CONTRA COSTA
MENTAL HEALTH
COMMISSION
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Current (2023) Members of the Contra Costa County Mental Health Commission

Laura Griffin, District V (Chair); Douglas Dunn, District III (Vice Chair); Ken Carlson, BOS Representative, District IV;
Kerie Dietz-Roberts, District IV; Gerthy Loveday Cohen, District III; Leslie May, District V; Joe Metro, District V; Tavane Payne, District IV,
Pamela Perls; District II, Barbara Serwin, District II, Rhiannon Shires Psy.D., District II; Geri Stern, District I; Gina Swirsding, District I;
(VACANT) Alternate BOS Representative for District _

Mental Health Commission (MHC)

Wednesday, February 1st, 2023, ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481
Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. Call to Order/Introductions (10 minutes)

II. Chair Comments/Announcements (5 minutes)

- **i. Review of Meeting Protocol:**
  - **No Interruptions**
  - **Limit two (2) minutes**
  - **Stay on topic**
- **ii. Reminder: Attendance requirements and Confirmation response for Quorum**
- **iii. ACR-150 African American Mental Health Awareness Week / AB 2242 and Senator Susan Eggman in the news!**
- **iv. Welcome Supervisor Ken Carlson, District IV!**

III. Public Comments (2 minutes per person max.)

IV. Commissioner Comments (2 minutes per Commissioner max.)

V. APPROVE January 4th, 2023 Meeting Minutes (5 minutes)

VI. "Get to know your Commissioner" – Kerie Dietz-Roberts, Commissioner, Mental Health Commission (MHC) (5 minutes)

VII. DISCUSS Justice Committee Efforts to Collect Data Regarding Mental Health Diagnoses in the Contra Costa County Jail Population, Barbara Serwin, Commissioner MHC (10 minutes)

(Agenda Continued on Page Two)

VIII. DISCUSS 2023-2024 Mental Health Commission Behavioral Health Budget priorities, Douglas Dunn, Commissioner MHC (5 minutes)

IX. RECEIVE Presentation: Behavioral Health Services (BHS) 2023-2024 budget; Dr. Suzanne Tavano, BHS Director and Pat Godley, Chief Financial Officer, Contra Costa Health Services (55 minutes)

X. BHS Director's report, Dr. Suzanne Tavano (10 minutes)

1. **Update on the Children's separate Crisis Services Unit (CSU)**
2. **Psychiatric Emergency Services**
3. **Assembly Bill 2275**
4. **Community Assistance, Recovery and Empowerment (CARE) Court**

XI. Adjourn

ATTACHMENTS:

- **A. Bill Text - ACR-150 African American Mental Health Awareness Week**
- **B. Bill Text - AB-2242 Mental Health Services**
- **C. California Senate's New Health Chair to Prioritize Mental Health and Homelessness, California Healthline January 6, 2023**
- **D. Board of Supervisors Installs New Leadership News Release 1.10.2023**
- **E. Ken Carlson Sworn in District IV**
- **F. Notes: Justice Committee Efforts to Collect Jail Diagnoses Data**
- **G. Notes: MHC Budget Priorities 2023-2024**
- **H. Legal Update: Brown Act Virtual Meeting Requirements**
  - **H1 Sample letter to Gov. Newsom**
  - **H2 Sample letter to Jason Elliott, Chief of Staff**

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the Executive Assistant to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Suite 200, Martinez, CA 94553, during normal business hours.

ACR-150 African American Mental Health Awareness Week. (2009-2010)

Assembly Concurrent Resolution No. 150

CHAPTER 74

Relative to African American Mental Health Awareness Week.

[Filed with Secretary of State August 09, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

ACR 150, Carter. African American Mental Health Awareness Week.

This measure would recognize each 2nd week of February hereafter as African American Mental Health Awareness Week.

Fiscal Committee: no

WHEREAS, According to the National Alliance on Mental Health, some mental illnesses are more prevalent in the African American community as compared to other cultures in the United States; and

WHEREAS, African Americans suffer as a result of suicide, depression, misdiagnosis, over use of involuntary hospitalization, incarceration, and self-medication via substance abuse; and

WHEREAS, The Office of Minority Health reports that African Americans are 30 percent more likely to report having serious psychological distress than Whites, yet Whites are more likely to receive treatment for a major depressive episode than African Americans; and

WHEREAS, Suicide is the third leading cause of death for all teens in the United States, and the third leading cause of death for African American youth 15 to 19 years of age, inclusive. The suicide rate among African Americans within the last 30 years has increased dramatically. Between 1980 and 1995 the suicide rates for African American youth 10 to 14 years of age, inclusive, has increased by 233 percent, compared to 120 percent for comparable Whites; and

WHEREAS, In the United States African Americans account for only 2 percent of psychiatrists, 2 percent of psychologists, and 4 percent of social workers; and

WHEREAS, Children in the foster care and child welfare system are more likely to develop mental illness, and African American children comprise 45 percent of the foster care system; and

WHEREAS, Prison inmates are at high risk for developing mental illness and less likely to be diagnosed with a mental illness, and half of all prisoners in the United States are African American; and

WHEREAS, The African American Mental Health Coalition is committed to empowering African American communities by promoting the benefits of mental health services, through education, advocacy, policy development, raising awareness, and decreasing the stigma surrounding mental health; and

WHEREAS, The African American Mental Health Coalition has introduced creative and innovative community-based programs and partnered with a variety of local community organizations to help prevent improper interventions, misdiagnosis, involuntary incarceration, and decrease the stigma related to mental health issues in the African American community; and

WHEREAS, The African American Mental Health Coalition is recognized as an important partner in the success of African American Health Awareness Week, through its continued efforts to provide services, information, and advocacy to individuals throughout the African American community, and to make positive changes by increasing awareness and eliminating barriers to care; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That the Legislature recognizes each second week of February hereafter as African American Mental Health Awareness Week; and be it further

Resolved, That the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

AB-2242 Mental health services. (2021-2022)

SHARE THIS:

Date Published: 10/03/2022 02:00 PM

Assembly Bill No. 2242

CHAPTER 867

An act to amend Sections 5152 and 5361 of, and to add Sections 5014, 5257.5, and 5402.5 to, the Welfare and Institutions Code, relating to mental health.

[Approved by Governor September 30, 2022. Filed with Secretary of State September 30, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2242, Santiago. Mental health services.

(1) Existing law, the Lanterman-Petris-Short Act (the Act), authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed. Under the act, if a person, as a result of a mental health disorder, is a danger to others, or to themselves, or is gravely disabled, the person may, upon probable cause, be taken into custody by a peace officer, a member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or another designated professional person, and placed in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. The act also authorizes a conservator of the person, of the estate, or of both, to be appointed for a person who is gravely disabled as a result of a mental health disorder.

This bill, on or before December 1, 2023, would require the State Department of Health Care Services to convene a stakeholder group of entities, including the County Behavioral Health Directors Association of California and the California Hospital Association, among others, to create a model care coordination plan to be followed when discharging those held under temporary holds or a conservatorship. The bill would require the model care coordination plan and process to outline who would be on the care team and how the communication would occur to coordinate care. Among other components, the bill would require the model care coordination plan to require that an individual exiting a temporary hold or a conservatorship be provided with a detailed plan that includes a scheduled first appointment with the health plan, the mental health plan, a primary care provider, or another appropriate provider to whom the person has been referred. The bill would require facilities designated by the counties for evaluation and treatment of involuntarily committed patients to implement the care coordination plan by August 1, 2024.

This bill would require a care coordination plan to be developed, as specified, and provided to an individual before being discharged from a hold or released after being detained for evaluation and treatment. The bill would also require a care coordination plan to be developed and provided to a conservatee prior to their release. The bill would require the county behavioral health department, among others, to participate in designing an individual’s care coordination plan. By placing additional duties on counties, the bill would impose a state-mandated local program. The bill would require, for purposes of care coordination and scheduling a followup appointment, the health plan, mental health plan, primary care provider, or other appropriate provider to whom

a person released from hold or a conservatorship is referred for services to make a good faith effort to contact the referred individual no less than 3 times, either by email, telephone, mail, or in-person outreach, as specified.

(2) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The MHSA also established the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act.

This bill, to the extent permitted under state and federal law and consistent with the MHSA and for the purposes of the above-mentioned provisions of the Lanterman-Petris-Short Act, would clarify that counties may pay for the services authorized in those provisions using funds from the Mental Health Services Fund when included in county plans, as specified, and would also authorize counties to pay for those services with specified funds from the Local Revenue Fund and the Local Revenue Fund 2011. The bill would make these provisions severable.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
Vote: majority   Appropriation: no   Fiscal Committee: yes   Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 5014 is added to the Welfare and Institutions Code, to read:

5014. (a) To the extent otherwise permitted under state and federal law and consistent with the Mental Health Services Act, both of the following apply for purposes of Article 1 (commencing with Section 5150) and Article 4 (commencing with Section 5250) of Chapter 2 and Chapter 3 (commencing with Section 5350):

(1) Counties may pay for the provision of services using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes.

(2) A person shall not be denied access to services funded by the Mental Health Services Fund based solely on the person's voluntary or involuntary legal status.

(b) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 2. Section 5152 of the Welfare and Institutions Code is amended to read:

5152. (a) A person admitted to a facility for 72-hour treatment and evaluation under the provisions of this article shall receive an evaluation as soon as possible after the person is admitted and shall receive whatever treatment and care the person's condition requires for the full period that they are held. The person shall be released before 72 hours have elapsed only if the psychiatrist directly responsible for the person's treatment believes, as a result of the psychiatrist's personal observations, that the person no longer requires evaluation or treatment. However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is placed under a 72-hour hold and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person from the hold, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release of a person who has been placed under a 72-hour hold, the hold shall be maintained unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist shall enter their findings, concerns, or objections into the person's medical record. If any other professional person who is authorized to release the person believes the person should be released before 72 hours have elapsed, and the psychiatrist directly responsible

for the person's treatment objects, the matter shall be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, the medical director shall appoint a designee who is a psychiatrist. If the matter is referred, the person shall be released before 72 hours have elapsed only if the psychiatrist making the final decision believes, as a result of the psychiatrist's personal observations, that the person no longer requires evaluation or treatment.

(b) A person who has been detained for evaluation and treatment shall be released, referred for further care and treatment on a voluntary basis, or certified for intensive treatment, or a conservator or temporary conservator shall be appointed pursuant to this part as required.

(c) (1) A person who has been detained for evaluation and treatment and subsequently released with referral for further care and treatment on a voluntary basis, shall receive, prior to release, a care coordination plan developed by, at a minimum, the individual, the county behavioral health department, the health care payer, if different from the county, and any other individuals designated by the person as appropriate, with input and recommendations from the facility. The care coordination plan shall include a first followup appointment with an appropriate behavioral health professional. The appointment information shall be provided to the person before their release. In no event may the person be detained based on the requirements of this subdivision beyond when they would otherwise qualify for release. All care and treatment after release shall be voluntary.

(2) The requirement to develop a care coordination plan under this subdivision shall take effect immediately, without waiting for the department to create a model care coordination plan, as required pursuant to Section 5402.5.

(d) For purposes of care coordination and to schedule a followup appointment, the health plan, mental health plan, primary care provider, or other appropriate provider to whom the person has been referred pursuant to subdivision (c) shall make a good faith effort to contact the referred individual no fewer than three times, either by email, telephone, mail, or in-person outreach, whichever method or methods is most likely to reach the individual.

(e) A person designated by the mental health facility shall give to any person who has been detained at that facility for evaluation and treatment and who is receiving medication as a result of their mental illness, as soon as possible after detention, written and oral information about the probable effects and possible side effects of the medication. The State Department of Health Care Services shall develop and promulgate written materials on the effects of medications, for use by county mental health programs as disseminated or as modified by the county mental health program, addressing the probable effects and the possible side effects of the medication. The following information shall be given orally to the patient:

(1) The nature of the mental illness, or behavior, that is the reason the medication is being given or recommended.

(2) The likelihood of improving or not improving without the medication.

(3) Reasonable alternative treatments available.

(4) (A) The name and type, frequency, amount, and method of dispensing the medication, and the probable length of time the medication will be taken.

(B) The fact that the information has or has not been given shall be indicated in the patient's chart. If the information has not been given, the designated person shall document in the patient's chart the justification for not providing the information. A failure to give information about the probable effects and possible side effects of the medication shall not constitute new grounds for release.

(f) The amendments to this section made by Assembly Bill 348 of the 2003–04 Regular Session shall not be construed to revise or expand the scope of practice of psychologists, as defined in Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

SEC. 3. Section 5257.5 is added to the Welfare and Institutions Code, to read:

5257.5. (a) A care coordination plan shall be developed by, at a minimum, the individual, the facility, the county behavioral health department, the health care payer, if different from the county, and any other individuals designated by the individual as appropriate, and shall be provided to the individual before their discharge. The care coordination plan shall include a first followup appointment with an appropriate behavioral health professional. The appointment information shall be provided to the individual before their release. In no event

may the individual be involuntarily held based on the requirements of this subdivision beyond when they would otherwise qualify for release. All care and treatment after release shall be voluntary.

(b) For purposes of care coordination and to schedule a followup appointment, the health plan, mental health plan, primary care provider, or other appropriate provider to whom the individual has been referred pursuant to subdivision (a) shall make a good faith effort to contact the referred individual no fewer than three times, either by email, telephone, mail, or in-person outreach, whichever method or methods is most likely to reach the individual.

(c) The requirement to develop a care coordination plan under this section shall take effect immediately, without waiting for the department to create a model care coordination plan, as required pursuant to Section 5402.5.
SEC. 4. Section 5361 of the Welfare and Institutions Code is amended to read:

5361. (a) Conservatorship initiated pursuant to this chapter shall automatically terminate one year after the appointment of the conservator by the superior court. The period of service of a temporary conservator shall not be included in the one-year period. When the conservator has been appointed as conservator of the estate, the conservator shall, for a reasonable time, continue to have the authority over the estate that the superior court, on petition by the conservator, deems necessary for (1) the collection of assets or income that accrued during the period of conservatorship, but were uncollected before the date of termination, (2) the payment of expenses that accrued during period of conservatorship and of which the conservator was notified prior to termination, but were unpaid before the date of termination, and (3) the completion of sales of real property when the only act remaining at the date of termination is the actual transfer of title.

(b) If, upon the termination of an initial or a succeeding period of conservatorship, the conservator determines that conservatorship is still required, the conservator may petition the superior court for reappointment as conservator for a succeeding one-year period. The petition shall include the opinion of two physicians or licensed psychologists who have a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders that the conservatee is still gravely disabled as a result of mental disorder or impairment by chronic alcoholism. If the conservator is unable to obtain the opinion of two physicians or psychologists, the conservator shall request that the court appoint them.

(c) (1) A facility in which a conservatee is placed shall release the conservatee at the conservatee’s request when the conservatorship terminates. A petition for reappointment filed by the conservator or a petition for appointment filed by a public guardian shall be transmitted to the facility at least 30 days before the automatic termination date. The facility may detain the conservatee after the end of the termination date only if the conservatorship proceedings have not been completed and the court orders the conservatee to be held until the proceedings have been completed.

(2) A care coordination plan shall be developed by, at a minimum, the individual, the facility, the county behavioral health department, the health care payer, if different from the county, and other individuals designated by the individual as appropriate, and shall be provided to the conservatee prior to their release. The care coordination plan shall include a first followup appointment with an appropriate behavioral health professional. The appointment information shall be provided to the individual before the individual is released. In no event may the individual be involuntarily held based on the requirements of this paragraph beyond when they would otherwise qualify for release. All care and treatment after release shall be voluntary.

(3) For purposes of care coordination and to schedule a followup appointment, the health plan, mental health plan, primary care provider, or other appropriate provider to whom an individual leaving a facility has been referred pursuant to paragraph (2) of subdivision (c) shall make a good faith effort to contact the referred individual no less than three times, either by email, telephone, mail, or in-person outreach, whichever method or methods are most likely to reach the individual.

(4) The requirement to develop a care coordination plan under this subdivision shall take effect immediately, without waiting for the department to create a model care coordination plan, as required pursuant to Section 5402.5.

SEC. 5. Section 5402.5 is added to the Welfare and Institutions Code, to read:

5402.5. (a) On or before December 1, 2023, the State Department of Health Care Services shall convene a stakeholder group to create a model care coordination plan to be followed when discharging those held under temporary holds pursuant to Section 5152 or a conservatorship. The stakeholder group shall include, at a minimum, the County Behavioral Health Directors Association of California, the California Chapter of the

American College of Emergency Physicians, the California Hospital Association, Medi-Cal managed care plans, private insurance plans, other organizations representing the various facilities where individuals may be detained under temporary holds or a conservatorship, other appropriate entities or agencies as determined by the department, and advocacy organizations representing those who have been involuntarily detained or conserved, as well as individuals who have been detained or conserved.

(b) The model care coordination plan and process shall outline who will be on the care team and how the communication will occur to coordinate care. It shall specify that the care coordination is a shared responsibility between, at a minimum, the county, the facility, and the health care payer, if different from the county. The model care coordination plan shall, at a minimum, also address the following:

(1) The roles of each entity to ensure continuity of services and care for all individuals exiting involuntary holds, including how referrals will be made and appointments will be scheduled pursuant to subdivision (d) of Section 5008. This shall include all of the following:

(A) Identification of county resources, programs, and contact information to facilitate referrals for individuals exiting involuntary holds or intensive treatment, including, but not limited to, suicide prevention, substance use disorder treatment, Medi-Cal Enhanced Care Management, Full Service Partnerships, assisted outpatient treatment, early psychosis intervention services, and resources published pursuant to Section 5013.

(B) Hospital aftercare and discharge planning processes pursuant to Sections 1262 and 1262.5 of the Health and Safety Code.

(C) Hospital policies and procedures in compliance with nationally accepted accreditation standards to reduce the risk of suicide, including, but not limited to, screening and assessing patients for suicidal ideation and suicidal risk, developing a safety plan with patients at risk for suicide, and following written policies and procedures addressing the care, counseling, and followup care at discharge for patients at risk for suicide.

(2) A requirement that the care coordination plan for an individual exiting a temporary hold or a conservatorship include a detailed plan that includes a scheduled first appointment with the health plan, the mental health plan, a primary care provider, or another appropriate provider to whom the person has been referred.

(3) County procedures and contact information for the availability of designated persons for the purpose of conducting an assessment pursuant to Section 5150. Designated individuals shall be available on a 24-hours-per-day, seven-days-per-week basis in order to ensure that individuals are released from the hold as soon as possible after it is determined they no longer require detention. In no event may the individual be involuntarily held beyond when they would otherwise qualify for release.

(4) County procedures for facilities and professional persons to request designation to perform assessments and evaluations, pursuant to Sections 5151 and 5152.

(5) County procedures and contact information facilities are required to use to obtain an assessment and evaluation of an individual, pursuant to Sections 5151 and 5152.

(6) Defined expectations for information sharing, including notification of and transmittal of applications pursuant to Section 5150 and plans to periodically convene to identify and resolve challenges.

(c) (1) Each county mental health department shall ensure that a care coordination plan that ensures continuity of services and care in the community for all individuals exiting holds or a conservatorship pursuant to this part is established.

(2) All facilities designated by the counties for evaluation and treatment under this part shall implement the model care coordination plan on or before August 1, 2024.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement Section 5402.5 by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

SEC. 6. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

California Senate’s New Health Chair to Prioritize Mental Health and Homelessness

By **Rachel Bluth**
JANUARY 6, 2023

California state Sen. Susan Talamantes Eggman, a Stockton Democrat who was instrumental in passing Gov. Gavin Newsom’s signature mental health care legislation last year, has been appointed to lead the Senate’s influential health committee, a change that promises a more urgent focus on expanding mental health services and moving homeless people into housing and treatment.

Eggman, a licensed social worker, co-authored the novel law that allows families, clinicians, first responders, and others to petition a judge to mandate government-funded treatment and services for people whose lives have been derailed by untreated psychotic disorders and substance use. It was a win for Newsom, who proposed the Community Assistance, Recovery and Empowerment Act, or CARE Court, as a potent new tool to address the tens of thousands of people in California living homeless or at risk of incarceration because of untreated mental illness and addiction. The measure faced staunch opposition from disability and civil liberties groups worried about stripping people’s right to make decisions for themselves.

“We see real examples of people dying every single day, and they’re dying with their rights on,” Eggman said in an interview with KHN before the appointment. “I think we need to step back a little bit and look at the larger public health issue. It’s a danger for everybody to be living around needles or have people burrowing under freeways.”

Senate Pro Tem Toni Atkins announced Eggman’s appointment Thursday evening. Eggman replaces Dr. Richard Pan, who was termed out last year after serving five years as chair. Pan, a pediatrician, had prioritized the state’s response to the covid-19 pandemic and championed legislation that tightened the state’s childhood vaccination laws. Those moves made him a hero among public health advocates, even as he faced taunts and physical threats from opponents.

The leadership change is expected to coincide with a Democratic health agenda focused on two of the state's thorniest and most intractable issues: homelessness and mental illness. According to federal data, California accounts for 30% of the nation's homeless population, while making up 12% of the U.S. population. A recent Stanford study estimated that in 2020 about 25% of homeless adults in Los Angeles County had a severe mental illness such as schizophrenia and 27% had a long-term substance use disorder.

Eggman will work with Assembly member Jim Wood, a Santa Rosa Democrat who is returning as chair of the Assembly Health Committee. Though the chairs may set different priorities, they need to cooperate to get bills to the governor's desk.

Eggman takes the helm as California grapples with a projected $24 billion budget deficit, which could force reductions in health care spending. The tighter financial outlook is causing politicians to shift from big "moonshot" ideas like universal health care coverage to showing voters progress on the state's homelessness crisis, said David McCuan, chair of the political science department at Sonoma State University. Seven in 10 likely voters cite homelessness as a big problem, according to a recent statewide survey by the Public Policy Institute of California.

Eggman, 61, served eight years in the state Assembly before her election to the Senate in 2020. In 2015, she authored California's End of Life Option Act, which allowed terminally ill patients who meet specified conditions to get aid-in-dying drugs from their doctor. Her past work on mental health included changing eligibility rules for outpatient treatment or conservatorships, and trying to make it easier for community clinics to bill the government for mental health services.

She hasn't announced her future plans, but she has around $70,000 in a campaign account for lieutenant governor, as well as $175,000 in a ballot measure committee to "repair California's mental health system."

Eggman said the CARE Court initiative seeks to strike a balance between civil rights and public health. She said she believes people should be in the least restrictive environment necessary for care, but that when someone is a danger to themselves or the community there needs to be an option to hold them against their will. A Berkeley Institute of Governmental Studies poll released in October found 76% of registered voters had a positive view of the law.

Sen. Thomas Umberg (D-Santa Ana), who co-authored the bill with Eggman, credited her expertise in behavioral health and dedication to explaining the mechanics of the plan to fellow lawmakers. “I think she really helped to put a face on it,” Umberg said.

But it will be hard to show quick results. The measure will unroll in phases, with the first seven counties — Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne — set to launch their efforts in October. The remaining 51 counties are set to launch in 2024.

County governments remain concerned about a steady and sufficient flow of funding to cover the costs of treatment and housing inherent in the plan.

California has allocated $57 million in seed money for counties to set up local CARE Courts, but the state hasn’t specified how much money will flow to counties to keep them running, said Jacqueline Wong-Hernandez, deputy executive director of legislative affairs at the California State Association of Counties.

Robin Kennedy is a professor emerita of social work at Sacramento State, where Eggman taught social work before being elected to the Assembly. Kennedy described Eggman as someone guided by data, a listener attuned to the needs of caregivers, and a leader willing to do difficult things. The two have known each other since Eggman began teaching in 2002.

“Most of us, when we become faculty members, we just want to do our research and teach,” Kennedy said. “Susan had only been there for two or three years, and she was taking on leadership roles.”

She said that Eggman’s vision of mental health as a community issue, rather than just an individual concern, is controversial, but that she is willing to take on hard conversations and listen to all sides. Plus, Kennedy added, “she’s not just going to do what Newsom tells her to do.”

Eggman and Wood are expected to provide oversight of CalAIM, the Newsom administration’s sweeping overhaul of Medi-Cal, California’s Medicaid program for low-income residents. The effort is a multibillion-dollar experiment that aims to improve patient health by funneling money into social programs and keeping patients out of costly institutions such as emergency departments, jails, nursing homes, and mental health crisis centers. Wood said he believes there are opportunities to improve the CalAIM initiative and to monitor consolidation in the health care industry, which he believes drives up costs.

Eggman said she’s also concerned about workforce shortages in the health care industry, and would be willing to revisit a conversation about a higher minimum wage for hospital workers after last year’s negotiations between the industry and labor failed.

But with only two years left before she is termed out, Eggman said, her lens will be tightly framed around her area of expertise: improving behavioral health care across California.

“In my last few years,” she said, “I want to focus on where my experience is.”

KHN (Kaiser Health News) is a national newsroom that produces in-depth journalism about health issues. Together with Policy Analysis and Polling, KHN is one of the three major operating programs at KFF (Kaiser Family Foundation). KFF is an endowed nonprofit organization providing information on health issues to the nation.

Contra Costa County
County Administrator's Office • 1025 Escobar Street • Martinez, CA 94553 • www.contracosta.ca.gov

NEWS RELEASE
January 10, 2023

Contact: Kristi Jourdan, PIO, 925-313-1183
Kristi.Jourdan@contracostatv.org
or
Robert Rogers, Office of Supervisor John Gioia
714-469-9267 Robert.Rogers@bos.cccounty.us

**Board of Supervisors Installs New Leadership
With John Gioia as Chair and Federal Glover as Vice-Chair
and Ken Carlson as newest County Supervisor**

(Martinez, CA) – Two of California's longest serving Supervisors, John Gioia and Federal D. Glover, take on leadership of the Contra Costa County Board of Supervisors, and Ken Carlson is sworn in as Contra Costa's newest Supervisor.

At today's Board of Supervisors meeting, Superior Court Judge Joni T. Hiramoto administered the oath of office to Supervisor John Gioia for his seventh term as a County Supervisor. History was made when Judge Hiramoto also swore into office former Pleasant Hill Councilmember Ken Carlson, Contra Costa's first LGBTQIA+ Supervisor. Supervisor Ken Carlson, who was elected to the Board of Supervisors on November 8, 2022, replaces retired Supervisor Karen Mitchoff.

Supervisor Gioia was also sworn in as Board Chair for 2023 and Supervisor Federal D. Glover was sworn in as Vice Chair.

District 1 Supervisor John Gioia represents Richmond, San Pablo, El Cerrito, Pinole, Kensington, El Sobrante, North Richmond, Rollingwood, Montalvin Manor and Tara Hills. John was first elected to the Board of Supervisors in 1998 and was re-elected last year with 85% of the vote (the highest vote percent of any Supervisor in California who faced an opponent). He is currently the third longest serving Supervisor in California and at the end of his current term of office will be tied as Contra Costa's second longest serving County Supervisor. He served five previous terms as Board Chair and takes the leadership role from outgoing Chair Karen Mitchoff, who retired at the end of her term.

"I'm proud and excited to continue my work representing the diverse communities of District 1 and fighting to achieve health and equity for all county residents," said Supervisor Gioia.

District 5 Supervisor Federal D. Glover, who represents Hercules, Rodeo, Crockett, Martinez, Bay Point, Pacheco, Clyde, Pittsburg and parts of Antioch and Marsh Creek, is the Board's first and only African-American Supervisor. He was elected to the Board in 2000, served four previous terms as Chair and is the fourth longest serving Supervisor in California.

District 4 Supervisor Ken Carlson represents Pleasant Hill, Concord, Clayton, and parts of Walnut Creek and Morgan Territory. In taking on his new role, Supervisor Carlson said "I am proud to represent the residents of District 4, to be the first Contra Costa LGBTQIA+ Supervisor and to continue my family's

legacy set by my grandfather. I look forward to improving our mental health crisis response, expanding our homeless services capacity, and ensuring all have equitable access to our County services."

Supervisors Gioia and Glover will lead the five-member elected body that sets the direction of County government and oversees its $4.4 billion budget to serve the 1.2 million residents of this diverse East Bay county with a "AAA" bond rating.

Board Chair Gioia and Vice Chair Glover intend to make "Health and Equity for All" their priority for 2023 as they lead the establishment of a new County Office of Racial Equity and Social Justice and continue their work to reduce health disparities across race and ethnicity.

For more information about Contra Costa County and its Board of Supervisors, visit the County's website at www.contracosta.ca.gov or the webpage: https://www.contracosta.ca.gov/7283/Board-of-Supervisors. For more information about Supervisor John Gioia, visit his County webpage at https://www.contracosta.ca.gov/5216/District-1-Supervisor-John-M-Gioia, for more about Supervisor Federal D. Glover, visit his County webpage at https://www.contracosta.ca.gov/781/District-5-Supervisor-Federal-D-Glover and for information about Supervisor Ken Carlson, visit his County webpage at https://www.contracosta.ca.gov/6291/District-4-Supervisor-Ken-Carlson.

###

SUPERVISOR
KEN CARLSON

District 4
Contra Costa County

Ken Carlson Becomes Supervisor

Dear District 4 Residents,

On Monday, January 2, 2023, Congressman Mark DeSaulnier administered the oath of office which officially starts my term on the Contra Costa County Board of Supervisors.

I am honored and humbled to have been elected to represent the communities of Pleasant Hill, Clayton, Concord, and Walnut Creek.

In case we haven't met, I have spent most of my life in Contra Costa County, including attending Pleasant Hill and Concord schools. In 2017, I retired from the Concord Police Department after 29 years of service. Some of my duties over the years included being a patrol officer, a crisis negotiator, a traffic investigator, and various investigative positions.

My public service continued as I served on the Pleasant Hill City Council from 2012 to 2022. During my tenure Pleasant Hill recovered from the Great Recession and built a solid budget based on fiscal stability. The Council with the passing of Measure K, funded, planned and constructed the new state-of-the-art Pleasant Hill Library. As the first LGBTQIA+ Councilmember and Mayor, I established June as LGBTQIA+ Pride Month in Pleasant Hill.

Now, as I get to work at the County level, my priorities include the build out of the A3 (Anyone, Anywhere, Anytime) Initiative, to continue to advocate for LGBTQIA+ issues, improve our aging infrastructure and expand housing options. I look forward to building relationships and working collaboratively with residents, community stakeholders and fellow elected officials.

Thank you for this opportunity to serve as your County Supervisor.

Sincerely,

Ken Carlson

District 4 Staff

I am honored to have an experienced team working with me from the start. Together they have over 30 years of experience working for Contra Costa County and over 20 years of experience working for State and Federal elected officials.

From left to right: Manny Bowlby, Executive Assistant; Lia Bristol, Deputy Chief of Staff; Alejandra Sanchez, District Representative; Supervisor Ken Carlson; Colleen Awad, Senior District Representative; and Lisa Chow, Chief of Staff.

Supervisor Ken Carlson | 2151 Salvio Street, Suite R, Concord, CA 94520

Unsubscribe abeck@cchealth.org [visitor.constantcontact.com]

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Notes on Justice Committee Efforts to Collect Data Regarding Mental Health Diagnoses in the Contra Costa County Jail Population
Commissioner Barbara Serwin, January 18, 2023

Topic:

The Justice Committee has requested data on the behavioral health diagnoses of the jail population in Contra Costa County from Detention Mental Health (DMH). This request has been denied by Behavorial Health Services (BHS), DMH, Health Services, and County Counsel

Core Issues:

- County Counsel, BHS, DMH and Health Services leadership refuse to provide aggregated mental health diagnoses data for incarcerated individuals due to privacy/HIPAA rules.
- County Counsel, BHS, DMH and Health Services leadership refuse to provide data because it would constitute "new" information / report and BHS is not legally bound to provide the PUBLIC with new reports.
- County Counsel, BHS, DMH and Health Services leadership insist that the Mental Health Commission is the public and has no rights to any data except for publicly available information.
- There is strong precedence of published aggregate behavioral health disorder in the jail population data.
- There is a confounding, persistent refusal by County Counsel, BHS, DMH and Health Services leadership to provide data – this is data that BHS and DMH should want themselves.
- County Counsel has performed what appears to be a significant amount of legal research to justify reasons for refusals.
- There is an unwillingness on the part of County Counsel, BHS, and DMH to answer MHC questions.
- There is an unwillingness on the part of County Counsel, BHS, and DMH to work together with the MHC to find a solution.
- County Counsel is not representing the interests of the MHC, despite its mandate to do so.

2021 - 2022:

- For over two years, Commissioner Geri Stern has repeatedly requested data on the behavioral health diagnoses of county jail incarcerated individuals who have been treated by DMH. The purpose of the requested data is to aid the Justice Committee in understanding the breakdown of behavioral health disorders to help determine what kind of treatments are needed for inmates with a behavioral health disorder: before, during, and after their time in jail. An important belief here is that treating people at risk of being incarcerated before they enter the jail system will decrease the odds of them actually being jailed and thereby contribute to a solution for decreasing the number of people with a behavior health disorder in jail and for reducing recidivism.

June 7, 2022:

- Commissioner Stern wrote a powerful email to the Commission, Board of Supervisors and staff, County staff in charge of BHS and DMH, other interested parties, laying out full request and arguments for meeting the request for "the collection of psychiatric/substance abuse diagnosis data from inmates at the West County and Martinez Detention facilities."
  - **Unfortunately, my Committee has been given many reasons why Detention Health cannot accommodate our request, including the catch-all reason of privacy issues.** Now we know the data exists and we know that it is documented electronically. **Since we are asking for data in aggregate, there are no privacy issues**.

July 22, 2022:

- Commissioner Stern received a response letter from the Deputy Director with responsibility of DMH, Lavonna Martin; the BHS Director, Suzanne Tavano; and the Health Services Director, Anna Roth. The letter was on Health Services letterhead, so it came from the top leadership of county Health Services.
  - "The record does not exist" and "The County is not obligated to create a record that does not exist in order to respond to a request for records or information. *(See Sander v. Superior Court (2018) 26 Cal. App. 5th 651, 665.)"*
    - **In other words, the county has never run a search on this criteria and aggregated the results into a simple report**
  - "Mining individual health records of incarcerated persons for diagnosis raises significant privacy concerns. Pulling individual data to aggregate does not guarantee that persons are not identifiable within the detention population. When the information in the data set is rare or matched up with publicly available information, then the person(s) can become identified, and their privacy compromised." *(Gov. Code, ' 6254(c), (k); Cal. Const., art. I, § 1; 45 C.F.R §164.500 et. seq; Cal. Civ. Code §§ 56.10 et seq.; 17 CCR 2500 et seq.)*
  - Commissioner Stern was reminded of other data that DMH has provided with in the past (only one relevant to mental health) and directed to the California Board of State and Community Corrections (BSCC) dashboard for other types of information.

July 29, 2022:

- Commissioner Stern responded to the Health Services response to her data request. In this email she asks:
  - How is it that the MHC should be constrained to public domain information? **The MHC is an appointed body, responsible to the Public, designed to provide oversite to Behavioral Health Services. California Mental Health Commissions are not limited to public domain information.**
  - **We need to focus on realistic concerns and not extreme and highly unlikely "privacy concerns."** There is a minuscule chance that some bad actor in the community might be able to identify an individual from a collective body of evidence gathered.

        - ♦ How and why will this data be mined by others who will potentially discover the identity of the individuals who are identified as having a particular Mental illness?
        - ♦ Who would finance this procedure to determine who is being identified and how would that party or entity gain access to those records in order to do so?
    - Why does extracting data have to result in the creation of new records versus a report based on existing data? **We are requesting a basic search on existing Electronic Health Records**.
    - **Why is Detention Health (DH) not compelled, or in fact greatly interested**, to discover and process information that will be useful to identify specific indicators which will potentially assist with treating people in the community before they enter Detention Health?

October 19, 2022:

- I (Commissioner Serwin) met with Assistant County Counsel Rebecca Hooley and BHS Director Suzanne Tavano to discuss the data collection issue. These are my notes to Commissioner Stern.

    - The MHC was not included in any Health Services meetings relating to the data collection. It is County Counsel's job to represent all county commissions and boards, but Rebecca Hooley was not aware of this.

    - Rebecca Hooley and Suzanne Tavano were in complete alignment on all issues; this was evident from the minute the meeting started. Everything they said was a wall against providing information from DMH that is not already public information. There was absolutely no progress made.

    - Rebecca insisted on meeting with the MHC Chair only, so the MHC's expert, Commissioner Stern, was asked not to attend. Rebecca said this was departmental policy. I asked for a written policy and she acknowledged that there is, in fact, no written policy.

    - I asked why was so much legal research was done regarding the data request. Rebecca stated that it is done for all public requests for information. I responded that this wasn't a public request – it was from the Commission. Rebecca wouldn't explain further. Lavonna Martin, who oversees Detention Mental Health, brought the request to County Counsel.

- Suzanne said over and over that the request was very nuanced and challenging and therefore a report would be difficult to produce.

- The main issue boiled down to what is the definition of a "new report". Rebecca and Suzanne kept repeating that since the report doesn't already exist, it is new and therefore not something that BHS and/or DMH have to produce.
    - I repeated several times that we are asking for a basic search against the EHR database on existing fields and then the results presented as a percentage.

- Suzanne finally indicated that she understood that the report is a matter of a basic query. They continued to argue that the report was new, however.
- There was almost no discussion re: HIPAA. It was as though the privacy rationale had been dropped.

- Suzanne repeated several times that DMH had already provided the Justice Committee with a lot of data.
  - I pointed out that it is very basic and mostly generic, and not related to what the Justice Committee is asking for.

- I pointed out the Justice Committee would like to meet with legal, Suzanne, Lavona Martin, an appropriate technical staff, to work out a report that would meet everyone's needs and constraints.
  - There was no response to this.
  - They said that any new request that would come from such work would have to be researched by County Counsel. We'd be starting from square one.

- I pointed out that the MHC has made multiple data requests to PES in the past and has never encountered resistance. Our needs were always met.
  - There was no response to this.

- I made the point that I would think that Suzanne and Lavonna would want this information too.
  - There was no response to this.

Examples of related published (public) aggregated data:

“Special Report: Drug Use, Dependence and Abuse Among State Prisoners and Jail Inmates, 2007 – 2009”, U.S. Department of Justice 2017, revised 2020

“Estimating the size of the Los Angeles County Mental Health Population Appropriate for Release to Community Services”, RAND Corporation, 2020

> *****DATA SOURCES to classify individual incarcerated individuals according to presence of a mental health disorder: “We used two data sources to assess the clinical criteria. First, data regarding incompetence to stand trial and conservatorship were provided along with the legal information provided by ODR. Second, data regarding clinical diagnoses, medications,and observed behaviors were obtained from the jail medical record. We obtained this information through a review of relevant mental health notes in the 12 months prior to the date of the data pull (June 6, 2019).”

Examples of sharing of information by Psych Emergency Services (PES) with the MHC:
- Demographic data on adult and child populations
- Details regarding children staying at PES for over 24 hours

Potential Next Steps:

- Air issue with the head of County Counsel to help facilitate cooperation (this suggestion was made by a BOS staffer to ask for guidance specifically from Mary Anne Mason, when she headed County Counsel, but she has recently retired and a new head has not been appointed).
- Bring issue to the full Commission for discussion.
- Make a request for Public Records.
- Air issue with the Board of Supervisors to help facilitate cooperation.

Agenda Item VIII Mental Health Commission

Budget Priorities List for the 2023-2024 Behavioral Health Budget

1. Housing and Care FIRST
2. Children’s Crisis Stabilization Unit (CCSU)
3. Funding of Crisis Response
4. Children's step down
5. Replace Nevin/Niereka House(s)
6. Housing
7. Trafficking

Mental Health Commission Budget Priorities—2023-2024—D. Dunn

- Housing and Care for the Justice Involved population
  A. Incompetent to Stand Trial (Felony)—State Funding provided
  B. Incompetent to Stand Trial (Misdemeanor)—MHSA funding?
  C. Behavioral Health Court (BHC)—MHSA Funding?
  D. Mental Health Diversion (MHD)—MHSA Funding?

- In the Background—CARE Court—State $1.5B Bridge funding?

- Replace Nevin & Nierika House as well as a Crisis Residential Facility (CRF) in east county (Antioch)—BHCIP Rounds 5 & 6

- Setting up and operating the Miller Wellness Center Children and Adolescent Crisis Stabilization Unit (CSU)

  A. County operated or select 3rd party Community Base Organization? To op3rate this 24/7 facility.
  B. Accept persons with any type of insurance or note as well as accept adolescents in crisis for Juvenile Hall.

- Funding Crisis Response
  A. Funded by Measure X Funding
  B. Federal funding to properly set up the Miles Hall Crisis Hub at the county owned Oak Grove site in Concord
  C. Major challenge—getting 24/7 county wide crisis response set up. Currently, only operating M-F 8:30-6:30 PM w/ 3 teams. Was 4 teams, incl. Sat. & sun. 8:30 AM-5:30 PM with it was the Mobil Crisis Response Team.

- Housing and care for Transition Age Youth (TAY) in Full Service Partnerships (FSPs) starting at age 16, like other counties.

- Children and Adolescent Step down unit from the new CSU like when SENECA operates in Alameda County.

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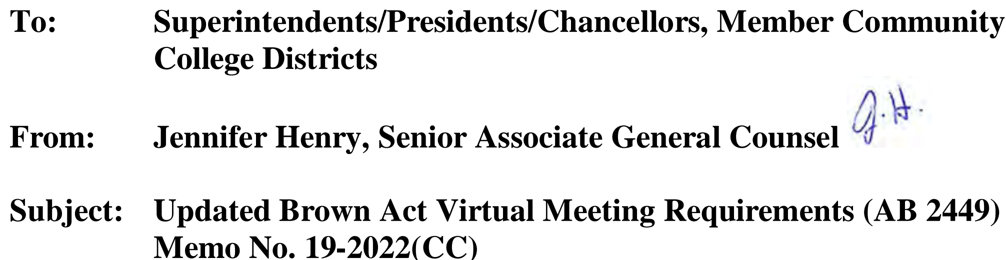
LEGAL UPDATE

November 8, 2022



To: **Superintendents/Presidents/Chancellors, Member Community College Districts**

From: **Jennifer Henry, Senior Associate General Counsel**

Subject: **Updated Brown Act Virtual Meeting Requirements (AB 2449)**
Memo No. 19-2022(CC)

Assembly Bill ("AB") 2449, signed into law on September 13, 2022, amends Government Code section 54953 to provide authority and specific requirements for public agencies to allow individual board members to appear at meetings via videoconference for "just cause" and under "emergency circumstances" while remaining in compliance with the Brown Act (Gov. Code §§ 54950 *et seq.*). AB 2449 goes into effect on January 1, 2023, and sunsets on December 31, 2025. AB 2449's primary difference from the pre-pandemic Brown Act rules on teleconferencing[1] is that the teleconference location does not have to be identified on the agenda or accessible to the public.

On the following pages, we have provided a chart comparing pre-pandemic ("traditional") teleconferencing requirements (which remain in effect and allow Board members to appear virtually for any reason, provided their location meets specific requirements) with AB 361 (which, while operative for the next two months, allows entire meetings to be held virtually under a statement of emergency), and the new AB 2449 rules for individual board members. Effective January 1, 2023, the Brown Act permits teleconferencing under any of the three options – traditional Brown Act teleconferencing, AB 361 state of emergency rules, and AB 2449 individual board member rules.

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[1] We use "teleconferencing" herein to mean conference via telephone or video, as defined in the Traditional Brown Act statute.

A: Rules Regarding a Quorum

Traditional Brown Act Teleconferencing Requirements	AB 361	AB 2449
During teleconference meetings, at least a quorum of the members of the local public agency body must participate from locations within the boundaries of the territory over which the local public agency body exercises jurisdiction.	Quorum not required to be located within the boundaries of the territory.	A quorum must participate in person from a singular physical location identified in the agenda, that is open to the public, and within the boundaries of the LEA.

B: Qualifying Circumstances Permitting Teleconferencing

Traditional Brown Act Teleconferencing Requirements	AB 361	AB 2449
• The teleconference location must be noted on the agenda. • The agenda must be posted at the remote location. • Each teleconference location must be accessible to the public so the public may attend the remote location. • Any vote must be done by roll call. • A majority of the Board must be located within the territory of the district.	• Only applies during a proclaimed state of emergency, where state or local officials have imposed or recommended measure to promote social distancing. • The board must hold a meeting during the proclaimed state of emergency to decide by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees. • Board must make findings every 30 days that the qualifying circumstances continue.	Individual board members may participate in board meetings remotely, if they notify the Board at their earliest opportunity, and have one of the following: - Just Cause: Individual board members can participate remotely when caregiving of a family member, a contagious illness, a physical or mental disability, or LEA-related travel prevents them from appearing in person; OR - May not be used more than two meetings per calendar year per Board member. Emergency Circumstances: Individual board members can participate remotely when

		there is a physical or family medical emergency that prevents them from appearing in person. - The board member must describe the emergency in approximately 20 words without disclosing any personal medical information. - Board must take action to approve the member's request. - A board member may not claim emergency circumstances more than three consecutive months OR 20 percent of the regular meetings within a calendar year

C: Agenda Requirements for Teleconferencing

Traditional Brown Act Teleconferencing Requirements	AB 361	AB 2449
Each teleconference location from which a member will be participating must be specifically identified in the meeting notice and agenda, including full address and room number. An agenda must be posted for the required period of time (24 or 72 hours) at each teleconference location from which a member will be participating.	Public agency must only give notice and post agenda in accordance with the Brown Act provisions for in-person meetings. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option.	The agenda must provide notice of how the public can access the meeting and provide comments. The agenda shall identify and include an opportunity for all persons to attend via a call in option, an internet-based option, and an in-person option. The board may not require a member of the public to submit comments prior to the meeting. There is no requirement to disclose the teleconferencing location.

D: Teleconference Location

Traditional Brown Act Teleconferencing Requirements	AB 361	AB 2449
Each teleconference location must be physically accessible to the public. Members of the public must be able to physically address the body from each teleconference location.	Public agencies do not have to let members of the public attend at each teleconference location, but must allow the public to access the meeting via a call-in or an internet-based service option. The public agency is not required to provide a physical location for the public to attend or provide comments.	Teleconferencing members must participate with both audio and visual, i.e. only via videoconference. Videoconferencing members must disclose whether any individuals 18 years or older are present in the same room and the nature of the relationship.

E: Public Comment

Traditional Brown Act Teleconferencing Requirements	AB 361	AB 2449
Public Comment must be allowed at the in-person meeting and from every teleconference location.	The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3. In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, ***the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment.*** Gov. Code § 54953(e)(1)(B). The legislative body ***shall not require public comments to be***	The legislative body must provide to the public a two-way audio-visual platform or a two-way telephonic service with live webcasting. The legislative body must provide a way for the public to remotely hear, visually observe, and remotely address the legislative body in real time.

	submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time. Gov. Code § 54953(e)(1)(E). An individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference ***may be required to register as required by the third-party internet website or online platform to participate***. Gov. Code § 54953(e)(1)(F). [Note: *The Brown Act does not allow a public agency to require a meeting attendee to provide their name and address as a condition of attendance and public agencies may need to consider whether pseudonyms will be allowed*]. A legislative body that provides ***a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register until that timed public comment period has elapsed.*** A legislative body that ***does not provide a timed public comment period, but takes public comment separately on each agenda item***, ***shall allow a reasonable amount of time***	

	per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register, or otherwise be recognized for the purpose of providing public comment. A legislative body that provides ***a timed general public comment period*** that does not correspond to a specific agenda item ***shall not close the public comment period or the opportunity to register until the timed general public comment period has elapsed***.	

F: Effective Dates

Brown Act Teleconferencing Requirements	AB 361	AB 2449
Government Code section 54953 was initially added in 1953, and amended in 1988 to allow for teleconferencing, with various amendments throughout the years. There is no intended sunset date.	AB 361 went into effect on October 1, 2021 and will sunset on December 31, 2023.	AB 2449 goes into effect on January 1, 2023 and sunsets on December 31, 2025.

Please contact our office with questions regarding this Legal Update or any other legal matter.

The information in this Legal Update is provided as a summary of law and is not intended as legal advice. Application of the law may vary depending on the particular facts and circumstances at issue. We, therefore, recommend that you consult legal counsel to advise you on how the law applies to your specific situation.

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January 23, 2023

Governor Gavin Newsom
1303 10th Street, Suite 1173
Sacramento, CA 95814
Phone: (916) 445-2841
Fax: (916) 558-3160

RE: Delay Canceling the COVID-19 State of Emergency until at least July 1, 2023

Dear Governor Newsom::

As a senior citizen and parent of a severely mentally ill loved one, I contracted COVID-19 this past December despite being fully vaccinated with latest bivalent vaccine and taking all possible masking and other precautions. I've also lost a brother-in-law physician who served Medi-Cal patients to COVID-19 in July, 2020 before the vaccines were developed and released to the public.

In addition, the latest variant, XXB 1.5 "Kraken" sub variant, is the most transmissible and immune evasive so far. It has spread like wildfire throughout the northeastern U.S. and is rapidly picking up infection speed in the Midwest. It is only a matter of time before it does the same in the West and here in California. Do you want to risk a massive influx of persons back into hospitals and, thus, threaten to break and crash California's hospital and public health system by prematurely ending the COVID-19 State of Emergency on February 28? That is the major risk you take if you stick to your present plan.

If you go ahead with this present plan, a significant number of senior citizen persons throughout the state who enjoy voluntarily serving on various statutory county boards and commissions, such as yours truly, will have to seriously consider stepping down in order to safely preserve their health. This is because AB 2449 mandates a return to meetings in a specified physical location when you end the COVID-19 State of Emergency. Do you want to spark a "brain drain" of talented public involvement on state and county statutory boards and commissions?

Because of these very legitimate concerns, I strongly request that you delay ending the COVID-19 State of Emergency until at least July 1, 2023. Thank you for listening and agreeing with this request.

Sincerely,

Douglas W. Dunn, MBA, LE
Vice Chair, Contra Costa Mental Health Commission
Chair, Mental Health Commission Finance Committee
Member, county MHSA Advisory Workgroup
Member, NAMI Contra Costa

January 23, 2023

TO: Jason Elliott, MPP
Deputy Chief of Staff to Governor Newsom
State Capitol, Sacramento, CA 95814
e-mail: Jason.elliott@gov.ca.gov

RE: Delay Canceling the COVID-19 State of Emergency until at least July 1, 2023

Dear Mr. Elliott:

As a senior citizen and parent of a severely mentally ill loved one, I contracted COVID-19 this past December despite being fully vaccinated with latest bivalent vaccine despite taking all possible masking and other precautions. I've also lost a brother-in-law physician who served Medi-Cal patients to COVID-19 in July, 2020 before the vaccines were developed and released to the public.

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Sincerely,

Douglas Dunn, MBA, LE
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Chair, Mental Health Commission Finance Committee
Member, county MHSA Advisory Workgroup
Member, NAMI Contra Costa