MENTAL HEALTH COMMISSION
JUSTICE SYSTEMS COMMITTEE MEETING MINUTES
October 26, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Geri Stern, called the meeting to order @1:32pm Members Present: Chair - Cmsr. Geri Stern, District I Cmsr. Alana Russaw, District IV Cmsr. Gina Swirsding, District I Presenters: Matthew Luu, Deputy Director of Behavioral Health Services Linda Arzio, Program Manager, Conservatorship/Guardianship Program Other Attendees: Cmsr. Leslie May, District V Cmsr. Barbara Serwin, District II Cmsr. Rhiannon Shires, District II Cmsr. Graham Wiseman, District II Angela Beck Jennifer Bruggeman Rebekah Cooke Patricia Gray, Napa County Re-Entry Program Teresa Pasquini Pamela Perls Jill Ray (Supv. Candace Andersen's office) Baylee Wechsler (NAMI, Contra Costa)	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Rebekah Cooke) I'm hoping this will help answer the questions we sent, but I wanted to ask Matthew Luu, my daughter is about to get let out without any step down. She was told she was getting out December 8th and I don' think there's been any communication or her new conservator has even met with her yet. He has been on the phone with her a couple times and I hope the criteria is a bit harder, or there is a step down so that she doesn't end up right back where she started from and not worse. Thank you for being at this meeting. (Cmsr. Stern) I hop we will have the time to get everyone's concerns addressed as much as they can be. I know this is a really complicated issue with a lot of intractable problems that people have been working on for decades and continue to work to try to improve. • (Teresa Pasquini) I will save my comments regarding conservatorship for that discussion. I just wanted to share with this committee that I am privileged to be invited to speak tomorrow morning at the California Behavioral Health Directors Association Policy forum on housing and homelessness at is pertains to the justice community. Specifically, they will be focusing on the incompetent to stand trial (IST) population and the crisis that is happening. I have participating in those meetings as well. I was invited to share my personal experience and to speak on the journey of the Housing that Heals project. I am excited about that. There has been an intentional effort for partnership for CBHDA (County Behavioral Health Directors Association of California) this past year, along with NAMI (National Alliance on Mental Illness) California. I will also be testifying in an upcoming hearing in Sacramento on LPS (Lanterman Petris Short) reform.	

• (Patricia Gray) I am interested in understanding the criteria for discharge from conservatorship and is there a measure, like comparing going in (ex. A year ago) and then upon release. What is the criteria for doing so? Do you look for change? If there is no change at all, is that something else that is compelling that conservatorships only last a year, when healing and a serious mental illness could last ten years. It doesn't mean they need to be conserved the entire time, of course; but I am wondering if there is some criteria. Maybe that will be addressed sometime during this meeting? (Cmsr. Stern) I can speak a little to that but I am sure Matthew Luu and Linda Arzio will be to discuss the criteria. I was recently interviewed by the superior court regarding my daughter's conservatorship (she has a developmental disability) and call me every couple of years to check in and see how she is doing. She has developmental disabilities, she is not going to get any better or be off conservatorship, so it is cursory. For those with a mental illness, I am sure there are differing criteria based on the level of functioning, if they are taking their meds, if they are able to hold a job, manage their money.	
III. COMMISSIONERS COMMENTS • (Cmsr. G. Swirsding) The last meeting we talked about those good examples taking care of consumers. I spoke to the State of Arkansas and contacted my friend that lives in Maui. He was unavailable but his wife stated one of the hospitals he goes to is Ridgeway Hospital, like many of the hospitals in Arkansas. The website is pretty explanatory. They have alcohol and drug counseling as well as mental health, both inpatient and outpatient at the facility. The uniqueness, my friend has schizophrenia and the group he is in also have schizophrenia. It is not mixed diagnosis. Here in California, groups are mixed diagnosis and it is hard to identify and get the help you need related to your own mental illness. In Arkansas, they split them into groups by diagnosis. I have had this experience in California (not now due to COVID Restrictions) where we met on a regular monthly basis. All the women in the group, were also sexually assaulted and shot out, same experience as my. Some are military, some are law enforcement and then those like me. It is like a mutual understanding on how to deal with living and our own mutual experiences and triggers. I belong to Herrick's outpatient program and it I one of the best, they saved my life and continue to do so. Just that alone, shows they care, which is a huge thing.	
IV. CHAIR COMMENTS: None	
V. APPROVE minutes from the September 28th, 2021, Justice Systems Committee meeting Cmsr. Graham Wiseman moved to approve the minutes as revised. Seconded by A. Russaw. Vote: 3-0-0 Ayes: G. Stern (Chair), A. Russaw and G. Swirsding Abstain: 0	http://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. DISCUSSION and UPDATE on Office of Conservatorship with Matthew Luu, Deputy Director of Behavioral Health Services and Linda Arzio, Program Manager, Conservatorship/Guardianship Program (Matthew Luu) Thank you so much for inviting me and Linda (Arzio) to run through the list of questions everyone has. The list of questions (sent over by Angela), both Linda and I worked on this. Linda will read the questions and go over the response we worked on. • H**ow many people have retired, transferred or quit the LPS office this past year?** First, the district correction about the question itself, we do LPS and probate and	

no longer segregate the cases, so the deputy conservators do both types of cases. We have had two people retire, one person transferred to another position and two people resigned.

- **How many have been replaced?** We have replaced two people thus far. It is very difficult to hire people these days. We are in the process of trying to the fill the other positions.
- **What training is provided to the new staff?** The type of work we do is incredibly detailed and there is a lot of intensive supervision, especially early on. There is a lot of hands on training and shadowing of other staff. I provide in-services ongoing in our monthly staff meetings. All of our deputy conservators must be a part of the California Association of Public Guardians, Public Conservators and Public Administrators. For that, they must have 40 continuing education credits through that organization every four years in order to be able to perform the duties of a conservator within the state of California.
- **How many LPS and Probate cases are currently in place broken down by category (T-con, LPS, Probate)?** We have approximately 100 probate case and approximately 206 LPS cases.
- **How many referrals for T-cons are received each month? How many are denied? How many renewals of LPS conservatorships happen annually? How many are denied?** On average, six (6) T-cons – quarterly average but it's per month, not per quarter. If we were to average a quarter it would be approximately six per month. This is new referrals for temporary conservatorships. In terms of total clients, we renew every year, it is a 120 just for LPS. For new admissions not meeting the criteria where we might deny them, it is maybe five (5) annually and it is usually because they don't meet the time requirements, not because they have turned them down for any other reason. The law is very specific in terms of time in. Within the welfare and institutions code (WIC), there is a rule called the '47 day rule' and no person can be held against their will for more than 47 days without due process. That means, within that time period, they must have their day in court. That does not mean the conservatorship must be signed by then, the conservatorship would be signed around 30 days before that and actually must have their first hearing date within 47 days. Every step of the process needs to be time perfectly and, if not, by law we cannot accept. Those are who we turned down and are not generally turned down for any other reason. If there is something incorrect in the paperwork, we send it back and tell them what corrections need to be made. Those no longer meeting criteria (that we don't renew) approximately 50 per year (not consistent), could be they are not renewed because they ask for a trial. That doesn't happen a lot because we win most of our trials. If we feel the person is able to make their own decisions again, we will just release them from conservatorship.
- **Who are all of the referring hospitals? How many referrals are now being made by judges?** Most of our LPS referrals from all the acute psych hospitals in the area: CCRMC, John Muir, Fremont Hospital, Herrick Hospital, CVH in Vallejo, all the Kaiser hospitals and other hospitals that Kaiser contracts with, as well as any private hospital where any of our county mental health client might present. Referrals from criminal court judges (in a years' time) we have received approximately 46, but don't file on all of those. When we are ordered by the court, regardless of which court, to do an investigation, we have to do it and write a report stating this person doesn't meet the criteria for some reason. The number of referrals received from the court is increasing exponentially. It will be competing with the number of referrals we receive from hospitals pretty soon.
- **What is the insurance coverage for the conservatees?** Even though we are part of the county system which basically bills MediCAL and MediCARE, we are a legal function and a public agency. We perform the function of conservatorship for any

and all members of the county. Our clients have MediCAL, MediCARE, Kaiser, VA and any and all of the private insurances. That doesn't mean we can provide them services within the county system but will still provide the function of conservator for them.

- **What is the breakdown of placements of all conservatees? ex DSH, IMDs, ARFs, which ones? How many are hospitalized during their conservatorship? *For example, I know that one CCC family member was hospitalized multiple times when placed in a lower level of care and they were not accepted back.*** We have approximately 16 clients in the DSH. Another 125 or so in other locked settings, such as Mental Health Rehabilitation Centers (MHRCs) and Skilled Nursing Facility (SNF) special treatment programs (STPs). Probably about another 80 in board and cares (B&Cs), again, that is not county probate, which is about a couple hundred probate and the majority of them are in nursing homes and B&Cs.
- **How does the county track Conservatees who have been taken off conservatorship? What is their step-down process? What is the recidivism rate for those who have been dropped?** I just went over the past year and looked at the list of clients that were referred to us for temporary conservatorship and about 16 out of approximately 80, over the past year, were repeat referrals. Those who had been on conservatorship before (and for whatever reason) went off conservatorship and were being referred back to us. <Matthew Luu to answer the rest of that question> (Matthew Luu) We can open up for questions and Linda and I will do our best to answer. What information we don't have readily available, we would be happy to take it down and look the information up and get back to the group.

Questions and Comments:

- (Cmsr. L. May) Going back to question #6, I think we need more explanation. Some people that don't meet the criteria, regarding having paperwork submitted by a certain day and certain requirements. Who is responsible for that? If someone is diagnosed as having a sever mental illness. You can definitely NOT depend on them making it to appointments, completing forms and all of that. So, who I the person that walks them through this process, and ensures all the dates and everything is being met so they are not denied services. (RESPONSE: Linda Arzio) First, it is the person in charge of the acute psychiatric unit who submits the paperwork, the client doesn't have to do anything. If there is a mishap having to do with the dates, it is because of miscalculation on the part of the referring clinical staff. We do make rounds, from time to time, to educate people about the importance of the timing and having the paperwork accurate and on time. Occasionally, you have someone making the referral who doesn't have the information. They don't always get to us in time to correct them. There are things that can be done to rectify that, even suggest 'you missed it this time, but if they are still ill, once you need to release them, you can 5150 them again in the parking lot if need be, if you are really that concerned about this person. In an extreme case, for example; recently we had an extreme case of an individual on a medical unit and the doctor said, 'I can't just release her, she is on a feeding tube and some other medical equipment", because she wasn't actually in a locked setting, and on a 5270, waiting until that expired and could start all over without even having to discharge them. So, there are some options and in rare occasions, we can ask to have time waived, but not something we like to do as we have a public defender who defends the clients we must deal with. They don't have to agree to waive time.
- (Cmsr. L. May) My concern is the human mistakes and an acute psychiatric unit could be the one that makes this mistake and the patient suffers. There needs to be some kind of fill in where these mistakes don't happen.

- (Patricia Gray) I am the Executive Director of a Forensic Re-entry Program in Napa and we are specific to that niche of persons with serious mental illness being released from jail or prison or on diversion programs. My question is regarding #10, going off conservatorship and back on, that is relevant also to a question in terms of measuring recidivism. So, how often do people who are released from conservatorship, within three years (recidivism is measure in three year periods, as you all know) how many end up back in jail or back on the conservatorship? Do you have those numbers? (RESPONSE: Linda Arzio) We don't currently measure recidivism, it is not a bad idea for us to do it and since conservatorship is not criminal, it is civil, we wouldn't necessarily measure it in terms of criminal terms. We don't follow whether people have a return to jail. It will be interesting to see with getting more referrals from criminal court if we might start following. You can normally get the referrals from criminal court. Although we take the crime into consideration, unless it's a Murphy conservatorship (a danger to society), they are still evaluated the same way any other LPS client – Are they gravely disabled due to a mental disorder. Sometimes, understanding how the crime happened can help you determine that. If this is something that happened because they were off their medication (based on voices or delusions or paranoia), then it might play in. Our focus, even with referrals from the court is whether this person is gravely disabled due to a mental disorder. Unless it is a Murphy as you are trying to determine if this person is a danger to society, which is very different.
- (Patricia Gray) I think it's a fair way to measure, whether or not it's an administrative violation that had them violate probation terms and end up being referred back to you. That is about 90% of persons of those released from (Napa) the state hospitals. CONREP (Conditional Release Program) measures are recidivism rate the same way. There is about a 3-5% recidivism rate for this population over a period of three years, for the last 20 years (in terms of CONREP) and they are doing great job. The recidivism rate from the CDCR (California Department of Corrections and Rehabilitation) of people with mental illness who are released in the community is approximately 80%. Two state agencies command this gap between them in terms of how they treat people with mental illness leaving the community from the state prisons (but I digress).
  The other question I had for you was, do you take into consideration, let's say they are conserved on day one for legitimate reasons by the court, how do measure, do you measure any progress that first year in terms of their ability to manage their medication, money, improvement in their relational skills so they are not getting into trouble in the community that ended with them being conserved in the first place? I am wondering about that and is of interest to me as a program executive too because I want to know how can I help? How can we help in developing our programs to focus in those areas? We certainly want our clients to have a lived experience of living independently. (RESPONSE: Linda Arzio) I don't know that we have a specific measuring tool. We don't. But each time we visit the client, we are doing an evaluation as to their level of grave disability and all the things mentioned (and more) are included in that evaluation. Grave disability has to do with food, clothing and shelter as a result of the illness. Are they able to make a rational/doable plan for themselves is always a basic investigation we are making when we meet with one of our clients. Even included in the law (when we go to court), the instructions the judge gives to the jury, if there is a jury trial, is does the client have insight? We are measuring the amount of insight they have. Do they realize they have an illness they need help with? That they need medication for? That they need assistance from others for? Are they able to carry on a rational, linear conversation that would be a sign they can live in the world in a functional way. The everyday things, are they able to do all their self-care? Those are things that are ongoing. The other edge of the conservatorship sword is preserving their rights. So, why we wouldn't necessarily have a goal of no recidivism, not that it's a bad goal, but protection of their rights. Once a person is able to do all that for

themselves, we really shouldn't be taking their rights away any longer. It is a little different than dealing with recidivism from crime.

- (Patricia Gray) My question then is: when you are going through this evaluation, do you read through, do you subpoena, do you get a hold of their records from their B&C and read and understand how they have been performing and whether they are medication compliant, whether they understand their mental illness, and in ways judging their insight? It is really very helpful… <cut off> (Linda Arzio) it is both with a direct evaluation of the individual reviewing their records and interviewing the staff that works with them, as well as family members. We work with a whole team and become part of the team. Ideally we are communicating with as many people in the lives of the individual as possible.
- (Patricia Gray) Thank you so much for that comprehensive answer. Then the last questions I have is, if the before any of that is done, do you find it helpful to tell the conservatee they are already getting a date before any of that investigation is done? Telescoping a date, they are going to be released before the investigation is done? (RESPONSE: Linda Arzio) it is not uncommon. It is pretty common, if the assigned deputy conservator starts to feel this person is improving a lot, it is often very beneficial to get them to be more involved in their life and planning. That will include in the conversation that 'we really feel you are doing a lot better and, at your next renewal date, we might be ready to release you from conservatorship, but here's some of the things I'd like to see you improve on or show me that you can do on your own. In order to confirm we are really ready to take that step." Often it is when you find out if they are really ready. If they are, they will often get really excited and begin to do more/show more and feel really good about themselves. It becomes and accomplishment rather than a punishment. Some never get to that place, but that is where you hope it to go.
- (Cmsr. L. May) I just needed a little more clarification and questioned Matthew Luu. It just didn't set right with me, how are they tracked? What is the step down process? To me, those are the most important questions as far as I could read. All are important, but #10 is the most important to me. Would you please speak to that Mr. Luu? (RESPONSE: Matthew Luu) What I can say to the group is some general processes we have in place within BHS. Example, many of you have heard about the bed committee. That is the committee that comes together to review clients who are at the county hospital and/or private hospital. Once a week we will review those clients to understand if they have repeated hospitalization (for example) and if they need treatment and need to be conserved. The hospital (CCRMC) are part of the committee that contributes the information to us to work together to determine the best course of treatment for the client involved. If it seems as though the client needs a period of treatment, the bed committee will work with the hospital to further the course of treatment and work with Linda's office to have them conserved. During the process when they are transitioning from an acute hospital to an MHRC or some locked facility, as Linda mentioned earlier, we track their process by having these treatment planning review process with the physician at the locked facility with their therapist and the county outpatient team is also involved in engaging with the person while they are at the locked facility to prepare them to come out/step down. This is where Linda's team would also gauge whether the person is ready to step down after a period of time or not. Depending on how the motivated the person is, how much participation over the course of time and if they are ready to come back to the community. Even prior to coming back into the community there is a planning process with the bed committee with a plan for what is the best type of facility for this person and their situation. The step down process is taking place on the weekly review and planning. The goal is working with the client and ensuring they are healthy and productive living in the community. We would love to increase the outpatient residential setting more and not have to expand the locked facility.

We don't want our clients to be locked up. The goal is to work with individuals and move them from the restrictive setting to the less restrictive.

- (Cmsr. L. May) How many visits do they need to have (4C or PES) to be considered for LPS… how many in a year? (Matthew Luu) I don't know if there are any specific number of in patient visits, it is really if they fit the criteria. (Linda Arzio) There is nothing the law that requires a specific number of hospitalizations, it really is up the discretion of the deferring doctor. (Cmsr. May) Thank you very much. I guess it changed from a couple years ago because it used to be they had to have a certain number of visits before they would even be considered.
- (Rebekah Cooke) I have a couple questions starting, my daughter is conserved right now and was told she was going to get let off, December 6th and never even met with the new conservator yet. Two phone calls and since she presents herself really well so they are ready to release her with $2000 and going to a homeless shelter in Mendocino is a good idea, it's a plan. It might not be a good plan, bit it's a plan. Unfortunately, I feel the AB1194 is being grossly overlooked. Repeated history, sadly what happens in the hospitals (and sounds like it is happening here) is that we are ignoring the fact there is a lot of history. My daughter had to work really hard to get conserved and finally the help she needed. Unfortunately, she also was put in a program right across from a liquor store and lost a bit of time, but is finally now at a facility where they are holding her accountable. She was caught drinking and has to go to a 90-day program. If she is disruptive or combative with the staff, there are consequences. Finally, there is a program that is actually going to help her heal and actually can have a roommate. If she goes to a homeless shelter, she will be combative with someone and will get hurt or she will hurt them because her mental disorder has steps to normalization. For some reason, she presents well and now they want to take her off the conservatorship. It makes no sense to may. She will repeat the cycle and the very minimum, you would think AOT would have to come step in. There has to be a step down. She has been 5150'd 18 times and that she presents herself well now after just a few months, it makes no sense to me. I am frustrated. There needs to be time where the conservator comes out and meets with her and he has to read to her file, and do his homework. He has not done so. I know that her previous conservator, Doug, is gone and there is a transition. I don't want my daughter to be lost in the transition because of the 'changing of the guards' and someone has to pick up the baton and do their due diligence so we don't lose. I don't know if she will make it back. What can I expect or do I just have to deal with this type of step down process that is unacceptable? (RESPONSE: Matthew Luu to Linda Arzio) I don't know the particulars of the situation, so maybe you could follow up with Rebekah directly, get more details and speak to this.
- (Rebekah Cooke) Just two other quick things. You said something about insurance, private insurance? I have to push back on that. I had private insurance for my daughter for years (Aetna) but was told from CCC that she will not get conserved without her being off her insurance. She has to get on SSI and there was no way they would even look at her. She would get 5150/5250/5170 was a challenge due to private insurance and no commitment they would do an LPS and we went round and round for years regarding this. Finally, I gave up her insurance. There is something that is very much a vicious cycle that you can't get out of it. (RESPONSE: Linda Arzio) Part of that, we are a legal function and we perform that regardless of the type of insurance but not all insurances will cover all services. For example, until 4-5 years ago, the county was the only mechanism to pay for an MHRC. Kaiser has made contracts to cover some of that but not usually for as long as the county. That is where you run into an issue of who is going to pay for that MHRC. That is the reality, most private insurance do not cover it, maybe the ancillary services but not the actual stay.

- (Teresa Pasquini) Just wanted to show the 21 years of conservatorship papers I have for my son. I'm grateful but not something I planned on for him when I carried him through our front door as a baby. He is happy too as he feels safe and comfortable on conservatorship. It is just I hear stories of other families that can't get a conservatorship or can't stay on one and it is why I am very focused on this discussion, why I submitted questions, why I am hoping we can start collecting data and information and understand what our county's criteria is and what the needs of our staff, community, hospitals, clients are. I through those questions out and I don't know if they are appropriate but this is something the community has to talk about. Linda, I was really pleased when you came to this committee back in February and shared your history and story because you were extremely honest. I appreciate you being here today and answering questions and I think we all want a collaborative conversation but there is a disconnect. There is a disconnect between what some people are experiencing and what reality is. I know that better than many because of 20 years of living this. I know what happened when my son was privately insured but was conserved. I know the history, the funding discrimination and is why I wrote the paper. I am hoping our commission this learning of this past year and bring forward some action that will allow our community to have a collaborative approach that is not adversarial and not allow family members like the one that was just mentioned to fall off a cliff again. How many people are coming off conservatorship and falling of the cliff again? That is not recidivism, not clinical justice but just being inappropriately stepped down? This is a question I have been wanting considered for a long time. It was part of the data that was requested in Housing that Heals. Again, we begged for a collaborative, partnership approach to that conversation. All these topics: the housing issue, the conservatorship issue, the state hospital issue happening is going to be clamping down on our county and we have to come up with a way to have these conversations and collect this data that is transparent and that is more open than (frankly) what I have seen. There is a disconnect with what I am hearing today and what I am hearing anecdotally from family members.
- (Cmsr. G. Stern) I'd like to jump in and dovetail what you are saying with what Deputy Director Luu was saying earlier about the focus being on outpatient / community based care, rather than locked facilities. I am wondering if there is an intermediate placement as a step down alternative needs to be brought into the conversation because it looks like an either or… it's either CBOs or locked. Well, what about an interim step because there are clients who need that more structured and confined setting initially to enable them to consolidate their gains they have made in the hospital before being put in a free community based situation where they can easily walk to the liquor store or meet their drug dealer. Is anyone looking at that? (Teresa Pasquini) We already have that. (Cmsr. G. Stern) Where is that Teresa? (Teresa Pasquini) Well, that's a good question too. That was part of the data we have been trying to obtain. Find out. Do a needs assessment on the levels of care we need and to track people, how are they doing? Determine how many beds we need at which level. Of course, we all want the least restricted situations but we can't forget how many people are very restricted in jail cells right now. That has become the beds that are always a yes. There is a crisis there we are trying to deal with. Again, I go back to the housing that heals paper, it was all laid out in that paper. I remind everyone, the Olmstead Act didn't say everyone should be in the least restrictive care, it says the most appropriate least restricted care. Everyone likes to forget the word 'appropriate'. In order to know if you are in the most appropriate level of care, there has to be some criteria determining that. It shouldn't just be whether you have a ten minute phone call with someone where they can spout out that 'yeah, I'm going to go here and this is how I am going to feed myself, etc.' when you have a history of not being able to do that.

- (Cmsr. G. Stern) Deputy Director Luu, can you respond to that?
(Matthew Luu) I know our Director, Dr. Tavano, created the position of housing chief with Kennisha heading that effort, and more recently the last few months we filled the Infomatics Chief who is looking at the data Teresa described earlier. There is a big gap with the data and is scattered in different systems so we are trying to have the Infomatics Chief to help us work with the hospital data people to coordinate and consolidate in an effort to analyze and look at the gaps. IF we don't have the data, we need to set up the mechanism to collect the data and analyze and actually bring it forth to the leadership and community for feedback where we need to go with that data. It is hard to come up with recommendations if we don't know what needs to be recommended. We are trying to set up different levels of care data. I saw a report from the commission that was sent over for San Francisco showing they have a mechanism to look at this data and looking up (any day of the week) knowing how many people are in the B&C, state hospital, lock facility, etc. so they can do their planning accordingly. We have the data but it scattered all over, not in one location and we are trying to gather it centrally. We need a similar dashboard to that of the hospital that we need for BHS. We have been on EPIC (electronic health record) for three and a half years but in comparison with the hospital it has been for longer than 8 years. Their ability to pull this information, the system is much more advanced and we are trying to replicate and set up to have the data and information we need to make those appropriate decisions. Hearing feedback is really crucial because if we look at the data but don't hear about the actual human experience, it doesn't help having a picture of what is going on in the community, where we need to plan and where we need to go.
- (Pamela Perls) I want to mention that many in the disabled community are very concerned about the opposite end of the conservatorship, the two pronged application. As a lawyer, I haven't seen that in court. I have seen a great reluctance to impose a conservatorship, even when it is really required. That is something people worry about a great deal. We are speaking to it now at the State Council because there is a bill that would reform conservatorship (I believe it is 634) I will let you know what our recommendations are. But that is the concern of many disabled people as they really worry. Many have comorbid conditions and have mental health conditions but worry they will be disadvantaged in some way and they will be more vulnerable to being conserved. Once we speak to this bill, I will bring that back to you at this committee.
- (Cmsr. B. Serwin) Thank you to Matthew Luu regarding Kennisha and Stephen's position. I want to encourage, particularly on the informatics' side that they have the resources they need to really do that work. It is incredibly difficult work, not only in terms of needs assessment but the technology of it. That technology in our bureaucracy and that of the hospital, ultimately linking it out to the CBOs and other hospitals and providers we need to link up with in order to track that information. If you need support from the commission on that point, it is something we actually invited Stephen Hahn-Smith to speak at a commission meeting about what his role is doing because we really believe the data is so important.

VII. DISCUSSION and PRESENTATION from Health Housing and Homeless Services (H^3) staff regarding overview of Housing Resources and accessing the Coordinated Entry System following release from detention

In the meeting minutes from last month, we brought up some of the issues we will be speaking to next month. Researching on how inmates find housing after being discharged or released from detention, I came across the name of Michael Fischer, Contra Costa Health Services (CCHS) administrator for Health Housing and Homeless Services (H^3). I sent him an email and received a call about two weeks later. He had

been on vacation and was very interested and animated about joining us for a meeting to speak on this issue and suggested that we invite a group of people who he works with and are as follows:

- Jenny Robbins, Chief of Program, Health Housing and Homeless Services
- Patrice Guillory, Director of the Office of Re-Entry and Justice
- Yuri Secoquian, Probation Manager (AB109/Pre-Trial)
- Ellen McDonnell, Chief Assistant Public Defender
- David Seidner, Chief of Detention Mental Health
- Jacqueline Kidd, Health Services Administrator, Detention Health
- Tiombe Mashama, Program Coordinator, CCHS Reentry Health Conductors Program)
- Janna Evans, Reentry Transition Specialist, Game Plan for Success
- Marie.Scannell, Program Manager BHD Forensic Services
- Jody Sicheneder, ASA III Inmate Welfare Sheriff's Office

These are the people he is asking to join us for next month, it is interesting and hopeful, as it is quite a lost of people that want to engage in this topic and have a collaborative discussion so we are all on the same page and maybe come up with some creative ideas for placing people when they are released from jail rather than just giving them a bus ticket or putting them on the street. All those invited to participate have agreed to come to this meeting next month so they could have another month, Michael Fischer spoke to his supervisor and wanted another 30 days to come up with a plan for what they wanted to speak to for this forum.

Comments and Questions:

(Cmsr. Teresa Pasquini) The attachments that we were included regarding this topic for the forum for some background data and have been attached to these minutes and consist of: (1) The Mental Health Commission Meeting Agenda for December 11, 2007; (2) the MHC meeting minutes for December 11, 2007; and (3) The MHC meeting minutes for January 24, 2008. These are from when Teresa was on the commission (2007/2008), when the program supervisor, Edna Freidman was retiring and came to the commission and gave some pretty scathing comments to the commission regarding her concerns regarding the way our county staffs and manages the conservatorship office. Teresa was asked that time to go to a family and human services committee meeting to share the commissions motion and give public comment based on her personal family experience with her brother and son.

The excerpts specifically called out from these documents:

- **Agenda December 11, 2007 RE: Conservatorship**. *DISCUSSION AND POSSIBLE ACTION ITEMS Background: • The Employment and Human Services Department, along with Mental Health Administration, will be presenting a proposal to the Board of Supervisors' Family and Human Services Committee December 17. (Adult Mental Health Program Chief Victor Montoya will address this at the January Commission meeting). Dorothy Sansoe will be available at the December 11 meeting to answer questions. If published by EHSD, the report will be available at the meeting. • The filing for the Program Manager position in the Conservatorship office closed on November 30, 2007. County Human Resources is in the process of promulgating the list and as quickly as possible (this is one of their top priorities) interviews will be held. • Determine Commission recommendation/response to: 1. Possible combination of program under one department/division (currently under both Employment and Human Services and Mental Health Services)* 2. Concern regarding vacant position(s) due to retirement, medical leaves, etc.* (https://cchealth.org/mentalhealth/mhc/pdf/agenda_dec11_2007.pdf)
- **Minutes December 11, 2007 RE: 10. Conservator Report.** *Ednah Friedman presented a written report on the history of the conservatorship program, and added her personal statement. In 1997 they had 429 cases, in 2007 they have 765

with less staff. She encouraged the Commission members to personally contact their supervisors and ask for long term staff to prevent needless suffering. Donna said the conservator programs are grossly underfunded. Contra Costa County Mental Health Commission December 11, 2007 (Rescheduled from November 29) 5 Janet Marshall Wilson handed out an article explaining the purpose of conservatorship and the rights a consumer can lose. Teresa made a motion that this Commission elect someone to make a statement to the Family and Human Services Committee of the Board of Supervisors' meeting on Monday that the staffing at the conservatorship program be funded properly and filled at the very least, if not enhanced, but not at the expense of other mental health programs. The motion was carried and Teresa was asked to make a statement from the Commission at the meeting. Donna said the county has to provide the resources and make the commitment to support this program.
(https://cchealth.org/mentalhealth/mhc/pdf/minutes_dec11_2007.pdf)

- **Minutes January 24, 2008 RE: 8. Report on Employment and Human Svcs Dept./Mental Health Admin.'s Proposal presentation** regarding conservatorship to the Board of Supervisors' Family and Human Services Committee December 17. Teresa Pasquini reported regarding presentation of Commission's recommendation at December 11 meeting. Reading a prepared statement, following her statement of the Commission's position, Teresa read comments in which she urged that the staffing issues be addressed immediately. Teresa said Edna Friedman was there and made her opinions known. Susan Bonilla expressed her concerns. The staffing issues have been submitted for the agenda for the February 5 Board of Supervisors meeting. Dorothy Sansoe said a recommendation was made to move positions to help ease the situation. • Report by Adult Mental Health Program Chief Vic Montoya Vic Montoya, rather than speak to the December 11 meeting, he said he would respond to the current staffing of the Conservator's Office. They are working to have the intake process become aligned with the urban conservatorship. ... there is finally momentum that has gone through the departments that resulted in recommendations that will be brought before the Board February 5 that ... will streamline a lot of functions and provides cross-training between conservatorship, LPS and probate. It strengthens the permanent staffing and the intake staff. Regarding staffing, Vic reported, "We are fully staffed in terms of conservators and probate," he said. February 5 is when Eric Cho, the new program manager, will begin and he is very skilled. They are still looking for a Property Trust Officer and hopefully recruiting for that will begin soon. The other position they don't have is a Project Patient Financial Specialist. They are responsible for reconfirms, but there are four other people currently who can perform that function. Cynthia said there are still not enough conservators to fill the need. Donna said there have been four reductions but they did not cut this section. Teresa asked why it took so long to offer Eric the job. She said there are a lot of concerns regarding the Conservator's Office. Vic said there are certain issues that are never privy to the public, but as they went through the interviews, Eric was not qualified at the time. So, they rewrote the qualifications and it was then that Eric was selected. It took from August to December to interview and offer Eric the position. Dorothy Sansoe encouraged people to attend the meeting on February 5. Kathi asked if the Commission wished to change the motion from the previous meeting. The Commissioners indicated that the previous motion should stand.
(https://cchealth.org/mentalhealth/mhc/pdf/minutes_2008_01_24.pdf)

Teresa gave this as context because there has been a lot of anecdotal information out in the community about the staffing, people leaving and not being there, along with family member's concerns regarding individual cases and wanted to use the to drive the change. It would be great to have a protocol in place that will allow our community and commission to track and understand the numbers.

(Cmsr. Geri Stern) Can you specify what numbers exactly and for what purpose? (RESPONSE: Teresa Pasquini) The list of questions I submitted. After I sent those questions, there was an article on the front page of the San Francisco Chronical that spoke to a really horrific sad story about a Vet found face down dead in a ditch whose family member had been trying to get them conserved and showed a lot of information and data, which was another example. See following: (https://www.sfchronicle.com/bayarea/article/A-struggling-veteran-was-found-in-a-Lands-End-16546952.php).	
VIII. Adjourned at 3:02 pm	