



CCJBH Diversion Reentry Meeting Minutes

Friday, October 25, 2024

3:00 PM – 5:00 PM

In-Person and MS Teams Webinar

Workgroup Purpose: The Council on Criminal Justice and Behavioral Health (CCJBH) Diversion/Reentry Workgroup meeting included presentations focused on understanding and evaluating the implementation of the Community Assistance, Recovery, and Empowerment (CARE) Act.

Councilmember Advisors: (Participating remotely)

Judge Stephen Manley, Santa Clara County Superior Court

Dr. Tony Hobson, Behavioral Health Director, Colusa County

Mack Jenkins, Chief Probation Officer, Retired., San Diego County

CCJBH Staff:

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

I. Welcome & Introductions

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

II. Councilmember Advisor Reflections on the August Workgroup

Ms. Camacho-Hall opened the discussion by referencing the [August 2024 Diversion Reentry Workgroup Recap and Key Points](#) document summary handout provided, which reflected on the August 2024 Diversion and Reentry Workgroup meeting. The focus of the August 2024 Workgroup meeting was on evidence-based corrections, including the Risk-Needs-Responsivity (RNR) Model and the multi-system implementation of Collaborative Comprehensive (CC) Case Plans. Ms. Camacho-Hall then prompted the Councilmembers to provide their reflections on the following questions:

1. What are the key takeaway(s)/reflection(s) from these presentations?
2. Based on these takeaways/reflections, what recommendation(s) would you propose for consideration in the CCJBH Annual Legislative Report (if any)?
3. Should CCJBH continue working on this issue and, if so, how (continued discussion in workgroup meetings, informational research, etc.)



Second Chance Act: The Councilmember Advisors noted that during the August 2024 Diversion and Reentry Workgroup meeting, there was only one California grantee of the Second Chance Act. The Advisors emphasized the importance of identifying strategies to secure additional funding under the Second Chance Act. They also expressed appreciation for the inclusion of clients in CC case plans during the development of treatment strategies and highlighted the significance of incorporating relapse prevention plans.

Dialectical Behavior Therapy (DBT) Skills Group: The Councilmember Advisors expressed support for DBT Skills Groups, recognizing their benefits in both group and individual settings. The discussion also addressed jail-based treatment for individuals deemed Incompetent to Stand Trial (IST). Concerns were raised regarding the effectiveness of such treatment, particularly for individuals who leave custody shortly after receiving services, as it may primarily benefit those with extended periods of incarceration. The Advisors recommended leveraging behavioral health services to establish stronger connections between jail-based treatments and community support systems to ensure continuity of care upon release.

Universal Release of Information: Councilmember Advisors expressed interest in Boulder County's implementation of a universal release of information and mentioned that there is no current guidance for one in California. They suggested that an effort be made to develop one. It was discussed that CCJBH should monitor California Advancing and Innovating Medi-Cal's (CalAIM) attempt at a similar concept as part of their 90-day in-reach program.

Unique Independent Living Apartment Complex: The Councilmember Advisors support the development of unique, independent living apartments for youth transitioning out of custody, recognizing their potential to provide stable housing and tailored services, such as onsite psychiatrists, case managers, and other supports, to facilitate reintegration into the community. Councilmember Manley praised the innovative repurposing of custody facility space for apartment-style living and emphasized the importance of addressing the crossover between foster care youth and those involved in the juvenile justice system, advocating for diversion opportunities to prevent further system involvement. However, concerns were raised about whether these apartments might be perceived as an extension of custody due to supervision by the Sheriff or Probation Officers, rather than as a genuine step toward independence. The Advisors underscored the need to evaluate resident perceptions and program outcomes to ensure these living arrangements are viewed as opportunities for personal growth and successful reintegration.



III. Desert Vista Consulting, Update on the Implementation of the CARE Act

Karen Linkins, PhD, *Co-Founder and Principal, Desert Vista Consulting*

Ms. Linkins began the presentation by providing a brief overview of the CARE Act. The CARE Act is an upstream diversion process aimed at breaking cycles of homelessness, criminalization, and institutionalization to provide services to those who are the most vulnerable in the population with untreated schizophrenia and psychotic disorders who meet certain criteria. Ms. Linkins emphasized that the CARE Act is not a program, but rather a process which uses existing programs. Ms. Linkins described that the CARE Act prevents restrictive conservatorship by supporting stabilization through medication, behavioral health services and housing. She stated that CARE Act's unique feature is holding behavioral health systems accountable and preserving the participant's self-determination.

Ms. Linkins discussed how the California Health and Human Services (CalHHS) has coordinated and supported communication between the Judicial Council and the California Department of Health Care Services (DHCS) to implement the CARE Act. CalHHS convenes CARE Act Working Groups and subgroups as well as runs the [CARE Act website](#) which has reports, provides medical and community engagement and outreach as well as responds to the media, legislatures and stakeholders. CalHHS also supports DHCS training and housing programs, including the Behavioral Health Bridge Housing (BHBH) program.

The CARE Act was initially launched in October 2023 in seven counties, with Los Angeles County joining in December 2023, San Mateo in July 2024, and Kern County in October 2024. The remaining counties are expected to implement the program by December 2024. Ms. Linkins stated that participants can access CARE Act services through county behavioral health departments, crisis teams, contracted providers, hospitals, and community members. Ms. Linkins noted that family-initiated petitions account for over 50% of participant entries, making this the most utilized entry pathway. She also highlighted the misdemeanor and felony IST (MIST and FIST) pathways, which have posed implementation challenges, but are receiving focused attention for improvement.

Ms. Linkins explained a key strength of the CARE Act is the accountability framework requiring counties to collaborate with courts to deliver effective, participant-centered services. She expressed that accountability is reciprocal, making CARE Act a mechanism to foster active participation among participants. Additionally, unlike other programs, the CARE Act can reimburse every outreach and engagement effort. Ms. Linkins introduced the "three-legged stool" model supporting the CARE Act's goals through multiple strategies that focus on participants' access to comprehensive wraparound services. Emphasis is placed on housing and stabilization support to help participants achieve sustained progress.



Large investments have been made on CARE housing to prevent and end homelessness, giving priority to CARE recipients.

The CARE Act has achieved several successes, particularly in the coordination between county behavioral health departments and available behavioral health services. Counties have maximized existing staff resources and expanded peer roles, which has helped them overcome workforce challenges and complete outreach and engagement efforts. Ms. Linkins noted that extensive community education about the CARE Act, supported by National Alliance on Mental Illness (NAMI) California affiliates, has further enhanced awareness. Additionally, outreach services have seen high levels of engagement in locating participants. However, Ms. Linkins acknowledged ongoing challenges, including lower-than-expected petition rates, which has prompted a focus on identifying alternative petition pathways. Ascertaining safety issues and eligibility criteria of participants has also been difficult due to co-occurring substance use disorders (SUD) and physical health conditions. Ms. Linkins shared that detailed data on the CARE Act will be included in the Early Implementation Report, available in December 2024, and the Annual Report, to be published in July 2025 and annually after. The Annual Report will provide demographic data, outcome measurements, and an equity assessment.

Ms. Linkins transitioned to legislation that has made improvements to the CARE Act. SB1400 has improved data collection and documentation processes, making it easier to track outreach efforts and understand outcomes for those found ineligible for CARE. SB 42 links the CARE Act to the Lanterman-Petris-Short (LPS) Act, establishing an additional entry pathway. Additionally, Sutter Hospital is providing training to streamline CARE petitioning.

Looking ahead, Ms. Linkins discussed CARE Act's expansion plans. Cohort 2 will launch in December 2024. In the meantime, technical training assistance and support of the CARE Act is underway. Meetings with Cohort 2 will aim to strengthen collaboration between behavioral health and court teams.

IV. DHCS Overview of the Evaluation of the CARE Act

Andy Potter, *Program Evaluation Section Chief, DHCS*

Stephanie Holliday, *Senior Behavioral Scientist, RAND*

Mr. Potter opened by sharing the DHCS' collaboration with RAND due to their expertise in examining the intersection of behavioral health, the justice system, housing, and homelessness, especially within California. He emphasized the critical role of independent program evaluators. The annual reports, as previously mentioned by Desert Vista Consulting, provided timely snapshots of the state's CARE Act implementation. However, RAND's independent evaluation focused on assessing the CARE Act's impact on participant recovery, housing stability, justice

system involvement, and outcomes. This evaluation benefits from input across a broad range of stakeholders.

Mr. Potter introduced Ms. Holliday, who outlined RAND's evaluation plan for the CARE Act. Ms. Holliday presented RAND's four main goals: documenting the theory of change, evaluating implementation, assessing outcomes and impact, and making recommendations. RAND entered into contract with DHCS in early spring 2024 to develop an evaluation plan through stakeholder meetings, data collection, and finding gaps in currently available data. RAND is also finalizing a survey as part of its data collection efforts, although it is still early in the evaluation process, so Ms. Holliday did not present findings.

A central focus of RAND's evaluation process is equity, emphasized by Ms. Holliday, in participant selection and stakeholder engagement to ensure broad representation and address language barriers. A preliminary version of RAND's evaluation logic model can be seen below:

CARE Evaluation Logic Model – Draft 5-13-24

Evaluation Questions	Strategies & Activities	Implementation Outcomes	Key Outcomes
<p>Implementation:</p> <ol style="list-style-type: none"> How prepared were counties to implement the CARE Act model? How was CARE implemented? What factors might be impacting the effectiveness of CARE? <p>Community Assistance, Recovery and Empowerment:</p> <ol style="list-style-type: none"> Did CARE participants increase their engagement in needed services? Was access to services equitable? Did CARE participants experience increased mental illness recovery and empowerment? Were recovery and empowerment outcomes experienced equitably? 	<p>Individual-Level</p> <ul style="list-style-type: none"> Participation in CARE process: <ul style="list-style-type: none"> Petition/Initiation Engagement Court process and development of CARE plan Service connection Service delivery Engagement of advocates, including peers, family, and volunteer supporters <p>System-level</p> <ul style="list-style-type: none"> County workflows to support CARE implementation System coordination and linkage, including County BH, Public Defenders, Courts, and County Counsel Data collection and sharing Accountability levers 	<p>Individual-Level</p> <ul style="list-style-type: none"> Number and description of individuals on different pathways: <ul style="list-style-type: none"> Elective clients Voluntary CARE agreement status Ordered CARE plan status <ul style="list-style-type: none"> Developed Accessed Shared Adhered to Psychiatric Advanced Directive status ↑ Perceived appropriateness of care ↑ Perceived quality of care/services ↑ Perceived choice in care/services ↑ CARE participant satisfaction with process ↑ Family/caregiver satisfaction with process ↑ Social support (emotional, tangible, informational) ↑ Awareness of service options <p>System-level</p> <ul style="list-style-type: none"> ↑ Coordination between County BH, Public Defenders, Courts, and County Counsel Barriers and facilitators to implementation Availability of appropriate services County accountability (e.g., claims, fines and sanctions) <p>• Equity/disparities in above outcomes</p>	<p>Community Assistance, Recovery and Empowerment:</p> <p><u>3-legged stool:</u></p> <ul style="list-style-type: none"> ↑ Engagement in services ↑ Medication stabilization ↑ Safe, stable, preferred housing <p>↑ Personal recovery (CHIME framework):</p> <ul style="list-style-type: none"> Connectedness, Hope, Identity, Meaning and purpose, Empowerment <p>↑ Achievement of personal CARE goals</p> <p>↑ Meaningful work or community engagement –e.g., employment, volunteering, caring for others or enrollment in education</p> <ul style="list-style-type: none"> ↓ ED use ↓ Hospitalizations ↓ Arrests and incarceration ↓ LPS and probate conservatorships <p>• Equity/disparities in above outcomes</p>

Ms. Holliday elaborated on RAND's evaluation questions, which aimed to determine whether the CARE Act was implemented as intended, including identifying variations across counties. The questions also gauge participant engagement, with recovery and empowerment as core objectives. She emphasized that RAND measures strategy and activity changes at individual and system levels. RAND also plans to assess participant demographics, including those in voluntary CARE agreements and CARE plans. Here, perceived treatment quality, social support, and improved county coordination are evaluated.



Referring to Desert Vista Consulting's points about multiple strategies utilized in the three-legged stool, Ms. Holliday explained that the evaluation of key outcomes uses the "three-legged stool" framework to assess progress in mental health service engagement, stabilization by medication, and housing security. Recovery is the primary outcome, measured through stakeholder feedback and data on hospitalizations, arrests, and conservatorships to evaluate the CARE Act's impact.

RAND's evaluation employs a multi-faceted approach, drawing on both qualitative and quantitative methods. Qualitatively, Ms. Holliday described RAND's thematic analysis through in-depth interviews at county and state levels, exploring CARE Act's implementation, challenges, and factors impacting effectiveness. Twelve counties and participants from the two cohorts will be included, with consideration made for geographic diversity and population size. The interviews will be conducted with implementation partners, the agencies involved, and CARE participants. The filing process and ease of the program will also be examined.

On the quantitative side, Ms. Holliday detailed data collection strategies, focusing on the volume and characteristics of participants served, to assess CARE's impact. Primarily, RAND uses existing data to gauge CARE outcomes, including Medi-Cal claims from the Department of Health Care Access and Information and data from Health Management Associates.

Additionally, RAND is developing a survey centered on the Connectedness, Hope, Identity, Meaning, and Empowerment (CHIME) framework, offering participants multiple response options for accessibility. The survey can be conducted through the phone, web, or in-person field interviews. It is based on respondents' perception of their quality of care and level of choice to get data that is harder to receive from the counties.

RAND's evaluation also considers components related to incarcerated individuals and criminal justice involvement, exploring whether the program helps participants avoid interactions with the legal system. Furthermore, RAND hopes to be enlightened about noteworthy CARE pathways like petitions from jail, the California Department of Corrections and Rehabilitation (CDCR), or from those who were deemed IST. Ms. Holliday emphasized stakeholder engagement, achieved through meetings and working groups, as crucial to shaping CARE materials.

In closing, Ms. Holliday outlined RAND's evaluation timeline. An interim report documenting findings will be available by September 1, 2026, with the final report expected by September 2028.



V. Stanislaus County Behavioral Health Department, Implementation of the CARE Act

Tony Vartan, *Director, Master of Social Work (MSW), Licensed Clinical Social Worker (LCSW), Stanislaus County Behavioral Health*

Chandra Campbell, *Program Manager, Stanislaus County Behavioral Health*

Mr. Vartan shared the department's experiences with being among the first in California to implement the CARE Act in October 2023. He noted that the CARE Act provides essential services to those who have yet to succeed in recovery, enhancing the county's capacity to support individuals who have traditionally not accessed services. Mr. Vartan then introduced Ms. Campbell, who continued the presentation.

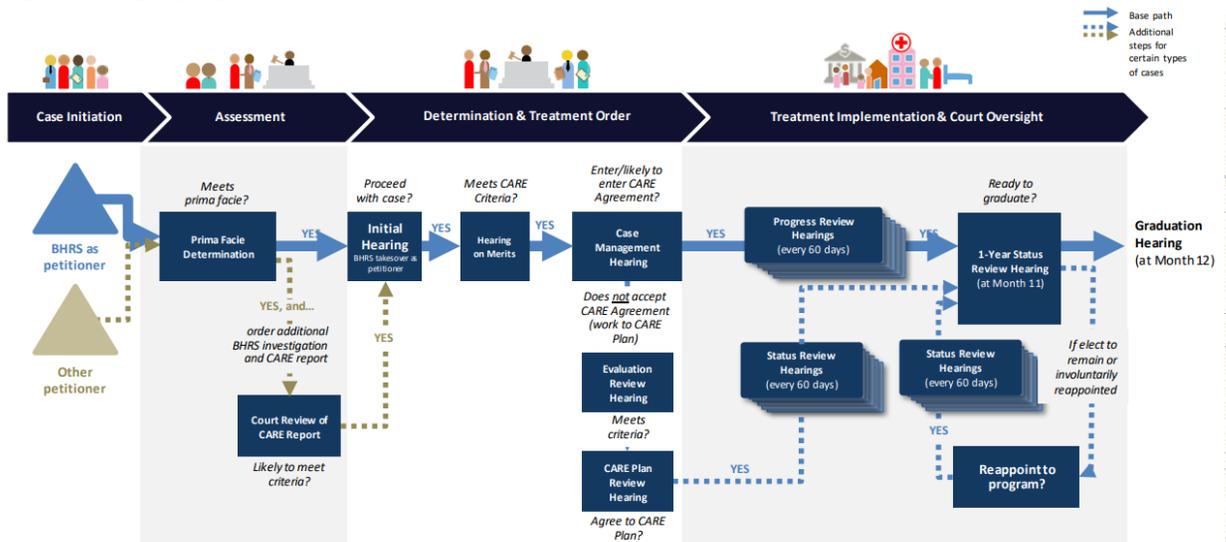
Ms. Campbell provided an overview of Stanislaus County's Behavioral Health and Recovery Services (BHRS), which serves a population of over 560,000 with 500 staff members and 80 programs. As the county's public guardian, BHRS emphasizes the recovery potential for individuals with mental illness and addiction. Ms. Campbell highlighted the court assessment and triage team, a forensic behavioral health service soon to be integrated into the Public Defender's office. This team conducts comprehensive psychosocial, mental health, and sexually transmitted disease (STD) screenings and provides treatment recommendations for justice-involved individuals with SUD and behavioral health conditions. These assessments guide decisions on whether drug or CARE courts are the most appropriate support options based on each individual's unique needs.

BHRS also offers programs such as multidisciplinary outreach teams, jail-based services, and collaborative courts, including adult drug courts, mental health courts, and veterans' treatment diversions. Ms. Campbell explained that the multidisciplinary outreach team, composed of behavioral health staff and law enforcement, has had notable success in working with CARE participants.

Ms. Campbell acknowledged and reiterated what Desert Vista Consulting stated in which CARE court is a civil court process for connecting individuals with a Serious Mental Illness (SMI), specifically schizophrenia spectrum and other psychotic disorders, to treatment under the oversight of a judge. It excludes psychosis resulting from traumatic brain injury, autism, dementia, or SUD, and individuals stabilized in voluntary treatment.

Regarding the referral pathway, Ms. Campbell emphasized that family, community, county, and tribal jurisdictions can submit CARE Act petitions directly to the court, which Stanislaus County accepts electronically or in person. BHRS provides support, training, and a self-help center to assist petitioners. She presented a process flowchart (shown below) that is divided into four separate sections: the case initiation when the petition is filed, the assessment or investigation, the determination and the order for treatment, and lastly, the treatment implementation and then the subsequent court oversight.

CARE Court



Stanislaus County Behavioral Health & Recovery Services

Courtesy of LA County CARE Court | 10

Ms. Campbell then outlined how Stanislaus County prepared for CARE court by collaborating with involved partners, stakeholders, other Cohort 1 counties, state representatives, and local-level executive oversight committees nearly a year before program implementation. The county also held bi-weekly workgroup meetings to develop workflows, communication strategies, and treatment plans. Extensive asset mapping helped identify service gaps, leading to increased contracted beds for transitional boarding care and improved treatment capacity. The county also leveraged the BHBH grant to expand services, with data from local psychiatric hospitalizations and court statistics guiding their planning.

Ms. Campbell described the CARE court treatment team, which provides trauma-informed care through behavioral health specialists, housing experts, and psychiatric nurses to deliver medication services with weekly court hearings that can be virtual or in person. She emphasized that CARE is a standalone level of care intended to utilize all available resources before the necessity of a conservatorship.

Following Ms. Campbell's segment, Mr. Vartan provided further insights stating Stanislaus County had served 86 individuals to date, with 57 petitions filed, 24 CARE agreements, and one CARE plan developed. He discussed the importance of early community engagement and training law enforcement, first responders, and hospital staff in early intervention and engagement for those needing treatment.

However, Mr. Vartan noted some initial challenges. One challenge note was referral points did not have specific information the petition required, which was addressed by developing new pathways for petition processing. He also emphasized that a



collaborative approach, as noted previously by Desert Vista Consulting and RAND, helped streamline access to care, especially for first responders needing information about participants' hospital histories.

Lastly, Mr. Vartan emphasized the importance of staff allocation and the value of early participant engagement, as criminal and new civil proceedings can be challenging when individuals are moved from one area to another. The county also focused on strengthening its crisis line and staff support, ensuring every participant has a clear pathway to resources and information, embodying a "no wrong door" policy.

Councilmember Discussion

Q: Councilmember Hobson thanked the presenters and acknowledged Stanislaus County for their well-established and robust continuum of care model for others to emulate. He discussed challenges in Colusa County with petitions and orders requiring participants to appear, noting the sensitivity of this process for providers. He asked Stanislaus County who is responsible for serving the client with the order.

A: Ms. Campbell explained that Stanislaus County utilizes outreach and engagement staff to deliver orders, which has proven an effective engagement strategy. This team provides the order, explains its purpose, and offers to help the client with the process. She noted that this approach helps establish trust and positions the staff as helpers for CARE participants.

A: Ms. Linkins added that other counties have contracted entities to serve orders instead of outreach and engagement teams.

Q: Councilmember Hobson noted that, in his experience, commercial insurance companies are often unwilling to reimburse county behavioral health departments for their services. He emphasized the importance of holding commercial insurance companies accountable and inquired whether Stanislaus County had any CARE participants with private insurance and, if so, whether reimbursements had been received for their care.

A: Ms. Campbell stated that a few participants had private insurance, but she was unsure whether the Stanislaus County Behavioral Health Department had been reimbursed. She offered to follow up with the accounting team.

A: Mr. Vartan concurred with Councilmember Hobson, acknowledging the challenges associated with securing reimbursements from commercial insurance providers. Stanislaus County has engaged in discussions with the California Hospital Association to address this issue and continues to monitor developments. Mr. Vartan expressed hope that ongoing education and collaboration with commercial health insurance providers will lead to a resolution of these challenges.



- Q:** Councilmember Manley inquired whether counties would see an increase in CARE petitions from judges as they seek appropriate treatment for individuals and if judges see CARE as an alternative to incarceration. He inquired about discharge plans for CARE participants after graduation.
- A:** Ms. Campbell explained that all graduates are required to have a discharge plan, as mandated by legislation. Stanislaus County utilizes CARE as a higher level of care and transitions clients to a voluntary Assertive Community Treatment model upon completion. This model maintains 24-hour care access and low staff-to-client ratios, similar to CARE, but without the court oversight component. Ms. Campbell also shared the positive news that Stanislaus County is about to have its first CARE program graduate.
- Q:** Councilmember Manley asked if RAND plans to track participants' outcomes post-CARE, specifically whether they remain in treatment or return to incarceration.
- A:** Ms. Holliday responded that RAND's ultimate goal is to track participants' progress following their completion of the CARE program. To achieve this, RAND has begun collaborating with various entities to access recidivism data while preparing for potential challenges in the process. However, there are indications that this data may only be available at an aggregate level rather than on an individual basis. RAND is actively continuing to explore solutions to address this limitation.
- Q:** Councilmember Manley noted that while his county has not yet implemented CARE, he has been utilizing Assisted Outpatient Treatment, which similarly engages individuals and provides follow-up care after treatment. He inquired whether RAND is also conducting follow-up assessments to determine if CARE participants remain engaged in treatment after completing the program.
- A:** Ms. Holliday answered that RAND hopes to use administrative data sources to set up a formal comparison over time for the two years before and after a client participated in CARE. They would like to determine if service engagement was different.
- A:** Ms. Campbell added that behavioral health departments are required to track data on CARE court graduations. It was initially for twelve months, but it may have been extended to three years.
- A:** Mr. Vartan noted that Stanislaus County also tracks individuals who engage in other services after failing to meet CARE petition requirements. This is considered one success of the program.
- Q:** Councilmember Jenkins thanked the presenters for providing a clear description of CARE. He appreciated that Desert Vista Consulting differentiated who the CARE Act's targets are and are not and enjoyed the clarity of the overview of



RAND's evaluation process. He also commended Stanislaus County for its accomplishments, as well as Councilmember Manley for his vision and effort to see CARE come to fruition. He sought clarification on the statistic that 50% of CARE petitions are initiated by family members. Additionally, Councilmember Jenkins asked if probation officers can file petitions.

- A:** Ms. Linkins affirmed that more than 50% of CARE petitions came from family members. She is happy with the family members, but also wants to maximize other petition pathways. As for probation officers, Desert Vista Consulting is collaborating with law enforcement agencies to test them as a potential pathway, noting it as a possibility. Ms. Linkins emphasized the importance of collaboration opportunities with clinical partners who have access to medical information unavailable to behavioral health teams with instances of successful collaborations between jails and counties. Desert Vista Consulting has also been educating sheriffs and first responders about CARE.
- Q:** Councilmember Jenkins clarified that his question was informed by the slides presented by Desert Vista Consulting, which outlined various CARE pathways. He emphasized that probation officers value additional resources to support individuals with SMI. He then asked Stanislaus County to share their perspective on the potential advantages and disadvantages of allowing probation officers to serve as petitioners under the CARE Act.
- A:** Ms. Campbell explained that probation officers can petition under the law enforcement category. However, she indicated that the evidence required for prima facie is difficult for law enforcement officers to meet. Stanislaus County's multidisciplinary team comprises probation officers and behavioral health staff. In this regard, probation officers work with behavioral health staff, who engage with the individual, collect medical records, and submit a petition on behalf of the probation officer.
- A:** Mr. Vartan emphasized the importance of collaboration, noting that Stanislaus County has successfully worked with partners to identify obstacles and develop effective solutions. While he acknowledged the value of family referrals, he stressed the need to consider their potential impact on family relationships. Using the County's first CARE program graduate as an example, he highlighted that the referral in this case came from a family member and did not negatively affect their relationship, demonstrating the potential for positive outcomes through such referrals.
- A:** Councilmember Jenkins congratulated Stanislaus County on their first CARE program graduate and reaffirmed his support for interdisciplinary collaboration, which he believes has been underutilized within the criminal justice system. He emphasized that seamless partnerships with healthcare providers are essential for achieving shared goals. He also expressed appreciation for pathways that



enable probation officers to guide individuals to CARE court through referrals made by behavioral health staff on their behalf.

A: Mr. Vartan highlighted Stanislaus County’s innovative approach, mentioning a unit within the Police Department dedicated to handling social calls as part of a chat team, which serves as an additional referral pathway. However, he noted that the unit’s capabilities and access to information are limited, prompting the Behavioral Health Department to take the lead in advancing cases.

Q: Councilmember Hobson inquired about available resources for behavioral health departments in cases where commercial insurance companies fail to provide reimbursements for services.

A: Ms. Linkins acknowledged the complexity of the issue and referenced a DHCS plan letter outlining reimbursement parameters and strategies. She noted the variability among insurance companies and emphasized the importance of counties reporting data on petitions involving commercial insurance. She committed to obtaining more detailed information for Councilmember Hobson on resources available to counties when insurance companies do not reimburse for services.

Public Comment:

Q: A public participant sought assistance in becoming a vendor for a reentry program and supporting housing and healthcare initiatives.

A: Ms. Camacho-Hall invited the commenter to email CCJBH@cdcr.ca.gov for assistance in connecting with the appropriate resources.

Q: Ms. Grealish addressed several critical issues:

1. **Accessing Data on Commercial Plans:** She highlighted the challenge of obtaining data on commercial insurance plans and noted that untreated SMIs initially affect young populations. She stressed the importance of early intervention to prevent the need for higher levels of care provided by counties, jails, and prisons. She also mentioned that some younger individuals may still be covered under their parents' commercial insurance plans.
2. **Partnership Between DHCS and DOJ:** Ms. Grealish proposed a potential partnership between DHCS and the Department of Justice (DOJ) to collect data on recidivism and arrests. She emphasized the importance of distinguishing between arrests and convictions, with a particular focus on convictions as a more accurate measure of criminal activity.
3. **Alternative Services for CARE-Ineligible Individuals:** She highlighted the need to identify and track alternative services for individuals who do not qualify for a CARE agreement. She commended the Stanislaus County Behavioral Health



Department for its practice of monitoring individuals who engage in other services when they do not meet CARE's requirements.

4. Appropriate Treatment in CARE Programs: Ms. Grealish underscored the importance of ensuring CARE participants receive not just treatment, but the appropriate treatment. She expressed concerns about providers who lack the necessary skill sets, willingness, or suitable environments to treat the SMI population, resulting in exclusions from programs. She recommended that these programs be tracked as part of the evaluation process.

VI. Announcements

The next [Full Council Meeting](#) The next Full Council Meeting will be on Friday, December 6, 2024, from 2:00-4:30 PM and will focus the 988 Crisis Continuum and CCJBH's 2025 proposed priorities. The Juvenile Justice Workgroup and Diversion/Reentry Workgroup meeting dates will be confirmed at the December Full Council Meeting.

VII. Adjourn