JUSTICE SYSTEMS COMMITTEE
MEETING MINUTES
February 23, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:34 pm Members Present: Chair - Cmsr. Geri Stern, District I Cmsr. John Kincaid, District II Cmsr. Kira Monterrey, District III Members Absent: Cmsr. Gina Swirsding, District I Other Attendees: Cmsr. Barbara Serwin, District II Cmsr. Graham Wiseman, District II Linda Arzio, Program Manager, Contra Costa Public Guardian Conservatorship Office Angela Beck Jennifer Bruggeman Rebekah Cooke Teresa Pasquini Christie Pierce Jill Ray, Supv. Candace Andersen's Office Stephanie Regular, Public Defender's Office Lauren Rettagliata Kristine Suchan	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Teresa Pasquini) Housing that Heals paper and research. Lauren Rettagliata and I joined with 16 other stakeholders on a push to support the Governor's $750 million infrastructure budget proposal for behavioral health. There is a new coalition that has been formed. We have been invited to join and have signed a letter and tracking through the legislature. We have invited to several different National Alliance for the Mentally Ill (NAMI) affiliates to share. Tomorrow we will be presenting to the leadership symposium of all NAMI California affiliates. We are spreading the message. • (Cmsr. Geri Stern) Does that $750 million include construction for long-term mental health care? (T. Pasquini) It is not for locked Institution for Mental Diseases (IMDs). I will send some literature to share with the commission and I'm sure Suzanne will share at the next meeting. It is a good faith commitment to show Centers for Medicare and Medicaid Services (CMS) that California is interested in building up our behavioral health infrastructure and is a show of good faith that, in order to apply for the IMD waiver the commission and all of us have been lobbying and advocating for the last two years.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Geri Stern) Data Collection: I had invited Megan Della Selva to speak regarding who is being treated in the jails. Sent a spreadsheet and requested she ask David Seidner and Jessica Hamilton if they would be willing to collect some data for us on numbers of people coming into the jail system monthly with behavioral health issues and the diagnosis category for each, as well as if they are conserved. I wanted to start collecting this data to get an overall	

picture of outpatient vs jail treatment. Who is being treated in the jails, numbers and outcomes?

- (Cmsr. John Kincaid) Article in Danville/San Ramon news, written by Julia Bond with the Pleasanton Weekly regarding the Miles Hall Lifeline Act. Requiring 911 calls reporting a mental health crisis to be transferred to 988. 988 is a new national suicide prevention and mental health crisis hotline. In California, it is named for Miles Hall and is an alternative police response to crisis involving mental health. It is sponsored by our local Assemblywoman Rebecca Bauer-Kahan with a number of other legislators, has a lot of support in the legislature and looks as though it will pass. Will forward to distribute. (Cmsr. G. Stern) Does that take the place of 211 or how does it integrate with 211? (Cmsr. J. Kincaid) 988 is a national mandate and it is nice to see a federal push in this direction. It will not replace 211. Eventually, this will be like calling 911 for police, this will be 988 for mental health assistance. It is a national service.
- (Cmsr. Graham Wiseman) The American Foundation for Suicide Prevention has been working on 988 for about six years. It will eventually replace 211. The issue was getting 988 number agreed upon by all carriers so that it would work. There has been a lot of work that has gone into this and really glad that California is signing on to the effort. The goal is to have it as a resource. A big part of the reason for it is, if you call 211 in Contra Costa, it gets answered at the crisis center. You call 211 in Alameda; you go into a queue and are lined up with everyone else that needs food stamps or housing. It illustrates the different responses by county and this will level the playing field nationally. Believe it goes live July 2022.
- (Cmsr. Geri Stern) One of the challenges with 211 is not enough public awareness to call 211. Do you know of media promotions to go into effect so that people are made aware of 988, rather than just word of mouth? We need a push on a national level for everyone to be aware of it. Are you aware of anything like that? (Cmsr. G Wiseman) because it is a federal program, Substance Abuse and Mental Health Services Administration (SAMHSA) is involved in it. That is where I'd expect the message to come from to push out nationwide.
- (Cmsr. Barbara Serwin) This would be of great interest to the Crisis Intervention project that is going on countywide right now. They may or may not be familiar with this. One of the goals is to consolidate onto a single number. It would be great if you could forward to Duffy Newman, or you could send to me and I will forward to Buffy Newman.
- (Cmsr. Graham Wiseman) SB21, mental health awareness license plate sponsored by Senator Glazer. The purpose of this license plate is, not only to reduce stigma and raise awareness of mental health, but also to raise funds for the California Department of Education to provide wellness centers and mental health support for our kids. It comes up for review before the transportation committee on March 17th. Letters of support can be accepted through March 10th. It needs to go through the Senate first. Once the bill has been approved, then the real work starts. We have to presell 7500 license plates with only private funding to support the advertising. DMV doesn't participate in that. We have 12 months to accomplish that goal. Once we reach that goal, then it becomes law and actual license plate orders can be fulfilled and they will start making them.

IV. APPROVE minutes from the January 21, 2021 Justice Systems Committee meeting

Cmsr. J. Kincaid requested changes to identify names for each comment. Jill Ray requests Supervisor Candace Andersen's name correction. With those changes, Cmsr. J. Kincaid moved to approve the minutes as revised. Seconded by G. Stern.
Vote: 3-0-0
Ayes: G. Stern (Chair), J. Kincaid, K. Monterrey
Abstain: 0

v. **DISCUSSION of Conservatorships. Linda Arzio, Program Manager, Conservatorship Public Guardian Office, Behavioral Health Systems**

Linda Arzio has been the program manager for the Conservatorship/Public Guardian office for five years and has worked with the severely mentally ill population for 25 years. It has been her main life's work. She has worked for the county 21 years this July and has worked in Conservatorship since 2006, starting as a deputy conservator for the first six years and became a supervisor and then manager. She has expertise in both working with the mentally ill and the conservatorship side.

(Linda Arzio) I was invited today to mainly speak on what is missing in the system to be fully functional. I am going to speak from the perspective of what it was like from when I first joined the conservatorship office compared to now, a span 15 years. There has been a lot of change in the entire Mental Health System over the last 25+ years. I have seen a drastic change in conservatorship over the five or six years (and not positive change). I'd like to start with my observations of what needs to change within the system for it to become functional again.

There are two types of conservatorships:

- Probate conservatorships for people who lack capacity due to neuro-cognitive impairment. Mainly those with dementia, head injuries, strokes and unable to function after. Approximately 1/3 of our clients are probate conservatees.
- LPS conservatorships are people with severe mental illness who are gravely disable as a result. Approximately 2/3 of our clients are LPS conservatees.

Although, we get referrals from anyone for probate, there are two main sources of referrals for LPS. Acute psychiatric units in our county - 4C or the Pavilion at John Muir, but receive referrals from any acute facility as long as they are a resident of our county. So, if a resident of our county needs conservatorship and show up in a hospital in Southern California, the referral comes to us. We conserve everybody. Although our mental health system serves people who are primarily MediCal recipients, our office conserves anyone that needs conservatorship. Regardless of if they have VA Benefits, private insurance, MediCal, MediCare or are completely uninsured. What our office performs is a legal function and, although we do some billing, it is not dependent on being able to bill.

The other source of referrals is from the criminal court. Eight years ago, when I first became part of management in this office, we were receiving approximately three (maximum) referrals from the criminal court a year. That has blossomed to approximately 26 in the last fiscal year. There are many reasons for this. In general, it's part of the general move towards getting mentally ill people out of the criminal justice system and getting them into the mental health system where they can have treatment. Some is a result of laws that have changed. Prior to two years ago, the only way the criminal court refer someone to conservatorship would be after they were being relieved form a 1370. A mentally ill person who has committed a crime and found to be incompetent to stand trial, they are then sent for competency training. This can be outpatient, (some counties) it can be in the local jail, many are in the state hospital. If, and when, whoever is training, finds them to be "unrestorable" (unable to restore this person to competency), it is recommended they be referred to conservatorship. That used to be the only way the criminal court could refer clients to the conservatorship office. There are new

laws that allow most all judges to refer someone for conservatorship. Thus far, we have only received referrals from the criminal court; however, the requirements to refer are a lot looser. We have gone from two to three a year to 26 a year.

This is an example of how our system is not working well: We will get a conservatorship on someone that is referred by the court. Sometimes they are still in the state hospital, sometimes in the jail. There comes a point where the criminal court judge puts them on conservatorship. They do not want to hold them in jail any longer and release them from jail. They are sent to PES on a 4011.6, basically a 5150 enacted by the judge. Unfortunately, when they are in PES, there are a whole other set of rules that become the deciding factor if they need to be in the hospital and then released or sent to a lower level of care that what was already determined for them to meet. We, in turn, advocate very strongly and insist, showing the judge has already agreed they need a mental health rehabilitation facility (MHRC). PES, in turn, states they do not feel the person meets the criteria to be in the hospital. The patient, in some cases, end up on the street. In other cases, they are sent to Crisis Residential. These are all scenarios that have actually happened. Some have ended up going to their family, in one case they were sent to a family member who had a restraining order against them. Then it becomes quite a struggle for us to get them back in the hospital because PES has already determined they do not need to be there. Some clients were released months ago and still are not in an MHRC. These are just some examples. Then we have people getting released from jail, pretty often and it comes up quite a bit. The hospital is not happy about it and somewhat take it out on us.

Going back to when the LPS statute was developed when the state hospitals were being shut down, it states the conservatorship program is being developed to take care of the gravely disabled. We are supposed to be independent, which means we make an independent decision regarding a patient's qualifications and regarding the level of care they need. However, at times we will have those that try 'meddle' and tell us not to conserve this person or that person or change their level of care. I have to continually remind people of the statutes, that our program was created to be independent in that sense. Our whole job is to protect the gravely disabled people. It is clear in the statute "develop a conservatorship program to take care of the gravely disabled people". Then one or two sections down, in the mental health department will use all its resources to provide care and treatment for those people. I know there is a lot of back and forth upset and anger that is very justifiable regarding how the state mandates this, but really hasn't allocated enough funding to actually accomplish this. The law is still stated that way and for us, it is very clear that when we have determined someone needs conservatorship; the resources should be given to that person and not just to place them anywhere, but to provide actual treatment for them.

I am aware the commission is planning on touring some of the MHRC facilities; although they are not perfect, they are the best we have. Some are very good, some do not like the state hospital(s) but Napa has some of the best treatment. Occasionally we have people in Metro and they do a very good job, as well. That aside, it is the best treatment we have for our most difficult clients who are suffering the most. There are some that will never be able to live outside a locked facility. We have quite a few of those clients. There are people who are just so gravely ill, that no matter what medication or treatment, they are unable to function in the community. Plenty of our clients can and do get better. They do not get better if they continue to cycle in and out of PES, the hospital, crisis residential and continually bomb out of BACs because they are not well enough to be at that level of care. Example: Someone released from jail, it was decided he needed an MHRC, he was released 7 months ago and still has not made it to an MHRC but has been kicked out of his mother's house twice, bombed out of two crisis residentials and was sent to a BAC, even after the conservator insisted 'can we now finally place him in an MHRC?' What happens as a result of this type of

situation, you have a someone with this horrible track record of having been evicted from so many different places become really difficult to place. If you don't give them a period time in an MHRC where they can prove, it is in their records to show, this is someone who is doing well and then might be able to be accepted by one of our supervised BACs, which most are very good. I was glad to hear we may be able to get more BACs.

There is always a lot of philosophizing regarding what kind of systems we should have in place to take care of those with mental illness. I am not one to philosophize, I am a realist and steeped in working with the most difficult mentally ill in our community. Those are the ones that end up on conservatorship and some are worse than others. The reality is we need more of every resource. Part of the reason we were caught in such a bad way with the pandemic is there has been a deficit prior to the pandemic. We did not have access enough MHRC beds, or other resources. The state really needs to take action regarding the state hospital system because it takes way too long to get those in need into the state hospital. These are people that are so severe, the MHRCs cannot take care of them; nor manage them and protect their other residents at the same time. There is a failure on the part of the state to provide enough state hospital beds. Our county needs access to more MHRC beds, our budget is not big enough. We have been told the budget is limited for years. This is how much BHS is receiving and if you run out, you are not getting any more. We are being told this. We just don't have enough BACs.

At least twice in the last three weeks, either the hospital or one of the crisis residential programs has insisted they are going to send one of our conservatees to the shelter. These are people, that by court order, do not have the right to consent or refuse their psychiatric medications. So, if they are being sent to a shelter that does not manage medication; either it is without their medication or the medications are being given to them when they don't have the right to have them in their hands. There is very poor supervision of medication administration in shelters. If someone chooses not to take their medication, the shelters have no authority to insist these conservatees take their medication. This is about as far as you can come from treatment that is the intent of the statute you can get, other than just putting someone on the street. This is not the intent of conservatorship. These are people that are already conserved. Luckily, in both cases, we were able to fight it and prevent it from happening. However, in both cases, these are people that are in need of an MHRC and neither case were we able to get them in an MHRC.

MHRC's are not perfect, but what they accomplish is very important. When you have someone, whether a short- or long-period of time, has not taken their medication, it isn't just that they are conserved and lost that legal right to choose, they have lost the mental capacity to choose what is good for themselves. The only way to get them back to the point where they can have some insight into what is best for themselves, is often just putting them behind a locked door where they can't escape, have no ability to access street drugs and there are those supervising to ensure they get their medication; then they have a chance. For the most part, even some of our 'not-so-great' MHRCs still provide a great deal of benefit and are very necessary for our conservatees to get better. It was great when we reopened 4D. It was very necessary. However, we need more MHRCs and it is not clear if having more funding would help, as there might not be enough openings. We may need to have our own MHRC. We may have to create a new one. We may have to get someone to contract and open an MHRC in our county. That would be very helpful for those coming out of the jail and really help the log jam on 4D/4C, where they are basically wanting to discharge people to lower levels of care because 'there are six other people who are so much worse'. Just because there are six other people who are 'so much worse' does not mean that one person doesn't also need that care. That is the kind of triage that is starting now. We need more MHRC beds, more BAC beds. The more you have places with structure and enough

that have locked doors, the more you are not only going to bring fluidity back into the jammed system; we are actually provide the type of treatment severely gravely disabled people need. Someone who is barely functioning cannot be expected to be successful when they are being put straight into a community placement when they are barely able to know they shouldn't just walk away or just go down the street to buy drugs, or walk home to a house where there is a restraining order against them. It is not fair to the client or their family. We need more of every resource.

I was also asked to speak on the difficulty of getting people conserved. Anyone can call the main number (925) 335-3900 and speak to the Officer of the Day. Parents of mentally ill adult children call frequently, trying to navigate and find out how to get their mentally ill adult child conserved. We take those calls; they are regular officer of the day calls. Anyone really involved with NAMI, understands to keep history (and if you have not, writing one up). Keeping a history, having a direct conversation with the doctor treating the individual is always really helpful.

The other piece that has happened is the fragmenting of our PES. Approximately a year and a half ago, one of my staff had to go on leave, had a client in (Hope House) and I promised I would make sure she would get into the hospital if needed and would get her referred to an MHRC, as she'd already been to PES three times in one month. I received a call from Hope House and had to detain her, send her to PES for the fourth time in one month. All four times were from crisis residential. I am unable to share much due to confidentiality. There were some pretty severe symptoms, not a danger to self or others, but definitely of grave disability. I spoke directly to the psychiatrist on PES, just to ensure he knew everything this client was exhibiting, how many time she had been sent to PES in a months' time. He told me she is not gravely disabled. I disagreed and shared why. Well come down, let's interview her together and I went down the next day. That morning there were close to 40 people on PES, there were people on cots all over the place. I met with the client with the doctor. She was talking to herself quite a bit, she was delusional and it was very clear. After she left the room, the doctor turned to me and stated "See? She's not gravely disabled." I looked at him and asked if that wasn't gravely disabled, tell me what is. He stated, 'our system is broken'. This means, to me, because they are so over-crowded and not enough beds, they have raised their bar so high it is ridiculous. This is why no one can get conserved. The only way you can get conserved is by getting into the acute unite or coming through the court. I don't know if that is the reason, we are getting so many more referrals from the court. Logic dictates that if they are not getting conserved because they are getting put on 4C from the hospital, maybe they are out in the community very psychotic and committing crimes. That is not factual, it is just observation. Luckily, I successfully advocated to get that individual on 4C and referred to an MHRC. By the time she got to 4C, they admitted 'of course she is gravely disabled'.

I believe 4C and 4D, they may be raising their bar too; not due to overcrowding, but because there is such a log jam to get people into long-term facilities. It is my observation and I believe that is happening everywhere, not just in our county. There is no diagnosing or finding clients gravely ill any longer, they just want to get them out as quickly as possible.

Questions and Comments:

- (Cmsr. Geri Stern) Linda, thank you. That confirms what our investigations have been discovering and it is very unsettling and tragic, unfortunately. It seems this is a criminal result of lack of funding for long-term care and a misunderstanding on the part of, possibly the state government. Long-term care is not locking people up and throwing away the key. It is a necessary part of behavioral health and the funding. The MHSA does not have funding for long-term care, it has funding for all kinds of community-based care, crisis intervention and preventative care. It's, as if, long-term care is so taboo,

people can't say the words without having their hair on fire. How are we going to treat these people after they have been conserved without options? It does seem like PES is broken because they haven't been given any place to put people. (L. Arzio) They have way too many people coming in and need to be expanded, or we need another PES. If the county decided to use Doctors Hospital, could put in a free-standing psych emergency room and an MHRC. (Cmsr. G. Stern) We spoke on this. I sent a long letter to John Gioia with no response from him. I did also speak to the building department in Pinole. There are two problems, funding and the neighborhood. People do not want psych facilities in that residential neighborhood. Aside from that, there are areas that are able to take care of people; like the California Psychiatric Transitions in Delhi, which is considered a remarkable facility. However, it is private and costs approximately $300k per patient per year (?) for treatment. These are very expensive alternatives. (L. Arzio) The County actually has a contract with CPT and some clients are there. (Cmsr. G. Stern) There are a lot of people that need to go there. It is just not realistic considering the cost and where the money has to come from. We don't have the money, there are people holding the purse strings very tightly for the available bed. The money needs to come from somewhere, someone needs to be advocating to get it added to the budget. We have a state-mandated conservatorship department that isn't funded.

- (Teresa Pasquini). Thank you, Linda, I appreciate everything you were saying, and I can attest. Conservatorships are the safety net for the most vulnerable people. One should not have to enter through the jail and not have to enter through failing over and over and over again. Housing that Heals covers the entire presentation and deals with the 'human log jam' and talks about the needs, the fiscal disparities and discrimination from the federal, state and local perspective and addresses solutions. I appreciate the committee really delving into this and hope there will be more research. I do not come from a blame and shame position, but partnering with the hospital and coming up with solutions. I worry about the clients, the morale of the conservators in our county. We don't know what is going on and it is why we are asking for more public sharing to learn and make improvements. The status quo isn't working for anyone. We have too many sick people that need help. I say yes to an MHRC in CC, we need a full-continuum. I would like to see my son come home to CCC before I die, as he's been in 8 facilities and they are fine facilities but he deserves to come home. We don't have that continuum here, in my opinion. Have there been organizational changes within the department? I did a search looking for the website of the public guardian and it pops up on the District Attorney's page now and, I think, the superior court. You used to have your own website. There is no information that is available; what a family member can do. (L. Arzio) We do have our own website, but unless you know the exact URL. (Jill Ray) I just googled "Contra Costa County Conservatorship and it pops up (https://www.contracosta.ca.gov/916/Public-Guardians-Office) overview with the information. (L. Arzio) We just created our own website, just before Dr. Walker stepped down from the position (four or five years ago). I will email to Angela to forward. (T. Pasquini) I am more concerned with the community needing this information. I get a lot of calls regarding conservatorship. I would like to have this to share. Thank you.
- (Lauren Rettagliata) Thank you, Linda. At times, I thought you might be directly quoting our Housing that Heals paper. There were complete paragraphs. When the conservator states that their conservatee needs a certain placement, Is that documented and put in record for Behavioral Health Administration and the Doctors to see? So that it is available for the treating arms to see this recommendation wasn't followed? Who do you actually interface with? Who do you actually work with, within Behavioral Health, your contact that would hear this person is being sent someplace where we, who directly know them

very well, say not a good idea? (L. Arzio). To address your second question first. Until February 28th, I report directly to the Adult and Older Adult Mental Health Chief. Starting March 1st, I will start reporting to the Deputy Director, Mathew Luu. This is a change that was ordered by Dr. Suzanne Tavano. They are just doing a lot of reorganization. I do not know why the change was made. I am sure it will have its pros and cons.

To answer your first question, it is very important but a little complicated so bear with me. In the statute (and it IS in the statute) that the conservator determines the level of care needed. However, it has to be approved of by the superior court judge. It can be contested by the client and their public defender, but ultimately, the judge decides. Those court referrals are really the best examples because this is where this has gone wrong so many times, but it should help understand how our system works. So, we have someone in the jail, they were referred to us by the criminal court judge. We go do an evaluation, review records, interview the client, family members and those who have worked with that client before. The deputy conservator performing the investigation writes a report and, as part of their report, they give a recommendation for the level of care/kind of treatment the person needs. A copy of that goes to the criminal court, but it goes before the LPS/probate judge. That is where it can be contested. If it is not contested and the judge agrees with it, where that goes is within the court order for that individual client. It will say right there what level of care they need. I'm speaking of people that have already been in adjudicated that need MHRC by the LPS/probate court, it is in their court order and they can't even get into PES. Even when they do end up in PES on 4C, the reason for that is twofold. The hospital, if they are not thinking in terms of being a part of a system, just thinking of themselves in a silo, as being a hospital, they are just strictly looking at whether this person meets the criteria to be in their hospital or not. There were days when the opinion of the conservator meant something. It is a legal determination. It is not just our individual opinions; it is in a court order. The hospital would take that into consideration. As a deputy conservator, I would get calls from Psych Emergency all the time, "Your client, so and so, is here. What would you like us to do with them?" That does not happen anymore. It is the other way around. They tell us. Yes, it is in that court order and Yes, we give it to the doctors and they don't care, is what I am telling you. The other part of that, in terms of me reporting to Behavioral Health, which is obviously separate from the system; I am the liaison and they have a transition team. I know because, before I came to work here all those years ago, I used to be the hospital and community liaison. I was the person who would go an evaluate the people the hospital wanted to send to locked facilities. There people who do their own separate evaluations. Sometimes they disagree with us and we will state we have a court order. They will say "we think they don't need it" They pay for the placement, we don't. It is not really too far from how it has been. The difference now is that the insurance company has a lot more muscle than it used to have. They do not have access to as many placements as they used to have. We used to have lots of BACs when I first came to work in this system. 60 days to get into a state hospital was a long time to wait. Now we have people waiting for two years to get into the state hospital. It is not just our county. I have talked to people in LA, they have people waiting for three years to get into the state hospital. This is the reality of what happens, even with the court order.

- (Lauren Rettagliata) It sounds as if the Doctors in the inpatient unit can defy the court order and do what they want. The other question I have, in the continuum of care, say we have someone in the highest level of placement in our county in the community (outpatient treatment). The assisted outpatient treatment has done everything by the book, and have been there (out 200 times to try making contact with this person). This person is not complying at

all, won't open their door, not appearing at AOT court, not doing anything they should do. The AOT judge should have a rung on the ladder where he can say, this person, in my opinion needs to be conserved. They are not complying with what they agreed in the community and are in grave danger themselves of either taking their own life or harming someone else. There is no other place for them but the street. It seems as if our system a broken because there really isn't a continuum of care. There are missing steps at the inpatient unit, back into a long-term intensive treatment. We are missing steps in our community that would allow them into an MHRC and be conserved; hopefully not forever. This would mean conservatorships could be limited to a year or two, maybe in some cases, six months; depending how your conservator evaluates a person. That is probably one of the best forms of understanding how a person who is intensely mentally ill is doing. (L. Arzio) LPS Conservatorships are already limited to a year, so LPS conserved clients have a high level of legal recourse. We need to renew an LPS conservatorship annually. Every year the client has the opportunity to contest, in court, their conservatorship. In addition, they have opportunities during the year to contest it, but they get at least one jury trial if they want in the year. It doesn't mean we don't evaluate on an ongoing basis; we do. We have to renew and there are certain requirements. We have to get two doctors to sign declarations stating this person still meets the criteria for being gravely disabled.

- (Cmsr. Geri Stern) It is clear the process to get conserved is onerous. Once someone is conserved it is extremely challenging to get placement. Two very difficult aspects to the conservatorship process. I don't hear anyone mention how to get these concerns to people in positions of power who are able to change the budget. Has anyone done so? (L. Arzio) Mathew Luu is going to be my new boss, this is something I can ask him about. He's actually been instrumental in helping us get some kind of specialty care for some of our probate clients paid for. However, you're talking about something that is really big, it would probably take the head of the hospital, behavioral health and all the main departments within the medical and mental health system coming forward to the Board of Supervisors or our Chief Financial Officer and saying "Look, We need this. If you can pay for a new administration building, you can pay for making sure the residence of our community are getting their needs met." Clearly there are a lot more people trying to exist. (Cmsr. G. Stern) It is going to get worse once COVID is lifted. We as the Mental Health Commission, part of our mission is to make these issues known to the legislature. It is what we are discovering, it is our mission and we need to move in that direction. Just complaining is not going to solve the issue. (L. Arzio) I will team up to make a case for what we need. I need permission from my boss, but I mean that. It is just two more years before I retire and I would love to see this office not fall apart. I want to see it do better. I would like to see these issues resolved before I retire.
- (Kristine Suchan) Linda, first, I would like to tell you how informative this was today. I really appreciate it and it was really helpful to hear. I would like your contact information. No disrespect, but as you are speaking of the judge and the doctors making the decision, it makes me wonder, exactly what authority the conservators do have. It is concerning to me. (L. Arzio) It has always been with the judge. What gives us our authority is the court order, signed by a judge. That is not new. (K. Suchan) In terms of placement? (L. Arzio) It starts with our recommendations. A judge is not going suggest that immediately. Sometimes they will at a hearing. If the client asks for a placement hearing, the judge will say this person does not really meet the criteria for a locked facility and will actually order our office to step them down. However, if we are unsuccessful, we refer them to five different BACs and all turn him down, we can go back to the judge and say, we tried and this is why they were denied

and the judge will accept that. That gives them the evidence that the person does need it. What is tricky: the doctors in the hospital, their legal criteria they are looking at is: Does this person meet the acuity to be this level of care? They really should consider that the client has already been determined to be gravely disabled. In my whole career, hospitals have never been good at determining grave disability. What they are looking at is danger to themselves and others, which is a lot easier to meet MediCal billing criteria. The MediCal rules have gotten stricter. Also, our county has pressed that everyone follows the MediCal rules because they don't want to lose money. They have lost a lot of money because they weren't meeting this criteria and the hospital did really well at the last MediCal review and they want to keep that going. It means we will continue to have a psych unit the county hospital. The conservatorship office lost its clout and not quite sure how to get it back. We should have clout, not just for the sake of it, but because our job is to protect and advocate for the most vulnerable of our population. • (Christy Pierce) Wonder if it would be worthwhile (I did LPS for years), San Francisco did get their own MHRC and I believe it's with Crestwood. I just have always thought it would be useful and worthwhile. If there is a workgroup or committee or something, I would be happy to help work on that. I think it helps all our clients. (L. Arzio) That would be so awesome. It has been worked on before. When Pleasant Hill first opened up, part of it was an MHRC and then they closed it and turned the whole thing into a BAC, not sure why. There are a lot of people that think we should have one, but there has to be enough motivation for the county to put money into it. (C. Pierce) The information the Justice System Committee wants to get from the jail regarding how many people go into the jail and are treated for which major mental illness. Also, if you can look at how many people get released from the jail straight on a 5150 to PES; I think you can make the link, in terms of the cost to the county. When clients are going through PES and getting conserved or getting the proper treatment; I can say (anecdotally) a lot are ending up in custody. So, the county is paying for them one way or another. Just to make that monetary link might help. (Cmsr. G. Stern) Yes, that was the reason for collecting the data. It is the same link we need to make to determine why we shouldn't spend more money for schools instead of bringing all those computers into the jail and teaching them while in jail. But nobody wants to take on. Thank you all for a wonderful participatory meeting. It is a long-term issue that will take a lot of effort and seems like we have a core group of people really interested it. Thank you all for hanging in there.	
VI. Adjourned at 3:04 pm	