MENTAL HEALTH COMMISSON
MHSA-FINANCE COMMITTEE MEETING MINUTES
December 16, 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 1:34 pm. <u>Members Present:</u> Chair, Cmsr. Douglas Dunn, District III <u>Members Absent:</u> Cmsr. Leslie May, District V Cmsr. Graham Wiseman, District II <u>Other Attendees:</u> Cmsr. Barbara Serwin, District II Cmsr. Rhiannon Shires, District IV Angela Beck Jennifer Bruggeman Carolyn Goldstein-Hidalgo Ivette Kwan, Program Manager Action Team, Mental Health Systems Teresa Pasquini Jen Quallick, Supv. Candace Andersen's office Stephanie Regular Lauren Rettagliata Michael Sisler, Assisted Outpatient Treatment Supervisor, Mental Health Systems Baylee Weschler, Social Justice Advocate, NAMI CC	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Lauren Rettagliata) Mayor Darrell Steinberg (of the Steinberg Institute) has been quoting parts of our paper and we are excited about that. Cmsr. Dunn, to you and everyone at NAMI (National Alliance for Mental Illness), we are being heard and thank you for everything. He actually mentioned AOT (Assisted Outpatient Treatment) and how there needs to be housing connected with AOT and Full-Service Partnerships (FSP) and the need for entitlement, as there is for the Intellection Developmental Disability (IDD) community. The fact that there is an entitlement for one, and not the other, this needs to be changed and needs to be changed now. I could only hear bits and pieces of this testimony as my son was home for the day. This testimony may actually help those like my son, as there is not enough for these people that do not respond voluntarily. That is what this whole committee meeting was about: What do we do for those who voluntary is just not enough?	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: • Addressing the last finance committee meeting: there were some comments that should have been addressed and cut short. For that as a committee chair, I apologize. Moving forward, as these come up in the future, I will exercise my chair prerogative and stop the conversation. As long as I am chair	

of this committee, everyone will be treated with respect at all times, regardless of their self-identified ethnicity, gender, etc. background. Such things as microaggressions will not be tolerated on my part. Again, for that I do apologize.	
V. APPROVE minutes from November 18, 2021, MHSA-Finance Committee meeting: Cmsr. Douglas Dunn moved to approve the minutes as written. Seconded by Cmsr. Barbara Serwin. **Vote:** 2-0-0 **Ayes:** D. Dunn, B. Serwin. Abstain: None	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. DISCUSS Efforts and Plans to Receive Persons adjudged Misdemeanor Incompetent to Stand Trial (MIST) back to county Behavioral Health and contractor operated programs beginning in January, 2022 The paper I put together for the persons about to come back to Contra Costa County (CCC) that are considered misdemeanor incompetent to stand trial (MIST), I would like to go through this briefly. I have questions to ask. I am glad that Carolyn, Ivette and Michael are with us, as well as Stephanie Regular in this meeting as we are looking for some key information from each of you. If I have some incorrect information in the handout entitled "Misdemeanor Incompetent to Stand Trial (MIST) Persons returned to CCC" please correct me. Stephanie, as I understand it, you indicated at a previous recent meeting, we were speaking on 15-25 MIST persons coming back this week from the state hospitals. (RESPONSE: Stephanie Regular) No, there are no longer any MIST persons at the state hospital. As of July, of this year, the county could no longer commit individuals who are misdemeanants, and they cycle really quickly. The numbers the change quickly. Again, there are no MIST persons currently at the state hospital. (Cmsr. Dunn) How many MIST persons are already back in CCC that need a place to go, services and treatment, etc.? (RESPONSE: Stephanie Regular) We have approximately 22 individuals who are MIST. (Cmsr. Dunn) In terms of 'landing areas' for this population, which is very important, I was heavily involved in helping set up the AOT program after advocating for it for three years (2013-2015) and I can tell you that both FSP and AOT contractor staff were never trained to handle heavily forensic involved clientele. This is an issue we will need to deal with now. I have raised some questions on this handout in terms of blending, slightly increased program size, persons considered disruptive. Carolyn and Michael, it is now your turn to chip in your comments. (Michael Sisler) It has been my experience dealing with the clients can be extremely tricky in these situations, or they just return and return and return. The idea is to try to catch them before they fall all the way down. Possibly we need better housing that is more sensitive to their needs, they lack insight and the possibility of them going back in is pretty sever and there is substance use surrounding as well (not all cases, but some). It is really important to focus how we are going to deal with the solution of this problem that is continually coming	**Meeting handouts can be found at** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

out efficiently and effectively, to the best of our ability. I understand it is a difficult task, but we need to work around how we can better serve without it just being dropped in our laps. We need to understand what we need to do.

(Ivette Kwan) When looking at this with what we already do with AOT, to do it right, we were discussing how housing plays a big key. We have individuals coming out, where are going place them? We were looking at our own master lease with 24 on-site staff. A house manager that would help with any disputes, monitoring curfew and so on. We also know that AOT plays a big part in the ability of our clients now, with a capacity of 75, of which 90% involved with substance abuse. Staffing would also include an AOD counselor, a clinician, peer-partner and housing staff. Cmsr. Dunn brought a good point regarding training. We would like to focus on trauma. Trauma focus, overall criminal justice is where we would lack insight, and also forensics, mental health first aid. These are just some of the things that came to mind as to how to support this population and it is coming rather quickly. Also, we are getting our MHS crisis prevention certification.

(Carolyn Goldstein-Hidalgo) To summarize, as a provider we want to put ourselves out there because we want to work with population and want to be the identified provider for these clients. We definitely know the needs of the population but we are lacking in training and creating a multi-disciplinary team to work directly with the clients. Adding additional clients to support the 22-25 clients, in addition to the 24/7 master lease which is definitely a different model than what we have set up with AOT and first key. We don't have 24/7 staff, but with this population we know the needs will be the supervision and continued support. We have it branched out so it isn't integrated with FSP and AOT, because of the level of care, it makes sense to have a dedicated team. To be integrated within the AOT model, under a forensics AOT would allow us the availability to work directly with the clients at the level of care without impacting the current programming needs for the other community members. With the additional staff, 24/7 housing and new staff, we are looking at $2mil to $3mil additional to support these additional client with the level of care needed and 24/7 staffing.

(Cmsr. Dunn) In terms of treatment, you spoke to not blending it into current and expanding current housing, because of their treatment being a separate housing and treatment area, could you expand for this population as you see has the treatment needs that are additional and different from your current AOT clientele and MHS' central county FSP clientele?

(Ivette Kwan) As far as our master lease, it would be. Right now, currently we don't have 24 hour care at master lease. We are there in the morning and evening, which cuts off at 5:30 p.m. So that would be changing and we would have a night shift and also staff in the day in order to have client care throughout the whole night and morning.

(Jennifer Bruggeman) I just want to tag on to what the MHS team is saying. It seems like there are some funding streams becoming available through the state through Measure X for bricks and mortar, but in terms of the services, that is obviously a key piece and we have been having some conversations with MHS. In terms of how to fund something like this, they have been involved in our innovation subcommittee meetings and there is some funding available through innovation right now. That is also temporary funding but it is up to five years, so it is a bit longer than what you just mentioned, Cmsr. Dunn. If anyone at this

group is interested in participating in conversations around that, because we really have to get some momentum around stakeholder advocacy with this, please come to the innovations subcommittee meeting, if you are able. The next one is Monday, the 20th at 2:30pm. Otherwise, please feel free to contact me offline and share your thoughts. I believe the next Consolidated Planning Advisory Workgroup (CPAW) meeting on January 6th, we will also touch on some of these potential innovation projects so, if you can't make the innovation subcommittee meeting, please try to attend the main CPAW meeting.

(Lauren Rettagliata) The innovation committee is usually a more drawn out process, as far as time, is it not? Time does not seem to be our friend on this issue, so my question is: We don't know how many of those 22 people will actually be in need of housing or will they all be in need of housing? Will another RFP (request for proposal) or RFQ (request for qualifications) have to be put out there and very quickly to get a handle on the exact cost? When we say between $2mil and $3mil, that is a million dollars a year that is in play and is this actually enough? It sounds like a lot of money, but we have to realize it costs at least $81k a year to keep someone in jail. So, when we are putting that multiple on them in the community, MHS has the ability to generate and give us real cost on this if we can give them the actual number of people that will be in the program. We have to realize our county sometimes can't believe it actually costs that much money when shown real costs. Something that was going to cost $1.5mil they would have $150k out there. I feel the county has to be prepared and are we at the point the point to ask for an RFP or RFQ? Can this be given to MHS because they have already been granted this? What we need from them are the real cost involved. They do have experience in other counties of actually providing for the MIST population. We need to get on the ball now.

(Teresa Pasquini) I was a bit late, has the master lease model been set as being the model this population be using in our county?
(RESPONSE Cmsr. Dunn) To try to house these individuals and expand additional housing, in the current mix of either FSP or AOT, clinically seems to be too disruptive.

(Teresa Pasquini) I heard that part, so has the county decided? Is this the first conversation whether public or have there been other conversations that have happened around this population? This is not a new, the population is here. I am trying to find context for what has already been decided or are we in the beginning stages?
(RESPONSE: Cmsr. Dunn) As I am aware, this is the first in-depth conversation we are having on the IST population. I chose the MIST because that is the most immediate need.

(Teresa Pasquini) I have been at the table for other conversations about this population a while back and didn't know if there had been any continuing conversations. I think the innovation pot of funds is a good one but unsure what is innovative about a fact team, this is evidence based and has already been proven, I'm not up on the current innovation rules. I understand the community planning process, especially in CCC, but we have had ongoing stakeholder process for eons and I just don't understand why we are reinventing the wheel. This is a population that has been here and we need to jump the line. Thee needs to be some real solid leadership around this. This should have been resolved and a process in place by now.

(Stephanie Regular) Just to provide context because this isn't a new pressing need. It has been an issue for a decade. The individuals found MIST have always been the responsibility of the county to provide a recommendation for inpatient or outpatient treatment. Up until July of this year, the county could recommend the DSH and use one its LPS beds in order to place that person in a state hospital bed. The use of state hospital beds for misdemeanants was fairly rare until (maybe) the past two years when it seemed we were seeing more of our clients placed in state hospital beds. Frankly, the majority of these individuals have always been in outpatient treatment since CCC developed an outpatient program (around 2014). It is not really a new need, it has always been, but in terms of the level of services the clients have received, the focus has always been on restoration services. The county provided a one-time a week competency restoration class for these individuals. There were referrals to county clinics and we are still trying to figure out what services were offered beyond that.

January 1st of this year, the big change will be there is no more restoration for MIST. There are four pathways the county can take is to refer to mental health diversion, if the individual isn't eligible, the court can refer to AOT or a conservatorship or dismiss the case. Those are the four options. There have been two meetings so far with the Public Defender's office (PD), the District Attorney's office (DA), the Metal Health court, the Public Guardians office, and Forensic Mental Health to discuss. It will largely fall on Behavioral Health to figure out how they will absorb these individuals into either mental health diversion, AOT, conservatorship because, if not, the case gets dismissed. What I have been pointing out due to very limited resources, especially for metal health diversion because that program is not just for MIST, it is also for Felony IST (FIST) and we receive funding from the DSH, we need to make sure our program has enough room to absorb the FISTs. So, given the limited resources we have for mental health diversion (conservatorships and AOT), what I am also hoping the county will focus on is that not all of these individuals need to be in the criminal system at all and if we connect them with services, we can dismiss the case and have the in services and not have the court follow them for a year.

What is incumbent on behavioral health is to figure out how to shift its focus from competency restoration to actually just providing treatment; and how it will shift those resources into mental health diversion to figure out whether or not they have sufficient resources to accommodate the people who are going to be referred. AOT and the Public Guardian's office to also consider how they will absorb these individuals. Frankly, these individuals have always been here for years. It is not a new problem but I am hoping this legislation will cause people to take it as a serious problem and actually provide the level of services this population needs. The final thing, regarding the new legislation, there are time limits on how long an individual can remain in custody. A referral for mental health diversion, presently the turnaround time is often in the 60 day range. There is only a 30 day period the person can remain in custody pending an MHD petition, 45 days for AOT, and 60 days for conservatorship. The investigation can continue beyond those time limits but the person can't stay in custody longer than those time limits, which is how it should be.

(Cmsr. Dunn) We need to figure out how to reduce the human 'log jam' from jail to either AOT or LPS, as soon as we can. I want to make sure what you are talking about (preferably too) is the kind of services the Los Angeles County Office of Diversion and Reentry was addressing. That is the type of services we would like to see. Correct? And if so, please elaborate.

(Stephanie Regular) That is somewhat fair to say. Los Angeles County has its issues as well, in terms as the amount of time they keep people in custody before referring them to services and basically using their jail as a place to involuntarily medicate and then place. I think that is a problem so it may be a better model in some ways, but I wouldn't say it's 'gold standard'. The one thing I would say is that Los Angeles County has been planning for months on how to respond to SB 317. Aside from the meetings that were initiated by my office, I am still unclear what planning this county is doing in response.

(Cmsr. Dunn) We have invited forensic mental health leadership to be at these meetings, and for whatever reason, they have not made it. Sooner or later, they are going to have to tell us and the community what their plans are (or not) and we feedback to them what we see needs to happen. A hot topic the Los Angeles office of Diversion and Reentry (ODR) spoke to was having an involuntary medication order they made clients aware of. In that presentation we all listened to, they spoke about having that and letting the clients know it will only be used as an absolute last resort. As I have seen in this COVID situation, and the zoom meetings I have been in with families, the current Deputy DA in charge of mental health litigation is very loathed to recommend persons for any kind of diversions, without an approved necessary involuntary medication order in the treatment teams 'back pocket'. With these justice involved persons, I'm interested in the clinician and other's take on the need for IMOs (involuntary medication order) for this population. I know there is a legal side and the clinical treatment side.

(Stephanie Regular) That is a really broad question and I will respond to it but I want to respond to Jennifer Bruggeman's question in chat that it's above the Forensic Mental Health's decision making. So, Dr. Tavano has been invited to the meetings. So far it has only been forensic mental health and Dr. Scannell who has attended. It is concerning. I don't know what planning is happening and I agree, it seems to need to happen at a higher level. As for the involuntary medication, I can speak to the legal aspects of it first that there is a fairly high standard of proof you need in order to secure an involuntary medication order. That is for a very important reason: it is a significant invasion of a person's liberty. I understand from the family's perspective that it is very hard because you want to see your loved ones receive the medications the need, but in order for the state to intervene and forcibly inject somebody against their will, there needs to obviously some due process protections in place to protect that person.

I know in many counties around the state it is different advocates, that are supposed to represent the interest of the person, take different positions. Legally we are supposed to advocate for their expressed wishes, even if it is not in their best interest. I can tell you as a public defender, it is very hard to do because we, too, want to see our client's get better. There is that whole mechanism of the state to advocate for the involuntary medication and we are the only ones to advocate for the person. Assuming it is the right thing to do, there usually should be enough evidence to prove it, regardless of whether or not there is a PD in the room saying this shouldn't happen. A lot of places it is just happening routinely

where the person who should be advocating for the person is just agreement and these orders are just happening so, I know some counties it is standard there will be an IMO because I believe the level advocacy and level of proof that is supposed to be occurring isn't necessarily occurring.

Anecdotally, whether or not IMOs are needed for every person who is IST being referred to the various systems, clients go to the DSH and they have been pretty irritated with our county because we send very few IMOs with the person. I think what is significant is how few petitions they file asking for IMOs. It is very rare and I would say it is probably in the range of six a year, may a bit more, but it is not a high number in comparison to the number of individuals who go to the state hospital each year. I think why that is so important is, if you actually provide really good treatment, you don't necessarily need an IMO. It is about working with the individual to get them to take the medication voluntarily, which is the most dignified way to do it.

(Cmsr. Dunn) When you say legal standard, we are speaking to beyond a reasonable doubt or substantially necessary.
(RESPONSE: Stephanie Regular) Clear and convincing evidence, which is one standard below reasonable doubt. Just one last point, the other thing in terms of IMOs and the way these are occurring in some counties where it's 'let's do an involuntary medication order, a long-term injectable, get them stable, get them out into treatment', if you don't do the work to get people to take the medication voluntarily, you don't necessarily have that long-term stability if it is a 'one shot, you're out the door' and then there's nothing beyond that.

(Carolyn Goldstein-Hidalgo) To add to what Stephanie was saying, it is not a 'one size fits all', you can't do that for all clients and think it's super beneficial. As you were saying, we need to provide the best quality service to all of them and address the medication needs individually. We completely agree with Stephanie and what she is speaking to at the treatment level. Of course, it is something that we should assess and evaluate for our clients based on what their treatment plan needs to be. We should go forward and advocate for it. We are going to recommend this process and should have the evidence and data and our notes and the services should reflect the reason why. If it is not needed because of the services we are providing and the relationship we have with these clients why would we need to go down that route?

(Michael Sisler) At this level, we have to find what where the insight is and how we can work with them and best benefit them. A lot of times it is either substance abuse or mental health and the combination is so elusive sometimes that it gets distorted and if they can stay off the substances long enough to get the medication, then they maybe they will have a chance or vice-versa. There is a lot of trickiness to the situation and to help it be successful. It is the 'artistic approach' to dealing with these individuals, individually. Everyone is different and as their own needs. Many have the housing needs, most have had trauma in their lives, helplessness and discouragement and really don't know how to navigate life and our job is to identify some goals, to help them come up with on their own, to make these baby steps to improve their lifestyle. If they can't see it, they will never attempt it and they have to see it for themselves. That is really the tricky part is to get them into that position and holding there. We shouldn't punish them for having a mental illness but at the same time we want to have leverage to get them to find the balance. It is not always successful but many clients that

are in and out of jail or institutions over and over again, short-term, substance abuse is usually a part of that, as well as mental health. The difficulty is catching them in the right moment to help them feel what it is like to be in balance

(Ivette Kwan) Back to the basics. Once an individuals basic needs are met, some of these problems (petty thefts, etc.), housing, diversion, suddenly they are compliant with medication and therapy because some of those basic needs are met. It does depend on the individual, what leads them to be compliant with treatment.

(Lauren Rettagliata) I want to thank Stephanie Regular for bringing us into the real world and telling us exactly what's happening and also to the MHS staff that are here today for telling us exactly what we are up against. Still, we haven't really solved the problems looming out there and come January 2022, after 60 days these people will have to be released. Is that our county's plan? That's a really bad plan. Just to release them without treatment or anything back into the community. I guess I would like to see a written response or statement from the Board of Supervisors (Bos) and Behavioral Health Services (BHS), what IS our county's plan for those who are MIST level, because it seems as if there isn't a plan and releasing them back into the community without even the possibility of offering them treatment. Medication isn't just the only thing these people need. They need structure, counseling (such as AOT or FSP). This committee needs an answer. The community needs an answer. What is the plan? Is the plan no plan? I really thank you Stephanie for being there all the time for our community at all the meetings. It is truly appreciated and also my thanks to Teresa and Doug for being there too.

(Stephanie Regular) I just want to add to what the MHS was saying and wanted to give a huge shout out for them because they are really amazing. I don't think we have to start from scratch because we have some really good models in this county, including AOT. I think one of the reasons why it is so successful is because they go to the person, not making the person come to them and they really work with their individual needs. I just thank you all so much. Then BHC, also is functioning really well. The evaluations and turnaround is so fast. That is very different from our other systems. The models are there, it's just about duplicating them to make them work for mental health diversion and the Public Guardian's office. Also, the amount of time for the AOT referrals to get processed.

(Cmsr. Serwin) I haven't been in the finance committee meetings regularly at all. Doug, you have been working on this topic for quite a while and I have to say it is appalling to hear that the plan of BHS is not something that's widely dispersed and being actively implemented such that it's visible, transparent and I think Lauren's recommendation, for first things first, getting that plan and evaluating it is essential because how else does the rest of the community determine what else needs to be done, what they need to be doing and what kind of dollar amounts need to be requested.

(Cmsr. Dunn) There is another major agenda item for the January finance committee meeting, the Niereka House and Nevin House issues. What is BHS plan for this and there will be a motion. (Cmsr. Serwin) Wouldn't you want to know the plan as soon as possible, do we really need wait that long? I think we should send an email to Dr. Tavano to find that out. (RESPONSE: Cmsr. Dunn) If that is something the MHC wants to push at its January meeting, by all means, yes. Take

that up at the Executive committee meeting to bring forth to main commission meeting, so it is on the agenda? (Cmsr. Serwin) We will not be having an Executive meeting next week. What I am saying is chair, that asking for a plan is straight forward and possible without having the full commission voting on that as a motion. So, if you and I can put our heads together with the support you suggested from Stephanie and Jennifer, we can do that very quickly.

(Carolyn Goldstein-Hidalgo) Stephanie, you spoke about four options with mental health diversion, AOT and all that. I want to say that, if we don't move forward with having a dedicated team from AOT and we are inheriting new clients next month, at our current contract level, we are not financially even stable to add on new training, additional housing. It is going to impact us significantly without. It may not be $2mil/$3mil but, to not even have additional funds for training, we are going to have to look at laying off staff, we are going to have to look at redoing our master lease to compensate for the trainings we are going to need to face and conduct. So, at the end of the day, if we are just looking at five clients, this is a whole different ballgame, I do need to request some discussion about modifying our contracts and our finances because we do want to provide amazing services to all of our AOT clients. But, at some point, if we don't get additional funding, we need to take it out of somewhere. We do need training and do need things for this MIST population because we do not want to fail them and we also don't want to give up the essence of our AOT program either. It has been successful. We love doing what we do and we have staff that want to work with these clients, but if we are not prepared, our staff are going to get burned out. We may have to close the master lease, just to compensate and do that. So, I just wanted to also put that out there too.

(Cmsr. Dunn) Thank you for doing so Carolyn. It sounds what you are looking for is some emergency funding, if possible. Correct? (RESPONSE: Carolyn Goldstein-Hidalgo) At least some discussion for training funding. Our budget is so tight, there is no additional funding to shift things where we are currently at and would need some support to get us prepared.

(Teresa Pasquini) I want to 100% support MHS request. I am sad and frustrated, it is not a criticism of this committee or any of the efforts that have been undertaken here. I am frustrated this hasn't been an elevated conversation before now. Lauren and I had a lovely conversation with Dr. Tavano and it was part of our conversation with her. It is not that it not that she is not aware, so I want to be respectful and mindful in knowing that there are multiple things on everyone's plate, but I am personally frustrated. I share that because I have had conversations months ago about a plan (and I don't remember which population, it may have been the diversion population) and I saw an amazing RFP that was submitted and it is not that this hasn't been communicated and out there and under discussion. We have had the AOT meeting and we just received a notice that our next quarterly AOT meeting is in February, so I will just go back to comments I have made in the Justice Committee and the Quality of Care Committee, I am personally acting like my hair is on fire because I know what it's like to have a loved one sitting in a solitary jail cell and not needing to be there, but needing to have planning going on. We need to be elevating this a lot more than it has been.

I spent the day in Sacramento yesterday testifying at the LPS hearing that was an all-day session and all these topics are very much on the Health and Judiciary

Committee's minds and there is talk of a special session being held, and multiple things regarding LPS and this being one of them. I hope to help and support this committee and all of our community to figure out how to make this happen in a way that we aren't cutting back on anyone. The Housing that Heals vision was a continuum of care vision. You get to the appropriate housing and the appropriate level of care that you need along the continuum whether you are in AOT, FSP, conservatorship and that is what we all have to start visualizing. That we have a continuum that allows someone to access the level they need to step up and down as their clinical and legal needs demand.

(Stephanie Regular) In terms of the need for training, I want to make clear that the needs of the population wouldn't be any different. AOT providers, any MIST that are being referred for AOT, it is not for purposes of competency training, because, again, there will be no more competency restoration. The referrals to AOT are the same as any other referrals and if an individual is accepted into AOT under the statute, the criminal case is supposed to be dismissed so there is not even a reporting requirement to the court or anything. There is nothing additional AOT needs to do other than what it would currently do for any other individual who is referred.

(Cmsr. Dunn) Carolyn when you say you would need additional funding for training to serve this population.

(Carolyn Goldstein-Hidalgo) I took a poll with the team between FSP and AOT of what IST means and no one knew. There is a component, even though we won't be involved in that level of care, but with the criminal justice history with the legal background, I think these are reports and assessment components that the team needs to have a scope of practice with it and we don't have it. We have the mental health component, we have a lot of trainings we have already done internally, but it scares me when I took a poll of "What is IST and how would that look differently" and no one knew. So, there is a part we do need to have the education and training because it is and may be a barrier. As Mike was saying, if we need to be able to assess for these levels so they don't go back. We don't have theat. If we look at our client capacity at 75, possibly two have criminal justice history. Overall, in the last five years when I looked over the statistics when we have had the IST conversation, we probably have had five clients or less. If there has not been many referrals, I do think we need to have that scope of practice and that assessment eyes to have all that. It may not be like the forensics at AOT, but I do think a lot of that will be critical for us to have that foundation to work with a different set of clients if that makes sense.

(Cmsr. Dunn) Yes and in terms of the need for training, we all agree. As chair of the MHSA-Finance Committee, what I am trying to get my hands around, is on an emergency basis, what do you think is the emergency training dollar amount you need for these persons coming to you so you don't have to cut back on other parts of your existing program? (RESPONSE: Carolyn Goldstein-Hidalgo) In a dollar amount for the forensics training, honestly, I don't know. Where can we go? How do we get all these new trainings? I just know with the dollar amount we currently have, we can't sustain anything that is going to hit us. If we have a new cost right now, we need to take it from somewhere else.

VII. MOTION: Based on our committee discussion, ask county Behavioral Health for additional funding, including MHSA and other funding sources, in the amount of $3mil for Assisted Outpatient Treatment and other programs placement of MIST clients

Executive Assistant read motion:

Based on our committee discussion, as county Behavioral Health Services for additional funding, including MHSA and other funding sources, in the amount of $3 million for Assisted Outpatient Treatment and other programs placement of misdemeanor incompetent to stand trial (MIST) clients.

- (Cmsr. Serwin) My only concern is more of a technical issue and perhaps some rewording can help with this. The overall protocol for the commission would be for this committee to recommend to the MHC that this money be requested for the BHS's MHSA budget. As you know, we are in the budget cycle and the commission will look at various priorities presented by the commissioners and the committees and prioritize those and then make and ask a recommendations to BHS and the BoS in one fell swoop. That meeting is January 5th. We could modify this motion to reflect that. This is something requested of the commission and I don't expect there'd be too much resistance at all.
- (Cmsr. Dunn) What are the changes you would like to make? (RESPONSE: Cmsr. Serwin) Based on our committee discussion…
- (Cmsr. Dunn) That is why I added 'or other funding' because I know for a fact that the state, it's relatively short-term, but they do have some additional dollars that they are putting the budget that the governor and legislature has signed off. Initially for additional BH work force additions. Granted, after two years, we are right back to where you are talking about.
- (Cmsr. Serwin) "Based on our committee discussion, ask the Mental Health Commission (MHC) to request $3mil for this budget." For the commission's 2022 goals, we voted at the recent retreat, we voted on topics/goals to pursue and then they were voted on. This population was one of the top priorities.
- (Lauren Rettagliata) I think that it's very important when you are going to ask for the $3mil that you actually have the justification of why you are going to need the $3mi. I think it exists out there if people have been following along the BoS of Santa Clara County for a much smaller population awarded over $3mil. I believe, if we need to see the RFP/RFQs, that MHS was one of the providers and I think it's very important for our BoS that we have underfunded AOT in our county and we need to show them what other counties are doing and what the true costs are. I'm not even sure that Santa Clara has it right. We need to look at what the true costs are to care for this population. Along with the dollar amount and the great ability you and Cmsr. Serwin have to put a motion together, we need the material behind it as to why we are asking for this specific amount.
- (Jennifer Bruggeman) I was basically I was going to agree and say the same thing as Lauren, to be a little more specific. In terms of the $3mil ask and what it is for. I just really also want to say, the supportive housing piece needs to be expanded and built out in our county and I think that is really what we are talking about and if we have more of that, more people will be

more successful in the community when they are stepping down from these locked placements.

- (Stephanie Regular) I just have a question about the training and the need to be at the meetings. I want to make sure we aren't leaving people out of, at least the discussions the courts are having. My understanding was that Dr. Scannell represented AOT, but perhaps I am missing that and someone else should be at the table. If so, please tell me who that should be so we can include you.
- (Carolyn Goldstein-Hidalgo) We do have a really great relationship with the county and we meet weekly for AOT. We have asked to have this discussion when I first heard about IST from you guys (four or five months ago?) from the finance committee and this topic was tabled for AOT Steering Committee which is scheduled for next month. That is the only conversation we have had so far. Everything I have learned about AOT and our involvement has been through this committee.
- (Stephanie Regular) Okay because I don't understand how it is set up, there is a difference between the county and the contracted provider. Is that what I'm missing? (RESPONSE: Carolyn Goldstein-Hidalgo) Correct, we are just the contract provider.
- (Stephanie Regular) If there is a point person who you think would be helpful be at the meeting, please share your information so I can include you and I will share that with the judge. The other thing, in terms of the technical assistance and need for training, the thing I want to throw out there is that the Council of State Governance has been providing technical assistance for the various counties and CCC has been chosen as one of them and it is somewhat specific to mental health diversion but I think we could probably shape what we need. Either I or my colleague will reach out to them to see if perhaps we can have technical assistance with regard to the AOT and how SB317 will affect AOT to see if, perhaps we can get some free training for you.
- (Cmsr. Dunn) Cmsr. Serwin, to wrap this motion up because time is really slipping from us, would it be helpful to add budget justification information with be forthcoming shortly?
- (Cmsr. Serwin) I think it needs to be said, but my concern has nothing to do with the meat and potatoes of the motion, it is just that this motion needs to be directed to the commission, not BHS. That is the only wording I'm concerned with. We are asking the commission to make this ask from BHS and the BoS.
- (Cmsr. Dunn) With your agreement, I will make the word motion change: *Based on our committee discussion, ask the Mental Health Commission (MHC) to ask Behavioral Health Services for additional funding, including MHSA and other funding sources, in the amount of $3 million for Assisted Outpatient Treatment and other programs placement of misdemeanor incompetent to stand trial (MIST) clients.*

Vote on Motion: *Based on our committee discussion, ask the Mental Health Commission (MHC) to ask Behavioral Health Services for additional funding, including MHSA and other funding sources, in the amount of $3 million for Assisted Outpatient Treatment (AOT) and other programs placement of misdemeanor incompetent to stand trial (MIST) clients.* Cmsr. Doug Dunn moved to vote on Motion as written. Seconded by Cmsr. Barbara Serwin. **Vote:** 2-0-0 **Ayes:** D. Dunn, B. Serwin. Abstain: None	
VIII. RECEIVE and DISCUSS the Proposed 2021 MHSA-Finance Annual Report	Referred to January Mental Health Commission (MHC) Meeting
IX. Adjourned at 3:03 pm.	