CCJBH
Council on Criminal Justice and Behavioral Health

Building bridges to prevent incarceration

CCJBH Full Council Meeting Minutes

Friday, January 28, 2022
2:00 PM - 4:30 PM
Zoom Meeting

I. Welcome & Introductions:

Councilmembers Present: Kathleen Allison, Christina Edens (on behalf of Stephanie Clendenin), Tony Hobson, Jim Kooler (on behalf of Michelle Baass), Stephen Manley, Danitza Pantoja, Tracey Whitney, and Anita Fisher.

Councilmembers Absent: Mack Jenkins

Staff Members Present: Brenda Grealish*, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH)*, Elizabeth Vice, Emily Grichuhin, Jessica Camacho Duran, Monica Campos, Paige Hoffman, Catherine Hickinbotham, Donna Lagarias and Daria Quintero.

Brenda Grealish welcomed participants to the meeting and gave an overview of the agenda.

Secretary Allison stated that the Budget Change Proposals will be with the Legislature next week. She is hopeful that the California Department of Corrections and Rehabilitation (CDCR) can support the behavioral health and justice-involved (BH/JI) population.

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

Vote: Motion to adopt the December Full Council Meeting minutes.

Motion to approve the vote: Dr. Tony Hobson

Second: Judge Stephen Manley

No public comment on vote

Ayes: 7
Nays: 0
Abstains: 1

The December Full Council Meeting Minutes were approved.

III. CCJBH Business Meeting

Last fall CCJBH staff started planning out the 2022 priorities. CCJBH will continue on certain projects, such as:

- Examining services, looking at all services across disciplines related to the BH/JI population, focusing on California Advancing and Innovating Medi-Cal (CalAIM), and continuing to track the progress of the Behavioral Health Continuum

Infrastructure Program (BHCIP) and diversion programs to engage the behavioral health population and deliver high quality services.

- Continuing to advocate for the prioritization and development of housing for the BH/JI population by:
    - Collaborating with California Interagency on Homelessness (Cal ICH) on various projects that they are working on to ensure that the needs of the justice-involved population are considered.
    - Pursuing the recommendations in *Reducing Homelessness for People with Behavioral Health Needs Leaving Prison and Jails*, produced by the Council of State Governments (CSG) Justice Center for CCJBH, including a webinar series that will occur monthly through April 2022. CCJBH will continue to work on promoting cross system education and collaboration to make sure that there is advocacy and education about the needs of the justice-involved population as it pertains to housing.
    - Promoting and tracking Returning Home Well.
- Working toward establishing and expanding the BH/JI workforce across multiple sectors by:
    - Supporting the efforts of the Department of Health Care Access and Information, which received funding through the Children and Youth Behavioral Health Initiative to expand workforce for justice-involved youth, which will benefit the justice-involved population as a whole.
    - Advocating for a Forensic Peer Support Specialist Classification.
    - Inviting subject matter experts to Full Council meetings to present on strategies to promote cross-system education between mental health professionals and the justice system so that staff in these sectors know how to talk to and engage with one another.
- Expanding examine BH/JI data reporting by:
    - Leveraging the Public Health Meets Public Safety project to marshal publicly available data for presentation in an online dashboard to support policy and program development.
    - Expanding the Medi-Cal Utilization Project, which matches data from CDCR on individuals released from prison to the Department of Health Care Services' (DHCS) Medi-Cal enrollment and service utilization data.
- Continuing community engagement, which includes workgroup sessions on a variety of topics, CCJBH's Regional Lived Experience Projects and continuing to host special events.

- Celebrating CCJBH's 20th Anniversary by reflecting on accomplishments, and reinstating the Best Practices Awards (a memo was published to the Councilmembers to develop a process to reestablish this idea).

Councilmembers were presented with an initial plan for Full Council and Workgroup meeting dates and potential agenda content, as follows:

- Full Council Meetings, which will occur quarterly from 2:00 – 4:30 PM:
  - On April 29th, WellSpace will present on their Sacramento County Substance Use Respite and Engagement program, which aims to divert/deflect individuals who come in contact with law enforcement to treatment instead of booking them into jail.
  - On July 29th, CCJBH aims to have a presentation on workforce. The Department of Health Care Action Access and Information has been working on building out behavioral health workforce for the justice-involved population. CCJBH is also planning to invite Dr. Twitchell to present on strategies for preparing mental health professionals to work with justice-involved clients.
  - On October 28th, CCJBH will focus on housing, including Returning Home Well, the California Department of Social Services; (CDSS) Continuum of Care Expansion of Board and Cares, and tracking the DHCS BHCIP grants that will be awarded throughout the year.
- The Juvenile Justice Workgroup, which meets bi-monthly from 1:00 to 3:00 PM:
  - On February 11th, CCJBH staff present an update on the Juvenile Justice Compendium and Toolkit Request for Proposal. The Office of Youth and Community Restoration (OYCR) executive director, Katherine Lucero, will be presenting on her vision for OYCR.
  - On May 13th, CCJBH aims to have a presentation on substance use disorder (SUD) and mental health services on school campuses for justice-involved youth.
  - On August 12th, CCJBH will begin discussion on the annual Legislative Report Recommendations.
  - On November 11th, CCJBH aims to have a presentation on the juvenile hall to school transition, including school transitions and how school credits will be transferred once juveniles leave correctional facilities.
- The Diversion and Reentry workgroup, which meets bi-monthly from 1:00 to 3:00 PM:
  - On February 18th, Riverside County will present on their Whole Person Care Pilot and discuss their preparation for the transition to CalAIM for Enhance Care Management and Community Supports.

- On May 20th, CCJBH aims to have a presentation on diversion, the passage of SB 317, and misdemeanor diversion. This workgroup will continue discussions with Councilmembers and Department of State Hospitals (DSH) on felony diversion. CSG Justice Center is currently doing a learning collaborative with counties to expand the use of diversion and to track the expansion of DSH's work on an incompetent to stand trial solutions workgroup.
- On August 19th, CCJBH will begin discussion on the annual Legislative Report Recommendations.

Councilmember Discussion:

Secretary Allison suggested that Cal ICH present on the progress they have made since there is now a new collective group. She also suggested that a presentation be made on CDCR's Integrated Substance Use Disorder Treatment (ISUDT) program, including the Medication Assisted Treatment.

Dr. Kooler suggested that a connection be made in the April Full Council meeting to the 988 system that is being put in place that attempts to divert people from the criminal justice system to behavioral health treatment.

Judge Manley stated that CalAIM is a critical issue that we need to get on top of. He stated it is complicated, so we should devote quality time to get it in action. For the counties that have been able to lower the number of individuals in the jails during COVID-19, the numbers have since increased, and the proportion of individuals in the jails that reflect the population we are focused on is increasing. CalAIM gives us an opportunity to do something about that. It requires a great deal of coordination, collaboration, and willingness to change systems that have been in place for a long time. The Sheriffs and the Managed Care Plans are critical to this process. CCJBH can encourage a collaborative outcome to create a well-designed program.

Dr. Hobson stated that he would like to hear how other counties are handling SB 317. There seems to be confusion at the local level as far as who is responsible for what between the behavioral health and criminal justice systems.

Council Vote:

Vote: Motion to adopt the priorities outlined in CCJBH's 2022 Priorities.

Motion to approve the Vote: Judge Manley

Second: Christina Edens

Public Comment on Vote

Q: A participant asked if there is any way a family member can get mental health treatment in a crisis.

A: Ms. Grealish stated she'd be happy to talk with the participant offline.

Q: A participant stated she is excited about the work being done regarding homeless and housing prevention and the workforce development. The participant asked about the CARF (Commission on Accreditation of Rehabilitation Facilities) for the workforce development and stated that no one is talking about any training. The participant asked how much emphasis is being put on workforce development so there is not a return to recidivism, and so that there is also an increase in opportunities for housing.

A: Ms. Grealish stated she does not know what CERF stands for and requested that participant send an email providing more information to the CCJBH email account.

Ayes: 8
Nays: 0
Abstains: 0

The priorities outlined in CCJBH's 2022 Priorities were approved.

IV. DHCS' Presentation on the Behavioral Health Assessment Report

Tyler Sadwith, *Assistant Deputy Director of Behavioral Health, DHCS*

Mr. Sadwith stated he will be presenting information on *Addressing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (hereafter referred to as the assessment) that is designed to serve as a foundation for the steps that DHCS and the Administration are taking to expand access and improve the delivery of health care prevention, treatment and supportive services through ongoing initiatives, as well as forthcoming initiatives. DHCS, in collaboration with stakeholders, produced an assessment report on California's behavioral health care system. The assessment is a tool that is intended to be used for planning and implementation at the state and local level.

Behavioral health is a top priority of the Newsom Administration. The COVID-19 pandemic highlighted the need to invest in behavioral health services. The assessment is intended to guide the planning and the discussion process of the Administration's specific positions or plans. It provides a framework to describe the core continuum of behavioral health care services, which helps the reader of the assessment be able to compare what is currently available in California with what could or should be available. The assessment aims to review available data, including claims data, national data sets and insights from stakeholders and experts on the need for key behavioral health resources in the State. It is designed to support planning for various behavioral health initiatives, such as Crisis Services Planning, BHCIP, responses to new federal funding opportunities, and a Section 1115 Serious Mental Illness / Serious Emotional Disturbance (SMI/SED) Demonstration Waiver proposal to strengthen mental health service delivery across the continuum of care. The assessment is intended to explore issues for a few populations in focus, including children, adolescents and youth, the American Indian community in California, and the justice-involved population.

The core continuum of care is comprised of fundamental elements of a strong and effective behavioral health care system. It is based on national guidance in clinical and policy research, literature and expert opinion. It is important to highlight the key principles, which include beliefs that the behavioral health system and the resources in the State should be person-centered, with a full array of services and an emphasis on upstream prevention and community-based care and supports. There should be a specific focus on achieving equity, and the resources should be culturally responsive and evidence-based. There are eight categories of services in the assessment that are fluid and designed to reflect patient flow and patient use through the continuum: prevention and wellness services, outpatient services, peer and recovery services, community services and supports, intensive outpatient treatment services, SUD residential treatment, crisis services, and intensive treatment services.

Regarding prevention and wellness, the upstream parts of the continuum are not part of the conventional Medi-Cal insurance model, which is design to respond or treat a condition after it develops, but this is a key part of the vision for a person-centered continuum of care. The continuum includes outpatient services, peer and recovery services, and community services and supports.

The pillars of the continuum look like similar to traditional services. They are intensive levels of care and are available today through a variety of funding sources, such as commercial insurance coverage, Medi-Cal, Mental Health Services Act (MHSA) funding, block grant funding, and other State and local funding. The goal of the assessment is to pinpoint and develop granular data and highlight targeted opportunities to improve access to the services so they are available to every individual in every community. The $2.2 billion in BHCIP is crucial to establish/expand facility-based services, to invest in mobile crisis infrastructure, and to expand the continuum of behavioral health treatment resources.

There are major initiatives that the State is undertaking to improve access to behavioral health care. Contingency Management is an intervention for stimulant use disorder. It has the highest body of evidence for treating stimulant use disorders and it is associated with reduced use, abstinence, and increases in treatment and retention. DHCS is working with counties across the state to implement this as a pilot program within the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The State is preparing to submit a Section 1115 SMI/SED Waiver to federal partners at the Centers for Medicare and Medicaid Services (CMS), which will be crucial to maximize and leverage federal funding for inpatient mental health care, which is part of the broader expansion of community-based behavioral health services. The SMI/SED waiver will be the mental health corollary of the DMC-ODS, specifically the part of Section 1115 Waiver focused on expanding Medi-Cal funding and coverage for SUD. It will allow California to receive federal Medicaid funding for services provided, which are called Institutions for Mental Diseases, and which are historically excluded from the Medicaid program.

Over the past several years, the State of California has made significant investments to strengthen its behavioral health system. There are a number of new and planned Medi-Cal initiatives that draw on existing and enhanced federal funding opportunities and include unprecedented investments from the state. This assessment will be used to guide and support the ongoing planning and implementation efforts for all initiatives. It will be used to help facilitate a data informed process for developing future initiatives, as well.

The CalAIM Justice Package in the Fiscal Year 2022-23 (FY 22/23) Governor's Budget Proposals is foundational. The State funding, coupled with the federal financial participation for covering a targeted set of Medi-Cal services during the pre-release period, and other federal funding DHCS is requesting, will support start-up costs, planning efforts, capacity building for prisons/jails, county social services offices and behavioral health agencies, hiring and training staff, developing policies and procedures, and upgrading IT systems. It is a major investment to begin to better support the BH/JI population. The Foster Care Model of Care Workgroup was convened by DHCS and the DSS and provided key insights into opportunities for developing a model of care that is better designed to meet the complex needs of the foster care population. Other critical elements of the Governor's Proposed Budget include the Behavioral Health Bridge Housing, which is designed to meet the Community Supports aspect of the core continuum and address affordable supportive housing across the state; the Mobile Crisis Services, which will be implemented as a Medi-Cal benefit across the state and leverage limited-time enhanced federal funding to partner with stakeholders and design a mobile crisis services package that is interlinked and aligned with the implementation of the 988 National Suicide Prevention Hotline; and the Medication Assisted Treatment (MAT) Expansion Program, which is designed to continue building on the approximately half a billion-dollar investment to expand access to MAT and prevention, treatment, and recovery resources.

The assessment determined an overall snapshot of the current state of behavioral health care in California, including how it impacts certain communities and populations:

- Roughly 10 percent of the adult population has a SUD and 4.5 percent have a SMI (in the past 10 years the rate of SMI has increase by about half).
- There are inequities and disparities among children with SED, especially at the intersection of systemic inequality, which leads to Black and Latino children from lower income families experiencing higher rates of SED relative to other racial and ethnic groups.

Data is important for the State and stakeholder partners to design, plan and implement new services and ongoing initiatives, and to ensure they are reaching the target populations. The public health emergency has intensified stressors and impacted mental wellbeing for everyone and the impact will be felt for decades. Trauma leads to long-term physical illness and mental illness, and the pandemic led to various types of trauma, including death, stress from illness, unemployment, food insecurity, housing insecurity, and social isolation. National studies show that the pandemic is leading to

about 50 percent of adults and youth showing signs of anxiety and depression. The assessment found that the suicide rate has been rising among California youth over the past 10 years, and it is projected from preliminary data that the pandemic is playing a role in the increases in the suicide rate. Mental health crises that result in a trip to the emergency department have increased by about one-third for adolescents and teenagers. The justice-involved population experiences greater rates of chronic conditions relative to the general population including, but not limited to, behavioral health conditions. Approximately one-in-three adults in prison and one-in-four adults in jail received mental health services. CalAIM's Enhanced Care Management benefit, which Medi-Cal Managed Care Plans are implementing, includes the justice-involved population as a targeted population. CalAIM's Community Supports offers housing supports, housing navigation, and other non-traditional social services that are available through Medi-Cal. Ninety percent of incarcerated individuals meet Medi-Cal eligibility limits, and nearly 50 percent of individuals in California with SUD have Medi-Cal. Individuals with group health, commercial insurance, or individual marketplace insurance often face challenges in accessing mental health services, and more than 40 percent found it difficult to find a provider that accepted their particular type of insurance.

Mr. Sadwith reviewed key findings of the assessment with respect to the pillars of the continuum of care.

- Outpatient Services: There is a shortage of psychiatrists across the state and an inequity in terms of where they are geographically located. The rate of psychiatrists per 100,000 residents ranges from 1.6 in San Benito County to 68.1 in Marin County. The COVID-19 pandemic ushered an uptake in the use of telehealth as a modality for delivering covered services. DHCS updated its Medi-Cal service coverage and reimbursement policy to maximize flexibility for telehealth service delivery during the pandemic and is now assessing opportunities for sustaining those policies. California community health centers found that the total behavioral health visits remained virtually unchanged during the pandemic because in-person services were transitioned to audio, telephone, or video conferencing visits.
- Peer and Recovery Services: It is clear from stakeholders that it is critical to have peers available to individuals with behavioral health conditions. There is not a lot of data related to peer and recovery services in terms of claims data in commercial insurance or Medi-Cal. The DMC-ODS covers recovery services, but there is little utilization of that service in respect to other DMC-ODS services. It is difficult to determine if a peer was delivering a service or someone else. Some counties have been using peers to deliver services under the Specialty Mental Health Services delivery system, but it is still difficult to determine if the peer is administering the service. The Medi-Cal Peer Support Services benefit was approved by CMS and may be covered in the DMC-ODS and/or Specialty Mental Health systems, beginning July 1, 2022, for counties that opt in. DHCS

recognizes the importance of connecting individuals with behavioral health needs to someone with lived experience, especially if they are ambivalent about asking for help and engaging in treatment. Peers also help with care transitions and assisting an individual with attending an outpatient appointment after leaving the emergency department or residential treatment. The California Bridge Program has used behavioral health navigators extensively. Over 150 hospitals are implementing MAT services and using behavioral health navigators, which has approximately doubled the rates of follow-up and retention after an emergency department visit. DHCS leveraged and enhanced federal funding opportunities under the American Rescue Plan to invest $40 million in the California Bridge Program.

- Community Services and Supports: Affordable housing was identified as a key problem that impacts every single person in California. Housing supports were identified as a critical need, which include permanent supportive housing models based in the evidence-based services model with wraparound services that are provided on a flexible and voluntary basis. Counties are delivering full-service partnership services that do support and coordinate access to community services, which is a critical intervention that should be maximized and scaled as an opportunity for improvement. Sober living environments are a key opportunity, as well as long-term adult residential levels of care.
- Medication Assisted Treatment: MAT is the first line of care for opioid use disorder and has the highest body of evidence for improved patient outcomes. State policymakers have invested efforts in funding service coverage policy designed to expand access to MAT under the drug Medi-Cal program and DMC-ODS. DHCS recently clarified that every provider at every level of care in the DMC-ODS program, which covers about 97 percent of the State's 13 million Medi-Cal members, has to either offer MAT on-site or have an effective referral mechanism to another MAT provider for patients while they are receiving care. DHCS also published guidance on policy formation that allows MAT to be provided in clinical settings and non-clinical settings, such as street medicine or mobile. The State leveraged $500 million in federal funding through the MAT Expansion Project, which has helped to fund the California Bridge Program. DHCS has invested $15 million in the Tribal MAT Project, which has implemented a number of specific initiatives over the past four years that were designed in close partnership with key tribal and urban Indian stakeholders. The initiatives aim to expand access to culturally-centered opioid and stimulant use disorder prevention, treatment, and recovery resources that are specifically designed to align with tribal values and practices. CDCR has expanded MAT through the ISUDT program in the prison systems. There has been significant progress over the past five years, but there are still gaps in access. There are counties without access to narcotic treatment programs, which is a key opportunity for improvement. Provider education and culture change is another area for improvement. Counties and providers have shared that even if the

service is covered, there is still a lot of education among patients, staff, leadership, and providers to work through the ambivalence and hesitation around the role of MAT in SUD treatment.

- Mental Health and SUD Residential Treatment: Residential treatment coverage was expanded through DMC-ODS, but 70 percent of counties still report needing more residential service availability. The adolescent population is a particular demographic that has unmet needs at this level of care. The American Society of Addiction Medicine (ASAM) has proposed to remove level 3.3, which is designed to focus on individuals with cognitive impairments and cognitive limitations, because it is not prevalent throughout the country. ASAM is proposing to integrate the expectation of level 3.3 to ensure that providers have the capability to serve that population across all levels of care. Mental health care is more difficult to identify gaps because ASAM does not provide a national standard for mental health like they do for residential and inpatient services. DHCS heard from stakeholders that there is a shortage of mental health residential treatment, including sub-acute needs. The SMI/SED Demonstration Waiver will support counties to have additional funding available to expand access to care in residential and inpatients settings, as well as community-based settings.
- Crisis Services: The Substance Abuse and Mental Health Services Administration (SAMHSA) describes the crisis continuum of care as consisting of three pillars: crisis call centers, mobile crisis response, and crisis receiving and stabilization services. DHCS' assessment expanded this to include crisis respite, crisis residential, and sobering centers. CalHOPE is a warm line resource that has helped to implement specific warm lines for communities like the California Consortium of Urban Indian Health who operate a Red Line, which is a peer and counselor run warm line specializing in the American Indian and Alaska Native (AI/AN) population. Some of the crisis continuum pillars are being put into place through the federal legislation passed by Congress to implement the 988 National Suicide Prevention Lifeline. The California Governor's Proposed Budget for Fiscal Year 2022-23 included a proposal for mobile crisis to be covered as a Medi-Cal State Plan, and DHCS is looking to develop that service on a statewide basis in 2022. Currently, Medi-Cal covers crisis intervention services and does not prohibit them to be delivered on a mobile basis, so mobile crisis services are allowed under Medi-Cal, although they are not explicitly specified. There is variation across the State in terms of the availability of mobile crisis services and teams, whether they are billing Medi-Cal or using MHSA funding. The County Behavioral Health Directors of California administered a survey in 2021 that identified the number of mobile crisis teams in each county and determined if they were sufficient, not enough, or no mobile crisis teams in each county. DHCS plans to submit a State Plan Amendment for mobile crisis services to be covered under Medi-Cal. Mobile crisis was the first round of funding under BHCIP and DHCS set aside $205 million for counties, cities, and tribal authorities to implement or expand existing mobile crisis teams.

- Inpatient Services: There is a shortage of inpatient mental health care in California. Some counties have sufficient access; some counties have some inpatient mental health beds, but not enough for the general population; and some counties have no inpatient mental health beds. BHCIP has additional rounds of funding specifically dedicated to planning efforts, also called "launch-ready efforts," for acquiring real estate and building behavioral health care facilities, including inpatient mental health. The Section 1115 SMI/SED Demonstration Waiver will be another tool that counties can leverage.

The report discusses the behavioral health needs and corresponding services specific to three populations of focus: children and youth, individuals who are justice-involved, and the AI/AN population. There is a lack of residential treatment for adolescents with SUD and the assessment identifies a key opportunity for improvement. In an effort to meet the needs of justice-involved individuals, DHCS is implementing a number of initiatives through CalAIM. DHCS looks forward to receiving approval from CMS to be the first state in the nation to cover services for Medi-Cal eligible individuals inside a correctional setting. The AI/AN community experiences fatal opioid-related overdoes at twice the rate of other ethnic and racial groups. Intergenerational trauma and stressors are unique drivers of trauma in this community. Stakeholders have shared that there is a lack of opioid use disorder prevention resources specific to the youth population. DHCS has been able to prioritize increasing opioid use disorder prevention, treatment, and recovery resources for the tribal and urban Indian population through the federal opioid response money from SAMHSA. The Tribal MAT Project, described on the California MAT Expansion Project website, has implemented a number of initiatives to increase awareness of opioid use disorder in tribal communities, awareness about overdoses, address stigma, distribute Naloxone, ensure ambivalence around MAT is recognized and discussed, and provide resources to increase MAT in tribal health and urban Indian health programs in conjunction with the resources to promote community-defined best practices that reflect traditional approaches to healing and wellness.

The assessment highlights a number of key opportunities across the State to improve prevention services and treatment options:

- It is critical to have a comprehensive approach to crisis services that connects people to the community-based behavioral health care system and not the law enforcement system. County behavioral health agencies and mobile crisis share a vision for crisis that includes mobile crisis response teams that are available 24 hours a day, seven days a week, and 365 days a year, in conjunction with the 988 Suicide Prevention Awareness Crisis Call Line.
- Long stays in emergency departments, board and cares, hospital administration, and inpatient psychiatric stays exceed individual clinical needs and strain the delivery system. The root driver is a lack of affordable housing and supportive housing resources, which was identified in the assessment as a key opportunity for improvement. Wraparound supportive housing resources are a key resource

for avoiding emergency department visits, inpatient stays, long-term residential placements, and incarceration.

- The assessment highlighted an opportunity to meet the growing mental health and behavioral health prevention and treatment needs for children and youth, which are core goals of the ACES Aware Initiative, revisions to the Specialty Mental Health Services Medical Necessity Criteria, the $4 billion investment in the Children and Youth Behavioral Health Initiative, and the Foster Care Model of Care Workgroup.
- The assessment describes challenges and opportunities related to addressing disparities and ensuring that services are culturally responsive and meet the needs of people of different gender identities, sexual orientations, races, and ethnicities.
- There is an opportunity to capitalize on existing initiatives and ensure they can be expanded and available on a statewide basis. Evidence-based services should be delivered with fidelity to the service model. For example, Assertive Community Treatment and Forensic Assertive Community Treatment can be implemented with a focus on serving individuals with mental illness who have criminal justice involvement under the Section 1115 SMI/SED Demonstration Waiver.
- The assessment highlighted the need to better meet the social drivers of health, including housing and employment for justice-involved individuals, and diverting and preventing incarceration. It also highlights the need to ensure individuals who are transitioning from incarcerated setting into the community are meaningfully and closely connected and engaged with services and supports, which are the primary goals of the CalAIM Justice-Involved Initiative.

Q&A with Councilmembers:

Q: Secretary Allison thanked Mr. Sadwith for his presentation and stated that it is exciting to see the work being done to take care of vulnerable populations.

Q: Judge Manley asked when a response will be received for the Section 1115 Waiver and the request California has made.

A: Mr. Sadwith confirmed Judge Manley is referencing the 90-day pre-release services for the justice-involved population. He stated DHCS was hoping to get approval in December 2021 when CMS approve the majority of CalAIM, but it was not approved then. The approval letter stated CMS is interested in approving the waiver and DHCS continues to have productive and optimistic discussions with CMS.

Q: Judge Manley asked if there is a central location where all the funding opportunities that counties should be accessing to complete grant applications are listed.

A: Mr. Sadwith provided the website link for the $2.2 billion in funding grants through BHCIP and the California DSS' Community Care Expansion Program.

Q: Dr. Hobson stated it is an exciting and overwhelming time to be in county behavioral health with all the changes. Many counties have been struggling to locate inpatient psychiatric beds due to the discriminatory practice of not accepting people from jail in the psychiatric hospital. It is nearly impossible to get someone who is incarcerated in a county jail into a psychiatric hospital because they can't discharge to a jail, even when they meet the criteria for a psychiatric placement on a 5150 or a 4011.6. What is DHCS' position on how to address this? Will they use psychiatric health facilities or other institutions for mental disease?

A: Mr. Sadwith stated he does not have an answer at this time, but will investigate and reach out to DHCS' inpatient mental health provider stakeholders to learn more about the root drivers of the issue.

Q: Dr. Hobson stated in small counties, such as Plumas County, county behavioral health is the treatment provider in the jail. When it is not appropriate for someone to be in jail, the judge can order involuntary medication, but it is up to the physician whether or not they want to administer the medication. Since it is not a designated treatment facility, it is prohibited to involuntarily medicate an individual, which raises the question of competency and results in individuals being declared incompetent to stand trial (IST) because the county behavioral health department is not able to provide the level of care they need. This impacts the DSH, county behavioral health and the sheriff's department, and it is a discriminatory practice against a segment of the population. There needs to be oversight and follow-up.

A: Mr. Sadwith thanked Dr. Hobson for raising the issue and stated the SMI/SED Waiver will highlight and act upon the recommendations from the IST Workgroup, which is very important to this Administration.

Q: Ms. Fisher stated this report is what family members have been wanting and the money is there, but there is a workforce shortage to develop professionals who can support the programs. There needs to be a plan for where the beds are going to go because San Diego County recently released an article about how a plan was rejected for a particular community due to Not in my Backyard (NIMBY). A plan should be developed to facilitate the programs throughout different communities.

A: Mr. Sadwith stated local ordinances and zoning are issues and the Administration has tried to use the State's platform to mitigate local municipalities from preventing the expansion of buildings or service facilities. The beds are in the pipeline with the $2.2 billion in BHCIP and that is the core purpose of the investment. There is a behavioral health care workforce shortage and the State, counties, and the California Health and Human Services Agency (CalHHS) are aware of it and are currently exploring opportunities.

Q: Ms. Edens stated it would be helpful to have a "cross-walk" that outlines the gaps and pairs them with the recommendations from the assessment, as well as noting how and where the funding sources align and the different opportunities across departments. DSH is a small portion of the criminal justice and behavioral health

population with felony IST, but they have funding opportunities in the FY 22/23 Proposed Governor's Budget and past opportunities such as the Diversion Program and Community Based Restoration. It is incumbent upon us to be mindful of how to ensure efforts are not duplicated and that they are aligned in filling gaps. It is necessary to be strategic about funding. CSG Justice Center has done work in this space to create an inventory of ways a county could look to fund a particular strategy and it may be worth employing them to do more of that work to assist with planning.

A: Mr. Sadwith stated DHCS intentionally did not want the assessment to have a rebuttal for every opportunity for improvement because they did not want it to seem as if the issue was solved. The assessment was designed to highlight opportunities. Mr. Sadwith agreed that it would be helpful to have an inventory across the CalHHS departments, whether that comes from CalHHS or the California Health Care Foundation.

Q: Judge Manley stated Santa Clara County has a sobering center that they use as a triage center in the community for people who are mentally ill to avoid incarceration. He asked if the definition of a sobering center permits for behavioral health and mental health treatment, and transitioning into the community mental health system, or if its definition would preclude using the sobering center specifically for mentally ill individuals.

A: Mr. Sadwith stated it depends on how the facility is licensed or certified, and how they are trying to receiving funding. Under CalAIM, the Medi-Cal Managed Care Plans have the opportunity to cover sobering centers, which by definition are limited to individuals who are under the influence of a substance. Individuals with mental illness who are not inebriated or intoxicated would not be covered since it does not meet the service definition. Crisis intervention services and crisis stabilization services are covered under Medi-Cal, so if the services are designed for mentally ill individuals who are experiencing a crisis, that could be a way to bill it as a covered service and receive reimbursement. Counties operate mental health services funding and Mental Health Block Grant funding, which allows them the flexibility to use this money at their discretion and they could possibly fund a sobering center of the nature Judge Manley described, even if it doesn't meet the Medi-Cal definition.

Q: Judge Manley asked if a co-occurring client would be covered. Approximately 90 percent of the individuals are using drugs when they are not taking their medication.

A: Mr. Sadwith stated it would be covered under the Medi-Cal Managed Care Plan Sobering Centers Community Support Service if the individual is under the influence and has a co-morbid mental health condition.

Q: Judge Manley stated in Santa Clara County, and from talking to judges in other counties, oftentimes when an individual decompensates, the family does not want them to go to jail, so they take them to a hospital emergency room. The same is true with homeless individuals who are mentally ill. Judge Manley asked if these

individuals will be included when the system is fully developed. He stated there is legislation that requires hospitals to provide a meal, clothing, and transportation to a safe place for homeless individuals and asked if this will be built into CalAIM? People often go to the hospital emergency room because everyone is trying to avoid them, including the police who take them there. The emergency room will put the individual back on the streets within hours and then they end up back in jail, but the individual went to the emergency room voluntarily to seek help and ends up in jail. It is a cycle that needs to be addressed.

A: Mr. Sadwith stated crisis services are designed to address that issue, and the assessment called out opportunities to improve the various services and the crisis continuum of care. The $2.2 billion in BHCIP can be used by counties and cities that apply to build new facilities for crisis stabilization. This would be a place for individuals to go instead of the emergency department. Mobile crisis teams are also funded under BHCIP, which provides a hotline in the county to call instead of calling the police or going to the hospital. A peer with lived experience of mental illness and a licensed counselor will provide mobile crisis services and take the individual to a crisis receiving facility, if necessary. The expansion of mobile crisis response teams is funded under BHCIP and will be reimbursable under the Medi-Cal State Plan Benefit.

*****PUBLIC COMMENT*****

Q: A participant from ACCESS California/Cal Voices thanked Mr. Sadwith for his thorough presentation and referenced peer support in the report. Page 50 states, “at the time of this report, no data are readily available on the extent to which peer support and recovery services are available in California.” The participant stated this speaks to an opportunity for collaboration and sharing information. Through the Mental Health Oversight and Accountability Commission funding, Cal Voices was able to publish a report that was developed through hundreds of surveys and interviews with leadership and clients across the state, as well qualitative and quantitative research to determine the state of peer support in California. Since the passing of the Mental Health Services Act in 2004, counties are permitted to hire peers. It is important to utilize the voices of those with lived experience when creating plans moving forward because we are stronger together.

A: Dr. Kooler showed appreciation for Cal Voice’s partnership in the CalHOPE program and their work with peer outreach.

Q: Is DHCS working with DSH to include IST populations in the Justice-Involved Advisory Committee?

A: Mr. Sadwith stated DHCS is partnering with DSH in the Justice-Involved Advisory Group.

Q: For those counties that have sufficient mobile crisis teams, do we know what the response time would be with the current fleet of teams?

A: Mr. Sadwith suggested reading the assessment to see if that data is included.

Q: Can the DSH Diversion Project gain access to the Methamphetamine Contingency Management Pilot?

A: Mr. Sadwith stated the Meth Contingency Management Pilot is a covered service available under DMC-ODS. Currently 37 counties participate in the DMC-ODS system under Medi-Cal, so it would be limited to those counties that have opted into the Meth Contingency Management Pilot. In those counties, is it limited to Drug Medi-Cal (DMC) certified DMC-ODS providers that chose to participate in the pilot. Mr. Sadwith stated he doesn't believe DSH is a DMC certified provider so they would probably not be able to access the pilot.

A: Ms. Edens stated DSH allocates the funds to the county behavioral health, who are contracted to support that program. There are no restrictions in terms of allowing a county entity access to the Contingency Management Pilot and they could leverage it as a supplement or add to the services. The only restriction is that DSH requires a 10 to 20 percent match and the match source can't be from another state funded program, it has to be from local funds. Adding the Contingency Management Pilot to supplement other services and to create and operate a county diversion program would be okay.

A: Dr. Hobson speculated that most of the DSH IST funded programs are DMC-ODS counties since it is usually larger counties that contract with DSH IST. If they are DMC-ODS, then the Contingency Management Funds would be useful.

Q: How was the information in the regional survey translated and disseminated to the Asian Pacific Islander (API) communities in Los Angeles? Was there an outreach to local API nonprofits for assistance in reaching out to the older traditional folks in the API communities? Especially when incarceration is such a taboo issue within the API community. Was appropriate training looked into before this outreach? Mental health issues are a big taboo issue in API communities.

A: Mr. Sadwith stated there was a statewide presentation to share the assessment when it was published. If the individual can provide contact information, Mr. Sadwith will share more information about translation and specific outreach efforts.

Q: Mobile response is now being funded by county DHCS grants, MHSA Innovation funds, and city Coronavirus Aid, Relief, and Economic Security Act funding. Is there a chart that shows where CalAIM and the different funding sources (e.g., MHSA, Realignment, Federal Financial Participation) overlap and are singularly focused or can be used as matching and leveraging by combining areas?

A: Mr. Sadwith stated he is not aware of a chart that DHCS has produced. There are grant funding opportunities available through the State Budget, as well as through the Crisis Care Mobile Units Grant funding, which is designed for planning and implementing or expanding the team. Ongoing financing or sustainability can be accessed through Medi-Cal coverage for mobile crisis services, which is designed to

provide reimbursements for services provided by the teams that have been established by the grant funding. Counties can use MHSA funding, and other funding, to deliver the services to their residents.

V. Announcements

CCJBH's next Full Council Meeting is April 29, 2022, and will feature a presentation from WellSpace's Substance Use Respite and Engagement (SURE) program. The Juvenile Justice Workgroup will be on February 11, 2022, from 1:00-3:00 PM and the Diversion and Reentry Workgroup will be on March 4, 2022, from 1:00-3:00 PM. The third webinar of the Housing Recommendations Implementation Series will be held on February 24, 2022, from 12:00-1:30 PM and will focus on common practices for connecting to and using housing as a strategy for diversion and reentry.

Visit the CCJBH website for new information and sign up for the CCJBH ListServ to receive weekly emails with CCJBH business information and relevant work being done by partners and state agencies.

VI. Adjourn