about a criminal act. Group 3, they engage in criminal behavior that is not the result of being cold or hungry, it's because they have a SMI that created significant psychosocial distress. Chair Bloom asked would you see a difference between Groups 1 and 2 just on a simple diagnosis? Dr. Chapman explained that Group 1 is made up completely of individuals with psychotic disorders and delusional disorders. Group 2 may include these illnesses as well, but the behavior is not a direct response to the delusion driving the activity. Chair Bloom asked if we can tell by looking at the initial intake sheet, when a person enters jail, whether they have a SMI and use that data to figure out if we are doing a good job with the programs that we're supporting. There is no way of nothing if we are making progress unless we can measure the outcome. Dr. Chapman explained that specialty mental health programs are delivered through the County and that level 3 programs are considered specialty mental health programs. On the other side, non-specialty service mental health	

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	programs are delivered through Beacon, Alameda Alliance, Blue Cross, etc. and not through the County specialty mental health system. If a person shows up in our system it is because someone thought they suffered from an SMI. They would show up in our system even if they bailed out very quickly. If they didn't suffer from an SMI, we would refer them back to the Health Plan. Dr. Chapman explained that Level 3 is the lowest level of services for individuals with mental illness, but is still considered SMI. If the Committee wanted to close the net, in terms of data, they could limit it to Level 1, which is considered the higher level of services for those with mental illness. **Question: Do you have some sense of the homeless population engagement in services?** Dr. Chapman responded that a large percentage of the homeless population does not have a SMI. There are a variety of conditions that make up a SMI. Even with people who are screaming in the streets, this may be the result of chronic substance use or withdraw and not a SMI. There are people with SMI who have flown under the radar and have not shown up for services. If a person is admitted to John George and is acute enough to need inpatient stay, if they have not already been linked to a service provider, they would be referred, and some never make it to that provider. In this case, it would be unclear. **Question to Sargent McCormick: Do you see people cycling through Jail who have been identified as having a mental illness?** Sargent McCormick explained that they are not clinicians. Any training that they receive is through the Academy. When they make an assessment, it is based on a legal document, with the following questions: Does the person present to be a danger to themselves, or others, or gravely disabled as a result of a mental illness? They don't make the determination on whether someone goes into a facility. In this case, a person would go to John George or another hospital and the clinicians would either endorse the hold or remove the hold and release the person back to the community. We see the frustration because we are on the front lines making the assessments. If you want to get long-term housing or treatment at the State Hospitals, your best bet is to go through the criminal justice system.	

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	Question: Do you capture data on those with SMI? Sargent McCormick explained that they have the ability to write automated 5150 reports, so we can query high utilizers. Our threshold is three. We can track those individuals to see if their system has had contact with them. In the past, the Board has looked at a county-wide system similar to CRIMS who collect data on individuals placed on 5150 holds, which was valuable. Many individuals are getting treatment by way of the criminal justice system. That was not the case a few decades ago where someone received their treatment in the community. The reason why we see so many people with mental illness in our jail and prisons is because the threshold to involuntary incarcerate someone is so much lower than our threshold to involuntary treat someone. Moreover, LPS laws were written in 1957 and have received limited modifications since their inception. These laws are very focused on the individual, but what we're saying now is that we're not allowing treatment to occur because the person is not realizing their own illness. We need to re-evaluate not only what is best for the individual, but the community, families and loved ones. A 5150 doesn't necessarily mean the person has a SMI. There are individuals who are placed on a 5150 who are under the influence of a substance. Sarah Oddie from Wilma Chan's office explained that the County is looking at the Cares First, Jails Last policy and what it might look like to move that forward. This policy will be discussed at the next BOS Health Committee meeting on May 10th. Whether someone is admitted into inpatient services at John George vs. discharged through PES, is the deciding factor of whether someone is considered SMI or not. This was a very productive conversation. We'll take this back to the Mental Health Advisory Board. With all of these organizations, are we working from the same page in terms on how we define SMI and what we're going to do moving forward?	
Next Steps		

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	There is consensus from the Committee that we need to align on the definition of SMI and ensure we are all on the same page. Next month, on the third Wednesday, we'll have the new Director of Forensic and Re-entry Services joining us to share his vision.	
Adjournment	Adjourned at 6:00 PM	

Minutes submitted by A. Gums