MENTAL HEALTH COMMISSION
JUSTICE SYSTEMS COMMITTEE MEETING MINUTES
October 17th, 2023 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Committee Co-Chair, Cmsr. Geri Stern, called the meeting to order at 3:30pm Members Present: Cmsr. Geri Stern, District I, Committee Co-Chair Cmsr. Pamela Perls, District II, Committee Co-Chair Cmsr. Gerthy Loveday Cohen, District III Cmsr. Tavane Payne, District IV Cmsr. Gina Swirsding, District I Guest Speakers Lavonna Martin, MPH, MPA, Deputy Director, Contra Costa Health Services Other Attendees: Cmsr. Laura Griffin (Co-Host)* Cmsr. Barbara Serwin, District II* Angela Beck Jennifer Bruggeman Manju Mathews Jen Quallick (Supv Candace Andersen's ofc) Jill Ray (Supv Candace Andersen's ofc) *off screen/non participatory due to quorum restrictions	Meeting was held at: 1340 Arnold Drive, Ste 126 Martinez, CA and via Zoom platform
II. PUBLIC COMMENTS: None.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Swirsding) spoke on the Walgreen's insurance double charging MediCARE and patients. Spoke to the MediCARE fraud department to investigate/research further. Cmsr. Swirsding is concerned that consumers of mental health services as well as seniors are being taken advantage of and that this policy is fraudulent. She will follow up with the commission as she hears back from MediCARE fraud department.	
IV. COMMITTEE CHAIR COMMENTS: Cmsr. Stern had one comment regarding how the meeting was going to run and how the questions (previously submitted to Director Martin) were going to be handled. Cmsr. Stern will take questions 1-5; Cmsr. Perls will follow with questions 6-13. We will hold all follow up questions until the end of Director Martin's responses. If you have any questions (in person, on Zoom or those blacked out), they will be submitted privately and will be asked at the end of the presentation from Director Martin.	
V. APPROVE minutes from September 19th, 2023, Justice Systems Committee meeting: • Cmsr. Gina Swirsding moved to approve the minutes as is. • Seconded by Cmsr. Gerthy Loveday Cohen **Vote:** 5-0-0 **Ayes:** G. Cohen, 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 Health with Question and Answers - Lavonna Martin, MPH, MPA, Deputy Director of Contra Costa Health Services (60 min)	
Good evening Commissioners. (Introduced herself), I am the Deputy Director with Contra Costa Health Services (CCHS) and have been in CCC for 23 years in service to our community. My area of expertise and passion are the social determinates of health. I have had the privilege of working in service to person experiencing homelessness, as well as individuals who have food insecurity (you name it), I have been in service to this population all of my career. In the last couple of years, I have taken on a new role and I am now really looking into serve the population that is currently incarcerated in our community. That is not a new population to me, it is really a shared community of individuals who are often in our detention facilities are also those who might end up homeless or circulating into our emergency department (ED), etc. Very much attuned and aware, but I have learned a lot over the last couple years as I have stepped into detention health and I am happy to be here today to share with a little of what we are doing and answer those questions you have asked. 1. What are the most important elements of the Detention Medical and Mental Health Plans? ANSWER: First, I just want to ensure everyone on the call and in the room is just (in general) familiar with Detention Health. I do have some slides I would like to start with that roll right into this first question. To start, it is important to mention for Detention Health what matters most and it boils down to the safety of our patients, quality of care, equity among all those we serve and the experience patience receive (their experience of care). We work to ensure this is something happening every single day. Last year, 15k bookings for the adult population across three facilities. Every single booking results in a nurse at intake and we are getting medical screenings on every single booking in and out of our facility. 45% of those bookings are released after intake. A much smaller number are actually housed in that facility. Approximately 60% of those individuals are actually housed in our facilities. Average daily population last year was 915. It does not change dramatically as we look at 2023. It is important to note that a third of those individuals housed in detention are under the age of 30. That is really important to note as oftentimes that population needs a different set of services and additional services to support them. 74% in 2022 identified as non-white and as I look at data to date for 2023, it looks like that number has increased to approximately 79%. In 2022, 49% received some level of mental health services; 10% of those individuals identify as female. We have a workforce of 189 authorized position in detention health services that includes eight disciplines including those that you are no doubt familiar with, our physicians, nursing, mental health clinicians, as well as physical therapists. We have 24/7 staffing at all facilities. Services we offer and are provided on site: medical care, dental, optometry, mental health, psychiatry, pharmacy, dialysis, occupational therapy, physical therapy, substance use disorder treatment. We also	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

transport individuals who might need specialty services that we cannot provide in house. If there is a surgery needed, we are making sure that transport happens to get the surgery they need. We are currently working toward compliance with our medical and mental health remedial plans. Honestly there is not a 'most important' aspect. It is really important to note that every single one of those items in the remedial plan work together. We cannot falter on one and expect to be successful in others. They are really tied together, so we don't prioritize on what's most important.

Our focus is to ensure that all of those aspects of the remedial plan and those elements are attended to, so when we think about (specifically) the mental health remedial plan, we want to ensure everyone has a plan of care. We want to make sure everyone at intake is screened appropriately, not only for their health but also mental health as indicated. We want to make sure our suicide prevention and our protocols are strong. We want to make sure access to care is available and timely access to care. When someone needs supports and services, we are ensuring we are meeting our requirements by ensuring those are attended to as quickly as possible. There is not just one major element that we think is most important but we are 100% focused on every single aspect of both our medical and mental health remedial plan.

2. Are the plans based on existing models? Whose models?

   ANSWER: It is important to note that the remedial plans were actually drafted by the Prison Law Office (PLO). It wasn't drafted in a silo, they pulled in a number of our internal subject matter experts - from BHS, Forensics, CCHS, our hospitals and heath centers, but also informed by four additional external experts that have expertise in correctional institutions regarding mental health, medical services, as well as the correctional side as custody is not here and it isn't my area. We did have all those experts supporting and driving what our remedial plan measures and metrics should be and look like.

3. What improvements were agreed to in addition to the Detention Medical and Mental Health Plans?

   ANSWER: I won't waste time here, it is delineated in the consent decree. I do encourage you all to take a look at that public document as it obviously covers our medical improvements we needed to make, as well as the mental health improvements we needed to make. One set aside in the consent decree were provisions to look at the ADA (American Disability Act) obligations to ensure our facilities and the workers supporting those individuals that have disabilities. Even though that is not a remedial plan, but the county is talking to the PLO and conducting evaluations, updating our policies and programs and actually touring other ADA programs throughout the state. We are ahead of it and want to ensure we are learning from others across California who might be a bit ahead of us in making those improvements as we go along. Not all those requirements are not solely on health. In custody, there is a long around physical facilities too.

4. What are the current challenges to implementation other than hiring staff?

ANSWER: It is staff. I wish I had a better answer but it really is staff. Recruitment and retention of staff is very difficult. Detention health is one of those places where, oftentimes, individuals come in, get their 'chops' and get trained, they do some really great hard work and it sets them up to do well in other aspects and portions of our system. Retaining individuals is hard, as they get really good experience coming into detention. Some of the other issues in general with staffing is that we are in a whole new post COVID world. There is a lot of telehealth, teletherapy and it just doesn't necessarily always work in a detention facility. We are always challenged by the shortage (in general) of clinicians, but also the flexibility that the post COVID world is offering many health disciplines that sometimes isn't always a fit for those incarcerated. Beyond that, I want to say we have made some really good progress in filling our vacancies over the past year or so. I can share that particularly with our nursing staff and providers, we had a 33% reduction in vacancies just over the last six months because we are really focused on bringing people in, figuring out what we need to do and ensuring we are extending where we share vacancies/openings.

We really have a great time focused with the medical director really focused on bringing in providers, as well as our nursing team, making sure we are bringing in the nursing we need. Mental health remains a challenge and we still have vacancies there. Six months ago, we have increased but lost another person. We have a ten percent increase just because we lost one person. I will say that has changed as we have a brand new person Manju Mathews, our new program chief, who will actually speak to you next question. Now that we have a new mental health program chief really focused on closing some of those vacancies. I want to congratulate her because I understand we have a new clinician starting tomorrow. The next challenge is space. It is just the reality. We don't have enough space to put people. We are hiring additional physicians and nurses, the physical plans (spaces) of the facilities is limited. Finding and always shuffling staffing and trying to figure out how we can bring in new providers that absolutely need to be on site is a challenge. We are meeting that by looking for new space. We are working hard to make sure we fit everyone in.

(Cmsr. Stern) Manju has agreed to speak at our meeting on November 21st and I don't know if we want to save her input for that date because we don't want to take away from your responses.
(Lavonna Martin) I can just share with you that her responses and my response, she is the subject matter expert on the next question around behavioral flags and so I think it is best for her to answer, coming directly from her.
(Cmsr. Stern) I understand but I am wondering if we should just table that until next month. That is a whole presentation in itself and, previously, we have had David Seidner here discussing those aspects and he took up a whole hour and a half, it is very specific. We will skip to question #6

<This question tabled until November 17th Justice System Meeting>

5. What is the process for identifying, assessing, treating, and discharging inmates who need mental health services?
    a. What types of behavior flag an inmate as potentially needing mental health services?
    b. How do inmates experiencing mental health symptoms access mental health help (i.e., self-identifying inmates)?
    c. What is the hand-off to the community for inmates receiving mental health treatment at different acuity levels? If someone is actively psychotic and has ended their jail sentence, how do you determine placement, and how do you follow up? Do your case managers follow up six months post-release?
6. What percentage of the new full-time employees are 1) Health Services, 2) Mental Health Services, and 3) Custodial?

    ANSWER: First, I can't speak to the custodial (Sheriff's Department) would be better positioned to tell you how many staff they have hired. The percentage of new full-time employees, we have hired many. Out of the 189 authorized full-time positions that we have and shared with you initially in the previous slide - 125 are nursing positions spread across our system; 22 are mental health positions. In both the nursing and mental health positions include the clinical managers because what they often do are pulled in as an __________ and qualified to provide service should they need to do that. Also the mental health position includes our substance use disorder counselor. In addition, we 21 authorized positions for providers, includes physicians, psychiatry, and allied health professions (physical and occupational therapists) and 21 authorized support staff positions, which is our clerical and some administrative service positions, it also includes me as I consider myself support staff. With all those authorized positions, currently in Mental Health, we have (as of tomorrow) ten (10) vacancies. We continue to hire and we have been able to hire full-time staff over the last six months we have hired one full-time staff. Nursing, we have been able to decrease vacancies from 54 vacancies to 36, so we hired 18 over the last six months for nursing. We were able to hire a physician, which also resulted in a reduction in vacancies. One physician, 18 nurses and (as of tomorrow) one mental health clinician were hired full-time.
7. What is the mental health staffing plan, e.g., what is the nurse-to-inmate staffing ratio for the general population and mental health unit?

    ANSWER: It is important to note we don't have staffing ratios per se. It is not an established ratio, rather we are going to assess all patients incoming, at intake we will ensure, as medically necessary, we are going to address those individuals with medical conditions and ensure the appropriate staffing is wrapped around them, as well as any patient request that may come in for individuals who want to seek services. Ratios can be determined by taking those authorized positions and based on the information I provided around average daily population, the number of nurses, plus physicians and mental health positions. <request for slides, received>.
8. What training is provided for managerial and custodial staff interacting with inmates with mental health needs? (How many hours and is there yearly continuing education required?)

ANSWER: I cannot, again, speak to the custody staffing. They have a huge system all on their own and I won't speak to that out of fear of misspeaking. Managerial health staff we have, it is important to note that all the managers are also licensed or certified, which they are required to maintain their licensing or certifications and that is different for every license. Physicians have a certain number of hours they need to complete to maintain. When we think about the managerial (our medical director must maintain her license and must and ensure she is receiving all the professional documents and hours to retain her license in good standing. Same with our licensed mental health staff, whether that is a LMFT or a LCSW and it is important that they, too, are also maintaining their CEU's and professional development requirements to remain in good standing. That also includes are nurses (RNs / CNAs) they all have their own requirements to maintain their licensing and it differs for everyone. I did not come prepared to tell you how many hours each of those disciplines. All the managerial staff we have are licenses. That license and credentialing work is also managed by our MedStaff and we are keeping track, ensuring that all those requirements are being met.

9. What percentage of the inmate population has mental health, substance use, or dual-diagnosis disorders? What are the numbers for these percentages?

ANSWER: (SCREENSHARE) Let's start with a 'sample week'. It is so important to not that when you ask for a percentage of the population because the population changes daily, it is really hard to tell you what that looks like. It is better when we speak to these things that we either look at a week or a month. They typically don't change too significantly, but I thought this would be a better way to talk about the question based on this.

Just as a starter, it is a sample week from Q3 (last quarter or July through September). There were 262 intakes (60% are released right at intake), 165 housed / retained for a period of time. We also had 257 released from jail and just as many coming in as being released and fewer housed, with an average daily population in this sample week of 900. It is important to note that 64% of those folks with an intake, had an intake within the last year; so we are talking about individuals who have come through our doors before.

Looking at the population, of those 262 intakes: 52% had an episode of homelessness; 40% had an emergency department (ED) visit at some point in time prior to them entering detention that week, a hospital admission at some point in time prior to coming that week; 25% had some connection to our psych emergency services (PES) prior to coming in that week; and 5% had a pregnancy episode and were seen at CCRMC. Of those 262 those actually housed: 77% had referral for a mental health team; 42% self-reported substance use; 26% of those individuals were placed opiate monitoring; 18% placed on alcohol monitoring; and 4% had some abnormal dentistry. Individuals coming into our system, are screened for mental health assessments and referrals, substance use assessments as well as dental screening and other health factors and ensuring we are putting people on the

appropriate protocols as necessary. That is some of the data that I hope answers the question.

Overall, I just want to share that in any given month over the last 12 months, anywhere from 40-50% of the patients were actually on a mental health case load. So, 40-50% of the average daily population (of the 900 or so), anywhere from 40-50% - dependent on what month you are looking at – on average are actually actively on a mental health case load.

10. Has the ADA Remedial Plan been created and implemented?

    ANSWER: No.

11. On a scale of 1-10, how would you rate the quality of care inmates receive from the providers supplied by HealthRight 360?

    ANSWER: I wish I could speak to that, but I can't. CCHS does not have a contract with HealthRight 360. That is not our contract so I am unclear, and I did check in with the Sheriff and he is also unclear. We are not sure if it is being held through probation or through adult ed.

12. Is the implementation of improvements within the five-year time frame on target? What key improvements have been implemented, and what still needs to be done?

    ANSWER: Yes, I do believe detention health absolutely on target. Our focus is not only in achieving outcomes put forth by the medical and mental health remedial plans but really about sustaining the improvements we have made as I have shared with a few of you that all those things confidential around very specific information on how we are doing but globally can say yes, I feel very confident that we are on target. Our focus it to make sure we are sustaining all the improvements and gains we have made. Not just continuing to improve how to we sustain those approvements over time. We want those to be institutional. It's not just about meeting our metrics but really providing good sustainable care in our detention facilities that will be her and around for years to come.

    When we talk about what remains to be done, I just want to acknowledge there are two components that we are continuing our eye on and mindful of is that we have another facility soon to open, really focusing on re-entry services and planning. We want to make sure all the improvements we have made across our other facilities are also deployed in the new facility. So, as the work continues to develop services and structures as that facility plans to open, we want to, again, ensure we are maintaining and constantly improving the work that happens.

    The final thing is CalAIM. Services for those individuals incarcerated were not eligible for Medicaid or MediCAL services. That is all changing with CalAIM. It is a game changer for our patients who want to ensure that the services are being delivered and provided while they are incarcerated can continue as they transition out. So, we are busy trying to ensure that, not only are we meeting our remedial plan metrics, but we also want to make sure that every service individuals are eligible for as MediCAL comes in being in 2026, we want to make sure all those pre-release services are available.

Comments and Questions: • (Cmsr. Perls) So there isn't a mental health unit, per se. (RESPONSE: Lavonna Martin) No, mental health is provided across our system, so those mental health clinicians are to ensure those persons who are identified with mental health needs, that they get the services they need. It means our mental health clinicians are not seeing the average / all 900 individuals on the average daily population. They are seeing individuals who have been identified as needing mental health support services. • (Jill Ray in chat) HealthRight 360 is the provider of the central and east reentry network which is funded through AB109. • (Cmsr. Serwin) Have we increased compensations packages for clinical staff as a recruitment tool? (RESPONSE: Lavonna Martin) Fantastic question. So thank you for that. We are absolutely looking to do that. So, one of the thing we were looking to improve recruitment. Changing pay takes a long time but review has most certainly been underway and one improvement we could immediately do is for those individuals, particularly on the mental health side, they were not actually getting on call pay and that is something afforded to them in the MOU and it was something that just wasn't made available. I think it was just an oversight and just not knowing it was a tool to be used. That has actually helped a lot toward retention. Can you imagine getting calls after hours and not being compensated? Our managers and nursing staff get that compensation and, again, it is afforded to our mental health clinicians and it was just wasn't exercised. That was implement this year. I think that has helped. We are continuing to look at retention and recruitment strategies and one of those things is looking at pay. • (Cmsr. Swirsding) What continuing education are required for those who work with inmates that have mental illness. My concern is if an inmate becomes violent, what kind of training do nurses and staff have in order to deal with a violent situation. (RESPONSE: Lavonna Martin) Thank you for that. There is a variety of training. There is a civilian training and everyone coming into the facility gets a training provided by law enforcement so all staff are and aware of how to remain as safe as possible while they are working in the facility. That training is mandatory before they start working. Those are also required, updates are required (a refresher). It is also important to not that we have a health education training coordinator full-time on staff and that health and education training coordinator, not only ensures our nursing team continues to be updated and trained on new policy, procedures, protocols, changes in regulations but that health education is also providing education to custody partners, as well. • (Cmsr. Swirsding) I'm concerned about people getting hurt by a patient. (RESPONSE: Lavonna Martin) Custody provides us that civilian training. Also I want to add that custody—we are escorted while in the facility. We always have an escort in the vicinity. The requirement for law enforcement (Sheriff) is to ensure the environment remains safe. That means they have to have appropriate levels of staffing to assure that happens. When someone is seen for a medical appointment, even though the deputy is not going into the room, the deputy is stationed	

appropriately so they are close and maintaining privacy as best we can. Again, it doesn't mean that someone won't necessarily get hurt. Honestly, sometimes there are reasons why individuals are receiving the supports they need around their mental health care and it means that sometimes they may be fully unaware they are causing harm to a provider or they are aware and our providers are trained to do appropriate distancing to ensure they are doing their best to address the needs of the individual without putting themselves in harms way. There is that additional layer of custody there and available should something happen is critically important. • (Cmsr. Stern) It was interesting that so many people are released. Do you have any information on why so many are released on same day? (RESPONSE: Lavonna Martin) It's a long history of changes in legislation. Overall there has been a decrease in bookings over the last decade. Changes with public safety realignment (AB109, 3 strikes law amendment, reclassifying certain crimes to misdemeanors and COVID). The biggest changes are those that used to have an individual detained for longer periods of time are simply site and release now. • (Cmsr. Perls) Are these individuals that are sited and released assessed at all for mental health before release? (RESPONSE: Lavonna Martin) Absolutely. Again, everyone who is booked, also must be screened. Everyone is screened. • (Cmsr. Perls) If an individual has some indication of illness, particularly mental health, are they hooked up with service or are they sent along? (RESPONSE: Lavonna Martin) I think this is where CalAIM is going to challenge us to do better. Yes, services and information is provided. Let's be clear, someone comes in, they may not have health insurance or don't know, we are making sure we provide that information. • (Cmsr. Stern) This begs the question, if they have a substance use problem or a mental health issue and the numbers of therapists available right now are not meeting the need. If you step that up and referring people to mental health follow up, is there some system in place that is ramping up hiring mental health providers for all these potential referrals? (RESPONSE: Lavonna Martin) That is some of the requirement as we come up to CalAIM. We have to design a plan. Some of that is increasing staffing to ensure we can fulfill that mandate in the next year and a half. All that is being looked at very closely. Often, it is actually about making sure there are enough clinicians and supports on the outside. • (Cmsr. Perls) Referring to Question #6, you mentioned nurses. Are they RNs or assistants, medical assistants, etc.? (RESPONSE: Lavonna Martin) This includes nurse practitioners, certified nursing assistants (CNAs), certified medical assistants, RNs. All are included in nursing staff. • (Cmsr. Stern) What percentage are psychiatric nurses? (RESPONSE: Lavonna Martin) We have one dedicated position, but I will say, we have other (more than one) acting in that capacity providing who are working with our mental health team. We have a psychiatric nurse working directly with our mental health team now and we have one recruiting for hiring. We also have a full nursing team that can support individuals and are available and an actual added services.	

- (Cmsr. Perls) Are these divided equally among the facilities? Are they shared staff? I just wonder, will there be someone on site at both facilities? Or just one?
  (RESPONSE: Lavonna Martin) It is a both and. There are some positions dedicated to specific sites. West County Detention Facility (WCDF), Martinez Detention facility (MDF), there are other positions that float because we also have Juvenile Hall, which we are not talking about today. We have nursing that can actually float between facilities and we need that flexibility. We don't want to have our entire staffing situation in one or two facilities. So that when needed, we need to flex people across facilities, we can do so. For emergencies we need to have floaters.
- (Cmsr. Stern) When we went on the tour of the facilities. They said this unit is the Psych Unit (which was being built).
  (RESPONSE: Lavonna Martin) I said there wasn't psychiatric staffing.
  M Module is the psychiatric module in Martinez. It is also important to note that M Module flexes, not everyone stays on M Module.
- (Cmsr. Perls) The ADA remedial plan, have you consulted with some of the primary disability advocacy organizations, like Disability California whose staff wrote the ADA, Disability Rights to get their perspective?
  (RESPONSE: Lavonna Martin) No, the answer is we just started our process and working with the PLO. We are doing evaluations as we speak, around the facilities and the services and started taking tours.
- (Cmsr. Swirsding) Service Dogs, when will the jail be open to that?
  (RESPONSE: Lavonna Martin) That is a question for the Sheriff's Office.
- (Cmsr. Stern) What is the new facility being built? Location? Number of inmates projected?
  (RESPONSE: Lavonna Martin) The new facility being built will not bring in new beds to the system. It is repositioning beds. MDF will decrease beds by 288 and those beds will be moved to a new facility that will sit on the same campus as WCDF. I did not include in slides, but you can search the Board of Supervisors Agendas. It is public information available. It is the West County Re-Entry Treatment and Housing program (WRTH)
- (Cmsr. Perls) Those are individuals due to be released in a certain amount of time? Or are they just individuals that have been relocated?
  (RESPONSE: Lavonna Martin) Relocated. Out of the 288 beds, 96 will specifically support individuals with mental health needs. So there will be 96 beds with the appropriate levels of support and the remainder will be general population. It will remain the same classification as MDF. Still maximum. Re-envisioning what Detention can look like with appropriate programming space.
- (Cmsr. Payne) Lavonna, thank you very much for your presentation? What can we do to help you?
  (RESPONSE: Lavonna Martin) That is a question I did not anticipate but I appreciate you asking that question. I think its what do I need to support you and continuing to share the information I shared today.
  I think these questions tend to come up a lot and just wanted to make sure I took the time to do a PowerPoint because I wanted to make sure the information is handy because it is a lot of information. So you can have something you can refer back to and there isn't misinformation.
  The best thing that I would appreciate is a 'bench' to help me. So as I

have shared the information with you, please share. If you hear something that doesn't sound quite right, please correct the misinformation. I pride myself in providing accurate information and I want you to be able to use that information to the best of your ability. Let me know if there is anything that I can do to continue to support you in that.	
VII. REVISIT Committee Goals and Next Steps	***Due to time constraints, this has been tabled for next month***
VIII. Adjourn: 5:00 pm	

CONTRA COSTA HEALTH

cchealth.org

Detention Health Services

Safety, Quality, Equity, Experience of Care

Adult Population

15334 bookings in 2022*

45% are released after intake.

915
Average daily population

30 under 30
Percentage of patients under age 30 at time of booking

74%
identify as non-white.

49%
receive some level of mental health services.

1 in 10 identify as female.

*Nursing intakes are completed for every booking

Data provide by Sheriff Dept JMS/ATIMS

CONTRA COSTA HEALTH

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Our Workforce

189 authorized FTE

8 disciplines

24/7 staffing

CONTRA COSTA HEALTH SERVICES
DETENTION HEALTH

Vol. 1, Issue 24

DETENTION HEALTH COMMUNITY DIGEST

WELCOME – MENTAL HEALTH CHIEF

Manju is originally from the Boston area and went to school at Columbia University and earned her degree in Social Work. She started working with Contra Costa County in 2019 as a Mental Health Clinical Specialist. Later transitioned to Detention Mental Health before promoting to Program Manager. Prior to being a social worker, Manju attended Rensselaer Polytechnic Institute majoring in Electrical and Computer Systems Engineering and she continues to have an interest in figuring out all forms of puzzles. In her free time, she enjoys spending time with her family and pup, reading cozy mysteries, watching Jeopardy and spending time near water.

Manju Mathews, LCSW, CCHP

"Rest and self-care are so important. When you take time to replenish your spirit, it allows you to serve from the overflow. You cannot serve from an empty vessel."

-Eleanor Brown

Mental Health Tip: Take mindfulness breaks throughout the workday to recharge and reduce stress. These can consist of whatever helps ground yourself and recharge- make a cup of tea, stretch, take a walk around your work area.

CA Code 1157, For Detention Health Use Only. Please send your feedback/suggestions to Sonia.Sutherland@cchealth.org, Ariana.Trimble@cchealth.org, or DHChampions@cchealth.org. Please share this Digest with your colleagues. Be a Wellness Influencer and send your Wellness Kit requests to CCHSWellness@cchealth.org.

Services

- Medical Care
- Dental
- Optometry
- Mental Health
- Psychiatry
- Pharmacy
- Dialysis
- Occupational Therapy
- Physical Therapy
- Substance Use Disorder Tx (MAT)

CONTRA COSTA
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Medical and Mental Health Remedial Plans

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CONTRA COSTA COUNTY
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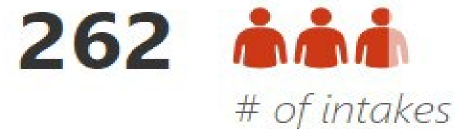
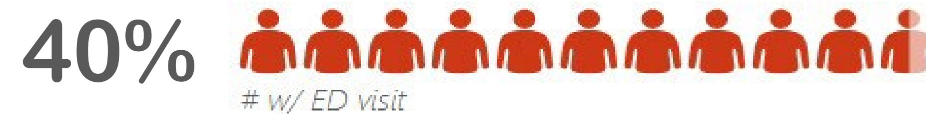
SAMPLE WEEK – Q3 2023

64% had a detention intake within the last year



Touches with Contra Costa Health

Prior Touches with CCH
262 Intakes



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Health Status at intake of 165 Housed

Next Steps & Future State

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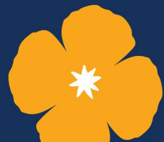
CalAIM for Justice Involved Initiative

A **historic Medi-Cal initiative** is providing coverage & targeted health services to eligible Californians released from prisons, jails, and youth correctional facilities.



Medi-Cal

Pre-release Medi-Cal enrollment

Pre-release Services/Medi-Cal Re-entry Services

Enhanced Care Management

Primary/Behavioral Health Warm Handoff

Community Supports

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Thank you

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