TUOLUMNE COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
REGULAR MEETING AGENDA

Time: Wednesday, September 7, 2022 @ 4:00 p.m. to 6:00 p.m.
Place: Tuolumne County Behavioral Health, Virtual Attendance Only

In order to protect public health and the safety of our Tuolumne County citizens, this Behavioral Health Advisory Board meeting will be physically closed to the public, however the public may participate and comment on any item via teleconference, U.S. Mail, email, or video conferencing through the Zoom platform at the following link:

Zoom (Video or Audio):
https://tuolumne-ca-gov.zoom.us/j/87551190916?pwd=TnRJNjhZVldaT0FITndMdFFKUjFwZz09
Meeting ID: 875 5119 0916 Passcode: 439380
Telephone (one tap mobile) +16694449171,,87551190916#,,,,*439380# US
Or Dial by your location +1 669 444 9171 US
Email: Email your comments to Attn: Pandora Armbruster at behavioralhealth@tuolumnecounty.ca.gov
U.S. Mail: Mail your comments to Attn: Behavioral Health Advisory Board, 2 S. Green St., Sonora CA 95370. Written comments must be received no later than 8:00 a.m. on the morning before the noticed meeting.

Important Public Notice: In accordance with Governor's Executive Order N-29-20, Accessibility Requirements, if you need swift special assistance during the meeting, please call (209) 533-6245. Under Executive Order N-25-20, members of the Tuolumne County Advisory Board may participate by teleconference.

AGENDA

CHAIRPERSON
Mary Anne Schmidt

VICE CHAIRPERSON
Sherry Bradley

BOARD OF SUPERVISOR'S REPRESENTATIVE
Jaron Brandon

ALTERNATE REPRESENTATIVE
Daniel Anaiah Kirk

SECRETARY
Heather Farris

OTHER MEMBERS
Cynthia Halman
Emily Valentine
Jenn Salazar
M. Elizabeth Marum
Marjorie Langdon
Maureen Woods
Susie DeMassey
Valerie Shuemake

I. **CALL TO ORDER - 10 minutes**
- Chair calls meeting to order.
- Announcement to attendees that the meeting is being recorded.
- Establish quorum with the introductions of Board Members
- Announce the August 3, 2022, Findings for AB 361 **(ATTACHMENT #1)**.
- Discussion and Action to determine whether the October 5, 2022, Behavioral Health Advisory Board Meeting will be either in-person or virtual. If virtual, make Findings for the October 2022 Meeting.

II. **INTRODUCTIONS – 2 minutes** County staff, guests and any public attendees that wish to be identified

III. **REVIEW ORDER OF AGENDA ITEMS – 2 minutes**

IV. **CORRESPONDENCE – 2 minutes**

V. **APPROVAL OF MINUTES – 5 minutes:** August 3, 2022, Meeting Minutes **(ATTACHMENT #2)**

VI. **PUBLIC COMMENT (3 minutes per person):**

Members of the public may be heard on any item, **not** on the Board's Agenda. A person addressing the Board will be limited to five minutes. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.

VII. **NEW BUSINESS AND ACTIONS:** Nothing agendized for this month

VIII. **AD HOC COMMITTEE BUSINESS:**

A. DATA NOTEBOOK **(ATTACHMENT #3A & #3B)** – 30 minutes: Sherry Bradley

B. BOARD MEMBERSHIP & RECRUITMENT – 20 minutes: Heather Farris
1. Update Recruitment Plan **(ATTACHMENT #4A, #4B & #4C)**
2. Best Practices for Recruitment & Vetting **(ATTACHMENT #5)**

3. Review pending applicants: William Olmstead, Alejandro Abarca, and Estrella Torres **(ATTACHMENT #6)**
4. Board members' terms up for reappointment: Sherry Bradley, Jenn Salazar, and Marjorie Langdon **(ATTACHMENT #7)**

C. SPEAKING TO THE BOARD OF SUPERVISORS **(ATTACHMENT #8)** – 8 minutes: Marjorie Langdon

IX. **REPORTS:**

A. SUPERVISOR' S REPORT – 5 minutes – Jaron Brandon, Tuolumne County Board of Supervisors Representative

B. DIRECTOR'S REPORT – 10 minutes – Tami Mariscal, Behavioral Health Director

C. BEHAVIORAL HEALTH ADVISORY BOARD CHAIR REPORT – Mary Anne Schmidt, Chair

D. BOARD MEMBER REPORTS/ANNOUNCEMENTS — (3 minutes per Board member): Members of the Advisory Board may share announcements and/or comment on matters, not on the agenda.

E. LEGISLATIVE UPDATES – 10 minutes – Tami Mariscal, Behavioral Health Director
1. Care Court SB1338
2. See State Analysis **(ATTACHMENT #9)**

Next Advisory Board Meeting is currently scheduled for October 5, 2022 @ 4 pm

X. **SUGGESTIONS FOR NEXT MONTH'S AGENDA - 3 minutes:** Board Members, Behavioral Health Staff, Members of the Public

XI. **ADJOURNMENT**

This agenda can be made available in alternative formats upon request. Late agenda material can be reviewed at the Behavioral Health Department, 105 Hospital Road, Sonora, CA 95370.

If you require special assistance (i.e., auxiliary aids or services) in order to participate in this public meeting, please call (209) 533-6245 at least 48 hours prior to the start of the meeting to enable staff to make a reasonable accommodation to ensure accessibility to this public meeting.

ATTACHMENT #1

Behavioral Health Advisory Board

County of Tuolumne

FINDINGS OF THE BEHAVIORAL HEALTH ADVISORY BOARD
AUTHORIZING REMOTE TELECONFERENCE MEETINGS
OF THE BEHAVIORAL HEALTH ADVISORY BOARD
FOR THE PERIOD AUGUST 5, 2022 THROUGH SEPTEMBER 2, 2022
PURSUANT TO THE RALPH M. BROWN ACT.

WHEREAS, all meetings of BEHAVIORAL HEALTH ADVISORY BOARD and its legislative bodies are open and public, as required by the Ralph M. Brown Act (Cal. Gov. Code §§ 54950 – 54963), so that any member of the public may attend, participate, and view the legislative bodies conduct their business; and

WHEREAS, the Brown Act, Government Code section 54953(e), makes provisions for remote teleconferencing participation in meetings by members of a legislative body, without compliance with the requirements of Government Code section 54953(b)(3), subject to the existence of certain conditions and requirements; and

WHEREAS, a required condition of Government Code section 54953(e) is that a state of emergency is declared by the Governor pursuant to Government Code section 8625, proclaiming the existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions as described in Government Code section 8558(b); and

WHEREAS, a further required condition of Government Code section 54953(e) is that state or local officials have imposed or recommended measures to promote social distancing, or, the legislative body holds a meeting to determine or has determined by a majority vote that meeting in person would present imminent risks to the health and safety of attendees; and

WHEREAS, on March 4, 2020, Governor Newsom issued a Proclamation of a State of Emergency declaring a state of emergency exists in California due to the threat of COVID-19, pursuant to the California Emergency Services Act (Government Code section 8625); and,

WHEREAS, on June 11, 2021, Governor Newsom issued Executive Order N-07-21, which formally

rescinded the Stay-at-Home Order (Executive Order N-33-20), as well as the framework for a gradual, risk-based reopening of the economy (Executive Order N-60-20, issued on May 4, 2020) but did not rescind the proclaimed state of emergency; and,

WHEREAS, on June 11, 2021, Governor Newsom also issued Executive Order N-08-21, which set expiration dates for certain paragraphs of the State of Emergency Proclamation dated March 4, 2020 and other Executive Orders but did not rescind the proclaimed state of emergency; and,

WHEREAS, as of the date of this Findings, neither the Governor nor the state Legislature have exercised their respective powers pursuant to Government Code section 8629 to lift the state of emergency either by proclamation or by concurrent Findings the state Legislature; and,

WHEREAS, the California Department of Industrial Relations has issued regulations related to COVID-19 Prevention for employees and places of employment. Title 8 of the California Code of Regulations, Section 3205(5)(D) specifically recommends physical (social) distancing as one of the measures to decrease the spread of COVID-19 based on the fact that particles containing the virus can travel more than six feet, especially indoors; and,

WHEREAS, the Behavioral Health Advisory Board finds that state or local officials have imposed or recommended measures to promote social distancing, based on the California Department of Industrial Relations' issuance of regulations related to COVID-19 Prevention through Title 8 of the California Code of Regulations, Section 3205(5)(D); and,

WHEREAS, as a consequence, the Behavioral Health Advisory Board does hereby find that it shall conduct its meetings by teleconferencing without compliance with Government Code section 54953 (b)(3), pursuant to Section 54953(e), and that such legislative bodies shall comply with the requirements to provide the public with access to the meetings as prescribed by Government Code section 54953(e)(2).

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NOW, THEREFORE, BE IT RESOLVED, FOUND AND ORDERED by the Behavioral Health Advisory Board, County of Tuolumne, State of California, in regular session assembled on August 3, 2022 does hereby resolve as follows:

Section 1. Recitals. All of the above recitals are true and correct and are incorporated into this Findings by this reference.

Section 2. State or Local Officials Have Imposed or Recommended Measures to Promote Social Distancing. The Behavioral Health Advisory Board hereby proclaims that state officials have imposed or recommended measures to promote social (physical) distancing based on the California Department of Industrial Relations' issuance of regulations related to COVID-19 Prevention through Title 8 of the California Code of Regulations, Section 3205(5)(D).

Section 3. Remote Teleconference Meetings. The Behavioral Health Advisory Board is hereby authorized and directed to take all actions necessary to carry out the intent and purpose of these Findings including, conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Brown Act.

Section 4. Effective Date. These Findings shall take effect immediately upon its adoption and shall be effective until the earlier of (i) September 2, 2022, or (ii) such time the Behavioral Health Advisory Board adopts a subsequent Findings in accordance with Government Code section 54953(e)(3) to extend the time during which its legislative bodies may continue to teleconference without compliance with Section 54953(b)(3).

ADOPTED this 3rd day of August, 2022 by the Tuolumne County Behavioral Health Advisory Board, by the following vote:

YES: 9 – Jaron Brandon, Mary Anne Schmidt, Heather Farris, Cynthia Halman, Jenn Salazar, M. Elizabeth Marum, Maureen Woods, Sherry Bradley.

NO: 0

ABSENT: 3 – Emily Valentine, Susie DeMassey, and Valerie Shuemake

ABSTAIN: 0

Tuolumne County Behavioral Health Advisory Board
(Minutes of the meeting of August 3, 2022)
DRAFT

2022 BHAB Membership	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jaron Brandon - BOS	✓	✓	✓	✓	✓	✓	✓	✓				
Anaiah Kirk – BOS Alt	E	E	E	E	E	E	E	E				
Mary Anne Schmidt, Chairperson	✓	✓	✓	✓	✓	✓	✓	✓				
Sherry Bradley, Vice-Chairperson	✓	✓	✓	✓	✓	✓	✓	✓				
Heather Farris, Secretary	✓	✓	E	✓	✓	✓	✓	✓				
Cynthia Halman	✓	✓	E	✓	✓	✓	E	✓				
Elizabeth Marum	✓	✓	✓	✓	E	✓	✓	✓				
Emily Valentine	E	✓	✓	✓	E	✓	E	✓				
Jenn Salazar	✓	✓	✓	✓	✓	✓	✓	✓				
Marjorie Langdon	A	✓	✓	E	✓	✓	E	✓				
Maureen Woods	✓	✓	✓	✓	✓	✓	✓	✓				
Susie DeMassey	✓	E	✓	E	✓	E	✓	E				
Valerie Shuemake	E	✓	E	E	A	✓	✓	E				

Present = ✓ Absent = A Excused = E **12 MHAB Members, 1 BOS Alternate**

Tuolumne County Staff in Attendance
Rebecca Espino, Director – Health & Human Services Agency
Tami Mariscal, Director – Behavioral Health Department
Lindsey Lujan, Agency Manager – Behavioral Health
Jenn Guhl, MHSA Agency Manager – Behavioral Health
Pandora Armbruster, Administrative Assistant – Behavioral Health
Others in Attendance
Terri Alford, Tuolumne County Superintendent of Schools

I. CALL TO ORDER

- Advisory Board Chairperson, Mary Anne Schmidt, announced to attendees that the meeting was being recorded.

  The meeting was called to order at 4:04 pm. Nine of the twelve members were present and accounted for at the time of roll call to complete a quorum for the Board. Behavioral Health Advisory Board members introduced themselves as roll call was taken. Those present were Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Cynthia Halman, Elizabeth Marum, Jenn Salazar, Marjorie Langdon, and Maureen Woods. Emily Valentine, Susie DeMassey, and Valerie Shuemake were not in attendance at the time of roll call.

- The July 6, 2022, Findings Resolution for AB 361 indicating that the Behavioral Health Advisory Board would be meeting virtually only for the August 3, 2022, meeting was incorporated into the meeting record.
- A motion was made and seconded to make the September 7, 2022, Behavioral Health Advisory Board meeting available for virtual attendance per AB 361 and through #2 of the associated Findings. The motion passed. (Ayes: 9 – Jaron Brandon, Mary Anne Schmidt, Heather Farris, Cynthia Halman, Elizabeth Marum, Jenn Salazar, Maureen Woods, and Sherry Bradley. Nays: 0 Abstentions: 0 Members Absent: 3 – Emily Valentine, Susie DeMassey, and Valerie Shuemake)

  As a result of this determination, the September 7, 2022, Behavioral Health Advisory Board meeting will be available through virtual attendance only, per the County Administrator's recommendation to allow in-person or virtual meetings, and not through a combination of both.

II. INTRODUCTIONS

Introductions were made by Tuolumne County staff in attendance, as follows: Rebecca Espino – Director, Health and Human Services Agency, Tami Mariscal – Director, Behavioral Health Department, Lindsey Lujan - Agency Manager, Jenn Guhl – MHSA Agency Manager, and Pandora Armbruster – Administrative Assistant. Terri Alford, Program Manager - Tuolumne County Superintendent of Schools was also present.

III. AGENDA REVIEW PERIOD

There were no suggested changes to the order of agenda items**.**

IV. CORRESPONDENCE

No correspondence was reported.

V. APPROVAL OF MINUTES

Jaron Brandon moved to approve the July 6th, 2022, Behavioral Health Advisory Board Meeting Minutes as presented. Elizabeth Marum seconded. Motion passed.

(Ayes: 7 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Jenn Salazar, Elizabeth Marum, Maureen Woods, and Sherry Bradley. Nays: 0 Abstentions: 2 - Cynthia Halman, and Marjorie Langdon Members Absent: 3 – Emily Valentine, Susie DeMassey, and Valerie Shuemake.)

VI. PUBLIC COMMENT: Members of the public may be heard on any item not on the Board's Agenda. A person addressing the Board will be limited to **three minutes**. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.

No public comments were received.

VII. REPORTS

A. SUPERVISOR'S REPORT

Supervisor Brandon shared information on the previous day's 10 ½ hour Board of Supervisors Meeting. The meeting focused on the selection of an outdoor shelter site for the homeless population in Tuolumne County

located in the Harvard Mine area near Jamestown. There is an estimated $650,000 start-up cost associated with this project with additional annual operating costs of approximately $380,000 for up to 30 pallet homes for 70 residents. Supervisor Brandon had several concerns with this project, but the Board voted 4-1 for the identified site. Jaron invited attendees to check out his Facebook page for more information.

Supervisor Brandon shared information regarding a recent meeting of the youth Membership recruitment group and thanked Teri Alford for her participation.

The Board of Supervisors recently approved a Permanent Local Housing Allocation (PLHA) Grant for $2.5M over a 5-year period to be used for permanent local housing. Part of this funding is going to the outdoor shelter, part to the Stanislaus Regional Housing Authority and part to the Homelessness Navigation Center.

A contract for Mobile Crisis Services was also approved through the Board of Supervisors. Tam Mariscal will be providing additional details surrounding this topic.

Jaron shared that he is currently visiting with county staff in groups of 5-6 to get to know everybody and the issues that they face. He recently met with Behavioral Health's Full Service Partnership (FSP) team and the Substance Use Disorder (SUD) team. These meetings were informative and very well received.

The Board of Supervisors recently received a presentation on opioid use from the District Attorney and Sheriff's Office which identified that Tuolumne County is #1 in morphine milligram equivalent (amounts per person) and #1 in the number of prescriptions (somewhere in the amount of 800 prescriptions per 1,000 people). These numbers are the worst and highest in the State of California. This is a substantial issue, and the county is currently engaged in a class action lawsuit against Perdue Pharmaceutical in hopes of a settlement which could provide funding for education, outreach, and prevention.

The group discussed the information provided and the data used to identify these alarming trends in opioid use. More information on this topic will be provided to the group soon.

B. <u>DIRECTOR'S REPORT</u>

Tami Mariscal provided additional information requested at last month's meeting surrounding the use of 988, the new Suicide Prevention Lifeline which went live in July 2022. This number was created to allow those in crisis to connect more easily with Suicide Prevention workers. There are currently 13 call centers located throughout California that will manage these calls as they come in. Calls are received by the centers, and if needed, routed to the appropriate local responders, i.e., police, etc. At this time, TCBH does not play an additional role because of this new 988 feature, but changes to how these calls are managed may happen in the distant future.

Heather Farris, Behavioral Health Advisory Board member, inquired whether the department had yet received any referred calls from 988 call

centers and if data would be gathered to learn how this number is working within our local community. Tami relayed that 988 does not currently work with our local crisis number. If a person utilizes the 988 Call Center and needs an increased level of care, they will be routed directly to the appropriate emergency responder.

Tami responded to inquiries received at last month's meeting about Mental Health Student Services Act (MHSSA) funding, a $2.5M pass-through grant which was sponsored by Behavioral Health to be used by Tuolumne County Superintendent of Schools (TCSOS) to provide mental health services to students in local schools.

Terri Alford, MHSSA Program Manager for TCSOS, shared additional information on this topic. TCSOS has already hired two additional clinicians and a mental health navigator through this program. If requested, she has several PowerPoint Presentations that she can share with the Behavioral Health Advisory Board at a future meeting.

Tami provided the group with information on the Crisis Mobile grant that was recently approved through the Board of Supervisors. The grant affords $600,000+ in infrastructure funding which allows for the purchase of vehicles and staffing, as well as specialized trainings. Tuolumne County Sheriff Bill Pooley and Sonora Police Chief Turu Vanderwiel are both interested in being a part of our team and as planning moves forward more information will be shared with the Behavioral Health Advisory Board.

Tami shared that staff vacancies and clinical recruiting continue to be a challenge for the department. An employee retention program will be deployed soon which is afforded through the Mental Health Services Act (MHSA) Workforce and Education Training (WET) funds which will allow incentives for new hires and the implementation of loan forgiveness for those entering into a two-year service agreement. As more details are developed, staff will be asked to come in to present a clearer overview of this benefit.

The Director notified the BHAB that the Juvenile Detention Facility (JDF) and the County Probation Department both have provisions in their contracts to provide mental health care to those in their care. The Behavioral Health Director is tasked with assuring that the care they receive meets the specifications necessary to be considered beneficial to the recipients. Since Tami was appointed as Director of Behavioral Health, meeting this requirement has been a focus of the Behavioral Health Department. Behavioral Health staff are now performing assessments, providing substance use prevention, case management and therapy. Tami recently met with the manager of JDF and Dan Hawks, Chief Probation Officer, to discuss their increased needs. Currently, the Behavioral Health Department does not really have capacity to provide more than we already do, especially a full-time clinician as they are requesting. After reviewing data, we are already delivering almost that in service delivery hours. This added need is not a requirement of our department and could adversely impact us increasing support to them in this way.

Tami is requesting the BHAB's support and understanding of the stretch to our resources and impact to our service providers. She would like a stronger voice for the department in advocating for solutions to ongoing struggles.

The group discussed several ways that the Behavioral Health Advisory Board (BHAB) could tackle advocacy strategies to address this issue without further impacting Behavioral Health staff.

Supervisor Brandon requested a future agenda item to discuss ways the BHAB can advocate for the Behavioral Health Department by speaking to the Board of Supervisors at upcoming meetings.

Mary Anne Schmidt created an Ad Hoc Committee consisting of Marjorie Langdon, and herself to work on speaking and advocating to the Board of Supervisors regularly regarding concerns and issues associated with the Behavioral Health Department. Mary Anne will reach out to Susie DeMassey to see if she may also be interested in participating in the Ad Hoc.

C. BEHAVIORAL HEALTH ADVISORY BOARD CHAIR REPORT
Mary Anne provided a written report with this month's agenda packet and hoped that all members and attendees had an opportunity to review it.

No comments or questions were received from attendees.

D. BOARD MEMBER REPORTS/ANNOUNCEMENTS
Cynthia Halman shared information on the Lantern of Light's upcoming educational presentations about the Mosaic Projects. These beautiful, mounted mosaics are now located at almost every Tuolumne County school. Lantern of Light will be delivering a brief synopsis about 988 at each school with Terri Alford, TCSOS, assisting. School counselors will also be in attendance. Cynthia also informed the group that Lantern of Light is hosting a fundraiser golf tournament on August 20th at Twain Hart Golf Club and reminded everyone that the Suicide Prevention Expo is coming up on September 30th.

VIII. AD HOC COMMITTEE BUSINESS

A. DATA NOTEBOOK – Sherry Bradley, Ad Hoc Chair

Sherry Bradley reminded the group that her brief report on this topic was included in this month's agenda packet. She relayed information on her recent meeting with Lindsey Lujan and Pandora Armbruster, Behavioral Health staff. Some data related to the Data Notebook Survey was provided at that meeting and more data will be gathered provided soon. A draft of the survey and a review of the data will be presented at the September Meeting. Sherry hoped that board members can come prepared to provide input at the September meeting so that the Data Notebook can be finalized and approved for submission at the October Meeting.

B. BOARD MEMBER RECRUITMENT& MEMBERSHIP – Heather Farris, Ad Hoc Chair

Heather Farris reminded Jenn Salazar and Marjorie Langdon that their Behavioral Health Advisory Board terms are due for renewal and requested

that they submit renewal applications. Both Marjorie and Jenn agreed to complete their applications for review at next month's meeting.

Heather shared information on a pending application for William Olmstead for a seat on the Behavioral Health Advisory Board. The group discussed their interest in potential transitional age youth applicants and agreed to postpone a decision until more work could be done with youth recruitment.

Heather Farris shared a PowerPoint presentation on the progress made by the Youth Recruitment Ad Hoc Committee which met for a second time this past month. They identified two engaged applicants and Terri Alford is in contact and is securing applications. Due to the success of the PRIDE postcards and Terri's assistance, it was decided that no additional advertising is needed at this time. The potential candidates will be invited to lunch to provide a warm welcome and a high-level overview of board membership. Several positive impacts of including transitional age youth on the Behavioral Health Advisory Board were identified in Heather's presentation. Heather requested feedback and input from the board on an orientation checklist for appointed youth before August 15th. The Youth Recruitment Ad Hoc group hopes to have a finalized plan in place by that date.

Heather requested feedback on accepting two potential transitional age youth on the Behavioral Health Advisory Board. The group agreed that this could be a positive impact for this body.

Pandora interjected that a youth member under the age of eighteen may not be allowed through county procedures. A request was made to contact County Counsel to get clarity on the age allowance of a youth member.

The group complimented the hard work and preparation this Ad Hoc put into this important task.

Jaron moved to recommend that the Board of Supervisors identify a Transitional Age Youth category as a part of the composition of the Behavioral Health Advisory Board. Sherry seconded the motion. After discussion by the group, a consensus was reached that more information was needed before taking action. Jaron withdrew his motion.

A discussion of **IX. NEW BUSINESS**, D. was held out of order.

Supervisor Brandon recommended that Mary Anne Schmidt move forward with the list of previously identified speakers (IX. NEW BUSINESS, D.) allowing for the scheduling of each speaker as she sees fit. Mary Anne informed Supervisor Brandon that the first speaker had already been identified as Dr. Brock Kolby, Behavioral Health Assistant Director, assigned for October. Mary Anne created an Ad Hoc Committee with Maureen Woods and Emily Valentine to work on a future proposed speaker plan.

Supervisor Brandon moved to table the remaining Items (A., B., C.) under **IX. NEW BUSINESS** and **X. SUGGESTIONS FOR NEXT MONTH'S**

AGENDA until the September Meeting. Maureen Woods seconded the motion. Motion passed. (Ayes: 10 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Cynthia Halman, Emily Valentine, Jenn Salazar, Elizabeth Marum, Maureen Woods, and Sherry Bradley. Nays: 0 Abstentions: 0 Members Absent: 2 – Susie DeMassey and Valerie Shuemake.)

IX. NEW BUSINESS

A. BH ADVISORY BOARD GOALS FOR FY' 2022-2023 – Mary Anne Schmidt, BHAB Chair
Tabled until September Meeting.

B. ANNUAL REPORT FOR FY' 2022-2023 – Mary Anne Schmidt, BHAB Chair
Tabled until September Meeting.

C. WEBSITE REQUESTS FOR THE BEHAVIORAL HEALTH ADVISORY BOARD – Mary Anne Schmidt, BHAB Chair
Tabled until September Meeting.

D. PUBLIC SPEAKER PLAN FOR FY' 2022-2023 – Mary Anne Schmidt, BHAB Chair
Discussed out of order. See minutes section immediately following Section **VIII. Ad Hoc Committee Business,** B. BOARD MEMBER RECRUITMENT AND MEMBERSHIP above.

X. SUGGESTIONS FOR NEXT MONTH'S AGENDA

Tabled until September Meeting.

XI. BEHAVIORAL HEALTH DEPARTMENT PRESENTATIONS

MHSA INNOVATIONS REPORT – Jenn Guhl, MHSA Agency Manager

Jenn Guhl, MHSA Agency Manager, introduced herself to the Behavioral Health Advisory Board and provided an overview of the Tuolumne County Behavioral Health Mental Health Services Act Innovations Concept using a PowerPoint presentation. A copy of that PowerPoint presentation is attached to these minutes.

Sherry Bradley inquired what the department expected to learn from this innovation project. Lindsey responded that part of the original submission for this concept stated that young parents are an important demographic that need help, parenting skills, coping skills, and emotional support. The department's wish and goal are that by engaging families through family events that are offsite, or are available at no cost to them, will provide them with the coping skills and emotional support they need to bring home to their own families to support stability.

Tami Mariscal agreed with the answer provided and reiterated that providing families with the tools they need to remain in care or complete care will assist them in creating stability in their homes. She clarified that this concept is in beginning stages and will be implemented on a small scale to assure that this is sustainable, well received and we are able to expand moving forward.

The group shared their appreciation and support of this concept and their belief that involving families in treatment is meaningful.

XII. ANNOUNCEMENTS

No announcements were shared.

XIII. ADJOURNMENT

The August 3, 2022, Behavioral Health Advisory Board meeting was adjourned at 6:03 pm.

The next Tuolumne County Behavioral Health Advisory Board meeting is scheduled for September 7, 2022, at 4:00 pm via videoconference through Zoom and teleconference only. Meeting information will be posted on the September 2022 Agenda.

TCBH Advisory Board

Tuolumne County Behavioral Health, MHSA Innovation Concept Presentation 2022

Jenn Guhl

MHSA Agency Program Manager | August 3, 2022

Innovations Concept

- TCBH Efforts for Youth Services
- Innovation Submission
- Identifying TCBH Gaps in Service
- TCBH Solution and Proposed Innovation Concept
  - What does our concept include?
- Research Our Concept Will Work

TCBH Efforts For Youth Services

- Community Partnerships
  - Multi-agency MOU that includes Child Welfare Services, Tuolumne County Probation, Tuolumne County Public Health, Tuolumne County Superintendent of Schools (TCSOS), law enforcement, the courts, Juvenile Detention Facility and others
- Mental Health Student Services Act (MHSSA)
  - TCSOS and TCBH
  - Overseen by Mental Health Service Oversight and Accountability Comm.
- Through these initial partnerships to increase efforts for children, Tuolumne County Behavioral Health began to focus more on families and youth.

Innovation Submission

"Support for struggling young parents (parents who are themselves transition age youth). These young parents are an important demographic that need help; parenting skills, coping skills, emotional support, financial support to finish school themselves. I believe this idea would fit the following purposes:--increase access to underserved groups AND--increase access to services, including, but not limited to, services provided through permanent supportive housing. I also believe that, if structured appropriately, this program would support the following innovative approach:--introducing a new mental health practice or approach, including, but not limited to prevention and early intervention. At the Tuesday, March 1st BOS meeting, they received a presentation on the status of youth and their needs in our county. Transition Age Youth particularly struggle as they age out of foster care, or are forced to live on their own due to personal situation or circumstance with their own family, etc. Add to that the fact that many of these young adults are becoming parents too, facing multiple obstacles in their new role as parents. They have many barriers they must overcome to raise their own child in a loving and supportive home."

Identifying TCBH's Gaps in Service

- The Process
- 5-Year Data Analysis
  - *Rate of return for youth is 20%*
  - *First average length of stay for admission is just at a year*
  - *Average length of stay for second admission is 7 months*
    - *This number continues to decrease with each new admission*
  - *20% of the youth over 5 years receives crisis services*
    - *Of those 20% that receive a crisis service, the average number of crisis per youth is four (4). Combined with an average length of stay of one (1) year, this means one crisis per quarter*
- The Primary Problem
  - *The primary problem is we need to reduce rate of return for youth by increasing their length of stay within the first admission by engaging youth and families concurrently.*

TCBH's Solution and Proposed Innovation Concept

- Create non-mandated activities and alternatives for youth and families
- Promote these activities in the systems that are most affected by youth and family's trauma
  - ✓ Child Welfare Services
  - ✓ Foster youth
  - ✓ Children's system of care partners
  - ✓ MHSA Outreach and Engagement
  - ✓ Perinatal
  - ✓ Probation/Judicial programs

TCBH's Proposed Innovation Concept includes:

- Non-mandated activities and alternatives for youth and families
- Connect families and youth with alternative and non-traditional mental health approaches
    - Mindfulness classes, mediation, sound therapy, yoga
- Introduce families to these non-traditional approaches through engaged family nights
    - Movie nights, themed food nights, bingo night
- Create ongoing educational opportunities with mild to moderate providers to help maintain ongoing stability with each step down
- Integrate Prevention and Early Intervention (PEI) education to youth

Research Our Concept Will Work

What are the benefits of family engagement?

- According to an article published in October 2010 by Erin M. Ingelsby on the National Library of Medicine, *"Engaging and retaining families in mental health prevention and intervention programs is critically important to insure maximum public health impact." "When families are asked about why they drop out of services, they frequently cite practical obstacles such as time demands and scheduling conflicts, high costs, and lack of transportation and child care* (Garvey et al. 2006; Kadin et al. 1997; Spot and Redmond 2000; Stevens et al. 2006).
- In October 2021, a study was published by BMC Health Services Research that asked almost 300 family members and careers "what have you as a career/family member received' and 'what they would have liked to have received'
  - The responses fell into seven categories the highest responses were centralized in two categories; provide or offer ongoing support to the family and provided psychoeducation to the families.
  - **Category # 1:** *"Help with supporting me to deal with my own emotions and heart ache when my child has episodes."*
  - **Category # 2:** *"Help with how the family responds to problems."*

Thank you

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CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health Planning Council

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family-member driven, recovery oriented, culturally and linguistically responsive, and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

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California Behavioral Health Planning Council
Advocacy • Evaluation • Inclusion

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the CBHPC. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Council staff to create an annual report to inform policy makers, stakeholders and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on the county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

[1]W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

[2]See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.
[3]SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[4]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2021-2022 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[5] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[6] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

[4]www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[5]Search for Adult Residential Facilities using the following Department of Social Services link: https://www.ccld.dss.ca.gov/carefacilitysearch/
[6]Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

* 1. Please identify your County / Local Board or Commission.

Tuolumne County Behavioral Health

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?

20

3. What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

6,988

4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

None, there is no wait list for placement

5. Does your county have any "Institutions for Mental Disease" (IMDs)?

- [X] No
- [ ] Yes (If Yes, how many IMDs?)

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-County	0
Out-of-County	100

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

1,000

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[7] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.

Preliminary data for January, 2021 had been posted in early February 2022, but those only contained data for the individuals in shelters or other temporary housing. There was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. The count for 2022 took place in many communities during the last week in February. The federal analysis and publication of that data will not be available for at least six to twelve months. Therefore, we are presenting the previous year's data for January 2020 in Table 3 as a baseline reference for comparison to the most recent year's data for 2021 and/or 2022, whenever that data becomes available. (Please refer to your 2022 Data Notebook pdf document for Table 3.)

[7]Link to data for yearly Point-in-Time Count:
https://www.hudexchange.info/programs/coccoc-homeless-populations-and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=CA&filter_CoC=&program+Coc&group=PopSub

8. During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)

- [ ] Emergency Shelter
- [ ] Temporary Housing
- [ ] Transitional Housing
- [X] Housing/Motel Vouchers Project Room Key
- [ ] Supportive Housing
- [ ] Safe Parking Lots
- [X] Rapid re-housing ATCAA
- [ ] Adult Residential Care Patch/Subsidy
- [X] Other (please specify)

Resiliency Village, GSAC Shower Bus, Tuolumne County Commission on Homelessness, Expanded Meal Programs through Interfaith

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Child Welfare Services: Foster Children in Certain Types of Congregate Care

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Examples of the foster care CDSS data for Q4, 2020, in CA:

- **Total foster youth and children: 53,180**
- **Total placed in an STRTP: 2,444 (or 4.6% of foster youth)**
- **Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)**
- **Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)**

9. Do you think your county is doing enough to serve the children/youth in group care?

◯ Yes FYI - There are less than 5 in county. This question is for BHAB's input.

◯ No (If No, what is your recommendation? Please list or describe briefly)

Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

10. Has your county received any children needing "group home" level of care from another county?

- (X) No
- ( ) Yes (If Yes, how many?)

11. Has your county placed any children needing "group home" level of care into another county?

- ( ) No
- (X) Yes (If Yes, how many?)

Less than 5

Part II: Impact of the Covid-19 Public Health Emergency on Behavioral Health Needs and Services

Background and Context

The Planning Council selected this year's special topic for the Data Notebook to focus on questions regarding the impact of the Covid-19 public health emergency on the behavioral health system during 2020 through 2021. Our goal for the choice of this topic is to evaluate effects of the pandemic on (1) the behavioral health of vulnerable populations in California, and (2) the impact on county behavioral health departments' ability to provide mental health and substance use disorder (SUD) treatment services in 2020 and 2021.

The major themes are as follows:

1. **The major effects on behavioral health in the vulnerable populations of adults, children and youth served by California's public mental health system. We will present some national data that describes some of the major effects.**
2. **The effects of the Covid-19 pandemic on the ability of county behavioral health departments to provide mental health and substance use treatment services.**
3. **The lessons learned and successes achieved during a time when everyone was challenged to be flexible and to devise new ways to support mental health while implementing Covid-19 public health protocols.**

This 2022 Data Notebook includes questions about effects of the pandemic on BH needs and services for children and youth, adults, and finally, some questions about potential county staffing challenges. To provide background and context for this part, we will discuss some of the limited public health data available thus far. The national data show that reports of serious behavioral health challenges were already trending upward in the two years prior to 2020. Further, the numbers of children, youth, and adults who need BH services appear to have increased further during both 2020 and 2021. Newer reports from California agencies that address similar issues have evaluated data collected in 2020 and 2021. Reports containing analyses of the most recent data are expected sometime in the second half of 2022.

In the strictest sense, we may not be able to establish that any of the changes in 2020-2021 were due to effects of the pandemic itself. Nonetheless, the continuing trends in 2020 and 2021 are cause for concern and attention, regardless of the difficulty of distinguishing cause from correlation and mere chance. Note that in our questions and discussion we often use the shorthand of speaking about the effects of Covid-19 on clients' mental health or on a county system's ability to respond to the larger challenges of the pandemic. We are not speaking in the biologic sense of what this virus does to a person's body, but rather the totality of the pandemic experience as we face this ongoing public health emergency.

We may find from the data we plan to collect through this Data Notebook that the pandemic had significant effects on system capacity to provide quantity, quality, or timeliness in the provision of many types of services, especially during the transition to online and telehealth services. Efforts to maintain Covid-19 protocols, (including social distancing), and limited access to technology may have increased barriers to access and impaired service delivery to our most vulnerable populations and to historically disadvantaged communities.

What were the Behavioral Health Impacts of the Covid-19 Pandemic on Children and Youth?

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Most recently, this urgency led the U.S. Surgeon General to issue a special health advisory[8]:

"Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade." said Surgeon General Vivek Murthy. "The COVID-19 pandemic further altered their experiences at home, school, and in the community, and the effect on their mental health has been devastating. The future wellbeing of our country depends on how we support and invest in the next generation. Especially in this moment, as we work to protect the health of Americans in the face of a new variant, we also need to focus on how we can emerge stronger on the other side. This advisory shows us how we can all work together to step up for our children during this dual crisis."

Before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the U.S. having a mental, emotional, developmental, or behavioral disorder. Additionally, from 2009 to 2019, the share of high school students who reported persistent feelings of sadness or hopelessness increased by 40%, to more than 1 in 3 students. Suicidal behaviors among high school students also increased during the decade preceding COVID, with 19% seriously considering attempting suicide, a 36% increase from 2009 to 2019, and about 16% having made a suicide plan in the prior year, a 44% increase from 2009 to 2019. Between 2007 and 2018, suicide rates among youth ages 10-24 in the U.S. increased by 57%, - PDF and early estimates show more than 6,600 suicide deaths - PDF among this age group in 2020.

The pandemic added to the pre-existing challenges that America's youth faced. It disrupted the lives of children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic's negative impacts most heavily affected those who were vulnerable to begin with, such as youth with disabilities, racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

The Surgeon General's Advisory on Protecting Youth Mental Health outlines a series of recommendations to improve youth mental health across eleven sectors, including young people and their families, educators and schools, and media and technology companies.

[8]"Protecting Youth Mental Health: The Surgeon General's Advisory", by Dr. Vivek Murthy, M.D., U.S. Public Health Service, pages 1-53. December 7, 2021. https://www

Challenges, Resilience, and Possible Lessons Learned while Addressing Behavioral Health Impacts during the Covid-19 Pandemic

Many agencies of the state have held discussions regarding the challenges and lessons learned from our collective experiences of continuing to provide services or a variety of administrative supports for those involved in provision of direct services. These discussions or assessments are an ongoing process at multiple levels.

In the 2020 Data Notebook, the Planning Council asked questions about the use of telehealth for mental health therapy to adults during early stages of the pandemic. Some service providers and clients encountered problems of access, such as technology issues, lack of home internet, or lack of adequate bandwidth, especially in rural areas. Other issues included the challenges of learning to work with the virtual therapy platform for both providers and clients. Some individuals had disabilities with impaired hearing and/or impaired vision (hard to see keys to type), which led to difficulties in access or to being completely unable to access telehealth. Also, there were language challenges for some individuals.

However, as we saw in the analyses of the responses collected from the 2020 Data Notebook, for clients who were able to overcome any technology barriers to access, they reported a fair degree of success in being able to improve their handling of mental health issues. Some clients were also able to get tele-health appointments for medication evaluation and prescriptions. Tele-health is an example of a rapid system-wide adaptation enabled by rapid policy changes for Medicaid/Medi-Cal at the federal and state levels, and rapid adaptation by local government and care providers.

The Planning Council advocates for a behavioral health system that can meet the needs of vulnerable populations and historically disadvantaged groups. Systemic, economic, or other societal factors that can reduce access to behavioral health services likely overlap with those factors that reduce access to medical care and preventative public health measures.

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African-American, and Native-American people.[9] Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. And due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"[10] symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including better adapting our outreach and messaging.

Next we turn to the discussion questions for Part II regarding the provision of behavioral health services in your community during the Covid-19 pandemic. Two questions ask for optional comments about either services for Children and Youth, or those for Adults. These 'open comment' questions could address unique county successes, continuing challenges, or lessons learned to aid future resilience, or any other com

12. Please identify the points of stress on your county's system for children and youth behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions of youth for episodes of self-harm and/or suicide attempts.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among youth.
- [ ] Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).
- [ ] Decreased access/utilization of mental health services for youth.
- [ ] None of the above
- [ ] Other (please specify)

13. Of the previously identified stressors, which are the top three concerns for your county for children and youth services? (Please select your county's top three points of impact in descending order)

Top concerns for children and youth services

1st	
2nd	
3rd	

14. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, mental health services for children and youth in your county during the Covid-19 pandemic?

15. Please identify the points of stress on your county's system for all adult behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among adults.
- [ ] Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).
- [ ] Decreased access/utilization of mental health services for adults.
- [ ] None of the above
- [ ] Other (please specify)

16. Of the previously identified stressors, which are the top three concerns for your county for all adults services? (Please select your county's top three points of impact in descending order)

Top concerns for all adults

1st	
2nd	
3rd	

17. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for all adults in your county during the Covid-19 pandemic?

18. Since 2020, has your county increased the use of telehealth for all adult behavioral health therapy and supportive services?

- (X) Yes
- ( ) No

19. Since 2020, has your county increased the use of telehealth for psychiatric medication management for all adults?

- (X) Yes
- ( ) No

20. Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders?

- ( ) Yes
- ( ) No
- (X) Not applicable (if your board does not oversee SUD along with mental health)

21. Many or most MAT programs rely on in-person visits by necessity in order to get certified to provide these services. [Some of these medications include buprenorphine, methadone, suboxone, emergency use Narcan]. As part of SUD treatment services, are you able to coordinate routine drug testing with clinics near the client?

- ( ) Yes
- ( ) No
- (X) Not Applicable (if your board does not oversee SUD along with mental health)

If Yes, how has this been useful in promoting successful outcomes?
If No, do you have alternatives to help clients succeed?

22. Have any of the following factors impacted your county's ability to provide crisis intervention services? (Check all that apply)

- [X] Increase in funding for crisis services
- [ ] Decrease in funding for crisis services
- [X] Issues with staffing and/or scheduling
- [ ] Difficulty providing services via telehealth
- [ ] Difficulty implementing Covid safety protocols
- [ ] None of the above
- [X] Other (please specify)

Hospital Covid protocols/safety measures

23. Did your county experience negative impacts on staffing as a result of the pandemic? (Please select your county's top points of impact from the dropdown menus, all in descending order of importance)

negative impacts on staffing as a result of the pandemic

1st	
2nd	
3rd	
4th	

Drop Down menus for question #23 are:

- Staff quit (part of mass resignation/social trend, etc.)
- Staff re-directed or re-assigned to support Covid-19 Teams
- Staff out to quarantine for self
- Staff out to care/quarantine due to family member's contracting of Covid-19
- Staff out due to disagreement to comply with safety protocols
- Staff out due to decision to not get vaccinated for Covid-19
- Staff out due to burnout
- Staff out due to inability to manage telework environment
- Staff unable to obtain daycare or childcare
- Other
- None of the above

24. Has your county used any of the following methods to meet staffing needs during the pandemic? (please mark all that apply)

- [x] Utilizing telework practices
- [x] Allowing flexible work hours
- [ ] Bringing back retired staff
- [x] Facilitating access to childcare or daycare for worker
- [x] Hiring new staff
- [ ] Increased use of various types of peer support staff and/or volunteers
- [ ] None of the above
- [ ] Other (please specify)

Covid restrictions reduced the use of peer run/volunteer support. Staff implemented supportive phone calls to those users impacted by the reduced availability of community centers .

25. Consider how the pandemic may have affected your county's ability to reach and serve the behavioral health needs of clients from diverse backgrounds. Has the pandemic adversely affected your county's ability to reach and serve clients and families from the following racial/ethnic communities? (Check all that apply.)

PowerPoint Presentation and 19/20 Data may assist in answering these questions.

- [ ] Asian American / Pacific Islander
- [ ] Black / African American
- [ ] Latino/ Hispanic
- [ ] Middle Eastern & North African
- [ ] Native American/Alaska Native
- [ ] Two or more races
- [x] None of the above
- [ ] Other (please specify)

26. Based on your experience in your county, has the pandemic adversely impacted your county's ability to reach and serve behavioral health clients and families from the following communities and backgrounds? (Check all that apply.)

- [ ] Children & Youth
- [ ] Foster Youth
- [ ] Immigrants & Refugees
- [ ] LGBTQ+ people
- [ ] Homeless individuals
- [ ] Persons with disabilities
- [ ] Seniors (65+)
- [ ] Veterans
- [ ] None of the above
- [ ] Other (please specify)

27. Which of the following pandemic-related challenges have presented significant barriers to accessing behavioral health services in your county? (Please check all that apply.)

- [ ] Difficulty with or inability to utilize telehealth services
- [x] Concerns over Covid-19 safety for in-person services
- [x] Inadequate staffing to provide services for all clients
- [ ] Lack of transportation to and from services
- [x] Client or family member illness due to Covid-19
- [ ] Client disability impairs or prevents access
- [ ] Mistrust of medical and/or government services
- [ ] Language barriers (including ASL for hard-of-hearing)
- [ ] None of the above
- [ ] Other (please specify)

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (please select all that apply)

- [ ] MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions
- [ ] MH Board completed majority of the Data Notebook
- [X] Data Notebook placed on Agenda and discussed at Board meeting
- [ ] Other (please specify)
- [X] MH board work group or temporary ad hoc committee worked on it
- [X] MH board partnered with county staff or director
- [ ] MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function

29. Does your board have designated staff to support your activities?

- ( ) No
- (X) Yes (if Yes, please provide their job classification)

Administrative Assistant

30. Please provide contact information for this staff member or board liaison.

Name	Pandora Armbruster
County	Tuolumne County Behavioral Health
Email Address	PArmbruster@co.tuolumne.ca.us
Phone Number	(209)533-6256

31. Please provide contact information for your Board's presiding officer (Chair, etc.)

Name	Mary Anne Schmidt
County	County of Tuolumne
Email Address	
Phone Number	

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?

ATTACHMENT #3B

August 26, 2022

FOR THE TCBH ADVISORY BOARD MEETING OF SEPTEMBER 7, 2022

Memo To: Tuolumne County Behavioral Health Advisory Board Members

From: Elizabeth Marum and Sherry Bradley, TCBH Advisory Board – Ad Hoc 2022 Data Notebook Committee

Subject: Advisory Board Member Input to Specific 2022 Data Notebook Questionnaire

Dear Advisory Board Members:

It is once again time for us to complete the 2022 Data Notebook for submission to the California Behavioral Health Planning Council. Our process will include the following:

- September 7, 2022 meeting: Review the draft 2022 Data Notebook and answer questions numbered: 9, 12, 13, 14, 15, 16, 17, 23, 26, 27, and 32.
- October 6, 2022 meeting: Finalize and approve the 2022 Data Notebook for submission by the deadline of October 28, 2022.

Please focus on the following materials which include the questions noted, above, and come to the September 7th meeting prepared to respond to them.

Please also take time to review the DRAFT 2022 Data Notebook, which is in the Agenda Packet. The Ad Hoc 2022 Data Notebook Committee has met with staff to complete the other questions.

Thank you.

Elizabeth Marum and Sherry Bradley

Ad Hoc Committee – 2022 Data Notebook

2022 DATA NOTEBOOK – ITEMS FOR BH ADVISORY BOARD MEMBER DISCUSSION/INPUT – Meeting of September 7, 2022

For Response to Question #9, below:

The county has fewer than 5 in the county that are in group care. I recommend we answer this question as "YES".

9. Do you think your county is doing enough to serve the children/youth in group care?

- ◯ Yes — FYI - There are less than 5 in county. This question is for BHAB's input.
- ◯ No (If No, what is your recommendation? Please list or describe briefly)

For Responding to Question #12, recommend we check the boxes for the answers as follows:

Yes – Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment

Reason: From the data provided by Lindsey Lujan, there WAS an increase in the number

Yes – Increased Emergency Department admissions of youth for episodes of self-harm and/or suicide attempts.

Reason: "From 2019 to 2020, youth between the ages of 10-18 and people who are Asian/Pacific Islander had an increase in suicide rates. Youth under 18 years of age had an increase in the average monthly self-harm injury rate in the same time period."

https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmIn2020-DataBrief-ADA.pdf

Yes – Other: Growing use of alcohol and drugs for youth in Tuolumne County.

Reason: Data collected as part of the state and district CHKS (California Healthy Kids Survey) shows that for elementary and secondary school students in Tuolumne County Schools the following:

Current alcohol or drug use (one or more days in the past 30 days)

- For all elementary students – 15% answered yes
- Grade 7 – 12% of students reported yes

- Grade 9 – 24% of students reported yes
- Grade 11 – 33% of students reported yes
- Non-Traditional – 45% of students reported yes.

Current marijuana use – Secondary students only:

- Grade 7 – 4%
- Grade 9 – 17%
- Grade 11 – 25%
- Non-Traditional – 36%

Very Drunk or high 7 or more times – Secondary students only:

- Grade 7 – 3%
- Grade 9 – 13%
- Grade 11 – 24%
- Non-Traditional – 36%

Current Binge Drinking (one or more days in the past 30 days)

- Grade 7 – 3%
- Grade 9 – 7%
- Grade 11 – 11%
- Non-Traditional – 21%

YES – Other: growing incidence of youth considering suicide

Students who have considered suicide in the past 12 months in Tuolumne County:

- Grade 7 – 25%
- Grade 9 – 26%
- Grade 11 – 21%
- Non-Traditional – 20%

Source of data:

https://calschls.org/reports-data/public-dashboards/

12. Please identify the points of stress on your county's system for children and youth behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions of youth for episodes of self-harm and/or suicide attempts.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among youth.
- [ ] Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).
- [ ] Decreased access/utilization of mental health services for youth.
- [ ] None of the above
- [ ] Other (please specify)

13. Of the previously identified stressors, which are the top three concerns for your county for children and youth services? (Please select your county's top three points of impact in descending order)

	Top concerns for children and youth services
1st	
2nd	
3rd	

For Question #14, recommend the following response:

The source of referrals during the Pandemic dropped (from schools).

Source of information: data review by TCBH staff

14. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, mental health services for children and youth in your county during the Covid-19 pandemic?

For Question #15, recommend the following responses:

It is recommended that we check "Decreased access/utilization of mental health services for adults.". The reasons for this are that Crisis Services in 19/20 were 779 (536 adults), and 20/21 they were 695 (483 adults), therefore there was a decrease and not an increase for adult behavioral services during the Pandemic.

15. Please identify the points of stress on your county's system for all adult behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among adults.
- [ ] Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).
- [ ] Decreased access/utilization of mental health services for adults.
- [ ] None of the above
- [ ] Other (please specify)

For Question #16, recommend the following response:

If we didn't identify any stressors or concerns for all adult services, we will enter "N/A"

16. Of the previously identified stressors, which are the top three concerns for your county for all adults services? (Please select your county's top three points of impact in descending order)

For question #17, recommend discussing any comments/concerns regarding access to, and/or performance of, behavioral health programs for all adults in our county during the COVID 19 Pandemic.

Possible topics:

- Closure of the Enrichment Center
- Closure of the Lambert Center
- Loss of volunteers working with programs

17. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for all adults in your county during the Covid-19 pandemic?

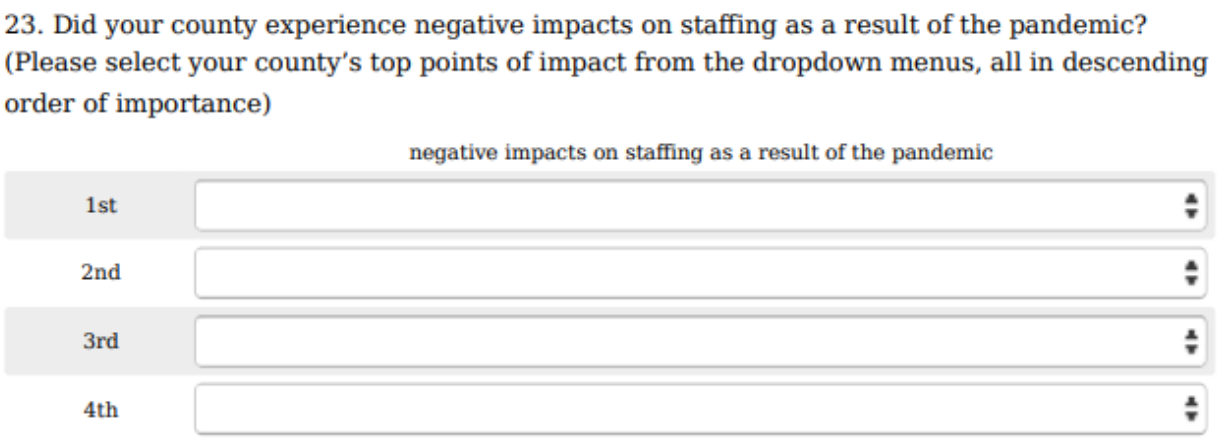
For Question #23, recommended response/s:

Board will need to add to "other" after viewing the responses based upon input from county staff.

From Question #23, here are the drop-down choices:

Drop Down menus for question #23 are:

- Staff quit (part of mass resignation/social trend, etc.)
- Staff re-directed or re-assigned to support Covid-19 Teams
- Staff out to quarantine for self
- Staff out to care/quarantine due to family member's contracting of Covid-19
- Staff out due to disagreement to comply with safety protocols
- Staff out due to decision to not get vaccinated for Covid-19
- Staff out due to burnout
- Staff out due to inability to manage telework environment
- Staff unable to obtain daycare or childcare
- Other
- None of the above



For Question #26 :

- Ask Jen Salazar to comment on her experience working with the unsheltered to see if there was an impact on unsheltered individuals or immigrants & refugees, or any impact with the LGBTQ community.
- Ask Area 12 if there was an impact on Senior Citizens
- Ask Non-profit(s) working with persons with disabilities if there was an impact
- Veterans were NOT impacted (***(Deb Esque responded to my email as follows: "No not really. We continued to go out to homes and meet with our clients during the pandemic. What we changed was how we did our day-to-day business, which was to do all encounters by appointment only. We're continuing this practice. Again, we have never closed our doors to meet with clients either in their homes our at the county office.")***

26. Based on your experience in your county, has the pandemic adversely impacted your county's ability to reach and serve behavioral health clients and families from the following communities and backgrounds? (Check all that apply.)

- [ ] Children & Youth
- [ ] Foster Youth
- [ ] Immigrants & Refugees
- [ ] LGBTQ+ people
- [ ] Homeless individuals
- [ ] Persons with disabilities
- [ ] Seniors (65+)
- [ ] Veterans
- [ ] None of the above
- [ ] Other (please specify)

For Question #27, Recommend the following:

Staff has checked the boxes for which they have data. We are asking Advisory Board members to weigh in on "Mistrust of medical and/or government services" and the "other" category.

27. Which of the following pandemic-related challenges have presented significant barriers to accessing behavioral health services in your county? (Please check all that apply.)

- [ ] Difficulty with or inability to utilize telehealth services
- [X] Concerns over Covid-19 safety for in-person services
- [X] Inadequate staffing to provide services for all clients
- [ ] Lack of transportation to and from services
- [X] Client or family member illness due to Covid-19
- [ ] Client disability impairs or prevents access
- [ ] Mistrust of medical and/or government services
- [ ] Language barriers (including ASL for hard-of-hearing)
- [ ] None of the above
- [ ] Other (please specify)

For Question #32, Board Members will need to provide feedback and/or recommendations to improve the Data Notebook.

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?

YOUTH MEMBERSHIP

Tuolumne County Behavioral Health Advisory Board

Youth Ad Hoc Update

August 2022

- There are a handful of counties who initiated the addition of TAY youth members beginning in 2017.

- San Francisco County appointed a TAY member in 2019 who has since been voted co-chair.

- Several Counties have entire Youth (TAY) Committees.

HTTPS://CALYOUTHCONN.ORG/WP-CONTENT/UPLOADS/2019/07/TAY_MENTAL_HEALTH_WEB_YEAR1.PDF

U.S. STATS

1 IN 5 TAY HAVE MENTAL HEALTH CONCERNS.

ONLY 20%

OF YOUNG PEOPLE WITH MENTAL HEALTH CHALLENGES RECEIVE SERVICES.

THE AVERAGE DELAY BETWEEN ONSET OF SYMPTOMS AND INTERVENTIONS IS

8-10 YEARS.

APPROXIMATELY

50%

OF STUDENTS 14 AND OLDER WITH MENTAL ILLNESS DROP OUT OF HIGH SCHOOL.

HTTPS://CALYOUTHCONN.ORG/WP-CONTENT/UPLOADS/2019/07/TAY_MENTAL_HEALTH_WEB_YEAR1.PDF

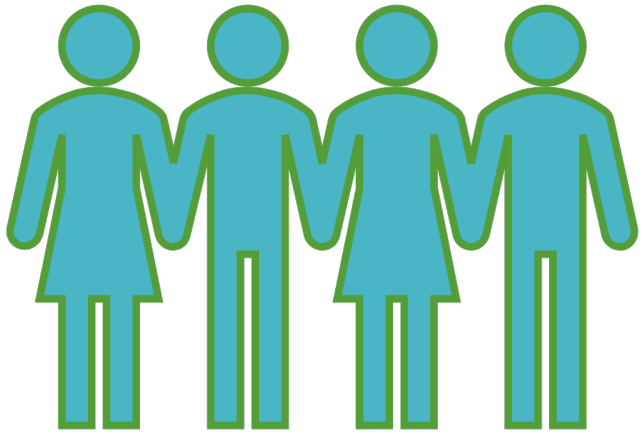
YOUTH IN TUOLUMNE COUNTY

In March 2022 Child welfare advocates presented the following statistics to the Board of Supervisors:

- Tuolumne County youth substance abuse and thoughts of suicide are at rates higher than the statewide average.
- 25% of seventh graders polled said they had thought about committing suicide at some point in the previous 12 mos. (16% higher than the state average).
- 34% of eleventh graders admitted to current use of alcohol or drugs (12% higher than the state average).

Tuolumne County Behavioral Health recently shared an FSP breakdown as well as community stakeholder survey results:

- Nearly 60% of Tuolumne County clients are youths (29% TAY, 27% CHILDREN).
- Tuolumne County Stakeholders polled in early 2022 indicated that "youth" is the common concern and need for focus (particularly in innovative outreach).



IMPACTS OF YOUTH MEMBERSHIP

- Prepares young people to work in the mental health world.
- Engages and educates the mental health world on how to work with young people.
- Youth bring innovation, perspective, a deeper understanding, and a beacon of hope.
- Initiates tapping into youth voice intentionally about programming needs of TAY.
- Helps to reduce stigma and barriers for youth at an earlier age.
- Engages a wider swath of the community.
- Creates a better path for future generations.

ASSEMBLY BILL 573
2021-2022 REGULAR SESSION

- Would establish the California Youth Mental Health Board within the California Health and Human Services Agency to advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement.
- 15 members between the ages of 15 and 23.
- This bill would require each community mental health service to have a local youth mental health board.
- Half of all lifetime mental health needs emerge before 14 years of age, and three-quarters before 24 years of age.
- Many children suffer without help. Approximately half to three-quarters do not receive mental health treatment or services.

WHY NOT GET AHEAD OF THIS AND START PREPARING TAY FOR EFFECTIVE AND PRODUCTIVE BOARD MEMBERSHIP?

TCBHAB WELCOMING AND SUPPORTING YOUTH MEMBERSHIP

CREATED YOUTH AD-HOC COMMITTEE

INITIATED A PRODUCTIVE RECRUITMENT STRATEGY

CURRENTLY IN DEVELOPMENT: ONE-ON-ONE MENTOR PROGRAM

CURRENTLY IN DEVELOPMENT: COMPREHENSIVE ORIENTATION PROGRAM

ONGOING COLLABORATION WITH TCSOS (TERRI ALFORD)

PLANS FOR FURTHER OUTREACH AND COLLABORATION WITH LOCAL ORGANIZATIONS (YES, COLUMBIA COLLEGE, SCNVC, ETC...)


THANK YOU

RESOURCES FOR INTERESTED TRANSITIONAL AGE YOUTH

NO STIGMA NO BARRIERS
HTTPS://WWW.NOSTIGMANOBARRIERS.ORG

CALIFORNIA YOUTH CONNECTION
HTTPS://WWW.CALYOUTHCONN.ORG

YOUTH IN MIND
HTTPS://WWWYIMCAL.ORG

YOUNG MINDS ADVOCACY
HTTPS://YMADVOCACY.ORG

VOICES
HTTPS://WWW.VOICESYOUTHCENTER.ORG

HTTPS://WWW.PEERSNET.ORG

TUOLUMNE COUNTY
BEHAVIORAL HEALTH
ADVISORY BOARD

YOUTH BOARD MEMBER OREINTATION AND ONGOING EDUCATION

Welcome to the Tuolumne County Behavioral Health Advisory Board

We are pleased to have you join us in serving the people of Tuolumne County. Our heartfelt thanks to you for committing your time, sharing experiences, and contributing a valuable voice.

Orientation, education, and the development of a vibrant Behavioral Health Advisory Board is an ongoing goal. We believe it is important to develop a culture of continuous learning, as board members will make decisions that may affect the community at large. It is important that our members communicate with a wise, thoughtful, and educated voice while engaging with and representing our community.

Orientation is a two-way process. New board members will learn about The Tuolumne County Behavioral Health Department and Behavioral Health Advisory Board, while sharing from their own experiences and viewpoints.

✓	Board Member Action	Facilitator/Source/Add Notes
	Meet and Greet RECEIVE/REVIEW COPY OF WIC 5604.2 RECEIVE CURRENT BY LAWS Review: -Purpose -Objectives -Responsibilities & Functions DISCUSS MEETINGS/QUORUM Review: -Submitting items to agenda -Providing notice if unable to attend -Ground rules -Use of Zoom *Review By Laws in entirety before Mentor meeting.*	Youth Ad Hoc member Name: Phone #:

	Note any question for Mentor.	
	Meet with assigned Mentor RECEIVE A COPY OF THE BROWN ACT Review: -Letter from Attorney General -4-page Brown Act Guide (The Basics, FAQ, Public Emergency Allowances) RECEIVE A COPY OF ROSENBERG'S RULES OF ORDER. Review with focus on: -Three basic motions -Courtesy and Decorum RECEIVE/REVIEW A COPY OF CONDUCT AGREEMENT AND PERSON FIRST LANGUAGE *Thoroughly review all documents prior to attending first Board Meeting. Note any questions for Mentor.* *RECEIVE COPIES FOR REFERENCE:* *-TCBHAB member roster*	Mentor Name: Mentor Phone #: Date: Time: Place: *(After BOS selection to appointment)*

	-TCBHAB member biographies	
	Attend first TCBHAB meeting INTRODUCTION BY MENTOR -Passive attendance only (no action/voting) *Take notes/record questions for Mentor*	Date: Time:
	Receive request from Tuolumne County Board of Supervisors Board Clerk. Make appointment to meet with Clerk for Oath of Office.	Heather Ryan _____location_____
	EXPLORE/REVIEW	IMPORTANT RESOURCES (WEBSITES, WEB PAGES, DOCUMENTS
	CALIFORNIA ASSOCIATION OF LOCAL BEHAVIORAL HEALTH BOARDS AND COMMISSIONS Locate, print/save, and read in entirety: -2022 Best Practices for California's CALBHB/C	https://www.calbhbc.org/training.html

	-Explore/become familiar with all tabs and pages *Record notes/questions for Mentor*	*(Complete prior to active meeting participation at your second board meeting)*
	COUNTY OF TUOLUMNE OFFICIAL WEBSITE Committees/Commissions -Create a user login/password and join -Sign up to be notified of Board meetings and other pertinent notifications.	https://www.tuolumnecounty.ca.gov/836/Committees-Commissions
	TUOLUMNE COUNTY BEHAVIORAL HEALTH WEBSITE TCBH FACEBOOK PAGE NETWORK OF CARE WEB PAGE TCBH ADVISORY BOARD WEB PAGE	https://www.tuolumnecounty.ca.gov/220/Behavioral-Health https://www.facebook.com/search/top?q=tuolumne%20county%20behavioral%20health https://tuolumne.networkofcare.org/mh/ https://www.tuolumnecounty.ca.gov/861/Behavioral-Health-Advisory-Board

	Write your biography and select your photo to be submitted for Website and Biography Flyer. *(Contact Mentor or Executive Committee member for assistance).*	Submit via e-mail to _____
	TRAINING-TRAINING	TRAINING-TRAINING-TRAINING-TRAINING-TRAINING-TRAINING-TRAINING
15 mins.	Review WIC 5604.2 Take: Duties of Local Boards Check/Quiz	https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-5604-2.html https://www.calbhbc.org/training.html
2 hrs.	Mandatory Ethics Training	https://localethics.fppc.ca.gov/login.aspx *You will need to create an account for recording purposes. You will be able to take this 2-hour training in increments.*
30 mins.	Take three: MHSA Modules	https://www.calbhbc.org/training.html *(Role of MHB, MHSA FISCAL, MHSA CPP)*
1 hr.	Unconscious Bias Training	https://www.calbhbc.org/unconsciousbias.html

1.5 hrs.	Mental/Behavioral Health Boards/Commissions Training	https://www.calbhbc.org/mentalhealthboardtraining.html
	Make an appointment to meet with Tami Mariscal (Director of Behavioral Health) or appointee.	Receive additional documents at Tami's discretion. Ideas: Acronyms Department Org Chart Program Flyers Newsletter/s "About our Program" slides Etc...

RECRUITMENT of Board/Commission Members from CALBHBC Best Practices

ROLE OF MHB

Local mental/behavioral health boards and commissions (MHBs) may recommend appointees to the County Board of Supervisors (or Governing Body). Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county. WIC 5604 (a)(1)

STRATEGIES

In order to achieve a diverse membership (ethnic, racial, sexual orientation) that includes a good mix of consumers, family members, and people with experience and knowledge of the mental health system, it is important to be intentional about inviting potential members to apply. Individual contact with people (phone calls, meetings for coffee) can be effective in both attracting people to the MHB and creating relationships for future interaction with the MHB. To represent various facets of the community that interacts with Mental Health, MHBs may want to reach out to:

1. Community Organizations, such as the Hispanic Chamber of Commerce or Tribal Organizations
2. Mental Health Adult Resource Centers/Consumer Groups
3. Commissions on Aging/Older Adult Groups, School Boards/School Districts
4. Criminal Justice (e.g. Sheriff, Public Defender)
5. College/Community College Boards/Staff

PROCESS

It is important to use a process that is public, fair and respects people's privacy.

1. Public posting of MHB openings (usually done by county staff)
2. On-line or printed application publicly available (usually on county website) Sample
3. Board/Commission Chair and/or Executive Committee receives redacted applications (from staff)
for follow-up interviews.
4. Two or more MHB members conduct a private interview (with set list of questions) followed by
possible recommendation to the MHB. (Suggested interview questions are provided at: www.calbhbc.org/templatessample-docs (under Recruitment))
5. The MHB votes to recommend individuals for possible appointment by the Board of Supervisors
(or Governing Body)
6. The Board of Supervisors receives the recommendations.
7. In some counties the process gets stalled at this juncture for a variety of reasons (e.g.,

the
Supervisor may be considering another candidate, it gets “lost” in the Supervisors office) and it may be necessary to track time of correspondence, possibly consider placing a call after one month to stress the importance of having a full complement of MHB members and remind the Supervisors to make appointments..

RULES FOR MEMBERSHIP - See Membership Criteria (WIC 5604) Page 33

Recruitment of Board/Commission Members Continued
[County Logo]
Contact:
[Name, Position]
[Phone]
[Email]
Sample Flyer or Press Release

Applicants sought for [Name of Mental or Behavioral Health Board/Commission]
The County Executive Officer announces two vacancies on the [Name of County Mental/Behavioral

Health Board/Commission]. These vacancies represent the following categories:
1) Consumer (an individual with lived experience of mental illness), with the terms expiring [Date(s)]
2) Family Member of Consumer, with the terms expiring [Date(s)]
3) Interested & Concerned Citizen, with the terms expiring [Date(s)]
The [Mental Health Board] meets at [time] on the [day] of each month at [address][and by teleconference]. The [15-member Mental Health Board] represents the categories of consumers, family members of consumers, interested and concerned citizens and a member of the Board of Supervisors. Applicants need not have any specialized or professional background. With the exception of consumers (under certain conditions), no member of the Board or his or her spouse shall be a full-time or part-time employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee, or a paid member of the governing body of a
Mental Health contract agency. Anyone interested in consideration for an appointment must submit a completed application form. Application forms are available at the County Executive Office, [address], telephone [phone number] or
online at [web address]. [Example Instructions: Click on “Application for appointment” under the “Current Openings” heading and follow the application instructions.
Recruitment will remain open until vacancies are filled.]

Recruitment of Board/Commission Members Continued
Recruitment Policy (Sample)
[Name of Chair], [Name of Board/Commission] Chair
[Name of Vice Chair], [Name of Board/Commission] Vice Chair
Policy #[Insert number]

Purpose
The purpose of this policy and procedure is to ensure an efficient and fair process for filling existing and
anticipated vacancies on the [Name of County] [Mental/Behavioral Health Board] [(MHB)]

Policy
All existing and anticipated vacant positions on the [MHB] will be filled in a timely manner. Recruitment
and member selection processes will meet all [MHB] CA WIC 5604. requirements in order to ensure
adequate consumer, family member, and general citizen representation, with an emphasis on achieving a
diverse membership (ethnic, racial, sexual orientation) of individuals who have experience with the
mental health system and/or the sectors in which it intersects.

Procedures:
1) Notify Clerk of the Board of Supervisors: When [MHB] positions become vacant, the [Name of
Board/Commission] [staff liaison] will immediately inform the Clerk of the Board of Supervisors,
providing the following information:
a) The date of the vacancy
b) The type of vacancy (i.e. consumer, family member, interested/concerned citizen)
2) Application Review: The [Name of Board/Commission] [staff liaison] shall review applications
to ensure that the applicant meets the criteria for [MHB] membership (See “Membership Criteria”
(WIC 5604) Page 33)
3) Interviews: Each applicant will be interviewed by at least two representatives of the [MHB].
Sample Interview Questions.
The representatives shall recommend candidates to the full [MHB] and the [MHB] at its next

regularly scheduled meeting shall finalize its recommendations to the Board of Supervisor(s) (In
some counties, individual Supervisors make appointments for their district) for their consideration
of appointment onto the [MHB]).
4) Reappointments: Current members who wish to serve an additional 3-year term are also
interviewed, and potentially recommended as outlined in #3 (above). [Adhering to term limit
[MHB] bylaw requirements (if any)]

Committee and Commission Application

BOS-22-22

Applicant

William Olmstead
832 627 4660
@ william@olmsteads.us

Application Information

Vacancy Applied For

Behavioral Health Advisory Board

Applying for Reappointment

--

City

Sonora

Residential Phone

832 627 4660

Cell Phone

--

How long have you lived in Tuolumne County? (months)

9

For Supervisorial Districts, refer here (https://tuolumne.maps.arcgis.com/apps/webappviewer/index.html?id=fe14d4f71bf849e29e2afdaa42ca056c&extent=-13471589.097%2C4519241.3068%2C-13233869.939%2C4649490.003%2C102100).

BHAB Member Role

Other

Mailing Address

133 Oak St.

Zip Code

95370

Business Phone

--

How long have you lived in Tuolumne County? (years)

1

Which Supervisorial District do you reside?

1

Name of present employer

Retired

Employer Address

--

Employer City

--

Employer State

--

Employer Zip Code

--

Occupation

Retired

Briefly describe the qualifications you possess which you feel would be an asset to the Commission/Committee/ Group for which you are applying.

Lawyer, teacher, school and business leader who has benefited from mental health (anxiety/depression) resources for 25 years.

List the community organization(s) and describe participation in which you have been involved.

CASA volunteer

I confirm that I have sufficient time to devote to this responsibility and plan to attend the required meetings if I am appointed to fill a vacancy. I understand that if I am appointed to a commission where a Disclosure of Assets Statement is required by State Law or Board Policy, I shall do so within ten (10) days of assuming office.

Signature

true

Applications not acted upon will expire after two years from the date submitted unless renewed by applicant.

I hereby consent that this document is considered a public record and will be available to the public.

William Olmstead

+233 050 273 3695
william@olmsteads.us

PROFILE: A legal and management professional with experience in business law, negotiations, and litigation; a manager with training and experience leading legal and education professionals, and a manufacturing facility. Certified as a contracts manager and as a compliance officer.

EDUCATION

Master of Education, Educational Leadership -- University of Alaska Anchorage	2004
Master of Arts, Elementary Education -- University of Alaska Southeast	2000
Juris Doctor -- Seattle University School of Law	1984
Bachelor of Arts, Political Science, Chemistry minor -- Western Washington University	1981

EXPERIENCE

Managing Director, Furnart Ghana Ltd., Accra, Ghana **November 2015 to Present**

Manager of a furniture and joinery manufacturer and retailer, employing 115 factory workers and 15 more in office and sales roles. Furnart underwent a rapid turnaround, as it returned to profitability in 2016 for the first time in a decade. Turnover was three times the historical average. Although the growth is rapid, the focus is on training and development for long-term sustainability.

Attorney, Houston, Texas **2011 to 2013**

Member of trial preparation team representing Transocean in Macondo oil spill litigation. Prepared expert witness deposition materials. Reviewed documents and prepared summaries for defending key witness depositions. Coordinated work of teams of 3---6 contract attorneys. Performed first and second level document review for discovery. Lead member of document review team in FERC market manipulation investigation.

Teacher and Administrator, Anchorage, Alaska **2001 to 2009**

As a school leader, interviewed teacher applicants, evaluated teacher performance, and led goal---setting meetings. As a program coordinator, tested computer---based educational programs, trained staff, analyzed results, and reported to stakeholders. Conducted training and professional development programs with employees and community members of up to 100 people.

Attorney, Juneau, Alaska **1984 to 2000**

Employment experiences:

- Law Office of William Olmstead 1997 to 2000
- Olmstead & Conheady 1991 to 1997
- Domke & Olmstead 1988 to 1991
- Weeks & Olmstead 1986 to 1988
- Law Office of Loren Domke 1984 to 1986

Provided clients with advice on business matters including negotiation of leases, sales, and contracts. Helped competing interest groups within business clients find common ground regarding negotiations, litigation strategy, and settlement terms.

Represented clients in broad range of contract disputes. Contributed to preparation of bids and RFP responses, and led challenges to adverse bid awards. Directed negotiations and litigation with federal government, municipalities, utilities, owners, and subcontractors on topics including commercial and residential construction, road building, blasting, and environmental consequences. Drafted commercial and residential leases, and real property sales agreements; litigated breaches, rights of way, easements, and eminent domain issues.

Wrote and litigated confidentiality and non-competition agreements; developed employee manuals; represented clients in federal Equal Employment Opportunity Commission and state Human Rights Commission administrative processes. Participated in employment cases involving wrongful termination, sexual harassment, discrimination, and union law.

Conducted and led investigations as trial counsel, both through the civil law discovery process and the less structured investigations necessary in criminal law. Appointed in a quasi---judicial role in real property partition action; managed pre---trial and discovery matters, reviewed evidence in courtroom, and issued binding decision.

Performed technical writing for the State of Alaska:
- Drafted a statewide sales tax code for the Department of Revenue.
- Revised the procurement policies and procedures in the State Administrative Manual.

VOLUNTEER

Lincoln Community School 2014 to 2015

Member of Board of Trustees Trusteeship and Head of School Search Committees.

AWAIC, Anchorage, Alaska 2005 to 2008

Board of Directors, President (2007---2008). Helped put the abused women's shelter on sound administrative footing. Rewrote Bylaws and Procedures Manual. Assisted with fund raising.

Youth soccer coach 2005 to 2011

Coached youth teams in a variety of organizations.

MEMBERSHIPS

Alaska Bar Association
Washington State Bar Association (inactive)
Rocky Mountain Mineral Law Foundation
National Contract Management Association
Ethics and Compliance Officer Association

Committee and Commission Application

BOS-22-32

Submitted On: Aug 10, 2022

Applicant

Alejandro Abarca
12096179456
@ alexabarca@comcast.net

Application Information

Vacancy Applied For
Behavioral Health Advisory Board

BHAB Member Role
Family of Consumer

Applying for Reappointment
--

Mailing Address
17775 Plaza Del Sur

City
Sonora

Zip Code
95370

Residential Phone
N/A

Business Phone
--

Cell Phone
209-617-9456

How long have you lived in Tuolumne County? (years)
7

How long have you lived in Tuolumne County? (months)
2

Which Supervisorial District do you reside?
5

For Supervisorial Districts, refer here (https://tuolumne.maps.arcgis.com/apps/webappviewer/index.html?id=fe14d4f71bf849e29e2afdaa42ca056c&extent=-13471589.097%2C4519241.3068%2C-13233869.939%2C4649490.003%2C102100).

Name of present employer
Sacred Bonds

Employer Address
14570 Mono Way, Suite A

Employer City
Sonora

Employer State
Ca

Employer Zip Code
95370

Occupation
Psychotherapist

Briefly describe the qualifications you possess which you feel would be an asset to the Commission/Committee/ Group for which you are applying.

PROFESSIONAL PROFILE

1. Over 12 years of Executive Director experience and Clinical Lead of various Integrated Behavioral Health (IBH) programs in primary care settings.

- Over 21 years of direct patient care experience using various certified clinical therapy modalities servicing those suffering from mild, moderate, or severe mental illnesses.
  1. Successfully managed and doubled IBH services for nearly 100,000 patients in 26 regional sites for a Federally Qualified Health Center (FQHC) in the San Joaquin Valley. Established experience managing various BH clinics tailored for specific populations within the communities served.
  2. Successful experience in fostering and maintaining strong relationships with various County Mental Health agencies allowing successful attainment and retention of Mental Health Services Act (MHSA) funded projects.
  3. Direct knowledge of RFP protocols and grant writing experience allowing successful capturing of additional funding streams from local, state, and federal agencies. Provided deliverables for grants that targeted high-risk patient populations such as those suffering from homelessness, substance use, and high utilizers of acute emergency services and/or hospital care.
  4. Created and developed an IBH program for a Native American healthcare consortium serving 15,000 patients residing within four rural counties in the Sierra Nevada foothills.
  5. Knowledge of behavioral health and healthcare industry trends and their relationship to the development of policies designed to ensure the company is best prepared and compliant.
  6. Proven ability to develop preventive and evidence based mental health approaches designed to improve patient service delivery and enhance patient outcomes.

- Personable and inclusive leadership style designed to enhance effective collaboration between executive and clinic team members.
  1. Strong communication and time management skills that translate into successfully identifying and correcting deviations from company objectives.
- Increased the Therapist to Doctor ratio from 1:10 to 1:4 fulfilling appropriate staffing proportions designed to optimize services.
- Certified as a Communications Trainer through the Institute of Healthcare Communication (IHC) allowing a skilled and tactful approach to sensitive staff and patient matters allowing the most positive resolution of grievances.

1. Unique perspective of mental illness due to being a family member of two relatives who live with severe mental illness (SMI). First hand experience on the impact those challenges have on families as well as how the service delivery gaps can lead to unnecessary burdens. This knowledge has fostered the development of a recovery-based perspective and heightened drive for advocacy of innovative approaches designed to enhance the lives of those affected by mental illness.

- Active constituent and speaker at various chapters of National Association of Mentally Ill (NAMI).
- Proficient in public speaking. Frequently sought out to present as a clinical expert on various mental health topics. Additional experience in presenting to community stakeholders and at Evidence Based clinical conferences.
- Bi-cultural and bi-lingual Spanish repertoire.

List the community organization(s) and describe participation in which you have been involved.

Sierra Waldorf School: Board Member 2016-2019
CSU Stanislaus MSW Community Advisory Committee

I confirm that I have sufficient time to devote to this responsibility and plan to attend the required meetings if I am appointed to fill a vacancy. I understand that if I am appointed to a commission where a Disclosure of Assets Statement is required by State Law or Board Policy, I shall do so within ten (10) days of assuming office.

I hereby consent that this document is considered a public record and will be available to the public.

Signature

true

Applications not acted upon will expire after two years from the date submitted unless renewed by applicant.

ALEJANDRO ABARCA, LCSW

17775 Plaza Del Sur, Sonora, Ca 95370 ▪▪ CELL (209) 617-9456
EMAIL ALEXABARCA@COMCAST.NET

PROFESSIONAL PROFILE

- Over 12 years of Executive Director experience and Clinical Lead of various Integrated Behavioral Health (IBH) programs in primary care settings.
- Over 21 years of direct patient care experience using various certified clinical therapy modalities servicing those suffering from mild, moderate, or severe mental illnesses.
- Successfully managed and doubled IBH services for nearly 100,000 patients in 26 regional sites for a Federally Qualified Health Center (FQHC) in the San Joaquin Valley. Established experience managing various BH clinics tailored for specific populations within the communities served.
- Successful experience in fostering and maintaining strong relationships with various County Mental Health agencies allowing successful attainment and retention of Mental Health Services Act (MHSA) funded projects.
- Direct knowledge of RFP protocols and grant writing experience allowing successful capturing of additional funding streams from local, state, and federal agencies. Provided deliverables for grants that targeted high-risk patient populations such as those suffering from homelessness, substance use, and high utilizers of acute emergency services and/or hospital care.
- Created and developed an IBH program for a Native American healthcare consortium serving 15,000 patients residing within four rural counties in the Sierra Nevada foothills.
- Knowledge of behavioral health and healthcare industry trends and their relationship to the development of policies designed to ensure the company is best prepared and compliant.
- Proven ability to develop preventive and evidence based mental health approaches designed to improve patient service delivery and enhance patient outcomes.
- Personable and inclusive leadership style designed to enhance effective collaboration between executive and clinic team members.
- Strong communication and time management skills that translate into successfully identifying and correcting deviations from company objectives.
- Increased the Therapist to Doctor ratio from 1:10 to 1:4 fulfilling appropriate staffing proportions designed to optimize services.
- Certified as a Communications Trainer through the Institute of Healthcare Communication (IHC) allowing a skilled and tactful approach to sensitive staff and patient matters allowing the most positive resolution of grievances.
- Unique perspective of mental illness due to being a family member of two relatives who live with severe mental illness (SMI). First hand experience on the impact those challenges have on families as well as how the service delivery gaps can lead to unnecessary burdens. This knowledge has fostered the development of a recovery-based perspective and heightened drive for advocacy of innovative approaches designed to enhance the lives of those affected by mental illness.
- Active constituent and speaker at various chapters of National Association of Mentally Ill (NAMI).
- Proficient in public speaking. Frequently sought out to present as a clinical expert on various mental health topics. Additional experience in presenting to community stakeholders and at Evidence Based clinical conferences.
- Bi-cultural and bi-lingual Spanish repertoire.

PROFESSIONAL EXPERIENCE

Sacred Bonds Counseling & Wellness 2020 to present

Executive Director

Responsible for a thriving private practice focused on innovative "preventive mental health" practices designed to strengthen the emotional bonds between children and their parents. In this manner, we can tend to any existing symptoms and stressors while also focusing on preventing unnecessary hardships on children while also teaching parents how to best tend to the emotional needs of their children. By doing so, we are improving the emotional resiliency of our children and community.

- Provide direct clinical services in a private practice setting using my eclectic repertoire to help clients overcome their emotional ailments and improve resiliency. Use of evidence-based practices with a diverse group of clients and their families who suffer from the impacts of mild, moderate, or severe mental illness.
- Trauma-focused therapeutic care with the use of EMDR and various techniques designed to address and heal from the underlying factors of symptom development.

Integrated Behavioral Health & Foster Care Consultant 2008 to present
Independent Consulting & Psychotherapy Private Practice

Over a decade of responsive and reliable expert consulting services ranging from direct care supervision to operational management consulting. I provide a wide array of services based on my expertise in administering Integrated Behavioral Health Programs and being a leader in that field. Years of receptive collaboration with several county agencies that provide social services for challenged youth and adults. Offer effective consultation for organizations that want to enhance their employee engagement and patient experience, through integration and whole health practices.

- Provide direct clinical services in a private practice setting using my eclectic repertoire to help clients overcome their emotional ailments and improve resiliency. Use of evidence-based practices with a diverse group of clients and their families who suffer from the impacts of mild, moderate, or severe mental illness.
- Independent consultative work with foster care agencies and direct contact with children assigned to certified foster homes. In this regard, I use my clinical and communication skills to promote strong relationships with foster youth and advocate on their behalf so that experience a successful placement.

Director of Behavioral Health Services July 2015 to October 2019
MACT Health Board, Inc., (MACT)

Responsible for creating the Integrated Behavioral Health Program (IBHP) at this Native American Healthcare consortium serving Native and Non-Native patients in the rural counties of Mariposa, Amador, Calaveras, and Tuolumne. As the Director of Behavioral Health Services (DBHS) I am responsible for the creation and administration of the program while also maintaining an active caseload and clinical practice providing therapeutic services to over 50 patients. The clinical and administrative responsibilities require strategic approaches and precise time management skills, which ensure successful communication with our CEO, Board of Directors, regional clinics and community partners. I aligned the program goals with the company's mission of enhancing the quality of services by staff training in which the culture of treatment includes awareness of how mental health factors directly impact the overall health of patients. This has allowed our treatment teams to create inclusive approaches that emphasize addressing the identified mental health ailments in a proactive manner thus augmenting the traditional medical model treatment modalities already in place. I successfully attained and maintain key accreditation credentials with entities like AAAHC and continuously ensure the department's compliance with relevant state and federal mandates. As Director of BHS, I'm directly responsible for recruitment and supervision of all Behavioral Health Providers (BHPs).

Proving the program's success, Integrated BH care has improved in all of the clinics since the programs' initiation. This is further evidenced by the 7-fold increase in yearly productivity. This exponential efficiency trend has allowed the BH department to financially sustain itself without the need for grant funding, which is a rare occurrence in community health centers. My networking skills helped to develop key relationships with representatives from county, state, and federal agencies allowing the successful acquisition of MHSA grants. This collaboration has fostered superior inter-agency partnerships in a community that previously lacked such participation in such. This forges the way for further expansion in this area, which could allow additional supplementation of our funding sources in all four counties as well sustaining these partnerships.

Managerial and Administrative Duties:

- Coordinate and gather statistical information for the preparation of monthly Board Reports to ensure clear communication of any program matters to CEO and Board Members.
- Responsible for the planning, organization, implementation, and supervision of the MACT Integrated Behavioral Health program in order to provide comprehensive high quality care in all of our clinics.
- Responsible for setting and attaining program goals and objectives that exceed budgetary guidelines with vast profits. Ensure department meets budgetary compliance.
- Directly responsible for the acquisition of two MHSA funded projects. Provided an innovative approach that addressed the mental health needs of pre and post-natal mothers in a preventive manner. Created an attachment-based curriculum with strategic touch points during pregnancy with BH staff and continuing for the first 5 years of the child's life.
- Lead of all behavioral health issues for MACT staff through in-service trainings, consultations, and other informal means.
- Responsible to recruit, train, and provide clinical supervision to licensed and unlicensed BHPs
- Develop policy and protocols to ensure efficient Electronic Health Record use, adequate documentation guidelines, and review of monthly, quarterly, and annual reports of program activities so that contractual and billing requirements are met.

Clinical Duties:

- Provide direct clinical care under the guidelines of the IBHP best practices model. This includes facilitating care through triage and referral to other BHPs when necessary. Assess the clinical status of child, adult and geriatric patients referred by primary care providers.
- Assist in support of our various programs such as our chronic pain and substance abuse approaches to aid patients with behavioral health co-morbidities that are often present with such conditions.

Director of Behavioral Health Services 2012 to 2015
Golden Valley Health Centers (GVHC)

As the Director of Behavioral Health Services, I was responsible for the administration and further expansion of an existing Integrated Behavioral Health Program. During my tenure, GVHC was a premier non-profit Federally Qualified Health Center (FQHC) serving patients in both Merced and Stanislaus County. During the early years of my administrative role, the organization served over 100,000 patients out of their 26 regional health centers. These health centers were providing medical and dental care and only limited BH services at a handful of sites. During my tenure, I expanded BH services by successfully networking and increasing MHSA and federal grant funding 3-fold. This allowed for the swift expansion of BH services effectively implementing BH care in 24 of the 26 sites allowing us to become one of the biggest IBHPs in the state. The agency's collaborative culture created an environment where we could implement innovative practices that flourished and allowed various pilot projects to become standards of care thus minimizing the service delivery gaps that negatively impacted our patients. These collaborative endeavors required an efficient use of my administrative time so that we could successfully meet the goals of the projects all while developing and maintaining relationships with our various community partners. I was able to achieve this all while providing direct clinical services three days a week, conducting clinical supervisions, training and evaluating other BHPs, and constantly collaborating with the Chief Medical Officer (CMO). I was also a formal member of the Executive Leadership Team driving the agency's vision of ensuring access to high quality, culturally responsive and

comprehensive primary health care for all, especially the underserved. Together, we successfully managed the complex needs of our patients by striving to meet our mission driven goals of enhancing the quality of care regardless of language, financial, and cultural barriers.

Managerial and Administrative Duties:

- Responsible for the planning, organization, implementation, and supervision of the GVHC Integrated Behavioral Health program. In collaboration with the CMO and Medical Site Directors and responsible for setting and attaining program goals and objectives within budgetary guidelines. Our IBHP consisted of 22 BHPs (mostly LCSWs and a robust group of ASWs), 3 psychiatrists, 2 case managers, and 2 addictions specialists, totaling 29 direct reports.
- Led staff with expertise on mental health disorders and behavioral health issues through in service trainings, consultations, and other more informal means.
- Often requested to host health centers and trained their clinic leaders to help them develop their own IBHP in a successful manner.
- Assisted in recruitment, selection and training of BHPs; provided ongoing clinical supervision to BHPs
- Directed the gathering of statistical information and the preparation of a variety of program reports; planned and developed new program efforts such as behavioral health-primary care integration.
- In collaboration with the CMO, developed and managed a 4 million dollar budget including contracts with the county and federal agencies to support our IBHP; contracts totaled approximately $900,000 annually.
- Developed policies and guidelines to ensure appropriate integration of the newly rolled out Electronic Health Records. Adequately documented and reviewed monthly/annual reports of program activities so that contractual and billing requirements were met.
- Electronic Health Record (NextGen) super user and provided the training and support to the BHPs.

Clinical Duties:

- Provided direct clinical care under the guidelines of the IBHP best practices model. This included facilitating care through triage and referral to other BHPs when necessary. Assessed the clinical status of patients, referred by primary care providers, through "warm hand-offs" and brief consultative contacts at the time of the primary care encounter.
- Assisted in support of our various pilots and programs to provide our patients with behavioral health co-morbidities that were often present with health related ailments; e.g., chronic pain management, substance use/abuse, PTSD, severe mental illness, etc.,

Assistant Director of Behavioral Health Services September 2008-January 2012
Golden Valley Health Centers (GVHC)

As Assistant Director of Behavioral Health Services, I was responsible for supporting the Director of BHS and fulfilling the administrative and clinical goals of the program. The BH department began expanding to various remote clinic sites requiring regional supervision at each site. I was directly responsible for the clinical supervision of unlicensed and licensed BHPs to ensure compliance with all state board licensing requirements. Another key function was to develop the necessary leadership skills to expand the current program and gain the support of inter-agency partners in the community.

Administrative and Clinical Duties:

- Responsible for assisting the Director of BHS on planning, recruitment, organization, implementation, and supervision of the GVHC behavioral health program.
- Provided direct clinical care to GVHC patients who had reported behavioral health symptoms.

Behavioral Health Provider July 2006-September 2008
Golden Valley Health Centers (GVHC)

- Provided therapeutic services in a clinical setting where emphasis was placed on an integrative model of treatment. A close collaboration with primary care physicians and other specialists was required to further enhance the existing standard model of treatment.
- Began to focus on shifting to a more inclusive culture of using mental health techniques enhancing our employee satisfaction and to help mitigate delicate managerial matters.
- Provided clinical services targeted toward the migrant and economically challenged population who received medical care services at GVHC.
- Implemented the primary mode of treatment, which was based in large part by extensive literature supporting the effectiveness of an Integrated Treatment Model, where the provision of medical services is coupled with behavioral health interventions.
- Assisted patients with a variety of concerns and/or emotional stressors using various techniques like Motivational Interviewing and others, designed to enhance the overall health of the patients.

Clinician I May 2003-July 2006
Merced County Department of Mental Health

- Conducted intake assessments and coordinated treatment/discharge planning for a variety of severely mentally ill clients, with emphasis in adult outpatient services.
- Provided clinical treatment and comprehensive mental health services to a variety of patients in collaboration with our county Probation Department and other agency partners.
- Met with individuals and groups, including families, to assist them with understanding complex mental and emotional problems and with developing realistic plans to resolve them.
- Advised clients on the availability of community resources.
- Assisted with training other Mental Health Department staff in diagnosis and treatment methods.
- Developed and conducted training and informational presentations for other County staff, school districts, and community agencies.
- Developed and implemented treatment plans to provide wrap around services to our clients; maintained extensive records, complex reports, progress notes, and correspondence with community partners.

Mental Health Worker, Dual Diagnosis September 1999-May 2003
Merced County Department of Mental Health

- Acquired clinical and case management experience all while completing a graduate degree succeeding in acquiring eventual employment as a Clinician.
- Worked directly with Marie Green Psychiatric Center clinical and administrative staff in order to enhance the collaboration between our programs.
- Provided direct services at Marie Green during weekends shifts supporting the needs of patients in collaboration with the clinical teams.
- Advocated for and provided case management services to support the severely mentally ill by successfully identifying and acquiring available community resources.
- Supported the clinical treatment and comprehensive mental health services of patients in collaboration with an active clinical team and community partners.
- Conducted intake assessments and coordinated treatment/discharge planning for a variety of severely mentally ill patients, with emphasis in adult outpatient services.
- Directly responsible for the case management needs of the adult males in our residential substance abuse program called Nick's Place and worked closely with administrative and clinical team members.
- Successfully led many substance abuse and mental health groups supporting the treatment plan goals of our clients.
- Allowed to be very proactive in joining the client in their journey and advocating for the various community resources. I focused on ensuring patience and understanding of these conditions that would often put them at risk for homelessness, social isolation, and worsened health.

EDUCATION & LICENSES

LCSW credentials attained in 2007

Master's Degree in Social Work; California State University Stanislaus, Turlock CA. (2003)
Bachelor of Arts in Psychology; California State University Stanislaus, Turlock CA. (1999)

PROFESSIONAL DEVELOPMENT

Graduate from the prestigious Clinical Leadership Institute (CLI): an 18-month program designed by the University of California, San Francisco and the Blue Shield Foundation to enhance the leadership potential of healthcare professionals in executive roles

Board Member at the Sierra Waldorf School focusing on ensuring a strong financial standing for a small private non-profit K-8 school.

Eclectic repertoire of theoretical and Evidence Based treatments for the emotionally or mentally ill and those who experience difficulties with chemical dependency issues; target populations range from the mild to severely mentally ill.

90-hour training program through California Association of Addiction Recovery Resources (CAARR) –focused on the implementation of treatment interventions for people with chemical dependency issues.

Committee and Commission Application

BOS-22-29

Submitted On: Aug 2, 2022

Applicant

Estrella Torres
2092068835
@ missestrella.torres@gmail.com

Application Information

Vacancy Applied For

Behavioral Health Advisory Board

Applying for Reappointment

--

City

Soulsbyville, CA

Residential Phone

(209)206-8835

Cell Phone

--

How long have you lived in Tuolumne County? (months)

0

For Supervisorial Districts, refer here (https://tuolumne.maps.arcgis.com/apps/webappviewer/index.html?id=fe14d4f71bf849e29e2afdaa42ca056c&extent=-13471589.097%2C4519241.3068%2C-13233869.939%2C4649490.003%2C102100).

BHAB Member Role

Other

Mailing Address

16955 Clouds Rest Rd

Zip Code

95372

Business Phone

--

How long have you lived in Tuolumne County? (years)

13

Which Supervisorial District do you reside?

2

Name of present employer

--

Employer Address

--

Employer City

--

Employer State

--

Employer Zip Code

--

Occupation

Student

Briefly describe the qualifications you possess which you feel would be an asset to the Commission/Committee/ Group for which you are applying.

I have a lot of expirience with mental health and I have always been very open about this topic. I think a youth's prespective would be a good additon and I am always willing to participate and give ideas.

List the community organization(s) and describe participation in which you have been involved.

I've worked with Center For a Non Violent Community as a youth mentor for about 3 years. I have also been a youth speaker and particapant with California Partnership to End Domestic Violence, through this, I got to speak to state senators about youths mental health during the pandemic. I am a member of YES! Partnership and many other committies.

I confirm that I have sufficient time to devote to this responsibility and plan to attend the required meetings if I am

Signature

true

appointed to fill a vacancy. I understand that if I am appointed to a commission where a Disclosure of Assets Statement is required by State Law or Board Policy, I shall do so within ten (10) days of assuming office.

I hereby consent that this document is considered a public record and will be available to the public.

Applications not acted upon will expire after two years from the date submitted unless renewed by applicant.

Estrella Holmes-Torres

16955 Clouds Rest Rd
Soulsbyville, CA 95372
(209) 206-8835
missestrella.torres@gmail.com

Skills

- Communication and People skills
- Leadership experiences
- Public Speaking
- Interpersonal Skills
- Video Editing

Experience

2019 - PRESENT

Center for a Non Violent Community, Sonora - *Youth Mentor*

- In videos talking about consent, boundaries, and safety
- Video editor

2020 - PRESENT

California Partnership to End Domestic Violence, Sacramento - *Youth speaker and participant*

- Spoke to California state senator and assembly member about youth mental health during pandemic on Orange Day
- Youth advisor to the Executive Board
- Participant on Youth and Love in our Culture

2021 - PRESENT

Yes! Partnership, Tuolumne County - *Youth representative*

- Participate in countywide meeting once a month
- Submit monthly report on youth in the community

2021 - PRESENT

Public Health, Sonora - *Youth advocate*

- Clarke Broadcasting Radio PSA on the dangers of Vaping
- Epic Youth Coalition

2017 - 2018

Captain Encouragement - *Youth actor*

- Travel to schools and teach about positivity and bullying

Education

2019 - PRESENT

Summerville Union High School - Tuolumne, CA

Awards

- Star Working Woman of the week, April 2022 on Clarke Broadcasting for my volunteer work.
    - https://www.kzsq.com/2022/03/star-working-woman-of-the-week-estrella-torres
- Featured in California Health Report -Resolve Magazine and Yes! Magazine.
    - https://www.yesmagazine.org/health-happiness/2021/05/18/california-teens-end-relationship-violence

COMMITTEE & COMMISSION APPLICATION

County of Tuolumne, California
Office of the Clerk of the Board of Supervisors
2 South Green Street
Sonora, California 95370
(209) 533-5521

Vacancy Applied For: Behavioral Health Advisory Board

Name: Marjorie Langdon Telephone: Res. 209 815 1813 Bus. _____

E-Mail: marjelangdon@gmail.com Fax. _____ Cell. _____

Street Address: 10155 Peppermint Circle Space 97, Jamestown, CA 95327

Mailing Address: _____

How long have you lived in Tuolumne County? 2 years

Which Supervisorial District do you reside? District 4

Name and address of present employer: NeuroNav - online/remote position

Occupation: Service Navigator

Briefly describe the qualifications you possess which you feel would be an asset to the Commission/Committee/ Group for which you are applying. (Attach extra page(s) if needed)

I have served on the board since December of 2021. I am detail oriented, a community organizer, and possess research skills that could benefit the board with information gathering.

List the community organization(s) and describe participation in which you have been involved.

Most recently volunteered with the Blue Zones Project fair at the Fairgrounds.

I ran a creative writing program in the Santa Cruz County Jail to help inmates think about next steps upon release.

I was a program manager for a 515 behavioral program for adults with intellectual and developmental disabilities.

I confirm that I have sufficient time to devote to this responsibility and plan to attend the required meetings if I am appointed to fill a vacancy. I understand that if I am appointed to a commission where a Disclosure of Assets Statement is required by State Law or Board Policy, I shall do so within ten (10) days of assuming office.

I hereby consent that this document is considered a public record and will be available to the public.

8/25/2022
Date

Marjorie Langdon
Signature

Applications not acted upon will expire after two years from the date submitted unless renewed by applicant.

Mail or deliver to the Clerk of the Board of Supervisors, 2 South Green Street, Sonora, California 95370

Revised February 2021
W:\Forms\Committee-Commission Application

Monthly Presentations to the Tuolumne County Board of Supervisors

Outline completed by: Marjorie Langdon

The Behavioral Health Advisory Board has agreed to present monthly to the Tuolumne County Board of Supervisors. The presentation material will be put together by an ad hoc committee. The members of the ad hoc committee right now are Mary Anne Schmidt and Marjorie Langdon.

The goal of these presentations is to:

1. Bridge communication and concerns between the Behavioral Health Department, BHAB, the public, and the Board of Supervisors.
2. Inform the BoS of what the BHAB is doing to support the BH department.
3. Inform the BoS of what the BHAB hopes to accomplish in the next month.
4. Present a *Call to Action* based on BHAB findings, discussions, and/or goals.

Every member of the Board will have an opportunity to speak/present at the BoS meetings. BHAB will attend/present once a month.

The template for presenting will be as follows:

1. Introduce yourself to the BoS (Name, role, and how long you have served.)
2. Present a short summary of the last BHAB meeting
3. Share what the BHAB wants to accomplish/what short and long-term benchmarks are.
4. End with a *Call to Action* – what does the BHAB want from the BHAB, community, BH department, and the BoS?

Input on the template and vision for this ad hoc committee from BHAB members, BH department, and public is appreciated.

SENATE THIRD READING
SB 1338 (Umberg and Eggman)
As Amended August 25, 2022
Majority vote

SUMMARY

Establishes the Community Assistance, Recovery, and Empowerment (CARE) Act.

Major Provisions

1) Establishes the CARE Act, which must be implemented by Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties by October 1, 2023, and the remaining counties by December 1, 2024, subject to delays based on a state or local emergency, or discretionary approval by the Department of Health Care Services (DHCS), up until December 1, 2025. Provides that the CARE Act only becomes operative upon DHCS, in consultation with county stakeholders, developing a CARE Act allocation to provide state financial assistance to counties to implement the CARE process.

2) Defines, for purposes of the CARE Act, certain terms, including:

   a) "CARE agreement" is a voluntary settlement agreement, which includes the same elements as a CARE plan.

   b) "CARE plan" is an individualized, appropriate range of services and supports consisting of behavioral health care, stabilization medications, housing, and other supportive services, as provided.

   c) "Graduation plan" is a voluntary agreement entered into by the parties at the end of the CARE program that includes a strategy to support a successful transition out of court jurisdiction and may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing services and supports. A graduation plan may not place additional requirements on the local government entities and is not enforceable by the court.

   d) "Parties" are the person who file the petition, respondent and the county behavioral health agency, along with other parties that the court may add if they are providing services to the respondent.

   e) "Petitioner" is the entity who files the CARE Act petition, but if other than the county behavioral health agency, the court is required, at the initial hearing, to substitute the director of county behavioral health agency or their designee as the petitioner, limiting the initial petitioner's rights to potentially receiving ongoing notice of the proceedings, and the right to make a statement at the hearing on the merits of the petition, with broader participation rights only if the respondent consents.

   f) "Respondent" is the person who is subject to the petition for the CARE process.

   g) "Supporter" is an adult who assists the respondent, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions

during the CARE process, including a CARE agreement, a CARE plan, and developing a graduation plan.

3) Provides that a respondent may qualify for the CARE process only if all of the following criteria are met:

   a) The person is 18 years of age or older.

   b) The person is currently experiencing a severe mental illness, as defined, and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Specifically exempts specified others conditions or disorders.

   c) The person is not clinically stabilized in on-going voluntary treatment.

   d) At least one of the following is true:

      i) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

      ii) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others.

   e) Participation in a CARE plan or agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

   f) It is likely that the person will benefit from participation in a CARE plan or agreement.

4) Provides venue provisions for where CARE Act proceedings may be brought.

5) Allows a petition to initiate a CARE proceedings to be brought by one of the following adults:

   a) A person with whom the respondent resides or a spouse, parent, sibling, child, or grandparent of the respondent, or another individual who stands in loco parentis to the respondent.

   b) The director of a hospital, or their designee, in which the respondent is hospitalized, or the director of a public or charitable organization, agency, or home, or their designee, that is currently, or within the previous 30 days, providing behavioral health services to the respondent or in whose institution the respondent resides.

   c) A licensed behavioral health professional, or their designee, who is treating, or has been treating within the last 30 days, the respondent for a mental illness.

   d) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated interactions with the respondent in the form of multiple arrests, multiple detentions, as provided, multiple attempts to engage the respondent in voluntary

treatment or other repeated efforts to aid the respondent in obtaining professional assistance.

e) The public guardian or public conservator, or their designee (and a respondent may be referred from conservatorship proceedings).

f) The director of a county behavioral health agency of the county in which the respondent reside or is present (and a respondent may be referred from assisted outpatient treatment proceedings).

g) The director of the county Adult Protective Services or their designee.

h) The director of a California Indian health services program, California tribal behavioral health department, or their designee.

i) The judge of a tribal court that is located in California, or their designee.

j) The respondent.

6) Allows a court, if a criminal defendant is found to be mentally incompetent and ineligible for a diversion, to refer the defendant to the CARE program, as provided,

7) Requires the CARE petition, which must be developed as a mandatory form by the Judicial Council (along with other forms necessary for the CARE process) and must be signed under penalty of perjury, to include, among other things:

a) The name of the respondent, their address, if known, and the petitioner's relationship with the respondent.

b) Facts that support petitioner's allegation that the respondent meets the criteria in 3).

c) Either of the following:

i) An affidavit of a licensed behavioral health professional stating that the health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent to submit to an examination, within 60 days of submission of the petition, and that the licensed behavioral health professional had determined that the respondent meets, or has reason to believe, explained with specificity in the affidavit, that the respondent meets, the diagnostic criteria for CARE proceedings.

ii) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to under the Lanterman-Petris-Short (LPS) Act, the most recent of which must be no longer ago than 60 days from the date of the petition.

8) Provides that if a person other than the respondent files a petition for CARE Act proceedings that is unmeritorious or intended to harass or annoy the respondent, and that person had previously filed a petition for CARE Act proceedings that was unmeritorious or intended to harass or annoy the respondent, the petition is grounds to declare the person a vexatious litigant, as provided.

9) Sets out the respondent's rights, including the right to be represented by counsel at all stages of a CARE proceeding, and requires the court to appoint specified counsel if the respondent does not have their own attorney.

10) Provides that all CARE Act hearings are presumptively closed to the public. Allows the respondent to demand that the hearings be public or allows them to request the presence of a family member or friend without waiving their right to keep the hearing closed to the rest of the public. A request by another party to make a hearing public may be granted if the court finds that the public interest clearly outweighs the respondent's privacy interest.

11) Requires, for all CARE Act proceedings, that the judge control all hearings with a view to the expeditious and effective ascertainment of the jurisdictional facts and the ascertainment of all information relative to the present condition and future welfare of the respondent. Except where there is a contested issue of fact or law, requires the proceedings to be conducted in an informal, non-adversarial atmosphere with a view to obtaining the maximum cooperation of the respondent, all persons interested in respondent's welfare, and all other parties, with any provisions that the court may make for the disposition and care of the respondent.

12) Requires that all reports, evaluations, diagnoses, or other information related to the respondent's health are confidential. Requires that all evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings are confidential.

13) Upon receipt of a CARE Act petition the court shall promptly review the petition to see if it makes a prima facie showing that the respondent is or may be a person described in 3).

    a) If the court finds the petitioner has not made a prima facie showing that the respondent is or may be a person described in 3), the court shall dismiss without prejudice, subject to 8).

    b) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), and the petitioner is the county behavioral health agency, the court shall do all of the following: (i) set the matter for an initial appearance; (ii) appoint counsel; (iii) determine if the petition includes all the required information and, if not, order the county to submit a report with the information; and (iv) require notice be provided.

    c) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), and the petitioner is not the county behavioral health agency, the court shall order the county agency to investigate whether the respondent meets the CARE proceedings criteria and is willing to engage voluntarily with the county, file a written report with the court, and provide notice, as required.

14) If the county agency is making progress to engage the respondent, allows the agency to request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

15) Within five days of the receipt of the report in 13), requires the court to review the report and do one of the following:

a) If the court determines that voluntary engagement with the respondent is effective, as provided, requires the court to dismiss the matter.

b) If the court determines that the county's report supports the petition's prima facie showing that the respondent meets the CARE criteria, and engagement is not effective, requires the court to: (i) set an initial hearing within 14 days; (ii) appoint counsel, unless the respondent has their own counsel; and (iii) provide notice of the hearing, as provided.

c) If the court determines that the county's report does not support the petition's prima facie showing that the respondent meets the CARE criteria, requires the court to dismiss the matter.

16) At the initial hearing:

a) If the petitioner is not present, allows the court to dismiss the matter.

b) If the respondent elects not to waive their appearance and is not present, allows the court to conduct the hearing in the respondent's absence if the court makes a finding on the record that reasonable attempts to elicit the attendance of the respondent have failed, and conducting the hearing without the participation or presence of the respondent would be in the respondent's best interest.

c) Requires a county behavioral health agency representative to be present, allows a supporter to be appointed, and allows a tribal representative to attend for a respondent who is tribal member, as provided, and subject to the respondent's consent.

d) If the court finds that there is no reason to believe that the facts stated in the petition are true, requires the court to dismiss the case without prejudice, unless the court makes a finding on the record that the petitioner's filing was not in good faith.

e) If the court finds that there is reason to believe that the facts stated in the petition appear to be true, requires the court to order the county behavioral health agency to work with the respondent and the respondent's counsel and CARE supporter to engage in behavioral health treatment. Requires the court to set a case management hearing within 14 days.

f) If the petitioner is other than the county behavioral health director, substitutes the county behavioral health director or their designee for the petitioner, as provided in 2e).

g) Requires the court to shall set a hearing on the merits of the petition, which may be conducted concurrently with the initial appearance on the petition upon stipulation of the petitioner and respondent and agreement by the court.

17) At the hearing on the merits:

a) If the court finds that the petitioner has not shown, by clear and convincing evidence, that the respondent meets the CARE criteria, requires the court to dismiss the case without prejudice, unless the court makes a finding, on the record, that the petitioner's filing was not in good faith.

b) If the court finds that the petitioner has shown by clear and convincing evidence that the respondent meets the CARE criteria, requires the court to order the county behavioral

health agency to work with the respondent, the respondent's counsel, and the supporter to engage in behavioral health treatment and determine if the parties will be able to enter into a CARE agreement. Requires the court to set a case management hearing. Requires notice to the tribe, if applicable.

18) At the case management hearing:

a) If the parties have entered, or are likely to into, a CARE agreement, requires the court to approve or modify and approve the CARE agreement, stay the matter, and set a progress hearing for 60 days.

b) If the court finds that the parties have not entered, and are not likely to enter, into a CARE agreement, requires the court to order a clinical evaluation of the respondent, as provided. Requires the evaluation to address, at a minimum, a clinical diagnosis, whether the respondent has capacity to give informed consent regarding psychotropic medication, other information, as provided, and an analysis of recommended services, programs, housing, medications, and interventions that support the respondent's recovery and stability. Requires the court to set a clinical evaluation hearing.

19) At the clinical evaluation review hearing:

a) Requires the court to consider the evaluation, and other evidence, including calling witnesses, but only relevant and admissible evidence that fully complies with the rules of evidence may be considered by the court.

b) If the court finds, by clear and convincing evidence, after review of the evaluation and other evidence, that the respondent meets the CARE criteria, requires the court to order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan.

c) If the court finds, in reviewing the evaluation, that clear and convincing evidence does not support that the respondent meets the CARE criteria, requires the court to dismiss the petition.

20) At the hearing to review the proposed CARE plan:

a) Either or both parties may present a CARE plan.

b) Requires the court to adopt the elements of a CARE plan that support the recovery and stability of the respondent. Allows the court to issue any orders necessary to support the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding, as provided. These orders are the CARE plan.

c) Allows a court to order medication if it finds, upon review of the court-ordered evaluation and hearing from the parties that, by clear and convincing evidence, the respondent lacks the capacity to give informed consent to the administration of medically necessary stabilization medication. To the extent that the court orders medically necessary stabilization medications, prohibits the medication from being forcibly administered and the respondent's failure to comply with a medication order may not

result in a penalty, including but not limited to contempt or the accountability measures in 29).

d) Allows for supplemental information to be provided to the court, as provided.

21) The issuance of any orders in 20) begins the up to one-year CARE program timeline.

22) Requires that a status review hearing occur at least every 60 days during the CARE plan implementation.

a) Requires the petitioner to file with the court, and serve on the respondent and the respondent's counsel and supporter, a report not less than five court days prior to the hearing, with specified information, including progress the respondent has made on the CARE plan, what services and supports in the CARE plan were provided, and what services and supports were not provided, and any recommendations for changes to the services and supports to make the CARE plan more successful.

b) Allows the respondent to respond to the report and introduce their own information and recommendations.

c) Allows the petitioner, the respondent, or the court to request more frequent reviews as necessary to address changed circumstances.

23) Requires the court, in the 11th month, to hold a one-year status hearing, which is an evidentiary hearing, to determine if the respondent graduates from the CARE plan or should be reappointed for another year.

a) Requires a report by the petitioner before the status conference, as provided. Allows respondent to call witnesses and present evidence.

b) Provides that the respondent may be graduated from the CARE program and may be allowed to enter into a voluntary graduation plan with the county. However, such plan may not place additional requirements on the county and is not enforceable, other than a psychiatric advance directive if included.

c) If the respondent elects to accept voluntary reappointment to the program, the respondent may request to be re-appointed to the CARE program for up to one additional year, subject to meeting certain criteria and court approval.

d) Allows the court to involuntarily reappoint the respondent to the CARE program for up to one year if the court finds, by clear and convincing evidence, that (i) the respondent did not successfully complete the CARE process; (ii) all of the required services and supports were provided to the respondent; (ii) the respondent would benefit from continuation of the CARE process; and (iv) the respondent currently meets the requirements in 3).

e) Provides that a respondent may only be reappointed to the CARE program for up to one additional year.

24) Provides mandatory timeframes, as well as continuances for good cause, throughout the CARE court proceedings.

25) Requires hearings to occur in person unless the court allows a party or a witness to appear remotely. Provides the respondent with the right to be in-person for all hearings.

26) Allows the respondent and the county behavioral health agency to appeal an adverse court determination.

27) Requires the Judicial Council to adopt rules to implement the CARE court provisions.

28) Allows the court, at any point in the proceedings, if it determines, by clear and convincing evidence, that the respondent, after receiving notice, is not participating in the CARE proceedings, to terminate respondent's participation in the CARE process. Allows the court to make a referral under the LPS Act, as provided.

29) Requires that, if a respondent was provided timely with all of the services and supports required by the CARE plan, the fact that the respondent failed to successfully complete their CARE plan, including the reasons for that failure: a) is a fact considered by a court in a subsequent hearing under the LPS Act, provided that hearing occurs within six months of termination of the CARE plan; and b) creates a presumption at that hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan. Prohibits a respondent's failure to comply with any order from resulting in nay penalty outside of this paragraph, including, but not limited to contempt or failure to appear. Prohibits a respondent's failure to comply with a medication order from resulting in any penalty, including under this paragraph.

30) Creates a process for penalizing counties or other local government entities that do not comply with CARE court orders. If the presiding judge or designee of the county finds, by clear and convincing evidence, that a local government entity has substantially failed to comply with an order, the presiding judge or designee may impose a fine of up to $1,000 per day for noncompliance, not to exceed $25,000 for each violation. Requires that any fines be deposited in the CARE Act Accountability Fund and used, upon appropriation, by DHCS to support that local government's efforts that will serve individuals who have schizophrenia or other psychotic disorders and who experience, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship. Allows the presiding judge or designee, if a county is found to be persistently noncompliant, to appoint a special master to secure court-ordered care for the respondent at the county's cost. In determining the application of the remedies available, requires the court to consider whether there are any mitigating circumstances impairing the ability of the county agency or local government entity to fully comply with the CARE Act requirements.

31) Requires DHCS, in consultation with specified groups, to provide optional training and technical resources for volunteer supporters. Requires that a CARE supporter do the following:

    a) Offer the respondent a flexible and culturally responsive way to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating, and implementing their own informed choices;

b) Strengthen the respondent's capacity to engage in and exercise autonomous decision making and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship; and

c) Assist the respondent with understanding, making, and communicating decisions and expressing preferences throughout the CARE court process.

32) Allows a respondent to have their supporter be in any meeting, judicial proceedings, status hearing, or communication related to an evaluation; creation of the CARE plan; establishing a psychiatric advance directive; and development of a graduation plan.

33) Sets forth the duties and limitations of the supporter. Bounds a supporter by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. Prohibits a supporter from being subpoenaed or called to testify against the respondent in any CARE Act proceeding, and provides that the supporter's presence at any meeting, proceeding, or communication does not waive confidentiality or any privilege.

34) Requires the Legal Services Trust Fund Commission to provide funding to qualified legal services projects to provide appointed legal counsel in CARE proceedings. Allows the Legal Services Trust Fund Commission to enter into no bid contracts.

35) Sets forth the provisions of the CARE plan, which may only include:

a) Specified behavioral health services;

b) Medically necessary stabilization medications;

c) Housing resources, as provided;

d) Social services, as provided; and

e) General assistance, as provided.

36) Requires that CARE participants be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program. If the county behavioral health agency elects not to enroll the respondent into a full service partnership, as defined, allows the court to review why not.

37) Provides that all CARE plan services and supports ordered by the court are subject to available funding and all applicable federal and state statutes, regulations, contractual provisions and policy guidance governing program eligibility, as provided.

38) Sets forth rules by which a county is responsible for the costs of providing services to CARE participants.

39) Requires the Health and Human Services Agency, as provided, to (a) engage an independent, research-based entity to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act; (b) convene a working group to provide coordination and on-going engagement with, and support collaboration among, relevant state and local partners and other stakeholders

throughout the phases of county implementation to support the successful implementation of the CARE Act, including during implementation.

40) Requires DHCS to provide training and technical assistance to county behavioral health agencies to support the implementation of the CARE Act, including trainings regarding the CARE statutes, CARE plan services and supports, supported decisionmaking, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives, and data collection.

41) Requires the Judicial Council, in consultation with others, to provide training and technical assistance to judges to support the implementation of the CARE Act.

42) Requires DHCS, in consultation with others, to provide training to counsel on the CARE statutes, and CARE plan services and supports.

43) Allows the Health and Human Services Agency and DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

44) Allows the Health and Human Services Agency and DHCS to implement, interpret, or make specific the CARE Act by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

45) Requires DHCS, in consultation with specified others, to prepare an annual CARE Act report. Requires state or local governmental entities to provide data required by DHCS. Requires DHCS to provide information on the populations served and demographic data, stratified as specified. Requires that the report include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing homelessness, criminal justice involvement, conservatorships, and hospitalization of participants. Requires the annual report to examine data through the lens of health equity to identify racial, ethnic, and other demographic disparities and inform disparity reduction efforts.

46) Requires DHCS to report on court data, as specified.

47) Requires an independent, research-based entity retained by DHCS, in consultation with others, to develop an independent evaluation of the effectiveness of the CARE Act. Requires the independent evaluation to employ statistical research methodology and include a logic model, hypotheses, comparative or quasi-experimental analyses, and conclusions regarding the extent to which the CARE Act model is associated, correlated, and causally related with the performance of the outcome measures included in the annual reports, highlighting racial, ethnic, and other demographic disparities, and including causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts. Requires DHCS to provide a preliminary evaluation of the effectiveness of the CARE Act to the Legislature three years after its implementation and a final report five years after implementation.

48) Requires a health care service plan and an insurance policy, after July 1, 2023, to cover various costs under the CARE program. Sets out requirements for health care services plans and insurance policies, effective July 1, 2023, to cover CARE plans, as provided.

49) Provides immunity to a county, or an employee or agent of a county, for any action by a respondent in the CARE process, except when the act or omission of a county, or the employee or agent of a county, constitutes gross negligence, recklessness, or willful misconduct.

50) Adds a severability clause.

51) Adds chaptering out amendments with SB 1223.

COMMENTS

This bills seeks to implement Governor Newsom's CARE Court program, which would allow civil courts to order those suffering from certain mental illnesses into treatment programs at the community level, similar to today's Assisted Outpatient Treatment under the LPS Act, but with, hopefully, more community-based supports and services, and more court oversight. In support of his proposal, the Governor has stated:

> Sadly, the status quo provides support only after a criminal justice intervention or conservatorship. CARE Court is a paradigm shift, providing a new pathway for seriously ill individuals before they end up cycling through prison, emergency rooms, or homeless encampments." In addition he states that, "CARE Court is about meeting people where they are and acting with compassion to support the thousands of Californians living on our streets with severe mental health and substance use disorders. We are taking action to break the pattern that leaves people without hope and cycling repeatedly through homelessness and incarceration. This is a new approach to stabilize people with the hardest-to-treat behavioral health conditions.

The growing problem of homelessness in California. Beyond simply seeing the growing number of tent encampments and unhoused people living on the streets, the most recent data on homelessness makes clear that California has a massive problem that, despite significant spending and efforts aimed at reducing it, continues to grow. The most recent single-night count from January 2020 (a count was made in 2022, but data has not yet been released) found that California had 28 percent of the nation's homeless population – over 160,000 – of which 70.4 percent were unsheltered, both of which are the highest rates in the nation. (California Senate Housing Committee, *Fact Sheet: Homelessness in California* (updated May 2021), *available at* https://shou.senate.ca.gov/sites/shou.senate.ca.gov/files/Homelessness%20in%20CA%202020%20Numbers.pdf.)

While there are many causes of homelessness, the high cost of housing in California is a significant contributor. (Legislative Analyst's Office, *California's Homelessness Challenges in Context*, Presentations to Assembly Budget Subcommittee No. 6 (Feb. 13, 2020).) Wages have not kept pace with housing costs, particularly for low-income households. (*Ibid.*)

According to the 2019 annual point-in-time count, 23 percent of California's homelessness population is severely mentally ill and 17 percent has a chronic substance abuse disorder. (Legislative Analyst's Office, *California's Homelessness Challenges in Context*, *supra*, citing the U.S. Department of Housing and Urban Development's 2019 point-in-time homelessness.)

California's mental health crisis. Mental illness is pervasive in California. About one in six Californians experience mental illness and one in 25 experience a serious mental illness.

(California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (March 2020).) These rates are higher among people of color and those living below the poverty line. (*Ibid.*) Among those experiencing homelessness, one in four individuals report having a serious mental illness. (*Ibid.*)

The pandemic exacerbated mental illness rates in California, and the state continues to face a shortage of facilities, services, and workers to appropriately care for its mentally ill population. For example, since 1995, the number of inpatient psychiatric beds in California has been decreasing, despite population growth and increased rates of mental illness. (California Hospital Association, *California Psychiatric Bed Annual Report* (Aug. 2018).) The state is projected to continue to face a shortfall of thousands of psychiatric beds for adult inpatient and residential care. (McBain, *et al., Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California* (2021) RAND Corporation.) Despite the high rates of mental illness among individuals experiencing homelessness, there is a dire shortage of supportive housing and wrap-around services to adequately treat mental illness within this population. The behavioral health workforce is insufficient to meet the growing demand for mental healthcare. One report projected that, if current trends continue, by 2028 California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, therapists, and social workers than are likely to be needed. (Coffman, *et al., California's Current and Future Behavioral Health Workforce* (Feb. 2018) Healthforce Center at the University of California – San Francisco, p. 55.) The growing mental health crisis has led to calls for reforming the mental healthcare system in California, including reforming existing law providing for involuntary detentions and treatment due to mental illness. Less attention has been paid, however, to the lack of services and support given to individuals who are involuntarily detained pursuant to standards now in place under existing law.

Constitutional and federal limitations on depriving individuals of liberty though involuntary confinement or forced treatment. Federal and state constitutional law prohibits individuals from being deprived of their liberty without due process of law. The 14th Amendment to the U.S. Constitution provides that no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The California Constitution provides: "A person may not be deprived of life, liberty, or property without due process of law or denied equal protection of the laws. (Cal. Constitution, Art. I, Sec 7.) In the 1975 U.S. Supreme Court case *O'Connor v. Donaldson*, the Court declared that a person had to be a danger to themselves or to others for confinement to be constitutional. (*O'Connor v. Donaldson* (1975) 422 U.S. 563.) In *O'Connor,* the plaintiff was confined to a mental hospital in Florida for 15 years, received a minimal amount of psychiatric care, and challenged his confinement numerous times before successfully suing his attending physician for violating his 14th Amendment right to liberty. The Court upheld the verdict in favor of the plaintiff:

> The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. . . . Nor is it enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if, in fact, it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed. (*O'Connor v. Donaldson* (1975) 422 U.S. at 574-75)

In the specific facts presented in *O'Connor*, the Court held that a person could not be placed on a conservatorship if others were willing to care for that person, holding that a state "cannot

constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." (*Id.* at 576.) While the Court recognized that the government might subject a mentally ill person to involuntary holds and treatments when necessary to prevent harm to that person or others, the government's power to do so is not unlimited and must respect the due process and liberty interests protected by the 14th Amendment. Understandably, the Court has not drawn any bright lines or offered up any neat "factor" test for identifying the precise conditions that would justify treating mentally ill persons against their will. Most states, including California, have statutes setting forth the requisite conditions in purposefully general language, and those statutes, and the manner in which they are implemented, are subject to judicial review. In addition to baseline constitutional requirements, the Supreme Court has determined that the federal Americans with Disabilities Act (ADA) prohibits the segregation of individuals with disabilities. In *Olmstead v. L.C.*, the Court held that placing individuals with mental illness in institutions "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment" (*Olmstead v. L.C.* (1999) 527 U.S. 581, 601), and unjustified institutionalization constitutes discrimination under the ADA. (*Id.* at 597-98.) Integrated services in the community should be provided instead.

This bill. This bill does not seek to refine or better coordinate existing programs for those with mental illness. Instead, it seeks to create and implement throughout California a new program for identifying those with mental illness who need treatment -- the CARE program. While the details of how the CARE program will operate are set forth in the SUMMARY, above, the basic premise is that a broad range of individuals--including family members, behavioral health professionals, and first responder--with knowledge of a person suffering from severe mental illness and a current diagnosis of schizophrenia spectrum or other psychotic disorder, could petition the civil court to have the person either enter into a voluntary CARE agreement, or be court-ordered into a treatment plan. The person would only qualify for the CARE program if, among other things, the person is currently experiencing a severe mental illness and has a current diagnosis of schizophrenia spectrum or other psychotic disorder.

The bill sets out the evidence that must be presented and timeframes for all court hearings. The individual (called the respondent, but the analysis will use the term participant once the person has a CARE plan) is provided with an attorney and, perhaps, a supporter for the duration of the process. They choose their own counsel and supporter, or the court will appoint an attorney for them. If the petitioner sets forth a prima facie case (sufficient initial evidence) that the respondent qualifies for the CARE program, the court must provide the participant and the county behavioral health agency with the opportunity to arrive at a voluntary CARE plan for the treatment of the participant, with the supports and services necessary, including housing, subject to many limitations, including availability and available funding.

The bill is designed to provide opportunities for the respondent to voluntarily agree to participate in a CARE agreement and to get the supports and services set forth in the agreement. However, if an agreement cannot be reached, and an evaluation proves that the respondent meets the CARE Act criteria, the bill directs the respondent and the county behavioral health agency to develop a CARE plan, which is then brought back to court for review, approval, or modification. Once the plan is approved, the bill provides for ongoing status hearings so the court can stay abreast of the progress being made and take corrective action, if necessary. To ensure that both the court is informed of the progress and to help the participant navigate the labyrinth of support and

services, the bill requires that county behavioral health reports to the court at each status hearing. The plan can last up to a year, but can be extended for an additional year if certain criteria were met.

While housing with supportive or wrap-around services would clearly be required for any unhoused participant to be successful in the CARE program, the bill does not require that housing be provided, but instead prioritizes the participant for certain housing. It is hoped that that the CARE program will have sufficient resources to provide housing, with wrap-around services, to those in the program who lack stable housing.

The bill contains a number of "accountability" measures designed to keep participants and counties on track. If a participant fails to complete the program, they may be dropped from the program; and their failure 1) is a fact that must be considered by a court in a subsequent LPS hearing, provided that the hearing occurs within six months of termination of the CARE plan; and 2) creates a presumption at that hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan. Further, if the presiding judge or their designee finds that a county or other local government entity is not complying with a court order, the judge may fine the county or other entity up to $1,000 for each day of noncompliance, up to $25,000 per incident; and if the county or other local government entity is consistently noncompliant, the presiding judge may, at the county's or other entity's cost, appoint a special master to secure the compliance. These penalties are subject to due process protections and mitigating factors and any penalty collected must be used to support activities in that county serving individuals with serious mental illness.

Being a brand new program, the CARE Act program appropriately requires an evaluation of the program so that the Legislature can learn how the CARE Act is working and what, if any, changes need to be made in order to make the program more successful. The report would be required to include demographic information about participants; services ordered and services provided to participants; success rates; participant involvement with the LPS system and the criminal justice system; and a survey of participants themselves. An interim report is due to the Legislature three years after the program begins, with a final report due in five years.

According to the Author
County behavioral health departments provide Medi-Cal specialty mental health services to those who are enrolled in Medi-Cal and have severe mental illness. However, many of the most impaired and vulnerable individuals remain under or un-served because (a) the individual is so impaired they do not seek out services, (b) the necessary services are not available at the right time due to administrative complexities and/or legal barriers, (c) client care lacks coordination among providers and services, resulting in fragmentation among provided services, and (d) little accountability at various levels of the system results in poor outcomes for the client, who is often living on the streets. This legislation seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.

Arguments in Support
In support of this bill, local governments from San Diego, including the City and County of San Diego County, write:

> The creation of CARE Courts by SB 1338 represents a thoughtful approach to addressing the behavioral health crisis we are witnessing on our streets and getting people connected with

the care they need earlier. It appropriately recognizes the continuum of care that this small but highly visible segment of the population with significant mental health disorders deserve. As with local agencies throughout the State, San Diego's communities are facing a daunting homelessness crisis. However, the unsheltered population is as diverse as the general population, all who come to their housing situation with different backgrounds, upbringings, and traumas. It is imperative that we provide multi-faceted solutions to help the myriad situations our fellow Californians face. Some unsheltered individuals recently lost a job and need quick and focused assistance; some have serious mental health and substance use disorder issues that have developed over many years resulting in an inability to care for themselves. . . .

CARE Court will provide a new and focused civil justice alternative to those struggling with schizophrenia spectrum or psychotic disorders and who lack medical decision-making capacity. The CARE plan envisioned by SB 1338 provides numerous safeguards to ensure personal civil liberties are respected and protected. Distinct from the Lanterman Petris Short (LPS) conservatorship process, this bill requires the County Health and Human Services Agency to establish a cadre of "supporters" who have the obligation to advocate for each person enrolled or potentially enrolled in CARE Court. Further, CARE Court enrollment is time-limited and is intended to last only one year, although it can be extended for one additional year. During the enrolled period, CARE plans can provide the needed time and intensive care to assist those more seriously ill on our streets.

Arguments in Opposition
A coalition of over 40 advocacy organizations, including Disability Rights California, writes in opposition:

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction. The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services. . . .

Instead of allocating vast sums of money towards establishing an unproven system of court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to homelessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing is proven to reduce utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing homelessness. . . .

Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court sets up a system of coerced, involuntary outpatient civil commitment that deprives people with mental health disabilities of the right to make self-determined decisions about their own lives. Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment provided in accordance with evidence-

based practices. Conversely, evidence shows that involuntary, coercive treatment is harmful. . . .

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face homelessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court. (Footnotes omitted.)

FISCAL COMMENTS

According to the Assembly Appropriations analysis:

1) Costs (General Fund (GF)) in the tens of millions of dollars to Judicial Council of California (JCC) for courts to operate the CARE Act. The 2022 Budget allocates $39.5 million from the GF in fiscal year (FY) 2022-23 and $37.7 million ongoing for the courts to conduct CARE court hearings and provide resources for self-help centers. According to the Administration, it is continuing to work with the JCC and counties to estimate costs associated with this new process. JCC estimates costs of approximately $40 million to $50 million related to conducting additional hearings, expanding self-help centers, and updating court case management systems.

2) Possibly reimbursable costs (GF and local funds) in the hundreds of millions of dollars to low billions of dollars to counties, including local behavioral health departments, to provide services to CARE court participants. According to the California State Association of Counties (CSAC), costs include as much as $40,000 per participant for at least 12,000 participants (although county offices believe the number of participants could be much higher - as high as 50,000 participants), court-ordered investigations, evaluations, and reporting requirements, and one-time start-up costs. Costs to the GF will depend on whether the duties imposed by this bill constitute a reimbursable state mandate, as determined by the Commission on State Mandates.

3) Possible cost pressure (GF) to the California Department of Health and Human Services (CHHSA), possibly in the millions of dollars to engage in an independent, research-based entity to advise on the development of data-drive processes and outcome measure for the CARE Act and provide support and coordination between stakeholders during the implementation process.

4) Costs (GF) possibly in the tens of millions of dollars to the Department of Health Care Services (DHCS) to provide training to support to people enrolled in CARE court. Costs include providing technical assistance to counties and contractors, overseeing stakeholder engagement on the CARE Court model, developing guidance for counties on CARE Court responsibilities; implementing processes to support ongoing data collection and reporting; analyzing data and developing an annual legislative report; and, publishing an independent evaluation. Costs may also result from increased Medi-Cal utilization rates by individuals referred to the CARE court program, who otherwise may not have been existing beneficiaries. Possible cost savings to state public health systems to the extent that peer support services provide support and assistance to Medi-Cal beneficiaries with mental illness

and reduce the need for more expensive downstream services, such as inpatient hospitalizations or incarceration.

5) Possibly reimbursable costs (GF and local funds) in the millions of dollars to counties for public defender services. This bill requires a person to receive counsel before ruling on a CARE court petition. Section 5977, subdivision (a)(5)(A)(ii)(II) requires a court to appoint a qualified legal services project to represent any person in the CARE court program that does not already have counsel. If a legal services project declines representation, the public defender is appointed. Only 14 counties have legal services organizations and most do not have enough attorneys to handle even their existing workload. Therefore, it seems far more likely this bill will result in increased duties on county public defenders. Existing law already requires public defenders to represent individuals in LPS and other conservatorships.

6) Cost pressure (GF), possibly in the hundreds of millions of dollars on state and local housing programs, to the extent this bill increases utilization of the specified housing programs, including the Bridge Housing program, HOME Investment Partnership Program, Housing and Urban Development (HUD) Continuum of Care program, and emergency housing vouchers, among other programs identified in this bill. In addition, as this bill reprioritizes CARE plan program participants in the Behavioral Health Bridge Housing program, it does not increase the funding for Bridge Housing in this bill. The 2021 Budget Act allocated a $12 billion multi-year investment for local governments to build housing and provide critical supports and homelessness services. The 2022 Budget Act includes an additional $3.4 billion GF over three years to continue the state's efforts by investing in immediate behavioral health housing and treatment, as well as encampment cleanup grants, and extends for an additional year support for local government efforts. It is unknown whether existing allocations for housing will be sufficient.

7) Costs (GF) to the Department of Insurance (CDI) of $17,000 in FY 2022-23 and $12,000 FY 2023-24.

8) California Department of Social Services (CDSS) reports no costs. However, this bill may result in considerable cost pressures, possibly in the millions of dollars, downstream to local county welfare departments. The Care Act will likely result in increased use of several programs such as the CalWORKS Housing Support Program, SSI/SSP, Cash Assistance Program for immigrants, CalWORKs, CalFresh, and homeless housing assistance and prevention. This bill may generate costs in the form of local assistance, as county welfare departments will have to conduct participant eligibility, redetermination, and screening for programs. While the bill would be implemented on a county-level, the workload for CDSS to provide technical assistance, program monitoring, and to issue new or updated guidance or all county letters to implement the bill may result in the need for GF money.

9) Department of Managed Health Care (DMHC) reports costs (GF) to draft regulations and provider technical assistance will be minor and absorbable.

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Melendez, Min, Newman, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Hertzberg

ASM JUDICIARY: 9-1-0
YES: Stone, Cunningham, Bloom, Davies, Haney, Kiley, Maienschein, Reyes, Robert Rivas
NO: Kalra

ASM HEALTH: 14-0-1
YES: Wood, Waldron, Aguiar-Curry, Arambula, Carrillo, Flora, Maienschein, Mayes, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Akilah Weber
ABS, ABST OR NV: Bigelow

ASM APPROPRIATIONS: 13-0-3
YES: Holden, Calderon, Arambula, Davies, Mike Fong, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, McCarty
ABS, ABST OR NV: Bigelow, Bryan, Megan Dahle

UPDATED

VERSION: August 25, 2022

CONSULTANT: Leora Gershenzon / JUD. / (916) 319-2334 FN: 0004277