MENTAL HEALTH COMMISSON
MHSA-FINANCE COMMITTEE MEETING MINUTES
November 18, 2021 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Douglas Dunn, District III called the meeting to order at 1:32 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Cmsr. Graham Wiseman, District II Presenters: Allison Becwar, LCSW, President & CEO, Lincoln Families Dynell Garron, Community-based Services Program Director, Lincoln Families Renee Lesti, LMFT, MDFT Clinical Program Manager, Lincoln Families Other Attendees: Cmsr. Kathy Maibaum, District IV Cmsr. Rhiannon Shires, District IV Angela Beck Jennifer Bruggeman Gigi Crowder Carolyn Goldstein-Hidalgo Jen Quallick, Supv. Candace Andersen's office Stephanie Regular	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: • Incompetent to Stand Trial (IST) Workgroup is wrapping up its work tomorrow. I will forward final version to the participants on this call as well as the Mental Health Commission, Jennifer Bruggeman and Dr. Suzanne Tavano. (Cmsr. Leslie May) Shouldn't this be presented to the Quality of Care committee (instead of this committee)? I am sure the Quality of Care would like to hear more about this. (Cmsr. Dunn) The meeting is tomorrow and the Quality of Care Meeting is next Tuesday? (Angela Beck) It is right after this meeting at 3:30pm. (Cmsr. Dunn) The final will not be ready until tomorrow. (Stephanie Regular) Regarding the workgroup, somehow independent organizations have submitted recommendations in response to the workgroup recommendations. I suggest, if you are going to forward the DSH Workgroup recommendations, that you have a complete record of what others have submitted, including NAMI, CPDA, ACLU, Baselone Center, Disability Rights, among others.	

V. APPROVE minutes from October 21, 2021, MHSA-Finance Committee meeting: Cmsr. Douglas Dunn moved to approve the minutes as written. Seconded by Cmsr. Graham Wiseman. **Vote:** 3-0-0 **Ayes:** D. Dunn, L. May, G. Wiseman. Abstain: None	
VI. RECEIVE Lincoln Families Program & Fiscal Review discussion and documentation for its Multi-Dimensional Family Therapy (MDFT) Program for the Lincoln Child Center, Allison Staulcup Becwar, LCSW, President & CEO, Lincoln Families Lincoln is a 138 year old organization whose mission is to disrupt cycles of poverty and trauma, empowering families to build strong futures. The three of us have been with Lincoln around 40-50 years cumulatively, and bring a lot of collective institutional knowledge. • Allison Becwar (CEO) has been with Lincoln for 21 years. • Dynell Garron (Community-based Services Program Director) has been with Lincoln for 11 years. • Renee Lesti (Associate Director of MDFT) as been with Lincoln approximately 14 years. Overview of Lincoln Families, we have three main strategies we work on across 16 different programs. • Educational Achievement: We have a number of programs focused on reducing the barriers to learning and attending school that are primarily mental health programs. We have run a very successful school-based mental health program in East Contra Costa County (CCC), specifically in Pittsburg, as well as Antioch where Renee started with Lincoln. I ran that program for a number of years early on with Lincoln. • Family Strengthening and Stability: We have number of programs that fall under family strengthening and stability, with the goal being "how do we help families stay together and thrive?" Particularly when they are going through some of the most challenging circumstances they may face. Our MDFT program falls under those programs. We have a number of programs in both Alameda and Contra Costa County working to help families stay together and/or reunify and be successful in all domains of their lives. • Community Wellness Programs: This is our efforts to help families before there is any need for systems involvement; and where we are really trying to strengthen and support the communities. One of our most effective approaches is through family resource centers. We can help cocreate hubs in the community where families can both give and get support that they need. Along with literacy programs where we are helping kids find a love of learning and reading early on; and working with schools to develop that love of learning. Multi-Dimensional Family Therapy (MDFT) Program: • Evidence-based model • Provides short-term, intensive therapy to families and youth struggling with substance use and mental health challenges	MHSA Plan Update Power-Point presentation screenshare during meeting.

- Provides a full-range of intensive services and our mission is to help youth get back on healthy developmental track and build successful futures.
  We do work with our folks in the communities so we are in the homes and schools (we are where they are at) so there is no barrier to treatment, we go to them.
- Components of MDFT: We work in four domains and very researched on the fact that there are a lot of contributing factors to get youth off track, and in order to help with that treatment work in the following:
  - Adolescent
  - Parent/caregiver
  - Family
  - Community
  - Team-based approach allows us to help facilitate change in the different domains as it is a model that really goes through the family as the context of healing.
    - ◊ Family advocate + Clinician = Comprehensive Support
    - ◊ Meet one (1) to three (3) times a week, based on overall goals, we determine which sessions will be conducted weekly.
    - ◊ Family/youth identify needs and goals
    - ◊ Comprehensive services help reduce risk factors
    - ◊ Provides the tools to increase protective factors to succeed.
- Components of MDFT: Model fidelity in portal
  - Measures type, length and frequency of interventions
  - Tracks certification of clinicians
  - Tracks clients improvement during treatment
  - Referral sources:
    - ◊ Probation – 80%
    - ◊ County – 15%
    - ◊ Community-based Organizations (CBOs) – 5%
  - Demographics (gender):
    - ◊ 2019-2020 (69): 70% male/30% female
    - ◊ 2020-2021 (54): 70% male/30% female
  - Demographics (ethnicity):
    - ◊ 2019-2020 (69): 31% African American; 16% Mexican American/Chicano; 11% Caucasian; 42% Other
    - ◊ 2020-2021 (54): 28% African American; 12% Mexican American/Chicano; 7% Caucasian; 53% Other
  - Demographics (age):
    - ◊ 2019-2020 (69): 96% 13-18 yo; 4% 6-12 yo
    - ◊ 2020-2021 (54): 100% 13-18 yo
- Program Outcome Highlights*:
  - Percent of families with improved family functioning (safety within the home, how the family is communicating within the home):
    - ◊ 2019-2020: 96%
    - ◊ 2020-2021: 92%
  - Percent of youth with stable mental health functioning:
    - ◊ 2019-2020: 84%
    - ◊ 2020-2021: 83%
  - Percent of youth in school/working:
    - ◊ 2019-2020: 87%

- ◊ 2020-2021: 75%
- Does not regularly resort to violence:
  - ◊ 2019-2020: 100%
  - ◊ 2020-2021: 91%
- No new child abuse/neglect reports:
  - ◊ 2019-2020: 96%
  - ◊ 2020-2021: 88%
- No new arrests:
  - ◊ 2019-2020: 93%
  - ◊ 2020-2021: 91%
- No drugs other than marijuana / alcohol:
  - ◊ 2019-2020: 89%
  - ◊ 2020-2021: 79%
- Met treatment goals:
  - ◊ 2019-2020: 80%
  - ◊ 2020-2021: 74%

* Based on successful program completion. Dip in percentages during 2021, this model is designed to be an in-person model and much of the work was done via zoom in 2021. Our theory is the impact of non-in-person participation (work/school and other barriers to in person activities).

NOTE: Average Service Length for 2019/20=6.5 mos.; 2020/21=8 mos. We were finding through telehealth we work in three stages. Stage 1 in-person is 4-6 weeks; however, through telehealth, it was taking longer and intentionally expanded that to 8-10 weeks to lay the foundation before moving to Stage 2.

- Staff Training
  - New Hire Orientation provides foundational trainings
    - ◊ Trauma Informed Practices
    - ◊ Cultural Humility
    - ◊ Attachment lens
  - MDFT Specific Training and Supervision
    - ◊ 6-month DVD Review and quarterly live supervision
      Receiving case reviews weekly with their supervisor, as well as recording themselves in session for DVD review where the therapy skills are enhanced and amplified for their skill development.
    - ◊ Live supervision with family coming into the office and having sessions where the trainer calls in to enhance the therapy in the room.
    - ◊ Case collaborations with family advocates and clinicians so everyone involved is current in the case and working in unison to help the families.
- Success Stories
  - (2019/2020) Male youth, started with Lincoln at 16 yo. Not on probation but living at home with his grandmother (and older sister). Experiencing a high level of anxiety and having panic attacks frequently throughout the week. Daily marijuana use and was in the community exhibiting high risk behaviors with his peers. The family goal was to help reconnect him grandmother, as he suffered early attachment with his parents. He was not attending school regularly and experiencing truancy issues. The clinician and family advocate with him and his grandmother. There were incredible changes between their relationship and started to know how

manage his anxiety and reach out to his grandmother when he was having a hard time. Substance use reduced quite a bit. Unfortunately, during treatment his grandmother passed away and experienced a tremendous amount of grief. We were still working with him and his family. The work he had done to learn to communicate, we were able to help him reach out to his aunts. Housing then became an issue because they had to sell the home and it was incredible to see him at that point to be able to really communicate with his aunts and what his needs were. By the end of treatment, he and his sister were living with a teacher at the school that had an in-law unit. He was not using any substances and in school, on track to graduated and working. Half was in person and then the pandemic hit and some of the treatment was through Telehealth.

- (2020/2021) Female youth (still active and closing in a week), 14 yo and on probation working. She lives with her Aunt. Her big challenges were early childhood trauma and experienced a lot of emotional dysregulation, had a couple of experiences at school peer fights, suspension and the relationship between her and the aunt was very strained. Daily marijuana use and not in school for over two months. Now she is a basketball superstar, in a new school, receiving academic support, on the basketball team. Very connected with her aunt and has been able to be coached by her aunt and is very accepting and receiving of her aunts structure in the home and having dinner together, connecting and traveling with her for sports. She is very close to getting off probation.

Questions and Comments:

- (Gigi Crowder) – The comment around stability, who you serve and I did participate with Mt Diablo Unified School District (MDUSD) and are these slides specific to your work in CCC or across the board for all Lincoln Programs. Is it CCC? (RESPONSE:) Specifically CCC, yes. (Gigi Crowder) well that is disturbing to me that there is a population of less than 10% African American and I'd like to the see the numbers go down. I don't want to see African Americans over-represented with IEPs (Individualized Education Program) and within our juvenile justice system. You have been doing great work. I just think over time, we should say "Hey, we are doing such great work, we don't see the disparity we used to" and to have a system that continues to see this pattern of African American students being tracked into these programs and the margins going up, we probably to shouldn't refer to this as stable, it should refer to it as still seeing this horrible trend. I anticipate with the MDUSD when they have their African American focus groups and a large part of their solution would put a lot of pressure on the families and the students to shift the tide. It is institutionalized structured racism that caused these kids to be labeled as needing an IEP. I believe in that school district, it was 38% of the African American students had IEPs.

  Working at NAMI (National Alliance on Mental Illness) , recognizing how mental illness shows up across the board and does that discriminate those intellectual disabilities by ethnicity, we just have to do a better job of addressing this. I hope this evidence based practice you are using is also practiced as evidence and is designed to meet the needs of cultural groups. Would language barriers be considered as well? It is depressing that we continue to have the California State Department of Education, over and over

show the significant over-representation for African American students and the solutions are to continue to put money into a system that is failing. We need to start addressing these issues, not just putting band aids over gunshot wounds. If we are really doing a great job, then we need fewer African American students being tracked. (Renee Lesti) I appreciate you lifting up the disproportionality. There are some interesting trends in the referral pipeline and the fact is the majority of our referrals are coming through probation right now. We also know there is a disproportioned number of black boys being criminalized. I think that is one of the things we are excited about trying to explore with the county on how we get referrals, the intensity of need should not necessarily always be associated with the intensity of systems involvement. We are not serving nearly enough girls in this county who may be really struggling with mental health and substance abuse challenges. We are pretty lopsided in our referrals. I want to add that, with the MHSA funding, we are able to see the youth while in Juvenile Hall and some of the most meaningful and curative change has happened during session in there and the amount of youth we are able to get off probation. Last year and the year before was exceptional. The work we are doing with youth back out of the system has been huge.

- (Cmsr. Leslie May) Did you have a strategic plan? I'd like to see that. I reviewed the program and physical review from 2017 (old) is there a current one?

  (RESPONSE: Allison Beckwar) I am pulling up the strategic plan, (Jennifer Bruggeman) The MHSA Program and Fiscal reviews were halted in early 2020 due to COVID protocols, no onsite visit and review is a very crucial component of the process and we haven't been able to perform those. The last reviews were in early 2020, unfortunately we are behind. We hope to resume that process in 2022. It is on pause so the 2017 is the latest.

  (Cmsr. Leslie May) When these do come out, will the commission be able to review them, as well? (Jennifer Bruggeman) Absolutely.

  (RESPONSE: Allison Beckwar) Briefly, our current strategic plan. We have four main quadrants we are actively working on
  - DO IT WELL: Efficiency, effectiveness and equity – making the lives of our staff more streamlined and easier to enable their ability to do the important work.
  - INNOVATE FOR IMPACT: Service models, strategic partnerships and systems change – how do we continue to raise the bar on our service models, leaning into strategic partnership and a lot of those community capacity building and also pushing for systems change so that we are able to see from our vantage point that there are recurring issues, how to push for systems changes as well.
  - BE THE BEST: Recruitment, recognition and retention – Ensuring we are bringing in high quality folks, training them well, taking good care of them and making it a sustainable workplace so they can keep doing this job. We know the trauma impacts of our families, it can really take a toll on our staff (combined with their own personal stories), we are constantly looking at how to manage that and promote community wellness within the organization.
  - TELL OUR STORY: Awareness, articulation, and advocacy – Building awareness and articulating what is happening, hearing from our families

what the impacts are and raising awareness and advocating for change. We have a number of staff advocacy workgroups around housing stability, reimagining public safety, needs of immigrant families, which are some of the main focuses currently.

That is all encircled with Diversity, Equity and Inclusion, utilizing the work of our equity teams to continue to push the agency to think and do differently because many of the traditional ways we have done business come from a white-supremacist lens and so we are constantly looking at how we unpack that and do differently.

- (Cmsr. Leslie May) When I worked for Lincoln, I observed (in the schools) there were youth that were under the Lincoln plan that I worked with that had actual medical intellectual delays. Those youth were put into a behavioral program and that they were having behavioral problems. When I realized and brought it to their attention, I caught a lot of flack because I dealt with the Board of Education, and I know you know what is going on in Pittsburg. It was horrible. I don't know if your relationships with that Unified School District has improved since there is a group that are gone? I noticed this was occurring with many black and brown children. I faced a lot of criticism when I brought it up. They are not having behavioral problems, they are delayed.

  (RESPONSE: Allison Beckwar) I appreciate that, I'm not sure if that was also in relation to our non-public school at the time. The counseling-enriched classrooms. That was quite a few years ago and we no longer have that contract with the Pittsburg. I would say that what we are really proud of is our school-based mental health programs in Pittsburg, when you look at the demographics of the youth served, we actually reflect the larger population of the district and think we are one of the few programs that are successful at helping the schools identify early warning indicators, reflect on bias and ensure we are getting kids enrolled that might have internalizing behaviors or symptoms that are completely under the radar. Really asking people to act on the 'why' when they see "unsafe behavior" often from our black youth. Asking, is that what we are seeing here? What is this about? What is the cause of what is going on? There is still a ton of work to still do but feel we are making change there.

- (Gigi Crowder) I just wanted to offer up the resources we have a NAMI to compliment the work you are doing with the families. All our programs are free and we have some course that family members can take. We are funded through the peer work investment/peer-certification that has to do with specific targeted work with the African American community. So, we have staff available to support your efforts. We have programs for the API (Asian/Pacific Islander) community and LatinX, as well, so we have staff reflective of the community and I just urge all programs, when they are hiring, to give consideration to hire African American males.

  (RESPONSE: Renee Lesti) Yes, I will email you, Gigi, and connect with you on the programs.

- (Gigi Crowder) It is also a good idea to have these strategies if you need to help with hiring African American males in any role you can find them in. Young black males need to see examples of people who look like them being successful. I am happy to see, we did a listening session with the Office of Racial Equity and Social Justice and had an earful from members of our

_____ community from District II, which probably there is not much need for it because kids from that area don't get picked up and track into juvenile hall in the same way do in Richmond, Pittsburg and Antioch, but we are here to offer resources if needed. • (Cmsr. Doug Dunn) In the program fiscal review, I know it is now four years old, there was a bit of a partially met issue with charting. How you were going to address that. What has been the process and progress? (RESPONSE: Renee Lesti) On the utilization review, our MDFT program is consistently going through the process smoothly and with good feedback. • (Cmsr. Wiseman) I just put in a chat, a reminder that it is illegal and against federal law to base hiring practices on race. I'm a little upset that it is being advocated here. I felt I needed to voice that concern. (RESPONSE: Gigi Crowder) I will voice a concern that I have. There is a movement in place, just like you hire for language capacity, and I'm hoping just like the peer certification, that people will finally realize that in order for us not say 'all lives matter' and recognize that black lives do matter and black minds matter, that we have to work outside of the box and strongly encourage people to apply who are reflective of the community served. I am not saying to list an announcement "must be black male to be hired" but you can use language and suggest who you are looking for. It is legal and it needs to happen and should be stressed whenever any agency that serves the community doesn't have hiring reflective of the community. I know all the EEOC language, but I also know that most systems are failing black boys and I will speak loudly about it whenever I have the chance to do so. And give strategies on recruitment and where to find people reflective of the community, so they know the jobs are available. Without apology. • (Cmsr. Wiseman) I actually… there is no rebuttal to this Ms. Crowder, the law is the law. It stuns me that you feel it is okay to base hiring on racial profiling. I just have to object strenuously to that and make sure everyone is clear that is a federal violation. You hire people based on their ability and capacity. (RESPONSE: Gigi Crowder) Again, as long as demographics and information that shows disparity, I can't understand why people get so outraged when you provide strategic approaches to alleviate some of the disparities but don't jump up and speak, but when they heard words like it's stable being mentioned for the concerns that we have…that baffles me. Especially from commissioners that see the same data over and over again and never address it, but my first time on the phone call and I addressed it. I have just as much concern about that as you do about someone suggestion that the hiring practices be strategic. I never said 'only hire black males' I said consider positioning yourself to hire reflective of the community and offered a strategy in which to do it. My goodness.	
VII. RECEIVE Update on state level Incompetent to Stand Trial (IST) Solutions Workgroup Developments—Douglas Dunn, Chair MHSA-Finance Committee The work is going to wrap up tomorrow and some of the biggest problems are the potential funding for what they want to do resides with this listening session of the Department of Healthcare Services (DHS) and it is the Department of State Hospitals (DSH) under which all this is supposed to take place. I have been hammering in all my comments that they want counties to do all this, without	

much (any real) funding. It is a recipe for disaster. The information from Stephanie Regular presented to this committee, we are looking at a 75 person program. There are three groups we have to look at: Felony Incompetent to Stand Trial (FIST), Misdemeanor Incompetent to Stand Trial (MIST), and the LPS/Murphy conservatorships (approximately five to seven) in this county. The purpose is to clear out the 'log jam' over time, is to send them back to the counties from which they came. I have pointed out in the motion for this committee, I believe CCC is going to have to look to either refurbishing or building a criminal justice (i.e.. Forensic) mental health rehabilitation center (MHRC) to handle the MIST, FIST, as well as a long-term Murphy conservatees because the DSH, in this workgroup, has made it clear they are sending these individuals back to the county. Where are they going to go? Right back to overloading our jails.

Questions and Comments:

- (Cmsr. Leslie May) I can't agree more. I found an historical article about a mental health hospital many years ago. A couple came in and wanted to change it from a facility for everyone (all diagnoses, all ages) and to convert it to what we are speaking to now. I am going to share the article and send it, I apologize for not having sent to include for the meeting. We have hospitals that are empty (right now). When COVID hit and we ran out of hospital space, the governor was able to save all those places that are closed and to stock them. It happened in less than 30 days (2 weeks), stocked, cleaned and running. Why is it that we have buildings, I understand we need to find something in our county so families don't have to go from 'east hell to west jalopy' to go visit their loved ones and to see to it their loved ones are receiving the care they are supposed to be receiving. But in the meantime, we have those same facilities that are closed, why can't we have those opened and use them for this population. It just doesn't make sense. Nothing is adding up.
  (RESPONSE: Cmsr. Dunn) Speaking of that, it is going to be a chief topic I am going to delve into in depth, at the next MHSA-finance meeting in December. This population being returned to their counties, those counties that have Institutes of Mental Disease (IMDs) that are licensed to care for Murphy conservatees, FIST and MIST (which is Alameda County), those facilities will be overloaded with these returns. Currently CCC contracts out of county for all these individuals and will be competing for already scarce space. We need to either rehabilitate buildings in this county or build new. The cost to build is cost prohibitive and strong NIMBYism.
  (Cmsr. Leslie May) I have been looking at this, just as I was looking for facilities for children (PES, 4C, etc.). There is too much property around here that is county owned and are available to re-open for this population. I see developers coming in and buying up land that has been empty and building housing units that are ridiculous for million dollar homes, etc. CCC needs to put in for this funding from the federal government (as well as the state). There so much funding and land, but in the meantime we need to have facilities that we can put our folks. We need to have plans in place now, not to wait until the last minute.
- (Cmsr. Graham Wiseman) Thank you both. The Concord Naval Weapons Station currently falls under the jurisdiction for Concord and I believe they contracted with Sino to develop that property. That may be a very glaring missed opportunity. One of the things we may want to do is to work in

collaboration with our county BHS. We are aware of this, Jennifer sits in the meeting, BHS is aware, so what is the county plan and how can we, as mental health commissioners help this? Can we advocate to the Board of Supervisors regarding the Measure X funding and encourage a part of that goes to whatever BHS advises as a solution. We need to hear from Ms. Bruggeman and the county on what their plans are. There must be plans, right?
(RESPONSE: Cmsr. Dunn) I would like to hear from Ms. Bruggeman and Kennisha Johnson (housing coordinator) to say what their plans are, if there aren't I am ringing this bell and it needs to be on County BHS's radar. These folks are coming back. We better have the building facilities and the programming facilities and therapy programs and personnel ready.

- (Jennifer Bruggeman) Great points folks are brining up on this and there is a lot of emphasis around the new funding including Measure X money earmarked for a local housing trust. I don't know what the details will really pan out to be but it will be interesting to see. I would recommend continuing to have Dr. Tavano include updates of the grants they are applying for as a standing item. As this federal money is coming in, I know they are actively applying for grants and many have to do with infrastructure. Keep it on her radar and continue to get updates. As far as MHSA, we are also advocating for expanding housing and (hopefully) have a new project under innovation, a project proposal we can put forth, but that would be community level. MHSA doesn't typically fund housing or treatment programs at the higher level (the MHRC level).
- (Stephanie Regular) Regarding the FIST, DHS original plan to realign so the counties were responsible for individuals charged with felonies and found to be IST, that was not passed as part of the bill, it was removed. It is not as pressing. I agree with all your points, in terms of building out housing, I would not agree with building out forensic housing or facility. I don't believe we will ever resolve the problem of the over incarceration of mentally ill people if we continue to focus on restoration. If that is the focus, you will continue to have mentally ill people I jail with short-term treatment, just to the point of getting them competent to plea to charges, it will start the cycle all over again. If we are going to focus on housing, it should not be forensic, it should be a long-term strategic housing so people can actually get well and be supported in the community. There is a more pressing issue, and that is SB 317 did pass. It goes into effect January 1, 2022. What SB 317 does, is there is no more competency restoration for individuals found incompetent to stand trial and charged with misdemeanors. Our current forensic program meeting with individuals once a week for the purposes of restoration should be no longer. I sincerely hope the county does not wait until January 1st to convert that program into something else. What the county will be responsible for, instead of providing competency restoration, is anyone found incompetent with a misdemeanor, the court has four options: (1) to refer the individual for mental health diversion; (2) refer to AOT; (3) refer for conservatorship; and (4) dismissal. If it's any of the three, our county behavioral health systems need to be prepared for the shift in focus from restoration to these other services. I hope those systems are prepared for this shift. We cannot wait until January 1st to plan for this.
(RESPONSE: Cmsr. Dunn) Thank you for raising this and that is something I can raise this issue to find out what are we prepared in this county to do with this population.

- (Jennifer Bruggeman) Do you know how many individuals that would impact? (RESPONSE: Stephanie Regular) We have about 40-50 misdemeanor individuals on our caseload at any given time. My understanding is forensic mental health currently has 12 on their caseload but does not account for those that continue to come in.
  (RESPONSE: Cmsr. Dunn) To comment, you don't want just prison housing and I agree. Here is the issue that I see currently, the deputy district attorney, and I am seeing this with supporting families who have loved ones in the IST situation, I have seen the Deputy DA for mental health litigation, Angela Lyddan, when they are involved in either attempted murder, murder or serious threat of injury, will say those individuals are not eligible for any kind of mental health diversion and have seen her persuade the presiding judge to not grant it. My question is, where do these people go if there is not some kind of treatment facility? A non-jail treatment facility for them to go to. My idea/definite long-term plan and desire is there to be step-downs from that, but because of the stance of many DAs throughout California, including here in CCC, is that it be jail for these individuals.
- (Stephanie Regular) It runs the gamut from MIST to the highest level of FIST. The denials are not just reserved for the highest level felonies. Unfortunately, we see individuals who charged with very low level crimes who are rejected for mental health diversion. In terms of where they are placed, I agree they should not be in a jail, the DSH is still available. My concern is that with such limited resource in the county, that I would not want the county to focus its resources on building forensic facilities. (Cmsr. Dunn) Not even if they are locked like Gladman in Alameda County, which handles primarily LPS from that county and have the licensed capability to handle IST and Murphy conservatorship individuals. What does CCC do when these individuals come back and the DA says unlocked mental health diversion is not an option?
- (Jennifer Bruggeman) Stephanie, can you clarify what you mean when you say forensic facility? Locked MHRC or do you mean something different entirely? Just so I can understand. (RESPONSE: Stephanie Regular) I was responding to Cmsr. Dunn's comment in terms of CCC needing a 'forensic' facility. My concern about building out a forensic facility that focuses on competency restoration. I believe we would be missing an opportunity to build actual housing that would provide long-term solutions. Forensic is for somebody in custody, usually.
- (Cmsr. Leslie May) I like to look at solutions. Currently, we have the Richmond Health Center campus that was closed on 38th Street in Richmond. It is a large campus. It has been empty. WHY? Why isn't the county utilizing properties they already own? Why isn't the county taking that building and converting, doing some infrastructure going in so it isn't a shovel ready project, we aren't building from the ground up, it is already a structure. Work on the structure and turn it into that type of facility so when these people are released they can go there and that is the step-down so they can still receive services (more intense services) until they are able to move from there into other facilities like Teresa Pasquini and Lauren Rettagliata have been discussing. What we need to do is look at our time, what is available now, what will it take to get the facility running and focus on getting the services available.
  (RESPONSE: Cmsr. Dunn) Those are the questions I would like to pose to Kennisha Johnson and others at the next Finance meeting in December.

• (Cmsr. Graham Wiseman) Cmsr. May has a specific property that she has been able to name. Do we have a list of vacant county buildings? Where to we find that? Who would manage that? (RESPONSE: Cmsr. Dunn) That is what I want to find out at the December meeting and I will put forth some ideas I have heard about and put them on the table and have a motion at the meeting in December. • (Angela Beck) Reading Teresa Pasquini Statement<Statement attached to these minutes> • (Carolyn Goldstein-Hidalgo) Personal quick feedback. Doug, I really appreciate you and your transparency of just informing us of where we are. I am sorry Stephanie left the meeting because I really appreciate the knowledge and what it needs for us. I want to speak at the AOT level because I keep hearing about AOT but we are not having discussions about what we need to do and that is really concerning to me. We are supposed to be ready for January. I am preparing my staff, I hired a new clinician that is getting on boarded now, but I am (kind of) doing this in the dark knowing what I am learning from the commission. It means a lot to me because I learn so much and get the feedback on what we needs, but I also don't know how that is going to impact us in the bigger scheme and that scares me. (RESPONSE: Cmsr. Dunn) As far as I see this, going forward forensic assertive community treatment training is going to be required and that is going to take money, etc. That will need to be provided by MHSA funding or if there is prohibition against that, some of the $12bil coming down from the state.	
VIII. Motion—Ask Contra Costa Behavioral Health Services (CCBHS) to include Institute of Mental Diseases (IMD) Mental Health Rehabilitation Center (MHRC) facilities, programming and staffing needs in its upcoming Behavioral Health Continuum Infrastructure competitive grant applications to the state I know Stephanie Regular had real concerns how this is being worded. If we could add: 'And stepdown facilities' because IMDs and MHRCs are locked facility and I am trying to answer the concern of Deputy DA Angela Lyddan who will say go to jail, but if we have a place that is locked but not jail, it is a step forwarded and that is why I would like it worded that way. Cmsr. Leslie May moved to vote on Motion as written. Seconded by Cmsr. Graham Wiseman. **Vote:** 3-0-0 **Ayes:** D. Dunn, L. May, G. Wiseman. Abstain: None	
IX. Adjourned at 3:14 pm.	