



CCJBH Full Council Meeting Minutes

Friday, March 22, 2024

2:00-4:30 PM

MS Teams Meeting & In Person

I. Welcome & Introductions, Roll Call:

Councilmembers Present In Person: Secretary Jeff Macomber, Christina Edens (on behalf of Stephanie Clendenin), Sydney Armendariz (on behalf of Michelle Baass), Judge Stephen Manley, Hon. Scott Svonkin (Ret.), and Dr. Tony Hobson.

Councilmembers Present Virtually¹: Dr. Enrico Castillo, Anita Fisher, Tracey Whitney, Dr. Danitza Pantoja, Diana Becton and Mack Jenkins.

Staff Members Present: Brenda Grealish, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH), Elizabeth Vice, Kamilah Holloway, Jessica Camacho Duran, Emily Mantsch, Cameron Byrd, and Belicia Smith.

Secretary Jeff Macomber welcomed Councilmembers and public participants and emphasized the agenda and discussions to come for the meeting ahead.

II. Request for Bagley-Keene In-Person Participation Exemption

Elizabeth Vice, *Staff Manager II, CCJBH*

Ms. Vice presented Senate Bill (SB) 544 highlights, which stipulate the CCJBH teleconference participation requirements pursuant to Government Code §11123.2. Effective January 1, 2024, and until January 1, 2026, CCJBH may hold meetings by teleconference as described under Section 11123.2. Government Code §11123.2 dictates that a majority of the members of the state body shall be physically present at the same teleconference location (for CCJBH, a minimum of seven members must attend, in-person, at one location). SB 544 further defines “teleconference location” as a physical location that is accessible to the public and “remote location” as a location being electronically tied to the teleconference, but not required to be accessible to the public. The notice and agenda shall not disclose information regarding a remote location.

SB 544 also requires that members participating remotely disclose whether there is anyone over the age of 18 present in the room at the remote location. Ms. Vice asked whether any Councilmembers participating remotely needed to disclose. No Councilmembers indicated a need to disclose.

In addition, Section 11123.2(j)(3) stipulates a member may notify CCJBH of their need to participate remotely due to a physical or mental disability, including a general description not to exceed 20 words of the circumstances relating to the member’s need to participate

¹ Per Bagley-Keene- § 11123.5 (b) A member of a state body as described in subdivision (a) who participates in a teleconference meeting from a remote location subject to this section’s requirements shall be listed in the minutes of the meeting.

remotely. CCJBH Council must act on exemption requests at the beginning of each Council Meeting. Ms. Vice emphasized SB 544 requires there be a total of seven Councilmembers present at one location, and that a member who attends and participates from a remote location may count toward the required majority if the member has a need to participate remotely related to a physical or mental disability that is not otherwise reasonably accommodated by the Americans with Disability Act, 42 U.S.C. Section 12101. Ms. Vice indicated such a request was made for this meeting and presented the motion to approve Councilmember Whitney's remote participation.

Vote: Approve Councilmember Whitney's Remote Participation due to health concerns.

Motion to approve the vote: Councilmember Manley

Second: Councilmember Svonkin

Councilmember Discussion

Q: Councilmember Jenkins inquired why a motion was required for a single Councilmember to participate remotely.

A: Ms. Vice explained the motion is to approve remote participation by Councilmember Tracy Whitney in accordance with Government Code §11123.2 for her to participate in this meeting remotely due to health concerns limiting her ability to travel. Approving the motion makes her attendance count towards the required majority.

A: Ms. Danni Lam, Office of Legal Affairs, California Department of Corrections and Rehabilitation (CDCR), further explained a "yes" to this vote allows Councilmember Whitney to be counted towards the required majority that must be "in-person" for the meeting to proceed.

No public comment on vote

Ayes: 11

Nays: 0

Abstains: 1

The motion to approve Councilmember Whitney's Remote Participation was approved.

III. Presentation: University of California, San Francisco (UCSF), Benioff Homelessness and Housing Initiative (BHII), California Statewide Study of People Experiencing Homelessness (CASPEH)

Margot Kushel, MD, Director, Benioff Homelessness and Housing Initiative

Dr. Kushel outlined the comprehensive findings of [CASPEH](#), led by the UCSF, BHII. This study highlights the causes and impacts of homelessness across California with a special emphasis on the experiences of the justice involved population. She emphasized that the homelessness crisis in our country is driven by the lack of supply of affordable housing. There are 34 available and affordable housing units for every 100 extremely low-income households. California's infliction is near the bottom, with 24 units of housing for every 100



extremely low-income households. This leaves California short 1 million units of housing for our lowest income households.

CASPEH, commissioned at the request of the California Health and Human Services Agency (CHHS), is the largest representative study of homelessness in the United States since the 1990's. The study used a mixed method approach. People were surveyed with questionnaires, and one in every eight people participated in an in depth interview to gain deeper understandings of the reasons behind their questionnaire answers. The in depth interviews were one of seven studies, and another one of those seven studies focused specifically on incarceration. The study was conducted in English and Spanish, and utilized interpreters for any other languages.

CASEPH used statistical methods to make it representative of all adults experiencing homelessness in the state. The project interviewed 3,200 individuals and weighted their data to represent these data as a whole and did 365 in-depth interviews. Highlights of the study were as follows:

- Of the people experiencing homeless in California, 90 percent were last housed in California, and 75 percent were living in the same county where they lost their housing. A significantly high proportion of adults experiencing homelessness in our state were native to California.
- The race/ethnicity demographics of adults experiencing homelessness in California revealed the racial disparities that exist:
 - 26 percent reported a Black racial identity, compared to 7 percent population statewide.
 - 12 percent reported Native American, Alaskan Native or Indigenous identity versus 3 percent population statewide.
 - 35 percent reported a Latino/a/x identity.
- Adults experiencing homelessness in California were disproportionately men:
 - 69 percent were cisgender men.
 - 30 percent were cisgender women.
 - 1 percent were transgender/nonbinary/other gender identified.
- Adults experiencing homelessness in California are aging. The median age of all participants was 47. Among single homeless adults aged 25 or older and not living with their children, 48 percent were 50 or older. Of those 50 and older, 41 percent had never been homeless, not even for a day, before the age of 50.
- Although mental health concerns were under-diagnosed because people had poor access to mental health care, the study found a high prevalence of mental health disabilities among participants. Twenty-five percent of all adults experiencing homelessness reported receiving a diagnosis of post-traumatic stress disorder (PTSD), 31 percent had had a suicide attempt at some point in their lives, and 27 percent had



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spent time during inpatient psychiatric hospital. Forty-four percent of those who had spent time in the psychiatric hospital had done so for the first time after the first time that they became homeless.

- Seventy-nine percent of all adults experiencing homelessness in California had, at some point in their life, been incarcerated in jail or prison, with 37 percent having had a stay in state or federal prison and 77 percent having had a stay in jail.

The CASPEH study analyzed how adults entered homelessness in California. Dr. Kushel highlighted the participants' paths in the six months before homelessness. Ten percent of participants were released from prison, often people who had been sent to some form of transitional housing. Additionally, 20 percent of participants had a prolonged jail stay in the six months prior to homelessness. Dr. Kushel emphasized that CASPEH believes the 14 percent who entered directly through a carceral setting is an underestimate of people who truly entered homelessness from an institutional setting. The remaining 3 percent of participants left their last stable housing to go to jail. These were individuals who had been stably housed, entered jail, and then exited that jail stay experiencing homelessness.

Dr. Kushel accentuated CASPEH participants' statements as they were exiting the prison system. One participant stated, "Nothing. Thank you, cut your bracelet off, and off you go... There's nothing. They don't know if you're going to go out and going to be homeless, if you're going back to being homeless, they don't – they don't ask any of that." Another participant stated, "I went to jail, and I lost my job. Got out of jail, was two months behind on my rent, and by the time I got a job at Foster Farms my thirty-day [eviction] notice had already been served."

When CASPEH examined whether people had received assistance when exiting prison or jail, very few said they had. The CASPEH only reported jail re-entry support for individuals who reported jail stays of 30 days or more. 19 percent of those individuals leaving jail and 18 percent leaving prisons reported receiving support obtaining or recertifying themselves for benefits. 17 percent of individuals leaving jail and 14 percent leaving prison reported receiving assistance reengaging with healthcare of any type, whether that was information on clinic locations, information on where to get Medicaid, or getting signed up for those programs. Finally, 17 percent of individuals leaving jail and 14 percent leaving prison reported receiving housing assistance. This assistance could include guidance to housing or being given information on where to sign up for housing lists.

The CASPEH explored what happened to people while they experienced homelessness. The study found people primarily experienced homelessness in unsheltered settings. When asked where they had spent the most time while homeless, 78 percent stated they had spent it in an unsheltered setting and 22 percent in a sheltered setting. Of the unsheltered, 21 percent lived in their vehicle and 57 percent lived in non-vehicle settings. Additionally, 36 percent of all CASPEH participants had their belongings confiscated by authorities at least once in the past six months. This statistic was much more common among unsheltered participants.



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Dr. Kushel highlighted the experience of a CASPEH participant who experienced surveillance challenges while they were experiencing unsheltered homelessness. The participant stated, “They gave me a court date... six months after when they supposedly arrested me and cited me out. And like I missed the court date because I forgot what day it was because I lost my ticket for it. I lost that in one of the times they made us move and they took all our stuff. And then the next time I got pulled over I was riding my bike and I had lights on the back part of my tailgate and then lights on the front... but the guy pulled me over anyway and he says I don’t have any reflectors on my wheels... so we’re gonna take you to jail.”

Dr. Kushel continued exploring the CASPEH findings on the experiences of people during homelessness. The CASPEH found 13 percent of adults experiencing homelessness in California were under community supervision on the day that the study interviewed them. Thirty percent went to jail during their current episode of homelessness with a median length of stay of two days. The CASPEH found a high burden of mental health symptoms while people were experiencing homelessness, with 12 percent having reported hallucinations and 5 percent having had an inpatient psychiatric hospitalization in the past six months.

Additionally, the CASPEH found substance use extremely common among individuals experiencing homelessness:

- Thirty-five percent used illicit drugs, such as methamphetamines, non-prescribed opioids, or cocaine, three times a week or more during their current episode of homelessness. This drug use was primarily driven by methamphetamine use, with 31 percent of participants using methamphetamines regularly.
- Eleven percent reported non-prescribed opioid use, with most of these individuals also using methamphetamines. Fewer than 2 percent reported using opioids alone without also using a stimulant.
- Only 3 percent reported actively using cocaine three times or more a week, although lifetime cocaine use was much higher.
- Nine percent of participants reported current heavy episodic alcohol use, defined as binge drinking six or more drinks at least once a week. By this definition, 40 percent of participants reported either regular illicit drug use or heavy alcohol use. Of participants who reported current regular illicit drug use or weekly heavy episodic alcohol use, only 10 percent were receiving any form of treatment or counseling, including peer counseling services like attending Alcoholics Anonymous or Narcotics Anonymous meetings. Interestingly, 26 percent of participants who reported regular use of alcohol or drugs indicated that they had wanted and sought treatment during their current episode of homelessness but were unable to access it due to barriers such as not being able to identify available treatment, not being admitted, or other obstacles.

- Eleven percent of participants reported surviving an overdose during their current episode of homelessness, highlighting the critical issue of those who did not survive their overdose.

Dr. Kushel noted that the CASPEH found that 48 percent of participants reported either a significant behavioral health problem or an indication of a significant behavioral health problem. These reports included current regular illicit drug use, heavy episodic alcohol use, current hallucinations, and recent psychiatric hospitalization.

The most common barrier that kept people homeless was the cost of housing. Almost 90 percent of participants reported their inability to afford housing was a major barrier to reentering the housing market. Other key barriers included criminal records, prior evictions, credit history, and discrimination. Fifty-three percent reported they did not have the documents needed to apply for housing.

Dr. Kushel described statements made by CASPEH participants regarding their experiences when attempting to reenter the housing market. One participant stated, “We came in as a couple and once our case manager found out he was in jail, he took him off the list.” Another participant noted, “Yes, my parole officer directed me to services here... He got me connected with the Rescue Mission and with programs that are also available for people with behavioral health problems. They’ve gotten me connected with the behavioral health center where I go in for group meetings about my behavior, work on, work on that with them.”

The CASPEH suggested several policy recommendations regarding homelessness. The primary recommendation included increasing access to affordable housing options and expanding targeted prevention, specifically for the justice-involved population and those with behavioral health concerns. Other recommendations include providing supports to match behavioral health needs, increasing household incomes, increasing outreach and service delivery during homelessness, and embedding a racial equity approach in homeless system service delivery.

Dr. Kushel highlighted Project Welcome Home: evidence for Permanent Supportive Housing (PSH). This project is a randomized controlled trial of Santa Clara County’s PSH. The targeted population is the chronically homeless and the highest users of services. The intervention included permanently subsidized housing, intensive case management, medical care, and voluntary services. Project Welcome Home was noted as being successful at keeping people housed. When the study was published, after four years, 86 percent of those who were randomized into housing remained housed. When the study was completed, at seven years, 91 percent of the participants who were approached did get into the program and get housing. Once people were housed, they were housed for an average of 93 percent at the four-year follow-up. It took an average of 2.5 months for participants in the intervention to find housing between when they were randomized into the study and the day they moved into their housing.

Dr. Kushel concluded her presentation with the overall CASPEH findings. These findings showed that homelessness is related to the lack of deeply affordable housing; the homeless population consists primarily of the aging population in poor health, with a high prevalence of mental health and substance use problems and poor access to care; the experience of homelessness is harrowing and filled with violence and despair; and ending homelessness will require sustained efforts to address root causes.

Q&A with Councilmember Advisors

- Q:** Councilmember Svonkin inquired whether the CASPEH study identified where preventative services might have been able to prevent any participants from being homeless.
- A:** Dr. Kushel clarified the problem with prevention is that it can be hard to predict who will become homeless among people that are all at a very high risk of homelessness. She emphasized that the largest predictor of homelessness is if an individual has ever been homeless before. Another large predictor of homelessness is involvement in the criminal legal system, which is why CASPEH recommends that interventions should begin at the time people are leaving incarceration.
- Q:** Councilmember Manley inquired about an interim solution to homelessness intervention at the time of release from incarceration until a successful housing development plan is implemented.
- A:** Dr. Kushel emphasized rehousing individuals as quickly as possible is a critical intervention service that can help recently released individuals from entering homelessness. Additionally, she stressed implementing services to keep homeless individuals safe while they are experiencing homeless in the interim between getting placed in permanent housing.
- Q:** Councilmember Manley sought clarification on whether the CASPEH examined participants' accessibility to shelters and/or participants views regarding the feasibility of shelters.
- A:** Dr. Kushel explained that 41 percent of participants had a time where they were seeking shelter and had been unable to get it. She also emphasized that there were mixed responses from participants regarding shelter housing. Individuals not wanting to be housed in a shelter does not mean they do not want housing.
- Q:** Councilmember Castillo asked Dr. Kushel's opinion on the problem of criminalization of homelessness and the vulnerability of individuals arrested for crimes of survival. Specifically, whether there are state level reforms Dr. Kushel can recommend to solve the problem of criminalization of homelessness.
- A:** Dr. Kushel expressed concern regarding the criminalization of homelessness. She emphasized that punishing individuals for public urination when there are no bathrooms places people in an endless cycle of disruption. Criminalizing homelessness increases



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people's traumas and decreases trust. She further explained the criminalization of homelessness is a harmful cycle that does not help mitigate the issue of homelessness.

- Q:** Councilmember Jenkins inquired whether the barriers to housing describing in the CASPEH presentation were self-reported. He also asked whether Dr. Kushel knew the percentages of individuals who were on either parole or probation/community supervision under Project Welcome Home.
- A:** Dr. Kushel clarified that the barriers to housing described in the CASPEH presentation were self-reported barriers from participants. She also clarified that the Project Welcome Home community supervision data was confusing because there were many participant responses that did not make clear of whether they were on probation or parole. Dr. Kushel believes this mixed data could reflect the confusion experienced among people under community supervision about what type of supervision they are under.
- Q:** Councilmember Jenkins commented on the role of community supervision agencies in addressing the responsivity of justice-involved individuals and homelessness through reentry planning. He noted that it is not uncommon for individuals to be on both parole and probation simultaneously. Councilmember Jenkins highlighted the importance of reentry planning, which involves a continuum of care starting from incarceration through to release and reintegration into the community. He emphasized that planning for release and meeting the needs of individuals as they return to the community are critical components of effective reentry.

Councilmember Jenkins commended the efforts led by the Secretary and the CDCR, particularly the Division of Adult Parole Operations, for their work in expanding targeted prevention and providing behavioral health supports. He pointed out that effective reentry planning should include assessments of homelessness status and incorporate it into case management objectives to ensure that individuals' housing and behavioral health needs are addressed.

Councilmember Jenkins also suggested conducting a survey of community supervision agencies, including parole and the 58 probation departments, to understand their efforts in addressing risk responsivity needs within the risk-need-responsivity model. He shared his experience from San Diego, where he collected data on individuals under supervision and their housing status, comparing it with point-in-time counts to identify gaps in services. This approach helped highlight areas where additional support and intervention were needed.

He proposed that such a survey could provide valuable insights into how different agencies prioritize and address homelessness and responsivity needs, offering a clearer picture of the gaps and challenges faced by justice-involved individuals in securing stable housing.

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

Q: A participant commented on the reported 22 deaths under the Project Welcome Home program and asked Dr. Kushel to speak to the high mortality rate. Secondly, the participant asked whether the CASPEH participant population had presence of sex offenders, members of the incompetent-to-stand population, or individuals with developmental disabilities. Lastly, the participant commented on SB 4 Affordable Housing on Faith Lands Act and the importance of learning from the lived experiences of the homeless population.

A: Dr. Kushel clarified the CASPEH found a marginally equal mortality between those enrolled in the housing program and those who remained unhoused. She believes this correlates to the demographic of the participants of the study. CASPEH chose participants who were the most difficult to house because they were either system involved and/or those with severe behavioral or mental health concerns. Housing those experiencing these significant health concerns cannot determinatively prevent death. This highlights the need for more innovative ways to prevent overdoses in supportive housing.

Q: A participant inquired whether the participants' history of mental health services was confirmed with county behavioral health to better determine how much of the mental health history might have been underreported.

A: Dr. Kushel highlighted that the CASPEH was conducted anonymously, meaning participant data was self-reported. She further explained underreporting is possible with self-reporting, but emphasized that the CASPEH focused on symptoms as opposed to the diagnosis.

Q: A participant commented, "As a person who is formerly incarcerated, I did not feel supported exiting the prison settings as a life term inmate who had to develop a parole plan ourselves, which required and was dependent upon outside support."

Q: A participant commented there are transition aged youth, minors, and transition aged youth's families that are impacted by the justice system, as well.

IV. CCJBH Business Meeting

A. Vote: Approve December 2023 Full Council Meeting Minutes

Motion to approve the vote: Councilmember Svonkin

Second: Councilmember Manley



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

Q: A participant suggested restructuring the council meetings to better address the needs of rural counties, which are often neglected. They proposed shifting the focus from juvenile justice, which is already being heavily covered, to high-priority issues affecting rural areas. The participant emphasized that while significant advancements are being made in urban areas, these do not always translate to rural counties. Therefore, dedicating time and energy to rural issues was recommended, with a brief report on juvenile justice as a possible solution.

Ayes: 10

Nays: 0

Abstains: 2

The motion to approve the December 2023 Full Council Meeting Minutes was approved.

B. Vote: Approval of the CCJBH 2023 Annual Legislative Report

Motion to approve the vote: Councilmember Svonkin

Second: Councilmember Manley

Councilmember Discussion

Q: Councilmember Svonkin sought clarification on how wide the report is distributed. He requested that every member of the Legislature receive the report, as well as County Board of Supervisors and other government entities.

A: Ms. Grealish explained the CCJBH Annual Legislative Report is distributed to the Legislature, published on the CCJBH website, and emailed through the CCJBH's listserv. Additionally, a webinar walkthrough of the report will be recorded and uploaded to the CCJBH website.

Q: Councilmember Jenkins sought clarification on whether the Chief Probation Officers of California (CPOC) is included in the CCJBH listserv and emphasized the importance of distributing the legislative report to each probation chief in the state.

Q: Councilmember Whitney highlighted that pre-COVID, CCJBH did legislative visits where the legislative report was reviewed in person.

A: Ms. Grealish clarified that legislative review meetings are in discussion now to determine if and when they will be scheduled.



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

Q: A participant requested that her name be removed from the list of contributors to the legislative report, as she did not work on it this year and wanted the staff who did to be accurately credited. She also commented that the report overly emphasized medical health care services and suggested that more attention should be given to criminal justice stakeholders. The participant highlighted the significant contributions of Dr. Thomas Insel, noting that his expertise was not adequately reflected in the report. She emphasized his key insights on mental health and the importance of addressing the right people, places, and purposes. Finally, she proposed that CCJBH should focus more on community restoration, not just in terms of restoring individuals to competency, but in truly revitalizing communities to support their populations effectively.

Ayes: 12

Nays: 0

Abstains: 0

The motion to approve the CCJBH 2023 Annual Report was approved.

C. Vote: Delegate Authority to the CCJBH Executive Officer to Make Updates to the Report During the Final Review Process.

Motion to approve the vote: Councilmember Svonkin

Second: Councilmember Manley

***** NO PUBLIC COMMENT *****

Ayes: 12

Nays: 0

Abstains: 0

The motion to approve delegation of authority to the CCJBH Executive Officer to make updates to the report during the final review process was approved.

D. Update on CCJBH/Department of Health Care Services (DHCS) Medi-Cal Utilization Project (MCUP) & Public Health Meets Public Safety (PH/PS): A Report on the Medi-Cal Enrollment and Behavioral Health Services Utilization for Individuals Released from CDCR in Fiscal Year (FY) 2019-20

Kamilah Holloway, *Research Scientist III, CCJBH/DHCS*

Ms. Holloway explained that the MCUP monitors enrollment into Medi-Cal, including selection of Medi-Cal Managed Care Plans (MCP) and utilization rates of Medi-Cal behavioral health services for people releasing from CDCR who suffer from mental illness(es) and/or substance use disorders (SUDs). The most recent report examines individuals released from CDCR in FY 2019-20. This project is a data matching collaboration between DHCS and CDCR. The purpose of MCUP is to inform policy developments and to maximize enrollment into and utilization of Medi-Cal services for

eligible justice-involved individuals transitioning from CDCR facilities back into the community.

Ms. Holloway further explained that, since many of these individuals often require specialized behavioral health care services, a central goal of this project is to provide annual reporting that may be used to support quality improvement efforts within relevant public systems, such as behavioral health and criminal justice, including strengthening and monitoring targeted outreach, engagement, and service coordination.

Ms. Holloway described the MCUP reporting process. MCUP reporting began in December of 2018 when an initial DHCS Medi-Cal eligibility data file containing a list of beneficiaries enrolled in Medi-Cal between July 2012 and December 2016 was matched to CDCR data to identify which of those individuals had been released from CDCR facilities. This matched data file was then linked to DHCS Medi-Cal behavioral health services claims data to examine the impact of the Affordable Care Act. The second round of reporting focused on Medi-Cal enrollment, Medi-Cal MCP selection, and Medi-Cal mental health and SUD service utilization for individuals released from CDCR during FY 2018-19. All the above findings can be found on the [CCJBH website](#).

The third round of reporting similarly examined individuals released from CDCR during FY 2019-20, following their Medi-Cal service utilization, and including data stratifications for COVID releases. COVID Releases are individuals whose release from CDCR was expedited during the month of April 2020 to slow and prevent the spread of the COVID-19 infection, wherein CDCR expedited the release of almost 3,500 incarcerated persons serving a sentence for non-violent offenses who did not have to register as a sex offender and who had 60 days or less to serve.

Ms. Holloway described the demographics for the FY 2019-20 releases. Most of the population was male (92 percent) and between 25-44 years of age (65 percent). The racial and ethnic makeup comprised of 36 percent Hispanic, 23 percent White, and 20 percent Black. Additionally, 76.5 percent has an identified behavioral health need at the time of their release.

Ms. Holloway also explained the Medi-Cal enrollment rates for FY 2019-20 releases. Most individuals released from CDCR are enrolled into Medi-Cal within one year (76 percent for those released in FY 2019-20). Of the individuals enrolled into Medi-Cal, the time to select a MCP was as follows: 22 percent selected a plan within one month, 55 percent within three months, 71 percent within six months, and 81 percent within one year. When comparing FY 2018-19 to FY 2019-20, Medi-Cal enrollment remained consistent within two years after release (79 percent compared to 77 percent, respectively) and Medi-Cal MCP selection also remained consistent within two years after release (89 percent compared to 85 percent, respectively).

Ms. Holloway next explained Medi-Cal behavioral health services utilization, which aligns with DHCS's behavioral health services reporting methodology. Specifically, service utilization is measured in terms of penetration rates, defined as utilization of one



or more (1+) services, and engagement rates, defined as five or more (5+) services. For individuals released from CDCR in FY 2019-20 who were enrolled into Medi-Cal, the CDCR-designated Behavioral Health Need and corresponding Medi-Cal behavioral health services utilization rates (within two years of release) are as follows:

- 52.5 percent had an SUD designation at release. Of these SUD designations:
 - 19 percent had a SUD service penetration, with 15 percent SUD service engagement.
 - 7 percent has a Specialty Mental health Services (SMHS) penetration, with 6 percent SMHS engagement.
 - 9 percent has a non-SMHS penetration, with 3 percent non-SMHS engagement.
- 17 percent had co-occurring SUD and mental health designation at release. Of these:
 - 29 percent had a SUD service penetration, with 19 percent SUD service engagement.
 - 30 percent had a SMHS penetration, with 24 percent SMHS service engagement.
 - 24 percent had a non-SMHS penetration, with 10 percent non-SMHS service engagement.
- 7 percent had an identified mental health designation at release. Of these:
 - 35 percent had a SMHS penetration, with 29 percent MSHS service engagement.
 - 23 percent had a SUD service penetration, with 15 percent SUD service engagement.
 - 21 individuals had a non-SMHS service penetration, with 8 percent non-SMHS service engagement.

Ms. Holloway explained that, while there were clear delays overall in selection of a Medi-Cal MCP reflected in the data, COVID-19 releases selected an MCP within one month of release at a much higher rate overall than scheduled releases (26 and 2 percent, respectively). COVID-19 releases were also more likely to select a MCP within the first six months of release. Notably, within six months of release, the lag between COVID-19 releases selection of an MCP began closing such that by the end of Year 1, the rate of selection was like the previous year's analysis. In addition, within the first year of release, over 80 percent of releases had selected an MCP. COVID-19 releases had slightly higher penetration rates for individuals who received any type of behavioral health service (in the range of 4 to 8 percent) when examined by CDCR-identified behavioral health need(s).

Ms. Holloway summarized the presentation by emphasizing Medi-Cal enrollment and Medi-Cal MCP selection remained consistent for individuals releases between

FYs 2018-19 and 2019-20. CCJBH remains concerned with the low utilization rates of Medi-Cal behavioral health services for individuals released from prison with identified behavioral health needs who are enrolled into Medi-Cal and, to learn more, CCJBH partnered with the California State University, Sacramento, to conduct listening sessions for individuals with behavioral health conditions who have lived experience in the justice system. Also, it is anticipated that implementation of California Advancing and Innovating Medi-Cal (CalAIM), as well as recent housing investments, will improve behavioral health service utilization rates.

Ms. Holloway explained the next steps for MCUP by stating that CCJBH received and is working to match/compile CDCR and DHCS Medi-Cal data for individuals released from CDCR in FY 2020-21 and FY 2021-22. The Calendar Year 2024 report will reflect updated Medi-Cal enrollment, MCP selection, and mental health and SUD services penetration and engagement rates. Additionally, CCJBH staff are working with DHCS to explore opportunities to examine member utilization of the new CalAIM enhanced Care Management (ECM) and Community Support services.

E. Update on the CCJBH Public Health Meets Public Safety Framework and Data Visualization

Kamillah Holloway, *Research Scientist III, CCJBH/DHCS*

Ms. Holloway recalled the Public Health Meets Public Safety (PH/PS) project goal and framework is to use data to inform policymaking at the intersection of criminal justice and behavioral health with the goal of reducing the number of people with behavioral health needs in California's justice system. The PH/PS data visualization parameters include using the most recent available data sources, which are not perfect data. The data does not show causality, it presents the "what not why." The framework is not a program or policy evaluation tool. Additionally, Ms. Holloway recalled the potential uses for the PH/PS Data Visualization include local government for local statistics and community investment, guiding future researchers on causality, accessible quantitative data for community members, state policy staffers, and grant writing on community needs.

Ms. Holloway highlighted additional data visualization metrics by stating that, in the spring of 2023, CCJBH Councilmembers voted to use unspent FY 2023-24 Mental Health Services Funds to establish a contract with the UC Berkeley Policy Lab during the summer of 2023 to identify additional relevant metrics for the PH/HS Data Visualization, which ended on August 30, 2023. This resulted in the identification of additional data metrics for the PH/HS Data Visualization: behavioral health prevalence rates, overdose rates, suicide rates, and behavioral health workforce shortage area data.

Ms. Holloway explained that the sources for the metrics identified by the Policy Lab include:



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- Health Resource Shortage Score: The Health Resources and Services Administration maintains a dataset that contains the geographic Health Professional Shortage Area federal designations for Primary Care, Mental Health, and Dental Health, including California specific data.
- Drug Overdoses and Suicide Rates (each metric is per 100,000 deaths): The Centers for Disease Control maintains a database referred to as WONDER that includes 20 collections of public use data capturing vital statistics and health indicators such as rates of cancer, tuberculosis, mortality and vaccination at all levels.
- The Behavioral Health Prevalence Rates - SMI prevalence rates were obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA) database and SUD prevalence rates were obtained from the National Survey on Drug Use and Health (NSDUH).

Ms. Holloway also explained that CCJBH applied for and was granted an embedded Resident Corrections Analyst (RCA) position, funded through the U.S. Department of Justice, Bureau of Justice Assistance Justice Reinvestment Initiative, to produce documentation of protocols for retrieving, cleaning, and standardizing PH/PS Data Visualization data and, time permitting, to develop fact sheets, informational briefs, and use case scenarios that may be used to advance the Council's mission and support local system planning efforts.

Finally, Ms. Holloway explained the CCJBH-UC Berkeley (UCB) Interagency Agreement (IA). On March 13, 2024, CCJBH entered an IA with the UC Berkeley Possibility Lab to maintain and update the PH/PS Data Visualization, continue building the PH/PS Framework, and engage with additional stakeholders on use cases, including how best to track the 2025 System Goals, inform statewide system efforts (e.g., CalAIM, 988 implementation), etc.

Councilmember Discussion

Q: Councilmember Hobson sought clarification on the statistic that 76.5 percent of the MCUP individuals had an identified behavioral health need at the time of their release. Specifically, whether those behavioral needs were derived from a formal diagnosis or an assessment.

A: Ms. Holloway and Ms. Grealish clarified that the CDCR behavioral health designations were based on mental health and substance use disorder assessments performed while the individuals were incarcerated.

Q: Councilmember Hobson also inquired whether the MCUP report will also be made available to County of Behavioral Directors Association, along with the Legislative Report.

A: Ms. Grealish confirmed both will be made available.

Q: Councilmember Manley inquired whether there were practices that could be implemented to get better engagement for those being released now that were learned from the COVID-19



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20 YEARS
*of building bridges
to prevent incarceration*

releases. Also, what costs were involved regarding any additional efforts that were made to engage those COVID-19 releases into treatment when they left prison.

- A:** Ms. Holloway clarified the listening sessions were conducted to determine the reasons for low service utilization. These sessions revealed community mobilization around individuals who were released, and the next step is exploring the reasoning behind this. She further emphasized that the gap between COVID-19 and scheduled releases closed after six months.
- A:** Ms. Grealish also emphasized that there were many COVID-19 flexibilities during that time where waivers were given to waive certain typical requirements. DHCS has sought to make some of those flexibilities permanent.
- Q:** Councilmember Macomber inquired whether Ms. Holloway recommends establishing a relationship prior to releases as critical and any other recommendations to increase the success rate for the CalAIM project.
- A:** Ms. Holloway emphasized that the implementation of the CalAIM 90-day in-reach initiative and early community engagement are crucial.
- A:** Ms. Grealish further emphasized that the people who participated in the MCUP listening sessions stated that having a person, especially if that person had lived experience and was a credible trusted community messenger, made participants feel comfortable throughout the process.
- Q:** Councilmember Edens sought clarification regarding the point at which people are enrolled into Medi-Cal.
- A:** Ms. Holloway clarified that the MCUP data is retrieved after release from prison and analyzed to determine enrollment within one month, three-month, six-month, one-year, and up to two-year increments to determine when individuals are being enrolled into Medi-Cal.
- Q:** Councilmember Edens further clarified that there is a percentage of individuals who are being released from prison that are paroled into the Department of State Hospitals (DSH). Once paroled, those individuals are committed to DSH and are precluded from 90-day in-reach. Therefore, these individuals cannot be enrolled into Medi-Cal before they are released from the state hospitals. This situation resembles a gap that Councilmember Edens wanted to highlight.
- A:** Councilmember Macomber expressed agreement with Councilmember Edens clarification.
- Q:** Councilmember Jenkins sought further clarification on whether individuals can enroll in Medi-Cal prior to release. He emphasized the importance of increasing the utilization rate of Medi-Cal and highlighted the connection between this issue and the findings of a housing study, which noted the need to address behavioral health needs. Councilmember Jenkins was not surprised that around 70 percent of the CDCR population was assessed as having behavioral health needs. He stressed the necessity of a continuum of care, including assessing and identifying needs while individuals are still incarcerated, ideally



starting at sentencing. Councilmember Jenkins sought confirmation that enrolling individuals in Medi-Cal before their release is indeed possible.

A: Ms. Holloway confirmed that as part of the CalAIM Justice-Involved, 90-Day In reach Initiative, individuals can be enrolled into Medi-Cal before they're released.

Q: Councilmember Jenkins highlighted the importance of this process, emphasizing that it aligns with the Council's discussions on the utility of case management services, including case planning as part of a continuum of care. He stressed that identifying needs through assessment processes and creating case plans to meet those needs with available resources is crucial if individuals are Medi-Cal eligible.

He further explained that parole agents play a key role in this process. He believes that parole agents must be proactive in case management, recognizing behavioral health needs, and ensuring individuals are aware of the benefits and services available to them. Councilmember Jenkins emphasized the importance of matching individuals to these services, which he sees as a fundamental aspect of case planning. He also noted that this approach should extend to probation officers, who can be trained to take on this role. He recommended this proactive case management as a key strategy to increase the utilization of Medi-Cal and other services upon release, suggesting it is both practical and achievable.

Q: Councilmember Fisher highlighted the need for peer support to help with the handoff between the time of release and reentry into the community.

Q: Councilmember Svonkin advocated for an annual presentation for the public to ensure more people can access information when there are new releases and data available. Additionally, providing accurate and up-to-date data can help with state budget analysis by providing critical information for future budget decisions.

Q: Councilmember Manley sought clarification on the CalAIM implementation date within CDCR and their readiness for that implementation.

A: Councilmember Macomber clarified that legislation requires an implementation date of March 1, 2026.

A: Councilmember Armendariz confirmed CDCR has a go-live period of two years between October 1, 2024, and September 30, 2026.

A: Ms. Grealish further clarified that additional updates from the local level on CalAIM implementation will be addressed at the September 2024 Full Council Meeting.

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

Q: A participant commented that she believes the lower utilization of Medi-Cal benefits and services by the justice-involved (JI) and behavioral health (BH) population speaks to the lack of trust that population has with the health care system. The participant emphasized the need for peer support services provided through the additional grants from the Board of State and Community Corrections (BSCC) and a place in the community that serves this

population and serves it well. The participant highlighted that, due to the felony exclusion, many individuals of the BH/JI population will be precluded from obtaining these services. Additionally, the participant addressed the delineation in the processing within CDCR of post-release community supervision versus parole and the comparison of those two statistics is like comparing apples to oranges. The vernacular is very important to differentiate what behavioral health means between the medical model, SUD, and other arenas. Regarding the PH/PS update, the participant emphasized the need for current definitions online and looking into the upcoming cradle-to-career data set. Finally, the participant highlighted utilizing environmental quality and air quality data to dedicate certain funding sources to underprivileged and environmentally burdened neighborhoods.

Q: A participant inquired how county criminal justice data is reflected in either the MCUP or PH/PS reports.

A: Ms. Holloway explained county jail data is not included in MCUP. However, the PH/PS report does have justice outcomes for county jail.

A: Ms. Grealish further explained that BSCC data is not available at the individual level so it cannot be matched to the release data for CDCR. Additionally, CCJBH is keeping track of any further updates regarding additional sources of information.

Q: A participant inquired whether it is necessary to wait for the full rollout of CalAIM or if referrals for CalAIM can be done now to begin accessing services?

A: Councilmember Armendariz explained the ECM benefit through CalAIM went live for the justice-involved Population of Focus on January 1, 2024, and that includes a lot of supportive services for things like housing and access to social supports. So, if a person gets released from CDCR or a county facility and they are enrolled into Medi-Cal, then they can work with their MCP to receive those types of supportive services. This is a separate program, but it is related to the Justice-Involved Initiative.

Q: The participant further inquired whether parole is currently doing those referrals.

A: Councilmember Armendariz clarified data is unavailable to show whether parole is currently doing those referrals, but the benefit through ECM is live.

Q: The participant further asked Secretary Macomber whether those referrals are currently part of parole protocols for CDCR and inquired whether a report can be given at the next meeting regarding the number of parolees who have been referred to these services.

A: Councilmember Macomber stated he believed they are, but would like to follow up with the participant later to confirm.

F. CCJBH Project Updates

Brenda Grealish, Executive Officer, CCJBH

- **JUVENILE JUSTICE COMPENDIUM AND TOOLKIT**

Ms. Grealish provided updates regarding the Juvenile Justice Compendium and Toolkit Contract. The Lived Experience Community Advisory Board (CAB) and System Representative CABs had their final meeting in February 2024 to provide input on the Training and Technical Assistance Plan. The draft Evidence-Based and Promising Practices Compendium Tableau has been posted to the CCJBH website. The Implementation Toolkit is currently undergoing internal review by the RAND Corporation. The final compilation of the Compendium and Toolkit will be launched on April 19, 2024, at the CCJBH Juvenile Justice Workgroup, and will include presentations from CCJBH Councilmembers Mack Jenkins and Danitza Pantoja, the Office of Youth and Community restoration (OYCR), CAB representatives, and the RAND Corporation. The RAND Corporation is engaged in conversations with the OYCR on implementation of the training and technical assistance plan.

- **WORDS TO DEEDS (W2D)**

Ms. Grealish explained that, in July 2023, the Council voted to allocate \$166,668 from CCJBH's annual budget to further the efforts of W2D. Due to the Council's high level of interest, a proposal for additional on-going funding is forthcoming intended to sustain W2D ongoing efforts for future years. CCJBH is partnering with the Mental Health Services Oversight & Accountability Commission (MHSOAC) through an Interagency Agreement to collaborate on W2D to maximize resources for the BH/JI population. These efforts will include two annual W2D convenings (one in July 2024 and one in Calendar Year 2025) and a workgroup and report to identify and document, respectively, the priority metrics for the BH/JI population, leveraging CCJBH's PH/PS Framework and Data Visualization to inform system monitoring efforts.

- **Lived Experience Projects (LEPs)**

Ms. Grealish explained during the April 2023 Full Council Meeting, Councilmembers voted to establish one State and three Local-Level LEP contracts. Through these new contracts, contractors will: increase advocacy and training opportunities for individuals with Lived Experience (LE); raise organizational and community awareness on the needs of the behavioral health and justice-involved population; promote evidence-based practices that support the employment of individuals with LE; and enhance collaborative efforts at the regional and local level. The LEP Local-level Request for Proposals (RFP) were released, and proposal submissions are due on April 8, 2024, by 3pm. The LEP State-level RFP was released, and submissions are due on April 12, 2024, by 3pm.

- **Legislative Update**

Ms. Grealish explained the 2023-2024 Legislative Session began on December 4, 2023, and CCJBH is tracking 107 bills this session. The bills being tracked by CCJBH cover juvenile justice and foster care, housing security, substance use disorders and issues addressing those deemed incompetent to stand trial. Additionally, Ms. Grealish

highlighted for more information and a list of bills CCJBH is tracking please visit the CCJBH [website](#).

- **Additional Updates**

- **Justice-Involved Peer Support Specialty:** CCJBH staff continue to track the California Mental Health Services Authority's Medi-Cal Peer certification process and Health Care Access and Information Community Health Worker certification process.
- **CalAIM:** CCJBH updated the [ECM Referral Flyer for Justice System Partners](#) to reflect the implementation of the justice-involved population of focus and new Medi-Cal MCPs within each county, both of which went live on January 1, 2024.
- **Housing/Homelessness:** CCJBH continues its collaboration with CDCR's Division of Adult Parole Operations, Division of Adult Programs, and Office of Research. This joint effort supports the CDCR Secretary's role as an appointed member of the California Interagency Council on Homelessness. CCJBH contributes by assisting to develop quarterly reports on the progress of CDCR's commitments, as outlined in [Cal ICH's Action Plan for Preventing and Ending Homelessness in California](#).
- **23rd Annual Legislative Report:** CCJBH has initiated work on the 2024 Annual Legislative Report, with plans to issue a call for report recommendations in early summer.
- **May is Mental Health Awareness Month:** CCJBH is planning informational Lunch and Learns to observe Mental Health Awareness Month. More information will be shared through CCJBH's website and weekly bulletin.
- **Juvenile Justice Facility Tour:** CCJBH Juvenile Justice Councilmember Advisors, CCJBH staff, and the Chief Probation Officers of California will visit the Merced County Juvenile Justice Facility in late-March.
- **Workgroup Updates:**
 - April Juvenile Justice Workgroup: The workgroup will launch the Juvenile Justice Toolkit with a collaborative presentation from CCJBH, the RAND Corporation and the Office of Youth and Community Restoration.
 - April Diversion/Reentry Workgroup: This workgroup will highlight programs and services from Camden County Department of Corrections in New Jersey, which utilizes Peer Support Specialists, called NuEntry Opportunity Specialists, to address the needs of the reentry population and Tarzana Treatment Centers

College, which is a certifying agency for the CalMHSA Medi-Cal Justice Involved Peer Support Specialty.

V. Upcoming Events

The next [Juvenile Justice Workgroup](#) meeting will be held on April 19, 2024, from 12:45 PM- 2:45 PM. The next [Diversion/Reentry Workgroup](#) meeting will be held on April 19, 2024, from 2:00 PM – 4:30 PM. The next [Full Council Meeting](#) will be held on June 28, 2024, from 2:00 PM – 4:30 PM.

VI. Adjourn