CCJBH
Council on Criminal Justice and Behavioral Health

Building bridges to prevent incarceration

CCJBH Full Council Meeting

Friday, April 30, 2021
2:00-4:30 PM
Zoom Meeting

I. Welcome & Introductions, Roll Call

Council Members Present: Diana Toche (on behalf of Secretary Kathleen Allison), Mack Jenkins, Stephen Manley, Danitza Pantoja, Stephanie Clendenin, Toby Hobson, Tracey Whitney, Jim Kooler (on behalf of Will Lightbourne)

Council Members Absent: Matthew Garcia

Staff Members Present: Brenda Grealish, *Executive Officer*, Angela Kranz, Elizabeth Vice, Emily Grichuhin, Jessica Camacho, Monica Campos, Paige Hoffman, Sara Dubay-Singh

II. Council Vote to Adopt the January Full Council Meeting Minutes

Vote: Motion to adopt January full council meeting minutes.

Motion to approve the vote: Judge Manley
Second: Chief Jenkins

No public comment on vote

Ayes: 6
Nays: 0
Abstains: 2

The January full council meeting minutes were approved.

III. UPDATE: Integrated Services for Mentally Ill Parolees (ISMIP) Program Transition

Robert Storms, *Associate Director, Division of Adult Parole (DAPO)*

Mr. Storms thanked Mr. Rinde from the County Behavioral Health Directors Association of California for his help bridging the communication with impacted counties when the news of ISMIP disbanding was released. He stated all counties have been excellent in the transition. San Bernardino assumed ISMIP's telecare contract, Los Angeles shared existing infrastructure and helped to develop a referral form with DAPO to ensure parolees are placed in the appropriate level of service, Santa Clara helped draw down federal reimbursement and has a reentry center where they will be able to centralize referrals for behavioral health, substance use, and housing. San Diego has also done great work. The process is on track to continue to refer and get parolees with higher level needs the services they need in within the counties.

Q&A with Councilmembers:

Q: Chief Jenkins asked if the number of parolees that are impacted by this program statewide is known, either a percentage or a number.

A: Mr. Storms stated the contract had about 600 slots over a period of 12 months served close to 1,200 parolees. Approximately eight percent of the 48,000 parolee population have a serious mental illness, and many also have substance use disorders needs to address.

****PUBLIC COMMENT****

No public comment was provided.

IV. CCJBH Business Meeting

Brenda Grealish, *Executive Officer, CCJBH*
Angela Kranz, *Research Scientist III, CCJBH*
Liz Vice, *Staff Services Manage II, CCJBH*
Jessica Camacho Duran, *Health Program Specialist II, CCJBH*

1. Update on Workgroups
    a. Juvenile Justice: Ms. Grealish thanked Council advisors Dr. Pantoja and Chief Jenkins for their work on juvenile justice issues. At the March 2021 Juvenile Justice Workgroup Meeting, the California Health and Human Services Agency's (CHHSA) Office of Youth and Community Restoration and the CDCR Division of Juvenile Justice provided updates on the DJJ transition per SB 823. The Board of State and Community Corrections (BSCC) provided an update on their work with SB 823 and presented their Summary of Findings from a survey on county probation, as well as their Request for Application process. Chief Probation Officer Brian Richart provided an overview on how county probation departments are preparing for the implementation of SB 823. CCJBH provided an update and timeline on the Council's Request for Proposal for a Juvenile Justice Toolkit to provide a compilation of information related to best practices and evidence-based programs that have been shown to be effective in serving youth involved in the criminal justice system who have serious behavioral health needs.
    b. Diversion/Reentry: Ms. Grealish thanked Council advisors Chief Jenkins, Judge Manley and Dr. Hobson for their work on addressing the need for diversion and reentry services. At the March 2021 Diversion/Reentry workgroup meeting, California Heath Facilities Financing Authority provided an update on the infrastructure funds to support diversion. In addition, as part of the project to address the Governor's Veto Message for SB 369, CDCR/CCHCS and CCJBH presented to stakeholders an inventory of reentry/transition barriers, and strategies to address the identified barriers, for review and public input. A two-

week public comment period was offered wherein stakeholders could provide additional feedback for incorporation into the final report. The draft report will then be posted for a final two-week public comment period before being formally submitted to the Governor's Office.

- 2025 Goals
    - Update on Metrics: Ms. Kranz and Ms. Camacho Duran presented on the CCJBH's 2025 Goals, beginning by thanking Councilmembers and stakeholders for the thoughtful discussion in the January 2021 meeting. The feedback gathered earlier was incorporated into the development of operational definitions, as feasible given the data available to CCJBH. The additional feedback from today's meeting will be used to document the operational definitions in the 2021 Legislative Report. CCJBH staff presented on the established 2025 goals, along with new proposed metrics to measure goals that have not yet been measured. The goals and proposed measures are as follows:

      Goal #1 The prevalence rate of mental illness and substance use disorders (SUDs) in jails and prisons should be similar, if not equal to, the prevalence rate of mental illness and SUDs in the community.

      Goal #1 Measurement Methodology:

      Reporting on Goal 1 was established in the 2020 Legislative Report. This metric compares the prevalence of mental health and substance use disorder needs in custody settings and in the community. This metric relies on data from CDCR reports on the in-custody population, the Jail Profile Survey administered by BSCC, and estimates generated by the Department of Health Care Services (DHCS) and Substance Abuse and Mental Health Services Administration.

      Goal #2 Community-based services particularly residential, are robust enough to meet demand starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges.

      Goal #2 Measurement Methodology:

      CCJBH staff proposed to track progress towards Goal 2 by reporting on the number of Medi-Cal plans meeting standards for the time/distance and timely appointments (Medi-Cal Managed Care (for mental health), Mental Health Plans, county Drug Medi-Cal), as reported in DHCS' annual network certifications, the number of inpatient beds per capita using data from CHHSA, and the number of Felony Incompetent to Stand Trail (IST) referrals using data from the Department of State Hospitals (DSH). To measure adequate system capacity for criminogenic needs interventions we propose to report on the implementation of Risk/Needs Assessments and Targeted Interventions by county probation using reports from the Judicial Council SB 678 Reports.

Goal #3 Through consistent dedication to workforce development, quality education and training, and on-going technical assistance to an array of service providers and partners, Californians benefit from the professionals having core competencies that provide effective integrated correctional and behavioral health services to achieve recovery and reduce recidivism.

Goal #3 Measurement Methodology:

For Goal 3, the proposed metric of behavioral health will be looking into the mental health professional shortage using data from the Office of State Health Planning and Development Health Professional Provider Shortage Report, information on Adverse Childhood Experiences (ACEs) trainings that have been completed will be gathered from the Office of the Surgeon General ACEs Report, and the number of counties that have participated in both our CCJBH and DSH diversion trainings will be determined through the CCJBH and DSH databases. To assess criminogenic needs interventions, CCJBH staff proposed to look at county probation training and cognitive-behavioral therapy data that has been reported in the Judicial Council SB 678 Reports.

Goal #4 Through state leadership to support data-driven practices and policy-making among criminal justice and behavioral health systems, continuity of care and desired public safety and health outcomes improve significantly.

CCJBH's reporting through the CDCR-DHCS Medi-Cal Utilization Project (MCUP) supports work toward Goal #4. Updated data for the project is forthcoming, with data sharing made possible by the newly passed CHHSA Inter-Agency Data Exchange Agreement. Results from data analysis will be used to drive system improvements, including quality improvement and/or new initiatives at the county level, with the ultimate goal of ensuring that justice-involved Medi-Cal beneficiaries receive timely access to needed behavioral health services. CCJBH is already working to expand reporting on key policy issues, such as housing service capacity for the behavioral health/justice-involved population, through its Public Health Meets Public Safety project.

Q&A with Councilmembers:

Q: Chief Jenkins stated the goal for metric two is to ensure adequate system capacity to serve the behavioral health and justice involved population through community based service. He emphasized that the probation population is among some that have behavioral health needs, and there needs to be adequate capacity in community based services. Part of the measure will track criminogenic risk and needs interventions. He requested clarity on what we will get from county probation's implementation of risk/needs assessments. Will we track that probation departments are completing risk/needs assessments?

A: Ms. Kranz stated the Judicial Council's Implementation of Evidence-Based Practices: Annual Assessment Survey to evaluate the effectiveness of SB 678 was administered to probation departments asking about their implementation of risk/needs assessments is the specific data that CCJBH staff is examining to determine if it is an appropriate data source for this metric. There are preliminarily conversations with the Judicial Council about getting access to county-level data.

Q: Chief Jenkins asked if it is the 678 Report being referenced.

A: Ms. Grealish answered yes, this data is the SB 678 data. The idea of looking at adequate system capacity for providing behavioral health services and criminogenic intervention for individuals is to establish a baseline that can be tracked over time. For behavioral health services there's a network adequacy report with requirements per county, such as inpatient beds and felony Incompetent to Stand Trial referrals. We hope that services would be built on a community level so individuals don't end up incarcerated for untreated mental health or criminogenic needs, and we are trying to measure the system capacity to reduce recidivism.

Q: Chief Jenkins stated all counties should be administering risk and needs assessments and should have available data on the assessed risk of everyone under supervision, and the criminal needs to focus on. The metric we should be calling is what those highest needs are, but that's directly reflected on the types of tools being used. For example, San Diego County Probation Department says they are monitoring 1,000 individuals on a high risk level and 75 percent of them identified a criminogenic need of criminal thinking. So the other metric that will help us is the percentage of their population that is enrollment in a criminal thinking program.

A: Ms. Grealish stated it is unknown if the SB 678 survey data will have that level of specificity or if it will just state who is doing risk/needs assessments and who is offering targeted intervention. It may not show the actual implementation of the intervention, but if it is in the data we will look at it.

Q: Chief Jenkins expressed concern that if we don't have that information than it may not answer our question about adequate capacity.

A: Ms. Grealish expressed understanding of his concern and stated we are hamstrung by available data and what is captured statewide. We intend to establish a baseline with publicly available data, identifying gaps in the data as we continue analyzing it.

Q: Ms. Toche stated the goal is to ensure adequate system capacity, but how are we determining what the need is if we don't know how much capacity we actually need? If we are only looking at county probation and 50 percent of the people released from prison, especially in mental health, go to parole not probation, we are missing a whole segment of the population that would be part of the denominator in determining adequate capacity.

A: Ms. Grealish answered that Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment for reentry is done upon transition, but I don't know if

anything is captured on the type of criminogenic interventions being provided post-release. That is something that can be built out as we learn more about additional measures. This is just a starting point to measure and track the 2025 goals with publicly available data. This is a point of departure and there is definitely not the whole picture.

Q: Dr. Hobson stated having lived through the implementation of network adequacy at the county level, I have seen how the provider beneficiary ratio is calculated. It's flawed and not based on need, but rather on prevalence rates, which are not county-specific. As a local example, we were told we were short on psychiatry time for children and had to increase our number of available psychiatry hours to meet an arbitrary formula. We had increase our contract to demonstrate that we had more hours available, but we will never expend that contract because the need is not there. I have been on the IST work group for years and Dr. Warburton has put out some data on the IST population. The underlying assumption is county behavioral health isn't adequate at addressing the needs of this population, which is why they end up in jail or State Hospitals. Since we can't force medication on people, and that's oftentimes what is needed, you have someone medicating with meth and no control over the individual, and they end up in jail. If they're willing to take medication, they start clearing up and are no longer incompetent. The data is not great and I don't know if those two measures are going to get us the information we need.

A: Ms. Grealish stated for clarification, I think DHCS is using the Holtzer (TAC HSRI) data, which breaks it down by expected need by county, not national data. When we met last January and we asked how to measure these metrics, we then went back and scoured to see what data was available and what data other people were using to make cases for different initiatives. This was the best data currently available. The data are very limited, and publicly available data likely won't tell the whole story. We are trying to put together pieces of the story and if there are other metrics, we can look at them, too.

Q: Judge Manley suggested that we need to know what the need is. What does the metric of measuring inpatient beds per capita mean? With the IST population, you say you're going to look at data from the DSH, but we know people are being diverted away. Why is there no measure for housing? We need housing for the mentally ill.

Q: Ms. Grealish stated that publicly available housing data doesn't exist or we having found it yet. The Homeless Coordinating Finance Council just implemented their Homeless Data Integration System about a month ago and we will be examining it as another potential data source. Are there any other data sources could we be using for housing?

A: Judge Manley stated we should try to measure housing. In the Governor's Veto Message, he talks about launching the Return Home Well, a partnership to have housing, healthcare, and transportation services. We could measure how many individuals with Correctional Clinical Case Management Systems (CCCMS) and Enhanced Outpatient Programs (EOP) designations who are coming out of prison to parole have housing. If you leave housing out you're painting a distorted picture.

Q: Ms. Grealish stated given that we're discussing metrics for our annual Legislative Report, we're bound by the data available, and we can identify needed data sources that are missing. Should we pull this goal and not measure it since there are not enough data available or do we include it in the Legislative Report with no data and state the necessary data to reach the goals? Or should we start reporting on what's available and also talk about what's not available, and plans for when it may become available?

A: Chief Jenkins stated he doesn't favor pulling the goal, but does agree with saying something along the lines of, "we are looking to see what broader data sets are available." We have already approved the goals, and I think they are still very reasonable, but our ability to measure the goal is only as good as the data that's available. Focusing on the criminogenic piece, I am wondering if there are more areas of data available than just the SB 678 Report. Probation departments have data, and parole may also, from COMPAS reentry to capture criminogenic need.

Q: Ms. Grealish thanked the Councilmembers for their input and posed the question of whether we should move forward with the metric. She noted that the metrics are not as complete as would be optimal to measure the goals, and that we will document it accordingly. It's not a perfect methodology, as Dr. Hobson pointed out with network adequacy. At this point in time we only have the data that is publically available, and it may get better in the future, but we have to base our analyses on what we have.

Q: Dr. Hobson stated he would hope that the DHCS would really look at the provider to beneficiary ratio because it seems like a little much and is making counties have to make it look like they have more providers just to satisfy a ratio. As a psychologist, we have to make a standardized evaluation of IST because one psychologist may evaluate somebody as incompetent and another may not because it is their clinical opinion and what they see at the moment. How does inpatient beds per capita play into all this?

A: Ms. Grealish stated it is per the population, looking at what beds are available per population.

Q: Judge Manley stated he doesn't understand what inpatient beds per capita means. Is it the county? Or what are you measuring it against? I'm concerned it's not the message. We don't want people thinking we have solved it because we have measured it and it looks good using that metric. We need to start with the metrics we have identified and the available data, but why can't we add housing as another metric and say we are not able to measure it, but we are trying to find a way? I'm concerned with the needs of high level outpatient care and if we have the resources to support the needs.

A: Ms. Grealish stated outpatient care is included in the network adequacy measures, but doesn't include inpatient which is why the per capita measure is included. It's not a perfect measure and when we write it up in the Legislative Report the Council will be able to see the draft. We have been in communication with the HCFC to connect with their data system and we just got our data sharing agreement with DHCS so we will be looking at the MCUP data.

Q: Ms. Grealish stated in terms of our goals and metrics, we have found the publically available data, but it's not complete. We want to include housing and social supports, and there is a lot we can build out on. Do you want us to look at the data we have, analyze it, and write it up in the Legislative Report? Then if something doesn't look right, or is not a good measure, we can pull it. It isn't the end all be all, more so a point of departure. Dose this look like a good place to start?

A: Dr. Hobson stated the Mental Health Oversight and Accountability Commission (OAC) tracks a lot of data for us and when Judge Manley talked about the EOP coming out, I often equate the EOP with Full Service Partnerships because they need a lot of support and wraparound services. In my county the Managed Service Provider Program works mostly with criminal justice involved folks because they often don't have housing, and we have trouble providing all the support because our dollars only go so far. Maybe the OAC's data would be something to bring in.

Q: Ms. Grealish stated we have been meeting with them to talk about their dashboard and some of the innovative work they're doing, and building up MUCP in that same way. In particular, for those designated as EOP upon release, how many were linked to Full Service Partnerships?

Q: Dr. Hobson stated another point he hadn't considered is the network adequacy for the mild to moderate population. In my experience with the counties I've been in, the Medi-Cal Managed Care plans don't have the network adequacy that is required, so we have to pick up a lot of those clients, which adds to the number of people we serve.

A: Ms. Grealish stated that was one thing we were going to look at in the DHCS Network Certification reports. It wasn't just the county behavioral health, but also the Medi-Cal Managed Plan network certifications. This is also something CalAIM is addressing in trying to better establish the assessment and transition of care to hopefully help get folks into the appropriate systems for their care.

Q: Chief Jenkins asked if this is an action item we have to approve to move forward?

A: Ms. Grealish answered yes. We will refine them as we go, but is this something you want us to work on now and start compiling the data and analyzing it? We will present the analysis to the Council, and we can pull it if it doesn't work, or finalize it if it is appropriate.

Q: Chief Jenkins asked if we were to approve it right now as presented, we aren't married to just these metrics and it would be an ongoing effort to expand or revise as necessary?

A: Ms. Grealish answered yes, we don't want to keep measuring something that doesn't make sense, and if there is new information we will definitely want to incorporate it.

Q: Chief Jenkins said as a Councilmember, he feels should assist in that effort and it shouldn't just fall on the staff. If I'm going to be critical of metrics and say the criminogenic needs are inadequate, then I feel an obligation to offer data available data sets to look at.

A: Ms. Grealish stated there are some growing pains because this is the first time we as a Council have engaged in this kind of exercise. Ms. Welch put the metrics in our 2019 Report and got the ball rolling. Even though we haven't started formally working on the report, we have already begun to identify the gaps and methodology that will need to be refined. Our vote today is whether this is a good point of departure, and we will be looking to our Councilmembers to help us advance from there. We haven't started analyzing anything yet. We have only performed a preliminary review to see what data are available.

Q: Judge Manley stated he's all right with it as long as it's phrased that it is left open. I think the metric of housing is critical. I work with parolees and probation every day and if we don't have housing, we aren't getting anywhere. And if we don't have a way to measure it, then we aren't doing our job. I think it can be measured with parole and tracking how many CCCMS and EOPs have housing. Getting data from the jail would also be a good start.

Q: Dr. Kooler motioned to accept the metrics understanding that they will be continuously improved with a particular focus on housing.

A: Dr. Pantoja seconded the motion.

A: Chief Jenkins expects to vote in favor of this motion, but doesn't think housing is the only goal that is missing. The current wording of the metrics are not fully adequate to measure the goals we've establish. I would like to keep the language that they will be further reviewed and evaluated because there's more than housing missing.

Q: Ms. Grealish proposed the wording "Adopt the 2025 Metrics with the caveat that they will be refined as more information becomes available, such as data related to housing."

A: Ms. Whitney stated she agrees with everything that has been said, but don't think housing is the only missing data. I know that there's a big interest in racial equity data right now that may be missing from data sets statewide. I agree we have to start somewhere and these are the metrics we have, but the analysis of the accompanying report will be key. As Dr. Hobson said, we are all very interested in the felony incompetent to stand trial population. It has been my experience that many of those folks have very long term serious mental illnesses, some are subject of conservatorship and, even after involuntary mediation or State Hospital stays, they are unable to return to competency. This would mean we need more mental health services to help those folks. Often when the IST numbers are up, people blame the lack of adequate treatment by county behavioral health, but some folks are so sick they never regain competency, and it's not necessarily the fault of the county behavioral health system.

The vote will be postponed to the end of the meeting when all Council members are present

- CCJBH Lived Experience Project (LEP) Update: Ms. Camacho Duran provided an update on the work of the CCJBH LEP Contractors. In February and March 2021, the contractors assisted with collecting stakeholder feedback for the SB 369 Veto Message project. In addition, individual contractor project updates were as follows:

- Cal Voices recruited two additional ambassadors, for a total of seven ambassadors, all of whom represent and serve the Superior and Southern regions of the State.
- Anti-Recidivism Coalition (ARC), in conjunction with other program partners, published a press release in March 2021 in support of having the Governor appoint a new Attorney General who favors policies that address the needs of the Behavioral Health/Justice Involved population.
- ARC is also in the process of launching a trauma-informed storytelling training for their members.
- TCN established their Advisory Site Committee, which is composed of Community Health Workers (CHW) and clinical staff at their Bay Area locations. They continually provide technical assistance and support to their CHWs.
- LARRP launched their leadership academy, in which 12 leaders are working on integrated health, education, and employment, as well as participating and giving public feedback in local stakeholder meetings, including CCJBH's SB 369 Veto Message Project.

- CCJBH Public Health Meets Public Safety Project Update: Ms. Camacho Duran reminded Councilmembers that the Council on State Government (CSG) Justice Center is the contractor for this project. Thus far, CSG produced a dashboard that compiles state level data that is publicly available and can be used to better understand the intersection between criminal justice and behavioral health. The dashboard can be accessed on CCJBH's website. In addition, in April 2021, CSG conducted a focus group consisting of participants with lived experience who were recruited with the assistance of CCJBH's LEP contractors, with a follow-up focus group to be hosted on May 10th. The goal of the focus groups is to gather feedback on the priorities of individuals with lived experience and how they can be integrated to inform the PH/PS project.

- Forensic Peer Support Specialist Update: Ms. Camacho Duran stated that, with the passage SB 803 Peer Certification, CCJBH staff embarked on a project to research the certification process for Forensic Peer Support (FSP) specialists. CCJBH staff have met with representatives from Georgia's Mental Health Consumers Network, Pennsylvania's Mental Health Consumers Network and Yale PRCH, and are currently working on drafting a report summarizing our research, recommendations, and best practices from the agencies we have met with. The FPS Specialty would be a model that could be used across the healthcare, behavioral health, and justice systems. Once the report is drafted, Councilmembers will be asked to review, and then stakeholder input will be sought before finalizing.

- Legislation: Ms. Vice stated that CCJBH is tracking 95 bills currently routing through the legislative process. The bills of interest to CCJBH are those that attempt to change the way mental health services, or other associated services, impact the justice-involved population in California. These measures include those that effect youth in the juvenile justice system, foster youth, the elderly, homelessness, and crisis services. For information on the 95 measures we are tracking, please refer to the legislative link on our CCJBH website.

Q&A with Councilmember Advisors:

Q: Judge Manley asked when the Forensic Peer Support Services Specialty draft will be available.

A: Ms. Grealish stated it will be available before the next full Council meeting, or possibly beforehand or we could call a special session.

****PUBLIC COMMENT****

No public comment was provided.

V. SB 369 Veto Message Mandate

Brenda Grealish, *Executive Officer, Council on Criminal Justice and Behavioral Health*
Lisa Heintz, *CCHCS Director, Legislation and Special Projects, Integrated Substance Use Disorder Treatment*
Robert Storms*, Associate Director, CDCR Division of Adult Parole Operations*
Kevin Hoffman, *Deputy Director, CDCR Division of Rehabilitative Programs*

Ms. Grealish introduced the next agenda item, the Senate Bill 369 Veto Message Mandate given to CDCR and CCJBH. The CDCR Division of Rehabilitative Programs, the Division of Adult Parole and the California Correctional Healthcare Services (CCHCS) Integrated Substance Use Disorder Treatment (ISUDT) Team presented on the work completed to date to support the SB 369 veto message.SB 369 would have established the California Reentry Commission to develop a new health and safety agenda for those returning home from custody, review the barriers to reentry and coordinate with other entities to establish a grant program for reentry services providers. The bill passed both the Assembly and the Senate in the 2019 Legislative Session, but was vetoed by the Governor, who placed the responsibility on CDCR and CCJBH to engage with stakeholders, evaluate the barriers to reentry and determine the necessary next steps. The SB 369 Barriers Table was created by the CDCR/CCHCS Transition Team and CCJBH with information gathered via a review of published records from the National Institute of Corrections, National Institute of Justice, Council on State Governments Justice Center, National Reentry Resource Center and Substance Abuse and Mental Health Services Administration. The CDCR/CCHCS Transition Team and CCJBH sought feedback on the SB 369 Barriers Table from various entities including councilmember policy advisors Judge Manley, Dr. Hobson and Chief Jenkins, Legislative staff and advocates involved with SB 369, and CCJBH's Lived

Experience Program advisory group with representatives from Anti-Recidivism Coalition, Cal Voices, Los Angeles Regional Reentry Partnership and Transitions Clinic Network. The Transition Team and CCJBH then sought broader stakeholder input to ensure a comprehensive inventory of reentry/transition barriers, and steps to overcome them, are captured. Opportunities for stakeholder engagement include: today's workgroup, SB 369 Veto Message Regional Lived Experience Focus Groups on March 22nd and 25th, the Annual Forensic Mental Health Association Conference, Words 2 Deeds Track on April 1st and the CCJBH Full Council Meeting on April 30th. There was a two-week public comment period scheduled to follow each stakeholder event. All the feedback from the public events will be incorporated into the final SB 369 Barriers Table, and a final report will be written for the Governor's Office to satisfy the SB 369 Veto Message, targeted for submission in July 2021. After the report has been submitted an Action Plan will be developed to address the barriers to reentry and implement solutions.

A link to the barriers table was provided to workgroup participants for reference. The table was organized by three categories: system, provider and individual level barriers, as well as potential solutions and strategies to address those barriers.

The system level barriers identified to date are as follows:

1.1 *System coordination within and between state departments.* There is limited coordination within state-level agencies that serve the justice involved population and the ISUDT transition team will work to identify service gaps and create plans to close them.

1.2 *System coordination between state and local level entities*. There is limited coordination across state-level and local agencies serving the justice involved population in processes regulation and timeline misalignment. This is a huge issue that they are working together on in an attempt to come up with solutions to minimize issues. Some improvements have occurred, but there are still gaps relative to the coordination and cooperation necessary to transfer inmates from state run facilities to their counties of release. The ISUDT Transition Team is engaging county level stakeholders to improve pre-release and transitions by developing improve protocols with greater efficiencies for all involved entities.

1.3 *System coordination between local level entities*. There is a wide variation in how counties interact with private agencies and work is being done to reduce the variance. A standard protocol will be developed to apply to the 35 different institutions that deal with different levels of services at counties.

1.4 *Misaligned or insufficient funding sources*. Service providers may not always be aware of available funding sources, the appropriate use of funds, or funds may be insufficient. Work is often duplicated when servicing the transition and reentry justice involved population so identifying and aligning funding sources will increase efficiency. Efficiencies may be found once the barriers are removed due to the duplication of work when servicing the transition and reentry population. Gaining knowledge of where the funding sources are and aligning them will aid in improvements.

1.5 *Data and information sharing challenges between CDCR and county departments/entities*. Issues of liability for potential breaches prevents some departments from establishing data sharing agreements with state departments, such as CDCR. COVID has relaxed some of the data sharing processes and CDCR has been working to reduce additional barriers with the creation of a county data sharing project. Five counties are currently signed up and three more plan to come on board in an attempt to streamline the data sharing process.

1.6 *Data and information sharing challenges between county departments and their contracted providers/CBOs*. Counties face similar data sharing issues between themselves that are seen on the state level and programs will be put in place to increase efficiency.

1.7 *Changes to policies and programs that are difficult to implement, fail to address identified issues and fail to obtain practical ideas from a broad range of stakeholders.* Often laws are enacted that address very small segments of the reentry population and don't include input from reentry stakeholders.

1.8 *Insufficient/ inappropriate services for criminal justice population*. Mental Health Courts and other specialized services are not always available, so service needs may go unaddressed or inappropriately addressed.

1.9 *Limited service capacity for the criminal justice population.* It can be difficult to find placements that are close to the release county and comply with parole conditions. The service capacity of smaller counties needs to be improved to successfully treat transitioning patients.

1.10 *Medi-Cal provider enrollment is too complex.* The certification is difficult and labor intensive, which can deter providers from participating and aggravate service capacity limitations. Collaboration with DHCS could improve this process.

1.11 *Inconsistent discharge planning practices.* The ISUDT Team has made significant improvements to the CDCR pre-release planning process and accelerated release, allowing for more comprehensive planning. It is difficult to make sure everyone is captured and to execute last minute releases, but the team is working towards that.

The provider-level barriers identified to date are as follows:

2.1 *Insufficient cross-training of service providers*. There are inadequate opportunities for service *providers* across the behavioral health, primary care, criminal justice, and other systems to become familiar with one another's systems. The siloed natured of the systems makes it difficult for information to flow and we need to break down this barrier so pertinent information about the individual can flow across all systems and the correct treatment is provided.

2.2 *Low program fidelity and implementation of ineffective programming*. Operating treatment programs inside an institution can be very difficult. Some programs have been

documented as effective, but they may not be implemented in the way that the curricula dictate. Other programs may not have been evaluated rigorously.

2.3 *Lapsed benefits after release.* Incarceration in prison can result in suspended benefits, such as Medi-Cal, Supplemental Security Income, Veteran's Affairs, Supplemental Nutrition Assistance Program, and housing. People are released with benefits that are no longer active and struggle with navigating, accessing and reinstating previous benefits. CDCR is working hard to connect people with resources once they get out and there are programs inside the institution that connect people with Medi-Cal benefits, but they don't become effective until 30 days after release and that is something that is being worked on.

2.4 *Limited continuity of care after release*. Individuals who are receiving services while incarcerated often don't continue to receive those services in their community, or are not informed of the available resources. This goes back to the information flowing across systems and making sure needs are addressed in the community.

2.5 *Service coordination and program placement when medical needs increase post-release*. People are placed in a post-release program based off their needs while incarcerated, so it can be difficult to coordinate services for people whose health needs change after release. Time is of the essence when connecting people with the necessary services to support them.

2.6 *Limited outreach and engagement*. Individuals transitioning from incarceration may have limited knowledge of recovery-oriented activities that can support reintegration. Resource availability differs from county to county. Some counties have case managers and peer navigators to connect individuals with the resources they need, and other don't. Ensuring the availability of resources in all counties is something that needs to be worked on.

The individual level barriers identified to date are as follows:

3.1 *Unmet housing needs and homelessness*. Individuals transitioning from incarceration have significant living restrictions that are placed without regard for rehabilitation or potential to reoffend. Parole and the community are working to mitigate or eliminate these restrictions. There are currently programs in place to transfer the services a person is receiving in their county if they need to be moved to another county due to safety concerns. Many programs have been developed throughout various counties to offer the same services. For example, if a person is restricted from living in Los Angeles County because there is a 1707 (Request for Victim Services) and the victim has requested that individual not live within 35 miles of their residence, it may take them outside their county of last legal residents. However, the same services would be available in the county they are transferred to. Although it does take them away from their family, the victims have a right to feel safe and the same services will be available to the individual in the new location.

3.2 *Medi-Cal enrollment and activation*. Last-minute changes in county of release causes individuals to be enrolled in a plan for a different county than they are released to, and it takes at least 30 days to transfer Medi-Cal which leads to delay of care. Individuals being released earlier than anticipated can result in counties not activating their Medi-Cal until their original release date and individuals having to contact their county Medi-Cal office to activate. CDCR's Division of Adult Parole operations managers have a prerelease process in which they work with inmates, whether they're released to parole, community supervision under the county, or discharging altogether, to get applied for medical veterans' health and social security disability incomes. Once they are on parole assistance is provided to navigate getting their medical benefits activates. There are some last minute changes in counties of release, but those are small and few, and probably unavoidable in most circumstances. The Victim Notification Request may require someone to be moved to a different county because of legal requirements. Medi-Cal benefits are getting activated for those on parole in much less than 30 days for the most part and it has improve quite a bit, although COVID did cause some delays. Other dynamics are involved with the activation of Medi-Cal enrollment, such as the distinction between inmates coded Medi-Cal and full scope Medi-Cal, where the county is required to reach out to DHCS and change the coding. Although this is a barrier, it's improving quite a bit and getting the right people involved will help.

3.3 *Unmet health care needs*. Individuals who receive health and behavioral health care services while incarcerated may not opt to continue those after release. Individuals are strongly encouraged to continue the treatment after incarceration and it is available, but cannot be mandated. There are resources such as Medication-Assisted Treatment, or access to Correctional Clinical Case Management System medication, if the individual desires to continue these services. Parole agents in the behavioral health and reintegration staff, and parole officers, work with individuals on probation to motivate the continuation of treatment through the involvement of families and community health workers. Although treatment can't be mandated, help can be offered to get health needs met.

3.4 *Trauma and culture shock.* Many incarcerated individuals have histories of trauma, and incarceration itself can be traumatizing. In addition, returning citizens, especially those who were incarcerated for long periods, can become overwhelmed with the culture shock of reentry/transition. There are resources available for long time incarcerated individuals, such as lifer homes to address long term needs. Parole and other community partners have established programs to help individuals who have been incarcerated for a long time navigate trauma and culture shock. The programs teach life skills, and even simple things such as how to use a cell phone or a self-faucet in a public bathroom.

3.5 *Unaddressed criminogenic risks/needs.* Community-based programs do not consistently provide interventions to address criminogenic risk and needs. Specific programs, such as those that address criminal thinking, anger management, negative peer association, family relationships, etc., may not be widely available. The systems of care and

infrastructure within all networks are not yet broad enough to address this area. Some areas, such as San Francisco, may have a lot of programs to address criminogenic risk and needs that include a high percentage of the involved population and others may not have those resources yet.

3.6 *Challenged family relationships.* Contact between incarcerated individuals and their families is often limited (for a variety of reasons), putting stress on family relationships and limiting availability of family support upon release. Regaining custody of children is a challenge. CDCR had to limit and suspend family visitation for most the year during 2020, but before that, and now as things get back to normal, there are still barriers and disinterest in family members coming to visit their relatives that are incarcerated. As individuals go out into the community, it is CDCR's job to help them have prosocial social environments and reconnect with family where appropriate.

3.7 *Limited human capital and poverty.* Formerly incarcerated people often have lower levels of education and employment, and face barriers to education and employment post-release, such as legal barriers that preclude licensure and certification. There have been some recent improvements, such as the modification of eligibility for Section 8 housing. Regulatory changes need to be changed for licensure and certification because of its legal statutory. The Division of Rehabilitative Programs has an Education and Employment Preparation Program for incarcerated individuals prior to release, but resources can still be expanded.

3.8 *Fines, fees, and restitution imposed by the criminal justice system exacerbate financial difficulties.* Parole doesn't imposed adverse consequences on parolees for not paying their fines, fees and restitution, but it does prohibit them from transferring out of state. It can be difficult for them to get ahead, but debt is hard for anybody.

3.9 *Lack of identification.* A lack of state-issued identification makes it difficult to apply for benefits upon release from incarceration. Formerly incarcerated individuals are required to attend a Parole and Community (PAC) team meeting within 30 days of release where the Department of Motor Vehicles and the Department of Public Social Services are present to assist in obtaining an ID or any other documents.

3.10 *Limited access to transportation to treatment/intervention services.* A lack of reliable transportation makes it difficult to receive necessary health and criminogenic risks/needs interventions. It has been as issue in the past, but improvements have been made for the agent of record to provide cash assistance to transfer an offended back and front from appointments. Or the Community Based Organizations to provide bus passes, as well as agents who are available to personally transport individuals.

3.11 *Limited access to appointments, such as court dates*. There may be insufficient appointments available, or appointment processes may be difficult to navigate. The addition of Community Health Workers offers a resource to help in this process and advocate for the individual. They can help with family court and having their parental rights restored, health care advocacy, keep up to date with appointments, etc. Although

this has been an issue in the past, there haven't been many issues since the addition of Community Health Workers.

3.12 *Limited access to a bank account and limited financial literacy*. Lack of knowledge about good financial practices can lead to difficulty with establishing a strong financial foundation. Formerly incarcerated people may not have bank accounts or credit. Services are offered while incarcerated for groups, such as women or lifers, to sign up for a checking account with no deposit required, and education from a credit union.

3.13 *Limited familiarity with opportunities for support and healthy activities.* Individuals may be released outside of where they use to reside, and they may be unfamiliar with resources in that community. Upon release, individuals are connected with an Adult Program Unit Reentry Specialist in their county who provides a brochure with a list of benefits services, mental health services, employment services and the Employment Development Department office in their area.

3.14 *Special considerations for youth and older people transitioning from incarceration*. Both older and younger people transitioning from incarceration require a special level of care. This is the reason for transitional housing programs, so groups of people who have common needs and are more mild-tempered are housed together.

3.15 *Special considerations for individuals convicted of sex offenses*. Sex offenders' social stigmas and legal limitations should be considered when pursuing social welfare programs. Sex offenders are often grouped together without regard to the severity of the offense due to legal requirements on registration and supervision. This does present barriers such as not being able to go certain places or access certain services, and it is something that needs to be addressed.

The SB 369 Barriers Table includes all the previously listed barriers, as well as potential strategies and solutions. Columns were added to identify the department(s) that would be responsible for addressing each barrier and to identify gaps that require new resources to be available or that conflict with existing work.
Ms. Grealish thanked the Transition Team for going over the barriers that have been identified to date and reminded participants that the SB 369 Barriers Table is posted on the CCJBH website, which includes the barriers listed and ideas/suggestions to address them that was gathered over the past several stakeholder meetings. She then opened the discussion to Councilmembers, then all attendees, to seek feedback.

Q&A Discussion with Council Members:

Q: Judge Manley suggested divvying the barriers into two groups: one with an early solution that could be put into effect quickly and another that would take more time and though. Two barriers that could be addressed quickly are identification and Medi-Cal. Identification should be able to be worked out so that people have an ID when they are released since the DMV and CDCR are both State agencies. He sees people every day in court who can't access treatment, or other things, because they don't have an ID. His county has a process

to get people their ID and it seems like something we can do upfront. Why does it take 30 days to transfer Medi-Cal? The state rules the procedure and that should not be a barrier to people who are already qualified and are Medi-Cal beneficiaries. They should have their Medi-Cal immediately available when they are released, even to a different county. Those are two examples of things that can be addressed, and possibly solved, right away so when we present this to the Governor we have not only identified barriers, but also come up with solutions that are already in place.

A: Ms. Grealish thanked Judge Manley for his thoughts and asked if he had any further suggestions. She stated there is work being done on Cal ID, and DHCS's CalAIM proposal in the 1115 Demonstration addresses access to Medi-Cal 30 days prior to release so people walk away with a beneficiary ID card.

Q: Chief Jenkins stated in regards to solutions, our response needs to speak to the very important need to define and support Collaborative Case Management for populations returning to our communities. We need to define the Collaborative Case Management efforts that should be involved in assessing the needs of the returning population, connect them to services, and have multiple players involved such as community based organizations, behavioral health providers, parole agents, and probation officers. We need to instruct on not only what the barrier is, but also how to handle it. It involves assessing what the needs are, inventorying resources, and working together with multiple players that have an interest in engaging individuals with those services.

A: Ms. Grealish stated Collaborative Case Management is included in the solutions, but we will make sure it's characterized in the way described. It has generated a lot of discussion and interest among providers and individuals with lived experience, so there is education taking place to get folks on board and coordinating with each other. She informed Chief Jenkins that he can email CCJBH staff if he has any questions since he is having technology issues.

Q: Dr. Hobson asked if the initiative to have Medi-Cal benefits restored 30 days prior to release also applied to county jails.

A: Ms. Grealish answered that it is for all incarcerated people.

Q: Dr. Pantoja asked if either Chief Jenkins or Judge Manley recalled the roundtable hosted by Stephanie Welch about 2 years ago that discussed homelessness of the incarcerated population, and a county that had attorneys help incarcerated people get access to SSI benefits.

A: Judge Manley stated that she was correct and that it is a serious barrier for those who are eligible for SSI benefits. In his county they are able to begin the process of reinstating benefits so everything is ready when they are released.

Q: Ms. Grealish stated that is included in DAPO's Transitional Case Management Program. Asked Angela to confirm that was included in the barriers table.

A: Ms. Kranz stated it is included in the barriers table under Collaborative Case Planning. SSI benefits are currently under post-release benefits, but she will make sure they are also under Collaborative Case Planning and system coordination.

Q: Chief Jenkins emphasized that the term "Collaborative Case Management" must have a definition because it is used differently by everyone. When we talk about the barriers, whether it be the lack of ID or the lack of engagement in SSI, the case management approach must include a comprehensive assessment of a person's identified needs when leaving prison and joining the community. If they don't have a place to live and will be homeless, we need to know that. If they don't have an ID to access services, that needs to be identified. If they still have a severe Substance Use Disorder or Serious Mental Illness that needs to be addressed. These things have to be coordinated by everyone providing services for that individual. We have to identify the barriers and collectively respond to them.

Q: Judge Manley asked if housing was identified as a barrier. He agreed with Chief Jenkins comments about coordination and stated that his county parole agents work very closely with the probation officers because often people who were released on parole get arrested again, and then they're on probation and the supervising agencies don't work together. We don't have any coordination or assistance to the individual in getting housing. They have been in prison and are not locals who have lived in the community and were in county jail, so they aren't able to get on lists for rapid rehousing or take the Vulnerability Index- Service Prioritization Decision Assistance Prescreen Tool. When you come back from prison you don't have the established time in the community to immediately qualify to get on the list. We have to find a solution because it is tragic to see homeless people in the street who are on parole and mentally ill.

****PUBLIC COMMENT****

Q: A Cal Voices representative stated she is appreciative of the conversation that we're having and the consistent focus that we are applying to these challenges that individuals with lived experience and criminal justice are experiencing, and have been for a long time. She wanted everyone to know that, while that was a lot of information, there was even more obtained from the focus groups we did. A lot of the focus group was about sharing the barriers and the solutions, and the subject matter experts came with solutions in hand. It is important that we as a community identify what we can do to overcome these challenges because they are real and we don't want to just complain, we also want to come with solutions, which is something Cal Voices empowers people with doing. I'm looking forward to supporting the solution efforts with the feedback from the focus group and empowering those individuals and letting them know their feedback mattered in this whole process.

A: Ms. Grealish thanked her for the information gathered from the focus groups and expressed that all the solutions, including those derived from the focus group, are listed in the barriers table that is posted on the CCJBH website. The solutions were excluded from today's presentation due to the amount of dense information being presented.

Q: A participant stated that "the set of lenses you're using to look at everything is a nice set of binoculars, but you're too far away from the playing field. I don't mean that in any disrespect. What I'm seeing as a case manager, drug and alcohol counselor, and as an individual who has been out of prison for almost 10 years after giving 15 years of my life, is that my lived experience allows me to recognize the barriers for what they are. Judge Manley is right about the depth of the need for housing. Addressing housing has to be one of your top three priorities. In regards to beds per capita, counties need as many beds as people they send to prison because you don't know what's going to happen to the individual while he's in prison. Mr. Jenkins hit a home run from a case management standpoint and everything a case manager needs to do. I had a caseload of 50 clients before COVID, and I had to develop special relationships with parole and US Federal Probation. I don't understand why they don't have any money, but at the same time I need those relationships, along with relationships with other agencies, to navigate the issues of no social security card or the DMV being closed. That leads to the next issue with CDCR. I'm on the reentry roundtable in San Diego and I sit on the Policy and Procedure Board as the co-chair, and we are sponsoring Senate Bill 717. It needs to be mandatory for CDCR to be responsible for the inmate from incarceration until he's off on parole. That means providing an ID, which shouldn't be an issue because it creates an issue of public safety if you put him out there. Fifty percent of those released during COVID were released homeless, whether they were co-occurring or high with substance use, they were still released back into the community with no ID and no place to go. You create a public safety issue by those failures. In addition, Mr. Storms must be up in the booth and I'm down here on the playing field. The length of housing needs to be one year minimum and without restrictions. I've had individuals on my caseload whose housing program made them quit their job because they couldn't go to the housing meeting, and that doesn't make sense. The trauma and shock exists pre-incarceration, during incarceration, and post-incarceration. If it's left untreated, you still have a sick individual upon release, so we need to be treating all the way through. For issues with family relations, individuals can't go back to their family because they're going to disrupt the homeostasis, then release and come right back to prison or be homeless. On the issue of lived experience, I'm really disappointed you guys didn't invite San Diego to the playing field. It's hard for me to have developed all these relationships with State Parole and Probation and for them to be utilizing my experience, but we don't have a voice here in San Diego. In addition, when it goes to Mr. Storms' ideal of how he's viewing this, and I mean no disrespect because he's an expert, but he's not viewing it from the playing field, he's viewing it from the rafters. He's right about everything he said should happen, but it's not happening on the playing field. Parole is not giving bus passes, parole is not making sure they get those rides, parole is not doing any of those things without me going to a supervisor or making it a public argument and public issue.

Lastly, Dr. Hobson, I appreciate what you said because I have clients that are Incompetent to Stand Trial, and he's right that there needs to be a framework because two doctors can't have different opinions on the same guy. All that does is create an atmosphere where that

individual is going to fail and stay sick because he's not getting the right level of care. I know this a very complicated issue because it is all intertwined with each other, but you guys are in a position where you need to listen to what's being said whether it's an individual or a group of people coming from prison. The very last thing is I don't know how Mr. Storms came up with that 8 percent number in regards to the ISMIP Program. The percentage is more like 25 percent. The majority of people that get out of prison are already mentally, emotionally, and socially challenged, and because there is no treatment internally, and if they won't be treated when they get there, then they won't come out sound enough to succeed. Getting treatment afterwards is like having co-occurring issues, they need to be treated simultaneously. Thank you for listening."

A: Ms. Grealish thanked the participant for his comments and reminded everyone that if there is a specific barrier or solution they want on the barriers table they can submit a written public comment. She then addressed the chat and asked if Mr. Storms would like to comment on it.

A: Mr. Storms replied that "he has heard his name a lot and knows he is representing parole on this very 'hot' conversation of barriers and solutions. One of the participants today felt insulted by my comment on the financial system and my intent was to explain that there are steps to achieving what would be considered sustainable action. First, we look at the primary needs, which it sounds like everybody agrees are food, clothing and shelter. We also have to look at what's achievable, and my goal was to say some things need to be stepped into, and some barriers may or may not be within our control to change. There are ways to move past those barriers, and sometimes go to the side, so I was offering some alternatives to someone getting out of incarceration and walking up to a bank to open a checking account and getting a credit card. I was trying to display that there are ways to learn to manage money and there are also ways to achieve what is needed through time and effective case management, like the participant was speaking to. From last meeting, we do have some staff from DAPO that are willing to meet with participants and discuss the area of concern with them in that locality, so I encourage participants to reach out if they would like that. As Chief Jenkins said, it's a Comprehensive Case Management that is needed, and that is what I was trying to message by going over the individual barriers. There is communication and a need for folks to really work with individuals to help them achieve where they need to go, but we have to be realistic in those goals and what's achievable."

Q: The participant thanked Mr. Storms and thanked the Council for their sensitivity in this area and the way they're addressing it. He stated, "It has been inspiring. I am the one that made the comment regarding Mr. Storms' suggestions, particularly around accepting what's available. To me it was to 'lower your expectations' and I think there's a better way to address men and women coming from and entering the workforce at livable wage careers. As it's been pointed out, licensing is an issue the State can take up, such as dealing with the DMV or connecting people with SSI. I think that approach would be more beneficial instead of saying, 'look at what's achievable' because that comes across as 'lower your

expectations because you have this criminal record so don't look at those professions or industries, just take what's achievable.' There are many banks and credit unions that help individuals establish their credit, and I think we will want to be careful because a lot of effort has gone into educating community members and helping them move away from check cashing places and high interest predatory systems and situations. There are many banks that partner with community based organizations to come in and teach financial literacy and help establish credit. Those are the options we should look at as opposed to simply starting with the Green Dot or just looking at what's achievable for employment. I think that sets a very low bar for success for the men and women coming home. Thank you."

Q: The participant thanked everyone and stated she appreciates the discussion. "To the person addressing the individual level barriers, I know these are difficult discussions and I want this to be taken in a collaborative spirit, but it is really hard when you meet with many people across the state and you hear the same themes and barriers, then you hear the slides being presented and it feels as if they're being defended. I think we need to think about if we are listening to defend or listening to understand and improve the system. I believe we all want to listen to understand and improve the system, but we also need to have that sensitivity to the individuals across the State that are saying over and over again that something is in place, but they're not experiencing it on the ground. I understand participant's passion and frustration and I want to let them know that we did reach out to San Diego, and we have a lot of representatives from San Diego, but I want to make sure he gets in touch with me so we can ensure you get on our distribution list because your voice is important and it matters. I would also like to highlight the collateral consequences that came up throughout all the focus groups. I believe there were 4800 to look at in California that are barriers. Judge Manley talked about looking at the solutions and what's in place right now and building upon that. I'm always an advocate for building upon the strengths that we already have and improving those so that we're reaching everyone."

Q: A participant from California Health Policy Strategies thanked all participants for an informative discussion. He asked a question related to the issue the Council was grappling with on data for individuals who are experiencing homelessness when they're released from prison. "I understand, what it sounded like one of the presentations mentioned, that the CDCR does collect data, but hasn't made it public yet. I'm wondering if we could find out what that data is and how it's collected and maybe build off that. That's the first time I've heard that data exists, and it makes sense to me that it would exist because parole must know how many of the parolees they're monitoring are homeless. So is that something that's obtainable or can it be released to the Council?"

A: Ms. Grealish stated we will follow up on that because CCJBH also were not tracking it.

Q:The participant stated, "this has come up before and he's heard estimates particularly for people with serious mental illness and the enhanced outpatient folks, we may be seeing 70-80 percent are leaving the prison with no place to live. All the other things we're talking about really pale in comparison in terms of being effective if we're not able to give them a safe place to live. Thank you and I look forward to seeing that data."

Council Vote on SB 369 Barriers Table

Vote: Adopt the SB 369 report outline and delegate authority to CCJBH Executive Officer to make administrative updates as seen fit.

Motion to approve the vote: Judge Manley
Second: Ms. Clendenin

No public comment on vote

Ayes: 8
Nays: 0
Abstain: 0

The SB 269 report outline was accepted.

Ms. Grealish stated there will be a two-week public comment period for additional ideas or comments on the SB 369 Veto Message project to be submitted to CCJBH at ccjbh@cdcr.ca by Friday, May 14, 2021. Using all information gathered, the CDCR Transition Team and CCJBH will draft a report summarizing the research feedback captured from research and the public stakeholder meetings, with the goal of an initial draft ready for internal review by the end of May or early June. After internal reviews, the draft report will be posted publicly for a final two-week public review and comment period. Thereafter, the Council will vote on the report at the full Council meeting on June 24th. We hope to submit the final report to the Governor's Office in July 2021. (*Note: The report took longer than anticipated and as of the publishing of these minutes, it is anticipated that the report will be submitted to the Governor's Office in August 2021.*)

Council Vote to adopt the 2025 Metrics

Vote: Accept the adoption of the the 2025 metrics with the caveat that they will be refined as more information becomes available, including data related to housing.

Motion to approve the vote: Judge Manley
Second: Chief Jenkins

No public comment on vote

Ayes: 8
Nays: 0
Abstain: 0

The 2025 Metrics were adopted.

VI. Announcements

Ms. Grealish stated May is Mental Health Awareness Month and, in honor, CCJBH staff will be initiating the month's activities with a presentation from Dr. Kooler on Tuesday, May 4th, from 12:00-1:00 PM. Also, the Diversion/Reentry Workgroup will be held on Friday, June 18th from 1:00-3:00 PM and the Juvenile Justice Workgroup will be Friday, June 25th, from 1:00-3:00

PM. The CCJBH Full Council Meeting will be Friday, June 30th, from 2:00-4:30 PM. The Words to Deeds Track with Forensic Mental Health Association of California information will be sent out on the listserv on Monday.

Mr. Storms addressed the data that a participant questioned on the mentally ill population. He stated, “The data answered a question from a Councilmember and was that eight-nine percent of the current parole population has a history of serious mental illness and 34 percent of the current parole population has a history of receiving mental health services. I was speaking to folks that have a serious mental illness that would have qualified for services under our contract with ISMIP. I know there are a lot of questions about parole so I put my email in the chat and we can set up a local meeting with parole staff if people want.”

VII. Adjourn

Ms. Grealish thanked participants for the great conversation and ideas. She stated we look forward to hearing public comments as they come in and will see everyone at future meetings.