Q1: What would be the most effective entry point/approach for someone interested in receiving SUD services?

Group 1

- Having enough staff to do full LOC in the jails.
- Streamlining clients to the right level of care so clients are not waiting to get placed.
- Making sure the right LOC are already in place such as 3.3 and 3.5 so that we are not putting 3.3
- and 3.5 clients in a 3.1 setting.

Group 2

In-Custody: When people enter the jail, they should be immediately screened for possibility of release into community services. Screening could be done by pre-trial services or a health agency embedded in the jail. The screening could assess if a person is a veteran, has a history of county mental health contacts, and/or a history of county SUD contacts or drug-related arrests. All three of these factors could result in an immediate release to an appropriate collaborative court or court diversion program.

For people flagged, but not eligible for immediate release, co-occurring treatment services should be provided in a segregated pod at the jail by a competent community provider. A daily list of new people entering the jail should be sent to the in-custody treatment provider. They may recognize people on the list and this would serve as a backup measure in case the screening program misses someone. In-custody treatment services would be voluntary.

Out-Of-Custody: We tried to Google search "Oakland drug treatment," and "San Leandro drug rehab," and other combinations like that. No county services came up in our search, only "for profit" agencies. One team member explained that CenterPoint did not experience an increase in calls following ACBH's recent public outreach campaign.
The 2-1-1 resource directory of essential community services should be immediately accessible by smartphone app for all public defenders, judges, probation officers, county health workers, police, and other points of contact for our target population.

Group 3

In custody:

a. SUD provider should have offices inside of the jail that allows client can come in to and access support for inside the jail that can bridge to the community (Re-entry services provided.):
    i. Someone helping them understand what the ALOC is for and how to share correct information
    ii. Helps client to have the same contact for warm handoff
    iii. Help client understand what they are being handed off to
    iv. Case management to help get basic needs
    v. Will need DMV access in order to access some supports that require an ID
b. Provider education so that jail staff is aware of and able to help clients get to the services the need
    i. On site staff to work clients
    ii. Some kind of form, card, cheat sheet for providers

1. Allows provider to make seamless link based on client needs

c. Approaches to clients that allow support prior to being ready to enroll
    i. Using motivational interviewing approaches that allow clients work with someone to identify what they want and need before release or allow SUD providers to engage with people prior to released and before proper participation in SUD treatment
d. Training staff in the jail
    i. Orient Sherriff's office staff to SUD and MH services and treatment process

e. Having a feedback loop approach with jail staff
    i. Jail staff and providers able to make comment, ask questions, and share when there are issues so that we can change procedure.
        1. Bring back data, how many enrolled, how many dropped, how many were connected but did not enroll.
    ii. Change culture around sharing and depending on each other

f. Evaluation of data available so that providers can identify what is working
    i. Pilot- 10 clients, 3-4 CBOs, so that we can identify where communication is working and what is failing

Out of Custody

a. Unhoused population, Providers engaging with those unhoused
b. Primary care providers education
c. Education for non-SUD providers including community churches, housing providers, probation, re-entry, MH
d. A streamlined process where providers can refer and communicate right away
e. Provider flexibility- CBO touch points for referral, feedback to change option, provider ability to literally and figuratively meet client where they are
f. Peer navigator for various departments

Q2: What would be the most ideal service delivery approach to ensure service retention and delivery of needed services?

- Considering length of stay on a case-by-case basis instead of pushing them out as soon as they are stable.
- Better resources and additional funding for SLE, APT. etc.

In-Custody: Needed services include evidence-based distribution of MAT at the jail, and a true co-occurring treatment unit. When the Sheriff Department is responsible for getting people to the services, it doesn't happen.

Out- Of Custody: Needed services include more co-occurring treatment beds (evidence shows integrated addiction and mental health treatment are more effective than sequential or concurrent treatments). There is a need for co-occurring recovery residences, adolescent and older adult cooccurring
residential programming, and TAY specialization.
For both in- and out-of-custody services, retention is influenced by a recognition of justice involvement as a special condition with its own (historical) traumas, biases, and challenges to the establishment of an early clinical alliance between client and provider. One can think of this population as having "tri-occurring" conditions.
Improvements could also be made around "warm handoff" strategies between providers.

Service Retention (In Custody)
a. Space to work
b. Route for client to access services
c. Sherriff's office support engagement

Q3: What would be the most effective approach(es) to supporting transition out of treatment and into recovery stabilization?

- Expand longer length of stay in housing through Medi-Cal on a case-by-case basis.
- Having a better transportation system under Medi-Cal. Example client is in SLE and has no transportation to attend his outpatient program.
- Expanding the funding for other services under Medi-Cal such as Employment, someone to help with tools for work, clothing, food. Etc.

In-Custody: Our group recognizes the need for robust discharge planning prior to release from custody. It would be beneficial for probation and the identified service providers to meet together with clients prior to release. We know that ACBH had a trailer in the Santa Rita parking lot for a while, but we didn't hear about any success stories from this strategy.

Out-Of-Custody: Historically, participants in treatment have not been allowed/encouraged to leave the program and attend community recovery meetings. Also, if clients are receiving their mental health services at the treatment site, a transition to ongoing services should be started early as this can be challenging to set up through the ACCESS system. Obviously housing and employment remain challenging for this population. Any opportunities in these areas would seem to be a good investment.