JUSTICE SYSTEMS COMMITTEE
MEETING MINUTES
August 24, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:45pm Members Present: Chair - Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent: Cmsr. Alana Russaw, District IV Other Attendees: Cmsr. Douglas Dunn, District III Cmsr. Graham Wiseman, District II Angela Beck Dr. Tarun Bhandari, CCRMC Chief Psychiatrist Cathy Botello Jennifer Bruggeman Dr. Stephen Field, BHS Medical Director Teresa Pasquini Pamela Perls Jill Ray, Supv. Andersen's Office Stephanie Regular Dr. Suzanne Tavano, BHS Director Jennifer Yen, CCC Sheriff's Office, Mental Health Evaluation Team (MHET) Deputy	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: NONE	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: I want to comment on this to be taken up with the Committee on Homelessness. I happened to notice a few ago, and asked Teresa Pasquini about this, this are very large tracts of unused parking lots at Pt. Richmond that are huge and sitting vacant. I was wonder if they are owned by county or privately but look like prime spots for trailers or temporary housing. I am wondering if anyone has any information regarding those tracts of land and has that been looked into. This is where the ship building used to take place. These are completely empty. Hoping someone can take that up and look into it. It is available space. Has anyone looked into this for temporary shelter for the homeless population? (Jill Ray) This is a non-agenda item, but I can just tell you in our county we don't temporarily set up encampments, like some other county's/city's do. I am happy to ask H^3 (Health Housing and Homeless Services) to see if they have looked into that area.	
V. APPROVE minutes from the April 27, 2021 Justice Systems Committee meeting Cmsr. G. Wiseman moved to approve the minutes as revised. Seconded by G. Stern. Vote: 2-0-0 Ayes: G. Stern (Chair), G. Wiseman Abstain: 0	**http://cchealth.org/mentalhealth/mhc/agendas-minutes.php**

VI. DISCUSS Number of IST persons in Detention for Financial reimbursement. Discussion with Detention Health and/or Douglas Dunn

The need for detention facility statistics for those who are incompetent to stand trial (IST) to determine how many incarcerated persons currently from Contra Costa County (CCC) are waitlisted for state hospital IST beds. I have asked these questions that were proposed by Commissioner Dunn and I sent an email to the new Detention Health Medical Direction, Dr. Sonia Sutherland. She stated, "We do not have the data you are requesting, perhaps you may need to work with the court for the information." I am not sure which court, and I don't know what she is talking about. Doug, do you have further information, did you gather anything at another meeting?

- (Cmsr. Dunn) Teresa Pasquini and I are involved as citizens and listening, as much as we can, to the state IST solutions workgroup. On the agenda for the meeting next Tuesday, is statewide (by county) IST information. I do not know what that entails but Teresa and I will have a much better idea when it is presented at the meeting next Tuesday (August 31 from 3:00 to 5:00 pm). I will convey that information to the full commission at it's Wednesday, September 1st meeting. (RESPONSE: Cmsr. Stern) Do you think they will have the information you have been asking for? (Cmsr. Stern) I hope so, but I do not know.
- (Cmsr. Stern) Does anybody have any idea which court Dr. Sutherland is talking about other than the probate court? (RESPONSE: Cmsr. Dunn) If you are talking about LPS Conservatorship, that is Civil, but it if it's LPS Murphy, that is both Civil and Criminal. Superior Court.
- (Cmsr. Stern) Do we have the names of any justices or judges we can contact? (RESPONSE: Cmsr. Dun) I do not know which judges deal with what. (Cmsr. Stern) I was frustrated by her comment because 'the court' is vague. We need the specific court, names of specific judges we can contact.
- (Stephanie Regular) I believe your question was how many CCC individuals have been found incompetent to stand trial and have been committed to the Department of State Hospitals (DSH). (RESPONSE: Cmsr. Dunn) Which persons, if you have information of those at the state hospitals and we are also interested in the number of persons in the jail that are public defender (PD) clients that are waiting for a state hospital bed.
- (Stephanie Regular) I have both and I would estimate that the PD office publicly represents approximately 95% of the individuals who have been committed out of the county with the remainder being either alternate defender office or conflicts panel. We probably represent even more than that, but it is just rough estimate. The number of individuals who we currently have committed, overall is 45 people (with 19 people at the state hospital and 26 waiting in the jail). In terms, of your other question, the probate court would not have this information, it would be the criminal court. The probate court deals with individuals who are either on or pending conservatorship, whereas these individuals are still in criminal court. The mental health judge is Judge Brady. I wouldn't expect there are a whole lot more than the 45 individuals.
- (Dr. Suzanne Tavano) Just to add. It is not any reluctance. It is not about knowing who they are treating, it would support who held the information regarding who has actually been determined to be incompetent to stand trial and that is why you were receiving the response. Dr. Sutherland doesn't have that information. <EA to research Judge Brady's contact info>
- (Teresa Pasquini) Incompetent to Stand Trial Solutions Workgroup is a public meeting and anyone on this call can attend and participate. There is a lot of data being shared and documents from the State perspective. The first meeting was very informative from the Department of State Hospital (DSH) perspective. There were some very telling comments about the situation and the challenge of finding solutions before the state. I am really happy that Stephanie Regular is a member

of that workgroup and know she is not representing Contra Costa there, but still happy she is there. I have a colleague from Yolo County (a Deputy District Attorney) attending. I am grateful for that. We hear about all these programs in place, the criminal justice reforms and $16mil spent on our jail for IST jail-based treatment but what is frustrating is it is like 'pulling teeth' to get information for this committee, which is the commissions place to share information with the community on what Contra Costa County is doing for this population. I am really happy to see everyone here today, but it is still very frustrating that it is such a challenge for our community to come together and have this conversation about collecting data, where is it, where are the numbers. We are not asking for names, we are just asking for numbers. It is frustrating because, as a member of the public, I am putting in my time and energy and constantly trying to be mindful of the conditions in Contra Costa, as the mother of someone who was in that horrible situation, I am pretty strident about advocating on this. I would really love to see this commission get more help and support from our county on having these conversations. We are supposed to be integrated and partnering and work together at yet it just doesn't feel like it when it comes to these conversations recently and trying to gather data. I am frustrated.

- (Cmsr. Stern) Doug (Cmsr Dunn) and I have been trying to get this information for weeks and months. We have just not been able to get responses for one reason another and it is probably time to make site visit to West County Detention or Martinez, to meet with staff directly. The last time we were there, we were able to get some answers but unable to see much of the facility. I think we need to go there to get the answers.
- (Teresa Pasquini) Is there anyone that can share with this committee where these conversations are happening in Contra Costa about this IST population, the 45 individuals (19 hospitalized/26 waiting)? Where are they waiting? Who can have this conversation with us, so it can help us have community conversations about solutions? I have spent a couple years working on solutions and the silence is disturbing.
- (Cmsr. Dunn) Within the commission, I am trying to be positive and move the process along. If I can add, another side of this is money in the governor's budget that has been signed ($2.2bil) to build facilities, need be, in counties to take care of this population. I have asked at the state level, is this workgroup going to be empowered to make rule for that, or not? It has not been determined. But as Dr. Tavano has conveyed at public MHC meetings, the way we have done things in the past, we are going to have to do so differently. My perspective, we are going to need to develop a system of care within this county an IMD-level facility, as well as step-down facilities. Unless the IMD's MediCAL reimbursement exclusions for persons 21 to 64 is lifted up by the federal government, Contra Costa is strapped from the ability to take care of this population. Currently Contra Costa is spending $5mil to $7mil / year on realignment funds for both conservatorships, as well as LPS Murphy conservatorships. We will need more funding. There is temporary funding in the state budget, but that will run out after some time. We need ongoing funding, and that is where repealing the IMD MediCAL reimbursement exclusion is so critically important.
- (Pamela Perls) There was an article in the East Bay Times about a week ago that reported the largest settlement in Pleasanton's history ($5.9mil) to settle a federal civil rights lawsuit filed by parents of a mentally ill man that died after police restrained and tasered him, Jacob Bower. The parents added a caveat to the settlement that required the sheriff and police captain meet with them to received their input on changes related to the treatment of people with mental illness. I have never heard of anything like that in a settlement, but I thought it was great and just wanted share that. <shared article to EA for distribution>

- (Cmsr. Swirsding) I am working on the how much money cities are getting from the federal government for mental health because we defunded our police department. So, cities that defund police departments are receiving money from the federal government for mental health. This is something I am very upset about because who is overseeing that money? I don't think the city should be getting money when the county already has the services. This is something I am working on (Doug and Geri) for this meeting. My complaint is why are cities defunding the police and asking money for mental health when we already have mental health services in the county? That money should be going to the county, not the city.

VII. DISCUSS Repeal of the Medi-Cal reimbursement, Motion from the MHC to the BOS to endorse this action

- (Cmsr. Dunn) What I know is the federal government has put out $3bil to states for mental health (and substance use disorders/behavioral health issues) to take that $3bil over 7000 counties and it gets to be a pretty small amount (over the entire country). What Contra Costa and/or the city of Richmond can get a hold of…I have not seen the process to apply for that money.
  - (Cmsr. Swirsding) I am working on this whole process of defunding to give a report to this committee. When our city (Richmond) has been bankrupted many times. I don't trust them with any funds.
  - (Cmsr. Stern) When you gather that information and find some pipeline or oversight body for that financing that would be very interesting to share.
- (Dr. Tavano) We don't operate detention health services at all (Dr. Field, Dr. Bhandari and I), it is not that we are withholding information, it is that we don't have it. What I want to say to this committee is that I am also participating and listening into the meetings that are being held by the SDH. We have a public defender as a seated member, so certainly she will represent. The part I feel I am responsible for participating is to stay up in the conversations and also part of the Workgroup on this and what we would really be looking at is what role do we play post detention, I am staying quiet because of that, but I am very actively engage in the discussions and we where will it be going and what role BHS will play in the future.

VIII. DISCUSS Potential psychiatric drugs on mental health crisis calls in the field, and introduction of Jennifer Yen, MHET Deputy, Contra Costa County Sheriff Department

Mental Health Evaluation Team (MHET) has been in the county for the last several years. I happen to be the liaison out of the valley station (parts of Orinda, Lafayette Canyon, all the way down to San Ramon unincorporated areas, as well as the three contract cities in that corridor. We would take a look at calls and I would refer them. Now with the Sheriff's office having a representative for all the unincorporated areas, as wells the contract cities, I would go above and beyond what I did before, which is referrals as well as outreach to see if they are open to services, if we are able to do services for the county or help navigate if they have private insurance. I currently work with the three appointed MHET officers that are covering the entire county for the incorporated areas, including Richmond (Officer Lande), Pittsburg (Officer McGuire), San Ramon (Officer Pettit). I work with all the clinicians, as well as with Concord that has their own.

- (Cmsr. Stern) What is your role for guiding the other officers when a mental health team goes out and calls the sheriff's department to help? How do you interface with that? (RESPONSE: J. Yen) We don't really change anything We still go out to the calls of service that are coming in through dispatch and we still handle them the same way. We go out and evaluate, we make a record of the criteria. If they do not, it becomes a referral. It is not just a person who has been 5150'd that can

be referred to MHET, it is someone who is just hearing voice or other calls of service that would be taking up patrols time, in order for them to go on other calls. MHET is able to go and speak to an individual and be there for an hour or two and observe to help resolve/de-escalate. Calls are reduced in that way. We also help them get connected to services and will also help reduce calls. There are many different ways to accomplish law enforcement call reduction and help resolve and refer these situations. It is not just those calls for individuals being 5150'd. I am a team of one, right now for the SO. If someone has a question or need help in guidance (language, what they should do next) they give me a call and I help guide the officers on these calls for next steps. We don't usually dispatch the duo of MHET to go out to the scene. MCRT is different and those are two clinicians without the officer and MHET has the clinician and officer team.

- (Cmsr. Stern) If someone were actively suicidal (gun to their head), who would be called-MHET or MCRT? (J. Yen) Patrol. (Cmsr. Stern) I was referencing this article from the chronicle that said a percentage (9%?) of mental health calls end up where the deputies shoot the individual who is having the mental health crisis. That was my original reason for bringing up the topic of medication and administration in the field and that is why I wanted to talk to Dr. Bhandari and Dr. Field and Dr Tavano, If there were a direct line from the MHET team to PES during a crisis if administration of any kind of sedation would be better than tasers or guns, along with the 60-page article that referenced the discussion of the 4th Amendment and how there didn't appear to be an infringement, if it were kept specifically and narrowly to contact with only medical teams and not having police make decisions about administering medication.
- (Dr. Tavano) There is supposed to be MHET clinicians there with every MHET officer. The MHET officers are funded through AB109. The MHET clinicians were not included in that, so BHS are paying for those MHET clinicians. My understanding is the MHET officers who has identified a number of people that are (somewhat) justice involved will notify the MHET clinician if clinical services are needed and that's that occurs. It is not really a mobile crisis team, per se. The other pitch I would put in, Deputy Yen, if the sheriff's office could help us? When the Sheriff's received their funding for an additional MHET officer, we did not receive any funding for a MHET clinician so we are stretching our three (3) clinicians to cover the entire county. If there is any support the SO might think about so we could better provide coverage. I just wanted to make comments to that it is not an MCRT. These are people being identified through law enforcement, somewhat justice involved (about to be justice involved), how to help these people out of being arrested / incarcerated, how to get them connected to support, etc.
- (Cmsr. G. Stern) Dr. Field and Dr. Bhandari, do you have any comments regarding administering sedation in the field for diffusing crisis situations? How it would be if someone called from the MHET or MRCT directly to you and asked for an evaluation over the phone? How would you feel about that? Is that something that would even be possible? (RESPONSE: Dr. Bhandari) I am sure that does not currently exist, that our county has a system where they would reach out to us from the field. I think it is usually the EMTs (Emergency Medical Technicians) that would respond first to a situation with law enforcement and/or MHET/MCRT and then make a determination of what needs to be done. We don't really get an opportunity to do that. If there was some way to do so, I would find it extremely hard to do so without putting eyes on a patient to advocate for medication administration in the field. (Cmsr. Stern) It has been done in different parts of the country, but it is a mess how they have done so with Ketamine and other meds that are really very strong drugs and not really appropriate. EMTs are making decisions, law enforcement are making decisions and it really should come from a psychiatrist. I was wondering how something like that, I don't see how an EMT

could make that decision, they are not empowered to make medication administration decisions.

- (Dr. Bhandari) Based on the article you shared, I don't think Ketamine is used in the field in California. It is an example from other states. We do not use Ketamine. I believe the EMTs may use versed, and that is probably the extent of my knowledge of EMT use. I am pretty sure the article quoted some practices we do not employ in this state.
- (Dr. Field) A couple things come to mind. Versed, EMT does have but do not know the scope beyond that but I have seen them used versed which is a sedative. Really it is the logistics that would be the problem and I am sure that is why it has been so messy in the rollout. To administer medication, that person has to be contained in some way (physically) to have a professional to administer the medication with a syringe. In a situation that is so out of control, trying to avoid tasing or shooting, I don't know it would be possible. It currently is administered once they are in the gurney in the rig to transport in order to make transport as safe as possible. So that seems to be the biggest barrier, having access to safely administer medication. Then, of course, having someone with knowledge, authority and licensing to make that decision and what medication, knowing the safety basics like vital signs as many medications can cause arrythmias, stop the heart and a number of other things. That is why versed (or the like) is really limited for EMT use because it is safe enough to provide some sedation but not a concern it is going to be overwhelming.
- (Cmsr. Stern) My concern is looking at the national picture speaking to putting a knee on someone's neck while handcuffed. That whole situation when the person was agitated getting into the patrol car. Once in handcuffs and on the ground, it is not that difficult to administer medication, but there has to be some kind of intervention somewhere between tazing and shooting to restrain or sedate people. We need to come up with better solutions. Officers worry someone will grab their gun or they will shoot something/someone. These situations get out of control so fast. There has to be some kind of protocol we need to figure out to get the whole conversation moving in a positive direction. I am just throwing this out for people to brainstorm because currently, sending people out on a crisis call, first we need more teams. Two or three teams do not seem to be enough for a whole county and we need more medically trained people out on these calls. I would just like some input.
- (Dr. Bhandari) More MCRT funding to expand those services would be my first thought. I feel you are right, currently we don't have enough resources to send a mobile crisis team to every event that might warrant it. If there is the ability to do so, it would be most helpful for these folks. (Cmsr. Stern) We had the big Rapid Improvement Event (RIE) just a couple of months ago and it seems rather anti-climactic and sad that we were only approved for two or three teams for the whole county after that?
- (Cmsr. Dunn) I've been following the Measure X meetings and that is the second most popular item. Chances are, there will be significant Measure X funding to greatly expand multiple MCRT teams in each supervisor district throughout the county. How that is going to shake out, I don't know. (Jill Ray) They are not anywhere near that decision and it goes to the Board of Supervisors (BoS) the end of September/October. We won't know anything that will be funded until that point. Want to be cautious with making those statements.
- (Cmsr. Swirsding) My comment would be the matter of liability. Administering medication without knowing the persons medical history, it could cause someone irreparable damage or death (cardiac arrest, seizures, etc.). I don't see how, from a liability standpoint, they could administer (esp.) psychiatric meds to someone. Secondly, many time when a person is shot, it is usually because they are armed and are pointing a gun at law enforcement. I do have officers willing to come to

the meeting to speak to that. (Cmsr. Stern) I understand, it is a very controversial subject. It is hard to pinpoint exactly who is at fault during those situations, but it appears that there are a number of situations where police officers have not been trained sufficiently to de-escalate a situation and have reacted precipitously where gunshots have resulted in death. (Cmsr. Swirsding) Well my police department (Richmond/San Pablo) has gone through Crisis Intervention Training. When they are called to a mental health call, many times EMS is sent out and do have input. Also, as far as the George Floyd situation, if (Chauvin) was working at our police department, he would not be working. If an officer has a lot of complaints as did this guy, they would have pulled him off duty. That's what needs to be changed. When you have numerous excessive force complaints against a particular officer, they need to be pulled off duty.

- (Dr. Field) I actually wanted to loop it in with Dr. Tavano because there is some room speak about the pilot, my follow up question is actually to Deputy Yen. I am just curious what kind of calls she gets, what kind of transactions you have and what kind of advice is needed. Really I wanted to follow up with the conversations about MCRT and the local access pilot that is going on. (RESPONSE: Jennifer Yen) We might be getting a bit confused. MCRT is the equivalent of what we would do on patrol. The receive a call and respond to them. MHET, we are more like the detective unit, we go in after the fact when things have calmed down and are not as volatile and deal with situations that way. Your MCRT could be walking into something that is volatile. At least in our department, each time they come out, they request a standby. We come to ensure they are safe. If we have to, we will call for EMS to transport if they are going to 5150'd. We also have the pilot program and I am not too familiar with so I cannot speak to that. My calls are usually just phone calls and they know I am on my way or I show up and introduce myself and speak to them, it is very low key and I usually get a pretty good response overall because it usually after the fact.
- (Dr. Tavano) Just to go back to involuntary medications in the field, it is a very complicated discussion and I think always put yourself into the position of – if you were the recipient of involuntary medications and being held down and handcuffed, etc. When people arrive, they do not know the person full medical history is or know the medications they are taking, they do not know if there is illicit substances in their system, etc. These are really important things when you involuntarily medicate an individual. Also, chemical restraints and involuntary medications is really considered a higher/stricter level of involuntary intervention than physical restraint because once you put a chemical into someone's body, it is there and you can't just take it off.

  We spoke to MHET, BHS has three (3) MHET clinicians to pair with the MHET officers and really would love to have that fourth clinician to round it out. The initiative has not stopped, we have moved into the small pilot periods and starting from the beginning, setting up. Going into this in November, we actually had 3.5 MCRT and were able to add an additional one to get close to five. This was with existing funding. We did not have and still don't have a call center, so the MCRT staff have been those that answer the phones, screen, triage, determine deployment and we are trying out build out a system where there is an actual call center. That is represents the Miles Hall Hub call center. The intent is to have dedicated staff to answer the phones and do all the other work so the MCRT can be deployed right away rather than sitting in an office taking the calls. We have had to troubleshoot multiple telecommunication issues as well as working with law enforcement, fire, etc. to come up with up with a dispatch system to be able to track teams in the field. There is a lot of working going on in the background. Once we have infrastructure set up, we will be able to move on to actually deploying different levels of teams. What we don't have is a Level 1 team (Wellness team) to intervene with lower level behavioral health issues and there is a lot to build out and it will take a lot of money to do this the way the community

has mandated it be done. We are hoping for the funds from Measure X but we are also applying for every grant opportunity we can. We were awarded some federal earmarks; one for MCRT and the other for the "HUB" as well as just submitting expansion application last week. Yesterday we submitted some grant applications for mobile crisis and infrastructure to support mobile crisis. We are doing the absolute best we can with the resources available and going after every bit of money we can possibly go after.

- (Cmsr. Stern) Thank you. Just to clarify, the MCRT is called from a 911 call? 988 calls? 211? How do they get called and what is their number? How do they get called? (Dr. Tavano) I'm sorry, you are talking about MHET? (Cmsr. Stern) No I am asking about MCRT. How do calls get diverted to them? (Dr. Tavano) The majority of calls are coming in from all over the county and we know the volume per city and continue to be from family members, next is law enforcement and third is community residents. There are 911 calls being funneled in as well as the 211 calls and the goal is to have one number '988' but we don't have that right now, in terms of the pilot study undergoing right now.
- (Cmsr. Swirsding) 211 is the crisis line. In a crisis it is hard to use the phone as is. One thing that is very easy to do is call 911 or 211. I know they are trying to get 988. Right now, the best / most effective is 211 and they are good at de-escalation. We have a good system right now.
- (Cmsr. Wiseman) Thank you for sharing that Cmsr. Swirsding. The federal number is covering the gaps. If you dial 211 in Alameda County, you go into a regular queue, which approximately 45-90min wait. It is just an inbound call to the county. So that federal number will be to cover the gaps and that number will be as common and memorable to you as 211 is now, as we roll that out. The reason for that number is not to cause confusion but to have a national phone number no matter where you are, when you call that number, this is the mental house crisis number (as 911 is for emergency). It will be 988. There is legislation through the state of California "The Mile Hall Act" regarding this number.
- (Cmsr. G. Stern) How do we publicize the new number for the public, how does this information get disbursed so everyone knows? There doesn't seem to be any one place where there is a public information site where people are told this is what you need to do. We used to have public service announcements. How will the county and state going to disseminating this information so people will know this is the number to call. (RESPONSE: Cmsr Wiseman) This has to do with the federal government, it is a federal policy and all the phone carriers they have been working with and that is how it will be disseminated to the public. I don't know the specific details but they have invested millions and millions of dollars into this program as have the carriers to make this function. It is a large scale roll out and have been working on it for a very long time.
- (Teresa Pasquini) I just wanted to touch back to the involuntary medication in the field and I would struggle with it, I appreciate the conversation but it is concerning to me. I would like to get into this more but we don't have the time, I did copy the chair and vice-chair of the commission on a recent experience I had with calling 911 and copied Suzanne and several other folks. We are still working through the issue but I can tell you as a former commission, as someone that has dialed 911 when absolutely necessary, what I went through and my husband went through recently was so disturbing in Richmond with a tenant of ours. The average people don't follow this stuff like we do. So yes, you are right, it will have to be a very widespread conversation and I will tell you calling 911 doesn't get you help these days. 211 will get you help, but it is frightening, actually how the level of concern going on in Richmond for some of our community members. I share Gina's concerns about the defunding issue and I will share more publicly as it continues, right now I am happy to hear the MHET 'after the crisis' team. I have been in communication with some really great people trying to work through it but I can't

even express the level of concern I have. In a two year effort to prevent dialing 911 that turned into crisis, then the chaos after that crisis. Hopefully it will be part of the learning process that is going on in our community right now. It was absolutely unacceptable situation. (Cmsr. Stern) was this for a mental health crisis gone wrong? (Teresa Pasquini) There is a homeless gentleman in Richmond that we did not want to see criminalized or hurt, reached out to 211, and all our partners trying to get him assistance. But because he wasn't willing to voluntarily go, that assistance never came. It ended up leading into him entering the apartment of a tenant and threatening our tenant who called 911 and still waiting after two hours not getting a call back from the Richmond police. My husband and I also called 911, being connected to Richmond police and having it go on for four to five hours. So, yes, I'm pretty upset but happy that I have the ability to communicate and share information. I am trying to do that thoughtfully and collaboratively, but I'm pretty disappointed in the efforts that happened here. I think our county partners are disappointed as well and it will be looked at but I had to speak up and share. I will be sharing more as it unfolds. • (Jennifer Yen) Richmond is the representative for the West end and have liaisons throughout the different departments that help work with Richmond's current liaison for that side of the county. He is assigned a clinician for MHET. I do not know if there is an actual liaison for each city, but each department does reach out when there is an issue. (Jill Ray) so in West County, the MHET team is housed in the Richmond PD but they are available to the entire west end. Just like the central county MHET program is in San Ramon but available to the entire central region. East County is housed in Pittsburg and available to the entire east end and they all do work collaboratively with the police departments that call to them for assistance. <Cmsr. Stern> Would it be possible, Officer Yen, to email the names, contact information for each of these officers in each the cities in the county so we can have those contact people. (Jennifer Yen) We can do that or we can do a presentation with that information for you. • (Cmsr. Tavano) I want to sincerely thank you for bringing issues forward. When we became aware of the situation, trying to speak to where we are starting to go now. When we heard what was going in, actually coordinated between the C.O.R.E. team (outreach team for unsheltered persons) and MCRT. The CORE member knew who this individual is and could recognize him. The MCRT never had contact or know who he was. We arranged for the two to arrive together so they CORE team could identify the person at the encampment and the MCRT stepped in to do the assessment and actually initiated a 5150 and, my understanding is the person was able to get away from law enforcement and that was the last I heard and will need to get an update. We are really trying to do more coordinate efforts, particularly between CORE and MCRT. • (Cmsr. Swirsding) I just wanted to add the Richmond PD includes San Pablo and other police departments. I don't know if they meet know but the used to meet on a monthly basis. They are very new at all this.	
IX. Adjourned at 3:03 pm	