CCJBH Full Council Meeting Minutes

Friday, June 28, 2024
2:00-4:30 PM
MS Teams Meeting & In Person

I. Welcome & Introductions, Roll Call:

Councilmembers Present in Person: Dr. Diana Toche (on behalf of Secretary Macomber), Christina Edens (on behalf of Stephanie Clendenin), Sydney Armendariz (on behalf of Michelle Baass), Mack Jenkins, Judge Stephen Manley, and Dr. Tony Hobson.

Councilmembers Present Virtually:[1] Hon. Scott Svonkin (Ret.), Dr. Enrico Castillo, Anita Fisher, Tracey Whitney, Dr. Danitza Pantoja, and Diana Becton.

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, Belicia Smith and Gabriella Wyatt.

Dr. Diana Toche welcomed Councilmembers and public participants and emphasized the agenda and presentation set for the afternoon.

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 remotely. CCJBH Councilmembers must act on exemption requests at the beginning of each Council Meeting. Ms. Vice emphasized SB 544 requires there be a

[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.

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 Tracey Whitney's Remote Participation due to health concerns.

Motion to approve the vote: Councilmember Manley

Second: Councilmember Jenkins

No public comment on vote

Ayes: 11
Nays: 0
Abstains: 1

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

III. Vote: Approve March 2024 Full Council Meeting Minutes

Motion to approve the vote: Councilmember Jenkins

Second: Councilmember Manley

No public comment on vote

Ayes: 12
Nays: 0
Abstains: 0

The motion to approve the March 2024 Full Council Meeting Minutes was approved.

IV. Presentation: Latest Innovations in Substance Use Disorder Treatment

Brian Hurley, *Medical Director, Substance Abuse Prevention and Control, County of Los Angeles Department of Public Health*

Dr. Hurley began his presentation by discussing the importance of medications used to treat opioid use disorder (OUD), alcohol use disorder (AUD), and other substance use disorders (SUD), highlighting their critical but often under-delivered role in treatment. He noted that, while no medications are approved by the Food and Drug Administration (FDA) for stimulant use disorders (StUD), it was vital for the Council to be aware of them. He continued by introducing a graph representing the over six-fold increase in overdose deaths in California, emphasizing the severe overdose crisis affecting over 10,000 Californians annually, with significant impacts in Los Angeles (LA) County and a broader crisis nationwide. Dr. Hurley pointed out that overdose rates do not impact all communities equally, with Black and African

American communities being disproportionately affected. He also mentioned the high overdose rates among Alaska Native and Native American populations, though he noted the smaller size of these populations leads to variability in rates.

Dr. Hurley explained that overdose is the leading cause of death among individuals experiencing homeless in LA County, far surpassing other causes such as coronary heart disease or homicide. Based on the findings in "Center of Addiction, Behind Bars II: Substance Abuse and America's Prison Population", he noted that 65 percent of the incarcerated population in the U.S. has an active SUD. In jail, regular use of opioids was reported at 17 percent, and up to 20 percent of those housed in prison meet the criteria for OUD. Dr. Hurley highlighted the significant risks associated with post-release periods for formerly incarcerated individuals, emphasizing the over 40-fold increase in overdose deaths immediately following release from custody. He pointed out that overdose is the leading cause of death for those leaving custody, surpassing violence, suicide, accidents, and physical health conditions. The risk of death from overdose is 100 times greater for this population compared to the public, particularly in the first two weeks post-release.
Dr. Hurley also stressed the importance of mental health systems in diagnosing and treating both mental illnesses and serious mental illnesses (SMI) to protect human health. However, he noted a significant oversight in the underutilization of available treatments that could reduce overdose risks, emphasizing the need for better implementation and access to these life-saving tools.

Addressing the changing drug landscape, Dr. Hurley pointed out that it is not the number of people using drugs that has increased, but the potency of the drugs themselves, particularly with the rise of fentanyl and high-potency methamphetamine. He detailed how fentanyl's extreme potency makes it highly dangerous, leading to respiratory arrest and death even in small amounts. Dr. Hurley advocated for widespread access to naloxone, a medication that can reverse opioid overdoses, which should be available not just to individuals who use drugs, but universally. He described naloxone as comparable to having fire extinguishers or defibrillators readily available for emergencies, underscoring its potential to save lives in cases of overdose. Dr. Hurley noted the hierarchy of need when it comes to naloxone, mapping out that the greatest need is for people leaving custody, followed by people who use drugs, and then the friends and family of those who use drugs.

Dr. Hurley then discussed the challenges in addressing the SUD crisis, emphasizing the transition from custody to treatment in LA County. He highlighted the inadequate reach of current treatment systems, noting only 6 percent of Americans in need actually receive treatment for SUD. Dr. Hurley advocated for bringing treatment to the people rather than waiting for them to seek it out, suggesting that conventional treatment paradigms are insufficient for the scale of the crisis. He pointed out that, despite his support for treatment, the existing systems fail to address the needs of the majority, with only a small fraction receiving any treatment. Dr. Hurley proposed enhancing community and primary care settings to treat SUD just as other chronic diseases are treated, like diabetes, where care escalates as the condition worsens. He emphasized the need for integrated care

approaches that consider addiction treatment as part of general healthcare, thereby reducing stigma and improving access. Addressing the misconceptions about SUD, he noted that the major barrier to treatment is not just access, but also the lack of perceived need by individuals suffering from SUD. He highlighted the stigma associated with seeking help and the common belief among individuals that they should handle their issues independently.

In discussing the penetration and engagement rates for people transitioning from custody, again referencing the CCJBH's MCUP report, he noted penetration rates between 27 percent and 30 percent for individuals with SUD only, which is a significant improvement from the 6 percent baseline. However, it indicates that the majority still do not access services. The situation appears slightly better for those with co-occurring disorders, likely due to the larger funding and capacity allocated to the specialty mental health system compared to the SUD system. Dr. Hurley notes that diagnosing someone with a SMI often results in more services than an SUD diagnosis alone, which might influence diagnostic practices and service access.

Dr. Hurley, referencing the U.S. Department of Health and Human Services Surgeon General's report "Facing Addiction In America," explains the importance of integrating SUD services to effectively treat addiction, as emphasized by former Surgeon General, Dr. Vivek Murthy. The report advocates for enhancing community health capacities, including the ability to initiate treatments in custodial settings, regardless of an individual's immediate interest in specialty treatment centers. This approach aims to build a more accessible and responsive system that can meet individuals where they are, potentially increasing treatment uptake and improving outcomes. Emphasizing the principles of harm reduction, Dr. Hurley highlights the need for SUD treatments to accommodate the user's readiness for change, rather than imposing strict abstinence upfront. This flexible, person-centered approach can significantly enhance engagement and retention rates, ensuring that treatment options are non-judgmental and accessible at various levels of readiness. He continued discussing the importance of addressing basic needs alongside addiction treatment, invoking *Maslow's Hierarchy of Needs*, to emphasize that recovery involves more than just medical interventions. He stresses the need for accessible, culturally responsive, and trauma-informed care, pointing out that lower barrier care should be flexible and responsive to individual needs. Dr. Hurley continued by emphasizing the need to build connections with individuals who have SUDs but are not actively seeking treatment. He outlined the importance of delivering outreach and housing solutions, as well as initiating outreach programs both in custody and during the reentry phase. Highlighting the challenges of implementing these changes, he noted the importance of staff buy-in, and the difficulties posed by high turnover rates among frontline staff, which can hinder the establishment of a consistent treatment culture. Dr. Hurley also addressed the resistance from organizational leaders comfortable with traditional rules, underscoring the need for continuous quality improvement and adaptation to more effective engagement and retention strategies for patients not ready to cease substance use.

Dr. Hurley expressed enthusiasm about LA County's "Reaching the 95%" initiative, aimed at connecting with the 95 percent of people who do not seek treatment for SUDs. He detailed the initiative's goals, which include optimizing outreach and engagement by expanding the availability of substance use staff and lowering barriers to care. This approach involves offering counseling, support groups, and other treatments even to those not fully committed to recovery, effectively reducing the distance between people and the treatment they need. Dr. Hurley also emphasized the significant role of language in shaping perceptions and interactions with individuals experiencing SUDs. He argues for the adoption of neutral, non-stigmatizing terminology to better support and understand those affected. By replacing terms like "addict" or "substance abuser" with "person with a substance use disorder," the approach becomes more supportive and medically accurate, reducing stigma and fostering a more effective treatment environment. This shift in language aims to enhance societal and clinical responses to substance use, highlighting the power of words in shaping treatment outcomes and public attitudes, using person first language to avoid stigmatizing.

Pivoting into the context of SUD treatment, Dr. Hurley asked, "How do we treat substance use disorders?" He outlined the primary treatment modalities, emphasizing that there are no magical solutions in addiction psychiatry. Instead, he explained that effective treatment involves a triad of approaches to include medications, counseling, and support, which are analogous to treatments for other chronic conditions like diabetes and depression. He stressed the importance of matching treatments to individual needs, highlighting that personalization in care is crucial. This methodological similarity across different health areas showcases a consistent approach in medicine—combining pharmacological and behavioral strategies to achieve better health outcomes.

Discussing the significant impact of medications for OUD, emphasizing their role in reducing overdoses and fatalities, he highlighted the effectiveness of methadone, buprenorphine, and naltrexone, which are FDA-approved. Methadone is described as a full agonist opioid requiring higher doses to achieve its effect, whereas buprenorphine can be prescribed more broadly due to recent regulatory changes. Dr. Hurley explained that while naltrexone is available in both pill and injectable forms, the injectable form is preferred for its efficacy. He advocated for patient-centered care, choosing medications based on individual patient needs and circumstances. Dr. Hurley continued by elaborating on the use of buprenorphine, noting its ability to block the effects of opioids, thus reducing the reinforcing nature of opioid use. He highlighted that, while some patients may still feel effects, they are not as intense or rewarding, promoting better treatment retention. Despite this, a significant number of patients might still use opioids on top of their medication; however, this is considered safer than using opioids without any medication as it significantly reduces the risk of overdose.

Dr. Hurley discussed the high risk of relapse for individuals with OUD who do not receive medication-assisted treatment (MAT), noting a 77 percent return to use rate within three months post-incarceration. He praised CDCR for implementing an addiction medication

program, aiming to reduce these relapse rates. Dr. Hurley advocated for a 'medication-first' approach (e.g., treatments like buprenorphine initiated promptly upon diagnosis), noting the importance of quickly administering medications for OUD upon diagnosis, even without a complete biopsychosocial American Society of Addiction Medicine (ASAM) assessment. Rather than strictly adhering to program timelines, an emphasis should be placed on the fact that medication should not be contingent on other treatment forms unless they are detrimental to the patient and reiterated the importance of keeping treatments patient-centered, flexible, and with minimal barriers to access. Dr. Hurley stressed the significant gaps in treatment within both community and correctional health settings, advocating for greater access and adherence to medication-first strategies to enhance treatment outcomes and reduce opioid misuse. He discussed the medications for AUD, noting that while they are less effective than those for OUD in terms of mortality, treatment retention, and reduced alcohol consumption, they still provide significant public health benefits by helping individuals reduce their alcohol consumption. He highlighted that these medications might prevent further DUIs and preserve liver health, underscoring their effectiveness despite a smaller effect size compared to OUD medications.

Next, Dr. Hurley introduced contingency management (CM) as the treatment of choice for StUD, launched in 2023. With over 44 sites in LA County offering CM, it provides incentives for patients willing to attend treatment programs, helping to reduce stimulant use. He explained that CM works best when reinforcement is immediate and based on objective measures like urine tests. He stressed the importance of referring individuals with methamphetamine use disorder to CM programs as it significantly impacts the stimulant-driven overdose crisis. Dr. Hurley addressed the medications that can help reduce stimulant use, noting that while some show promise in clinical trials, their effectiveness is generally lower than medications for OUD. He explained that agonist treatments for StUD, such as using other stimulants like Adderall, do not work as well due to the complex effects stimulants have on the brain. He emphasized that such treatments should only be administered by specialists in addiction psychiatry or medicine due to their high risk.
Dr. Hurley described a study on extended-release naltrexone injections for StUD, noting a modest but significant effect compared to placebo, with 11 percent more responders in the treatment group. He explained that responders had at least three out of four negative urine screens during the measurement period which, while not full abstinence, is a positive outcome.

Dr. Hurley closed out the presentation by stressing the importance of connecting individuals to ongoing treatment post-release, advocating for maintenance treatments and highlighting resources like the LA MAT website, which lists community health centers offering addiction medications. He emphasized the need for universal access to addiction medications throughout the health care system, as outlined in the ASAM criteria. He also mentioned the California Substance Abuse Service Helpline for clinical support and referrals, and the LA County MAT consultation line through the Ambulatory Care Network for on-demand prescriptions. Dr. Hurley also highlighted the toolkit, How to Integrate Pharmacotherapy for

Substance Use Disorders at Your Mental Health Clinic, emphasizing the need for organizational readiness and leadership support for successful implementation.

Q&A with Councilmember Advisors

Q: Councilmember Whitney inquired about budgetary constraints affecting the availability of buprenorphine in jails, particularly in comparison to its use in Orange County versus LA.

A: Dr. Hurley explained that the primary cost concern was not the medication itself, but rather staffing costs associated with administering it. He discussed how in LA, the lack of sufficient nursing staff to perform observed dosing was a significant barrier. He contrasted this with Orange County, where existing staff were tasked with the additional duties, thereby managing costs effectively. Dr. Hurley emphasized that, while the actual pharmacy cost of injectable buprenorphine is higher than sublingual forms, the overall cost considerations were more about staffing and administration than the medication itself. He also mentioned that despite the challenges, it was easier to access injectable buprenorphine within custody due to the assertive administration practices, ironically making it more accessible there than in the community.

Q: Councilmember Castillo asked for Dr. Hurley's thoughts on decriminalization and diversion efforts to decrease the arrest and incarceration of individuals with SUD. He inquired about the importance of these efforts and sought examples of best practices.

A: Dr. Hurley, distinguishing his personal views from those of LA County, stated that he supports the decriminalization of substances for personal use, aligning with ASAM policies. He emphasized that treating individuals who use drugs as needing help rather than punishment can significantly impact their recovery and integration into society.

Q: Councilmember Fisher shared her personal connection to the issue as a mother of an adult son with co-occurring disorders, including schizophrenia and substance use, who has been incarcerated multiple times. She mentioned her son's recent access to Suboxone and expressed hope due to his current stability on the medication. She also highlighted her involvement with a local board distributing Narcan and training people in homeless encampments, emphasizing the importance of accessible treatment and support.

A: Dr. Hurley acknowledged Councilmember Fisher's contribution and efforts, expressing optimism for her son's situation and appreciating her active role in supporting addiction treatment and recovery in the community.

Q: Councilmember Svonkin expressed curiosity about strategies for maintaining public safety while also supporting individuals with mental health issues within the criminal justice system. He inquired about balancing accountability with support for those suffering from these disorders, highlighting the challenges of public demand for both safety and supportive measures.

A: Dr. Hurley discussed global best practices from his experiences in cities like Barcelona, Copenhagen, and Lisbon, which focus on low-threshold, medically supervised drug consumption rooms to reduce public drug use and related crimes. These cities provide services that include drug dosing with anonymity and integration of health services, creating a supportive environment that reduces the necessity for public drug use. He emphasized that creating accessible environments with comprehensive support services can significantly enhance public safety and personal health, reducing the need for punitive measures and potentially lessening the burden on the judicial system. Dr. Hurley suggested similar strategies could be beneficial if adapted to local laws and contexts, mentioning efforts in LA County to establish drop-in centers that provide safe spaces without fully legalizing safe consumption sites.

A: Councilmember Whitney discussed the intersection of criminal justice and mental health support, focusing on the effects of Proposition 47, which reduced certain drug felonies to misdemeanors and led to a drop in treatment program participation. She emphasized the importance of mental health diversion programs, which can dismiss charges if individuals engage in treatment, arguing that these programs motivate participation in treatment and ultimately benefit society by addressing underlying issues rather than imposing punitive measures. Councilmember Whitney supports using these programs not only for traditional mental health conditions, but also for SUDs, highlighting their potential to transform and improve outcomes by providing alternatives to incarceration.

Q: Councilmember Jenkins expressed confusion regarding the treatment approaches for SUDs, referencing his extensive experience in the criminal justice system and treatment courts. He highlighted the Diagnostic and Statistical Manual of Mental Disorders criteria for SUDs and questioned the alignment with low-barrier models such as harm reduction, especially given the significant life disruptions indicated by the criteria. Councilmember Jenkins sought clarity on how these models contribute to recovery if they do not directly lead to sobriety.

A: Dr. Hurley acknowledged Councilmember Jenkins' confusion and clarified that the primary goal of treatment is to restore function, which does not necessarily require abstinence for all individuals. He explained that low-barrier treatments are designed to initiate individuals on the path to recovery by accommodating their readiness for change, supporting gradual improvements in functioning that could potentially lead to sobriety when they are ready.

Q: Councilmember Jenkins acknowledged his understanding of the therapeutic focus on restoring function rather than insisting on abstinence. He interpreted Dr. Hurley's mention of "function" and the pathway to recovery as potentially transitory, depending on the individual's circumstances, suggesting that recovery processes could vary in duration.

A: Dr. Hurley affirmed Councilmember Jenkins' understanding, clarifying that the transition through recovery could indeed span years, depending on the individual's specific needs and progression. He emphasized that low-barrier treatments are designed to start

individuals on their recovery path without demanding immediate abstinence, thereby accommodating varying timelines for achieving functional restoration.

Q: Councilmember Jenkins probed further into the concept of "coerced treatment," reflecting on the justice system's influence and the potential for treatment under duress, where individuals might not voluntarily choose to enter treatment, but do so under legal pressure or as an alternative to incarceration.

A: Dr. Hurley explained that while some aspects of treatment might appear coercive, they are intended to offer individuals a choice between incarceration and treatment, thus still maintaining a level of voluntary participation. He discussed the broader implications of treatment modalities that allow individuals to engage in recovery efforts that are better suited to their conditions and life contexts rather than rigid, program-centered approaches.

Q: Councilmember Jenkins inquired about CM for stimulant use, emphasizing that the approach does not necessarily involve group interventions or other psychosocial counseling. He sought clarification on whether CM alone could suffice in the absence of these traditional treatment elements.

A: Dr. Hurley confirmed that CM does not require group participation or other traditional treatments to commence. He explained that, while these elements are beneficial and available, they are not mandatory for starting CM. The goal is to attract individuals into treatment using incentives (the "carrot" approach), and once engaged, they often opt to participate in additional supportive activities, but it's not a precondition.

Q: Councilmember Jenkins further questioned if the absence of mandated additional treatments like medications or groups within CM meant the model could stand alone as part of a comprehensive treatment plan.

A: Dr. Hurley emphasized that CM should be seen as an entry point into a broader treatment spectrum. It is designed to be part of an integrated approach where patients, once engaged, are exposed to a range of available treatments and can choose to participate in additional services based on their needs and preferences, making the process highly personalized and patient centered.

Q: Councilmember Manley inquired about the prevalent issue of fentanyl being mixed with methamphetamine, which is the primary drug found in street-related deaths in Santa Clara County area. He asked Dr. Hurley what medication could be used for patients who are using both methamphetamine and fentanyl.

A: Dr. Hurley clarified that about 5 percent of methamphetamine samples contain fentanyl. He emphasized that not all methamphetamine includes fentanyl, but the inconsistency of its presence makes it highly dangerous. For treatment, if the individual is using fentanyl, medications like buprenorphine are recommended for opioid use. If the person is using methamphetamine, CM combined with off-label medications specifically for methamphetamine use is suggested.

Q: Councilmember Manley also addressed the integration of substance abuse and mental health services. He noted his long-standing efforts to see integration in Santa Clara County where significantly less funding is allocated for substance abuse than for mental health. He mentioned an understanding that state mandates may soon require these services to be integrated.

A: Dr. Hurley responded that integrating substance use and mental health services involves a complex process that includes investing in specialized SUD systems and ensuring all other health systems recognize substance use as a core issue. He alluded to the California Advancing and Innovating Medi-Cal (CalAIM) initiative as a mechanism to support this integration but noted that explaining the full implementation process would require a more extended discussion beyond the current setting.

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

Q: A public participant expressed his admiration for the presentation, noting that it shared a wealth of knowledge. He mentioned his previous success using CM principles with parole violators, emphasizing the significant improvements seen despite a lack of formal understanding of the methods at the time. The commenter also highlighted the geographical disparity in program availability across California counties, expressing a desire to replicate successful models like those in LA. He called for better coordination among counties to standardize and expand access to effective programs. Additionally, he addressed the need for clearer information and data sharing across the state to improve program transparency and efficacy.

V. CCJBH Business Meeting

CCJBH Project Updates

Brenda Grealish, Executive Officer, CCJBH

- **CCJBH Legislative Reports**

Ms. Grealish provided an update on the CCJBH legislative reports, detailing the dissemination of the 2022 and 2023 reports to county behavioral health directors and Boards of Supervisors. She noted efforts to coordinate briefings on these reports' recommendations for legislative staff and mentioned upcoming "Lunch and Learn" webinars in July to provide an accessible overview of the report recommendations. Additionally, Ms. Grealish highlighted that work has begun on the 2024 Legislative Report, with a call for recommendations from Councilmembers expected soon.

Councilmember Jenkins responded to Ms. Grealish's update on the legislative reports, expressing appreciation for the thoroughness of Dr. Hurley's presentation and its relevance to the Council's work. He acknowledged the efforts to solicit input for the reports and suggested considering time for Councilmembers to discuss their insights after presentations, emphasizing the value of sharing diverse perspectives and experiences to enrich the Council's consensus and recommendations. Councilmember Jenkins highlighted

the importance of public discussion in compliance with the Bagley-Keene Open Meeting Act and encouraged leveraging CCJBH Workgroups to enhance council deliberations.

- **JUVENILE JUSTICE COMPENDIUM AND TOOLKIT**

Ms. Grealish provided updates on the Juvenile Justice Compendium and Toolkit Contract. The contract with RAND ended in April 2024, culminating in the launch of the California Juvenile Justice Toolkit on April 19, 2024, at the CCJBH Juvenile Justice Workgroup. This toolkit was widely promoted through CCJBH's listserv and the Office of Youth and Community Restoration's (OYCR) communication channels.

A methods report detailing the development of the toolkit is undergoing final review and will be posted on the CCJBH website upon approval. Additionally, a Training and Technical Assistance Plan was completed in April 2024 and provided to OYCR for implementation. RAND and OYCR are currently discussing how to support counties interested in implementing evidence-based programs identified in the toolkit.

- **WORDS TO DEEDS (W2D)**

Ms. Grealish updated the Council on the Words to Deeds (W2D) initiative, highlighting the allocation of $166,668 from CCJBH's annual budget in July 2023 to support its ongoing efforts. Partnering with the Mental Health Services Oversight & Accountability Commission, they have secured matching funds. This partnership will facilitate two annual W2D convenings, one on September 5th and 6th, 2024, and another in 2025, focusing on identifying key metrics for the justice-involved behavioral health population, leveraging and informing CCJBH'S Public Health Meets Public Safety (PH/PS) Framework and Data Visualization

- **Public Health Meets Public Safety (PH/PS)**

Ms. Grealish provided updates on the Resident Corrections Analyst (RCA) and UC Berkeley Possibility Lab collaborations. The RCA grant, funded by the Bureau of Justice Assistance, aims to improve data retrieval and standardization practices for CCJBH's PH/PS Data Visualization initiatives. With the RCA grant concluding in August 2024, the UC Berkeley Possibility Lab will take over to maintain the data inventory and visualization updates. This includes developing a data refresh schedule and continuing the dialogue on data relevance for crisis response services related to California's 988 line and broader system goals.

- **Medi-Cal Utilization Project (MCUP)**

Ms. Grealish provided an update on the Medi-Cal Utilization Project (MCUP) status. CCJBH is actively analyzing Department of Health Care Services (DHCS) Medi-Cal data from FY 2020-21 and 2021-22, focusing on individuals released from CDCR. The upcoming Calendar Year 2024 report will offer insights into Medi-Cal enrollment, Medi-Cal Managed Care Plan selection rates, and the utilization of Medi-Cal mental health and SUD services. Efforts are underway with DHCS to explore new data avenues, particularly around Enhanced Care Management (ECM) and Community Support services.

- **Lived Experience Projects (LEPs)**

Ms. Grealish provided updates on the Lived Experience Projects (LEPs). During the April 2023 Full Council Meeting, Councilmembers voted to establish one state and three local-level LEP contracts, which were subsequently released in April and May 2024. The contracts are currently being finalized with selected LEP contractors, with announcements of the selected contractors scheduled for the September Full Council Meeting.

- **Additional Updates**
  - **Legislative Tracking:** CCJBH is currently tracking 138 bills in the legislative session that began on December 4, 2023. These bills cover areas such as juvenile justice, foster care, housing security, SUDs, and issues concerning those deemed incompetent to stand trial. For a complete list and more details, you can visit the CCJBH website.
  - **Justice-Involved Peer Support Specialty:** CCJBH is actively monitoring and promoting the justice-involved peer support specialty through the California Mental Health Service Authority's Medi-Cal peer certification process. This initiative was highlighted during the last CCJBH Diversion and Reentry Workgroup meeting, where the implementation within the CDCR's Integrated Substance Use Disorder Treatment program was discussed. The program is now certifying incarcerated individuals as Medi-Cal peer support specialists, preparing them to join the community workforce upon release, thereby enhancing both their reintegration prospects and the available support network.
  - **CalAIM:** CCJBH continues to work to support CDCR's criminal justice system partners in efforts to implement ECM referrals for Individuals with behavioral health needs who are involved in the justice system.
  - **Housing/Homelessness:** CCJBH continues to support the CDCR Secretary's role as an appointed member of the California Interagency Council on Homelessness. On June 10, 2024, CCJBH Submitted a letter of support and recommendations to Department of Housing and Urban Development (HUD) in response to their proposed rule, "Reducing Barriers to HUD-Assisted Housing."
  - **May is Mental Health Awareness Month**: CCJBH hosted four informational Lunch and Learns to observe Mental Health Awareness Month.
  - **1115 BH Connect Addendum**: DHCS opened a 30-day public comment for a new addendum to the Section 1115 BH-CONNECT Demonstration from June 14, 2024, to July 14, 2024. CCJBH will review the addendum and provide feedback to address the unique needs of the BH/JI population.

- **Workgroup Reflections**:
  - **June Juvenile Justice Workgroup**: This workgroup continued the discussion on the definition of restorative justice that will be adopted by CCJBH and featured presentations on residential treatment for justice-involved youth with serious mental illness and SUD.
  - **June Diversion/Reentry Workgroup:** This workgroup highlighted presentations on services and programs that utilize peers to provide SUD treatment in carceral and community-based settings at the state and local levels.
  - In future Full Council Meetings, Councilmember Workgroup Advisors will provide an overview and reflections of the previous Juvenile Justice and Diversion/Reentry workgroups.

VI. Upcoming Events

The next Juvenile Justice Workgroup meeting will be held on August 16, 2024, from 12:45 PM- 2:45 PM, and will focus on the Children and Youth Behavioral Health Initiative. The next Diversion/Reentry Workgroup meeting will be held on August 23, 2024, from 2:00 PM – 4:30 PM, and will highlight the multi-system implementation of criminal justice system evidence-based practices (e.g., collaborative case planning and the Risk-Responsivity Model) and how this approach can be used to support the implementation of new state initiatives .The next Full Council Meeting will be held on September 27, 2024, from 2:00 PM – 4:30 PM and will focus on CalAIM implementation at the county level.

VII. Adjourn