JUSTICE SYSTEMS COMMITTEE
MEETING MINUTES
May 25, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:35pm Members Present: Chair - Cmsr. Geri Stern, District I Cmsr. John Kincaid, District II Members Absent: Cmsr. Gina Swirsding, District I Presenters: Megan Della Selva, MD. Other Attendees: Cmsr. Alana Russaw, District IV Cmsr. Barbara Serwin, District II Angela Beck Jennifer Bruggeman Teresa Pasquini Pamela Perls Jill Ray, Supv. Andersen's Office Stephanie Regular	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Teresa Pasquini) I want to ensure this committee and commission are aware of the major revised budget changes at the state and the governor's proposal to discontinue the contracts with the counties for state hospital beds to make room for more ISTs (incompetent to stand trial). There is major alarm across the state with families like mine. NAMI California just came out with a strong opposition to this. There is literally no place for these people to go. They want to transfer 800 people out of the state hospitals and send them back to the counties. The counties are not prepared to accept these individuals. I would really hope there is going to be discussion regarding this. It will impact this committee, our jails, our communities, our IMDs that will aggravate the human log jam that Lauren and I have been talking about for months across the state. While we need solutions and people should not be left languishing in state hospitals longer than necessary, I hope it is something that can be a community conversation regarding how to make this process/transition if it does happen. We do not need another de-institutional catastrophe in California. • (Cmsr. G. Stern) Thank you for those comments. Commissioner Dunn did send some information to Cmsrs. Serwin, Wiseman and myself regarding this just before the meeting. I am not sure I understand what is going to happen and I don't understand why since we have this budget surplus now, why they are doing this. It seems puzzling. Do you know anything about the rationale or motivation for this, Teresa? (RESPONSE: T. Pasquini) I do. I have been working with lobbyists over the weekend. I just became aware this last week. Commissioner Dunn is in the same advocate stream that I am. This is not really a surprise, there is a backlog of 1500 ISTs, waiting in solitary cells. We absolutely do not want that to happen, I think from a humanitarian position, I would agree with whatever the ACLU filed. I am unaware of the brief, not read, because I have a son in that position. I am aware of that torture. I am assuming good intentions on that;	

however, the intent was probably to have the state open up more beds. I do not know, but because everyone wants to play the human and fiscal shuffle with this population, the state has decided the counties have statutory obligation for the LPS community and those sent to state hospitals on civil commitments. Our California continuum is jammed and we don't have enough of these types of beds to take care of these people. That was the intent of the 'Housing That Heals' paper, to draw attention to this crisis that everyone knows about. This would be a shuffle of people out of state hospitals and likely rotate back through our county jails and back to the state hospital. It is cruel, inhumane. If we want to keep doing the same thing over and over, that is the definition of insanity, without having any place for them to go.	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: Just want to point out it was a little tricky to pull together an agenda for this month. There are a lot of questions from last meeting, those busy with Spring Break and it took a while to get answers and responses. I am pleased to have David (Seidner) and Sonia (Sutherland) here today to share some information and answer questions.	
V. APPROVE minutes from the April 27, 2021 Justice Systems Committee meeting Cmsr. J. Kincaid moved to approve the minutes as revised. Seconded by G. Stern. Vote: 2-0-0 Ayes: G. Stern (Chair), J. Kincaid Abstain: 0	**http://cchealth.org/mentalhealth/mhc/agendas-minutes.php**
VI. DISCUSS demographics, common diagnoses and interventions, and discharge planning for clients of psychiatric services of the Martinez and West County Detention Centers, as well as Detention Center current challenges and priorities, Dr. Megan Della Selva, Chief Psychiatrist, Detention Health Services There has been significant improvement in psychiatric staffing at the detention centers over the last two and a half years. Currently we have psychiatrists at two jails in the county: Martinez Detention facility (MDF) and West County Facility. At MDF, we have a psychiatrist inhouse seven days a week for 16 hours a day. West county we have a psychiatrist inhouse five days a week on ten-hour shifts. We have increased the presence in staffing of psychiatry in both these jails. During the time a psychiatrist in the building, we have a psychiatrist on call to respond to emergencies, as well. This is a significant increase over the last couple years. A day in the life/typical caseload: As of yesterday, the population is 810 inmates between the two facilities; and 384 are current mental health services caseload. Over the last year, with COVID, books are down and the jail hasn't been quite as full. The mental health caseload has decreased a small amount, along with that; however, we still carry a pretty substantial caseload of patients who are seen routinely. The psychiatrists inhouse are here to see patients all day. We have a schedule of patients that we see, and as individuals come into the jail, they are seen by a nurse at intake. They are asked routine questions to screen for mental illness: • Do you have a history of mental illness? • Are you currently experiencing symptoms? • Do you take medication? They run through this screening intake and then refer, as appropriate, to mental health. Anyone referred is scheduled for a full psychiatric assessment with one of psychiatrists here. We are evaluating and seeing patients pretty quickly. For more acute patients who come in and are really actively ill are generally seen within a couple	

of days, at most. Those more stable continue on medication from the community and overall have their mental illness under control, we work to see them within ten days of them coming in. We are seeing all quite quickly and are also available for crisis intervention for those with more serious acute needs (something happens/goes wrong) if an individual is decompensating, we have the availability in our schedule to respond to crisis situations in the jail and interpret.

Overall, we function like in the community setting, in terms of seeing patients, providing evaluation, diagnosis and treatment with medication. We really cover the whole spectrum of mental illness here. We certainly have a significant population of people with severe mental illness, chronic persistent mental illnesses like schizophrenia, bipolar disorder as well as patients with controlled depression and anxiety and adjustment disorders with coming into a detention facility (it is very stressful for a lot of people). We are here to assist. We see the whole the spectrum of mental illness, just like any other setting. We have a triage system based on patient acuity level and every time a psychiatrist is performing an evaluation or follow up / determining the best time to follow up with that patient. There is a psychiatric nurse to help manage schedule and ensure follow up in a timely manner. We really have been keeping up with the schedule and have not been backlogged. Our staffing has really improved to the point that if we say a patient needs follow up (in three days, one week, two weeks); we are able to accommodate.

There were also some questions regarding release planning and it is different than the community. It is not like having an inpatient unit, we are in control of the release and can plan for that. Sometimes our patients are released unexpectedly and sometimes we do know when they are being released. Psychiatrists are available and do our best to provide everyone taking a prescribed psychiatric medication to give them a thirty (30) day supply of that medication as they are leaving the facility. That is really the main role of the psychiatrist in release planning.

The mental health clinicians take on the bulk of the reentry planning/release planning. In terms of psychiatry, we are doing our best to ensure people have their 30-day supply of medication as they walk out the door to help maintain stability until they are able to contact outpatient team. If it is necessary and appropriate, our patients are sent right to PES, if they are acute, or the clinicians are working with them to come up with an appropriate release plan in the community and getting them information for resources to obtain appropriate follow up treatment in the community.

Questions and Comments:

- (Cmsr. G. Stern) Do you have any data when people come in, do you know how many people were seen in the community by the mental health crisis response team (MCRT), or were they seen by MCRT first and then sent to detention health, or just brought in by the police? Do you have any data on that? (RESPONSE: Dr. Della Selva) I do not have that data available to me, as it is not currently tracked. Just since practicing her, the vast majority of patients are just brought in by police from the community. If it does happen, sometimes people are brought in following a discharge from a hospitalization or a visit to PES at CCRMC. If that is the case, we have access to those records and I can see in the chart. This is part of our process every time we see a new patient come in; we review history. We can see all their previous encounters.
- (Cmsr. G. Stern) You are saying you get people who are coming from PES, have they been arrested and then taken to PES? (RESPONSE: Dr. Della Selva) Not sure. If there is medical concerns, first, sometimes the deputies will take the person to the hospital first to address any medical issues; sometimes the psychiatrists from PES are consulted while the patient is in the emergency department (ED) or if there appears to be an acute psychiatric issue. So, there are times they do get evaluated through the ED services at Contra Costa Regional Medical Center (CCRMC) before coming here.

- (Cmsr. B. Serwin) I am interested in the integration of detention psychiatry with the medical electronic record. Are you fully integrated, then?
  (RESPONSE: Dr. Della Selva) Yes, same system as CCRMC and access to all records within the county. If we are able to have a signed release of information, we can request from outside the system and those will also integrate into our electronic medical record and it will all be in one place.
- (Cmsr. B. Serwin) When the nurse does an assessment, did you say that it is a booking. (RESPONSE: Dr. Della Selva) If intake, yes that is a booking.
- (Cmsr. J. Kincaid) I am curious what your experience is with Kaiser Mental Health, as you mentioned John Muir, are you able to get records? Sometimes Kaiser acts like their own law unto themselves and sometimes they are very cooperative, it depends on the clinic. Just wondering your experience is with Kaiser. (RESPONSE: Dr. Della Selva) I can only speak the fact, with my patients' records, I frequently do see records from Kaiser. I don't have data in terms of how many requests we have put in and how many they respond to, but it is not unusual to see records from Kaiser that have been sent to our system.
- (Teresa Pasquini) I just wanted to address, sharing of information, one of the pieces of our sequential intercept mapping (SIM) process was to ensure we are sharing information with NAMI members or our community. There are websites with forms that can be shared with jails. I raised that issue during the SIM original two sessions held and brought it up after the fact as the search of the jail website, there was not much good information available to family members of those incarcerated who can fill out information. Maybe that has changed, but I haven't looked. Just wanted to raise that flag and hope that has changed and is available. Second, I would like to refer back to my public comment, I was at a hearing yesterday on this item on the Department of State Hospitals (DSH). One of the comments from the DSH Medical Director was that "medication management is not happening in jails." I don't believe that to be true, based on my knowledge. There are some unfortunate conversations happening at some level that are not necessarily representative of our community services. Third, are you involved with jail-based competency programs? How are those being managed?
  (RESPONSE: Dr. Della Selva) Yes, of course we provide medication management for those in our detention center. I can't speak for other county jails, but that is a primary role. It is certainly is a challenge, particularly for people with chronic severe mental illness in which a part of their illness is that they really lack insight into the fact they have mental illness and require medication to remain stable. The state hospitals, it is possible they would have petitioned and been granted to provide involuntary medication to people in the state hospital. People get competent, come back to the county, and then decide not to take their medication (don't need / not benefiting). One of the major improvements we have been able to make within our county, and our system, we now have the ability to petition for involuntary medication in our setting. We have two avenues to pursue that based on an individual's competency status. The criteria is somewhat rigorous. Sometimes even those quite ill do not meet the criteria within our system in the way the legal petitions are set up within the county. It is something we are always paying attention to with our severely mentally ill patients. Do they meet criteria for involuntary medication if they are not taking it? This is an avenue we have persuade quite successfully, in terms of petitioning the court and doing our best to continue treatment, as necessary in the jail system. It is an ongoing issue we are always working to improve.
  As far as the jail-based competency program, I do know there are jails that have been California / County jails that do have that type of program set up. We do not currently have that program set up, but it is something in planning. Our modules in the jail have been periodically renovated. The next step is to renovate one of our modules (at least part of it) to be in conjunction with DSH as a competency restoration module. That is something in the works and renovations have already begun.

- (Cmsr. G. Stern) I feel everyone here would appreciate what you shared with me regarding your background in forensics and your work/training. Would you share your background with us? (RESPONSE: Dr. Della Selva) Residency at the University of Maryland in Baltimore. I am board certified as a general adult psychiatrist but did pursue extra training in the form of a fellowship (also with the University of Maryland) in Forensic Psychiatry, in addition to general adult psychiatry. Part of that work I have done in the past is doing competency evaluations, criminal insanity evaluations, conditional release evaluations. Those are now things I do currently, but practice much more clinically now. I have worked in county jails in Maryland and here, I have also worked for CDCR (California Department of Corrections and Rehabilitation), the California Health Care Facility in Stockton. I have experiencing working in both the jail and prison settings in a couple different state jurisdiction and been able to experience / observe the differences in how they are operating.
- (Cmsr. G. Stern) I think it is pretty refreshing we have such a well-rounded psychiatrist who is actually specializing in forensic psychiatry. That is rare, I don't know that many psychiatrists who specialize in forensics or programs for that. (RESPONSE: Dr. Della Selva) There are few than one per state. Most forensic fellowship programs take two people a year, so probably just under a hundred forensic psychiatrists coming out of training g per year (not a whole lot). One of the other psychiatrists that works here at MDF with me, is also forensically trained. The others did not do a fellowship and are not board certified in forensic or general practice psychiatrist have pretty extensive experience within the correctional setting.
- (Cmsr. G. Stern) We did get an answer on 'Could we collect the data of the mental health diagnosis for those booked or during intake?' We can, it is possible, we just haven't gotten the procedure as to how to do that (hit a wall), so I am unsure where we go from here, but would still like to pursue at some point so we get an idea. You have said people come in with all kinds of diagnosis. Ideally, identify individuals with mental health crisis teams before they commit a crime, so they would not end up in jail but rather CCRMC or PES but not to the point of committing a crime. We don't want to criminalize our mental health population.
- (Stephanie Regular) First, Historically, detention mental health closed services to individuals who declined mental health treatment (either two or three times) and I am wondering if that is still the policy or if it has changed? Clearly, as you stated, a lot of these clients lack the insight that they need the treatment but still need to be check in on, even if they are declining treatment. Has that policy shifted at all? (RESPONSE: Dr. Della Selva) I don't know what the specific policy language is around that, but can tell you in practice, things have changed regarding who is responsible for making the decision to close down someone to mental health services and that now does lie with the psychiatrist. There is no specific policy I am aware of that, if someone declines our visits two or three times, we automatically close them out. We do evaluate clinically whether we feel they would benefit from mental health services. If someone is doing well and not on medications and don't feel they need the services and, as a psychiatrist doing a mental health assessment, I agree. I usually come to that decision with them. I will talk with them and, if I don't see any concerning symptoms, concerns and it is reasonable and clinically indicated, we will close them out. While, of course, reminding them how they can request that to be opened again down the line if something were to change. Many mental illnesses can come and go at different times. If someone is very acutely ill (such as a psychosis), I will make the decision to keep them open to services and let them know it is their choice to talk to me, or to take medication or not, but will still come by to check on them to evaluate. We continually evaluate whether someone is reaching that threshold and the need to petition for involuntary medications. We certainly would not close them out just based on their preferences if there is evidence they are suffering from mental illness and require treatment.

- (Stephanie Regular) Are you the person who is personally the chief psychiatrist making that decision or is any of the psychiatrists or clinicians? (RESPONSE: Dr. Della Selva) It is any of the psychiatrists. It falls to the psychiatrists, not the clinicians, that make the decision, whether it is closing the services or downgrading their acuity level within the jail.
- (Stephanie Regular) The second question is regarding releasing individuals with 30-days of medication and whether or not there are instructions provided with the medication? Just to provide anecdotally, and hopefully this is a rare circumstance, where we had a client released with basically a bag full of medication and no instructions. One of the attorneys from my office actually picked up the individual and they were trying to figure out what the medications were, when they were supposed to be taken and at what doses. It was both medical and psychiatric medication and it was really challenging to navigate. So, I am wondering what is the typical standard and practice? If it is just listing the medication and nothing more, maybe there is opportunity to discuss that further and how that is looking like once the person is released? (RESPONSE: Dr. Della Selva) Thank you for bringing that up. There is a pharmacy here and the physician orders the medication, like at any pharmacy. We enter the name, dose, instructions, how many to dispense, etc. It is my understanding that those instructions were provided from pharmacy with the medications as the patient is walking out the door. It is also horrifying to hear that there was a bag of medication without label and instruction. That certainly should not be happening and would be happy to talk with our pharmacist about this. I hope this is not happening routinely and would be happy to look into that with pharmacy staff. (Stephanie Regular) There were labels, just a question of what medication to take at what time, because there were so many medications.
- (Cmsr. B. Serwin) You mentioned what kind of diagnoses you have, and wondering if the distribution is similar to what it is in the general population? (RESPONSE: Dr. Della Selva) It is a great question and I do not have specific numbers. My experience has always been skewed toward people with more severe mental illness and seeing a high population of that, working in correctional facilities, as compared to an outpatient clinic and the like. My general sense, just looking at numbers of treatment, in terms of diagnosis here within the jail compared to a routine outpatient psychiatric clinic is that we probably do have a higher number of individuals with chronic several mental illnesses. My general sense is that we see some very severe at a slightly higher percentage rate compared to what you would see in the community.
- (Cmsr. B. Serwin) ADHD is an issue and I know there are co-occurring issues and I am wondering if you do see a lot of patients with ADHD? Do you do any assessment for that or ODD and any of these more neuro-psych kind of issues? (RESPONSE: Dr. Della Selva) Yes, again, we see people within the whole spectrum of the DSM diagnoses here. The one thing that is more of a consideration in a detention environment, as compared to the community, is the prescription of controlled substances. We have to take into consideration, due to the facility concerns for diversion and for that reason, we generally are not prescribing stimulants, just like how we are very conservative in prescribing opioids or any controlled substance in the jail. There is a little more of a safety concern to that. That is not to say that it absolutely never happens. There are some non-stimulant medications we can use for treatment of ADHD that we can provide here. There are slightly different considerations than in the community, but it is on our radar and as psychiatrists we have training and can diagnose and treat clinically and we do our best to treat the whole spectrum of mental illness.
- (Cmsr. J. Kincaid) I don't want to be too political here, but in meeting Mr. Seidner, he is particularly sensitive to issues of security and safety. There are number of questions he is reluctant to answer about patient flow, policy, housing because he keeps bringing up 'well we don't to get into specifics, this is a public meeting'. Part of our job is to understand these systems and it raises concern with me, and

the commission, as to what degree your operations influenced by custody decisions, is it a collaborative relationship, or do they really have primary control over everything? I used to have Mr. Seidner's job many years ago. My experience is that it was very collaborative, the deputies were worried about a more open concept environment and we had a very collaborative relationship with security decisions, how many hours somebody would get out on the treatment unit, etc., and it worked really well. When I hear these responses coming from him, coupled with the secrecy surrounding the prison law office negotiations, a lot of this has really not been open to the public and what the county is doing in these facilities and I am just curious what your experience has been through all of that reality and, in terms of interfacing with custody?
(RESPONSE: Dr. Della Selva) I can understand how that is a concern. Ultimately, this is a custody facility, and they are the ones who, in the end, are responsible. So, there is that dynamic, but I would say we do have a very collaborative relationship with custody. Since I have been here, we do make decisions together, we have a weekly conference and discuss acute patience, any concerns, and present are the mental health clinicians, psychiatrists, both classifications of custody staff, including mental health deputies and sergeant and nursing staff. It is a multi-disciplinary collaborative approach. I would say, more often than not, we come to agreement on whether an individual is safe to be out around others or needs time to recuperate by themselves and not safe to come out with others and say it is a collaborative approach toward safety. I have had great experience with our custody staff, in particular our mental health deputies. I think they really do care about these individuals; they want them to do well, be safe and also, integrate into the module and have free time and socialization and all those things.

- (Cmsr. J. Kincaid) You talked about a mental health sergeant and deputies? Back when the facility opened, in those days it was the M module – medical and mental health module. We evolved a system where deputies would volunteer to work there because some were interested and some were not. It sounds like similar practices are ongoing. What is a mental health sergeant?
(RESPONSE: Dr. Della Selva) I don't know all the nuances of the custody structure and somewhat a little reluctant to get it wrong but we do have the mental health deputy staff and they receive extra training in helping and managing those with mental illness. Custody staff has a hierarchal structure and the sergeant oversees that staff and serves as a liaison between mental health and custody staff.
- (Teresa Pasquini) I just want to say thank you so very much for what you are doing and thank you for coming and sharing so authentically with us. (RESPONSE: Dr. Della Selva). Well, I am very passionate about correctional mental health and these are some of our most vulnerable and needy patients in our community and deserve quality care anywhere that they are and feel committed to it and very happy working here. We have a great staff and am very proud of improvements in our mental health program over the last few years. We are always striving to make it better. Thank you for the opportunity to share.
- (Cmsr. G. Stern) Thank you so much. We are so grateful for your visit and participation and I am sure we will have other questions. We will email you with any follow up.

VII. DISCUSSION a new San Francisco Treatment Center for the homeless and mentally ill to open in the San Francisco Mission District

I hope everyone had a chance to review the article in the agenda packet regarding the new Treatment Center opening for the homeless and mentally ill in the Mission District in San Francisco. It was really interesting, a few days before that article came out in the Chronicle, I had sent an outline to Supervisor John Gioia's office regarding the Contra Costa Wellness Center. I was trying to see if we could open a center that wouldn't create pushback in the community by having a mental health center near a

residential area. I understand the community not wanting to have psychiatric treatment/mental health services near their homes and then this article came out and it seems very similar to what I was proposing. This moves us into the next agenda item and discussing the CCC Wellness Center Program Concept.

VIII. DISCUSS a Contra Costa County Wellness Center Program concept, Sonia Bustamante, Chief of Staff for Supervisor John Gioia, Contra Costa County District I

I received a call back from Sonia Bustamante, Chief of Staff for John Gioia and had confirmed she would be attending the meeting to speak on this but is unable to attend. Sonia mentioned that Supervisor Gioia was invited to visit this treatment center in San Francisco. His focus is homelessness and the homeless population, not so much mental health; but did say he had originally voted against the module being created at West County Detention Center because he was not in favor of criminalizing mental health and the mentally ill.

I would like to open this up to discussion. We received the notification from Doug on the State Hospital 'patient dumping' and we have a lot of money in the budget and the budget action bulletin is pointing toward more treatment options. I don't know if there is anything in the works for a long-term health option for conservatees or detention health, but I did ask Sonia to contact someone or forward contact information for the legislative contact person (possibly the chief of staff for Nancy Skinner) to work on the legislature to get more long-term health care beds.

- (Teresa Pasquini) The Hummingbird facility, it is part of a continuum that is absolutely necessary in any community. Lauren went to visit a respite center in Santa Cruz and it is why we included it in our paper, as respite centers are key. However, they are not a suitable replacement for those needing a higher level of care. I did not have time before the meeting but was going to share several letters co-signed as 'Housing that Heals' and what came out of our meeting with Senator Janet Eggman. She is the chair of the Health Budget committee and is really a champion in the senate for people who live heroically with serious mental illnesses. We have been meeting since the end of last year with the executive team of the Behavioral Health Directors Association and NAMI-CA (National Association for Mental Illness, California) with family members from the Bay Area to work on housing solutions and drawing attention to the gaps that exist for those living with serious mental illnesses. We have been working in partnership with them and co-signed with approximately 50 other stakeholders on the original $750mil budget line item in the governor's budget to issue grants to build up the public systems infrastructure. It was very focused on unlocked facilities (BACs, ARFs and respite centers). Revisions came out and that budget item went from $750mil to $2.4bil. Now the proposal is very large but again does not speak to IMDs or MHRCs, which would be a suitable option for state hospitals and jail cells. I think it is a gap, it is recognized as a gap, but ideologically people are not lined up for a strong push against any locked facility. However, we have a lot of people in jail cells. We have been actively involved and working with our state partners and family advocates across the state on these issues trying to keep this commission aware. I was not aware of the discontinuation of the LPS admissions. My understanding is CCC has 20 beds at state hospitals but I do not know the census and if you all are receiving the update. We were hoping you would be tracking more on to understand where this population is and how are they tracking in our system and how are they doing.
  We had a public comment from a very upset family member who had a sister at Napa state hospital and gave a very concerning public comment regarding her sister had been there forever and all of a sudden she was going to be discharged. There is just a lot of concern, not just in CCC but across the state about loved ones who have been at state hospitals for years and are all of a sudden being released, without adequate discharge plans. Yesterday, Senator Eggman said 'There is a crisis on our streets, a crisis in our mental health system, and this doesn't make

sense. Sick people are getting sicker' and is very concerned about where these people are going to go? Senator Eggman's is from Stockton and is co-chair of the Mental Health Caucus with Senator Weiner and has been a champion of Laura's Law.

- (Cmsr. G. Stern) Where is the avenue to pursue long-term care beds for mental health? Where is the opening with this huge influx of money? There is an obvious need. We all know you can't just discharge people from the state hospital to the street. Where can we focus our attention to find some beds, make some facilities available for people and make it happen before they are all discharged. This is not acceptable and we shouldn't allow it to even potentially happen. Do you have any insight into this?
- (Teresa Pasquini) I've been focused on this for 15 years in our county and across the state (and nation). We also wrote a letter to the DHS pushing on the IMD waiver. The Housing that Heals paper was my best effort to communicate what I think the drivers of despair, disparity and discrimination are for people and how to get people into a place they are able to have voice and choice. Right now, no one does in the system. It is not okay to keep pretending we are providing a 'voice and choice' system to everyone because we just are not. The state and the counties are playing games (for years) on who is going to pay for the bed. It is a form of patient dumping. It sounds like the DHS wants to be another arm of the correction system. We have to deal with those that lack insight, don't know they're sick and give them a chance to get better than criminalizing them.
- (Cmsr. G. Stern) Please forward Senator Eggman's contact information.
  (Teresa Pasquini). Yes, I don't have her email but her staffer's information. I joined today because I am really curious to know what our county's plan is. I am really frustrated and coming in trying to share what I know transparently. I was grateful to hear from Dr. Della Selva today and, again our love our county system and I think it is one of the best as we stated in our paper. But I am very concerned with not hearing and understanding how all these different pilot projects are taking foot in our community and how they are working. Not everyone can be diverted to respite center, not everyone can be diverted away from a hospital bed. Some people need hospital beds.
  (Cmsr. G. Stern) That's right and we haven't had any direction that I am aware of from anyone in Behavioral health who is guiding us to where potential solutions are happening. I reached out to Dr. Tavano to gather data and haven't heard back.
- (Jennifer Bruggeman) Dr. Tavano could give you an update on anything she is aware of but she is on vacation right now.
- (Cmsr. G. Stern) We need to put that on our agenda to push that forward and have some focus. There doesn't seem to be any focus. We keep getting diverted onto other topics. We have that presentation by the professor in New York, which was an incredible delineation of the problem and identified all the areas. You would think that's an action plan or call to action to do something, and yet I don't see the MHC focused on that particular action. We have Rapid Improvement Events and working on MCRTs, which are great. There needs to be more MCRTs and long-term health options and we need some focus.
- (Cmsr. B. Serwin) We have not addressed it head on. We did make a commitment on 'Housing that Heals' and proposed we work on a proposal for a Value Stream Mapping (VSM) project, which was pushed back on pretty hard by Dr. Tavano and Supervisor Andersen. It was left as we will deal with that at the committee level and there are a lot of different ways to approach the problem. We should decide what we are going to do to attack this problem.
- (Cmsr. G. Stern) I just hope it doesn't devolve into a lot of discussion without a lot of action.
- (Cmsr. B. Serwin) We could start the project by defining the actions up front.

- (Teresa Pasquini) I would just like to draw your attention to our paper that gave an outline of an action plan too.
- (Jill Ray) I just wanted to comment since my boss's name was raised to clarify. The idea was not pushed away to be ignored. The concept of studying these issues deeper, it was just not now as we are in the middle of this Crisis Response VSM and Rapid Improvement Event (we have another one coming up in June) and to get that heavy lift. I want to just remind everyone we are coming out of a pandemic and it has been an 'all hands-on deck' across the entire county. People have been moved into different positions to respond to that. As we are slowing down on that and pulling back on some of the extra efforts, I think we are going to see people pivot. I also wanted to ask about this big lump sum of money, but if you look at the budget hearings, I am trying to identify which big pot of money you think is available for new programs.
- (Cmsr. G. Stern) It is regarding the budget action bulletin we received today from Commissioner Dunn that was forwarded to us. It is state funding, $9.3 billion for housing investment and support including behavioral health infrastructure.
- (Jill Ray) This is state funding. The county and the state is a complex system and just to give you an overview. When looking at funding, we have a lot of advocacy going at the county level and through our state delegation and our federal delegation constantly looking for opportunities either for pieces of legislation to solve issue we are facing or to ask for funding. That is ongoing constantly and all our departments provide their legislative priorities and those are all put into our legislative platform at the state and federal levels. If you are looking at new advocacy, that needs to be done through the BoS, if you have something you are interested in, a piece of legislation. You can certainly run it through our 'Legislation Committee' to find out if (1) it fits within our platform and (2) if not, the committee can review and determine whether or not that it is something the BoS would support, watch, or oppose. As far as new funding, that would be through the department it would impact (BHS, HS or Sheriff, etc.).
- (Cmsr. G. Stern) would that be something the MHC could make a recommendation or propose to the BoS? Is that how the chain of command works?
- (Jill Ray) Absolutely. We encourage our advisory bodies, if you hear of a piece of legislation or know something is going on or a grant opportunity that is coming forward to definitely bring it forward to the full commission and have that discussion whether or not you are going to request the BoS to support that piece of legislation or that funding ask and it can be pushed through our legislative platform and the chair of the BoS can sign that letter. If it is not, it needs to go through our legislation committee to find out what position the BoS wants to take on it.
- (Cmsr. G. Stern) I would like to propose to Commissioner Serwin as Co-Chair to take some of the items on 'Housing that Heals' as action plans and start moving in the direction of proposing to the BoS acquisition of funds to create long-term health beds. Does that sound like something we can move toward?
- (Cmsr. B. Serwin) Absolutely, it is long overdue and we are wrapping up the Site Visit Plan, we will do that.
- (Teresa Pasquini) I didn't come to criticize and complain about that, just to give information that I wasn't sure you had.
- (Cmsr. B. Serwin) I'm glad you brought us back to the Action Plan of the paper. Every time I read it, I snap back to focus and this is what we need to do.
- (Teresa Pasquini) Just a reminder it is suggestions to our community to come together and co-create a shared agenda and shared action plan so not trying to dictate.
- (Alana Russaw) I just wanted to applaud Teresa because I feel a lot of times we get stalled on one issue and you keep the momentum and fire going behind and under us. I just wanted to applaud you for that and to keep please coming. The squeaky

wheel gets the attention so please continue to be the squeaky wheel. Please continue that advocacy.	
IX. Adjourned at 2:59 pm	