Supervisor Williams, 12/14/2021, item 5g

Intake assessment: The current assessment process is inadequate. The nurse just asks the written list of questions and puts down the arrestee's answers, which are often inaccurate. Arrestees will often claim incorrectly that they have no mental health or substance use history or problems and will deny any suicidal thoughts, so they are screened as having no issues. Often with psychotics and addicts, they can "feign good" in superficial assessments but begin to decompensate in more in-depth assessments. Also, a second assessment should be conducted a few days later once the person has cleared of substances to evaluate their "clean" mental status and their adjustment to the jail. Also, the clinician should seek and review documents and input from collateral sources before clearing the inmate instead of waiting for the inmate to break out in severe symptoms. $150k/yr for such a clinician seems pretty high.

Service evaluation: To do a complete quality assurance performance improvement and medication management review, Jenine Miller estimated a workload of approximately 40 hours. This requires meeting with the jail and Naphcare to review the system and process, document and data review, chart reviews, and medication prescribing review. An independent evaluator should also be assessing the quantity and quality of NaphCare services. A medical professional would be appropriate to evaluate NaphCare's medical services.

Personnel costs: NaphCare indicated that the $570k mental health staff cost in the budget is for JBCT (competency) staff. Those staffs are supposed to be paid from the JBCT contract with the Dept of State Hospitals.

Mentally ill in isolation: We need data on how many mentally ill are put in isolation cells, for how long, and what treatment they are getting while in there. Recidivism rates are high among this population, especially the impoverished and homeless mentally ill.

Counseling: I didn't hear a word spoken about counseling services for mentally ill inmates, or for that matter, any other treatment than medication offerings. Depression is understandably a common response to incarceration, and the research on antidepressant medications shows them to be largely ineffective, have adverse side effects, and be inferior to counseling. This is definitely not the best practice. Psychotic delusions are also often best treated with counseling than antipsychotics (which in turn more effectively handle hallucinations).

Psychiatric: I understand mentally ill inmates in the JBCT program get weekly psychiatric visits while trial-competent mentally ill inmates mostly only get a psychiatric visit every 2-3 months. I would like an explanation as to why this is our practice by design.

Delay in getting involuntary medication orders (IMOs) for trial-incompetent inmates: Judges should routinely order IMO evaluations (which need to be done by a psychiatrist) at the same time that they order the competency evaluations (which are typically done by a psychologist). Some judges currently do this some of the time. What can the county do to work with judges to minimize the suffering of inmates caused by delays? What are the action items, and who will follow through? Can we see the raw data and associated charts of delays, including detail on whether the delay is the county, state, or courts?

Local employees: In the JBCT, they replaced local professionals with out-of-county subcontractors. Can we see data to prove this change has provided an equal or better level of outcomes? Does the new trainer have experience with competency issues in a jail setting or with inmates?

LPS conservatorships: There needs to be a discussion of this for the homeless mentally ill to lower the crime/illness/recidivism rate for these folks. Who will draft the next steps?

Has the California State Supreme Court decided the placement of 1368s in county jails to be cruel and unusual punishments? What actions should the county take to conform to modern expectations?