JUSTICE SYSTEMS COMMITTEE
MEETING MINUTES
March 23, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:33 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 Angela Beck Jennifer Bruggeman Jan Cobaleda-Kegler Rebekah Cooke Teresa Pasquini Jill Ray, Supv. Andersen's Office Stephanie Regular, Public Defender's Office Lauren Rettagliata Kristine Suchan	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Lauren Rettagliata) Two items: First, Teresa (Pasquini) was on a call this morning with the Francis Greenburger Center that deals with Criminal Justice and the severe mental illness and the decriminalization of mental illness throughout the United States. This was attended by quite a few people (close to 100 people across the US, leadership). I wanted to thank Teresa. I was only able to listen to parts, but it was amazing. Second item, on a sadder note. John Kincaid and I are both residence of Danville. We had the shooting of the young man that was homeless and living in the Park'n'Ride for a number of weeks prior to the killing. He was visited on more than one occasion by crisis mental health were attempting to help this person. However, he was still staying on the bus stops. This was the second police involved death of a person with severe mental illness. We REALLY need to have better crisis intervention training (CIT), especially for our police officers out in these suburban areas. It is not just the inner city. The sad thing, my own son (just two or three weeks before) had pulled a knife on someone in Martinez. My son of privilege is a large man, but the Martinez police deal with this issue much more on a daily basis, those with mental illness living on the streets. These officers knew to take him to psych emergency services (PES). He is now back to his residence/program. But, what about this poor man in Danville? And his family? These are questions we should ask as a mental health commission (MHC): What are the parameters that our crisis mobile unit can work within? When can they really get all the resources of the community to get someone into treatment? Where this man's parents informed when the crisis mobile unit contacted him? Can they be informed? How do we change laws so they can be informed, that these agencies are trying to reach out to their adult child / loved one? People that know the family, they are distraught and did not want their son to die on	

the street. When you read the comments on the 'Next Door' app, it is a real dichotomy; half feel it is very sad and the other half state "I'm really glad that he is off the street/glad the police killed him." The other half of the community responds "Don't you get it? He was severely mentally ill." Thank you for letting me comment. It breaks my heart that we now have a second death in Danville.

- (Cmsr. Stern) Thank you Lauren. We had the Sheriff's Department out early last year, speaking on CIT and asked them from many different directions "do you think that your officers are getting enough training?" They were quite adamant they get sufficient training. Then these incidents are happening repeatedly, I do not know what the recourse is. If they are not actually achieving the goals and better outcomes. If people keep getting killed, that's not enough training. Barbara, do we have enough power as a commission to call the Sheriff's department and…?
- (Cmsr. Serwin) The ongoing Crisis Intervention (CI) Rapid Improvement Events (RIE), is squarely taking on these issues: How law enforcement is interacting with the mobile response team and how people are encountered by the mobile response team are passing these people along, either through recommended treatment or de-escalating, etc. This is a good point of input into the law enforcement piece of it. The RIE is happening next week and I am very involved with the triage and assessment piece (the upfront piece) where dispatch takes the call and triage goes to local law enforcement or for further assessment to determine if it is a mental health issue and what actions are to be taken by which agency. I can certainly, absolutely send on the Lauren's comments to include in the CI training in general. There are certainly different models out there to overhaul the law enforcement agencies culture, overall directives and hands on training follow up team in place. What was the other issue, Lauren?
- (Lauren Rettagliata) How do families find out the mobile crisis unit is interacting with their loved one? They may be able to help out, but they need to know what is happening to do so. It just doesn't seem to be any communication. Does HIPAA prevent it? Are there work arounds?
- (Cmsr. John Kincaid) The officer, a Sheriff's Deputy--Danville's police services are contracted with the county, this is the same deputy that was the shooter in both instances. This was half a block from Supervisor Andersen's office (the first shooting) and the other one right over 680 near a shopping area. The fact that it is the same deputy and they are supposedly those receiving the best training is 'interesting'. (Cmsr. Stern) someone needs to bring this up next week, as it is really not acceptable.
- (Rebeka Cooke) First, there are not that many sheriff's in that department, so it isn't that unlikely it is the same deputy. My experience with the Danville Police Department – My daughter (with her grave MH illness), knocking on doors at two o'clock in the morning and a neighbor has all this film of her, she could have been shot and this is after all the history Danville Police/Sheriff's department (Officerr Smith) were there and met with her at four in the morning. Did you not find that gravely disabled? I was told 'No, she was presenting herself well.' She was knocking on doors in the middle of the night, with her history; there has got to be some definitions that clarifies 'gravely disabled' and all these individuals have same type of history. I am failing to understand how they cannot find them to be gravely disabled.
- (Cmsr. Stern) Yes, it seems that when these episodes happen, we should have a follow up meeting with the sheriff's department to reconvene and review the process so we get an idea of the sequences of events happened to get redirection moving forward. Do they have follow up? Do they think they are doing a good job and think there is nothing wrong? We do not know what they

do. There is not effective communication between the Police and sheriff's departments and contributing to more bad outcomes. • (Teresa Pasquini) I have a lot of trust in the RIE/Value stream mapping events and I do trust that process; however, I have to say that this four deaths in one county in a couple of years is outrageous and four men of color; two in the same city? I am not here to blame and shame law enforcement. It is a societal problem that we dumped onto law enforcement and corrections staff and they are not trained to deal with these illnesses. We have participated in several CITs and they are very well done but Contra Costa County (CCC) only funds them $15,000 to fund them and it is not enough. It is voluntary. It is luck and heroics whether you get a CIT officer. I am glad this is part of the RIE process and hope the commission participates in this and brings it back to the community to understand and know the solutions. As a commissioner in 2008 I begged for a psychiatric emergency response team for our county but were told it was too expensive and there were other priorities. I am glad it is being discussed now and urge to look beyond	
III. COMMISSIONERS COMMENTS: None	
IV. APPROVE minutes from the February 23, 2021 Justice Systems Committee meeting Cmsr. J. Kincaid identified two name changes (Assemblywoman Bauer-Kahan and Supervisor Candace Andersen's name correction). With those changes, Cmsr. J. Kincaid moved to approve the minutes as revised. Seconded by K. Monterrey. Vote: 3-0-0 Ayes: G. Stern (Chair), J. Kincaid, K. Monterrey Abstain: 0	**http://cchealth.org/mentalhealth/mhc/agendas-minutes.php**

V. PRESENTATION: Working with Clients in Pretrial Diversion: A Therapist's Perspective, Kira Monterrey, LCSW, MPA, CFTP, Mental Health Commissioner District III, Owner/Therapist, Healthy Minds Counseling Center
I have been working with clients in the court system since 2014 with the Veteran's Administration (VA) as well as in my private practice.
• Pretrial Diversion, a brief overview:
  • California law (penal code 1001.36) allows some defendants to seek mental health treatment in order to postpone further action in their case.
  • Pretrial diversion can be requested at any point prior to the trial/sentencing
  • Participant must consent and be willing to comply with treatment
  • If the participant cannot afford treatment, public funds are available
  • If defendant's participation in treatment is successful, the court will dismiss the charges
  • If diversion is not successful or a new felony or criminal charge occurs that makes them ineligible for diversion, the court can reinstate the charges
• Eligibility:
  • Defendant must have a current diagnosis from the DSM5
  • Not eligible if diagnosed with either of the following disorders: anti-social personality disorder, borderline personality disorder, or pedophilia
  • Both misdemeanor and felony defendants are eligible
  • Must not pose an unreasonable risk to the public
• Therapeutic Process in Pretrial Diversion
  • Participant reaches out to therapist
  • Therapist agrees to take on case
  • Participant consents to treatment
  • Complete psychosocial assessment and diagnosis
	Pretrial Diversion Presentation by Cmsr. Monterrey was shared as a PowerPoint presentation during meeting.

- Collaborate on treatment goals and create treatment plan
- Clinician provides updates to the court/ DA's office, typically the court or DA's office asked the client if they can have their therapist provide an update/summary letter. Release of information must be provided.
- Assessment and evaluation of treatment goals continues throughout treatment
- If treatment is successful, terminate treatment

- Treatment Considerations:
  - Lack of insight or motivation
    - ◊ Not highly motivated
    - ◊ Do not think they need therapy
    - ◊ Lack of insight into their behaviors or their MH diagnosis
    - ◊ Typically, there is a lack of resources or knowledge of their resources available to them.
  - Need to bolster up resources / social support system
    - ◊ Provide information on resources available and encourage seeking help through those resources
    - ◊ Social support system might not be the best influence
    - ◊ Help/encourage to form new social support
    - ◊ With COVID there is an extra layer of difficulty regarding new social support system
  - Non-compliance
    - ◊ Attend treatment but not do the work
  - Avoidance behaviors: missing appointments, not completing homework, discussing non-relevant issues in treatment
- Frequently Used Interventions:
  - Motivational Interviewing
    - ◊ This is the core (most important) approach I use in conjunction with the following therapies.
  - Cognitive Behavioral Therapy
    - ◊ A very good intervention for helping someone change their thoughts, belief patterns and behaviors and developing insight.
  - Acceptance and Commitment Therapy
    - ◊ A third wave of CBT, which explores values and is a very powerful technique. When you can help someone clarify their values and work toward living those out, that is a great tool for behavior change.
  - Dialectical Behavioral Therapy
    - ◊ A good tool for emotional regulation
  - EMDR (Eye Movement Desensitization and Reprocessing)
    - ◊ Interactive psychotherapy technique used to relieve psychological stress. It is an effective treatment for trauma and post-traumatic stress disorder and enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences
    - ◊ A lot of clients I see do have either adverse childhood experiences or trauma that has happened prior, so I will use this trauma processing technique.
  - Cognitive Processing Therapy
    - ◊ Also, a trauma focused technique.
- Motivational Interviewing
  - An evidence-based approach to behavior change
  - A must to use in any court-mandated or court diversion cases
  - Can be used throughout treatment with other interventions
  - Assesses readiness and techniques are designed to increase motivation in treatment
  - Stages of change are fluid
- What is Motivational Interviewing (MI)?

- *"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."* (Miller & Rollnick, 2013, p. 29)
- The most current version of MI is described in detail in Miller and Rollnick (2013) Motivational Interviewing: Helping people to change (3rd edition). Key qualities include:
- MI is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice).
- MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change.
- MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.
- It is important to note that MI requires the clinician to engage with the client as an equal partner and refrain from unsolicited advice, confronting, instructing, directing, or warning. It is not a way to "get people to change" or a set of techniques to impose on the conversation. MI takes time, practice and requires self-awareness and discipline from the clinician. (Miller & Rollnick, 2009)
- https://motivationalinterviewing.org/understanding-motivational-interviewing

- When MI is useful:
  - **Ambivalence is high** and people are stuck in mixed feelings about change
  - **Confidence is low** and people doubt their abilities to change
  - **Desire is low** and people are uncertain about whether they want to make a change
  - **Importance is low** and the benefits of change and disadvantages of the current situation are unclear.
  - https://motivationalinterviewing.org/understanding-motivational-interviewing
- Stages of Change – The first thing I assess when a client comes into therapy. Which stage are they in? This is going to determine which intervention to use:
  - Pre-Contemplation: no intention of changing behavior
  - Contemplation: aware a problem exists but with no commitment to action
  - Preparation: intent on taking action to address the problem
  - Action: active modification of behavior
  - Maintenance: sustained change; new behavior replaces old
  - Relapse: fall back into old patterns of behavior
  - Upward spiral: learn from each relapse
- Communication with the court
  - Usually send a summary of treatment rather than the entire records
  - Components of a summary letter:
    - ◊ Identify Client
    - ◊ Diagnosis and relevant symptoms
    - ◊ Length of treatment
    - ◊ List interventions used
    - ◊ Summary of client's progress in treatment and current level of motivation
    - ◊ Any recommendations

- Case Study:
  - 19 y/o male
  - Facing felony charges for burglary and Larson
    - ◊ In pretrial diversion and was able to continue attending school and work, which are both positive factors

- Dx of post-traumatic stress disorder (PTSD) and major depressive disorder (MDD); as well substance use disorder (SUD)
- Trauma history:
  - ◊ Alcoholism and verbal / physical abuse by father
  - ◊ Witnessed shooting of friend several months prior to burglary / larceny
- Three previous suicide attempts
- Recent breakup
- Client was in the contemplative stage of change (aware, but not energized to make those changes)
- Interventions used:
  - ◊ MI
  - ◊ CBT
  - ◊ ACT
- Plan was to target trauma next with CPT
- Attended treatment approximately six months
- Depression symptoms made progress slow
- Client complied with treatment plan and completed homework
- Changed his social supports (who he was spending time with) they were continuing to get in trouble and decided to create distance and be on a better path
- However, client terminated treatment early after his case was dismissed in court
- Client moved to relapse stage of change and has resumed treatment

- Positive Outcomes of Pretrial Diversion:
  - Clients with mental health disorders who may not have otherwise sought treatment are more likely to seek treatment
  - Possibility of establishing a positive therapeutic alliance, making it more likely they will seek treatment in the future
  - Less costly for public

Questions and Comments:

- (Cmsr. B. Serwin) How do they define successful or unsuccessful treatment? (RESPONSE) In my experience it is mostly based of a therapist recommendation.
- (Cmsr. G. Stern). You stated the client reaches out to the therapist for this pretrial diversion. That would imply they had some insight or motivation, so does that somehow morph or change once they get into therapy? (RESPONSE) Sometimes, their attorney will say, we'll go this route instead and they may be seeking therapy simply because of the pretrial diversion, not necessarily because they think they do some work or may not be insightful as to how their MH Diagnosis is impacting their behaviors or their life or getting them into trouble. Or they may know that and may not want to change. Not always the case, but some cases. (Cmsr. G. Stern) so some people see it as a way of avoiding jail and just decide to try it? (RESPONSE) Correct, some people.
- (Cmsr. Serwin). It seems like there is an ownness on the client to reach out to the therapist to convey an update is needed. What percentage of people actually get through that? Do you feel, overall, most are motivated or able to follow through? (RESPONSE) Staying out of jail or not being convicted is a huge motivator. Most do get through the process; it is just to the degree of how much success they may or may not have. That just depends on the individual client. Then there is the matter of them getting through the process without reoffending or committing another crime (staying out of trouble) as they are doing the work as well. The success rate is actually pretty high.
- (Teresa Pasquini) What is the numbers are (the inmates) are they seriously mentally ill? Are they mild to moderate? Or is it usually misdemeanors you are dealing with? Nonviolent crimes? (RESPONSE) I don't have data, only

speaking from my perspective, not from all. They are not inmates (yet) because they haven't been to trial. You can refer to them as defendants or clients. The clients I work with are pretty high functioning and not typically seriously mentally ill.

- (Cmsr. Stern) How long does the court order for the treatment? Is it different for every individual? Is there a set time limit? How often do you send summary letters? Monthly? (RESPONSE) It varies on the individual. There is not a specific time, it depends on the District Attorney's office (DA) and what they determine. Typically, six months they will request a summary letter; every few months (monthly is very unusual) before a court date.
  (Cmsr. Stern) Do any clients stay in therapy a year? (RESPONSE) Not typically for pretrial diversion, sometimes people come back to treatment after.
  (Cmsr. Stern) The whole time they are in treatment, they are not in jail? (RESPONSE) Correct. They have not been convicted yet. Clients typically would rather be in treatment than be convicted and go to jail.
- (Cmsr. Kincaid) I have a client currently out of MH Diversion and I am required to fill out 'local rule of court forms' for the treatment plan and treatment progress once a month. It is interesting, and it may not be the same program under the same statute, but the MH court has developed these forms. The procedure you are describing is different. (RESPONSE) That is why I was a bit confused. This is pretrial diversion and wondering if MH treatment court is a different program. They may already be convicted and then have to attend treatment after going to court, in lieu of going to jail. Does anyone know the answer to that question? (Cmsr. Kincaid) Post-conviction may be a condition of probation. I don't think he has been convicted. This is a person with a post-traumatic brain injury in a care home. It is just interesting the procedural difference. (Jill Ray) My understanding of MH court is they have been convicted and in lieu of serving a sentence and if they fail, they then go to jail or serve the sentence they were going to serve.
- (Cmsr. Serwin) Are some of these defendants on medication? (How) do you work with the psychiatrist on that? Coordinate? (RESPONSE) Yes, some are. You can't force someone to take medication. This particular client was on medication and working quite well. Upon relapse and return to treatment he had also stopped the medication, so that is another thing to address: The medication was working well, why did you stop? What are the benefits of resuming? In many cases, yes, they are and it is important to coordinate treatment with the psychiatrist.
- (Cmsr. Stern) How often do you get referrals? (RESPONSE) They self-refer, once every couple of months. If they can't afford treatment, they would go through the county's public mental health services.

VI. DISCUSSION of email from Dr. Megan Della Selva, Chief Psychiatrist, Contra Costa County Detention Health Services

(Cmsr Geri Stern) I have invited Dr. Megan Della Selva, Chief Psychiatrist at the West County and Martinez Detention Centers to our meeting for two months and has not been able to attend. Following is a list of questions and her responses. The most disturbing answer I asked was during intake, if the inmate is asked if they are conserved. She stated NO. It seems odd, why would they not ask? Shouldn't the conservator know if their client is taken into custody? Why would they not ask?

- **Mental Health Diagnostic Category information, can we have access to this data?**
  Response: I have looked into the type of data we can pull, but have been informed that while we can obtain general numbers of patients being referred to mental health on a monthly basis, we are not able to sort by specific diagnoses.
- **Initial intake questions: During the intake process, is the inmate asked if they are conserved?**

Response: In terms of the conservatorship issue, this has been a question we have been thinking about, as well. Our current understanding is that it does not translate to the correctional environment, and as far as I know, we do not ask people this question in intake.

Dr. Hamilton requested a formal legal opinion on this matter from county council a couple of months ago, but we have not yet received this. She plans to follow up with them for an update

Questions and Comments:

- (Cmsr. Kincaid) It is a small number of people and they do prescreen for mental health symptoms and treatment. The main focus is identifying people who need care. If they are going be incarcerated, they will be providing the care. You raise an interesting point, I don't know that conservatorship status shows up on a Criminal Identification and Information (CI&I), generally law enforcement only has access to (and the courts). It is a completely different system and does not show up, that would be one solution for it, if the legal status was added by the Department of Justice (DOJ) to a printout like that. (RESPONSE) If someone has been court ordered as gravely disabled and have been assigned a public guardian, that is important information. It is a judicial order and should be within the scope of intake questions. (Cmsr. Kincaid) Yes, but it is not criminal. (Cmsr. Stern) It seems like another place for individuals to get lost, not following up on their complete status.
- (Teresa Pasquini) That would be a good question to pose to David Seidner. There was VSM and RIE on the jail intake process and depending on who was on the team whether someone raised that question, whether it was considered. It would be good information. I think it's really important for the MHC to stay on that and get an answer. Part of the intake process is managed by Health Care Services and should be known. It just makes sense and another piece of information that can provide better care, which is supposed to be the intent of the VSM event that took place for the jail and everyone agreed to.
- (Cmsr. Stern) If someone is identified as being conserved, they should have their records brought to the attention of the detention facility psychiatrist, who then would be able to follow up on treatment, who their therapist is, who their public guardian is and didn't seem all that concerned about it. (Teresa Pasquini) Criminal charges trump civil so it is a delicate situation to maneuver, but it is necessary information to help decriminalize mental illness.
- (Cmsr. Stern) The other topic I asked if she could keep data on this, numbers of people that are admitted to the detention facilities who have behavioral health (BH) issues. She stated there approximately 100 per month that have BH issues that are admitted to detention services. I wanted to see if they could break it down by diagnosis and I was told they can't. The reason for my inquiry was so that we could determine, are we missing something? Are these clients that could be treated in the community before they commit crimes? Why do we have to have them go to jail to get treatment? I will try again next month.
- (Kristine Suchan) We have notified the psychiatrist, asked these questions. Is there space or room for her to respond? I hope there is an opportunity to get her in to respond. My guess is they already have the data and could break it down. Why aren't they? Why is that data not being available to the general public or the people advocating for their loved ones? They have the capacity to track, but why are they not? It is a critical piece of someone getting treatment vs getting criminalized and we need to be more demanding with how do we get the status of conservatorship into the assessment process, if it doesn't already exist there? I have a hard time believing they do not know if someone is already conserved. I think there are records and have the ability to find it out, the question is why is it not happening?
- (Cmsr. Kincaid) It is easy to know how many people are under treatment, but the diagnosis breakdown, someone has to physically go into each record and

count. It is used for treatment planning and implementation. If there was an intern or university student looking for credit to come in and do that. Administratively it is not easy to do. (RESPONSE) I was not asking to go back retroactively; I was asking moving forward to track. There is someone who performs intake. (Cmsr. Kincaid) I am just saying that is asking someone doing intake to perform an extra task. It is just not going to happen.

- (Teresa Pasquini) Our county paid a lot of money to install the EPIC system and it is a very extensive IT system and it can be easily access. No one needs to count; they can run a search and get the information. The community needs it to make decisions regarding what we need. We need the information.
- (Jill Ray) The question is why can't they provide the information? Why are you not able to sort by specific diagnosis? Let's figure out what is not working and how we can make that work. Could be very good reasons why it is not going to work (a detention system issue?) (RESPONSE) That is why I want her to come, I think she and David Seidner should come together so we can get full answers.
- (Cmsr. Serwin) I think it is a good time to ask these questions now because if they are instituting this IT System now, this is the time in the process to identify what needs there are/what information needs to be captured as the person moves through the system. If it is captured at the time of diagnosis the information should be entered into the system and that would just be a database query.
- (Cmsr Stern) I am sure there is a good percentage of substance abuse, and a whole range of diagnosis, and we need to know if there is a way to treat these people so they don't end up in jail to begin with.

VII. REVIEW Presentation: Absent Authority-Evaluating California's Conservatorship Continuum, Alex V. Barnard, Department of Sociology, New York University. Where do we go from here?

Most everyone in this meeting attended this presentation and I thought it was a wonderful that he had done all of this research on conservatorships, which (sort of) took the place of a VSM. All the information and data he collected was really tremendous. I question why was he doing research in California from NYU? He identified was what I had a hunch about to begin with and that is there is no one overseeing the whole conservatorship process. There is no one in charge to look at everyone, the whole system. There are some looking at one aspect, others another but no one person in charge.

- (Cmsr. Kincaid) Sometimes this just requires political will. Conservatorship is very important to a small group of people. It just doesn't get a lot of press and attention until something falls apart.
- (Cmsr. Stern) I don't think most people understand that because people are conserved and having issues with long-term treatment. There are so many homeless people: there are those that may be conserved; need to be conserved; don't have a place to go; are not able to get treatment. It is all wrapped up with so many different aspects of mental health and no one has really put it out into the public forum to educate the public about how pervasive an issue this is. Or how people are just falling through the cracks and not getting the treatment they need.
- (Teresa Pasquini) I don't know why he studied California. It might be because he went to school here and was appalled by what he was seeing on our streets. I think he is also a family member and doing comparative research. I think he gave a state an amazing gift of information we have all known about and the gaslighting we have been subjected to for a very long time on how everything was working well and we know better. As far as it being a fall number of people, it might be true; however, it is an important conversation. If it is your loved one, you want that conversation to happen. I appreciated everyone that attended from our county and did just participate in a conversation with Greenberger foundation. On that panel was Ira Burnim from the Bazelon

Center for Mental Health Law, which is one of the leading national groups that opposes any kind of coercive care and treatment and probably one of the reasons our laws are so restrictive, in terms of getting people care involuntarily if medically necessary. It is a conversation that will have to continue. There will definitely be community education taking place. I have just joined the board of a new organization that will be pushing hard on the status quo. There is no justification for the suffering taking place on our streets or jails.

- (Rebekah Cooke) I would just like to add that when you hear it doesn't affect a lot of people. These shootings are affecting all of us. It is easy to sit back when it is not your child and your family is not going through hell. But when you are afraid for your kids to go to school or to the supermarket or anywhere? That is mental illness and that is untreated mental illness.
- (Cmsr. Stern) There is so much untreated mental illness in the community, it is scary. I will say this as a realtor, I meet with clients all the time and would estimate 75% of the time, someone in that family I am dealing with has untreated mental illness. Fortunately for my background I can deal with them. It is hard when they are not in therapy and/or on medication to have to deal with huge financial decisions and very emotional topics (like selling a family home). I see it every day and it is scary.
- (Cmsr. Serwin) It is such a good point Rebekah. Then we have riots and other repercussions through society. There is so much fallout and communities need to be hearing these things.
- (Cmsr. Kincaid) Dr. Barnard earned his PhD in 2019 at UC Berkeley. It may have been part of his doctoral program that initiated that research.
- (Lauren Rettagliata) He is a family member, as well. There is a lot of talk regarding the Lanterman–Petris–Short (LPS) Act in our California legislature about 'is it time to take a deeper look at this'? Does this need to be updated? He saw that California legislators were discussing this without having the research and the material really need to have significant decisions made. So, he was providing our state legislators and those looking into this, (such as behavioral health administrators) with the information and spoke directly to a lot of behavioral health administrators at the top levels in our state. In order to have a clear understanding of just how broken our system is and to have the background information to make educated decisions.
- (Jill Ray) All the legislative work at the State level is great but, as we know, the state is very large. I can tell you that Supervisor Andersen, as a result of a lot of the research I have been doing, it has been going on for quite some time--long before Laura's Law. Then Laura's Law highlighted the issue we have with this population, which is not necessarily conducive Laura's law. What do we do with those people who fail out of Laura's Law? I have been gathering research from a multitude of sources and that presentation was amazing. Supervisor Andersen actually wants to move forward and speak to the different players in our county to determine what can be done to improve. We are in the process of outreach to a variety of personnel in the county that are involved in the system to find out where our system can improve. Our system is not moving in the same direction other counties are, as we have some challenges in some of our systems that other counties don't have. I am investigating why that is and there will be more information coming forward but want you to know Supervisor Andersen considers this one of her priorities right now and is speaking to the new County Administrator about what we can do in our county to make it better.
- (Cmsr. Serwin) It would be great to have an in-progress status report from you, what you do know. What you found to date and where your current focus is moving forward right now, priorities? That would be awesome because I do know you have been doing so much work.
- (Cmsr. Stern) Yes, if we could have a quarterly update on what Supervisor Andersen has discussed with interested parties. (RESPONSE-Jill Ray) I probably

won't be able to give you that information but can tell you what I've done in the last month because I am doing the outreach to the various parties, Supervisor Andersen is just letting our County Administrator know that it is a priority to her so the County Administrator can help support the division and departments that need to address this. I am happy to share moving forward.	
VIII. Adjourned at 3:03 pm	