

CCJBH Diversion Reentry Meeting Minutes

Friday, June 7, 2024

3:00 PM – 5:00 PM

In-Person and MS Teams Webinar

Workgroup Purpose:

The Council on Criminal Justice and Behavioral Health (CCJBH) webinar showcased presentations on services and programs that utilize peers to provide substance use disorder treatment in carceral and community-based settings at the state and local levels.

Councilmember Advisors:

Mack Jenkins, Chief Probation Officer, Retired, San Diego County
Judge Stephen Manley, Santa Clara County Superior Court
Dr. Tony Hobson, Behavioral Health Director, Colusa County (absent)

CCJBH Staff:

Staff Members in attendance: Brenda Grealish, CCJBH Executive Officer, Elizabeth Vice, Jessica Camacho Duran, Emily Mantsch, Cameron Byrd, Belicia Smith, Gabriella Wyatt, and Catherine Hickinbotham.

I. Welcome & Introductions

Ms. Grealish welcomed participants, gave an overview of the agenda, and shared the purpose of the workgroup. Councilmember Jenkins and Manley introduced themselves to the participants.

II. Community Medical Centers (CMC) – Recovery Services

Lei McMiller, *LMFT, Director of Substance Use Disorder Services*

CMC provided an overview of their programs for individuals who suffer from behavioral health conditions (i.e. mental health and/ or substance use disorders). CMC is celebrating 45 years as a nonprofit organization, having expanded from two clinics and one mobile site to 28 neighborhood health centers in the San Joaquin area and two in Solano County. CMC provides a range of services including primary and specialty medical care, mental health for low to moderate needs (including psychiatry), case management, dental services. CMC's mission has consistently been to work collaboratively to improve the health and well-being of the community.

CMC's behavioral health services include the Transitions Clinic Network (TCN), Mobile Care Response Treatment (MCRT), California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM), psychiatry, and integrated

behavioral health services. The organization focuses on justice-involved individuals referred through law enforcement or court partnerships, such as drug and Driving Under the Influence (DUI) courts. CMC employs community health workers (CHWs) with lived experience to deliver these services, aiming to reduce recidivism within the justice system. By addressing substance use, mental health, and medical needs, CMC provides comprehensive wraparound services to support individuals' overall well-being.

Ms. McMiller explained that all treatment services at CMC are trauma-informed and focused. Counseling services are available within clinics and through telehealth, funded by grants and billing services. The TCN program, developed in collaboration with community-based organizations (CBOs), aims to improve health and reentry outcomes for incarcerated individuals. It employs individuals with histories of incarceration to build trust and facilitate access to necessary services.

CHWs assist patients with obtaining essential documentation such as identification documents (IDs), birth certificates, and Social Security cards. Ms. McMiller expressed that CHWs connect patients with primary care, behavioral health services, and resources for transportation, housing, and other recovery needs. Referrals to CMC come from the California Department of Corrections and Rehabilitation (CDCR), internal sources, CBOs, and self-referrals. A CMC case manager triages this information and assigns a CHW to reach out to the client upon release. Currently, CMC serves over 192 individuals, with this number continuing to grow.

The SUD program, initiated in 2018 using County Behavioral Health Innovation Funds from Mental Health Service Act (MHSA) and Proposition 47, adopts an integrated whole-person approach. It focuses on individuals struggling with homelessness, SUD, mild-to-moderate mental health issues, and/or law enforcement involvement, aiming to reduce the impact on jails and emergency rooms (ERs) by lowering barriers to care. The SUD team includes counselors, licensed clinical social workers, SUD counselors, medical providers, and nurses who provide medication-assisted treatment (MAT). The support team comprises case managers, patient health navigators, CHWs, and peer counselors.

Regarding SUD services, Ms. McMiller stated services include outpatient and inpatient services, respite residential services, and outpatient youth and adolescent services. Outpatient services cater to individuals aged 18 and older, offering trauma-informed care, MAT for opioids and alcohol, one-on-one mental health and substance use counseling, group counseling, and monitored detox sobering. The respite residential service offers a 14-day transitional stay with 24-hour monitoring, SUD treatment, and whole-person care. The adolescent and youth program serves ages 12 to 26, offering services through the Stockton Unified School District and CMC's pediatric clinic on California Street in Stockton, CA.

CMC collaborates with community-based programs, county courts, behavioral health organizations, DUI and drug courts, law enforcement, managed care plans (such as Health Plan of San Joaquin and Health Net), county behavioral health, high schools, and hospital EDs (like Saint Joseph, Lodi Memorial, and Dameron).

CMC's physical facilities include Waterloo Recovery in Stockton, Respite Residential/Medical in Stockton, and Tracy Recovery in Tracy. An upcoming sobering center in Manteca is also planned. Data on the CMC SUD program indicates that the quarterly bed occupancy for Respite Residential is 332 bed days, with 45 percent of individuals receiving aftercare and 12 percent continuing to long-term recovery through partnerships. 30 percent of SUD patients receive MAT treatment, with individuals receiving Oral Suboxone, Vivitrol, or Sublocade injections. Among the CMC population, 8 percent are homeless, and 46 percent are below the poverty rate. The SUD program's enrollment increased from 52 percent to 82 percent in the past year, maintaining service continuity during the COVID-19 pandemic.

Ms. McMiller concluded with a video testimonial from an individual who benefited from the CMC SUD program, illustrating the organization's commitment to providing second chances and comprehensive services to those in need.

III. CDCR: Division of Rehabilitative Programs (DRP), Occupational Mentor Certifications Program (OMCP) Paul Galloway, Substance Use Disorder Certified Counselor *II Journey Counselor*

Thomas Deschaine, Certified Alcohol and Drug Counselor *I Journey Counselor*

OMCP concluded a two-part CCJBH Diversion/Reentry Workgroup series on the background and certification process of DRP's OMCP facilitated at Valley State Prison (VSP). Their presentation began by providing an overview of the OMCP, which provides incarcerated individuals with the training and education needed to become Alcohol and Other Drug (AOD) Counselors and allows participants to provide valuable mentorship within prisons as a paid position through DRP. OMCP mentors provide guidance and peer-to-peer support to incarcerated individuals assigned to Cognitive Behavioral Interventions (CBI), a component of the program jointly operated by CDCR and California Correctional Health Care Services, Integrated Substance Use Disorder Treatment (ISUDT). Currently, 14 OMCP graduates who released from prison are now working as contracted staff who provide AOD services inside the institutions and community-based programs. Mr. Galloway encouraged participants to visit www.the50film.com to gain information about the process of OMCP's changes over time and its goal and vision.

In 2009, CDCR's DRP collaborated with Orange County Department of Education, Options Recovery Systems, and others to recruit and train 50 incarcerated people at California State Prison, Solano, to obtain a certification as Substance Abuse Counselors recognized by the California Department of Health Care Services

(DHCS). This collaboration was highly successful, causing CDCR to expand and continue the program in 2011. OMCP is now operating at seven facilities across the state. The OMCP program at California State Prison, Los Angeles, began on July 12, 2021. The typical length of an entire training program for an OMCP cohort is one year. The breakdown of that training includes 360 hours for the ISUDT phase, 80 hours of study preparation, 350 hours of education and 255 hours of clinically supervised practicum. The AOD counselor certification that they receive after they complete those internship hours is from the California Association for Alcohol/Drug Educators, recognized by DHCS.

Mr. Deschaine provided the eligibility criteria for the OMCP. To be eligible for OMCP, individuals must have more than five years left to serve on their sentence and have avoided any serious rules violations over the past three years or security housing unit terms in the past 3-5 years. Both are reviewed on a case-by-case basis. They must have a reading level of 9.0 or above and must complete and submit an application packet to their institution Correctional Counselor (CC) II or I or DRP CC III and participate in an interview process. The application process requires submittal of a resume, at least two-character references from staff members, any certificates earned, and a 500-word essay answering the following question: “How do I maintain my recovery AND what can I offer others to sustain their recovery?”

Courses covered during the AOD education element of the program include a minimum of 50 hours of training in each subject: Overview of Addiction, Neurobiology & Pharmacology, Individual, Group, & Family Counseling, Personal & Professional Development, Case Management, Law and Ethics, and Practicum & Orientation.

Participants in the OMCP are recruited from institutions statewide to receive training at one of the seven training sites across California. These include California Correctional Institution, California Men’s Colony, in San Luis Obispo, California State Prison, Corcoran, California State Prison, Los Angeles County, California State Prison, Solano, Central California Women’s Facility (CCWF) in Chowchilla, and VSP in Chowchilla.

Upon successfully completing the OMCP and passing an AOD exam proctored by an accredited AOD certifying agency, participants return to the institution from which they are recruited, transfer to an institution in need of OMCP’s, or remain at the training site, based on CDCR need, where they assist CBI contract staff in co-facilitating ISUDT groups. OMCP graduates have an important role in the CBI component of the ISUDT program. Inside CBI classes, mentors assist the staff contracted by DRP to operate those classes by providing guidance to participants and peer-to-peer support of understanding and utilizing the course curriculums. OMCP maintains the safety and security for contractors during CBI classes by supervising the group, adhering to standard CDCR safety and security policies and procedures, and utilizing OMCP mentors to demonstrate group norms. They are

paid for this work while in prison, with pay increases for each successful advance in classification, up to \$2.00 per hour as an OMCP Certified Mentor. OMCP graduates also facilitate other types of programs while they are incarcerated, like youth diversion programs at CCWF and VSP. Once released, OMCP graduates have been hired by nonprofits/community-based programs and have come back to the prisons to facilitate other programs.

An OMCP mentor leverages evidence-based education and life experience to provide guidance and peer-to-peer support to incarcerated individuals assigned to the CBI program. They work as a liaison between the incarcerated population and staff, assist in the delivery of CDCR DRP ISUDT programming at various institutions, and participate in Peer Awareness Group (PAG) to maintain accountability within the program. OMCP mentors also serve as role-models and encourage CBI participants to take part in monthly various community Awareness Workshops such as Domestic Violence Awareness Month, Cancer Awareness Month, Recovery Month, etc.

The OMCP contributes to rehabilitative communities by role-modeling pro-social behaviors for incarcerated community, encourage non-ISUDT participants to seek treatment through ISUDT, and addressing community needs by spending time with the youth offender and newly incarcerated populations to guide them towards rehabilitation opportunities.

The OMCP faces common challenges and utilizes several best practices to ensure the program's success. Many departments or agencies outside of DRP are unfamiliar with the level of professional and personal development that is undertaken when participating within the OMCP. This leads to DRP representatives constantly having to remind and explain the OMCP credential(s) and the process to obtain them to ensure the appropriate consideration is given to individual case factors and recommendations for career advancement. This applies to OMCP attempting to reenter the institutional setting, as well as OMCP appearing before the Board of Parole Hearings (BPH). Successful OMCP best practices include daily meetings between OMCP mentors and contracted facilitators, OMCP use of appropriate self-disclosure, maintaining professionalism, guiding by behavior, and following group norms and CDCR policies. The local DRP team is responsible for referring all disciplinary issues to headquarters DRP team if any arise.

The presentation concluded with a discussion of accomplishments of former OMCP mentors. Several OMCP graduates have returned as contract staff after paroling. Many OMCP graduates have either created or joined non-profit organizations to provide continued AOD and other human services. Several OMCP graduates have pursued higher education obtaining bachelor's or master's degrees and professional licensure.

IV. California Correctional Healthcare Services (CCHCS) - Integrated Substance Use Disorder Treatment (ISUDT) Program

Barbara Barney-Knox, *Deputy Director for Nursing Services, ISUDT*
Edmund Montgomery, *Assistant Director for Nursing Services, ISUDT*
Janene Delmundo, *Deputy Director, Nursing Services, ISUDT*

This presentation focused on the CCHCS ISUDT program, highlighting their utilization of Peer Support Specialists to provide SUD services, which began through an effort to provide apprenticeship for incarcerated individuals. The main objective for the Peer Support Specialist program is reaching the incarcerated subpopulation who have been historically underserved. The program's goals include improving rehabilitative outcomes, supporting the work of CDCR staff and programs, and providing job opportunities post-release. The program is modeled from the OMCP, including similar processes for applications, interviewing, disciplinary action, and providing job opportunities on release. The starting pay for a Peer Support Specialist is \$38,000 – 50,000 per year. There is also a prospective opportunity to develop a higher level of a peer support specialist who earns \$60,000 – 70,000 per year.

She then provided an overview of the vision for peer support, which is to formalize the peer support program with a certification program and increase rehabilitation support available. The mentors are to gain skills so that when they leave, they enter the job market with experience, which will help to secure employment in the community.

The ISUDT peer support effort is part of the \$3 million annual ISUDT program allocation and is part of multiple tasks in the CDCR Strategic Plan, including CDCR's six Embedding Equity initiatives and it is one of four main pillars to the California Model. Having the incarcerated population serve as peers allows them to speak to their peers regarding care and provide information back to the program about health care initiatives.

Ms. Knox provided information on the Peer Support Specialist Certification Act, which was chaptered in 2020, but certification was not available until this year. The act allows for Medi-Cal to reimburse for health care peer support. To qualify for reimbursement, the peer specialist must have a Peer Support Specialist Certification. DHCS is responsible for this program and delegated the California Mental Health Services Authority (CalMHSA) to develop a certification process and approve training groups. Certification requires completion of CalMHSA 17 core competencies training, which is a minimum of 80 hours by an approved entity. CDCR has received designation as a CalMHSA-approved training entity.

Ms. Knox recalled the job opportunities for peer support specialists. New access to federal funding has prompted new jobs in health care organizations. Peer support specialists receive good pay at \$40,000 – 50,000 per year. Life experience counts when competing for jobs including former incarceration, transient population, chronic

mental illness or mental illness, and other historically underserved groups. Ms. Knox then detailed the two types of peer support specialists that the ISUDT Program will employ and train:

- ✓ The Recovery Support Specialist to help people with recovery, rehabilitation, and usually work in a nonpolitical setting like a housing unit.
- ✓ A Navigator to works in the broader health care system. They specialize with people with SUD but can also support rehab recovery and pre-release. A Navigator can also work in clinical settings including admissions where or in the Training and Technical Assistance (TTA) arena.

Training for Peer Support Specialists includes a 40-hour general orientation, the 17 CalMHS Core Competencies over two weeks, a one-week group facilitation practicum, and specialty on-the-job training. Mr. Montgomery emphasized that these competencies are essential for the Medi-Cal Peer Support Specialist certification exam, enhancing job market competitiveness and securing living wage jobs. The comprehensive curriculum covers hope, recovery, wellness concepts, group facilitation, employment preparation, advocacy, self-awareness, digital literacy, navigation, referral services, safety, crisis planning, psychiatric rehabilitation, documentation, cultural competence, conflict resolution, confidentiality, professional boundaries, ethics, and trauma-informed care.

Providing deeper insight to the group facilitation process Mr. Montgomery explained that [R1](#) is the company that the ISUDT Program partnered with for group facilitation training. Their curriculum is an evidence-based curriculum that covers mental health and wellness, SUD and addiction life skills, which includes topics such as stages of change, phases of addiction, emotions, feelings, and healthy boundaries.

Mr. Montgomery explained the Peer Support Specialist Program career ladder and pay scale explaining the program adopted an apprenticeship style model that begins with a baseline Peer Support Technician and then advances to a Lead Certified Peer Support Specialist as they increase their knowledge of the program and CDCR. Ms. Delmundo further highlighted that the Peer Support Specialist Program is a feeder into OMCP. The goal is that, once participants have gone through their baseline skills, it will simplify going through the OMC program to learn more of the curriculum.

Detailing the implementation schedule of the Peer Support Specialist Program, Ms. Knox explained that the first cohort launched in 2024 and finished in April 2024. Since then, a total of about 200 peer support specialists have entered the program at 5 institutions. The second cohort training will begin this month and the third group will begin in September 2024. It is expected that there will be approximately 980 Peer Support Specialists statewide by July 2026.

Ms. Knox then provided an overview of the Peer Support Specialist Program project progress, explaining the goal is to complete the rollout by the end of 2025. There is much support needed from headquarters at the regional level, and the program is currently spread too thin to take on more than four or five institutions at a time. There are Nurse Consultants from Mr. Montgomery's team that help support the progress goals. The program hopes to have about 1,000 Peer Support Specialists to help with the work ensure the incarcerated population gets the support they need.

Ms. Knox concluded the presentation by displaying posters that the Peer Support Specialist Program uses to advertise to the incarcerated population the benefits of this training, education, and certification in their re-entry into the community.

Councilmember Discussion

Q: Councilmember Jenkins expressed his gratitude for the presentation and inquired how the CMC program is funded and whether it was adequately funded.

A: Ms. McMiller responded that CMC is primarily funded through grants, including funds from the opioid settlement received through the city. She noted that certain stipulations attached to the grant funding limit some of the services that CMC can provide. Despite these limitations, grant funding allows CMC to serve more individuals than would be possible with other types of funding. Ms. McMiller also mentioned that CMC is not currently funded through Drug Medi-Cal, but is exploring this possibility for the future.

Q: Councilmember Jenkins asked whether CMC serves people in the justice system who are considered high-risk from a justice perspective.

A: Ms. McMiller explained that CMC categorizes its clients as mild-to-moderate from a medical perspective. She acknowledged that these individuals might be considered high-risk from a justice system perspective, a designation of which CMC staff may not always be aware.

Q: Councilmember Jenkins noted that the behavioral health or medical profession uses terms differently than the criminal justice system and asked for confirmation that CMC serves what might be considered high-risk individuals from a justice system perspective.

A: Ms. McMiller affirmed this, noting that CMC works directly with DUI cases and the court system. She stated that referrals from CDCR for individuals transitioning out of incarceration include some background information, primarily medical, to ensure CMC can provide the necessary services. She emphasized that minimizing barriers for these individuals is a priority for CMC, ensuring they receive the medical care they need.

Q: Councilmember Jenkins inquired whether CMC clinicians would benefit from more detailed background information on a patient's criminal history.

- A:** Ms. McMiller mentioned interest in receiving more information regarding safety because CMC is a CBO that is open to the public.
- Q:** Councilmember Jenkins suggested that better outcomes are achieved when the justice system and behavioral health providers share detailed information about the factors in their criminal histories that might be leading to their behavioral health issues.
- A:** Ms. McMiller agreed, noting that CMC conducts comprehensive psychosocial assessments when a person first meets with them.
- Q:** Councilmember Jenkins asked if Ms. McMiller was familiar with the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment, describing it as a criminal risk, need, and behavior-related assessment.
- A:** Ms. McMiller responded that she had not heard of a COMPAS assessment.
- Q:** Councilmember Jenkins inquired whether CMC clinicians work in collaboration with parole agents for those individuals who are justice-involved.
- A:** Ms. McMiller confirmed that such collaborations occur through the TCN program, which facilitates these interactions.
- Q:** Councilmember Jenkins asked about the starting point for the justice-involved population that CMC serves.
- A:** Ms. McMiller explained that referrals to CMC could originate from various sources, including law enforcement, the courts, the TCN program, CDCR referrals, or even self-referrals by individuals seeking assistance. She emphasized that CMC aims to reduce community barriers that impede individuals from accessing the care they need.
- Q:** Councilmember Jenkins requested examples of the barriers encountered by the justice-involved.
- A:** Ms. McMiller identified transportation and stigma as significant barriers. She noted that individuals often hesitate to seek help due to uncertainties about the confidentiality of their information. She assured that CMC maintains strict confidentiality, sharing information only when necessary, to mitigate these concerns.
- Q:** Councilmember Jenkins asked whether the TCN program includes any form of proactive outreach, such as a "handout" for individuals about to be released from incarceration.
- A:** Ms. McMiller clarified that the TCN program facilitates a "reach-in" approach, providing a bridge for individuals transitioning out of incarceration. This process involves pre-discharge coordination and ensures that individuals are connected to CMC upon their release, although exact discharge dates may vary.

Q: Councilmember Jenkins inquired whether all 192 members of the TCN program are parolees.

A: Ms. McMiller clarified that not all of them are parolees. She explained that these individuals have a history of incarceration and have been connected to CMC either during or post-incarceration. She acknowledged that, while some may currently be on parole, others might simply have past incarceration histories without current parole status.

A: Ms. McMiller mentioned the contribution of James Mackey, a former director of their program. She highlighted his significant role in the TCN program, particularly in facilitating connections between CMC and those still in the jail system, those being released, and those on parole. His involvement has been crucial in bridging these gaps and enhancing the program's effectiveness.

Q: Councilmember Manley inquired whether CMC takes in individuals who are actively experiencing psychosis and need medication assistance at all times.

A: Ms. McMiller clarified that CMC never turns anyone away, but seeks to connect them with the most appropriate care available. For those with severe diagnoses, such as active psychosis, CMC coordinates with the county behavioral health services to ensure these individuals receive the necessary specialized care.

Q: Councilmember Manley inquired where those individuals with severe psychoses go to receive services.

A: Ms. McMiller stated that the county of behavioral health provides services to individuals with severe diagnoses.

Q: Councilmember Manley asked about the ECM model and whether it is the same as the one associated with CalAIM, and if CMC bills Medi-Cal for these services.

A: Ms. McMiller confirmed that the ECM model is under CalAIM and that these services are indeed billed through the Medi-Cal system.

Q: Councilmember Manley inquired about the average caseload for a case manager at CMC.

A: Ms. McMiller explained that they strive to keep caseloads to about 30 individuals per case manager, though this number can fluctuate. She emphasized the intensive nature of their case management, which she likened to “case management on steroids,” involving regular monitoring and logistical support, such as ensuring clients attend health care appointments. CMC case managers also facilitate transportation, working with managed care to provide lift systems or mobile units for clients who need assistance reaching their appointments.

- Q:** Councilmember Manley inquired about the immediate housing options available for individuals entering CMC's programs, particularly for those who are unhoused.
- A:** Ms. McMiller noted that housing solutions are tailored to individual needs and circumstances, including emergency housing or long-term plans based on financial assessments. She stressed that CMC aims to avoid re-traumatizing clients by ensuring stable housing placements that contribute to successful outcomes, not just temporary solutions. For initial housing, CMC has contracts with local hotels and collaborates with shelters to accommodate individuals based on factors, such as family status and gender.
- Q:** Councilmember Jenkins expressed his gratitude for the Peer Support Specialist Program presentation and inquired who was the brainchild of the program.
- A:** Ms. Knox stated she came up with the idea of apprenticeship because she is the chair of the Interagency Advisory Committee on Apprenticeship through the State of California under the Department of Labor. When the grants started funding through and money started being available for the justice-involved, she thought to begin an apprenticeship for health care with the incarcerated population. Former Director Jane Robinson was responsible in getting the program partnered with ISUDT because there was already funding for it.
- Q:** Councilmember Jenkins sought further insight from both Mr. Galloway and Mr. Deschaine about their experiences with the OMCP.
- A:** Mr. Deschaine clarified that both he and Mr. Galloway were both life-term inmates who were found suitable for parole, and whose experiences with OMCP prepared them for their transitions into the community. After successful re-entry, they returned to the program as Journey Counselors.
- Q:** Councilmember Jenkins inquired whether Mr. Galloway and Mr. Deschaine were required to do drug-testing while going through the OMCP curriculum and training.
- A:** Mr. Deschaine clarified that both he and Mr. Galloway were randomly drug tested when they went through the program, but the drug testing requirement has changed since then.
- A:** Ms. Knox further clarified that when OMCP started, CDCR had not totally embraced ISUDT and SUD as a medical disease. Once it was embraced, the goal was to be non-punitive and understand the trajectory of the disease may include relapse and recovery, and that this cycle does not mean that they are not a viable candidate to continue in the program.

Q: Councilmember Jenkins stated he is a strong believer that regular substance use testing is a critical part of maintaining sobriety and recovery. He does not use the terms “recovery” and “sobriety” in the same way, but believes drug testing is a critical part of getting to and sustaining recovery.

A: Arturo Buitron, who works with the OMCP team, commented in response to Councilmember Jenkins question. He stated that initially when the program started, random drug testing was a requirement. However, since the implementation of the ISUDT program in 2020, drug testing stopped because the candidate pool is statewide there are incarcerated individuals on the MAT program. The OMCP did not want to preclude these individuals, noting that there is a lot of potential out there in the incarcerated population who suffers from substance use disorder.

Public Comment

Q: A member of the public stated that that there are now several hundred OMCP graduates who have also been released from prison and are available to work as substance use certified counselors. In the field, substance use and treatment programs are in a workforce shortage crisis. So, it would be helpful if instead of having to rely just on the informalities of a grapevine, CDCR were to join forces with some of the programs that are leading the OMCP program like Options Recovery, Amity, Phoenix House, and Center Point. Additionally, CDCR could examine the possibility to construct a job board both of available positions that could be made available to the graduates who want to post themselves as available for hiring.

A: Councilmember Manley thanked every presenter for their presentations and urged the public commentor to find ways to reach out and let everyone in the community know who is potentially a prospective employer, whether it be a treatment program or a government agency. It is important to go out there and convince the employers that they should be taking these individuals because there aren't enough treatment professionals.

A: Ms. Grealish further stated there's also significant needs for people with serious mental illness and even more so for the co-occurring population given there is such a huge need.

V. Announcements

The next [Diversion/Reentry Workgroup](#) will be on August 23, 2024, from 3:00-5:00 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 such as CalAIM, the CARE Act, etc. The next [Juvenile Justice Workgroup](#) will be on August 16, 2024, from 12:45-2:45 PM, and will focus on the Children and Youth Behavioral Health Initiative, with presentations from



the California Department of Public Health's Public Education and Change Campaign, the Department of Health Care Services' Universal Fee Schedule and Behavioral Health Virtual Services Platform. The next [Full Council Meeting](#) will be on June 28, 2024, from 2:00- 4:30 PM, and it will focus on the latest innovations in SUD treatment.

VI. Adjourn