JUSTICE SYSTEMS COMMITTEE
MEETING MINUTES
April 27, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:35pm Members Present: Chair - Cmsr. Geri Stern, District I Cmsr. John Kincaid, District II Members Absent: Cmsr. Gina Swirsding, District I Cmsr. Kira Monterrey, District III Presenters: David Seidner, Mental Health Program Chief Sonia Sutherland, MD, Interim Medical Director, Detention Health Other Attendees: Cmsr. Douglas Dunn, District III Cmsr. Barbara Serwin, District II Cmsr. Graham Wiseman, District II Angela Beck Jennifer Bruggeman Rebekah Cooke Vi Ibarra Teresa Pasquini Jill Ray, Supv. Andersen's Office Lauren Rettagliata	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Jill Ray) Announcement: Contra Costa County (CCC) has reached a million doses of COVID vaccine given as of Sunday. Walk in clinics available in various communities. Please refer any and all the vaccine website to find out where they are. We are also starting to administer the J&J vaccine again and can call the vaccine hotline to find out which clinics are administering those for any that would benefit from the one dose vs. two dose protocol. • (Teresa Pasquini) Lauren (Rettagliata) and I have had the privilege of presenting at the Alameda County Behavioral Health Board, who invited us to prevent our "Housing that Heals" work at their adult meeting. Great feedback and heard some really amazing working being done from family members. Alameda county has done some innovative work with MHSA, working with folks living at (SROs) and described an "Inreach Program" (as opposed to an outreach program). It was very inspiring to partner with our neighboring county and, since we do share many of the same programs, it is good for us to establishing regional partnerships. • (Lauren Rettagliata). At that meeting, we were also able to hear they received a Grant from the Department of State Hospitals for Diversion. Provider "God's Love Ministry" (GLOM) in Fremont. This provider also serves CCC. They also won the right to be chaplain for two jails in Alameda county; noting they are non-denominational. Already diverted eight (8) people from the state hospital. If someone is convicted of a felony and sent to the state hospital, but if it is decided there is a possibility they can live in the community, they are sent to GLOM, a residential program and if clients complete their program, there is possibility the	

felony could be expunged from their record. This is a transitional residential facility. The report was shared by Katharine Jones (Behavioral Health, Alameda Diversion) and Kerry Abbott (Homeless Care and Coordination).	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: Just want to point out it was a little tricky to pull together an agenda for this month. There are a lot of questions from last meeting, those busy with Spring Break and it took a while to get answers and responses. I am pleased to have David (Seidner) and Sonia (Sutherland) here today to share some information and answer questions.	
V. APPROVE minutes from the March 23, 2021 Justice Systems Committee meeting Cmsr. J. Kincaid moved to approve the minutes as revised. Seconded by G. Stern. Vote: 2-0-0 Ayes: G. Stern (Chair), J. Kincaid Abstain: 0	**http://cchealth.org/mentalhealth/mhc/agendas-minutes.php**
VI. PRESENTATION: Detention Health Update, Sonia Sutherland, MD, Interim Medical Director; and David Seidner, Mental Health Program Chief Dr. Hamilton and I had the opportunity to present to the full Mental Health Commission (MHC) and gave an overview of the prison law office process, high-level updates on some of the physical and mental health improvements. We were asked a bit more specific questions regarding physical health delivery system, what is happening with physical health and are sharing briefly for background and context and providing resource for the committee. Again, MHC has seen the material; but want to give that timeline of the multiple year effort CCC has been engaging in with the prison law office. Prison Law Office Settlement - Our mission is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems -- ONE CARE We are familiar with these timelines in terms of the consent decree has been adopted and we are moving into the monitoring and surveillance stage of the consent decree. Even prior to the consent decree being adopted by the county, we have been striving to improve the health care delivery system since 2016, if not earlier. However, we really kicked into earnest as of 2017 and forward when the components of the Remedial plan we were being very specifically laid out. • Negotiations began in 2017 • Consent decree approved by the Court February 2021 • Medical and mental health remedial plans are within standards of care, negotiated and agreed upon court ordered provisions. • Many improvements began in 2017 ◊ Value Stream Mapping ◊ Rapid improvement events based on feedback from VSM California law (penal code 1001.3) • Track Levels of Mental Health Care • Strength Based and Recovery Model • Ongoing assessment of the individual's mental health needs ◊ Identification of risk factors ◊ Support adjustment to detention environment • Psychiatrist's order for Track Levels of Mental Health Care • Coordination and Case Conference with Health and Custody staff • Suicide Prevention Program	Detention Health Update Presentation by Sonia Sutherland, MD and Davide Seidner was shared as a PowerPoint presentation during meeting.

- Joint training co-facilitated by health and custody trainers
- Health and Custody collaboration for suicide prevention
- Continued support during suicide precautions and after must not pose an unreasonable risk to the public

- Patient Centered Care
  - Prioritized Mental Health improvements
  - Improved identification of care needs at intake
    - ◊ Standardized screening tools and process
    - ◊ Increased privacy
  - Improved identification and treatment of substance use disorders
  - Increase staffing to provide consistent care across disciplines including psychiatry, mental health clinicians, physicians, nurse practitioners and nursing staff
  - Intentional, strategic improvements to address patient needs
- Current State – Updated 4/21/21
  - Ongoing improvement efforts within the standards of care, the negotiated and agreed upon court ordered provisions.
  - Robust multidisciplinary COVID response
  - 0 COVID related hospitalizations or deaths
  - Vaccinations underway since January 2021

Questions and Comments:

- (Cmsr. G. Stern) I have heard about the track system three or four times and trying to understand it a little better. After individuals are in Track 3 for 180 days, where do they go in detention health? Do they change residences? Do they leave West County Detention and go elsewhere?
  (RESPONSE: D. Seidner) Those days are average length of stay, so someone could be a Track 3 for the duration of their incarceration. Again, the track system is intended to go up and down as needs occur. Then it is matched with the care and contact. For example, someone might be acute at a Track 2 for a couple of days and then ends up as a Track 4. The levels of care are determined as they follow the patient. As a person is housed is really driven by the Sheriff's Department. The health department (HSD) makes a recommendation. If someone is very sick, the recommendation our team can make is really just a mental health module. The patient will remain at F module for treatment and will do a case conference and meet with the patient as they are recovering. Then recommend the individual would be transferred to other housing modules but the Sheriff's Department makes the final decision on where they are placed. There are individuals in Track 3 and 4 at Martinez Detention Facility (MDF), West County and Marsh Creek, as well. The Track levels are not driving the locations. The only time is if an individual is unable to manage in the general population and would be housed for a period on F-module. F-module has a certain capacity too, not everyone would be there. Track 1 and 2 would be on F-module.
- (Cmsr. G. Stern) If the individual doing well and discharged from the MH (F-module) into the general population? (RESPONSE: D. Seidner) Right. We are really striving towards recovery, so if an individual might be suicidal and that suicidality will remit but still present and someone could go to the MH module and go to West County but we would still follow that individual. We do have mental health services at all three facilities and an individual could be in recovery and managing their symptoms and might be housed at MDF or West County at Track 4. It is the Sheriff's decision, not a health decision.
- (Cmsr. G. Stern) When they are 'better' and graduate from Track 4, then they go into the general prison population and stay for the duration of their sentence. Is that what happens? (RESPONSE: D. Seidner) Everyone in detention is in jail, so either pretrial or sentenced and waiting to get sent to prison. Those are criminal

justice pathways. From our perspective the pathway is important but more so the care when in our facility. So certain individuals are waiting to go to prison and we serve them. Certain individuals are waiting to be released back to the community and serve them. For the criminal justice activity where health services is really like a passenger in the back of a care. We are not driving the process. Our scope is to help individuals recover while in the jail facility. (S. Sutherland) The Track levels are not necessarily related where the inmates are located within the jail. Again, the location is determined by the Sheriff's office. We are looking at their Behavioral health care and that is where the track level is assigned, based on their needs. The two are separate. Track levels are their induvial health needs and have nothing to do with where they are housed. (D. Seidner) If someone is struggling with suicidality, which is common in corrections, that person remains in our caseload until release. We continue to check in and always offer services, we don't close them in terms of caseload, it is unsafe. There is flexibility and keep matching our services with their needs. We service individuals in all three adult facilities. Where they are housed is not driving our care. Our care is not driving where they are housed. We do have individuals who are recovering and stable and they are housed with other men and women who may not have any mental health challenges.

- (Jill Ray) I know there are situations where individuals go to court and then suddenly released. I don't know that it happens with Track 1 individuals just because they are so seriously decompensated, but I am curious about the transition if they leave custody suddenly and how do transitions happen to the appropriate level of care. (RESPONSE: D. Seidner) Individuals struggling with MH challenges going from a highly structured institution to a less structured community setting is a chasm, and quite unsafe at times. Some of the safety measures we have put in place: (First) in all the psychiatrist notes, there is a workflow-if anyone is released at any time on any psychotropic medication, either there is an ability for eScript to their local pharmacy and given enough notice, we try to put release medications in the individual's property. The majority of individuals go to court and are released. It is time served, function of their criminal justice, so there is little time in the moment for release or discharge planning. That said, our treatment team has been meeting with the patients and doing discharge planning from the beginning. It is an ongoing conversation with all of them. The person could be going to prison and will work with them on transitions. The individuals who might be released to the community, we are doing reentry planning as a part of our work. Track 1 / 2 patients it is in the workflow to do a 5150 evaluation and if they meet criteria to do a hold, then detention health entrance department has the ability to initiate a 5150 and tend to reserve that when it is only necessary. We don't want individuals to go from a restrictive facility to another restrictive facility. It does happen and we work with the public defender's office and try to refer to crisis residential for Track 1 / 2 patients. We also have people out of county. We work with Alameda county and try to refer individuals to the Crisis Residential in Alameda County. COVID has really changed the trajectory of re-entry, as well as walk-ins to behavioral health clinics. We do encourage Miller Wellness, but reentry is complicated and COVID and reentry is even more complicated. We definitely want to disrupt the cycle of recidivism. We do see individuals cycling back into the system within days, which is very distressing to us. Disrupting with assisted outpatient therapy (AOT) and Laura's Law is one option with diversion as another option. These are all still emerging practices and I wouldn't say we have a handle on it but we are striving to deepen those pathways
- (Cmsr. G. Stern) People coming into the system, when they leave, do they have a felony or misdemeanor on their charts? (RESPONSE: D. Seidner) I can't speak to those, that is a criminals justice that would need to speak to that. The care team and the criminal justice system is separate.

- (Cmsr. J. Kincaid) When you say housing is entirely up to the Sheriff's department, there is certainly some overlap, as it is dependent on behavior and classification, correct? At booking, when the mental health screening is processed, how is housing determined and how does the treatment staff have input into that? If any? There used to be something called ambulatory classification system which is a collaboration between treatment and custody staff who work together, but that was only on the treatment unit, which is now F-module? (RESPONSE: D. Seidner) I am going to speak to workflow, but again this is a public meeting and want to respect facility, officer safety, our staff safety and patient safety. Many individuals incarcerated ask those specific questions about our workflow and there have been attempts to elope from the facility, so I want to answer your questions but I also want to be mindful of our safety. Yes, in nonspecific terms, every person booked goes through a health assessment. Individuals who are screened positive for mental health services go through a mental health assessment. Yes we make recommendations on housing placement for every individual we assess. Any transfer between facilities, we make housing recommendations. The only time we would recommend segregating and keeping individuals away from the general population or protective custody would be the track 1 and 2 patients I have spoken about who are very impaired, sick and need much more care than a non-mental health housing module could offer.
- (Cmsr. D. Dunn) What about incompetent to stand trial individuals? If they are declared incompetent, hopefully they get a state hospital bed and go there. What happens when they are recovered enough to come back and face charges? How is that handled in the jail? (RESPONSE: D. Seidner) Incompetent to stand trial is purely attorney activity, I am not going to get into that discussion. The public defender (defense counsel) declares the doubt, there is a whole process. We are aware of individuals where a doubt has been declared and once the person is committed to department state hospital, then they are waiting to be transferred. When the come back from the department state hospital and return to our care, individuals who are competent to stand trial can be at any of the three adult facilities. The legal status is not an indication of mental health needs or acuity. That is a legal determination and we do our own independent mental health psychiatric evaluation. The only thing I would add is, as we talk about pursuing involuntary medication administration for some individuals who are committed to department state hospital, we have pursued involuntary medication off that statute. We have another statute available to us (PC 2603), where we can pursue involuntary medications outside of the IC process. We are here to address mental and physical health questions, not legal process.
- (Cmsr. G. Stern) We would like to address the questions we had on our list. I had one more important question regarding identifying those that are conserved when they enter the system. Is there any question on the initial intake that asks individuals if they are conserved? Is there any way to identify if they are conserved? (RESPONSE: D. Seidner) We have electronic health records that are shared with Behavioral Health, with psychiatric emergency services (PES), inpatient and ambulatory. Typically, we do not see conservatorship status. That is a civil status. What typically happens is the conservators office will notify us when an order for investigation has been started and as much information we have for those conserved. Some individuals who are released from detention that may have been in our care go into IMDs, so a portion of the conserved individuals leaving detention do go into the civil locked facilities. Then we would coordinate with the conservators office for those transfers.
- (Teresa Pasquini) Speaking as someone who has gone through this process with a family member that was criminalized and placed into custody while in the hospital, there was a lot of coordination and collaboration between the sheriff, the court and the mental health departments. It is something that is very important, whether you are asking at intake or not, I think from the system's

perspective, if we want people to not recidivate, then we need to figure out how to incorporate information into the systems that will allow facilitation of the best experience while in jail. The 'One Care Everywhere' philosophy that was established during the rapid events, but also to make sure we have all the players at the table when the incompetent to stand trial process in going. As I mentioned, I was just at the Alameda meeting and they did mention their diversion (DSH) pilot project (our county has one as well), included the district attorney (DA), the public defender (PD), the courts and the public guardian, as well as inpatient and outpatient. It is critical for the public guardian's office to be at these meetings. (RESPONSE: D. Seidner) The diversion program and forensics mental health input into the diversion program, as well as the services for individuals who are diverted. We are part of that discussion and our role is for the care and preparing the individual for the transition.

VII. DISCUSSION regarding the collection of mental health diagnosis of inmates during intake at the detention facilities: Comments from Rajik Pramanik, MD, Chair office of Informatics and Technology, Chief Medical Informatics Office, Contra Costa Health Services

(Cmsr G. Stern) The impetus behind collecting that data is to examine the diagnosis we could, potentially, target in the community prior to people entering detention and possibly divert that from happening, as a preemptive/preventative step. Focus the effort differently. We were hoping for data to help toward that goal.

- (Sonia Sutherland) This is a new question, and do not know the history of this particular question. I would say, in general, any type of population, we would want to know the trends. It is important, but I can't specifically speak to this question.
- (David Seidner) The psychiatrist see our patients we serve, there is a diagnosis and typically is a diagnosis if the individuals are seeking care, if the psychiatrist is prescribing medications as part of their treatment plan. There have been a variety of diagnosis, adjustment disorders. Many of the people we serve who try to harm themselves would not be referred to behavioral health. Individuals have tried to end their lives in custody and also have an adjustment disorder. Our way to focus on the acuity identification is through the track levels.

VIII. REVIEW questions asked of David Seidner for the Medical Remedial Plan

- (Sonia Sutherland) This Remedial plan is a result of the four-year negotiation, that has been court ordered. To address the questions:
  - Define "Reasonable Efforts": It is the guideline and as to defining reasonable efforts, that was up to the experts in the negotiation and is a legal term and a court ordered plan and cannot define that.
  - The provider being different from the person who prescribed the medication: That is common within detention, hospital. It has been prescribed out in the community, now the client has come into the health care setting working with this client, they will need to verify the medication and order within the system we are in and it is very typical.
  - Why aren't all inmates given a physical?: First, we follow guidelines in the remedial plan for clinically significant findings to help determine, but it does not mean the inmates can't have a physical. Anyone can request a physical. They are offered and it is provided if requested.
  - The process for sick call requests: The system is working; I can't speak to that except that it is working.
  - Several questions regarding timelines: To address the timeline questions, in general, the remedial plan is really "the outer limit" (the do not cross line). Another description is 'the floor' but we always aim for the ceiling. When you see timelines in this plan that was negotiated over four years, agreed by all parties, court ordered; it is the 'do not exceed this limit'. However, I

clinical care, I assure you, we evaluate patients based on what is happening with them right now. The clinical decision making done, as doctors, nursing partners and our care team, we do an immediate treatment as indicated. While these are our 'outer' limit, it does not prevent these to be addressed sooner rather than later. This does not mean we wait until day 21. We address as clinically indicated and do not exceed these outer limits.

- (David Seidner) Just to add/support. Care happens, we deliver care. We are preventative, we want to disrupt crisis but they do happen. The Remedial plan guidelines are informative and important, but they do not drive care. The people we serve drive care. Care drives care. It is important to have the remedial plan and data and survey and inspection and support by the Board of Supervisors and the community. These dates are 'road signs' but do not drive the delivery of care we are doing.
- (Sonia Sutherland) Detention is a very fluid place, if they have to go to court, they have to go to court. If they have to meet with their lawyer, they meet with their lawyer. This was a four-year process. So, again, these are the outer limits.
  - The Hepatitis C question: Everyone person is at risk for Hepatitis C. We use a risk-based determination, but just about every patient is screened. This is a population that we do a lot of treatment for various conditions that they likely did not have access to in the community.
  - The other question regarding the emergent and urgent time frames. Those terms are not aligned with the set days. Something urgent within a diagnostic imaging an x-ray won't necessarily have the same timeline as a clinical problem that is urgent or emergent. We do not want to exceed or get close to these limits in the remedial plan. The goal is to deliver the care that meets the needs of the population.

Questions and Comments:

- (Cmsr. G. Stern) What about the dental exams? (RESPONSE: Sonia Sutherland) That is similar to the Hepatitis C; when it's clinically indicated and necessary, it does happen. I spoke with the dentist shortly before this meeting. Anyone can be referred for a cleaning, offered or requested and it is definitely done when it is clinically indicated. Again, this is based on need. They are getting dental screening exams and addressing dental issue and there is a whole timeline for following that care.

IX. DISCUSS How to engage Judges Virginia George and Suzanne Fentstermacher involved in determining Conservatorship cases into coming to our meeting and discussing issues of concern with them

I have contacted Judges Virginia George and Suzanne Fentstermacher assistants to see if they could come in and answer some questions regarding conservatorships and their feelings, experience, insight and where they see it going, any problems we should know about. They just refuse to come because they are too busy. If anyone has any suggestions or questions that I can review on the phone and share, but they won't even respond to an email. If you have any ideas or connections.

- (Cmsr. J. Kincaid) There is a courts administrator. Possibly send questions to the courts administrator would be a good way to broach that. You are inviting them into a public meeting, and that may be part of it. If we want to come up with some questions to be answered and we come up with two or three, we might be able to get some feedback. Or present to the presiding judge is the administrating judge.
  (Cmsr. G. Stern) who is the presiding judge? (Cmsr. J. Kincaid) It is on the website. Each judges department has a supervising judge. And the presiding judge is the 'top' judge over all the departments. The courts administrators office that administrates the courts. Not sure who it is this year as it rotates annually.

• (Cmsr. G. Stern) I would like some help generating some questions to pose to these judges because they are on the front lines and make the final determination if someone should be conserved or not. I would like to hear from them what they think about what happens to these conservatees when they are out in the community and can't get the care they need. Long-term care solutions they may have ideas about. We should invite them in as partners to help try to problem solve. They are identifying and committing them. If they have ideas, I'd like to hear from them. They are an active participant in this process. • (Cmsr. J. Kincaid) I just looked it up and it is Judge Baskin this year. Judges get these requests frequently from many. It doesn't surprise me that it is difficult to get them to come to a meeting. • (Teresa Pasquini) It is critical to have conversations with all layers of the system that are impacting the decision making and judges are the ultimate decision makers in this. I'd like to see this be successful and commend and support you. • (Cmsr G. Stern) The reason I wanted to pursue this, as judges, if we determine a certain course of action is the way to go, they have a stronger voice to present to legislative bodies. I'd like to incorporate them into our efforts so they might help transmit the information we are discovering to those who can push this up the judicial ladder for laws to change.	
X. Adjourned at 3:03 pm	