CCJBH
Council on Criminal Justice and Behavioral Health
20 YEARS of building bridges to prevent incarceration

CCJBH Full Council Meeting Minutes

Friday, July 29, 2022
2:00 PM - 4:30 PM
Zoom Meeting

I. Welcome & Introductions:

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

Councilmembers Absent: None.

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

Brenda Grealish welcomed participants to the meeting and gave an overview of the agenda. Ms. Grealish stated Senate Bill 189 was added to Government Code Section 11133, which allows "*a state body to hold public meetings through teleconferencing and make public meetings accessible telephonically, or otherwise electronically, to all members of the public seeking to observe and to address the state body, subject to the notice and accessibility requirements in subdivision (d) and (e),"* and will remain in effect until July 1, 2023.

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

Vote: Motion to adopt the April Full Council Meeting Minutes.

Motion to approve the vote: Judge Manley

Second: Chief Jenkins

No public comment on vote

Ayes: 9
Nays: 0
Abstains: 0

The April Full Council Meeting Minutes were approved.

III. Healthcare Workforce Development

James Regan, *Assistant Deputy Director of Healthcare Workforce Development, California Department of Health Care Access and Information (HCAI)*

The *California Future Health Workforce Commission Report*, produced in 2019, outlines the strategic vision for health workforce in California guided by three strategies. HCAI uses these strategies to guide all their program activities, including the behavioral health initiatives discussed in this presentation. The *Health Workforce Strategies for California: A Review of the Evidence*, produced by the California Health Care Foundation in April 2021, provides a representation of the portfolio of programs administered by HCAI in relation to health workforce. An individual's career timeline when pursuing a health profession is enhanced by the programs HCAI offers along the way (e.g., career fairs, initial training or education, scholarship programs, organization grant opportunities to higher education institutions or clinical organizations, and loan repayment). For financial support, HCAI has five organization grant programs, six individual scholarship programs, and seven loan repayment programs. HCAI houses California's Primary Care Office and has recently inherited the State Office of Rural Health from the Department of Health Care Services. Additionally, HCAI designates health professional shortage areas by partnering with federal agencies and designates medical service study areas to measure and track outcomes. HCAI has recently established the Health Workforce Research Data Center, which will serve as a central repository for health workforce data in California in order to measure supply and demand by profession, geography, and other demographics over time, etc., to understand the areas of greatest need and target support accordingly. HCAI has recently launched the Health Workforce Education and Training Council, which is an 18-member Council of experts across the health, public health, and public policy areas.

In 2021, HCAI, in partnership with many other state and local partners, launched the Children and Youth Behavioral Health Initiative (CYBHI) to increase access to high-quality, culturally and linguistically coordinated, behavioral health services for children and youth across the state. The investment for broad behavioral health workforce in the CYBHI will improve access to and quality of behavioral health services by increasing the number of behavioral health professionals and evolving their training to better meet youth needs. The creation of a behavioral health coach workforce will augment the behavioral health workforce and increase availability of behavioral health services for youth and expand the career ladder for individuals pursuing behavioral health careers. Specifically, HCAI's CYBHI Workforce Program will support:

- Substance Use Disorder (SUD) Practitioners to expand the SUD workforce through education and training experiences.
- Psychiatry and social worker's educational capacity to expand on existing programs, such as psychiatry residency programs and psychiatric mental health nurse practitioner training programs, as well as launch new programs to support social work stipends and training hours.

- The Behavioral Health Workforce Pipeline Program is designed to make sure that opportunities and pathways in the behavioral health workforce are clear and to support the awareness and education around behavioral health professions.
- The Behavioral Health Coach role is still being established through stakeholder engagement. There are opportunities to participate and give feedback on the draft model, education and training requirements, supervision, etc.
- Train New Trainers is a fellowship scholarship that HCAI has hosted for a while to train primary care practitioners in psychiatry and will expand to include more advanced SUD training for existing professions in the primary care workforce.
- Peer Personal Training and Placement Program is a crucial support for individuals with lived experience to share their experience and support and expand peer personal training and placement across California.
- SUD Workforce support through the existing Allied Health Scholarship Program to provide scholarships for SUD certification, as well as a number of programs under development. The Earn and Learn Program will provide education and paid apprenticeship experience to SUD counselors. The Train New Trainers Model will be adopted to the SUD space to offer grants to organizations that provide training to non-provider professionals who work with or come into regular contact with children and youth. Finally, the Recruitment and Retention Grant will be used to support the recruitment and retention of SUD professionals through organizational grants.
- The CYBHI Justice and System-Involved Youth work stream. Preliminary ideas include using the Train New Trainer Model to train existing professionals that serve children and youth in foster care, homeless, and justice systems; enhanced training on effective behavioral health strategies with justice and system-involved youth; and grants to organizations to provide training to child welfare workers, probation officers, juvenile camp staff, community-based organization staff, etc.

Q&A with Councilmembers:

Q: Chief Jenkins asked for clarification on the age range of youth involved.

A: Mr. Regan stated that, in the context of the CYBHI, the age range is 0-25.

A: Chief Jenkins stated, from a criminal justice standpoint, that covers two completely different systems. The juvenile justice system stops at age 17 and the transitional age youth system is from 18-25. The literature around 18-25 year old males applies equally to the juvenile justice system and the adult system.

Q: Chief Jenkins asked if HCAI's work on SUD training includes the justice-involved population, specifically.

A: Mr. Regan stated it does not currently, but the point of the work stream is to support behavioral health services, including SUD support, for system-involved children and youth.

Q: Ms. Fisher shared that National Alliance on Mental Illness (NAMI) San Diego was a recipient of the Peer and Personnel Training contract when she was the Education Director. The contract is now in phase two and has successfully trained individuals with lived experience to work in behavioral health throughout California.

Q: Judge Manley asked how substantial the scholarships are and what the terms are for loan repayment to try to recruit more individuals to enter the behavioral health field.

A: Mr. Regan stated the scholarships range from $20,000 to $105,000, depending on profession. The higher scholarships are awarded to independent practitioners, and then are tiered to license-level professionals and certified professions. Over 100 health workforce professions are supported across all of the scholarships.

Q: Judge Manley asked what the scholarship amount is for individuals who work in the community, such as case managers or SUD counselors.

A: Mr. Regan stated it is approximately $15,000 to $20,000 for SUD counselors.

Q: Judge Manley asked, what are the top shortage areas that HCAI has identified?

A: Mr. Regan stated HCAI works with federal partners to designate health profession shortage areas, which are categorized into the main health professions. The areas are based on federal guidelines and measured by geography and ratio-to-population. The goal is to provide more resources to assist and increase the health workforce and access to care in areas with fewer practitioners and higher shortages. The highest shortages are in psychiatry and social work, but there are shortages all throughout California. HCAI hopes to reduce the shortages through the new Health Workforce Research and Data Center, which will include software infrastructure for data collection and reporting to provide consistent data products from research. HCAI has partnered with the Department of Consumer Affairs to get data on licensed professions, as well as other departments who play crucial roles in certifying different health professions.

Q: Dr. Hobson asked what is being done with educational partners to equip postsecondary educational institutions to prepare students to work with Medi-Cal beneficiaries and individuals with co-occurring disorders.

A: Mr. Regan said that is part of the work being expanded through the new Health Workforce Education and Training Council, which is comprised of representatives of California Community Colleges, California State Universities, and Universities of California, as well as experts across healthcare and behavioral health fields. The Council will examine ways that training and education can prepare practitioners for the real world and examine the capacity to train individuals in different fields, effectively increasing the quality and quantity of expertise. The Council will also examine the cultural concordance and diversity of practitioners by supporting current programs to increase workforce diversity, such as the Song-Brown Healthcare

Training Workforce Program that supports post-graduate training slots for select professions.

Q: Dr. Hobson suggested that HCAI consider something similar to the Title 4 Program for mental health professions, which requires social workers to work with a designated population for a number of years to pay for their schooling.

Q: Ms. Grealish stated the work HCAI is doing to make data and information more accessible and readily available is wonderful. Are there currently any reports published on the information being collected for behavioral health workforce?

A: Mr. Regan stated HCAI is hoping to have initial data products available by the end of the calendar year. The data system just launched in July 2022, so they need to ensure the reporting capabilities are in place.

Q: Ms. Grealish stated CCJBH has established four goals to achieve by 2025, and Goal #3 is ensuring there is sufficient workforce across the different sectors that serve our population, so these data will be very helpful in tracking behavioral health capacity. We will also be able to use these metrics to ensure people are getting the right training to work with the justice-involved population. CCJBH is working with individuals with lived experience to better understand if they are accessing job opportunities within the behavioral health and criminal justice spaces and has found there are often barriers to hiring the justice-involved peer population. Is HCAI currently doing any work in that space or planning to do so?

A: Mr. Regan stated HCAI is doing work on peer personnel and SUD, and they often partner with the Department of Health Care Services (DHCS) who are the experts in that area.

Q: Judge Manley noted that the start of the target age for the CYBHI is 0 years old and asked how many of HCAI's initiatives are aimed at professionals who work with children in pre-transitional kindergarten or pre-kindergarten. He stated he has become increasingly concerned about the ACE scores and the reporting on children who had a lack of support when they were three or four years old.

A: Mr. Regan stated the goal is to provide high quality care regardless of age. The CYBHI is targeted at practitioners who are serving an audience of 0 to 25 years old. There are unique needs in the early childhood years of 0 to 5, some of which may include behavioral health services for new parents or guardians who aren't used to the unique early childhood needs.

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

Q: A participant asked who they can contact regarding getting involved with peer personnel under HCAI as a person with lived experience and some peer support training.

A: Mr. Regan stated they can reach out to CYBHI@hcai.ca.gov for questions on CYBHI or general questions regarding peer support.

Q: A participant asked if student loan repayment assistance is available for individuals with a Masters of Social Work (MSW) who work for Federally Qualified Health Centers (FQHC), but are not doing behavioral health therapy and are not licensed.

A: Mr. Regan stated he believes so and that is something being discussed with the CYBHI funding dedicated to helping social work workforce. One of the key components of the loan repayment programs is that the individual agrees to a service obligation in a shortage area for two to four years, which is a dual strategy to provide financial assistance to someone entering the workforce or scholarships to get there. The program hopes to reduce the shortage of practitioners in certain geographic areas and awardees often get places in community settings, such as FQHCs. There are currently MSW scholarship opportunities, and HCAI is in the process of developing a MSW loan repayment opportunity that should be released within the next four to six months.

Q: A participant asked if Mr. Regan is aware of a San Diego study that shows an 8,000 position mental health shortfall and the county relationship with feeder schools in that area. Have any considerations been given to county unions to allow more flexibility so licensed people do not have to be burden with administrative requirements rather than specifically be direct services providers to achieve higher pay (e.g., private companies have wide pay bans to allow laterals and retain key subject matter experts).

A: Mr. Regan stated there are a wide variety of county relationships with various schools of behavioral health and mental health in counties and it isn't necessarily something HCAI is always involved in. HCAI does want to explore all avenues to reduce barriers as part of the CYBHI Workforce Initiative. Ultimately, the administrative services are always going to be necessary for care coordination, as well as direct services, so HCAI offers a variety of programs to serve both.

Q: A participant stated they were recently denied their license from the Board of Behavioral Sciences due to a crime that was committed 32 years ago. As an African American man, they feel it is important to be available to individuals who have had similar experiences and the crime is an immutable fact. They currently work as a clinical case manager, but are stuck with student loans and not able to get their license. Is there any recourse?

A: Mr. Regan stated HCAI doesn't have purview over licensing and it seems like the individual should explore options with the Board of Behavioral Sciences.

Q: A participant asked for additional information on HCAI's workforce retention and licensure support, specifically for Licensed Clinical Social Workers (LCSW).

A: Mr. Regan stated that HCAI has been hearing from MSW programs across the state that there are often limits to the number of master students they can support, so HCAI has provided grant funding to increase the number of acceptances into the MSW program. Additionally, there are high requirements, including approximately 3,000 clinical hours required to get from MSW to LCSW status, which has been identified as a barrier because the clinical hours are often unpaid. HCAI is considering financial support through organizational grant awards or stipends to assist postgraduate MSWs in obtaining their clinical hours towards licensure. HCAI is also considering paid apprenticeships for graduates of MSW programs to get real world experience from a veteran LCSW.

A: A participant added that MSW clinical hours are often unpaid because people want to work in private practice psychotherapy. There are many behavioral health jobs for unlicensed MSW clinicians who are obtaining their hours.

Q: A participant asked if HCAI is participating in the Open Data Portal to make it easier to see county-level data, and asked if there is a list of current reports submitted to the Legislature to level-set collaborators while HCAI develops a better data system.

A: Mr. Regan stated HCAI does have a variety of data reports posted on the Health and Human Services Open Data Portal, but there is not much on workforce yet.

IV. Criminal Justice and Behavioral Health Collaboration to Address the Needs of the Justice-Involved: Curriculum and Training to Build Workforce Capacity

Mack Jenkins, *Councilmember, Council on Criminal Justice and Behavioral Health*
Geoff Twitchell, *PhD, Assistant Clinical Professor, University of California San Diego*

Throughout his career, Chief Jenkins had learned a lot about the justice-involved population, including the fact that a significant percentage have behavioral health issues. When he became Chief for San Diego County, he created a Behavioral Health Treatment Director position, which was filled by Dr. Twitchell. The position represents the collaboration that must exist between probation and behavioral health to effectively serve the population. The San Diego Treatment Director provides department training on trauma, and developed a Juvenile Trauma Responsive Unit; assists in teaching and enhancing officer intervention skills; informs agency policy on youth/adult interventions and evaluates programs for future system decision making; and helps build interagency relationships between probation, behavioral health providers, and community-based organizations. Key takeaways of the partnership include:

- The evolution of the criminal justice system through research and science in behavior change results in the possibility of robust decreases in recidivism.
- The criminal justice and behavioral health disciplines have distinct cultures, philosophies, expertise and perspectives necessitating deliberate and careful bridging.

- Collaboration produces the best client and community outcomes benefiting public safety and public health. Through interface and integration with the behavioral health community, criminal justice partners learned that many treatment providers were at a loss for working with the justice-involved population.

The timeline to develop the collaboration between criminal justice and behavioral health displays the significant evolution of both fields. Recently the systems began to routinely come together to treat the BH/JI population. In 1990, criminal justice researchers in Canada developed the Risk Need Responsivity (RNR) model, which outlines the principles of effective intervention and can produce reduction in recidivism up to 30 percent when applied routinely and with fidelity to the model. From 2011 through 2014, there was a period of change with Public Safety Realignment, through AB 109, Behavioral Health Realignment and implementation of the Affordable Care Act. Public Safety Realignment slowed the revolving door of parolees with the increase of community probation supervision, and mandated the criminal justice system to rehabilitate individuals and address behavioral health issues, but this was not the criminal justice system's scope of practice. The implementation of the Affordable Care Act in 2014 created a new population of single men who were eligible for Medi-Cal benefits and involved in the justice system, and necessitated the criminal justice and behavioral health system collaborate together. In the last year, there has been an emergence of a variety of initiatives, such as CYBHI, CalAIM and CARE Court, which will make the systems more comprehensive and address more social determinants of health (e.g., housing, employment, and food insecurity).

There is a shared application of the RNR model in a criminal justice and behavioral health collaboration. The criminal justice system has evolved through the incorporation of knowledge gathered through research and the application of science-based principles of behavior change. In addition, there is now more knowledge regarding interventions that address behavioral health issues found in a justice-involved population. Employing research and science-based interventions requires a symbiotic partnership between supervision and treatment. The criminal justice system has six principles of evidence-based effective interventions. The evolution of criminal justice is focused on behavioral change, not just on disposition and punishment, and aims to change behaviors that are labeled as criminals. The interventions include risk assessments to determine recidivism risk, enhancing motivation, focusing on behaviors and attitudes by targeting specific behaviors and teaching new skills, rewarding change by using positive reinforcement, supporting community partners utilizing resources in the community and evaluating by tracking outcomes. The issue is not accountability or treatment, the focus must be both. Collaboratively, applying the RNR model is a part of the evolution of the criminal justice system.

The criminal justice supervision model in RNR collaboration has three aspects.

1. Risk: The balanced approach model is applied to identify which individuals need to be served.

2. Need: Includes screening for what criminogenic needs need to be addressed through criminogenic risk and needs assessments.
3. Responsivity: Addresses criminal factors such as attitudes and behaviors and how service providers should intervene. This aspect uses cognitive based interventions. At this part, it is important to communicate and coordinate with behavioral health partners to best serve an individual in the criminal justice system.

The behavioral health system has its own definitions of the aspects in the RNR model. On the behavioral health side, “risk” recognizes the difference between recidivism risk and psychiatric risk, as well as the overlap. Both factors together guide appropriate grouping of individuals for safety and best outcomes. The “need” aspect identifies the clinical needs and diagnosis through clinical assessment. Reducing recidivism and further criminal behavioral becomes part of the treatment and recovery goals. The “responsivity” addresses the “how” through cognitive behavioral therapy (CBT) and psychological and medical interventions. Criminality joins mental illness as a treatment target, as necessary, and there is close communication with criminal justice partners.

In collaboration of criminal justice and behavioral health entities, the following checklist ensures proper care:

- For decision-makers, there must be a formal relationship that exists between the supervision agency and behavioral health agency. Information-sharing must be sufficient for Collaborative Case Management between supervision and providers. There needs to be sufficient interdisciplinary trainings in place to promote and sustain collaborative relationships between supervision officers and behavioral health providers. The criminal case continuum must include criminal risk assessments, a mental health and SUD screening, and a clinical assessment, along with coordinated case planning.
- For line-level officers, there must be a seamless relationship with the behavioral health providers in the jurisdiction; refer or provide criminogenic treatment; complete a criminogenic risk and needs assessment, and share the results with treating behavioral health providers; develop case plans that identify and target criminogenic needs; share supervision case plan goals with behavioral health providers; and address general and specific responsivity needs.
- For clinicians and treatment providers, there needs to be a seamless relationship with community supervision in the jurisdiction. These providers must complete a clinical assessment and share that information with supervision partners; develop treatment plans that address both clinical and criminogenic needs; share treatment plans with community supervision partners; address general and specific responsivity needs; and ensure integration in instances where there are multiple plans with supervision partners.

The criminal justice system uses the balanced approach to supervision, and RNR is part of the science and ongoing evolution in criminal justice. Collaborative Case

Management is a best practice and necessary for comprehensive client care. The criminal justice field is evolving and collaboration is key. The effective application of RNR requires a collaboration between criminal justice and behavioral health for success and client safety. Effective collaboration requires specific steps are taken by service providers. There are many misconceptions about mental illness causing criminal behavior. Mental illness is not a direct cause of crime, symptoms rarely cause crime, psychiatric services can help reduce crime (but alone is not sufficient to do so), and specialty supervision and psychiatric treatment reduce recidivism.

Training providers is important to fill the gap in service for the justice-involved population by building community workforce capacity. In San Diego, criminal justice and behavioral health providers collaborated and utilized the inter-professional collaborative practice core competencies to create the Justice Involved Services Training Academy (JISTA) curriculum. There are four competencies that can be used to help to train different professions to work collaboratively, productively and effectively, which are: 1) values and ethics for inter-professional practice, 2) roles and responsibilities, 3) inter-professional communication, and 4) teams and teamwork.

JISTA includes six days of training over a three-month period of time. The first day provides an overview of the justice system, and the second day discusses communication, collaboration, best practices, Whole Person Care and RNR. The third day includes training on treatment planning, group selection and composition, group work, and criminogenic needs and responsivity and the fourth day is an overview of understanding criminal thinking, evidenced-based practices in conducting groups and selecting and utilizing evidenced-based curricula. The fifth day of the academy discusses change management, change agent and staff development, and the final day of the academy includes presentations of capstone projects and graduation. JISTA was designed in a small group seminar format, with an emphasis on skill building in order to change attitudes within the culture while walking away with skills to implement. The academy includes a CBT format to successfully work with this population. It is limited to 15 treatment programs at a time and includes an administrative lead and frontline supervisor clinician, for a total of 30 for participants per cohort. The academy builds a shared foundation of knowledge in the community, develops workforce skills specific to the unique and complicated needs of the population, and prepares participants to successfully implement reasonable change in their program that fits the best practice model.

Data available from the first two cohorts of participants showed that all ten items of the self-knowledge, self-report items moved in positive directions after having gone through the training academy in all four competency areas. The overall satisfaction of the training and the trainers were relatively high. Qualitative data was also collected through participant feedback throughout the training. Formal focus groups were held after each of the cohorts completed their training, which found that the participants had a new respect for each other’s skill set, and recognized each other's strength and importance in the field. This is significant because working in public safety and behavioral health

collaboration requires trust, and these breakthroughs showed that there was less suspicion of motives, a common language that they could share, and a model that they could work from together.

The presenters suggested conducting interagency training in order to demonstrate priority of system leadership, and that agencies should:

- develop or acquire curriculum and trainers
- develop an implementation plan for the community
- conduct interactive skill-based experiential training using IPC competencies
- introduce evidence-based language and guidance in treatment contracts
- evaluate program fidelity to principles of effective intervention, and
- provide ongoing technical assistance and booster training for improvement and sustainability.

The six takeaways of the program are:

- Clients are shared by both the criminal justice and behavioral health systems. There is an increasing overlap and a necessity for effective partnering to address multiple, complex and unique needs of the justice-involved population.
- Cultural differences must always be considered. There needs to be deliberate acknowledgment and skillfully directed discussions to bridge the distinct cultures and philosophies of criminal justice and behavioral health to further collaboration.
- Collaborative Case Management is the lynchpin for sustainable partnerships that result in comprehensive client care.
- Utilizing the Inter-professional Collaborative Practice (ICP) model provides a framework for knowledge and skill acquisition, and facilitates further appreciation of discipline-specific culture, attitudes and perspectives.
- While criminal justice evaluation has naturally led to many collaborative efforts, partnering with behavioral health in training optimizes acceptance and legitimacy within the behavioral health discipline.
- Federal, state and county systems might consider proactively developing an infrastructure to develop and sustain a workforce with the specialized skills required by CalAIM, CYBHI and CARE Court.

Councilmember Discussion

Q: Dr. Hobson stated that county behavioral health entities are working in close partnership with probation officers to address social determinants of health. The creation of a problem list is what they are moving toward and it is as close as it gets to a shared case plan. A probation officer that is recovery-oriented can make a tremendous difference in someone's life.

Q: Judge Manley stated that diversion is a concern. The Legislature is moving criminal justice towards diversion programs. Mental health diversion is underutilized in the State. There is a bill pending that would increase the number of individuals who

would be referred to mental health diversion, but the problem is that probation departments are not mentioned in the Legislation and are often reluctant to take on the role of monitoring these individuals. Secondly, the short amount of time that individuals are on probation conflicts with the amount of time that someone needs to be in treatment. Although it is a policy decision by the Legislature, it has made the job of a judge more difficult, which means that early collaboration is needed to immediately launch forward with treatment plans. There are not enough probation departments who are willing to supervise misdemeanor offenders who have high need and who are extremely high risk. It is a work in progress. Finally, CalAIM is a wonderful opportunity to broaden this collaboration because it includes jails, custody health, social services, housing and treatment. There will be a need for supervision for individuals in the criminal justice system. It is an opportunity to expand on the program to meet the need of this population.

A: Ms. Grealish stated that DHCS is working on a Technical Assistance Marketplace. There have been conversations about what a training package might look like for training the Medi-Cal Managed Care Plans' Enhanced Care Management Providers. It will be with which CCJBH can assist DHCS. To Judge Manley's points, social determinants of health lay the foundation for interagency collaboration, in general, because the same principles are needed by housing and social services. Also, different entities use the same terminology in different ways, which can cause misunderstandings and frustration. With time, everyone can learn each other's systems, roles and responsibilities to have a shared and clear understanding of that terminology.

A: Chief Jenkins stated that terminology is one of the elements of a curriculum on interdisciplinary training. Two statements that are used interchangeably are responsibility factors and social determinants of health. They have to be addressed with the justice-involved population if we are going to optimize the effort to achieve the best outcomes, including behavior change and recidivism reduction. We, as a Council, can address many of the things we are discussing in CCJBH's Annual Legislative Report. As we recognize and support the mental health diversion laws in place, if individuals with mental and behavioral health are diverted into effective treatment, but treatment or intervention is absent address the crime causing factors, the research says we will not make an impact on this population.

Q: Dr. Hobson stated that probation as a part of a treatment team and a part of ECM is not farfetched. Probation is a part of the treatment team in helping individuals get connected to rehabilitation services, which is now a part of ECM.

Q: Ms. Fisher asked if JISTA is still taking place in San Diego County.

A: Dr. Twitchell stated he is not sure if it is still taking place after the COVID-19 pandemic. The issue with these initiatives is sustainability and something like a natural disaster could have stopped the continuation of the program.

Q: Ms. Fisher asked if parole would play a part in collaboration.

A: Chief Jenkins stated that parole agents must play a part in collaboration.

Q: Ms. Whitney stated Los Angeles County has wanted to create a curriculum similar to JISTA for defense attorneys, prosecutors and judges to collaborate with clinicians. Ms. Whitney stated she will take all the recommendations she has learned today with her to her day-to-day work. In Los Angeles County, the probation department is not involved in even the felony mental health diversion cases. They do not consider that as part of their process because the case is non-criminal. Unless it is a particular specialized cohort where the Office of Diversion and Reentry has a special arrangement with the probation department, the felony mental health diversion cases do not have the assistance of the probation department. Many community members, activists, and stakeholders in Los Angeles feel that the probation department is inherently a law enforcement organization that lacks sufficient rapport with the criminal justice population to be able to work with individuals who have a mental illness in a truly collaborative way. If this training was shown in Los Angeles County, it may change some people's opinions. There is a deep community suspicion against probation departments, in general, and that is something that needs to be addressed.

A: Chief Jenkins stated that it is a simple question of evidence versus ideology. This presentation promotes the use of research and science-based principles for systemic change. It is a challenge in Los Angeles County because of the size of the departments.

Public Comment

Q: A participant asked if any collaboration has been initiated with the UC San Diego Underground Scholars program, which is comprised of and supports formerly incarcerated students. Lived experience can offer some of the best knowledge and developing processes that are aimed at supporting systems of impacted individuals.

A: Dr. Twitchell stated that he is not sure if it has been implemented in UC San Diego, but it has been implemented in UC Santa Barbara.

Q: A participant asked if JISTA is implemented elsewhere in California. Can you identify funding sources for training?

A: Dr. Twitchell stated he is not aware of it being implemented across the State and that could be because of the culture change. It took about three years for criminal justice and behavioral health systems to provide funding. It took dedication and a significant amount of time to implement this type of training and collaboration.

A: Chief Jenkins stated that collaboration should incorporate implementation science steps. It is an area that provides clear best practices on how this should be done to impact the different elements of the criminal justice and behavioral health systems.

Q: A participant stated that Cal Voices has many subject matter expert advocates throughout the State who would love an opportunity to have a Q&A dialogue and conversation with CCJBH. Conversations can include issues and challenges related to reentry and reducing recidivism.

V. Announcements

The next Juvenile Justice Workgroup meeting will be held on September 16, 2022, from 12:45-2:45 PM via Zoom and will feature a discussion on the draft CCJBH 2022 Annual Legislative Report recommendations related to the juvenile justice system in California. The Diversion and Reentry Workgroup will be held on September 16, 2022, from 3:00-5:00 PM via Zoom and will feature a discussion on the draft CCJBH 2022 Annual Legislative Report recommendations related to the furtherance of diversion and reentry activities throughout California.[1] The next Full Council Meeting will be on October 28th, 2022, from 2:00-4:00 PM via Zoom.

VI. Adjourn

[1] Note that the Juvenile Justice Workgroup and Diversion and Reentry Workgroup were rescheduled to a later date.