CCJBH Full Council Meeting Minutes

Friday, April 29, 2022
2:00 PM - 4:30 PM
In-Person and Zoom Meeting

I. Welcome & Introductions:

Councilmembers Present: Diana Toche (on behalf of Secretary Kathleen Allison), Stephanie Clendenin, Stephen Manley, Danitza Pantoja, Tracey Whitney, Mack Jenkins, and Anita Fisher.

Councilmembers Absent: Tony Hobson, Dr. Kooler (on behalf of Michelle Baass)

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

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

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

Vote: Motion to adopt the January Full Council Meeting Minutes[1].

Motion to approve the vote: Judge Stephen Manley

Second: Dr. Danitza Pantoja

No public comment on vote

Ayes: 5
Nays: 0
Abstains: 1

The January Full Council Meeting Minutes were approved.

III. CCJBH Business Meeting

CCJBH has a new Research Scientist III, Kamilah Holloway. She previously worked in the Medi-Cal Behavioral Health Division at the Department of Health Care Services (DHCS), providing oversight and planning for network adequacy of county behavioral health plans (specialty mental health and substance use disorder services), as well as coordinating data collection and reporting for quality assessment and performance improvement.

[1] Councilmember Stephanie Clendenin was not present at the time this vote was taken.

a) Annual Legislative Report

Councilmember Anita Fisher held a walkthrough webinar of CCJBH's 2021 Annual Legislative Report on March 30, 2022. CCJBH staff have started drafting the 2022 Annual Legislative Report. It is anticipated the first draft of the report will be completed by August of 2022.

b) Mental Health Awareness Month

During the month of May, CCJBH will be hosting a series of Wednesday lunch-and-learn activities for Mental Health Awareness Month from 12:00-1:00 PM. The activities will start May 4th and occur every Wednesday thereafter. In addition, CCJBH will dedicate a section in the weekly newsletter for mental health resources. The itinerary of activities is reflected below:[2]

- May 4, 2022: CalHope
- May 11, 2022: Board of State and Community Corrections, Adult Reentry Grant Program
- May 18, 2022: Lived Experience Presentation
- May 27, 2022: California Department of Public Health – Office of Health Equity, Community Mental Health Equity Project

c) Juvenile Justice Workgroup

- The February workgroup featured a presentation from the Office of Youth and Community Restoration (OYCR). The presentation included an update on the progress of the workgroup, including background, organizational structure and the vision for the future.
- The upcoming Juvenile Justice Workgroup will be on May 13, 2022. The workgroup will feature presentations from three county programs, Los Angeles County, Glenn County, and Sacramento County, on the collaboration between probation and behavioral health to provide convenient behavioral health services to justice-involved youth to optimize successful outcomes.

d) Juvenile Justice Compendium and Toolkit Contract

The Juvenile Justice Compendium and Toolkit Contract was awarded to the RAND Corporation. The contract was executed on April 13, 2022. CCJBH and RAND will meet for a Contract Kick-Off Meeting in early May 2022. CCJBH staff will collaborate with OYCR throughout the duration of the contract.

Councilmember Discussion:

Q: Chief Mack Jenkins discussed the importance of following up on CCJBH's Juvenile Justice Recommendations in the Legislative Report. He stated the Council has been

[2] Note that the presentation schedule for CCJBH's Mental Health Awareness Month activities changed after this meeting occurred. The updated schedule is reflected in these minutes.

anticipating the creation of an office like the OYCR and is looking forward to seeing how the recommendations are addressed by the OYCR.

A: Ms. Grealish stated CCJBH has been working closely with the OYCR and thanked Councilmember Advisors, Chief Jenkins and Dr. Pantoja, for their help in developing the Request for Proposal and the concept of the evidence-based practices compendium and toolkit. The contract poises well for the OYCR and CCJBH has been having frequent meetings to support them as they grow. CCJBH has shared their Juvenile Justice Recommendations with the OYCR, along with the process on the recommendations.

e) Diversion and Reentry Workgroup

- The March workgroup featured a presentation by Dr. Judy Nightingale on Riverside County's Whole Person Care Program, which transitioned to California Advancing and Innovating Medi-Cal (CalAIM) on January 1, 2022. The program is designed to assist complex and high needs justice-involved clients. The presentation focused on the history of the program and highlighted successes and outcomes.
- The upcoming Diversion and Reentry Workgroup will be on May 13, 2022. The workgroup will focus on the implementation of SB 317, featuring the Council of State Governments (CSG) Justice Center, Judicial Council, county behavioral health, and the lived experience perspective.

f) Mental Health Diversion: Consultation, Technical Assistance and Policy Recommendations Contract

The CSG Justice Center is currently working to:

- Provide subject matter expert specialty consultation services and technical assistance to counties to enhance, sustain, and/or expand local capacity to successfully implement mental health diversion.
- Facilitate collaboration meetings to assess what is, or what is not, working within local diversion systems and examine impacts of COVID-19 on diversion efforts.
- Prepare a final report reflecting a proposed set of policy recommendations that identify next steps to support best practices statewide, which is anticipated in December 2022.

g) Medi-Cal Utilization Project (MCUP)

An initial project of MCUP will be to create a Data Match "Refresh" for the California Department of Corrections and Rehabilitation (CDCR) and DHCS for fiscal year 2019 and 2020. The MCUP analysis presented in the 2021 CCJBH Legislative Report will be expanded.

h) CCJBH's 2025 Goals

- Goal 1: The prevalence of Serious Emotional Disturbance / Serious Mental Illness (SED/SMI) is currently being reported.
- Goal 2: System capacity analyses is currently being reported.
- Goal 3: The behavioral health/justice system workforce analyses is in progress. CCJBH staff will work to create an operation definition, identify data sources, and develop metrics to analyze and follow trends of workforce capacity. The metrics will be reported.
- Goal 4: Improving outcomes for the behavioral health/justice involved population by leveraging data to inform policy through MCUP is currently being reported.

Councilmember Discussion:

Q: Chief Jenkins asked if Goal 1 is the prevalence of individuals accessing SED/SMI services.

A: Ms. Holloway stated the prevalence of SED/SMI in the criminal justice population for those coming out of prison and statewide is being reported.

Q: Chief Jenkins asked if we have the ability to identify those who are justice-involved in the database.

A: Ms. Holloway stated it is a measure indicator in that database.

Q: Judge Manley asked if the prevalence rate of individuals coming out of jail can be tracked.

A: Ms. Grealish stated there is no state repository for jail data.

Q: Chief Jenkins stated this data is a first step towards examining the parolees and individuals on post-release community supervision (PRCS) who might be utilizing services.

A: Ms. Holloway stated MCUP will utilize the data to expand and examine possible disparities and outcomes. The results of the analyses will be reported in CCJBH's 2022 Legislative Report.

Q: Chief Jenkins said a statewide database is needed from jails to know who has been enrolled and to have a central repository.

A: Ms. Grealish said there is also the option to go county-by-county to get data. The Public Policy Institute of California did a Public Safety Realignment study examining 12 counties that could be used as a model. Another option is to continue to track DHCS' data as they work through CalAIM and the justice-involved indicators. That pathway will work closely with jails to get people enrolled in Medi-Cal so that may be a potential source for data. CCJBH is also tracking DHCS' Population Health

Management work to stratify the justice-involved population at large throughout the state to ensure individuals are getting the services they need.

Q: Judge Manley suggested looking to the Board of State and Community Corrections (BSCC) because the sheriffs are required to report data and he has been concerned over recent years that the data doesn't reflect the reality. It may take legislation or a recommendation from the Council on CCJBH's Annual Legislative Report. It seems they have the data and it is a question of them collecting it appropriately and reporting out. If there were a mandate he believes there would be more success. The current data is very confusing and the CSG staff had difficulty determining how many people in jail are taking psychotropic medication or have been screened and assessed as mentally ill. The current data is not correct for the commitments.

A: Ms. Grealish stated CCJBH's 2021 Legislative Report did state that a statewide repository is needed to report on the data for the jail population, although it didn't explicitly mention BSCC. CCJBH currently uses the Jail Profile Survey, which is aggregate numbers. The 2021 Legislative Report stated that even though the data that are reported to BSCC show an increase in psychotropic medication use, it is not categorized into the reason for taking the medication. Psychotropic medication can be used for a variety of reasons and by individuals with mild-to-moderate mental health or SMI. The data are not as precise as we would need it to be to truly understand what portion of the jail population is mild-to-moderate, SMI, or co-occurring.

Q: Chief Jenkins clarified that the data is for people coming out of state prisons and asked if it will include individuals on mandatory supervision serving their sentence locally.

A: Ms. Grealish stated the data sharing agreement is between CDCR and DHCS. The data includes individuals releasing to parole and PRCS.

i) Public Health Meets Public Safety

Public Health Meets Public Safety is a two-year contact with CSG Justice Center to identify data that can be used to help inform policy making. The CSG Justice Center is currently working on the Data Dashboards and anticipate it will be completed in May 2022. In June 2022, the CSG Justice Center will work on developing a dissemination plan for the launch of the Data Dashboard, as well as develop Policy Briefs that capture the data presented in the dashboard. In July 2022, the CSG Justice Center will develop recommendations for a future strategy to sustain the work established through this contract. The dates are subject to change due to CCJBH extending their contract.

j) Lived Experience Projects (LEP)

CCJBH has four LEP contractors that work in the different regions throughout the state, as well as one statewide contractor. All of the LEP contractors have successfully submitted progress reports for the first quarter of year two. They will

participate in the upcoming CCJBH May is Mental Health Awareness activities. They will also continue to participate in the LEP Advisory Team meetings on a quarterly basis. The update for each region is as follows:

- Anti-Recidivism Coalition (ARC) (Central Region): ARC continues to provide workshops, trainings, and services to clients. ARC is in the process of developing a Digital Policy Toolkit.
- Cal Voices (Superior and Southern Regions): Disseminated a statewide stakeholder survey that will help inform policy and program activities. Cal Voices continues to host stakeholder convenings, roundtables, and provided a Peer Provider Workshop.
- Transitions Clinic Network (TCN) (Bay Area Region): TCN is in the process of completing testimonial videos that highlight the experiences of individuals who have behavioral health needs and are justice involved.
- Los Angeles Regional Reentry Partners (LARRP) (Los Angeles Region): L.E.A.D.E.R.S. continue to work on issues related to education, integrated health, and employment of individuals with lived experience. LARRP will be providing Public Speaking workshops for the L.E.A.D.E.R.S. to participate in.

CCJBH continues to work with California State University of Sacramento (CSUS) on a state-level LEP project. CSUS has completed the report on the findings and recommendations for the Lived Experience Hiring Solutions Workshop. The report is still in the review process and will be published once the review process is completed and approved. Upcoming, CSUS staff are working with CCJBH on a stakeholder engagement project to gather information on service delivery preferences for individuals with behavioral health needs who are justice system involved.

k) Forensic Peer Support Specialist Report

CCJBH continues to work on the Forensic Peer Support Specialist Report. CCJBH participates in the Medi-Cal Peer Certification Stakeholder Advisory Council Meetings held on a biweekly basis by California Mental Health Services Authority. CCJBH continues to track best practices for the implementation of a forensic peer support specialty.

l) Housing

CCJBH and CSG recently completed a five-part housing webinar series, *Building Blocks for Coming Home: How California Communities Can Create Housing Opportunities for People with Complex Needs Leaving the Justice System*, that took place from December 2021 to April 2022. The videos of the webinars are posted on the CCJBH website. The webinar topics included:

- *Building Partnerships Between Housing and Criminal Justice Systems in California*

- *Defining, Screening, and Assessing for Homelessness Risk*
- *Common Practices for Connecting to and Using Housing as a Strategy for Diversion and Reentry*
- *Developing New Housing*
- *Leveraging Rental Assistance and Supportive Service Funding for People with Behavioral Health Needs Leaving Jails and Prisons*

CCJBH continues to track the efforts of the U.S. Interagency Council on Homelessness, the California Interagency Council on Homelessness, the Housing and Community Development', as well as the California Department of Social Services' Community Care Expansion and DHCS' Home and Community Services Waiver.

m) Legislation and Budget Summary

CCJBH is continues to monitor the progress of 173 bills to advance mental health services for adults and juveniles in the areas of homelessness, access to behavioral health, workforce development, and Medi-Cal eligibility. A list of the tracked bills can be found on CCJBH's website.

Councilmember Discussion:

Q: Judge Manley inquired about the $1.3 billion investment for DHCS' Housing and Homelessness Incentive Program (H-HIP). He stated the plans were supposed to be developed at the local level and are due soon. He is concerned about the number of mentally ill individuals in the criminal justice system that are a part of incentive programs. These individuals need to be prioritized for housing assistance. He would like to see how many justice-involved individuals are in the programs that the counties plan to implement. Additionally, he would like to know how many individuals on parole and in Enhanced Outpatient Programs (EOP) are homeless when they are released. The general data from CDCR provides information on the percentage of individuals that are homeless in the total population. It is critical to know the number of EOP parolees because we need to prioritize that population for housing.

A: Ms. Grealish stated DHCS' H-HIP funding is part of the Coronavirus Relief funding that supports DHCS' Home and Community-Based Services Waiver. The waiver specifies that the funding is supposed to be used for a variety of populations, including justice-involved individuals with behavioral health needs. CCJBH gave feedback on the waiver and DHCS should be coming out with updated metrics, which CCJBH staff will track. It is a priority of our Council to know how many people from the behavioral health/justice-involved population will benefit from these new housing funding sources. In regards to the EOP data, CDCR is currently working on getting that data and many departments need that kind of information. It was a recommendation in last year's legislative report at a very high level, but we will try to be more granular in this year's report.

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

Q: A participant from Orange County's local Behavioral Health Advisory Board stated he appreciated the information shared here across the state. As a citizen, it is important that each agency see each other as customers, set each other up for success, and work together. It is disheartening to see the level of confusion and concern and that some agencies do not have the information readily available that they feel is necessary to do their job. It is often seen at the local level. There are state mandated boards and commissions that have Welfare and Institution Code responsibilities that allow them to do a lot on a consistent basis. It might be a way to delegate data capturing and would be helpful to citizens on local boards to have a state to county information flow. The participant cautioned that the CARE Court can't buy us out of a problem if the product isn't for sale. You can't have a workforce dependent strategy if there is no workforce to hire. Los Angeles and Orange counties have a 30 percent vacancy rate for behavioral health. Personal, private foundations, and private investment should be considered because they can get things moving more quickly and easily.

IV. WellSpace Health Presentation on The Crisis Receiving for Behavioral Health Program:

Jonathan Porteus, PhD, *Chief Executive Officer, WellSpace Health*

WellSpace Health's primary services are in Sacramento, Amador and Placer County. Historically, WellSpace Health started in the 1950's as a mental health and suicide prevention program, and over time it turned into a free clinic that evolved and blended into what it is today. In 2021, WellSpace Health served 125,000 people and encountered about 400,000, which equaled to 1,400 people receiving services per day. Of the population serviced, 100 percent were low income, 10 percent were uninsured, and 5 percent were unsheltered. WellSpace Health has a distinct honor serving this region. It also runs the drug court in Sacramento County and has partnerships with correction and public safety entities. The Crisis Receiving for Behavioral Health (CRBH) focuses on engagement, behavioral health and substance use. WellSpace Health is a suicide prevention program that serves 50 of the 58 counties. The suicide prevention lifeline will transition to 988 in mid-July 2022. A few years ago the federal government added mental health crisis to the suicide prevention line.

The program includes a strong infrastructure, using the framework of accreditation from a joint commission and providing cross-reference certification through patient-centered medical and behavioral health joint commissions. The current Medi-Cal status of patients who enter the program will be assessed to determine that the whole ecosystem of the client and family's needs are being addressed. WellSpace Health is subject to the oversight of the Substance Abuse and Mental Health Service Administration for their Federally Qualified Health Center (FQHC). The American Association of Suicidology is the accrediting body for crisis centers and there are 13 accredited crisis centers in California that make up the 988 network.

The clinical model of WellSpace Health's CRBH program is a strong belief in recovery across everything they do. Any service provided must ensure the client is getting the most out of the health recovery orientation. WellSpace Health has 21 Community Health Centers and the program tries to maximize what is happening inside of each one. Every site has licensed behavioral and mental health providers, in addition to coordinators who assist the providers in referring patients to services. There is also a telephone number that is provided to clients to contact a psychiatrist on call who can provide consultation. Most of the people WellSpace Health serves have chronic relapsing conditions, such as substance use disorder (SUD), so the system accommodates to that. If someone becomes psychiatrically unstable, there is a higher level of care that includes psychiatric nurse practitioners to step in.

The goal is to stabilize clients and get them on the right medications and on a road to recovery. If someone continues to decompensate, they will be referred to a higher level of care. The organization has a full continuum of SUD treatments, evidenced-based strategies for co-occurring mental health and SUD in residential settings, and an extensive outpatient SUD program that includes regular intensive outpatient services along with robust medically assisted treatment services. In addition, corrections and criminal justice has allowed advances in medication assisted treatments. WellSpace Health has a program inside the correctional facility for people to get monthly injections when reintegrating back into society so they are stable when they transition. After being released, they go to the Community Health Centers monthly to continue the injections and counseling as part of their reentry program.

There are urgent changes that need to happen in the next 90 days before the implementation of 988 to prepare for mental health crises responses. What the community needs is a system to receive individuals in crisis. There are too many people sent to jail or emergency rooms when they are in crisis. Oftentimes, these crises can be stopped or deescalated. There is a lot of opportunity in the community for a local dispatch system to help individuals who are in crisis get connected to services. Most clients just need a safe place to recover from their current crisis where they can be triaged to the next appropriate level of care. Law enforcement has been supportive of the work because this program has given them a quick option when they come across an individual in crisis. WellSpace Health has developed a three-minute drop off when officers drop off clients at the Community Health Centers. It changes the dynamic between law enforcement officers and clients because crisis receiving provides officers with a safe place to take clients that is not jail and lowers the stress level of the client and the officer. Crisis receiving allows everyone to work to the best of their abilities in the places where they are meant to be working.

CRBH provides short-term (4-12 hour) recovery, detoxification, and recuperation from the effects of sub-acute behavioral health crisis. It is staffed 24/7 with health care professionals to provide medical monitoring, SUD counseling, and connections to supportive services upon requests. Clients are transported to and from CRBH directly by authorized referral partners and WellSpace Health mobile response teams. Drivers

are trained in motivational interviewing to help clients move from one level of care to another. The importance of staff with lived experience is understood and promoted with the Community Health Worker certification program. There are former clients who now work for the program. CRBH does not allow walk-in care, clients must be referred from law enforcement or emergency medical staff.

All services offered at CRBH are offered 24/7 and are medically monitored. Services include:

- A bed or reclining chair
- Water, light snacks, shower, and bathroom
- SUD Counseling
- Mental health clinicians
- Case Management and Peer Support
- Enhanced Transportation

The Care Team is comprised of a program manager, administrative assistant, transportation technician, and maintenance technician, and there is a nursing station, which adds a sense of professionalism to the clinic. The CRBH facility is located next to Sacramento's main jail, converted from a FQHC, and includes 20 beds. CRBH is looking at ways to allow for individuals being released from jail in the middle of the night to be held at the facility until morning when probation staff can engage with them. It is difficult to assess whether an individual has mild-to-moderate mental illness or SMI when they are intoxicated, so it is important to give people an opportunity to stabilize before determining their psychiatric state. CRBH allows a space to gather data and triage people to the next appropriate level of care.

Data from October 1, 2020, to March 21, 2022, are as follows:

- 766 unique patients
- 1,937 sobering sessions, indicating that many patients returned for multiple visits
- 58% of patients intoxicated on alcohol and 28% under the influence of amphetamine
- 67% male and 33% female
- 57% White, 24% Black/African American, 13% Hispanic/Latino, 3% Asian Pacific Islander
- 21% of patients under 30, 49% between 30-50, and 30% over 50 years old
- 88% of patients had a safe and sober discharge
- 91% of patients were dropped off at their original pickup location
- 4% of patients were transitioned to more formal treatment

CRBH is an innovative program that welcomes people intoxicated on all substances, many of whom also have co-occurring mental health conditions. There are compassionate engagement and referral options for law enforcement and community-based providers for persons presenting a public safety and public health hazard who do not require jail or a hospital. The program implemented an effective method of engaging

patients who have not self-identified a need for SUD treatment services and streamlined a process of referral into withdrawal management and other treatment services if they opt in to longer term services. In the first quarter of 2022, 196 unduplicated patients completed 499 sobering sessions, which puts CRBH on track to double the engagement of the first year. The direct referrals for people who visit multiple times are increasing, demonstrating that the model works with harder to serve clients. Patients with acute alcohol intoxication tend to be older (30-49) and amphetamine intoxication younger (18-39). Among patients 18-29, there is a split between alcohol and amphetamines 39 percent to 35 percent respectively. The Drug Medi-Cal Organized Delivery System was able to examine the point of care decision criteria and modify the entry criteria to allow people to be referred straight to CRBH.

Critical supports in the community include:

- Withdraw management
- Residential and Outpatient SUD Treatment
- Medication Assisted Treatment
- Intensive Case Management
- Walk-In Primary Care
- Care Transitions Centers
- Partnerships with Law Enforcement, Providers and the City/County

Patient stories demonstrating success of CRBH:

- An intoxicated and psychotic patient was lying on the railroad tracks under a bridge. When the police officer showed up they were going to call an ambulance, but realized they were 10 minutes away from CRBH, so they asked if the individual wanted to go there to detox. CRBH gives police officers a safe place to drop off individuals in the community who are intoxicated and have them assessed for psychosis.
- A patient on crack cocaine, after his second referral into CRBH, requested co-occurring mental health and SUD treatment and was referred directly into a modified therapeutic community. He successfully completed this residential rehabilitation level of care.
- A “psychotic” patient brandishing a knife volunteered for CRBH after the police engaged him and peacefully disarmed him. The patient was actually in a state of acute amphetamine intoxication. After two hours at CRBH, the patient was transported to the hospital due to labored breathing and low oxygen levels. The patient never required incarceration and was instead provided the opportunity to stabilize up, get medical care, and receive a referral into outpatient care.
- A patient was referred to CRBH rather than the hospital with unknown substance use diagnosis. Once in care, it was determined that the patient was not intoxicated, but suffered from a serious mental health condition. The patient was supported through the psychiatric crisis and connected to an appropriate level of outpatient care.

- A woman with six children, all removed from her care due to ongoing drug use, was referred to the CRBH by the Sacramento County System of Care due to acute amphetamine and cannabis intoxication. During her 6 hour CRBH stay, the patient requested SUD treatment and was referred to a modified therapeutic community, where she remained at the time of this presentation.

The goal of CRBH is to get people into the appropriate level of care by identifying their motivation and having the right people engage at the right time. The program is not cheap, but it is more cost effective than other systems in place, and gives relief to police officers and the corrections system by providing a specialist the patient can be referred to 24/7. There is interest in expanding the program and offering 24/7 mobile crisis support. An alternative destination model is currently being explored that would allow emergency medical services to take individuals to a different setting, but this will likely require new legislation.

Q&A with Councilmembers:

Q: Chief Jenkins suggested Dr. Porteus write an article on his work as a resource for the behavioral health and criminal justice systems. The article would also help to launch dialogue on expanding the program. What level of engagement have you had with law enforcement leadership? It seems that law enforcement's role in this program is deflection, which is defined as law enforcement playing a role with individuals in the community who might be subject to arrest.

A: Dr. Porteus agreed that a component of the program is law enforcement deflection. One of the inspirations for the program was a model in Tucson, Arizona where individuals are allowed to flag down a police officer and request treatment and they are required to take them. WellSpace Health worked with the officers, chiefs, and senior leadership in the police department, as well as the undersheriff, probation, and state partners to develop the program. The program is focused on civil rights and making sure people are treated equally. If someone is intoxicated, they are going to fight, and someone who is frightened will react with whatever mechanism they are conditioned with. The goal of the program is to de-escalate by offering alternatives to arrest for the officers and a place to drop them off.

Q: Chief Jenkins asked if the percentage of individuals on probation or parole could be tracked in the demographics. He noted that there were 400,000 total encounters and 125,000 people served.

A: Dr. Porteus stated that is data for the health center and includes encounters with providers and with street nurses in the community.

Q: Chief Jenkins noted that 88% of patients had a safe and sober discharge and only 4% went into treatment. He stated that seems low and that there may be a higher percentage of individuals at other levels of treatment. There may be an opportunity to gather data from probation on individuals who engaged in treatment.

A: Ben Avey stated the primary referring agency is law enforcement and when the program first started the patients questioned whether they were being taken to jail or treatment. It has taken time to build trust within the community because the people being referred have not requested treatment, but once they complete the treatment they are coming back because they realize their wishes are being respected. This is a nontraditional referral pathway so the referral numbers are relatively low.

A: Dr. Porteus stated a new shelter was built in Sacramento to serve approximately 100 people, but was not able to serve many of the individuals who needed it because they were intoxicated. The sheltered started calling WellSpace to bring people to the sobering center for four to six hours, then bring them back to the shelter.

Q: Stephanie Clendenin stated it is heartening to see an alternative pathway and the program seems like something that would be beneficial for individuals to be diverted prior to being deemed incompetent to stand trial. Often times individuals with SUD or psychosis are detained for low level offenses and things escalate as they are taken to jail and they end up with felony charges. She asked if there is demographic data around the percentage of individuals that are homeless.

A: Mr. Avey stated the vast majority, approximately 98 percent, of clients identify as homeless upon arrival, but after conversations begin to take place it is determined that they do have family they can stay with if the staff can help them facilitate that conversation. Due to COVID-19, downtown Sacramento has been shut down, but it is anticipated that as things begin to open there will be more people leaving bars intoxicated who may need services. This has been a conversation around funding, especially with CalAIM, but CRBH is unique in that it is open to everybody regardless of insurance status, which is essential to being low barrier.

A: Dr. Porteus stated there are housing vouchers for people with SMI or SUD, but it is required that you have a diagnosis and a case manager to use the U.S Department of Housing and Urban Development (HUD) voucher. WellSpace Health is able to do the diagnosis, but CalAIM will be able to assign people a case manager if they are on Medi-Cal. This will allow the vouchers to be assigned to a greater number of clients.

Q: Judge Manley stated there is a similar facility in Santa Clara County that is located across from the jail and has 16 recliners. It started as a sobering center and is now a triage center that can hold patients for less than 24 hours. Are we meeting the needs of the community with the limited capacity? Should we have more centers located in different parts of the county? It is his opinion that we need either more centers or larger centers. In Santa Clara County, the facility is located in the center of the county and is not assisting law enforcement agencies in the southern part of the county because of the distance. In terms of demographics, the percentage of Hispanic/Latinx and Black/African American individuals being served doesn't seem to reflect the population. The white percentage is much lower than the combined ethnic population in the criminal justice system. What is the cost to the city and

county to operate the program on a yearly basis? He stated he realizes it costs less than jail and will yield better outcomes, but is curious about the total cost.

A: Dr. Porteus stated the yearly cost is $2.6 million for 20 beds. The cost includes two enhanced transportation teams, but does not include the 24 hour operating, it only includes some of the shifts. He agrees with Judge Manley's instinct that more facilities are needed and believes there should be regional facilities. Judge Manley's comment on demographics raised the question of whether there is a bias of who gets referred to the CRBH program. Dr. Porteus committed to determining whether there is privilege playing into who is referred to the program.

Q: Anita Fisher stated she has an adult son who received the majority of his mental health care for his co-occurring disorder in jails and prisons. She thinks the program is wonderful, but that there is not enough. What do you do with the overflow if there are over 20 referrals? Is this a harm reduction program?

A: Dr. Porteus stated it is a harm reduction model. They would love for people to move to abstinence quickly, but it is unrealistic to expect that. They do have multiple relationships with law enforcement, so there are some programs that are completely abstinence oriented, such as drug court or probation-based treatment programs. In terms of housing, WellSpace Health meets with HUD each year to request that some of the vouchers can be used for abstinence. The majority of vouchers are for the housing first model, which does effectively treat many people, but there are approximately 10 to 20 percent of people who are undermined in their recovery by the fact that substance use is allowed in the housing. When CRBH is full, they unfortunately have to say they are closed and can't accept any more referrals. If CRBH were able to expand to more sites, they would likely fill those spots as well because there is need in the community.

A: Mr. Avey said that harm reduction had to be expanded for CRBH to allow for individuals being referred to have a place to store their belongings. Upon arrival, an individual's belongings are placed in a locked box and the staff doesn't question what is included. If individuals think their paraphernalia is going to be confiscated they will not come in and a conversation to get them into treatment won't be able to occur.

Q: Dr. Pantoja stated Los Angeles County has three facilities because of the size of the county. What is the response time for the mobile crisis team to respond to a call?

A: Dr. Porteus said he is not sure of the exact time, but it is not more than an hour. There needs to be a solution to reduce the time, such as having more units.

Q: Dr. Pantoja asked what the messaging to the community is to call a mobile response unit rather than law enforcement. In her experience families in crisis in the home call law enforcement, which results in the youth entering the juvenile justice system.

A: Dr. Porteus said they don't currently market to the community because the program runs on temporary funding and CalAIM is still being sorted out. They are frightened

about putting themselves out there as the provider then having funding run out or having changes such as the ambulance being able to take individuals directly to CRBH.

A: Mr. Avey said the focus is to empower CRBH's 17 referral partners to have the conversation and create pathways for referrals. They are considering the connection between an individual calling 988 for crisis support and being referred to CRBH for services.

Q: Ms. Whitney asked what the maximum amount of time an individual is allowed to be in the program and if there is a legal requirement for them to be out in a certain amount of time.

A: Dr. Porteus said the time limit is 23 hours and 59 minutes. There have been discussions for clients to leave and come back, but they want to ensure the system is responsive and not becoming an upstream system.

Q: Ms. Whitney said Los Angeles' Urgent Care Center model has the same time requirements, but more services are always needed. She liked the mobile aspect of CRBH because Los Angeles' Urgent Care Centers only allow clients to enter by foot or from law enforcement. It is not ideal to have law enforcement transfer people and she was interested in the alternative destinations from paramedics and is hopeful the law can be amended to allow for that. Penal Code section 849 had to be amended to allow law enforcement officers to bring individuals to destinations to receive treatment instead of jail, but para-professionals are governed by different medical rules. In Los Angeles, there were individuals who were arrested and reported being homeless. The paper vouchers were found on their physical person, but they weren't able to access the housing. There was also a high rate of individuals losing the vouchers and not being able to get replacements.

A: Dr. Porteus stated being unsheltered is a risk factor for losing vouchers, but so is being intoxicated or psychotic. There was a case in Hawaii where a man was shot by police because he had broken into a house to get food, but he had $2,000 worth of food stamps in his pocket. An electronic system would be beneficial, but there is still the assumption that these individuals have the behavioral and cognitive ability to be able to use the resources. In some counties, the emergency medical services don't make money off their transports and they are often more inclined to considering alternative destinations. Crisis respite centers are an alternative placement for individuals who need more than 24 hours of service. They are typically staffed with individuals with lived experience and are connected through to the county infrastructure through Mental Health Service Act money. There are also crisis observation placements for individuals in need of more acute care.

A: Mr. Avey said the mobile crisis aspect of the program was a result of solving another problem. This type of service is nearly unanimously opposed by local communities so they ensured there would be no walk in's to the facility and that everyone would be transported in and out.

Q: Ms. Grealish asked if the Behavioral Health Continuum Infrastructure Program (BHCIP) funding has been considered.

A: Dr. Porteus said they have considered it and they could possibly get some of the program funded, but they want the program to be inclusive and the funding is for specialized populations.

A: Mr. Avey said WellSpace has over 100 unique programs and approximately half of them are in the behavioral health space. They are considering leveraging BHCIP funding to expand the residential treatment campus, but want to ensure that clients who come to CRBH are able to have their needs met. Currently they are funding about 20 different programs to meet the unique needs of clients.

A: Dr. Porteus said the program has a number of individuals in the CDCR Correctional Clinical Case Management System who benefit from structured treatment. The transition from incarceration can be difficult and lead to increased risk of recidivism, so a model similar to CRBH could be beneficial.

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

Q: A participant asked how much money it took to stand up the program. They also stated Orange County has a similar program called Be Well. That program ran into a problem with ambulances bypassing the facility to go to a closer emergency room. The participant asked if the program is next to the jail or if it is part of the FQHC.

A: Dr. Porteus stated the facility just happens to be next to the jail.

Q: The participant asked if a similar facility could be developed with a FQHC and get funding through any currently available funds.

A: Dr. Porteus stated he is not aware of any funding for all the people being served at CRBH. Sobering centers will be a billable service under CalAIM, but it will be up to the plan to determine the criteria for a sobering center.

Q: The participant asked if the Joint Commission opened the facility to private and public health insurance reimbursement.

A: Dr. Porteus stated the program doesn't currently get reimbursement. They accept everyone who walks in and are trying to determine where funding streams will be. They anticipate approximately a quarter of the funding coming from CalAIM. In terms of start-up costs, CRBH was able to use an existing FQHC and only had minor renovations, so the start-up costs was relatively low compared to other programs. The program was opened in three months and they did not receive funding for the start-up costs.

V. Announcements

CCJBH's Juvenile Justice Workgroup will be held on May 13, 2022, from 12:45-2:45 PM, and the Diversion and Reentry Workgroup will be held on May 13, 2022, from 3:00-5:00 PM. The next Full Council Meeting will be on

Friday, June 29, 2022, from 2:00-4:30 PM. All meetings will be hybrid meetings, with both in-person and virtual capabilities.

VI. Adjourn