MENTAL HEALTH COMMISSION
JUSTICE SYSTEMS COMMITTEE MEETING MINUTES
November 21st, 2023 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Committee Co-Chair, Cmsr. Pamela Perls, called the meeting to order at 3:33pm <u>Members Present:</u> Cmsr. Geri Stern, District I Cmsr. Pamela Perls, District II Cmsr. Tavane Payne, District IV Cmsr. Gina Swirsding, District I <u>Members Absent:</u> Cmsr. Gerthy Loveday Cohen, District III <u>Guest Speakers</u> Manju Mathews, LCSW, CCHP, Detention Mental Health Program Chief <u>Other Attendees:</u> Cmsr. Laura Griffin, District V Angela Beck Jennifer Bruggeman Jen Quallick, (Supv Candace Andersen's ofc)	Meeting was held at: 1340 Arnold Drive, Ste 126 Martinez, CA and via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: None	
IV. COMMITTEE CHAIR COMMENTS: None	
V. APPROVE minutes from October 17th, 2023, Justice Systems Committee meeting: • Cmsr. Tavane Payne moved to approve the minutes as is. • Seconded by Cmsr. Gina Swirsding **Vote:** 4-0-0 **Ayes:** T. Payne, P. Perls, G. Stern, and G. Swirsding	**Agendas/minutes can be found at:** http://cchealth.org/mentalhealth/ mhc/agendas-minutes.php
VI. DISCUSSION of Current Status of Contra Costa Detention Mental Health with Question and Answers – Manju Mathews, LCSW, CCHP, Detention Mental Health Program Chief (Manju Mathhew) It has been some time this committee has heard an update from us (David Seidner) regarding detention and I am not sure where it was left off regarding all the changes implemented, things going on in terms of programming, but would like to give an overview. It is better to hear from you what the questions are, I appreciate the questions you have provided. We are trying to provide the best services we can with detention. We have a small group of committed staff who continue to come every day to Martinez and Richmond to provide the mental health services that are needed for our population. I have been working with Detention since 2019 and we have seen the numbers of mental health patients grow dramatically. We estimate it was approximately 20% of the inmate population; however, as of this summer, we have reached 50% of the population being open to mental health and that is a	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

significant number of individuals. This also does include the wide-range of what mental health looks like for different individuals. There are individuals who are able to manage their mental health needs quite well on their own, just need a prescription, while there are others that do not recognize or acknowledge the mental illness they may be facing and are unwilling to take medications and present with aggression, instability, irritability that needs more support and treatment from staff available.

We have come up with a way to identify patients and the needs they may have. We use a track level system (1-4). Initially this has been really helpful to see who really needs the help in the facilities. Who just needs a check-in or speak to the psychiatrist about their medication(s). Those that want a weekly or every other week therapy session, focusing on anger management, focusing on intimate partner relationships and communication issues they have had. To know we can provide that basic care (medication assistance and therapeutic services), we are also supporting individuals as track 1 or track 2, who are presenting with very acute mental illness; whether it is untreated psychosis, or individuals identifying suicidality as soon as they enter the facility.

There is quite a lot going on and we want to ensure we are providing the appropriate treatment in a timely manner. Just because an individual comes in and we do not know much about them, it does not mean we are not starting instantly on their treatment from the moment they are booked and need services immediately, maybe they used a substance and are agitated. We are already determining treatment, services in custody through release and services outside of custody. Over the years we have slowly changed to meet the needs of the individuals asking for the services.

We are working on how to identify to provide the right amount of services, right type of services, from the moment they enter until they leave. Fine tuning what that looks like, if this is someone with us for a long period of time vs someone who is in for a week. We have limitations when it is for a short amount of time. If we have at least 48 hours' notice, we are able to provide certain services and connect with programs, speak to clinics. The more information and time we have, the better able we are to work to identify what programs would help best.

Questions for MM *(RESPONSE in Italics)*:

1) When the Sheriff campaigned for the new jail detention building, he stated that the primary intent was to house facilities for services for individuals with MH conditions. Given this stated intent, why has a large portion of the building been used to house an overflow of inmates from other jail facilities? *I can't speak to what the Sheriff's department intended, what was stated. My understanding overseeing the MH program, we will have the substantial amount of individuals who are mental health patients house at the Worth(?) Building. This facility will hold all the individuals that were to be initially F-module and M-module (the Behavioral Health individuals). What we have seen is that we thought it would be a replacement, taking those individuals and bringing them over. We have identified and know there are far more individuals that need to be housed. It is not overflow but taking our MH patients and bringing them to that location so we are having these acute patients housed in a space that is suited for them. The right services, right individual cells/double cells depending on the need. It is not my understanding there is overflow with individuals that are not MH population.*

2) Staffing for both screening and MH treatment at the jails appears to be sparse. We recognize that like many other employers, the County jails are finding it difficult to hire and retain employees. However, the County has committed to providing appropriate and timely MH treatment for incarcerated individuals with MH conditions.
   a) What are the policy changes your dpt. plans to make to overcome the hiring problem and fulfill the County's commitment above?
   There is no policy change when it comes to overcoming the hiring problem. We are expanding our recruitment efforts. We are going beyond our usual hiring. Rather than just the Contra Costa website, we are using LinkdIn and other recruitment sources. We are using additional supports to work through sending these potions out into the community so they know the positions are available. We are also looking into how to bolster our current MH staff with other disciplines/classifications. We are looking to see how we can use community health workers, medical social workers. As of right now we have the one classification of 'Mental Health Clinical Specialist' and want to expand that there will be other individuals that will be able to perform components of what we have a need for in the facility that will greatly assist the program. There is an idea that we are not providing timely services, and/or concern we are not providing the services at all. I want to ensure the MH Team has been able to continue to provide the MH services as we have been held to offering. We facilitate our daily groups that occur on occur on the MH modules, we are performing our intakes, regular routine, assessments and appointments with every individual as indicated for their track level. We are constantly monitoring how we are with patient care. We are not jeopardizing the care we are providing due to staff level. We are just having to stretch our timelines a bit.
3) The County has committed to:
   a) preparing MH transition plan prior to an individual's release; and
   b) ensuring that appropriate and timely services are in place to effectuate each individual's MH transition plan post release.
   c) Is there a written transition plan for each individual needing continued MH services on release?
   d) How are services are being prepared to assist these individuals?
   e) Is funding available from the state? From the county?
   f) Are there adequate staff for evaluating individuals both on intake and prior to release? Which staff and how many are currently preparing transition plans for services post-release?
   As of right now, there is no written transition plan that an individual is provided with and will have on hand with how they will be supported post-release. However, this also may change with CalAIM. The individual's that are working on the pre-release team all have their work flows that allows for a set procedure to be in place to know they are addressing that individual's needs. For instance, when we know an individual is to be released, we have our nurse or medical discharge team, what are that person's needs? Do they have an injectable medication? Do they have medications that need to be sent to a pharmacy? Are we referring to a crisis stabilization unit, a shelter, a Board and Care? Speaking with the conservators office, preparing those items, programs that may be needed, the medical team is providing those things.
   Our re-entry specialist working on identifying what different programs the

individual wants/needs to be connected to and how can we connect them with those individuals. If this re-entry specialist meets with an individual and they say they want AOD services, we put in that referral. We are regularly speaking with the individuals involved with that person's care. We know some individual's are open to the clinics and identifying each clinic and can we schedule an appointment with a rapid access clinicians so they might have a smooth transition from the jail to the clinic so there is not drop in medication or treatment and care.
Every individual is different. Some only want the access line and not want to set up at time of release. That is every individual's prerogative and we don't force anything. Every conversation is different. When we are able to connect individuals with a shelter, hope house, family, what is appropriate, ends up being a very positive service. We are still working on being able to identify releases, we don't always know with enough notice when individuals are releasing from custody, but when we do, we are preparing just like this procedure is stated. Start to finish.
The MH services within the facility is all provided by county. With CalAIM, this will transition what service look like. We will start to see over the next year as the infrastructure with the jail is being built for how it looks.
There is one dedicated re-entry specialist, a medical discharge team (pre-/ post-release team) that works with individuals (6 people), clinicians also work on transition plans, but it is part of their work with individuals and aren't actually on that team but do that work with individuals.

4) We at the Justice Committee were told that preparing transition plans and putting community services into place will be handled solely by MediCAL and Cal AIM, without any County involvement.
   a) How much collaboration is there currently between Detention Mental Health, and Cal AIM and MediCal re. the provision of mental health transition plans and services following release?
   Many members of detention health are actively involved with CalAIM/MediCAL and the county team how we are doing our applications and transition into these pre-release services that will be incorporated. We have one workgroup every month that is for all detention health leadership that attend the meeting with re-entry services, and other external provider/partners to see how we can do this that is meeting everyone's needs at the same time. It is a constant conversation.
   b) Are there any deficiencies that you see that will not be handled by CalAIM and MediCAL that you would like addressed?
   It is hard to say if there are any deficiencies when it hasn't been implemented. We have thoughts and intentions on what can be offered/provided. We won't know until it is implemented. We might need to focus more in one particular area than current. Consulting groups inform us what we are missing, what the patients are telling them what they want, that is how we constantly check on ourselves and intentions.
   c) What role will your department play in transition planning and arranging services in the community in order to meet the County's obligation to plan for and follow up on services needed after release from the County jail?
   Our role will continue as it is now, if not increase. We are trying to ensure we have connections with all partners in the county so we are able to work on these transitions and have more direct conversations / warm hand offs with our partners. We regularly have a list of individuals that

will be released soon (not a perfect system) and know which part of the county they are in, who they connected in past and speaking with that clinic to ask what do we need to do? Are they open or closed to those services? Do we need to reopen and set up with a Rapid Access Clinician? Are they already familiar and know this person is normally unhoused and only goes to that particular section of the county at certain times of the year. There are variables with our conversations with the clinics and various shelters. We want to ensure we have these conversations on an individual basis so that it is not assuming that the county is going to take care of everything. We know we will still have to have a connection with each external partners so the warm handoffs continue. We will continue to do as we have.

5) The County is obligated to follow The Americans With Disabilities Act ("ADA") in its jails. In the last three years, the County has failed to craft ADA policies and procedures for its jails.
   a) What is the County, and more specifically your department, doing to put into place a policy and set of procedures to meet the needs of individuals in the jails who are protected by the ADA?
   b) What training are you and sister agencies providing to educate staff in Detention MH staff, Crisis Intervention, and the Sheriff's Office regarding ADA eligibility and protections?

   We as health services are working together to craft that ADA policy and procedure as we speak. This is a weekly conversation in the works for a few months now. We are fine tuning the language for this. We are working with custody partners, being in line with and making sure we are attending to our program needs with their ADA policy as well. There is an ADA coordinator within the sheriff's dept. that is leading the charge on being in compliance with the requirements within the facilities. They are spiriting the project to move into that state. I can't speak to what the Sheriff's office is doing as they have their plan in place. A part of that plan is a training for all staff working in the facility (initial and on-going annually). The goal is to have it done before January.

6) When is an inmate given the opportunity to ask what medications are being given to her/him/them? Subsequent to the initial MH screenings, are there other opportunities to self-refer and/or be referred for MH screening?

   They have an opportunity to ask what their medications are from the moment they have the conversation with the psychiatrist. There is an initial psychiatric assessment, it is in-depth and at the end, there is a discussion together what the recommended treatment would be for that individual and that is also the time they talk about potential side-effects, what it is being used for, how it could benefit them, how long it takes – there is a whole conversation that occurs when treatment is prescribed from the doctor. There is a refusal form when they don't want to have that conversation stating they refuse the medication and don't want to speak about the treatment. Then, at any point, they are able to ask any health service staff about medications. Generally, the mental health clinicians won't necessarily speak about medications (out of scope) and won't answer questions that might be about dosage or appropriateness to the individual. They can be told what it is but then they are referred to nursing to explain the use and affects. They can also, always ask. There are inmate request forms, they can also ask deputies to speak to the psychiatrist, psyche nurse for mental health about their medications. There are numerous opportunities for them to ask. The only time

someone would not get that answer is if they are asking custody who do not have that information. After the initial screening, they have ongoing routine appointments with the clinicians and follow up appointments scheduled. They may say they don't want medications or speak about them and then change their mind and we continue to schedule those follow up appointments. There are treatment meetings schedule to discuss appropriate treatment as well.

7) In the community areas of the jails, how are inmates identified by staff as to what track they are?
Generally custody staff are not informed on an individual's track level. It is a mental health determination. It is used to identify how often an individual needs to be seen, that is for MH purposes and doesn't need to be known by custodial staff. If their behavior is changed, they will let MH staff know to assess. They do not need to know track level.

Comments and Questions:

- (Cmsr. Payne) When they come in immediately, from that point on you are trying to identify problems (evaluate). When they come in combative, officers have to deal with them as such. How do you distinguish between the fact they are being combative or they are so due to mental illness? (RESPONSE: Manju Mathews) Most times, it is just in conversation. Sounds strange when someone is combative to have a conversation. But there is a mental health clinician, there is custody, nursing all present in that moment when they are going through intake and being combative. We have to be able to see if they are oriented and are they aware of what is going on, are they making statements that may sound delusional or paranoid? Does it sounds like they are under the influence of a substance. These disciplines are all present and with their training, they will be able to identify. Is this someone that needs to just sober up? Is it someone who is substance induced psychosis? We really just have see but want to make sure we are providing that care. Sometimes the treatment is the same regardless of it being a substance induced episode vs. a biological episode occurring.
- (Cmsr. Stern) Could you remind us all of the track levels? (RESPONSE: Manju Mathews) Track Levels: (1) Most acute-untreated, showing behaviors of most concern; (2) History of mental illness, only now presenting with symptoms and may be expressing harm; not performing self-care (showering, etc.); (3) Individuals that need extra support, help with appointments, and medications-generally aware of their needs but not always remembering; and (4) less problematic, aware of their MH issues, on medication and able to be clear on needs and advocate for themselves.
- (Cory Gaeta – parent of inmate with mental health challenges came to meeting with questions specifically for Manju Mathews. Stated son's name but redacted for meeting minutes. Several questions posed to Ms. Mathews regarding her son's situation and condition but not transcribed for privacy purposes)
- (Cmsr. Stern) How would you characterize the difference between how Detention MH treats these individuals vs a locked psychiatric facility? (RESPONSE: Manju Mathews) I have not worked in a locked facility so I can't speak to this. In detention, our receiving mental health treatment is comparable to communities, that is our standard. We have psychiatrists and clinicians that work with individuals either daily, every other day, twice a month or once a month, dependent on their needs.

• (Cory Gaeta – more individual questions to set appt. with Ms. Mathews)	
VII. Revisit Committee Goals and Next Steps	***Due to time constraints, this Agenda Item will addressed next meeting***
VIII. Adjourn: 5:00 pm	