CCJBH

Council on Criminal Justice and Behavioral Health

Building bridges between criminal justice & behavioral health to prevent incarceration

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Acknowledgements

Thank you to the numerous presenters at the Council on Criminal Justice and Behavioral Health workshops and meetings who provided their insights and shared their experiences to enrich the work conducted in 2018. We greatly appreciate your time and passion for program improvements. A special thank you to our partners in San Diego County for the opportunity that allowed council members and stakeholders to experience firsthand the power of providing community alternatives to incarceration and the vital importance of supporting those returning home to improve health and safety outcomes.

We would also like to thank our partners in prevention, diversion and reentry such as the Board of State and Community Corrections, California State Association of Counties, County Behavioral Health Directors Association, California State Sheriff's Association, Chief Probation Officers of California, Judicial Council of California, Forensic Mental Health Association of California/Words to Deeds, Mental Health Services Oversight and Accountability Commission and many others for their efforts to prevent the incarceration of individuals with mental illness and substance use disorders.

The Council is grateful for the leadership and contributions of former Secretary Scott Kernan who showed dedication, commitment and active involvement in working with the council. We welcome and are eager to work under the guidance of Acting Secretary Ralph M. Diaz.

The Council also appreciates the many long hours staff dedicated to producing this report.

Above all thank you to the many individuals and organizations that participate in Council workshops, meetings and events. It is your participation that gives our work meaning, value and ultimately impact where it is needed – *California's Communities*.

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The Honorable Gavin Newsom
Governor-Elect of the State of California
State Capitol, Suite 1173
Sacramento, CA 85814

Dear Governor-Elect Newsom:

The Council on Criminal Justice and Behavioral Health (CCJBH) serves as a resource to assist and advise the Administration on best practices to reduce the incarceration of youth and adults with mental illness and substance use disorders with a focus on prevention, diversion and reentry strategies. Based on what has been learned by the Council in the past few years, we recommend that the new Administration begin with a focus on strengthening services and supports for individuals with complex needs who are vulnerable and at-risk of incarceration, homelessness, hospitalization and other negative outcomes. By effectively serving these individuals in communities, California can sustain shifts in service delivery towards prevention and early intervention rather than costly incarceration and institutionalization. This report will provide a roadmap regarding how this can be accomplished.

CCJBH is grateful that your public service demonstrates awareness and commitment to the issues this Council is charged with supporting the Administration to improve. CCJBH has the unique and often challenging responsibility to advise on how to maximize the impact of several funding sources (i.e. Medi-Cal, Mental Health Service Act, Realignment, Categorical Grants, etc.) to best serve the specific target population of individuals with behavioral health disorders who are formerly incarcerated or at risk of incarceration. That population is often the most likely to have complex substance use, mental health and physical health disorders while experiencing several challenging life conditions such as poverty, homelessness, unemployment and limited social networks.

Addressing these individuals to receive the care and services they need in the community is critical to retaining resources to fully fund a continuum of care – including prevention and early intervention. By providing housing, effective services and treatment to the vulnerable before and after incarceration (especially during the transition home), the growing overrepresentation of individuals with serious behavioral health issues in jails and prisons, filling emergency rooms and living on our streets can be reduced. Doing so will require your leadership to support and defend equitable opportunities to services – including housing for the forgotten. To achieve this requires the state to lead by example, facilitating data-sharing in the interest of supporting continuity of care, saving lives and spending taxpayer money wisely.

In anticipation of being as effective as possible for the new Administration, CCJBH's Annual Legislative Report for 2018 identifies three key findings and corresponding steps that can be taken at the local, state and federal level to improve efforts to reduce the incarceration of individuals with behavioral health disorders, especially those with complex challenges. Below is a summary of the key findings.

Finding One: Failure to Meet the Needs of Individuals with Serious Mental Health and Substance Use Disorders is caused by a Significant Lack of Resources for the Community Behavioral Health System

Individuals often find their way into the behavioral health system through incarceration or hospitalization. These results are hardly surprising given the tasks the system has been indirectly assigned - eliminating poverty, solving homelessness and ending discrimination. These unreasonable expectations only serve to further overwhelm a system that must address the complex needs of individuals who may have co-occurring substance use and mental health conditions, criminogenic risk factors, major and multiple medical problems, and chronic homelessness. The poor outcomes attributed to this under-resourced system have led to calls for greater investment in institutional care such as jails, prisons and state hospital beds. Such a move would almost certainly come at the cost of funding for community based-services, further exacerbating the very symptoms that have led to the current situation.

CCJBH urges increased investment in community-based services, particularly residential, starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges. By working with partners from criminal justice to social services, the community behavioral health system can develop the capacity to serve those most in need, as well as, collaborate with partners to prevent substance use and mental health challenges from resulting in harmful individual and societal costs.

Finding Two: California's Homeless and Housing Crisis has Undermined the Success of Community Alternatives to Incarceration for People with Behavioral Health Challenges

From chronic homelessness to housing insecurity, the lack of safe and affordable housing impacts the delivery of much needed mental health and substance use treatment services. From individuals who slipped into incarceration due to crimes of poverty, substance use and untreated mental illness to those whose reentry is compromised because there is no place to call home; the deficiency of housing options is putting individuals at great risk of health care emergencies, recidivism or more likely both.

CCJBH urges that any effort to address homelessness and the housing crisis must consider critical factors that uniquely impact people with justice involvement and behavioral health challenges.

Finding Three: Data and Information is not Systematically Collected to Inform Policymaking and Program Investments or to Support Accountability and Quality Improvement

Barriers to data-sharing, whether real or perceived, are keeping criminal justice and behavioral health care systems from supporting continuity of care and monitoring whether interventions and strategies are successfully reducing recidivism. Determining when and how data can be exchanged for program improvements or desired health or public safety outcomes, is critical to supporting integrated service delivery that is effective for the individual and accountable to the taxpayer.

CCJBH urges state leadership to support data-driven practices and policy-making among criminal justice and behavioral health systems to ensure continuity of care and achieve desired public safety and health outcomes.

We are eager to support your Administration to be as successful as possible in our shared mission to do better for those individuals who often are overlooked due to the challenges they present or the discrimination they face. In partnership, we will support California to not only retain its reputation as thoughtful and resourceful justice and health care reformers, but to lead the nation's progressive policies to reduce the incarceration of individuals with behavioral health disorders.

Stephanie Welch, MSW
Executive Officer
Council on Criminal Justice and Behavioral Health
California Department of Corrections & Rehabilitation

CC: Assembly Speaker Anthony Rendon
Board of State and Community Corrections
California State Association of Counties
California State Sheriff's Association
Chief Probation Officers of California
County Behavioral Health Directors Association of California
Forensic Mental Health Association of California - Words to Deeds
Judicial Council of California
Mental Health Services Oversight and Accountability Commission
Senate Pro Tem Toni G. Atkins

A. History, Background and What Makes the Council on Criminal Justice and Behavioral Health Unique

History and Background

Historically, persons with mental health and substance use (behavioral health) disorders have been over incarcerated. Entering the criminal justice system is often the first time individuals with behavioral health disorders are diagnosed and offered treatment. Currently there are more than 2.2 million incarcerated individuals in the U.S.[1] In an analysis produced by the Bureau of Justice Statistics (BJS), 1 in 4 (26 percent) jail inmates and 1 in 7 (14 percent) prison inmates met the threshold for experiencing psychological distress in the last 30 days.[2] The same study by the BJS found that 37 percent of prisoners and 44 percent of jail inmates had been told in the past by a mental health professional that they had a mental disorder.[3] For individuals in jail, 3 in 4 have a diagnosis of both a substance use disorder (SUD) and a mental illness.[4]

The consequence of behavioral health disorders not being met effectively in the community is costly. People with mental illness have higher recidivism rates and stay longer, once incarcerated, than those who do not have these challenges.[5] A study by PEW and the MacArthur Foundation (2014)[6] found that correctional spending on adults with mental illness alone is 2 to 3 times higher than for those without mental illnesses. In California it costs an average of $81,458 per year to house an inmate so this figure only grows with more significant physical and mental health care needs.[7] Moreover, there are also costs incurred through the State Hospital System where roughly 90 percent of the individuals served are forensic commitments. $1.4 billion in State General Fund (SGF) resources was dedicated to State Hospital operations for fiscal year (FY) 2017-18.[8]

In 2001 California had the foresight to establish the Council on Mentally Ill Offenders (COMIO) through the passage of Senate Bill (SB) 1059. COMIO was codified as Penal Code (PC) section 6044 as a 12 member council chaired by the Secretary of the California Department of Correction and Rehabilitation (CDCR) and is comprised of the Department of State Hospitals (DSH), the Department of Health Care Services (DHCS) and appointed expert representatives from the criminal justice and behavioral health fields such as probation, court officers and mental health care professionals. Membership reflects a variety of diverse perspectives; current members include:

The Council on Criminal Justice and Behavioral Health Council Members

Chairperson: Ralph M. Diaz, *Secretary (A)*, California Department of Corrections and Rehabilitations. The Secretary of CDCR is at times represented by Dr. Diana Toche.

Vice-Chairperson: Manuel Jimenez, *Retired Behavioral Health Director*, Alameda County. Mr. Jimenez was appointed to CCJBH by Governor Edmund G. Brown, Jr. in 2012.

Stephanie Clendenin, *Director (A)*, Department of State Hospitals. The Department of State Hospitals is at times represented by Dr. Mark Grabau or Dr. Katherine Warburton.

Jennifer Kent, *Director*, Department of Health Care Services. The Director of DHCS is at times represented by Ms. Brenda Grealish.

The Council on Criminal Justice and Behavioral Health Council Members

Jessica Cruz, *Executive Director*, National Alliance on Mental Illness - California. Ms. Cruz was appointed to CCJBH by Governor Edmund G. Brown, Jr. in 2015.

Mack Jenkins, *Retired Chief Probation Officer*, San Diego County Probation Department. Mr. Jenkins was appointed to CCJBH by Governor Edmund G. Brown, Jr.in 2015.

Matthew D. Garcia, *Field Training Officer*, Sacramento Police Department. Mr. Garcia was appointed to CCJBH by the Senate Rules Committee in 2016.

Alfred A. Joshua MD, MBA, FAAEM, *Former Chief Medical Officer*, San Diego County Sheriff's Department. Dr. Joshua was appointed to CCJBH by Assembly Speaker Toni G. Atkins in 2015.

Tracey Whitney, *Los Angeles County Deputy District Attorney*, Mental Health Liaison. Ms. Whitney was appointed to CCJBH by Attorney General Xavier Becerra in 2017.

Honorable Stephen V. Manley, *Santa Clara Superior Court Judge*, Judge Manley was appointed to CCJBH by Chief Justice Ronald M. George of the California Supreme Court in 2010.

Recently there is growing recognition that addressing mental health and SUDs collaboratively is essential to achieving improved public safety and health outcomes. Despite this, the treatment of mental health and SUDs is not effectively integrated creating an inefficient and costly system that is not easy to navigate or administer. This is concerning considering that the correlation between mental health, SUDs and incarceration is substantial. More than 50 percent of inmates in prisons and 70 percent of those in jails met criteria for substance dependence or abuse in the year prior to the arrest.[9] These challenges follow them home as nearly 10 percent of probationers and parolees have a serious mental illness and 40 percent have a SUD.[10] According to the BJS, 53 percent of drug abusing inmates in prison have three or more prior criminal offenses.

For youth the correlation is even more substantial. Research shows a significant connection between untreated mental illness, substance abuse and juvenile delinquency. Nearly 70 percent of the 2 million youth arrested each year have a mental health disorder, of which 25 percent suffer from a severe mental illness impairing his or her ability to function.[11] These youth are entering a juvenile justice system that is ill-equipped to assist them. A study published in the Journal of American Medical Association (JAMA) found that 5 years after detention the majority of youth had 2 or more behavioral health disorders and 17 percent of males had co-occurring disorders.

Responding to the need to treat mental health and SUDs more effectively, California PC Section 6044 was amended (Chapter 268 Sec. 11 of 2017) to reinforce the importance and existence of COMIO within CDCR and to expand the scope of the Council. Effective January 1, 2018 the name of the Council changed from COMIO to the Council on Criminal Justice and Behavioral Health (CCJBH) to reflect the new responsibilities of preventing adults and juveniles with SUD and co-occurring mental health and substance use disorders (COD) from entering and reentering the California justice system.

What Makes CCJBH Unique

Unlike a Council that provides oversight and accountability, CCJBH is statutorily obligated to investigate policies and systems that may impede access to services, identify best practice models and strategies, and promote cost effective solutions for implementation. These obligations are defined below.

Statutory Responsibilities – Council on Criminal Justice and Behavioral Health	
Penal Code Section 6044 (e) (1)	Identify strategies for preventing adults and juveniles with behavioral health (substance use and mental health) needs from becoming offenders
Penal Code Section 6044 (e) (2)	Identify strategies for improving the cost effectiveness of services for adults and juveniles with behavioral health needs who have a history of offending
Penal Code Section 6044 (e) (3)	Identify incentives to encourage state and local criminal, juvenile justice and behavioral health programs to adopt cost-effectiveness approaches for serving adults and juveniles with behavioral health needs who are likely to offend or have a history of offending
Penal Code Section 6044 (f) (1)	Improve service coordination among state and local behavioral health, criminal justice and juvenile justice programs
Penal Code Section 6044 (f) (2)	Improve the ability of adult and juvenile offenders with behavioral health needs to transition successfully between corrections-based, juvenile-based and community-based treatment programs
Penal Code Section 6044 (h) (1)	CCJBH shall file with the Legislature, not later than December 31 of each year, a report that shall provide details of the Council's activities during the preceding year, including recommendations for improving the cost-effectiveness of behavioral health and criminal justice programs
Penal Code Section 6044 (i)	CCJBH is authorized to apply for any funds that may be available from the federal government or other sources to further the purposes of this article
Penal Code Section 6044 (j) (2)	The Council may expand its purview to allow it to identify strategies that are preventive in nature and could be directed to identifiable categories of adults and juveniles that fall outside of the above definition (which refers to a target population defined in Sec. 6044 (j) (1)

CCJBH's overarching mission is to reduce the incarceration of youth and adults with mental illness and SUDs which requires a focus on prevention, diversion and reentry strategies. The Council provides recommendations to the Legislature and Administration on how best to accomplish this and is charged with supporting the improved coordination between state and local partners, as well as, criminal justice and behavioral health system partners. For example, the Council examines studies that identify that nearly 10 percent of children in foster care are there because of parental incarceration,[12] as well as the fact that 13 percent of the incarcerated population spent time in foster care.[13] It is also of interest that there are several identified best practices in community supervision for individuals with serious behavioral health conditions, but the system is often too overloaded to implement them because nationwide there are 4.5 million people on probation or parole.[14] While the Council does not specifically advise on service delivery during incarceration which is managed by other entities, the primary interest of CCJBH

is how services are planned and delivered to support individuals when they are home, either through diversion and alternative custody or reentry after serving time institutionalized.

The focus of CCJBH is not limited to a specific funding stream such as the Mental Health Services Act (MHSA) or Public Safety Realignment (AB 109). Rather CCJBH has the unique and often challenging responsibility to advise on how to maximize the impact of several funding sources (i.e. Medi-Cal, MHSA, Realignment, Categorical Grants, etc.) to best serve a specific target population – individuals with behavioral health disorders who are formerly incarcerated or at risk of incarceration. That population is often the most likely to have complex substance use, mental health and physical health disorders in addition to experiencing several challenging life conditions such as poverty, homelessness, unemployment and limited social networks. CCJBH does not assertively engage with the Legislature or introduce legislation but fulfills statutory obligations by offering timely information, resources and solutions. The Council accomplishes this by learning from program implementers and service users while also examining data and pertinent research.

In pursuit of fulfilling statutory obligations, the Council participates in research projects to better understand how to advise policy decisions. CCJBH independently evaluates how formerly state-incarcerated adults are being connected to services by monitoring Medi-Cal utilization to study and understand the relationships between recidivism and health outcomes. On-going the program aims to assess the role health care, and more specifically behavioral health care, has on recidivism through expanded partnerships with other state agencies and departments, as well as stakeholders in evaluation and research.

CCJBH also collaborates with stakeholders and state entities on projects with timely importance. In FY 2018-19 CCJBH was granted the additional opportunity to contract with organization(s) that represent individuals (youth and adults) with lived experienced in the justice and behavioral health systems. Contractors use outreach and engagement, education and training, and technical assistance activities at both the local and state-level to support the policy, research and program work of the Council.

The Council also provides consultation to the DSH in the administration of county contracts to support the diversion of individuals with mental illness who are, or who are at risk of being determined, incompetent to stand trial (IST) for a felony crime. Through this role, CCJBH provides or procures subject matter expertise to county implementers. CCJBH will assess program investments for lessons learned to identify any necessary state or local policy changes needed to sustain and even grow mental health felony community diversion programs in the future.

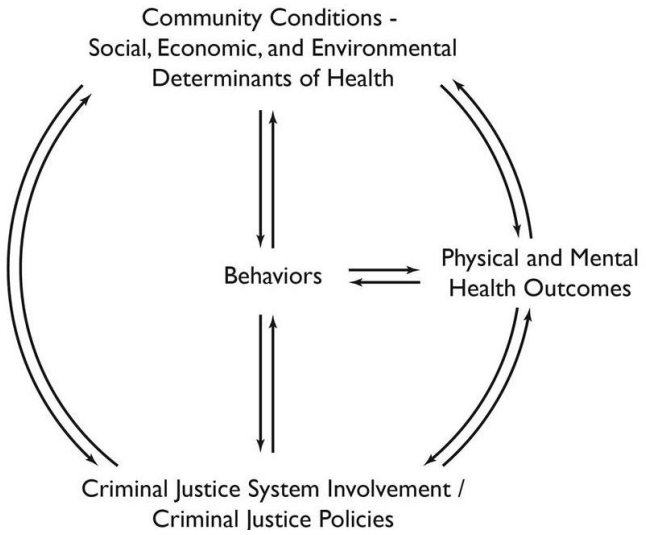
B. The Influence Social Conditions Have in the Intersection of Criminal Justice and Behavioral Health

Individuals at-risk of or involved in the justice system face a number of social and environmental challenges. Social determinants of health (SDH) are the conditions in which we are born, grow, work, live, and age, the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status. These forces and systems include economic policies, social norms, social policies and political systems.[15] There

are a number of important links and similarities between SDH, social determinants of behavioral health and social determinants of criminal behavior (SDCB).

To improve health outcomes, action on the SDH is necessary. To reduce crime and improve public safety, the SDCB must be identified and addressed. Since the SDH and SDCB are broadly similar, there should be an adoption of a broad public health approach focused on prevention and social justice for identifying and taking action. [16] See ***Figure 1***[17], this diagram represents a way of thinking about these relationships and how change in any one domain may affect change in another.

Figure 1 **Criminal Justice and Public Health Framework**



One of the determinants of both health and criminal behavior is poverty and socioeconomic status. This is significant because poverty or low socioeconomic status (SES) can have profound negative effects on health. Numerous studies have shown that individuals with lower SES have higher rates of mortality, morbidity, disease and mental illness. A number of studies have also found that poverty and low SES during childhood is a distal risk factor for subsequent criminal and substance misuse behaviors. This does not mean, of course, that poverty alone is responsible for these anti-social behaviors. There are other SDH that contribute to these factors.[18]

Housing, mental illness and access to healthcare are also SDH and SDCB and quite often overlap for vulnerable populations. For example, about a fifth of the 1.7 million homeless people in the United States suffer from untreated schizophrenia or manic-depressive illness. And not surprisingly, mental illness often prolongs homelessness. Approximately 26 percent of homeless adults staying in shelters live with serious mental illness and an estimated 66 percent live with severe mental illness and/or SUDs. Mental illness and homelessness also puts people at an increased risk of being the victim of a crime as well as being arrested for a crime, particularly disorderly conduct and property theft.[19]

Determinants of health can affect justice involvement, behaviors and physical and mental health outcomes through:

- Homelessness and poverty are criminalized, leading to justice involvement.

- Both structural and institutional racism lead to over-policing of African American communities and disproportionate punishment of people of color throughout the justice system.
- Unemployment can lead to a host of behavioral issues: drug use, theft and forms of violence.
- Conditions that lead to Adverse Childhood Experiences, such as exposure to violence in the community, homelessness, or incarceration of a parent, can lead to behavioral issues in school and beyond, substance abuse, as well as mental health disorders.

Physical and mental health outcomes can affect criminal justice involvement and determinants of health through:

- Physical or mental health issues can lead to unemployment and housing instability.
- Mental health crises can lead to arrest.
- Debt from health care expenses can lead to inability to pay bills, poverty, homelessness or arrest.

Recent reforms lead by the Brown Administration have sought to include addressing social determinants of health and criminal behavior which has led to healthcare for those formerly justice involved.

C. Key Accomplishments of the Brown Administration – Health Care and Criminal Justice Reforms

Communities that are disproportionately impacted by the poor living conditions associated with increased behavioral and criminogenic risk factors are also the same communities that have been historically disenfranchised from medical care. The primary barrier to tackling complex health needs, like behavioral health challenges which increase the risk of recidivism, has previously been the large number of people who lack health insurance.[20] Beginning in 2014 the Affordable Care Act (ACA) opened up the health care system to the uninsured, allowing many, if not most, of the formerly incarcerated or at-risk of incarceration to become eligible for affordable health care services for the first time. Under the ACA, California elected to expand eligibility to most adults with incomes under 138% of the federal poverty level which supported over 3.7 million uninsured to enroll for a total of 14 million Californians.[21] Prior to the ACA approximately 9 out of 10 individuals who spent time in county jails was uninsured.[22]

In addition to the expansion of eligibility, the ACA established mental health and SUD benefits as services covered as Essential Health Benefits (EHB). The ACA requires that all insurance plans must cover EHB without annual caps aiming to lessen the financial burden. Moreover, in 2014 a new outpatient mental health benefit that includes psychotherapy, medication management and other associated services was now offered to Medi-Cal beneficiaries.[23] Coupled with the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), the significance of this cannot be emphasized enough, especially for individuals needing substance use services because the need is not minimal. DHCS estimates that 13.6 percent of the newly eligible Medi-Cal beneficiaries have a SUD treatment need.[24] For the first time individuals with SUD treatment needs not only had increased access to insurance that was more equitable, prohibiting restrictive

caps on needed services, but treatment was more accessible and affordable. Service providers no longer had to rely solely on inadequate federal, state, or local short-term grants. For California, Medi-Cal ability to support access to healthcare provides one of the most powerful tools in preventing incarceration and recidivism and therefore is a significant instrument in improving public safety.

To fully appreciate the critical impact that health care reform has had on public safety in California, recent reforms to the criminal justice system must be understood. For nearly a decade California has embarked on several significant criminal justice reforms to address mass incarceration at the state level that at its highest was roughly 250,000 Californians. Since the peak, state incarceration numbers have fallen significantly and hover around 130,000 with another 44,000 on state parole.[25] While the reforms represent efforts to comply with federal orders to reduce the prison population, others would argue that reforms were intended to accomplish much more. For example, reforms recognized that many were serving sentences that were excessive for their crimes. More importantly, as low-level offenders they can be effectively supervised at the local level where they are more likely to have access to services and supports to address conditions that might have led to criminal behavioral including SUD, mental health challenges and significant levels of trauma. In other words, California had to reduce the prison population, but did so in a way that supports the value of rehabilitation and second chances.

In 2009, SB 678 provided financial incentives to counties to implement effective methods to reduce the number of felony offenders that would return to prison due to probation violations while SB 18 removed some low-level offenders from active parole supervision.[26] But it wasn't until AB109 that the door swung wide open to sweeping policy changes. Prior to this any felony conviction carrying a sentence of a year or more resulted in prison time and time supervised on parole. Now the responsibility of low-level offenders, who had committed non-violent and non-serious crimes, was shifted to probation and county jail systems.

A series of voter approved ballot initiatives followed the implementation of AB 109 and reinforced the trend of moving non-serious and non-violent offenders to the community. Proposition 36 amended California's "three strikes" law to limit life sentences for a third "strike" to only violent and serious crimes while allowing re-sentencing for those who got a third strike life sentence for a non-violent and non-serious crime.[27] Proposition 47 followed reducing certain non-violent and non-serious crimes, which were mostly property and drug crimes, from felonies to misdemeanors. It also allowed for re-sentencing under certain guidelines and restrictions. The initiative recognized that the individuals impacted by the policy change, either returning home or remaining in the county, were often in need of substance use and mental health treatment. Finally, Proposition 57 approved in November 2016 further strengthened the emphasis on rehabilitation as a means to achieve public safety by including the ability to earn credits for participation in rehabilitative and educational programming.[28]

Figure 2 details the nexus between criminal justice and health care reform over the years and during the Brown administration from 2011-2018.

***Figure 2*. EXPANDED HEALTH CARE IN CONJUNCTION WITH CRIMINAL JUSTICE REFORM: A UNIQUE OPPORTUNITY FOR CALIFORNIA TO ADDRESS BEHAVIORAL HEALTH CARE NEEDS FOR THE JUSTICE-INVOLVED**

HEALTH CARE REFORMS

1991 Realignment and the **Mental Health Services Act (MHSA)** supported a behavioral healthcare system in California that was county-driven but tax revenue reliant

The **financial crisis** of the **mid to late 2000s** disseminated the state's health care safety net, including behavioral health services despite revenue from the **MHSA**

In **2010** the **Affordable Care Act** was signed into law which offered significant opportunities and challenges by expanding services and eligibility, particularly the inclusion of **essential health benefits** and the availability of never before **health care for low income, childless adults** under **expanded Medi-Cal** (CA's Medicaid Program).

In **2015** the **Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver** launched so that counties could substantially expand substance use benefits – including to the justice-involved

By **2016 Whole Person Care (WPC) Pilots** were being developed to provide comprehensive and coordinated care for high utilizing Medi-Cal recipients including those reentering from correctional settings

CRIMINAL JUSTICE REFORMS

2009 Senate Bill 678 Provided financial incentives to counties to reduce the number of felony offenders sent to state prison for probation failures.

2011 Public Safety Realignment (Assembly Bill 109) Shifted low level felons (non- serious & non-violent) to probation and county jail systems

2012 Proposition 36 Revised the 'three strikes law" so that a life sentence was only imposed with a NEW serious and violent crime

2014 Proposition 47 Reduced penalties associated with certain lower-level drug and property offenses

2016 Proposition 57 Increases the number of inmates eligible for parole consideration by awarding sentencing credits to inmates for positive behavior such as participating in rehabilitative programming. The measure also makes changes to state law to require that youths have a hearing in juvenile court before they can be transferred to adult court.

HEALTH CARE AND CRIMINAL JUSTICE REFORM WORKING TOGETHER TO SAVE LIVES AND MONEY

• Community mental health treatment is more effective and less expensive than incarceration: The annual cost of incarcerating an average state prisoner in California is over $70,000, not including mental healthcare costs, while the cost of treating a person with mental illness in the community is approximately $22,000.[29]

• For those released from jail with serious mental illnesses, having Medicaid coverage and receiving behavioral health services lead to a 16 percent reduction in recidivism.[30]

• The use of publicly funded substance use services resulted in 18 percent less rearrests in Washington.[31]

HOW CAN CALIFORNIA IMPLEMENT WHAT WORKS

• Through the Drug Medi-Cal ODS over 30,000 2016-17 referrals are projected to come from the criminal justice system and this represents only 20 of the 58 counties. Plans are still being approved and implemented.

• Almost half of approved WPC Pilot Plans focus on individuals released from institutions including correctional settings. Other pilots will likely serve the justice-involved due to a focus on homelessness, high utilizers with chronic conditions and individuals with mental health and substance use disorder conditions.

• More counties are seeing the benefit of using AB109 funds for evidence-based substance use and mental health treatment.

• Under Prop 47, 23 counties, cities, law enforcement agencies and educational institutions have been awarded over $103 million in funds for the next three years to provide programs and services, including housing and employment assistance, for justice-involved youth and adults living with substance use and mental health disorders.

D. Recommendations for the New Administration

Methods

In anticipation of being the most constructive as possible for the New Administration, CCJBH's Annual Legislative Report for 2018 identifies a limited number of key findings that are critically in need of action at the local, state and federal level. Recommendations are organized by activities that can be implemented locally, state and federal action is provided. The following steps were taken to determine the limited number of key issues to examine in the report:

- Reviewed findings and recommendations from CCJBH's annual reports published within the last three years to identify issues that remain vital but unaddressed.
- Reviewed several recent statewide reports that summarize some of the challenges with reducing the incarceration of individuals with behavioral health issues, as well as provide recommendations on how best to resolve these challenges. Reports reviewed came from organizations such as the Judicial Council of California, the Legislative Analysts' Office (LAO), the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the American Civil Liberties Union of California.
- Reviewed several policy and legislative priorities among organizations that have constituencies operating in criminal justice and behavioral health systems, such as the County Behavioral Health Directors Association (CBHDA) and the California State Sheriff's Association (CSSA).
- Reviewed several national reports on the intersection of criminal justice and behavioral health including how to address priority national issues such as the opioid epidemic and overrepresentation of individuals with mental illness in jails and prisons.

Critical issues for action identified from this review across organizations and perspectives included:

- Increase funding for infrastructure development.
- Strengthen responses to people in crisis and develop accessible services as an alternative to jail or hospitalization.
- Integrate substance use and mental health disorder treatment so they are more seamless.
- Improve care coordination and communication between criminal justice and behavioral health care partners.
- Incorporate interventions likely to reduce future crime with substance use and mental health services.
- Invest in the workforce to fill shortages and help improve skill sets and knowledge.
- Use data to understand local strengths and challenges, to improve outcomes and to determine future investments.

The review of materials described above identified shared reasoning regarding why certain critical issues were not yet effectively addressed, among them:

- Funding or Financial Resources
- Political Will
- Community Support
- Knowledge of What Works

To refine the focus of the 2018 findings and recommendations, CCJBH developed a statewide survey for key partners who also are working to reduce the number of youth and adults with behavioral health issues from incarceration. These key partners include administrators and providers of services, court officials and other elected officers, and people with *lived experience* either as someone who identifies as being formerly incarcerated or having a behavioral health disorder or a family member of such a person. In addition to asking partners about the issues found in the review of materials, CCJBH felt it was imperative to include questions that examined the role social conditions such as poverty and discrimination play in exacerbating incarceration. Finally, known key policy issues from 2018 that will continue well into 2019, such as the implementation of felony pre-trial mental health diversion and addressing the homeless and housing crisis, were included to assess how partners perceived the level of implementation difficulty. Some of the results of the survey are shown in ***Figures 3*** and ***4***.

Overall, 189 stakeholders responded to the survey, with the majority of these individuals identifying themselves in roles such as criminal justice and behavioral health administrators, providers, family members and consumers of services. Approximately 19 percent of respondents identified themselves as formerly incarcerated. Survey respondents identified three critical issues that need to be addressed by the new administration: 1) Strengthen responses to people in crisis and develop accessible services as an alternative to jail or hospitalization, 2) Incorporate interventions likely to reduce future crime with substance use and mental health (behavioral health) services, and 3) Integrate

Figure 3

What do you think is most needed to support action on these critical issues? (n=175)

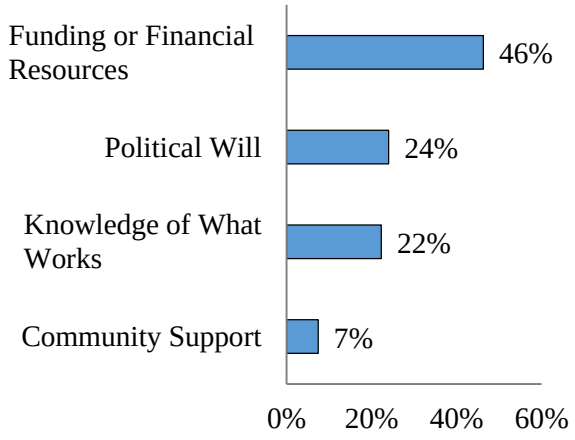
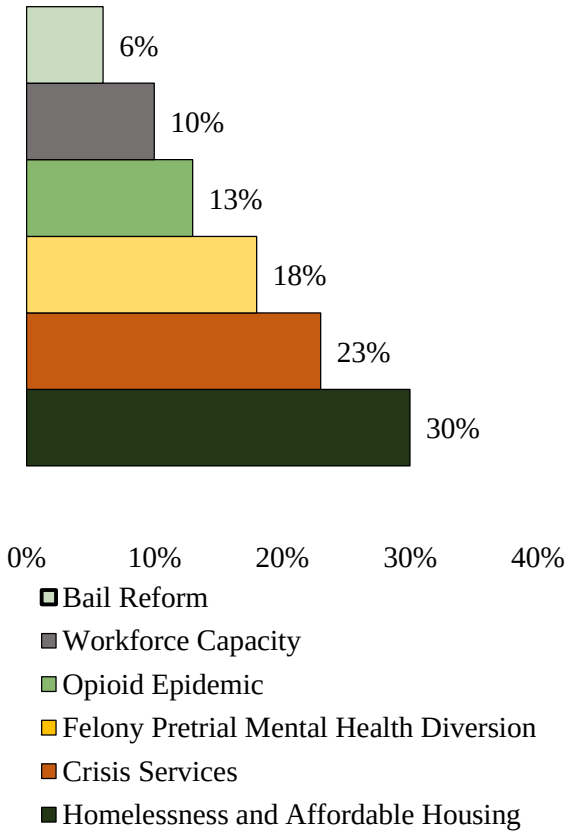


Figure 4

What do you think is the most immediate challenging criminal justice and behavioral health policy issue that the new administration is going to have to implement? (n=178)



substance use and mental health disorder treatment so they are more seamless. Regarding capacity, the majority of respondents indicated having the lowest capacity for providing funding for infrastructure development, and the highest capacity to integrate substance use and mental health disorder treatment. Survey respondents indicated that the most immediate challenging criminal justice and behavioral health policy issue facing the new administration is addressing homelessness and affordable housing. For a complete analysis of survey results please see Appendix C - CCJBH Annual Statewide Survey Stakeholder Engagement - Priorities for New Administration.

The remainder of this report describes findings and recommendations prioritized for the new administration based on reviewing existing state and national policy reports, assessing survey findings and incorporating the expertise and perspectives of CCJBH members and partnering organizations. While recommended action is organized in a step by step process, sequentially accomplishing these tasks is not necessary to achieving outcomes. Ideally actions could be taken in each step through an on-going commitment to reducing incarceration of individuals with substance use and mental health disorders.

> ***"These are people! People usually with parents and siblings and children who are directly affected by the choices this Administration will make. It will either build up our communities or hurt them."*** *– Behavioral Health Provider*

Findings and Recommendations

Finding One: Failure to Meet the Needs of Individuals with Serious Mental Health and Substance Use Disorders is caused by a Significant Lack of Resources for the Community Behavioral Health System

Individuals often only find their way into the behavioral health system through incarceration or hospitalization. These results are hardly surprising given the tasks the system has been assigned by default - eliminating poverty, solving homelessness and ending discrimination. These unreasonable expectations only serve to further overwhelm a system that must address the complex needs of individuals who may have co-occurring substance use and mental health conditions, criminogenic risk factors, major and multiple medical problems, and chronic homelessness. The all but inevitable poor outcomes attributed to this under-resourced system have led to calls for greater investment in institutional care such as jails, prisons and state hospital beds. Such a move would almost certainly come at the cost of funding for community based-services, further exacerbating the very symptoms that have led to the current situation.

CCJBH urges increased investment in community-based services, particularly residential, starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges. By working with partners from criminal justice to social services, the community behavioral health system can develop the capacity to serve those most in need, as

well as, collaborate with partners to prevent substance use and mental health challenges from resulting in harmful individual and societal costs.

Step One: Commit to Community Alternatives to Support Prevention, Diversion and Successful Re-Entry

To make such a commitment requires a plan that identifies where investments need to be made with a reasonable structure that can measure progress and impact. To accomplish this locally or even statewide, CCJBH recommends using the "Sequential Intercept Model" (SIM) developed by Mark R. Munetz, MD and Patricia A. Griffin, PhD, which provides a framework for communities to use to design "points of interception" where an intervention can be made to divert individuals from falling deeper into the criminal justice system.[32] The model assists in targeting strategies to the needs of distinct communities; identifying how to increase the diversion of people with mental illness from the criminal justice system to community treatment (See Appendix B for a detailed overview of SIM). CCJBH recommends including individuals with SUDs in the model so that the focus is the behavioral health system. While the model helps identify how communities can plan for everything from pre-trial diversion to successful community supervision, the SIM framework is grounded in the belief that the most effective way to prevent the majority of incarceration among those with behavioral health disorders is to have an accessible and varied behavioral health and social service system that can address issues before individuals are in crisis or justice-involved.

> ***"We need a comprehensive approach and strategies for change which will examine what we are doing and recognize where changes need to be made and ensure they are implemented statewide. We need greater community involvement and input and to be willing to require true innovation, doing something that has not been tried before."*** *- Behavioral Health Provider*

The SIM framework is endorsed by the National Association of Counties (NACo), with support from behavioral health and law enforcement organizations, as part of the Stepping Up Initiative, which is aligning national, state and local efforts to reduce the incarceration of people with mental illness.[i] Thirty four California counties already participate in the initiative, supported by the Bureau of Justice Assistance, which also supplies technical assistance from the Council on State Governments Justice Center. For more information about the Stepping Up Initiative see https://stepuptogether.org/wp-content/uploads/Stepping-Up-Overview.pdf

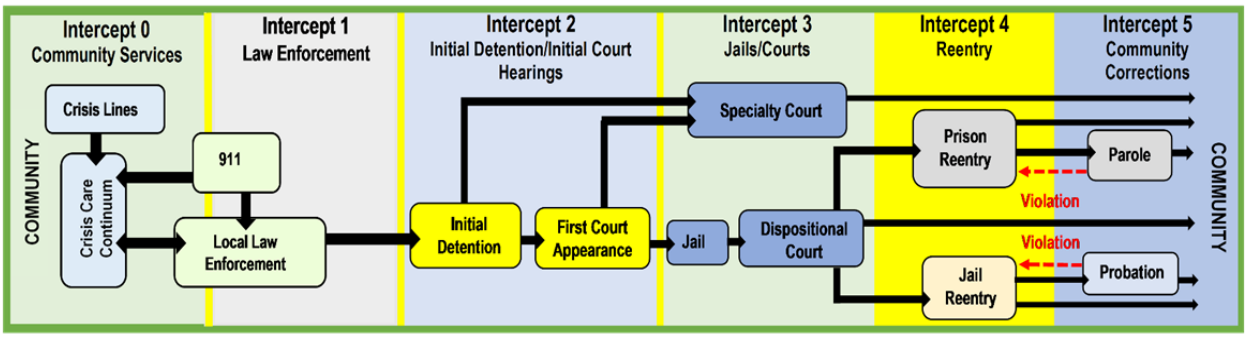
THE STEPPING UP INITIATIVE

A National Initiative to Reduce the Number of People with Mental Illnesses in Jails

[i] More information on the Stepping Up Initiative is available at: https://stepuptogether.org with the toolkit is available at: https://stepuptogether.org/toolkit

Counties are actively assessing and mapping where they can focus and enhance interventions across the intercept model with blended resources, including funds from AB 109, the MHSA, Medi-Cal, Federal and State funds, and Local County General funds. Several of these local efforts have been examined in previous CCJBH annual reports.
For more information on Sequential Intercept Mapping see ***Figure 5***.

Figure 5 **Sequential Intercept Mapping**



Additionally, financial mapping should be conducted so that both local and state partners are aware of which elements across the SIM are funded adequately or inadequately. In addition to Medi-Cal funds, local financial mapping can assess how and to what extent a variety of funding sources such as AB 109, MHSA, Prop 47, County General Fund and other grants are being used or could be redirected to support prevention, diversion and reentry efforts. To do so successfully can be difficult because it requires an understanding of where to make investments driven by need and consistent with varying state and local values such as self-determination, right to healthcare, recovery, resiliency and wellness. In addition, it is problematic to assess needs when individuals with behavioral health challenges, including serious mental illness, often do not get treatment.

> ***"In working for Probation for over 17 years . . . . offering actual drug treatment programs inside the jail would be a great idea, with transition options to outside residential treatment."*** *– Behavioral Health Provider*

According to Substance Abuse and Mental Health Services Administration (SAMHSA), for Californian adults between 2011 to 2015 only slightly more than one-third with a mental illness reported receiving treatment or counseling during the past year. This was lower than the national rate of 42.9 percent.[33] Is it a lack of available, quality, accessible services or something else which could be as simple as transportation or as complicated as stigma that is keeping individuals in need from seeking help? Moreover, available data to inform decisions such as the number of individuals in jails with serious mental illness or rates of homelessness among the formerly incarcerated with mental illness are difficult to obtain. Counties are beginning to collect this information through assessments and local Point-In-Time (PIT) homeless counts.

The state should provide more opportunities to counties for these efforts as well as support organizations like CCJBH to do the same on a statewide basis. For example, we know that in California the number of acute psychiatric beds per 100,000 population decreased 42 percent from 1995 through 2016. During this time, 37 facilities either eliminated inpatient psychiatric

care or closed completely. California would need an additional 1,158 beds to reach the national average of 20 beds per 100,000 population.[34] What we don't know is whether or not reaching something closer to the national average is really what will work to support California's needs that are aligned with California's values.

> ***"People experiencing mental health crises frequently go to hospital emergency departments for help. Many people can be stabilized by the emergency department or by referral for outpatient care. However, an increasing number of emergency visits resulted in discharges to inpatient psychiatric care. Recent studies have suggested more timely access to outpatient treatment and specialized psychiatric crisis services could reduce the need for inpatient care".***
> - *California Health Care Foundation's Health Care Alamance March 2018*

In other words, the solution is not more acute psychiatric beds but something different or more likely something in addition to. Without prevention and early intervention strategies it will be impossible to curb growing costs for the nearly 1 in 5 Californians living with a mental health condition but where should investments be directed for the 4.2 percent already diagnosed with a serious mental illness?[35]

While independent living and supportive recovery is the goal, if needed and depending on local dynamics and capacity, there are a variety of behavioral health residential treatment options for those who need a higher level of care, many of which CCJBH has explored in previous reports. A partial list includes:

- MHSA Full Service Partnerships (FSP), which include housing supports.
- Mental Health Rehabilitation Centers, which provide 24-hour program services designed to assist clients to develop skills to achieve self-sufficiency and independent living in the community.
- Psychiatric Health Facilities (PHFs), which provide 24-hour acute inpatient care designed to be a lower-cost alternative to acute psychiatric hospitals. (Note: PHFs are prohibited by state regulations from admitting or treating individuals with primary diagnoses of chemical dependency disorders).
- Skilled Nursing Facilities/Special Treatment Programs, which are 24-hour programs that serve clients with a chronic psychiatric impairment whose adaptive functioning is moderately impaired. Therapeutic services assist individuals with self-help skills, behavioral adjustment, interpersonal relationships and pre-vocational preparation.
- Residential Substance Use Disorder Services, are provided in DHCS licensed residential facilities and have been designated by DHCS as capable of delivering care consistent with American Society of Addiction Medicine (ASAM) treatment criteria. Federal funding for residential services are currently restricted to facilities with 16 beds or fewer by interpretation of federal law under the Institutions for Mental Diseases (IMD) exclusion. However, under the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot, DHCS has received authority for federal financial participation for expenditures currently restricted under the IMD exclusion, which will allow residential services to be provided in facilities with no bed capacity limit.
- Community Residential Treatment Services (CRTS), which provide 24-hour treatment in a home-like setting to individuals with mental illness who are unable to care for

themselves in independent living. There are three categories of CRTS, including 1) Short-Term Crisis Residential (an alternative to acute hospitalization that may last up to 3 months); Transitional Residential (an activity program that encourages utilization of community resources for up to 18 months); and Long-Term Residential (provides rehabilitative services for up to three years to help individuals develop independent living skills).

- Permanent Supportive Housing, which is affordable housing combined with voluntary supportive services in which service providers proactively engage tenants and offer treatment plans.
- Board and Care/Adult Residential Facilities, provide care for adults age 18-59, who are unable to provide for their own daily needs.

The state can support CCJBH to collaborate with other necessary state and local partners to conduct a thorough analysis of the supply and demand for the variety of residential options, including safe and affordable housing, needed to support the substantial demand for community based behavioral health alternatives to incarceration.

Don't Forget Stigma and Resulting Discrimination

Whenever community alternatives are the goal it is critical to be mindful of the necessity of education and actions that ensure equitable opportunities. In addition to the broader work needed outlined above, there are two new significant policies that this administration will inherit and need to shepherd through enactment. Felony pre-trial mental health diversion and bail reform have the potential to increase opportunities for community alternatives to incarceration for individuals experiencing behavioral health issues. This is positive and progressive policy change but successful implementation will require aggressive tactics to protect against the negative consequences of stigma and resulting discrimination.

A consistent barrier to support for community alternatives is the pervasive myth that individuals with serious mental illness are violent and dangerous, especially if they have been involved with the justice system. Most people with mental illness will never become violent. In fact, studies show that mental illness contributes to only about 4 percent of all violence, and the contribution to gun violence is even lower.[36] Research shows that a history of violence, including domestic violence; use of alcohol or illegal drugs; being young and male; and/or a personal history of physical or sexual abuse or trauma, increases risk, but mental illness alone is not a predictor of violence.[37] In fact according to the U.S. Department of Health and Human Services (HHS), people who have severe mental illness are 10 times more likely to be victims of violence.

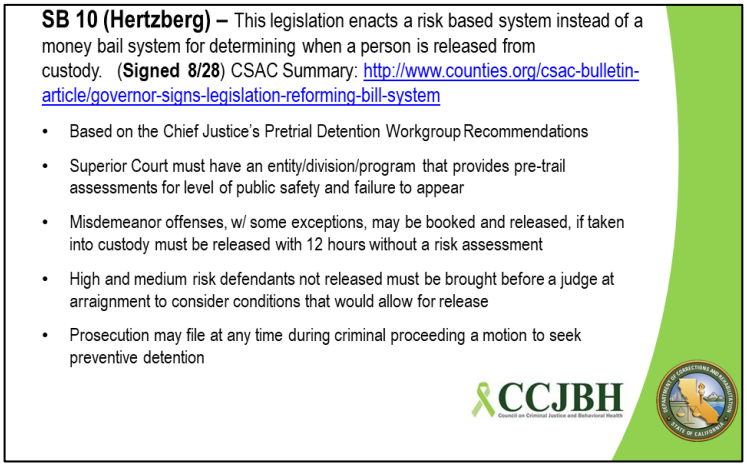
> ***"People with mental health challenges are not dangerous criminals."***
>
> *- Provider*

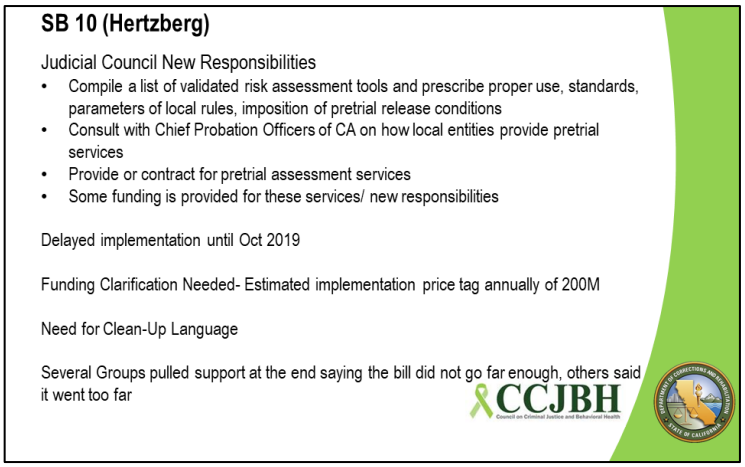
Individuals experiencing significant mental health symptoms can demonstrate odd behavior that others may perceive as unusual and even threatening. These individuals are often homeless and engaging in crimes of survival not predatory behavior. CCJBH has heard personal testimony from individuals in recovery who acknowledge that when in the throes of untreated mental illness or substance abuse their actions were out of their control. These are not individuals who are a threat to public safety but in need of help.

"Community mental health education to better understand that mental illness and addiction are health issues which must be addressed like any other illness - with compassion- is desperately needed." *- Family Member*

Mental illness as a basis for diversion should be the rule not the exception and people with serious behavioral health disorders should be treated equally and without bias in the application of bail reform. CCJBH is committed and prepared to support the new administration in achieving successful implementation of both of these policies.

See Appendix D and Appendix E for details on SB 10: Pretrial Release and Detention or visit http://www.courts.ca.gov/pretrial.htm.





Felony Pre-trial Mental Health Diversion – Assembly Bill (AB) 1810 and SB 215 (2018) amended PC Sections 1001.35-1001.36 to create a pathway for courts to authorize pre-trial diversion for individuals with serious mental disorders who committed certain felony or misdemeanor crimes. Additionally, AB 1810 established Welfare and Institutions Code (WIC) 4361 which allows a funding opportunity for DSH to contract with counties for $100 million over 3 years to support a specific target population of individuals with serious mental illness who have the potential to be or are deemed IST on felony charges. Participating counties can use one-time funds to develop or enhance existing strategies to serve those often underserved or inappropriately served who have complex mental health needs. These individuals are most likely homeless or at high risk of being so, and who frequently interface with the criminal justice system rather than being served by the health care system. As a consulting body to DSH, CCJBH will provide technical assistance, including to local partners as well as disseminate lessons learned to non-participating counties and consistencies to support future adoption of felony pre-trial diversion programs.

"Rather than spend money on making people competent to stand trial, focus on delaying or suspending charges and making people well enough to enter wrap around community support systems. Convictions exacerbate the stigma people endure, including within the mental health system." *– Family Member*

Step One Recommendation: Commit to Community Alternatives to Support Prevention, Diversion and Successful Re-Entry		
Local Action	**State Action**	**Federal Action**
Counties can undergo local sequential intercept mapping which provides a framework to identify points of interception where an intervention can be made to divert individuals from falling deeper into the criminal justice system. The process can assist in balancing investments across the continuum from prevention to community corrections, targeting resources to unmet needs or to address gaps. In addition to Medi-Cal funds, assess how and to what extent a variety of funding sources such as AB109, MHSA, Prop 47, County General Fund and other grants can be used to support these efforts. To support the success of developing and sustaining community alternatives, be mindful of the necessity of education and committed to taking action to ensure equitable opportunities.	It is paramount to increase resources for community-based mental health and substance use treatment facilities. Infrastructure investments like the Community Services Infrastructure Grant Program, administered by the California Health Facilities Financing Authority (CHFFA), need to be substantially expanded. Success will require the State to eliminate regulatory barriers to siting and licensing. The State can support CCJBH to build upon existing efforts to lead agencies, departments, advisors and stakeholders to: 1. Catalogue existing state and federal efforts in prevention, diversion and reentry, including the authority and funding provided by different entities, 2. Identify strengths and barriers in existing efforts including opportunities to improve coordination to address gaps in prevention, diversion and reentry efforts, 3. Develop a prioritized plan of legislative, regulatory, financial, educational and training and technical assistance activities for statewide action, and 4. Create a reasonable structure to measure the progress and impact. CCJBH can collaborate with other necessary state and local partners to conduct a thorough analysis of the supply and demand for the variety of residential options, including safe and affordable housing, needed to support the substantial demand for community based behavioral health alternatives to incarceration. CCJBH will provide technical assistance to local partners to support community alternatives for individuals identified for pre-trial mental health felony diversion. CCJBH will analyze and provide recommendations on the implications of Bail Reform for people with serious behavioral health disorders (i.e. identifying strategies to deliver services post-release/pre-trial, risk assessment tools and bias, adequate resources for probation and courts).	In its first set of recommendations to Congress, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) identified increasing opportunities for diversion and improving mental health care for the justice-involved as one of five priorities. Specifically, the ISMICC should support enhanced efforts to identify how policies in each participating federal department, such as SAMHSA, Centers of Medicare and Medicaid Services (CMS) and U.S. Department of Housing and Urban Development (HUD), may contribute to barriers to community alternatives to incarceration for individuals with serious mental illness. The ISMICC should analyze such identified policies and make recommendations to revise policies to better support community alternatives.

Step Two: Preserve California's Expansion of Medi-Cal and Improve how Mental Health and Substance Use Services are delivered as Essential Health Benefits

The 2017 CCJBH annual report documented how Medi-Cal expansion and the requirement under the ACA to provide mental health and substance use services as EHB created a path for much needed services for the justice-involved population. While the biggest threats to dismantling the ACA have for now passed, California should remain vigilant as it is still quite possible that efforts to undermine it continue. For one, 2019 is the first year in which there is no longer a tax penalty for not being insured. According to Covered California up to 20 percent of California individual and family enrollees may end up cancelling their coverage once there is no penalty.[38] Removing the penalty starts a cycle in which younger and healthy people drop out and rates rise and the higher the rates the more likely more people will also drop out.

Of more relevance to individuals with behavioral health conditions, the ACA and the MHPAEA ensure that health insurance plans, including Medi-Cal, treat mental health and SUDs the same way that they treat other health conditions. In October 2017 DHCS submitted a Medicaid Mental Health and Addiction Equity Act Compliance Plan which outlined how California intends to comply, and improve compliance with the Medicaid Parity Final Rule.[39] This plan was updated in May 2018 demonstrating significant progress with compliance such as developing protocols to provide oversight of network adequacy and training for providers. In addition to regular updates from DHCS on how system providers are performing with compliance requirements, it would be important for policymakers to learn if people using the services have noticed any improvements.

Fundamentally the ACA and MHPAEA seek to ensure equal opportunities to adequate health care, specifically behavioral health care. This means everyone should have opportunities for prevention, early intervention and regular office or clinic visits for maintenance of more chronic conditions rather than a reliance on crisis care and hospitalization. For individuals who are formerly incarcerated, CCJBH's Medi-Cal Utilization Project has the capacity to study some of these questions. The projects described in more detail in ***Figure 6*** not only can look to see when mental health and substance use treatment is accessed but in which setting, outpatient vs. inpatient, how long from release and are the patterns of service consistent with quality care standards.

Overtime the project will examine bigger policy questions such as whether or not access to behavioral health care reduces costs due to reduced recidivism and hospitalization. A measurable goal for the administration would be to track progress in California's prevalence rates in the community which are for serious mental illness 4.2 percent, mental health conditions 15.4 percent, illicit drug abuse 3.3 percent, alcohol abuse 6.4 percent and general substance use including pain medication 9.1 percent. In state prison the prevalence rates of serious mental illness is three to four times higher than in the community. [40] The goal would be for these numbers to be consistent with each other.

Figure 6

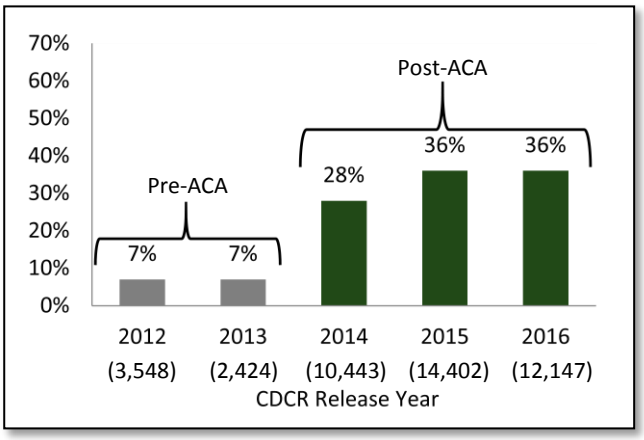
MEDI-CAL UTILIZATION PROJECT

The Affordable Care Act, and in particular Medicaid expansion and the inclusion of mental health and substance use disorder treatment as one of ten essential health benefits, has provided enormous opportunities to build community alternatives to incarceration. Recognizing the need for additional research in the area of the impact of the Affordable Care Act and the Medicaid expansion on justice-involved individuals, the Council partnered with the Department of Health Care Services to lead an on-going project on health care service utilization. Specifically, this project examines the proportion of CDCR's formerly incarcerated that received Medi-Cal services between 2012 (Pre-ACA) and 2016 (Post-ACA), the services received, and the time span to receive services post release.

Prelimary results show:

- An increase in the percent of CDCR's formerly incarcerated receiving a Medi-Cal service between 2012 (pre-Medi-Cal expansion) and 2016 (post-Medi-Cal expansion) from 7% to 36%.
- 49% of individuals designated as Correctional Clinical Case Management System (CCCMS) [ii] received at least one Medi-Cal service in 2016, this was an increase from 14% in 2012.
- The percentage of Enhanced Outpatient Program (EOP)[iii] designees released from CDCR who received at least one Medi-Cal service increased from 22% in 2012 to 52% in 2016.

Percent of CDCR Release Cohort Receiving at Least One Medi-Cal Service, 2012-2016



Data Source: Analysis of CDCR and Medi-Cal 2012-2016 data from the CDCR/DHCS Medi-Cal Utilization Project
*Numbers in parentheses represent the number of individuals receiving at least one Medi-Cal service during a CDCR release year.

[ii] Correctional Clinical Case Management System (CCCMS), another category within CDCR's mental health designation, facilitates mental health care by linking inmate/patients to needed services. [i]
[iii] Enhanced Outpatient Program (EOP) is defined by CDCR as a mental health service designation applied to severely mentally ill inmates receiving treatment at a level similar to day treatment services.

Step Two Recommendation: Preserve California's Expansion of Medi-Cal and Improve how Mental Health and Substance Use Services are delivered as Essential Health Benefits		
Local Action	**State Action**	**Federal Action**
Locals, with support from mental health advocates, can collect stories from individuals about how access to mental health and substance use services through Medi-Cal has led to positive outcomes in their lives including employment, secured housing and family reunification.	Analysis from CCJBH's Medi-Cal Utilization Project will document and provide evidence that individually who have been formerly incarcerated are using the new Medi-Cal benefit available due to the expansion and examine if and how mental health and substance use services are being accessed. CCJBH can track progress in California prevalence rates in the community for serious mental illness mental health conditions, illicit drug abuse, alcohol abuse and general substance use including pain medication with prevalence rates in jails and prisons. The prevalence rates while incarcerated should not be higher and should trend downwards.	Support the stability and success of the ACA), and protect California's health care reform policies including Medi-Cal Expansion and providing substance use and mental health services as EHB.

Step Three: Make Medi-Cal More Effective by Maximizing Federal Reimbursement and Retaining State and Local Resources for Non-Federally Reimbursable Services

If the most effective way to reduce incarceration is to grow alternative community-based behavioral health and social services, maximizing federal reimbursement for health care services must be primary. Medi-Cal provides health care services but individuals with behavioral health needs who are at-risk of incarceration or who are formerly incarcerated have far more needs that just healthcare. Facing challenging life conditions such as housing and food insecurity, lack of education and vocational training, and minimal social networks necessitates saving every dollar possible for non-healthcare needs. Furthermore, Medi-Cal supports service transactions like paying for prescriptions and consultations with health care professionals; it is not meant to provide for infrastructure investments for adequate facilities to deliver services or adequate training to support a high quality culturally competent workforce. The 2017 CCJBH Annual Report highlighted specific strategies to maximize federal reimbursement ranging from aptly resourcing Medi-Cal screening and enrollment efforts to assistance with health plan selection pre and post-release. The Council suggests reviewing those recommendations in detail at this link: COMIO 16th Annual Report. In addition to these recommendations still being relevant, the CMS should amend State Official Letter 16-007 to clarify that Medicaid can be used to support inmates who are in alternative custody programs in community-based reentry centers that are not located in prisons.

> ***"For more effective reentry planning and care coordination, please consider removing barriers caused by the Medicaid inmate exclusion"***
>
> *Behavioral Health Administrator*

For 2018 CCJBH has selected issues that if addressed effectively could result in the ability to better use local and state resources to support the complex needs of individuals with serious mental illness and SUDs who are justice-involved or at risk of such involvement.

Waivers for Medicaid to Cover Inpatient Psychiatric Care - While there have been efforts to make the Medicaid program more flexible such as clarifying that some housing and transportation services are appropriate for reimbursement; local and state funds must cover gaps in federally reimbursable services.[41] Historically the most costly of these gaps are for services in IMD, which are inpatient facilities of more than 16 beds with the majority of residents being treated for serious mental illness. Before Congress created Medicaid, inpatient behavioral health services were funded by states and the IMD payment exclusion was aimed at preserving this financing and preventing states from shifting mental health service costs to the federal budget through Medicaid.[42]

In the past few years there have been demonstration projects through section 1115 waivers that are testing lifting this provision but they have only been for short-term (15 days) treatment and more recently longer-term (30 to 90 days) residential treatment of SUDs, including as a strategy to address the opioid crisis.

> ***"If federal laws prohibit Medi-Cal from being available during county jail incarceration, come up with a viable solution for state-funded health care coverage during incarceration so there's not a break in the type of prescriptions, established patient/doctor relationship, addiction services, etc. A break in coverage sets someone back in the recovery process and increases future jail expenses due to recidivism."***
>
> *– Criminal Justice Administrator*

A State Medicaid Director letter from CMS dated November 13, 2018 has the potential to guide policy change regarding the use of IMDs significantly, including for California. Consistent with mandates under the 21st Century Cures Act, the purpose of the letter is to outline opportunities to design innovative service delivery systems, including opportunities for demonstration projects through a section 1115 waiver.[43] One such demonstration opportunity will allow federal financial participation (FFP) for short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs in exchange for states ensuring improved access to community service alternatives in addition to being cost neutral consistent with existing federal requirements. In an effort to protect from significantly shifting state and local resources to hospital care, the letter outlines several actions that must be taken to improve community-based care. Similar to the SUD demonstration opportunity, which California already takes part in, in order for the demonstration project to be approved, states must articulate how they will achieve the following goals:

- Reduce utilization of lengths of stay in emergency departments (ED) among Medicaid beneficiaries with serious mental illness (SMI) or severe emotional disturbance (SED) while awaiting mental health treatment in specialized settings,
- Reduce preventable readmissions to acute care hospitals and residential settings,
- Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during the acute short-term stays in residential treatment settings throughout the state,
- Improved access to community-based services to address the chronic mental health needs of beneficiaries with SMI and SED including increased integration with primary and behavioral health care, and

- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

At the time of writing this report, it is unknown if California will apply for an IMD psychiatric payment exclusion waiver. Preliminary reaction to this opportunity is cautious but open to understanding how such as waiver would lead to stronger community-based services. There is no question that there is a need along the service continuum for acute care, especially if it is delivered with requirements to provide linkages to appropriate step down community-based services. Yet the necessity of federal cost neutrality makes it quite difficult to not "cut" or "reduce" Medicaid resources dedicated to community programs. It is the Council's position that the lack of an effective system of intensive community-based services is the primary driver in increased hospitalizations, homelessness and incarceration so more resources directed to inpatient care does not resolve these concerns. On the other hand, if counties do not have to spend very limited local funds on IMD beds and instead are directed to support services such as diversion, discharge planning and linkages to social services, there could be net positive results for those with complex behavioral health needs. It will be paramount to understand how the state will assure increased community-based services before moving forward with any kind of waiver application.

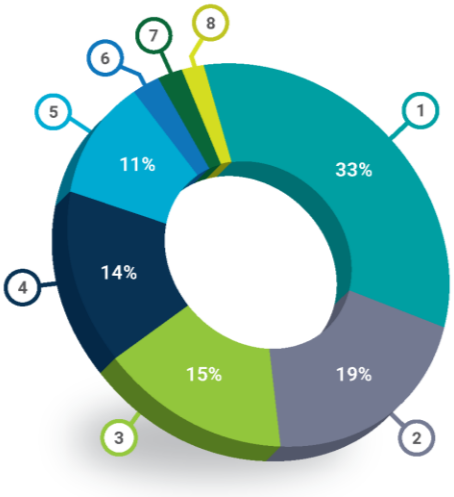
Supporting County Flexibility While Encouraging More Efficiency - While influencing Medicaid policy to increase FFP is important, there are state and local resources that could be put to better use to support the complex behavioral health needs for individuals who already are justice-involved. According to an analysis provided by CBHDA of the $8 billion that funds California's community-based behavioral health system, federal reimbursement under Medicaid for mental health and SUDs is about 45 percent of the total funds whereas locally administered funds including MHSA, 2011 and 1999 Realignment and county general fund are closer to 48 percent with the remaining less that 2 percent coming from the SGF, see ***Figure 7***. Concerted efforts should be made to understand how these resources, in addition to AB109 (which can be used for substance use and mental health treatment, housing and employment) are contributing to reduced incarceration.

> ***"More attention and funding should be provided to increase the number of educational programs and transition services to inmates in county jails."***
> *- Behavioral Health Provider*

Figure 7

California County Behavioral Health Funding

California counties receive over $8 billion in funds for behavioral health. The money comes from a variety of sources.



1	Federal Mental Health Medicaid Matching Funds	$3.04 billion
2	Mental Health Services Act	$1.77 billion
3	2011 Realignment	$1.39 billion
4	1991 MH Realignment	$1.31 billion
5	Federal SUD Medicaid Matching Funds	$990 million
6	Federal SAPT Block Grant	$225.6 million
7	Other (MH Block Grant, County MOE, County GF)	$212.8 million
8	State General Fund	$162.7 million

Recently the LAO produced a report on how to improve 1991 Realignment based on reviewing historical fiscal and programming changes.[iv] The LAO suggests changing cost-sharing ratios to better align with principles of Realignment such as giving counties the ability to manage and control costs which is difficult with entitlement programs. The state could "swap" a portion of the counties' fiscal responsibilities for In-Home Supportive Services (IHSS) for a share of another program currently supported by the SGF. The LAO suggests the "swap" could be for state forensic commitments.[44] Counties are responsible for nearly all of the mental health treatment for low income Californians with the one exception - individuals who are found IST or not guilty by reason of insanity on felony cases. Currently counties are responsible for these same individuals if the crime is a misdemeanor and the LAO argues that the mental health needs of felony court commitments are generally similar and counties are in the best position to efficiently serve these populations.[45] The Council would also argue counties are also well positioned to prevent individuals with serious mental illness from interacting with the criminal justice system in the first place. In addition to considering the merits and implications of this proposal, counties can participate with CCJBH and other stakeholders to identify effective payment models for resources like Realignment (1991, 2011 Behavioral Health and AB109), MHSA and Medi-Cal to better serve the justice-involved population with behavioral health issues.

Providing State Clarity to Support Equity in Services - In practice there remains confusion about if, and to what extent, individuals on parole are eligible for community-based mental health services including programs funded by Medi-Cal, especially if MHSA funds are used as match to draw down federal funds or to fully fund program components. Medi-Cal funds cannot be capped and counties must provide the required match. This is primarily through Realignment funds, which can vary depending on revenue. If these funds are expended, MHSA funds are

[iv] It is beyond the scope of this report to conduct a thorough analysis of Realignment policy. For more information, some resources include the LAO's *"Rethinking the 1991 Realignment"* and PPIC's *"Public Safety Realignment Impacts So Far"*.

often used to provide the match. The Medi-Cal expansion has complicated understanding how to comply with the MHSA parolee exclusion. FSPs and other programs that provide intensive services for high-risk and need individuals can be resourced through several funding sources, so how can one determine if a parolee should be excluded if part of the funding source is an entitlement? Counties are the experts at maximizing resources for behavioral health and are responsible for using federal, state and local funds as regulation and policy dictates. Any additional funding for services in the community for parolees should build upon entitled services which draw down federal funds so that state and local funds can be reserved to provide match and address gaps in the system such as infrastructure or housing.

DHCS is working with behavioral health and criminal justice stakeholders to clarify and provide guidance to counties on when and to what extent Medi-Cal and MHSA funds can be used for the justice-involved, including parolees who are now Medi-Cal beneficiaries. Issues CCJBH hopes will be clarified:

1. Can MHSA funds under WIC 5813 (f) support appropriate jail-based services such as discharge planning?
2. How can MHSA funds be used for individuals on parole and probation?
3. If a person is on parole but commits a new offense and is placed on county probation and mental health treatment is needed, as a county citizen are they eligible for MHSA programs, specifically FSPs?

In addition and specifically for the legislature to consider - is the MHSA parolee exclusion out of date and keeping individuals who are Medi-Cal beneficiaries from equal access to services?

Investigate if and to what extent SGF resources that support Parole Outpatient Clinics (POC) are paying for Medi-Cal reimbursable services. Assess how state and county resources can be leveraged so that SGF can be used for much needed non Medi-Cal reimbursable services such as rental assistance.

Step Three Recommendation: Make Medi-Cal More Effective by Maximizing Federal Reimbursement and Retaining State and Local Resources for Non-Federally Reimbursable Services		
Local Action	**State Action**	**Federal Action**
Enroll Individuals in Medi-Cal. Local jails can screen for eligibility for health care coverage and other benefits at intake either by custody staff or in partnership/ contract with county health and social services staff. Efforts should be consistent with local eligibility screening and determination processes and protocols. Maximize AB 109 funds for evidenced-based community correctional practices, including	CCJBH can research and disseminate other state strategies to expedite Medicaid eligibility and enrollment such as the use of peer educators to support managed care plan selection prior to release. CCJBH can explore strategies where Medi-Cal plan selection could be completed simultaneously with eligibility and enrollment processes in small counties that have one plan option. For multi-plan counties, prior to release	Congress should pass legislation to ease and/ or undo the federal Medicaid inmate exclusion and require states to suspend, instead of terminate, Medicaid coverage for justice involved individuals. The CMS should amend State Official Letter 16-007 to clarify that Medicaid can be used to

Step Three Recommendation: Make Medi-Cal More Effective by Maximizing Federal Reimbursement and Retaining State and Local Resources for Non-Federally Reimbursable Services		
Local Action	**State Action**	**Federal Action**
substance-used and mental health treatment. While these individuals may be eligible for Medi-Cal, some may not be and many may need housing, transportation, vocational and correctional services to support their participation in Medi-Cal services. Counties can assess how AB 109 funds and MHSA funds are adequately investing in treatment services for the justice-involved or at-risk of justice involvement to reduce incarceration as well as improve behavioral health outcomes. This should include strategies such as crisis services, alternative custody and behavioral health courts. Counties can participate with CCJBH and other stakeholders like Probation to identify effective payment models (AB 109, MHSA, Medi-Cal) for the justice-involved with behavioral health issues. These models should be disseminated to all counties. Explore recent recommendations on improving Realignment policy by the LAO regarding making counties responsible for all forensic court commitments in exchange for reducing counties' IHSS costs to improve incentives to provide effective community-based services for this population.	individuals can receive information to choose a specific provider within the network of the plan selected upon release. Health navigators can assist with activation and the first appointment post-release. DHCS, in consultation with behavioral health and criminal justice stakeholders, can clarify and provide guidance to counties on when and to what extent Medi-Cal and MHSA funds can be used for the justice-involved, including parolees who are now Medi-Cal beneficiaries. Issues to clarify: 1. Can MHSA funds under WIC 5813 (f) support appropriate jail-based services such as discharge planning? 2. How can MHSA funds be used for individuals on parole and probation? 3. Is the MHSA parolee exclusion out of date and keeping individuals who are Medi-Cal beneficiaries from equal access to services? Investigate if and to what extent SGF resources that support POC are paying for Medi-Cal reimbursable services. Assess how State and County resources can be leveraged so that SGF can be used for much needed non Medi-Cal reimbursable services such as rental assistance.	support inmates who are in alternative custody programs in community-based reentry centers that are not located in prisons. The HHS should exercise existing authority to provide additional state flexibility in the Medicaid program to cover justice-involved individuals such as: 1. Identifying patients in county jails who are receiving community-based care and then maintaining their treatment protocols; 2. Developing treatment and continuity of care plans for released or diverted individuals; 3. Initiating medication assisted treatment (MAT) or other forms of medically necessary and appropriate intervention for jailed individuals with opiate addiction whose release is anticipated within 7 to 10 days; and 4. Reimbursing peer counselors to facilitate reentry and increase jailed individuals' health literacy.

Step Four: Use Available Evidence-Based Practices to Serve Individuals with Complex Needs with Integrated Services (i.e. criminogenic risk factors, co-occurring substance use and mental health disorders, major medical conditions)

Integrating Behavioral Health and Correctional Services - An essential step in better serving individuals with complex needs who are justice-involved is to develop programming alternatives in the community that provide an array of integrated services to pick and choose from. This approach recognizes that it is too simple to determine that the root cause of incarceration is solely due to untreated mental illness. One study documented that only 10 percent of the persons incarcerated with mental illness committed a crime that could be directly linked back to psychiatric symptoms.[46] Alternative models should be used because there is little evidence that providing psychiatric services alone can reduce crime.[47] Individuals with behavioral health issues who are justice-involved are a diverse mix. Some will have serious and debilitating mental illness, others have what appears to be deviant behavior but are more likely crimes of poverty and homelessness, and many will have co-occurring SUDs committing crimes to support addiction.[48] There are also others that genuinely have criminogenic risk factors in addition to general risk factors.[49] The onset of mental illness disrupts prosocial relationships, educational goals and employment, and increases the risk of misuse of substances. These are some of the very same risk factors that lead to anti-social and criminal behavior. While the reason for the presence of risk factors may be different for offenders with mental illness compared to those without, both have the same risk factors for recidivism that need to be addressed.

> ***"As a parent of adult sons with mental illness, I've often wondered why when a family member calls for help, the police come, not a health provider of some sort….. Having police show up as if the person has committed a crime is not the answer and only exacerbates the problem."*** *– Family Member*

There is an urgent need to use evidenced-based correctional practices and psychiatric services to prevent incarceration and recidivism.[50] This does not mean that all individuals with mental illness who interact with the justice system have criminal thinking and behavior. But when managing limited resources it does demonstrate the importance of having tools to determine who has the highest risks and needs, what type of programs will be effective based on that information, and assessing whether existing and available staff have the skills to provide those interventions. ***Figure 8*** outlines one existing evidence-based approach.

Figure 8 - Risk-Need-Responsivity Model

The "Risk-Need-Responsivity" (RNR) model is a tool for correctional authorities in facilities and in the community to identify and prioritize individuals to receive appropriate interventions.[51] Several standardized tools are in use such as the Correctional Offender Management Profiling for Alternative Sanctions, Level of Service Inventory-Revised and the Level of Service – Case Management Inventory.[52] Offenders with low risk scores do not need intensive supervision and services in the community and if placed with high risk offenders their level of risk for reoffending actually increases. The model contains the following underlying principles:[53]

- Risk Principle: Match the intensity of individuals' treatment to their level of risk for reoffending,
- Need Principle: Target criminogenic needs – the dynamic factors that contribute to the likelihood of reoffending (i.e. substance use),
- Responsivity Principle: Address individuals' barriers to learning in the design of treatment intervention (i.e. address cognitive impairments due to mental illness), and
- Criminogenic risk factors are "static" or "dynamic": Static risk factors cannot be changed like gender or ethnicity, but dynamic risk factors can be changed with interventions.

Dialectal Behavioral Therapy and Motivational Interviewing have particularly been found to be effective in addressing the "responsivity" factor for offenders with mental illness by supporting the management of symptoms to maximize benefits from correctional interventions.[54]

Cognitive-Behavioral Therapy (CBT) has been a long accepted evidence-based intervention for addressing distressing feelings, disturbing behavior and targeting improvements in symptoms such as depression and anxiety. The Gains Center for Behavioral Health and Justice Transition identified the following as typical CBT interventions in correctional settings: [55]

- Thinking for Change,[56]
- Moral Recognition Therapy,[57]
- Interactive Journaling,[58] and
- Reasoning and Rehabilitation.[59]

In compliance with the 21th Century Cures Act, the Government Accountability Office (GAO) published a report in 2018 on the prevalence of mental illness in prisons, the costs of treatment during incarceration, and which strategies are associated with reduced recidivism.[60] After an extensive literature review the GAO, similar to CCJBH, promoted the adoption of the Criminogenic Risk and Behavioral Health Needs Framework (2012) developed by the Council of State Governments, Department of Justice (DOJ), SAMHSA and subject matter experts to reduce recidivism/promote recovery through the following steps:

- Assess clinical and social needs and public safety risk
- Plan for treatment and services that address individuals' needs during custody and upon reentry
- Identify community and correctional programs responsible for post-release services
- Coordinate the transition plans with community-based services to avoid gaps in care[61]

The report also found that most programs studied did not adequately collect information to track their effect on recidivism and Medicaid enrollment and access to Medicaid services alone were not enough to reduce recidivism. Rather the study hypothesized that the complex level of behavioral healthcare and social needs of this population required multiple services elements and intensive cross system collaboration. Elements found to have statistical significance in reducing recidivism included: pre-release/discharge planning, substance use treatment, case management, specialized community supervision and housing assistance.[62]

Integrating Substance Use and Mental Health Services for the Justice Involved **-** The need for integrated services includes the need to truly integrate substance use and mental health care. This report and previous CCJBH reports have identified the high rates of COD among the justice-involved. The need for integrated and effective services continues to grow as more becomes understood about this complex population. Individuals with CODs in the criminal justice system often have more than one mental disorder and have a history of abusing multiple substances.[63] Individuals with CODs present a variety of unique challenges across the continuum of the justice system including aggressive interactions with law enforcement, lack of programs in jails and prisons, and often are the recipients of inadequate supplies of psychotropic medications or reentry services when released leading to a rapid reoccurrence of acute psychiatric symptoms.[64]

> ***"I think it is important for justice partners to educate behavioral health services on the needs of justice-involved clients to build programs for them. Not have programs designed first without a clear understanding of the needs/differences of justice involved clients."*** *– Officer of the Court*

There is emerging evidence that there are several best practices to address the complex needs of justice-involved individuals with CODs across the prevention, diversion and reentry continuum. A review of evidence-based models for individuals with CODs in criminal justice settings found positive outcomes associated with pre-booking diversion strategies such as crisis intervention teams, psychiatric emergency response teams, crisis stabilization units and community service officers. Despite this researchers concluded that the absence of ancillary community services like housing, transportation, child care, and available short-term and long-term health and behavioral health treatment lessened, if not neutralized the impact to pre-booking diversion strategies.[65]

The same analysis identified benefits from Mental Health Court (MHC) models, including roughly an average 10 percent reduction in recidivism and increased retention in community treatment but these outcomes were less likely if the court participant had a COD. There are treatment-based court models that have made key adaptions for individuals with CODs such as dually credentialed staff, blended substance use and mental health screenings, structured treatment models like Integrated Dual Disorders Treatment (IDDT), partnerships with community mental health services and specialized community supervision with small caseloads. Court programs have also strengthened their results for individuals with CODs by targeting criminogenic risk factors, providing more comprehensive case management services and using peer mentors and support groups to strengthen engagement in community-based services. This is all positive but more learning is needed as the authors pointed out,

> ***"Despite the emergence of specialized COD court programs, at this time there have been no rigorous evaluations conducted to determine the impact of those programs on criminal recidivism, utilization of behavioral health services, or psychological functioning."***[66]

Once incarcerated, delivering and receiving integrated substance use and mental health disorder treatment is difficult. While there are several effective treatment and supervision models for individuals with CODs such as RNR, CBT and IDDT, similar to many COD programs in the community, justice settings often have sequential or parallel treatment models in which one diagnosis is treated before the other or the individual is enrolled in two sets of programming - one for each diagnosis. This can be further complicated by mental illness being traditionally treated by the health care division while SUD is treated by the rehabilitation division. Upon reentry and during community supervision, Forensic Assertive Community Treatment (FACT) teams that employ multidisciplinary teams of substance use and mental health care providers partnered with specialized probation and parole counterparts have demonstrated reduced hospitalizations and fewer jail bookings.[67] Similar to the challenges faced by those diverted pre-booking, the lack of housing, child care and other social service supports leads to less success in sustaining recovery after the more intensive reentry services are no longer available.

> ***"Many community-based mental health and rehabilitation programs are simply unwilling to provide services for those with the 'triple stigma' of dual diagnosis and a criminal history."***[68]

Supporting Medication Assisted Treatment (MAT) **–** Between 17 and 19 percent of individuals in jail and prisons have regularly used heroin or opioids prior to incarceration while formerly incarcerated individuals are 40 times more likely to die of an opioid overdose within two week of release.[69] There is a strong relationship among opioids, depression and suicide with individuals who administer opioids via injection being 13 times more at risk of dying by suicide.[70] Studies show that when MAT and counseling start in prison and continue into the community it is more effective than just starting MAT after release.[71] Considering these statistics, it is literally an issue of life or death to use effective and integrated services not only while one is incarcerated but especially in the transition home.

According to the HHS, MAT is the use of medications in combination with counseling and behavioral therapies, which are effective in the treatment of opioid use disorders (OUD) and help some people to sustain recovery.[72] MAT has expanded rapidly to combat to the opioid crisis. The American Correctional Association also supports MAT for the treatment of OUD in correctional settings and worked with the ASAM to develop recommendations specific to the needs of correctional policy makers and healthcare professionals which are organized into four categories - screening and prevention, treatment, reentry and community supervision, and education of justice system personnel.

Overall the policies call for actions that are consistent with practices that would improve the delivery of integrated care, for example using reliable and valid screening tools upon initial intake, providing individualized treatment which is inclusive of primary and mental health care, supplying training and education regarding how to manage recovery and relapse, and providing discharge planning from pre-release through reentry and to reintegration. To review the detailed recommendations please see Appendix F.

In the coming months California will make key decisions about resources and policies regarding how best to address the opioid crisis, including among individuals with criminal justice involvement. Federal legislation passed in October of 2018 will bring resources and much needed policy changes to support states including H.R. 6 – Support for Patients and Communities Act.[v] CCJBH has provided some recommendations regarding specific actions to take in this report, but above all the Council asks that the administration ensure that individuals with criminal justice involvement are provided equal opportunity to treatment and services. While it will take time to develop comprehensive SUD and integrated COD services, a good place to start immediately would be to stop opioid overdose deaths. One way to do so could be to replicate a promising comprehensive model being administered by the New York State Department of Health and the New York State Department of Corrections and Community Supervision which has three targeted components:

- Individuals in correctional settings who are soon to be released with training about the risk of opioid use and how to administer intranasal Naloxone,
- Corrections staff and parole officers are all trained on overdose prevention but more importantly understand and support that the success of the program hinges on staff acceptance and the knowledge that all people are susceptible to addiction not just people who are incarcerated, and
- Family members of the incarcerated who are trained to support the returning individual as well as the capacity of the community to respond to overdose.[73]

"Relationships with those closest to the client are critical. Making it easier for loved ones (families and friends) to be involved with decisions and supports could be a very cost-effective way to improve long term health and welfare. Incentive care and support from friends and family who have given so much already that they are ready to give up." *– Criminal Justice Administrator*

Findings from an evaluation of the program found:

- Across professional classifications and among the incarcerated and their families, all felt the need for such as program was relevant and empowering,
- Training increased knowledge and confidence to administer Naloxone,
- Individuals on conditional release vs parole were more likely to take Naloxone kits, with those not taking kits concerned about being seen as someone who supports drug use or being accused of using or condoning drug use, and
- The majority of individuals felt having the ability to save a life or contribute to the public good warranted facing fears about being violated on parole.

"The community based organizations are already there and have roots - we need to decrease the amount of probation violations that invariably send people back to jail for simple mistakes, like failing to register a new address when you move." *- Survey Respondent*

[v] For legislative language for H.R. 6 visit https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf.

Step Four Recommendation: Use Available Evidence-Based Practices to Serve Individuals with Complex Needs with Integrated Services (i.e. criminogenic risk factors, co-occurring substance use and mental health disorders, major medical conditions)		
Local Action	**State Action**	**Federal Action**
Conduct universal screenings with reliable and validated tools for mental illness, substance use and/or COD and criminogenic risk at jail intake. Doing so will provide valuable information to support diversion, needed services, and improved connections to necessary care. Use the "RNR" model to identify and categorize risks and needs and cognitive behavioral health therapy with a documented evidence base including Thinking for Change and Moral Recognition Therapy. Use COD treatment programs across all different settings in the justice system from IDDT in drug and MHCs to MAT in jails and during reentry to FACT while on community supervision. Document lessons learned from the California Health Care Foundation's (CHCF) study of 20 counties who are expanding MAT in county jails and drug courts.	CCJBH can promote the adoption of the Criminogenic Risk and Behavioral Health Needs Framework to ensure that resources are directed towards those with high behavioral health and criminogenic risk needs. CCJBH will collaborate with other entities in 2019 to investigate programmatic, regulatory or financial barriers to integrated care (correctional, substance use, mental and physical health). Identify if there are state solutions that can be proposed as part of the 2020 Medi-Cal waiver renewal. To address the high risk of overdose post-release, direct DHCS to use new Opioid Federal funds to supply correctional providers (State and Local) with naloxone to offer upon release to those identified with an OUD treatment need. CCJBH will collaborate with other state partners to raise awareness and tackle the stigma associated with SUDs. Support California's public education campaign efforts regarding opioid safety and treatment.	Congress should consider how to use resources within the DOJ to support the wider adoption of programs identified by the GAO as demonstrating higher rates of recidivism reduction for individuals with mental illness. Such programs include multiple support services, most notably extensive community supervision, substance use treatment and housing. Monitor the implementation of key elements of the federal opioid package (H.R. 6) for impacts to justice-involved individuals with SUD and COD. Ensure that California is appropriately represented in the HHS Secretary's stakeholder group that will develop a report on best practices in health care related transitions for incarcerated individuals.

Step Five: Follow Individuals Home and Continue the Investments Made During Institutionalization

How to effectively address OUD among the justice-involved provides a clear example of why it is so critical to follow individuals home and continue investments made in health care and wellness during institutionalization. Released inmates have high rates of poverty, unemployment and ultimately homelessness – wreaking havoc on health status. Being released from incarceration is marked by significant stress and seeking needed health care is often not a priority. Worsening health status and lack of primary care may be associated with higher rates of recidivism, while not having a primary care provider may lead to under-treated or untreated

mental health and SUD, which are indirectly linked to recidivism.[74] An analysis of over 60,000 Texas inmates showed that individuals with CODs had a substantially higher risk of multiple incarcerations in the five years post-release than individuals with just a mental illness or a SUD alone.[75]

Some studies show that past incarceration has a clear negative impact on health. Recently released inmates disproportionately use ED for health care and have high levels of preventable hospital admissions, which could be linked to high rates of mental illness that impose obstacles and interfere with one's ability to follow through with accessing timely care.[76] In a survey of over 1000 returning offenders from prisons, the Urban Institute found that 4 in 10 men and 6 in 10 women reported a combination of physical health, mental health and substance abuse conditions.[77] These individuals reported poorer employment noting that health problems interfered with their ability to work and a need for housing assistance.[78]

Efforts to address these issues refer to improving the "warm hand-off" which is when local service providers work together with criminal justice partners to support the smooth transition of an individual from incarceration to home. For those returning from state incarceration with behavioral health disorders it is not enough that individuals are enrolled in Medi-Cal but assistance is needed locally to navigate the myriad of available health care and social services that exist to support reintegration. Recognizing this, the Adult Reentry Grant Program was established through the Budget Act of 2018 (SB 840, Chapter 29, Statute of 2018) and appropriated $50 million in competitive awards to community-based organizations (CBOs) including nearly $10 million to support the warm handoff of individuals transitioning from prison to communities.[vi] For those returning home from jail, the NACo has published recommendations for roles that counties can play in reentry planning ranging from providing housing to physical and behavioral health care to workforce and training programs and transportation.[79]

> ***"We need faith-based and private companies open to hiring people with mental health challenges and/or criminal backgrounds."*** *- Behavioral Health Provider*

These are positive directions but far more is needed for those with complex behavioral needs returning home. Public safety entities and county Mental Health Plans should collaborate to identify optimal strategies to engage individuals who are being released from jail or prison into appropriate health or behavioral health care. This may include pre-release discharge planning and/or transition to community-based services. CCJBH is well-positioned to improve service coordination among state and local partners by working with CDCR and counties to identify referral and care coordination pathways from state incarceration home, identifying strengths and weaknesses as well as barriers to remove. CCJBH can provide recommendations to address gaps through resources, training, technical assistance or policy changes.

Once home, individuals with complex behavioral health needs require comprehensive and coordinated services. CCJBH's 2017 Annual Report provided ample analysis regarding two elements of California's current Medi-Cal program that can help design and implement behavioral health services that work for the justice-involved population. The DMC-ODS and the Whole Person Care (WPC) Pilot Program expand available services across the continuum of care

[vi] For more information http://www.bscc.ca.gov/s_adultreentrygrant_program.php

and also acknowledge that services must be tailored to individual needs, some of which are very significant and require addressing challenging social conditions, such as providing housing assistance and transportation.[vii] What is critical now is to listen and learn from county administrators, providers and service users participating in these substantially challenging pilots so that changes needed to enhance effectiveness and sustain long-term programming can be incorporated, if appropriate, into California's Medi-Cal program.

A recent analysis commissioned by the CHCF assessed early lessons from the DMC-ODS pilots.[80] The report surveyed participating counties and found that keys to success included having strong and early engagement with providers regarding program requirements and on-going communication about the DMC-ODS so that a variety of partners, including criminal justice, were educated and informed about system changes. This is important considering that one of the remaining challenges identified by counties was a need to work with criminal justice partners to inform them of how court-ordered treatment must now be consistent with ASAM criteria. This requires increased reliance on behavioral health partners to determine what services are medically necessary rather than court officials determining service needs.[81] Other challenges identified by counties are similar to ones plaguing those implementing WPC pilots that focus on the reentry population such as stigma and the resistance of many to accept that behavioral health challenges, including addiction, are not moral and personal failures but medical conditions.

> ***"There is a stigma on drug users. Most people don't think of addiction as a disease - they feel it is a life choice. At one point, it was, but once addiction takes over, it no longer is a life choice. It is a disease. Addicts have a HARD time finding a safe place that is affordable, where they can ask for help. Mental health requires help for the SMI, AOD programs do not."***
>
> *– Behavioral Health Administrator*

In addition, not to any surprise, counties expressed concern over not being able to supply the necessary trained and capable workforce needed to serve the complex needs of this population. CCJBH will continue to monitor the progress WPC pilots and the roll out of DMC-ODS, reaching out to county implementers to listen about challenges that need to be addressed to target the justice-involved with mental illness, particularly those with co-occurring disorders.

Step Five Recommendation: Follow Individuals Home and Continue the Investments Made During Institutionalization		
Local Action	**State Action**	**Federal Action**
Public safety entities and county Mental Health Plans should collaborate to identify optimal strategies to engage individuals who are being released from jail or prison into appropriate health or behavioral health care. This	CCJBH will monitor the progress of the WPC pilots and the roll out of the DMC-ODS reaching out to county implementers, when appropriate, to hear about challenges to be address to target the justice-involved with mental	U.S. Department of Justice's Office of Justice Programs can expand funding available through Second Chance Act Grants and Innovation Grants to provide more assistance to individuals returning to the community following incarceration with

[vii] It is not within the scope of this report to provide a full update on the implementation status of the DMC-ODS or the WPC Pilot Program. In addition to reviewing CCJBH's 2017 report pages 32-39, CCJBH recommendations reviewing information available on the DHCS website at: https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx and https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Step Five Recommendation: Follow Individuals Home and Continue the Investments Made During Institutionalization		
Local Action	**State Action**	**Federal Action**
may include pre-release discharge planning and/or transition to community-based services. For participating counties, services under the DMC-ODS can work to both prevent incarceration of those with SUDs as well as to serve the justice-involved population upon reentry. Grassroots community organizations can apply for resources to support the warm hand-off from the Board of State and Community Corrections (BSCC) Adult Reentry Grant Program.	illness, particularly those with co-occurring disorders. CCJBH is well-positioned to improve service coordination among state and local partners. CCJBH can identify referral and care coordination pathways for a sample size of counties, identifying strengths and weaknesses as well as barriers. Recommendations to address gaps through training, technical assistance or policy change could be provided. CCJBH will consider how future stakeholder contracts can best inform policy makers and program providers on effective practices upon reentry and during community supervision.	significant needs who are at the most risk of negative health and public safety outcomes. Consider how to apply recommendations provided to the Administration from the Council on Economic Advisors (CEA) into priorities for federal programming. The CEA identified that investments in substance use and mental health reentry programs that use cognitive behavioral practices are most likely to reduce recidivism and result in reduced incarceration spending over time. (See recommendations to make Medicaid more effective for justice-involved populations)

Step Six: Sustain and Grow Community Alternatives by Investments in Workforce, Education and Training

So far every step discussed that can help resolve the failures of an under resourced community-based behavioral health system requires the presence of an adequate, diversified and well-trained workforce. The challenge of addressing behavioral healthcare workforce shortages is long-standing in California. Over twenty years ago the California Behavioral Health Planning Council (then known as the California Mental Health Planning Council) led various efforts to address human resource challenges ultimately creating the Human Resources Project which advised on a wide scope of workforce education and training strategies. When the MHSA was designed, thankfully it included a component for Mental Health Workforce Education and Training (WET) programs. A total of $444.5 million was made available for the WET component over a ten year period. Today many of those programs continue under the guidance of the Office of Statewide Health Planning and Development. These grant programs include education capacity building,

pipeline, consumer and family member employment, regional partnerships, student stipends, student loan assumption and research and evaluation.[viii]

According to the current (2014-2019) WET Plan,

> ***"California's public mental health system suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse populations they serve. There are critical issues such as the maldistribution, lack of diversity, and under-representation of practitioners across disciplines with cultural competencies including, consumers and family members with lived experience to provide consumer and family driven services that promote wellness, recovery, and resilience."***

It is not only the behavioral health system itself that is concerned about its future workforce. The larger healthcare community has identified behavioral healthcare workforce deficits as some of the most critical that will impact the future health care delivery system. The California Future Health Workforce Commission, https://futurehealthworkforce.org/ which formed in August 2017 to develop a master plan to bolster the health workforce identified behavioral health as one of three primary areas of required attention. A 2018 analysis by the Health Force Center at the University of California San Francisco, found that California did not have an adequate supply of behavioral healthcare workers with the necessary demographic characteristics or skills and credentials to deliver the type of behavioral health care (e.g., prescribing/medication management, counseling) that people need from public and private health insurance plans.[82] Some of the key findings from the analysis include:

- Ratios of behavioral health professionals to population vary substantially across California with the lowest in the Inland Empire and San Joaquin Valley,
- African-Americans and Latinos are underrepresented among psychiatrists and psychologists relative to California's population; and Latinos are also underrepresented among counselors and clinical social workers,
- Wages vary widely across behavioral health occupations. Psychiatrists have the highest while substance abuse and addiction counselors have the lowest, and
- If current trends continue, California will have 41 percent fewer psychiatrists than needed and 11 percent fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors and licensed clinical social workers than needed by 2028.

To address significant deficits, the study's authors insist on efforts that will increase the supply of the workforce including adding more residency slots for psychiatrists, investing in models of care that rely on alternatives to psychiatrists, and making a commitment to bring racially and ethnically diverse groups into the behavioral healthcare workforce which requires substantial financial support for undergraduate and graduate level education. In addition, CCBJH would argue, as reported in previous annual reports, that the employment of individuals with lived experience in the behavioral health and/or criminal justice systems, either individually or through

[viii] For more information about the MHSA and how it funds Workforce, Education, and Training (WET) Programs we recommend reviewing previous WET Five-Year Plans which can be reviewed on the OSHPD website at: https://oshpd.ca.gov/loans-scholarships-grants/grants/wet/

a loved one, is a documented promising practice and viable option to expand the behavioral healthcare workforce.[ix]

While expanding the workforce is essential, there is a lot of education, training and technical assistance needed right now to support the success of current behavioral healthcare initiatives with individuals who are justice-involved. Throughout this report, best practices and integrated services have been described as crucial ingredients to improving health and public safety outcomes. The current workforce has not been provided the tools and skills to implement these models of service. CCJBH wants to partner with state and local stakeholders to invest in curriculum for the new workforce, as well as training for the existing workforce, on core competencies to provide effective integrated correctional and behavioral health services to better promote recovery and recidivism in custody and community settings. Opportunities for cross professional training between various criminal justice, behavioral health and primary care systems should be provided and these efforts could be appropriately supported by a learning collaborative funded by MHSA Innovation funds.

> ***"Education of all systems and providers is key. Whether it is BH providers, jailers, judges, etc. we all need to be speaking the same language and know how this can work if we are good partners."*** *– Behavioral Health Administrator*

Step Six Recommendation: Sustain and Grow Community Alternatives by Investments in Workforce, Education and Training		
Local Action	**State Action**	**Federal Action**
Expand the use of peers who are formerly justice-involved as an essential element of the service team, especially when providing COD services, including strategies that support Medi-Cal reimbursable services. Invest in curriculum for the new workforce, as well as training for the existing workforce, on core competencies to provide effective integrated correctional and behavioral health services to better promote recovery and recidivism in custody and community settings.	Create statewide certification with standardized curriculum for Peer Support Specialists who provide quality services allowing this workforce to be considered qualified providers for Medi-Cal reimbursement through Medi-Cal Specialty Mental Health Services Investigate how peers, Community Health Worker (CHW)s and SUD counselors can work to serve people with co-occurring disorders. Strengthen collaborative relationships by cross-training Peer Support Specialists, CHWs and SUD Counselors. CCJBH will work with policy and community partners to address barriers to employment for Peer Support Specialists, Forensic Peer Specialist, Consumer Peer Specialist, Veteran Health Peer Specialist and Mental Health Peer Specialist.	Provide federal guidance on consistency in scope of practice, qualifications and quality of services provided by Peer Support Specialists. Federal agencies like the SAMHSA and the National Institute for Corrections can increase efforts, including grants to local agencies for training and technically assistance on best practices in integrated care for the justice-involved with behavioral health challenges. Doing so is critical to supporting effective criminal justice reform policies.

[ix] Please see both the 2016 and 2017 CCJBH Annual Reports for more comprehensive analysis of the role individuals with lived experience can play in service delivery at: https://sites.cdcr.ca.gov/ccjbh/publications/

Step Six Recommendation: Sustain and Grow Community Alternatives by Investments in Workforce, Education and Training		
Local Action	**State Action**	**Federal Action**
Provide opportunities for cross professional training between various criminal justice, behavioral health and primary care systems. These efforts could be supported by a learning collaborative funded by MHSA Innovation funds. Beyond supporting crisis intervention training for law enforcement and first responders, invest in Officer Wellness and Peer Support programs to promote wellness, reduce critical incidents and use of force, and improve behaviors and community relationships.	Consider a California counterpart for elements of the federal opioid package (H.R. 6) to support workforce, education and training. For example, expand first responder training regarding opioid safety and develop a student loan repayment program to increase the substance use treatment workforce. CCJBH will establish a center of excellence in diversion on the website with webinars and featured tools from experts in the field but focus more on what individuals are doing in CA. The purpose is not to re-create expertise/ tools but to methodically identify it, and bring it to all 58 counties in a user-friendly, relevant and timely matter.	A significant majority of individuals who work with the justice-involved with behavioral health problems have incurred student loan debt and are working in public service employment or for non-profit agencies. Congress should adequately resource the Department of Education to ensure the responsible administration of the Public Service Student Loan Forgiveness Program. Congress should provide oversight of the program to confirm borrowers' complaints are addressed and that the complicated process of applying for the program is corrected.

Finding Two: California's Homeless and Housing Crisis has Undermined the Success of Community Alternatives to Incarceration for People with Behavioral Health Challenges

From chronic homelessness to housing insecurity, the lack of safe and affordable housing impacts the delivery of much needed mental health and substance use treatment services. From individuals who slipped into incarceration due to crimes of poverty, substance use and untreated mental illness to those whose reentry is compromised because there is no place to call home; the deficiency of housing options is putting individuals at great risk of health care emergencies, recidivism or more likely both.

CCJBH urges that any effort to address homelessness and the housing crisis must consider critical factors that uniquely impact people with justice involvement and behavioral health challenges.

Step One: Prioritize Housing for the Most Vulnerable and the Most in Need

Recently the Prison Policy Initiative using data from the BJS found that formerly incarcerated people are almost 10 times more likely to be homeless than the general public with another nearly 15 percent reporting homelessness prior to admission into prison. Men, and specifically formerly incarcerated African American men, have much higher rates of unsheltered homelessness. Rates of marginal housing are 3 times higher than that of the homeless with no history of justice-involvement.[83]

In 2017 research from Chapin Hall at the University of Chicago found that of the 3.5 million young people ages 18 to 25 experiencing homelessness in a year, nearly half also had been incarcerated in the juvenile or criminal justice system. Moreover it is estimated that half of the chronically homeless were homeless during the ages of 18 to 24. Youth and young adults face similar circumstances (i.e. collateral consequences) as their adult counterparts struggling to secure housing and employment due to their justice involvement. Often when youth exit the juvenile justice system they are over the age of 18 and their parents or guardians are no longer legally required to house them. While many are able to return home other youth are not, putting them at risk of mental distress, recidivism and homelessness.[84]

> ***"There's not enough services and resources for juveniles with serious mental health issues"*** *-Provider*

It is not surprising that there are high rates of homelessness among adults and youth with behavioral health challenges and justice-involvement, and there are significant consequences. U.S. Interagency Council on Homelessness assessed that nearly 50,000 people per year enter shelters directly after release from correctional facilities.[85] According to the Corporation for Supportive Housing, about half of the homeless report a history of incarceration and parolees and probationers who are homeless are seven times more likely to recidivate. Of particular concern, a recent analysis by DSH identified that of individuals found IST locally for a felony charge, an average of 47.2 percent reported being unsheltered homeless at admission with individual county rates ranging from 15 to over 83 percent.[86]

It has been challenging to understand exactly who is homeless and why in order to direct resources to those most in need. Recently more local Continuums of Care (CoCs) are including questions about justice and behavioral health status in PIT Counts and through additional surveys and evaluations.[x] CoCs are local community planning bodies that make decisions about funding priorities and consist of stakeholders (i.e. non-profits, business leaders, local government officials and law enforcement) committed to ending homelessness. In November of 2018, California Health Policy Strategies (CalHPS) published a brief estimating the statewide number of unsheltered homeless individuals who report histories of mental health issues or illness and justice involvement by looking at PIT counts from 2017 and 2018 and other surveys from the three most populous counties in the state - Los Angeles, Orange and San Diego. The results include the following key findings for unsheltered adults:

[x] The Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care (CoC)s to conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night.

- 26 percent increase in the number of unsheltered homeless individuals in the 5 year from 2013 to 2017,
- 70 percent report a history of incarceration,
- 28 percent report having recently been released from jail or prison,
- 13 percent report being presently under community supervision, probation or parole,
- 32 percent report both having "mental health issues" and being formerly incarcerated, and
- 15 percent report both a "serious mental illness" and being formerly incarcerated.[87]

Considering these recent findings, it is completely reasonable to conclude that individuals with significant behavioral health challenges and justice-involvement should be prioritized for housing. A method being used to support prioritizing housing for the most vulnerable is broadly referred to as coordinated entry. Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred and connected to housing and assistance based on their strengths and needs. [88] Individual communities can use available data and research to decide which factors are most important to determine priority such as significant health or behavioral health challenges and functional impairments or the high utilization of crisis services including emergency rooms, psychiatric facilities and jails. [89]

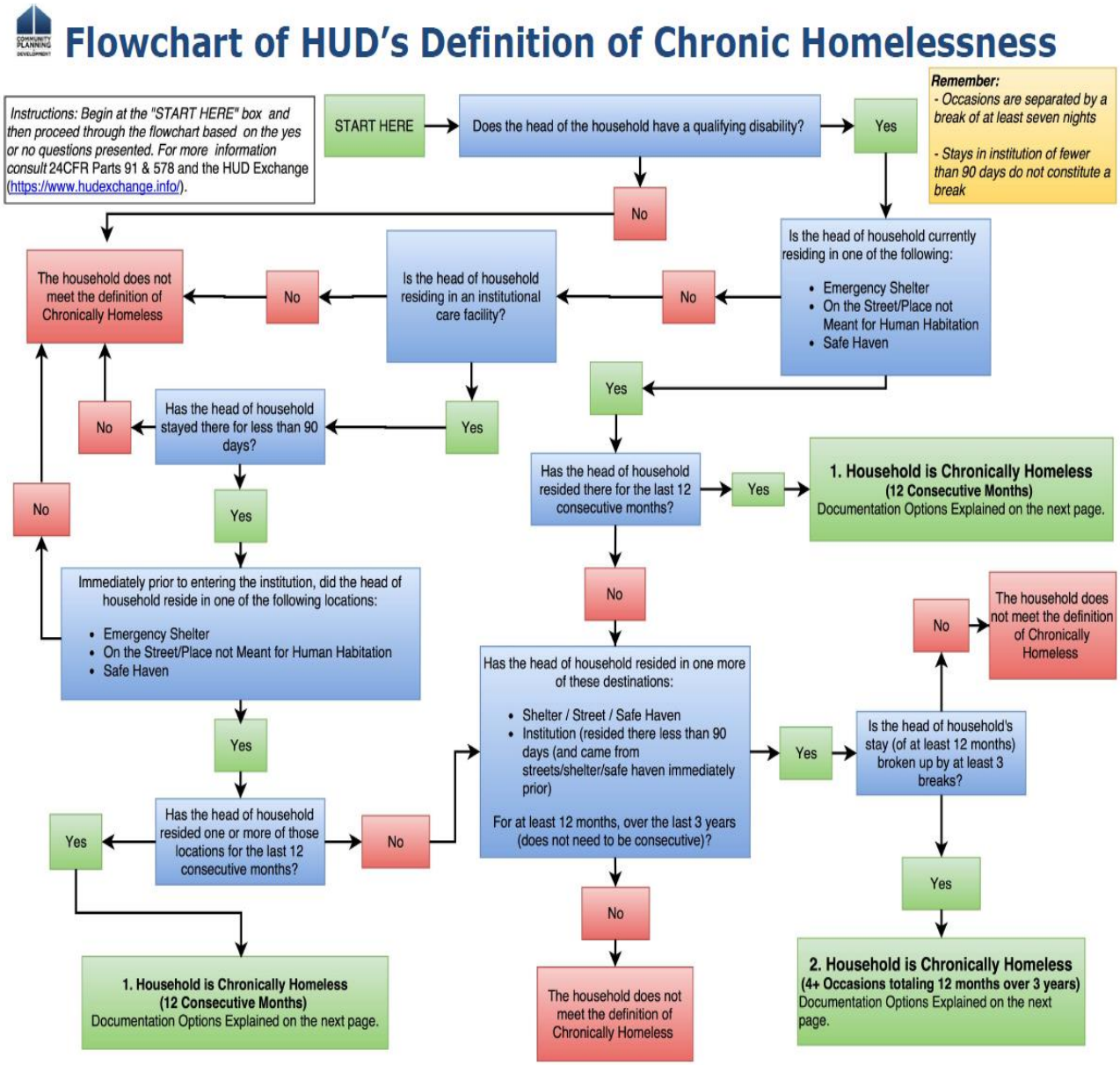
> ***"A working relationship between community based programs and parole/probation is a good start. Lack of funding for sober housing remains the biggest issue."***
> *- Behavioral Health Provider*

> ***"This is not just an issue of state hospitals or state prisons which have too many persons suffering from mental illnesses. This is a crisis situation for the counties, in which persons with mental illnesses live (and die) on the streets, or are inappropriately crowding our jails (where their illnesses may get worse, and where they also face a risk of greater mortality). Keeping mentally ill persons in jail because there is no place else for them to receive mental health treatment is unjust."***
> *- Survey Respondent*

This process is implemented through Coordinated Entry Systems (CES) which use technology to coordinate provider efforts, create a real-time list of individuals experiencing homelessness in the community, and serves to quickly and efficiently match people to available housing resources and services that best fit their needs. Entering a local CES includes a referral and an assessment process which intends to improve accuracy, speed and consistency to target scarce resources. [90] Many counties use the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) and have included justice status as an important factor in assessment. Efforts like this that target formerly incarcerated individuals with high health and behavioral health needs who are at risk of homelessness are demonstrating improved housing outcomes, reduced incarceration and saving money. A study of the Frequent Service Enhancement (FUSE) program in New York City found that after 12 months 91 percent of FUSE participants remained housed and experienced a 40 percent reduction in days incarcerated and over a 24-month period the total per person cost saving was 76 percent. [91]

In practice there are some limitations to this approach that must be addressed to ensure that individuals with justice involvement and behavioral health challenges are getting equal access to housing opportunities. While these limitations may be due to federal policy dictated by the HUD is does not mean that California and local communities cannot explore reasonable and allowable exceptions or advocate for federal changes. It is unclear if individuals who are exiting jails, prisons or state hospitals are being assessed upon discharge into the CES for their community but it does not appear to be a disallowed or excluded activity, just challenging. Efforts must be made between state and local partners to ensure high-risk individuals are assessed into the local CES as part of discharge from incarceration. If there are barriers to that, referrals to the CES should be accepted if not prioritized from probation and parole.

Figure 9



Likely a more challenging federal barrier are policies that require entities that receive specific federal funding to prioritize individuals who meet the criteria for "chronic homelessness". In following the flow chart HUD created to help explain who is "chronically homeless" (see ***Figure 9***) it is clear that someone who has "chronicity" due to their behavioral health disorder still cannot qualify as "chronically homeless" if he or she has been incarcerated for more than 90 days, even if he or she was chronically homeless prior to incarceration. Incarceration is considered a "break in homeless" which reduces the priority status of individuals exiting incarceration, especially from prison due to the more extended length of stay. Considering that California has its own resources related to housing assistance, it is possible that California can explore using adapted definitions. For example the No Place Like Home (NPLH) Program, which will supply permanent supportive housing to individuals with a serious mental illness, includes the term at-risk of chronic homelessness in its criteria for eligibility. At-risk of chronic homelessness is defined by the California Department of Housing and Community Development (HCD) as persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing stability.[xi] CCJBH is eager for the Homeless Coordinating and Financing Council (HCFC) to explore if and how this definition can be applied to California-specific housing and homeless programs.

Step One Recommendation: Prioritize Housing for the Most Vulnerable and the Most in Need		
Local Action	**State Action**	**Federal Action**
Local CES are used to assess strengths and needs quickly. Jails and prisons can explore if and how individuals exiting can be entered into CES prior to release. Partners included in CES should widely vary and include criminal justice. Administrators of local housing programs can prioritize housing for the most vulnerable, high risk and high need individuals with mental illness, substance use and justice involvement. Counties who use the VI-SPDAT should include justice status as part of this tool.	CCJBH can identify and disseminate best practices in the application of CES with criminal justice referral entities. The HCFC can consider how to apply the definition of at-risk of chronic homelessness to various state homeless programs. As defined by the HCD at-risk of chronic homelessness includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization and transition age youth experiencing homelessness or with significant barriers to housing stability.	Provide information to HUD regarding the negative unintended consequences of the revised 2015 definition chronic homelessness. This definition determines program eligibility and remains a clear barrier for the justice-involved. U.S. Interagency Council on Homelessness (USICH) can work with HUD to update the definition of chronic homelessness to include individuals exiting an institution (including jails, prisons and state hospitals) to homelessness after 90 days and with a history of homelessness.

[xi] To learn more about the No Place Like Home Program we recommend visiting the website and reviewing the wide variety of helpful resources regarding the $2 billion in bond funding to support long-term special need housing at: http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

Step Two: Support the Expansion of Housing and Housing Assistance Options

For the last several years a variety of initiatives have incrementally chipped away at growing unaffordability in housing and rising rates of homelessness in California but today it appears we are in crisis. On any given night in California there are about 134,000 people without a home, which is up 14 percent in just one year with nearly 40,000 of those individuals meeting the criteria for chronic homelessness.[92] Moreover, these numbers mean California now accounts for nearly a quarter of the nation's homeless. In a response to this emergency the 2018-2019 California Budget provided a number of one-time opportunities to address the crisis and specifically acknowledged and provided direction to local implementers that funds should be used to prevent criminal justice involvement, including diversion and reentry housing assistance. Counties and cities are already applying for the nearly $1 billion in funding available under these initiatives:[xii]

- Homeless Mentally Ill Outreach and Treatment Program - $50 million in funds to be administered by DHCS to counties with allocations determined by based on a county rates of homelessness among individuals with mental illness and the overall population. Funds are intended to provide short-term services and housing assistance while other programs are under development that can provide for long-term assistance like the NPLH Program which will provide permanent supportive housing for individuals with serious mental illness.

- Adult Reentry Grants - $50 million in funds administered by the BSCC on a competitive basis with CBOs to support individuals who have been incarcerated in state prison. Funds must be spent on rental assistance, rehabilitation of property to support housing and services to support the transition home from incarceration. Funds are not specifically targeting individuals with behavioral health issues but considering the evidence of higher risk of homelessness and recidivism among those with behavioral health issues, it seems of merit to use funds to serve higher risk and need populations.

- Community Infrastructure Grant Program – $67.5 million in funds administered by the CHFFA to counties who apply, (technically these funds were allocated in 2016 but the resources are just now available) including as joint regional projects, based on allocations determined by population and the quality of the application. These limited funds provide for long-term investments for needed mental health and substance use treatment infrastructure (i.e. facility acquisition, renovation, IT) to support diversion efforts.

[xii] Additional resources to address homelessness were also included in the budget, such as $36 million for the Housing for a Healthy California Program to support housing for Whole Person Care Pilots. These programs did not specifically include the goal of preventing incarceration and therefore are not included in this analysis but for more information we suggest reviewing: http://www.counties.org/sites/main/files/fileattachments/county_homelessness_funding_chart_sep_5_2018_final.pdf

- Pre-Trial Felony/Incompetent to IST Diversion Program - $100 million in funds administered by the DSH through contracts with counties who have the highest rates of IST referrals to DSH and who have submitted information regarding how funds will be used to expand, adapt and provide new community-based programming to support diversion of individuals with serious mental illness charged with felony crimes who may also be experiencing homelessness. While funds are limited to a three year timeline the program aims to support sustainable programming in the future. Recognizing that this is challenging work, the MHSOAC was awarded $5 million in funds to support efforts for counties to use a portion of their MHSA funding for innovative practices aimed at preventing individuals from becoming so unwell that they are at-risk of incarceration and being deemed IST. Counties can receive support to implement innovative practices at each intercept (0-5) across the SIM which includes prevention, diversion and reentry practices.

- Homeless Emergency Aid Program (HEAP) - $500 million in funds administrated by the HCFC to counties and cities for urgent and immediate needs to address homelessness with funds needing to be expended by June 2021. Forty-three CoCs statewide and identified large cities are eligible to apply and will locally determine how to best use these limited short-term resources. Allowable funding activities are intentionally broad but include services such as street outreach and criminal justice diversion, rental assistance and subsidies such as housing vouchers and eviction prevention, and capital improvements like additional emergency shelters and transitional housing. [xiii]

In October of 2018 CCJBH wrote a letter to each of the 43 CoCs encouraging local consideration of prioritizing HEAP resources for individuals with behavioral health issues that are justice-involved. In addition, the letter described the Council's interest in being more of a resource to the CoCs who are interested in better understanding how to address the complex needs of this target population. The response was mixed, but the need for technical assistance to serve the housing and overall service needs of this complex population was high in medium to smaller communities. While the influx of one-time funding will critically help in the short-term, it is unclear if and how the state will provide leadership and support to local implementers, such as technical assistance and evaluation to sustain long-term change.

Can assistance be provided to counties to determine if and how each of the initiatives described above can build capacity and fill gaps in the housing and service continuum to support diversion efforts over time? Can information captured by the locals on which housing strategies are the most effective for what types of populations be shared with the state and widely disseminated to support the adoption of best practices? Possibly this is a role the HCFC can play and CCJBH can contribute to those efforts by adding further suggestions on how existing funding through resources like AB109, the MHSA and Medi-Cal can be better leveraged to support housing services.

[xiii] The September 20th 2018 CCJBH Council meeting including presentations from each of the entities here responsible for administrating these funds. For an enhanced understanding of these programs we suggest reviewing documents available at: https://sites.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/4/2018/09/CCJBH-FINAL-Council-Meeting-Agenda-9.18.18-1.pdf

Step Two Recommendation: Support the Expansion of Housing and Housing Assistance Options		
Local Action	**State Action**	**Federal Action**
If viable, counties and cities can go directly to the voters to get more resources to develop affordable housing and to address homelessness either through additional local taxes or bond measures. Local CoCs can use funds provided by the HEAP to address the complex housing needs of justice involved individuals (youth and adults) with behavioral health challenges. Counties can apply for NPLH Funds to develop permanent supportive housing for people with mental illness who are homeless or at risk of chronic homelessness.	CCJBH can provide guidance to maximize the use of Medi-Cal so that resources saved on healthcare, including by parole and probation, can be directed towards housing for the reentry population ranging from rental assistance to transitional and permanent supportive housing. This can be based on guidance provided by the CMS in 2015. CCBJH in collaboration with other state departments can provide guidance on how funding sources like AB109, the MHSA, Proposition 47 and other non-Medi-Cal resources can be used for housing options for the justice-involved with behavioral health challenges. Support housing and service providers to explore opportunities to expand group housing options as an alternative to single family units.	National criminal justice reform efforts can include recommendations from the USICH which call for criminal justice systems to be resourced to support immediate housing options like short-term rental assistance & rapid re-housing.

Step Three: Support Housing Best Practices

Considering the scarcity of existing housing, it is essential that what is available is used as wisely as possibly. HUD promotes Housing First models which are increasingly promoted as a best practice for individuals with behavioral health challenges who have been justice-involved. According to HUD:

> ***"Housing first is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without barriers to entry such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry."***[93]

In California through SB 1380 (Chapter 847 commencing with Section 8255 of WIC 2016) Housing First is a required, (with very few exceptions), approach to any state agency or department that funds, implements, or administers housing or housing-related services to individuals who are experiencing or who are at-risk of homelessness.[94] Currently agencies and departments, including the CDCR and DHCS, are undergoing internal reviews to determine which programs must comply with Housing First principles and to what extent changes needed

in order to satisfy the requirements. The four standard Housing First models (including Residential Treatment) include:

- Emergency Shelter – Short-term (ideally less than 30 days) offering immediate access but typically few services for high need populations and often not appropriate for such populations
- Rapid Re-Housing – Medium-term (no limit on stay) focusing on providing housing stability for low to medium need individuals
- Transitional Housing – Medium-term (limited stay) supporting future housing readiness but often screens out high need individuals
- Permanent Supportive Housing – Long-term (no limit on stay) providing significant support services for high need individuals to achieve permanent housing stability
- Residential Treatment – Treatment model which is subject to licensure and supports various length of stay depending on care needed.[xiv]

In the past CCJBH has expressed some concern that a strict application of Housing First principles, particularly low-barrier entry which includes the harm reduction model, could pose some challenges for individuals trying to meet conditions of probation or parole. Individuals living in recovery may prefer a living situation that is completely sober. Options can be found for that individual and she or he does not have to be excluded from housing support. Concerns about how to comply with Housing First requirements can be alleviated with some basic training and technical assistance. The HCFC, which is charged with overseeing the implementation of the Housing First requirements, can offer technical assistance to state agencies and departments. When applicable, they can also support those partners in training their own staff and contractors on how the principles can be adapted and co-exist with probation and parole requirements. The HCFC, in collaboration with CCJBH, could also explore how local CoCs could provide training and support to local law enforcement and criminal justice partners. As long as public safety remains a goal of programming, individuals who are justice-involved should be supported with Housing First models and successfully doing so will require involving probation and parole.

Step Three Recommendation: Support Housing Best Practices		
Local Action	**State Action**	**Federal Action**
CCBJH can reach out to CoCs to learn more about how various housing first models (i.e. emergency shelters, rapid rehousing, transitional housing, permanent supportive housing and residential treatment) are including equal opportunities for those being released from institutions like jails, prisons and state hospitals. Understand how local screening criteria are used so that justice status is not an	CCJBH can work with the HCFC to ensure that required conditions of parole and probation can co-exists with Housing First requirements and best practices. CCJBH can identify, in collaboration with CoCs, what additional guidance or training and technical assistance can support the adoption of Housing First practices for individuals who have	Provide information to the HUD and the USICH regarding support for Housing First practices that can be adopted within a framework that takes into consideration the needs of individuals on community supervision and

[xiv] For more information view fact sheets at https://www.huduser.gov/portal/publications/hsgfirst.pdf and http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf

Step Three Recommendation: Support Housing Best Practices		
Local Action	**State Action**	**Federal Action**
exclusionary but rather inclusionary factor.	to comply with supervision requirements.	protects public safety.

Step Four: Create Equitable Housing Assistance Opportunities and Combat Housing Discrimination

Without complete, accurate and thorough data it is difficult to document that individuals experiencing serious behavioral health issues who are justice-involved are not equally accessing housing assistance opportunities. Understanding who is homeless, for what reasons, and for how long is a difficult task which can be compounded when considering the unique traits of individuals who carry stigmatized statuses like mental illness, addiction and criminal backgrounds. While the brief by CalHPS was able to report estimated rates of unsheltered homelessness among individuals with mental illness and justice involvement, it also acknowledged some significant challenges with the data. A problem statewide is that PIT counts and local evaluations use different methodologies and definitions such as mental health issue vs mental illness which makes direct comparisons across counties to identify regional and statewide patterns very difficult.[95]

This is also true of questions associated with justice status. Knowing if a person has recently exited prison vs jail or if someone is currently on probation vs parole could be helpful in assessing gaps and identifying which system partners may need more funding, training or other supports to provide adequate housing.

Local CoCs can be encouraged to use recommended definitions for variables like justice status and behavioral health conditions so that the Homeless Management Information Systems (HMIS) are collecting data that can be used to describe local and statewide trends.[xv] Supporting these efforts could be part of the activities of the HCFC which is beginning the process of developing a California Homeless Data Integration System which aims to collect and integrate data from all of the local HMISs administered by CoCs. CCJBH is participating in the development of the Statewide Homeless Information Management System to ensure that justice status is being collected with appropriate specificity so that it can be considered as a variable examined to determine levels and rates of housing and housing assistance.

Even if there is data to support equitable distribution of housing assistance and to inform practices, without active and resourced efforts to combat housing discrimination, history has demonstrated that individuals carrying multiple stigmas – especially previous criminal history – will be indirectly and directly denied housing. In the 2016 and 2017 reports, CCJBH has supplied several recommendations regarding how to combat housing discrimination ranging from supporting local public housing authorities, to sharing best practices for the justice-involved, to helping educate individuals about their housing rights and knowing what to do if violated. Other strategies have included streamlining zoning requirements and burdensome

[xv] A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

regulations and providing cash incentives to housing providers who serve individuals with behavioral health issues and justice-involvement.

Looking ahead to 2019, what is necessary is for our communities to be more accepting of people experiencing homelessness and housing insecurity because there is state leadership that conveys a zero tolerance policy on "Not in My Backyard (NIMBY) or NIMBYism." Doing so requires dedicated resources and a state entity adequately resourced to investigate claims of discrimination and violations of fair housing laws. Collecting this information from individuals, and especially providers in local communities, can inform future state policy needed to provide equal opportunities for recovery and wellness for all Californians experiencing homelessness.

Step Four Recommendation: Create Equitable Housing Assistance Opportunities and Combat Housing Discrimination		
Local Action	**State Action**	**Federal Action**
Without understanding who is homeless and why, communities cannot prioritize limited resources. Local CoCs need guidance and support to collect appropriate information about justice status (i.e. probation vs parole, recently released from jail vs prison, etc.) to equitably plan and provide assistance. Communities must be adequately resourced to coordinate a comprehensive set of strategies that collect information and data from places who work with people who are homeless including jails, prisons, state hospitals and juvenile detention facilities. Homeless management information systems and other data sources must build and maintain information about people experiencing homelessness and their outcomes. Improve access to local Public Housing Authority (PHA) resources for individuals who have convictions by modifying standards of admission/screening – e.g. shorten the length of time in which a review of a conviction or public safety concern can be considered, use individualized assessments and allow explanations for special circumstances, eliminating all	CCJBH will participate in the development of the Statewide Homeless Information Management System to ensure that justice status is being collected with appropriate specificity so that it can be considered as a variable in increased access to housing and housing assistance. CCBJH can review local policies and ensure they are consistent with federal law, and consider ways to support Californians to know their housing rights and how to file grievances when they are denied. CCJBH will explore if and how the Medi-Cal Utilization Program can include homelessness and housing insecurity in analyses. CCJBH can monitor local and state efforts that reduce the criminalization of homelessness for people with behavioral health issues, report on trends and identify best practices. HCD should consider streamlining zoning procedural requirements as part of the implementation of NPLH in part of help ease the burden on interested providers who already will be operating in an extremely expensive market and burdensome regulatory environment. Strengthen state-level efforts to combat NIMBY community responses for housing	Federal partners can educate advocates and implementers about the 2016 clarifications of the application of fair housing act standards to the use of criminal records (April 4, 2016 Letter, HUD Notice 2015-10). All public housing authorities and private housing providers must comply with this guidance. Arrest records cannot be the basis for

Step Four Recommendation: Create Equitable Housing Assistance Opportunities and Combat Housing Discrimination		
Local Action	**State Action**	**Federal Action**
provisions screening applicants out of the Housing Choice Voucher (Section 8) and Public Housing programs due to probation or parole status, and direct the PHA to prioritize people who are justice involved and have a behavioral health or serious health need for Section 8 or other public housing.	for individuals with behavioral health needs and/or individuals who have been formerly incarcerated. Explore how the Housing Accountability Act can enforce the development of appropriate housing for special needs populations who may be experiencing discrimination.	denying admission, terminating assistance, or evicting tenants.

Finding Three: Data and Information is not Systematically Collected to Inform Policymaking and Program Investments or to Support Accountability and Quality Improvement

Barriers to data-sharing, whether real or perceived, are keeping criminal justice and behavioral health care systems from supporting continuity of care and monitoring whether interventions and strategies are successfully reducing recidivism. Determining when and how data can be exchanged for program improvements or desired health or public safety outcomes is critical to supporting integrated service delivery that is effective for the individual and accountable to the taxpayer.

CCJBH urges state leadership to support data-driven practices and policy-making among criminal justice and behavioral health systems to ensure continuity of care and achieve desired public safety and health outcomes.

Step One: Systematically collect data

As said best by Clive Humby, "Data is the new oil. It's valuable, but if unrefined it cannot really be used".[96] In California there is an abundance of data that is collected by state agencies and by local counties. However, as Humby describes, much of this data is unrefined and therefore remains underutilized or unused all together. One contributing factor to the underutilization of data, at least at the county level, is the lack of systematic data collection. For example, the Council of State Governments Justice Center found in their analysis that only a handful (25 percent) of counties reported employing universal screening and assessment for mental illness, substance use, and criminal risk either at the jail or on probation, and only 17 percent of counties reported providing assessments for all mental health and substance use in their jails.[97] CCJBH has supported efforts to better understand the challenges that counties face in collecting data. In 2017 the Stepping Up Initiative provided support for a California Summit to promote jail

diversion for individuals with mental illness. Hundreds of leaders from across the state shared their insights on the issues based on their cumulative expertise. Not surprisingly, much of the feedback centered on data issues including: 1) Insufficient data as a barrier to identifying the target population and to informing efforts to develop a system-wide response, 2) Program design and implementation are not evidenced based, and 3) Initiatives are most often small in scale and outcomes and impact are not measured.[98] CCJBH continues to lead conversations on these issues through coordinating California's Criminal Justice and Behavioral Health data workgroup and more recently collaborating with the Council of State Governments Justice Center to host the 2018 California Forum on Public Safety Measures and Outcomes. The theme that has emerged from these efforts is that counties need the capacity and resources to ensure the right data can be collected, analyzed and used to inform policymakers and administrators on where to make investments (e.g. programs, facilities, workforce, training, evaluation, technology, etc.). Ways to accomplish this could include investigating how dedicated funds provided under the MHSA or AB109 could be used to improve and enhance data collection efforts and support the exchange of knowledge across counties and regions.

Step One Recommendation: Systemically collect data so that the target population is accurately identified and informed decisions can be made system wide	
Local Action	**State Action**
Counties can use a standard definition of mental illness, substance abuse and recidivism across the state in community corrections so that comparisons and trends across counties and statewide can be drawn. CCJBH recommends the use of the BSCC definition of recidivism and the Welfare and Institutions statutory definition of mental illness and SUD as guidance for inclusion in Medi-Cal programs. Counties can explore to the extent possible resources from various funding streams such as the MHSA and AB109 could be dedicated to data improvement practices.	CCJBH can explore with the Council on State Governments (CSG) Justice Center and other state-level partners representing local constituencies, such as the CSSA, the CBHDA and the Chief Probation Officers of California, where shared definitions beyond mental illness could be agreed upon. The more shared definitions that can be agreed upon, the more likely statewide trends in incarceration can be identified. Improved understanding of length of stay in jail for individuals with behavioral health challenges could also aid in understanding statewide trends. The state could consider ways to better support local law enforcement to begin early data collection efforts and to update data collection systems.

Step Two: Support counties to know their data

It is useful to acknowledge and recognize that there is a need for additional resources to support data efforts by counties, however, in the face of what some view as insufficient capacity and resources a key question that must be addressed is, what can be done now to support counties getting to know the data they currently collect? One example of how this can be done is the collaborative work undertaken by the Public Policy Institute of California (PPIC) and the BSCC. The PPIC and the BSCC collaborated on a Multi-County Study to help provide counties with the basic data system structure needed to begin to evaluate trends both within and across counties of the incarcerated population. The study includes participation of twelve counties, representing

over 50 percent of California's population. The study has collected and merged state and local criminal justice data in building a data infrastructure capable of linking county data systems and researchers have begun to evaluate the effects of key criminal justice reforms. As highlighted in various CCJBH council meetings,[99] research findings from the Multi-County Study have shown the impact that reforms such as Prop 47 have had on recidivism. For example, using data from the Multi-County Study PPIC researchers found a reduction in arrests by law enforcement and convictions following the implementation of Prop 47.[100] Data from the Multi-County Study has also been used to examine the impact of AB 109 on recidivism.[101]

> ***"Data and evaluation support, including guidance on evaluating the impact of behavioral health services on public safety outcomes for communities would be beneficial to policy and program discussions"*** - *Criminal Justice Administrator*

The next phase of the study is to transfer the developed jail population forecasting tools and jail policy tools to the BSCC who will continue to support counties. Although there is a clear need for additional data and assessments, particularly for those with mental health and substance use needs, data that remains unused cannot be improved. The Multi-County Study highlights the need to effectively mine the data currently collected, as well as develop additional assessments so that data can drive and inform effective recidivism policies and practices.

Step Two Recommendation: Support Counties in Getting to Know their Target Population	
Local Action	**State Action**
Counties can better understand the prevalence of mental illness in the jail population by using validated screening and assessment tools at booking, including a brief screen for mental illness and SUD to determine treatment needs. Tools should be gender specific but simple enough that anyone can administer them. Counties can partner with organizations studying issues of recidivism such as the PPIC and the 12 County Study of AB 109 implementation or California Forward's Justice System Change Initiative. Both initiatives assist counties with establishing baseline data to better understand who is coming in and out of jail and why. This approach assists counties to develop projections on what kinds of service alternatives to create to reduce incarceration.	CCBJH can promote easy to use validated screening tools for jails such as the brief justice mental health screen, correctional mental health screen for men, correctional mental health screen for women and the jail screening assessment tool. CCBJH can share with counties, when appropriate, information regarding how individuals exiting state incarceration may or may not be using their Medi-Cal benefits for health and behavioral health services. This can help inform local policies and practices. Considering the elevated rates and dangers associated with opioid use, CCBJH further recommends that all incoming detainees be screened with reliable and validated tools that provide clinically useful data in the treatment of opioid use and other SUDs. Moreover, to successfully tackle the crisis it is a critical to understand how many individuals suffering from OUD are entering jails and prisons.

Step Three: Provide guidance/confidence for data-sharing

In a brief produced as part of the Stepping Up Initiative experts in the field of diversion note that one of the primary reasons more progress in reducing the incarceration of individuals with mental illness has not been achieved despite significant investments is because, "there is insufficient data to identify the target population and to inform efforts to develop a system-wide response."[102] The authors continue noting that data is not available to establish a baseline and because counties struggle to systematically collect information about the mental health and substance use needs of each person booked into jail, this information cannot be analyzed to inform planning for local investments. However, data on individuals with behavioral health needs that are justice involved does exist, it is just not readily accessible by counties. Counties should not be forced to solely shoulder the burden of designing and implementing a data system to collect and track data for individuals when state departments such as the DHCS, DOJ and CDCR (which houses CCJBH) already collect and monitor data for these individuals. As discussed previously, criminal justice reforms in conjunction with health care reforms have made addressing the needs of the criminal justice population, particularly those with behavioral health needs, a public safety as well as a public health issue.

In examining data issues faced by counties through a public health lens, there are shining examples of how sensitive data can be shared for public use, without violating patient confidentiality, to improve the health of all Californians. For example, the California Health and Human Services Agency (CHHS) has led the "free the data" movement in California developing the CHHS open data portal.[103] The open data portal permits public access to non-confidential health and human services data. The goal of the Open Data Portal initiative is "… to spark innovation, promote research and economic opportunities, engage public participation in government, increase transparency and inform decision-making."[104] In addition to providing access to aggregate level state-wide health care data, CHHS has published a handbook to support the use of their data and provide a better understanding of the limitations of the available data. This example, of one California state agency and how they have addressed data sharing issues is encouraging, and it is something that other California state agencies can adapt or build upon.

> ***"Behavioral health personnel find it challenging to appropriately communicate due to Health Insurance Portability and Accountability Act (HIPAA) or other confidentiality issues."*** *– Survey Respondent*

Strong state leadership is necessary to ensure that agencies and departments who want to partner and share data can do so in an efficient and responsible manner. Data collaboration between governmental partners can be unnecessarily hindered by rules and regulations that are well intentioned but may prevent data sharing that could make government operations more successful. Data-sharing agreements between state agencies that support the study of what investments are working and why can lead to improved public health and safety in California. Barriers to appropriate data-sharing can be overcome, and must be, to support quality policies and programs. Through strengthened data sharing practices within and across state agencies and

departments, California can model the kind of actions that can be taken locally at the county level to support data-informed decision making.

Step Three Recommendation: Provide guidance and confidence to support data sharing	
Local Action	**State Action**
Counties are creating local adaptions and solutions to sharing data across criminal justice and behavioral health systems such as best practices in contracting for jail-based behavioral health services to support continuity of care. Counties can share those strategies with each other through a learning collaborative supported by MHSA Innovation funds.	The state can consider expanding guidance on the appropriate exchange of personal health and criminal justice information. The California Office of Health Information Integrity, within the CHHS, is responsible for ensuring compliance with HIPAA and other privacy laws. While the agency published guidance in 2017 to clarify laws and regulations including those for the justice-involved population with behavioral health needs, users want more in-depth direction, training and technical assistance. CCJBH can partner with CSG to investigate how other states (i.e. Texas, Oregon, & Michigan) have developed models to support data-sharing as well as statewide databases to facilitate data-sharing. CCJBH can help identify and provide tools and resources to address common concerns from counties including: 1. Lack of knowledge when patient consent is needed to exchange criminal justice or behavioral health information 2. Lack of data systems with required interoperability 3. Lack of approved policies or agreements in place to share and exchange data 4. Lack of staff capacity or training to collect, analyze, or share data.

Step Four: Invest in quality data and research

CCJBH's Medi-Cal utilization research program is an example of how California state agencies can invest in quality data and research to improve government practices and individual outcomes. In addition to showing how two of the largest state agencies in California can collaborate to share data, findings from CCJBH's research program provide evidence that formerly incarcerated individuals are using their Medi-Cal benefits and the study has provided information on patterns of health care service access and utilization among individuals formerly incarcerated. In particular, research from CCJBH has shown the need for having a better system that allows for immediate use of health benefits when exiting CDCR as well as a warm handoff between CDCR's health care system and a provider selected by individuals prior to leaving CDCR. Appendix C provides additional details of CCJBH's Medi-Cal Utilization study.

Investing in quality data and research is critical to curbing long-term spending and to stop spending on programs that do not meet expectations. CCJBH is equipped to take lessons learned from the Medi-Cal utilization research program and consider other useful applications so that data is being used to inform decision-making. For example, what does the state know regarding trends in diversion and incarceration rates among youth and adults with mental illness and SUDs? A variety of data can help answer this question, but it must be tapped. The statewide monitoring system could track trends and identify gaps by assessing a wide variety of indicators available in existing datasets. For example, the California Health Interview Survey can provide

information associated with reduced incarceration such as increased available crisis response alternatives, while the Jail Profile Survey can assess increased treatment capacity or reduced rates of needed services. With state leadership demonstrating the value and necessity of quality data and research, strides can be made to reduce unintended outcomes for individuals struggling with behavioral health disorders in, and at-risk of becoming part of, the criminal justice system.

Step Four Recommendation: Invest in quality data evaluation and research to improve outcomes	
Local Action	**State Action**
Counties can explore shared costs to develop or improve existing systems that have the capacity to support required interoperability. Counties can explore strategies to leverage resources through administrative costs in partnership with local educational institutions and universities offering in-kind support for evaluation and research.	State agencies and departments have a significant amount of data and can identify ways to make administrative de-identified data more available to research and evaluation entities eager to study best practices to achieve positive public safety and health outcomes. CCJBH can work with evaluation experts to develop a statewide monitoring system for diversion to track trends in incarceration for state policymaking and accountability to taxpayers. The system could assess indicators available in existing datasets like the California Health Interview Survey and the Jail and Juvenile Detention profile surveys to track activities associated with the reduced incarceration of youth and adults with substance use and mental health disorders.

Appendix A

In anticipation of a new administration in 2019 the Council on Criminal Justice and Behavioral Health (CCJBH) has identified three key findings essential to understanding how community program deficiencies, the homeless crisis and inefficient data and information have adversely impacted people who are justice-involved with behavioral health challenges. CCJBH has provided recommended activities to address these issues step-by-step from a local, state and often federal standpoint.

Finding One: Failure to Meet the Needs of Individuals with Serious Mental Health and Substance Use Disorders is Caused by a Significant Lack of Resources for the Community Behavioral Health System

Individuals often only find their way into the behavioral health system through incarceration or hospitalization. These results are hardly surprising given the tasks the system has been assigned by default; eliminating poverty, solving homelessness and ending discrimination. These unreasonable expectations only serve to further overwhelm a system that must address the complex needs of individuals who may have co-occurring substance use and mental health conditions, criminogenic risk factors, major and multiple medical problems, and chronic homelessness. The all but inevitable poor outcomes attributed to this under resourced system have led to calls for greater investment in institutional care such as jails, prisons and state hospital beds. Such a move would almost certainly come at the cost of funding for community based-services, further exacerbating the very symptoms that have led to the current situation.

CCJBH urges increased investment in community-based services starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges. . By working with partners from criminal justice to social services, the community behavioral health system can develop the capacity to serve those most in need, as well as, collaborate with partners to prevent substance use and mental health challenges from resulting in harmful individual and societal costs.

Recommendation	Local Action	State Action	Federal Action
Step One: ***Commit to Community Alternatives to Support Prevention, Diversion and Successful Re-Entry***	Counties can undergo local sequential intercept mapping which provides a framework to identify points of interception where an intervention can be made to divert individuals from falling deeper into the criminal justice system. The process can assist in balancing investments across the continuum from prevention to community corrections, targeting resources to unmet needs or to address gaps. In addition to Medi-Cal funds, assess how and to what extent a variety of funding sources such as Public Safety and Behavioral Health Realignment, The Mental Health Services Act (MHSA), Prop 47, County General Fund and other grants can be used to support these efforts. To support the success of developing and sustaining community alternatives be mindful of the necessity of education and committed to taking action to ensure equitable opportunities.	It is paramount to increase resources for community-based mental health and substance use treatment facilities. Infrastructure investments like the Community Services Infrastructure Grant Program, administered by the California Health Facilities Financing Authority (CHFFA), need to be substantially expanded. Success will require the State to eliminate regulatory barriers to siting and licensing. The State can support CCJBH to build upon existing efforts to lead agencies, departments, advisors and stakeholders to: 1. Catalogue existing state and federal efforts in prevention, diversion and reentry, including the authority and funding provided by different entities, 2. Identify strengths and barriers in existing efforts including opportunities to improve coordination to address gaps in prevention, diversion and reentry efforts, 3. Develop a prioritized plan of legislative, regulatory, financial, educational and training and technical assistance activities for statewide action, and	In its first set of recommendations to Congress, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) identified increasing opportunities for diversion and improving mental health care for the justice-involved as one of five priorities. Specifically, the ISMICC should support enhanced efforts to identify how policies in each participating federal department, such as SAMHSA, Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Housing and Urban Development (HUD), may contribute to barriers to community alternatives to incarceration for individuals with serious mental illness. The ISMICC should analyze such identified policies and make recommendations to revise policies to better support community alternatives.

Recommendation	Local Action	State Action	Federal Action
		4. Create a reasonable structure to measure the progress and impact. CCJBH can collaborate with other necessary state and local partners to conduct a thorough analysis of the supply and demand for the variety of residential options, including safe and affordable housing, needed to support the substantial demand for community based behavioral health alternatives to incarceration. CCJBH will provide technical assistance to local partners to support community alternatives for individuals identified for pre-trial mental health felony diversion. CCJBH will analyze and provide recommendations on the implications of Bail Reform for people with serious behavioral health disorders (i.e. identifying strategies to deliver services post-release/pre-trial, risk assessment tools and bias, adequate resources for probation and courts).	
Step Two: ***Preserve California's Expansion of Medi-Cal and Improve how Mental Health***	Locals, with support from mental health advocates, can collect stories from individuals about how access to mental health and substance use services through	Analysis from CCJBH's Medi-Cal Utilization Project will document and provide evidence that individually who have been formerly incarcerated are using the new Medi-Cal benefit available	Support the stability and success of the Affordable Care Act (ACA), protect California's health care reform policies including Medi-Cal Expansion and providing substance

Recommendation	Local Action	State Action	Federal Action
and Substance Use Services are delivered as Essential Health Benefits	Medi-Cal has led to positive outcomes in their lives including employment, secured housing, and family reunification.	due to the expansion and examine if and how mental health and substance use services are being accessed. CCJBH can track progress in California prevalence rates in the community for serious mental illness mental health conditions, illicit drug abuse, alcohol abuse and general substance use including pain medication with prevalence rates in jails and prisons. The prevalence rates while incarcerated should not be higher and should trend downwards.	use and mental health services as essential health benefits.
Step Three: ***Make Medi-Cal More Effective by Maximizing Federal Reimbursement and Retaining State and Local Resources for Non-Federally Reimbursable Services***	Enroll Individuals in Medi-Cal. Local jails can screen for eligibility for health care coverage and other benefits at intake either by custody staff or in partnership/ contract with county health and social services staff. Efforts should be consistent with local eligibility screening and determination processes and protocols. Maximize Public Safety Realignment (AB 109) funds for evidenced-based community correctional practices, including substance-used and mental health treatment. While these individuals	CCJBH can research and disseminate other state strategies to expedite Medicaid eligibility and enrollment such as the use of peer educators to support managed care plan selection prior to release. CCJBH can explore strategies where Medi-Cal plan selection could be completed simultaneously with eligibility and enrollment processes in small counties that have one plan option. For multi-plan counties, prior to release individuals can receive information to choose a specific provider within the network of the plan selected upon release. Health navigators can assist with	Congress should pass legislation to ease and/ or undo the federal Medicaid inmate exclusion and require states to suspend, instead of terminate, Medicaid coverage for justice involved individuals. The Centers for Medicaid and Medicare Services (CMS) should amend State Official Letter 16-007 to clarify that Medicaid can be used to support inmates who are in alternative custody programs in community-based reentry centers that are not located in prisons.

Recommendation	Local Action	State Action	Federal Action
	may be eligible for Medi-Cal, some may not be and many may need housing, transportation, vocational and correctional services to support their participation in Medi-Cal services. Counties can assess how AB 109 funds and MHSA funds are adequately investing in treatment services for the justice-involved or at-risk of justice involvement to reduce incarceration as well as improve behavioral health outcomes. This should include strategies such as crisis services, alternative custody and behavioral health courts. Counties can participate with CCJBH and other stakeholders like Probation to identify effective payment models (AB 109, MHSA, Medi-Cal) for the justice-involved with behavioral health issues. These models should be disseminated to all counties. Explore recent recommendations on improving Realignment policy by the LAO regarding making	activation and the first appointment post-release. DHCS, in consultation with behavioral health and criminal justice stakeholders, can clarify and provide guidance to counties on when and to what extent Medi-Cal and Mental Health Services Act (MHSA) funds can be used for the justice-involved, including parolees who are now Medi-Cal beneficiaries. Issues to clarify: 1. Can MHSA funds under WIC 5813 (f) support appropriate jail-based services such as discharge planning? 2. How can MHSA funds be used for individuals on parole and probation? 3. Is the MHSA parolee exclusion out of date and keeping individuals who are Medi-Cal beneficiaries from equal access to services? Investigate if and to what extent State General Fund (SGF) resources that support Parole Outpatient Clinics are paying for Medi-Cal reimbursable services. Assess how State and County resources can be leveraged so that SGF can be used for much needed non Medi-Cal reimbursable services such as rental assistance.	The U.S. Department of Health and Human Services (HHS) should exercise existing authority to provide additional state flexibility in the Medicaid program to cover justice-involved individuals such as: 1. Identifying patients in county jails who are receiving community-based care and then maintaining their treatment protocols; 2. Developing treatment and continuity of care plans for released or diverted individuals; 3. Initiating medication-assisted treatment (MAT) or other forms of medically necessary and appropriate intervention for jailed individuals with opiate addiction whose release is anticipated within 7 to 10 days; and 4. Reimbursing peer counselors to facilitate reentry and increase jailed individuals' health literacy.

Recommendation	Local Action	State Action	Federal Action
	counties responsible for all forensic court commitments in exchange for reducing counties' In-Home Supportive Services (IHSS) costs to improve incentives to provide effective community-based services for this population.		
Step Four: ***Use Available Evidence-Based Practices to Serve Individuals with Complex Needs with Integrated Services*** ***(i.e. criminogenic risk factors, co-occurring substance use and mental health disorders, major medical conditions)***	Conduct universal screenings with reliable and validated tools for mental illness, substance use and/or co-occurring disorders (COD) and criminogenic risk at jail intake. Doing so will provide valuable information to support diversion, needed services and improved connections to necessary care. Use the "Risk-Need-Responsivity" model to identify and categorize risks and needs and cognitive behavioral health therapy with a documented evidence base including Thinking for Change and Moral Recognition Therapy. Use COD treatment programs across all different settings in the justice system from Integrated Dual Disorders Treatment in drug and mental health courts to MAT	CCJBH can promote the adoption of the Criminogenic Risk and Behavioral Health Needs Framework to ensure that resources are directed towards those with high behavioral health and criminogenic risk needs. CCJBH will collaborate with other entities in 2019 to investigate programmatic, regulatory or financial barriers to integrated care (correctional, substance use, mental and physical health). Identify if there are state solutions that can be proposed as part of the 2020 Medi-Cal waiver renewal. To address the high risk of overdose post-release, direct DHCS to use new Opioid Federal funds to supply correctional providers (State and Local) with naloxone to offer upon release to those identified with an Opioid Use Disorder (OUD) treatment need.	Congress should consider how to use resources within the Department of Justice to support the wider adoption of programs identified by the U.S. Government Accountability Office (GAO) as demonstrating higher rates of recidivism reduction for individuals with mental illness. Such programs include multiple support services, most notably extensive community supervision, substance use treatment and housing. Monitor the implementation of key elements of the federal opioid package (H.R. 6) for impacts to justice-involved individuals with SUD and COD. Ensure that California is appropriately represented in the HHS Secretary's stakeholder group that will develop a report on best practices in health care related transitions for incarcerated individuals.

Recommendation	Local Action	State Action	Federal Action
	in jails and during reentry to forensic community assertive treatment while on community supervision. Document lessons learned from the California Health Care Foundation's study of 20 counties who are expanding MAT in county jails and drug courts.	CCJBH will collaborate with other state partners to raise awareness and tackle the stigma associated with substance use disorders (SUD). Support California's public education campaign efforts regarding opioid safety and treatment.	
Step Five: ***Follow Individuals Home and Continue the Investments Made During Institutionalization***	Public safety entities and county Mental Health Plans should collaborate to identify optimal strategies to engage individuals who are being released from jail or prison into appropriate health or behavioral health care. This may include pre-release discharge planning and/or transition to community-based services. For participating counties, services under the Drug Medi-Cal-Organized System of Delivery (DMC-ODS) can work to both prevent incarceration of those with SUDs as well as to serve the justice-involved population upon reentry.	CCJBH will monitor the progress of the Whole Person Care pilots and the roll out of the DMC-ODS reaching out to county implementers, when appropriate, to hear about challenges to be address to target the justice-involved with mental illness, particularly those with co-occurring disorders. CCJBH is well-positioned to improve service coordination among state and local partners. CCJBH can identify referral and care coordination pathways for a sample size of counties, identifying strengths and weaknesses as well as barriers. Recommendations to address gaps through training, technical assistance or policy change could be provided.	U.S. Department of Justice's Office of Justice Programs can expand funding available through Second Chance Act Grants and Innovation Grants to provide more assistance to individuals returning to the community following incarceration with significant needs who are at the most risk of negative health and public safety outcomes. Consider how to apply recommendations provided to the Administration from the Council on Economic Advisors (CEA) into priorities for federal programming. The CEA identified that investments in substance use and mental health reentry programs that use cognitive behavioral practices are most likely to reduce recidivism and result in

Recommendation	Local Action	State Action	Federal Action
	Grassroots community organizations can apply for resources to support the warm hand-off from the Board of State and Community Corrections (BSCC) Adult Reentry Grant Program.	CCJBH will consider how future stakeholder contracts can best inform policy makers and program providers on effective practices upon reentry and during community supervision.	reduced incarceration spending over time. (See recommendations to make Medicaid more effective for justice-involved populations)
Step Six: ***Sustain and Grow Community Alternatives by Investments in Workforce, Education and Training***	Expand the use of peers who are formerly justice-involved as an essential element of the service team, especially when providing COD services, including strategies that support Medi-Cal reimbursable services. Invest in curriculum for the new workforce, as well as training for the existing workforce, on core competencies to provide effective integrated correctional and behavioral health services to better promote recovery and recidivism in custody and community settings. Provide opportunities for cross professional training between various criminal justice, behavioral health and primary care systems. These efforts could be supported	Create statewide certification with standardized curriculum for Peer Support Specialists who provide quality services allowing this workforce to be considered qualified providers for Medi-Cal reimbursement through Medi-Cal Specialty Mental Health Services Investigate how peers, Community Health Worker (CHW)s, and SUD counselors can work to serve people with co-occurring disorders. Strengthen collaborative relationships by cross-training Peer Support Specialists, CHWs, and SUD Counselors. CCJBH will work with policy and community partners to address barriers to employment for Peer Support Specialists, Forensic Peer Specialist, Consumer Peer Specialist, Veteran Health Peer Specialist, and Mental Health Peer Specialist. Consider a California counterpart for elements of the federal opioid package	Provide federal guidance on consistency in scope of practice, qualifications, and quality of services provided by Peer Support Specialists. Federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute for Corrections can increase efforts, including grants to local agencies for training and technically assistance on best practices in integrated care for the justice-involved with behavioral health challenges. Doing so is critical to supporting effective criminal justice reform policies. A significant majority of individuals who work with the justice-involved with behavioral health problems have incurred student loan debt and are working in public service

Recommendation	Local Action	State Action	Federal Action
	by a learning collaborative funded by MHSA Innovation funds. Beyond supporting crisis intervention training for law enforcement and first responders, invest in Officer Wellness and Peer Support programs to promote wellness, reduce critical incidents and use of force, and improve behaviors and community relationships.	(H.R. 6) to support workforce, education and training. For example, expand first responder training regarding opioid safety and develop a student loan repayment program to increase the substance use treatment workforce. CCJBH will establish a center of excellence in diversion on the website with webinars and featured tools from experts in the field but focus more on what individuals are doing in CA. The purpose is not to re-create expertise/ tools but to methodically identify it, and bring it to all 58 counties in a user-friendly, relevant and timely matter.	employment or for non-profit agencies. Congress should adequately resource the Department of Education to ensure the responsible administration of the Public Service Student Loan Forgiveness Program. Congress should provide oversight of the program to confirm borrowers' complaints are addressed and that the complicated process of applying for the program is corrected.

Finding Two: California's Homeless and Housing Crisis has Undermined the Success of Community Alternatives to Incarceration for People with Behavioral Health Challenges

From chronic homelessness to housing insecurity, the lack of safe and affordable housing impacts the delivery of much needed mental health and substance use treatment services. From individuals who slipped into incarceration due to crimes of poverty, substance use and untreated mental illness to those whose reentry is compromised because there is no place to call home, the deficiency of housing options is putting individuals at great risk of health care emergencies, recidivism or more likely both.

CCJBH urges that any effort to address homelessness and the housing crisis must consider critical factors that uniquely impact people with justice involvement and behavioral health challenges.

Recommendation	Local Action	State Action	Federal Action
Step One: ***Prioritize Housing for the Most Vulnerable and the Most in Need***	Local Coordinated Entry Systems (CES) are used to assess strengths and needs quickly. Jails and prisons can explore if and how individuals exiting can be entered into CES prior to release. Partners included in CES should widely vary and include criminal justice. Administrators of local housing programs can prioritize housing for the most vulnerable, high risk and high need individuals with mental illness, substance use and justice involvement. Counties who use the Vulnerability Index: Service Prioritization Decision Assistance Tool should include justice status as part of this tool.	CCJBH can identify and disseminate best practices in the application of CES with criminal justice referral entities. The Homeless Coordinating and Financing Council (HCFC) can consider how to apply the definition of *at-risk of chronic homelessness* to various state homeless programs. As defined by the California Department of Housing and Community Development (HCD) at-risk of chronic homelessness includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing stability.	Provide information to HUD regarding the negative unintended consequences of the revised 2015 definition chronic homelessness. This definition determines program eligibility and remains a clear barrier for the justice-involved. USICH can work with HUD to update the definition of chronic homelessness to include individuals exiting an institution (including jails, prisons and state hospitals) to homelessness after 90 days and with a history of homelessness.

Recommendation	Local Action	State Action	Federal Action
Step Two: ***Support the Expansion of Housing and Housing Assistance Options***	If viable, counties and cities can go directly to the voters to get more resources to develop affordable housing and to address homelessness either through additional local taxes or bond measures. Local Continuums of Care (CoCs) can use funds provided by the Homeless Emergency Aid Program to address the complex housing needs of justice involved individuals (youth and adults) with behavioral health challenges. Counties can apply for No Place Like Home (NPLH) Funds to develop permanent supportive housing for people with mental illness who are homeless or at risk of chronic homelessness.	CCJBH can provide guidance to maximize the use of Medi-Cal so that resources saved on healthcare, including by parole and probation, can be directed towards housing for the reentry population ranging from rental assistance to transitional and permanent supportive housing. This can be based on guidance provided by the Centers for Medicare and Medicaid Services (CMS) in 2015. CCBJH in collaboration with other state departments can provide guidance on how funding sources like Public Safety Realignment, the Mental Health Services Act (MHSA), Proposition 47 and other non-Medi-Cal resources can be used for housing options for the justice-involved with behavioral health challenges. Support housing and service providers to explore opportunities to expand group housing options as an alternative to single family units.	National criminal justice reform efforts can include recommendations from the U.S. Interagency Council on Homelessness (USICH) which call for criminal justice systems to be resourced to support immediate housing options like short-term rental assistance & rapid re-housing.
Step Three: ***Support Housing Best Practices***	CCBJH can reach out to CoCs to learn more about how various housing first models (i.e. emergency shelters, rapid rehousing, transitional housing, permanent supportive housing and residential treatment) are including equal opportunities for those being	CCJBH can work with the HCFC to ensure that required conditions of parole and probation can co-exists with *Housing First* requirements and best practices. CCJBH can identify, in collaboration with CoCs, what additional guidance or training	Provide information to the U.S. Department of Housing and Urban Development (HUD) and the U.S. Interagency Council on Homelessness (USICH) regarding support for *Housing*

Recommendation	Local Action	State Action	Federal Action
	released from institutions like jails, prisons and state hospitals. Understand how local screening criteria are used so that justice status is not an exclusionary but rather inclusionary factor.	and technical assistance can support the adoption of *Housing First* practices for individuals who have to comply with supervision requirements.	*First* practices that can be adopted within a framework that takes into consideration the needs of individuals on community supervision and protects public safety.
Step Four: ***Create Equitable Housing Assistance Opportunities and Combat Housing Discrimination***	Without understanding who is homeless and why, communities cannot prioritize limited resources. Local CoCs need guidance and support to collect appropriate information about justice status (i.e. probation vs parole, recently released from jail vs prison, etc.) to equitably plan and provide assistance. Communities must be adequately resourced to coordinate a comprehensive set of strategies that collect information and data from places who work with people who are homeless including jails, prisons, state hospitals and juvenile detention facilities. Homeless management information systems and other data sources must build and maintain information about	CCJBH will participate in the development of the Statewide Homeless Information Management System to ensure that justice status is being collected with appropriate specificity so that it can be considered as a variable in increased access to housing and housing assistance. CCBJH can review local policies and ensure they are consistent with federal law, and consider ways to support Californians to know their housing rights and how to file grievances when they are denied. CCJBH will explore if and how the Medi-Cal Utilization Program can include homelessness and housing insecurity in analyses. CCJBH can monitor local and state efforts that reduce the criminalization of homelessness for people with behavioral health issues, report on trends and identify best practices.	Federal partners can educate advocates and implementers about the 2016 clarifications of the application of fair housing act standards to the use of criminal records (April 4, 2016 Letter, HUD Notice 2015-10). All public housing authorities and private housing providers must comply with this guidance. Arrest records cannot be the basis for denying admission, terminating assistance, or evicting tenants.

Recommendation	Local Action	State Action	Federal Action
	people experiencing homelessness and their outcomes. Improve access to local Public Housing Authority (PHA) resources for individuals who have convictions by modifying standards of admission/screening – e.g. shorten the length of time in which a review of a conviction or public safety concern can be considered, use individualized assessments and allow explanations for special circumstances, eliminating all provisions screening applicants out of the Housing Choice Voucher (Section 8) and Public Housing programs due to probation or parole status, and direct the PHA to prioritize people who are justice involved and have a behavioral health or serious health need for Section 8 or other public housing.	HCD should consider streamlining zoning procedural requirements as part of the implementation of NPLH in part of help ease the burden on interested providers who already will be operating in an extremely expensive market and burdensome regulatory environment. Strengthen state-level efforts to combat Not in My Backyard community responses for housing for individuals with behavioral health needs and/or individuals who have been formerly incarcerated. Explore how the *Housing Accountability Act* can enforce the development of appropriate housing for special needs populations who may be experiencing discrimination.	

Finding Three: Data and Information is not Systematically Collected to Inform Policymaking and Program Investments or to Support Accountability and Quality Improvement

Barriers to data-sharing, whether real or perceived, are keeping criminal justice and behavioral health care systems from supporting continuity of care and monitoring whether interventions and strategies are successfully reducing recidivism. Determining when and how data can be exchanged for program improvements or desired health or public safety outcomes, is critical to supporting integrated service delivery that is effective for the individual and accountable to the taxpayer.

CCJBH urges state leadership to support data-driven practices and policy-making among criminal justice and behavioral health systems to ensure continuity of care and achieve desired public safety and health outcomes.

Recommendation	Local Action	State Action
Step One: ***Systemically collect data so that the target population is accurately identified and informed decisions can be made system wide***	Counties can use a standard definition of mental illness, substance abuse and recidivism across the state in community corrections so that comparisons and trends across counties and statewide can be drawn. CCJBH recommends the use of the BSCC definition of recidivism and the Welfare and Institutions statutory definition of mental illness and SUD as guidance for inclusion in Medi-Cal programs. Counties can explore to the extent possible resources from various funding streams such as the Mental Health Services Act (MHSA) and Public Safety Realignment could be dedicated to data improvement practices.	CCJBH can explore with the Council on State Governments (CSG) Justice Center and other state-level partners representing local constituencies, such as the California State Sheriffs Association, the CBHDA and the Chief Probation Officers of California, where shared definitions beyond mental illness could be agreed upon. The more shared definitions that can be agreed upon, the more likely statewide trends in incarceration can be identified. Improved understanding of length of stay in jail for individuals with behavioral health challenges could also aid in understanding statewide trends. The state could consider ways to better support local law enforcement to begin early data collection efforts and to update data collection systems.
Step Two: ***Support Counties in Getting to Know***	Counties can better understand the prevalence of mental illness in the jail population by using validated screening and assessment tools at	CCBJH can promote easy to use validated screening tools for jails such as the brief justice mental health screen (BJMHS), correctional mental health screen for men (CMHS-M), correctional

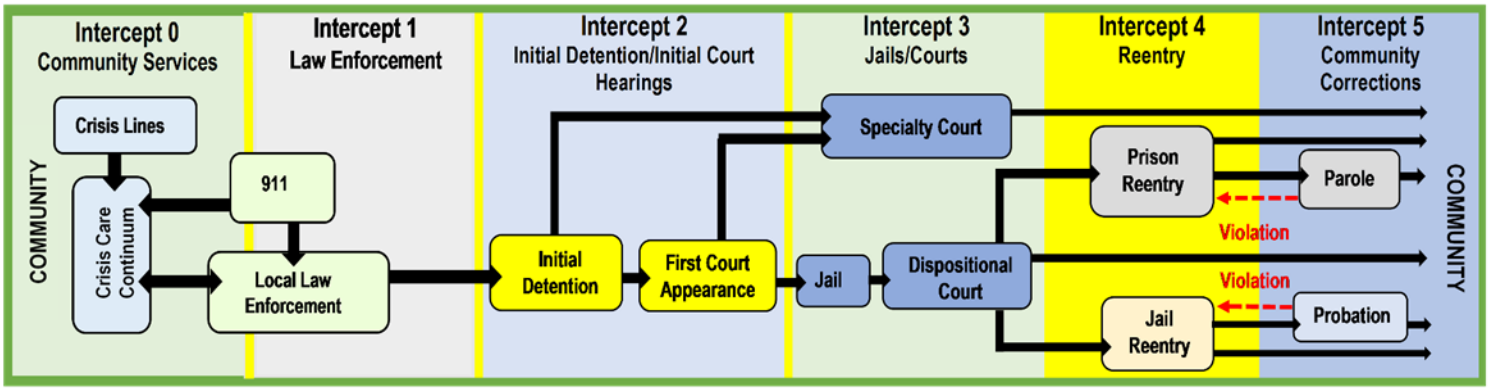
Recommendation	Local Action	State Action
their Target Population	booking, including a brief screen for MI and SUD to determine treatment needs. Tools should be gender specific but simple enough that anyone can administer them. Counties can partner with organizations studying issues of recidivism such as the Public Policy Institute of California (PPIC) and the 12 County Study of AB 109 implementation or California Forward's Justice System Change Initiative. Both initiatives assist counties with establishing baseline data to better understand who is coming in and out of jail and why. This approach assists counties to develop projections on what kinds of service alternatives to create to reduce incarceration.	mental health screen for women (CMHS-W) and the jail screening assessment tool (JSAT). CCBJH can share with counties, when appropriate, information regarding how individuals exiting state incarceration may or may not be using their Medi-Cal benefit for health and behavioral health services. This can help inform local policies and practices. Considering the elevated rates and dangers associated with opioid use, CCBJH further recommends that all incoming detainees be screened with reliable and validated tools that provide clinically useful data in the treatment of opioid use and other SUDs. Moreover, to successfully tackle the crisis it is a critical to understand how many individuals suffering from opioid use disorders are entering jails and prisons.
Step Three: ***Provide guidance and confidence to support data sharing***	Counties are creating local adaptions and solutions to sharing data across criminal justice and behavioral health systems such as best practices in contracting for jail-based behavioral health services to support continuity of care. Counties can share those strategies with each other through a learning collaborative supported by MHSA Innovation funds.	The state can consider expanding guidance on the appropriate exchange of personal health and criminal justice information. The California Office of Health Information Integrity, within the California Health and Human Services Agency, is responsible for ensuring compliance with HIPAA and other privacy laws. While the agency published guidance in 2017 to clarify laws and regulations including those for the justice-involved population with behavioral health needs, users want more in-depth direction, training and technical assistance. CCJBH can partner with CSG to investigate how other states (i.e. Texas, Oregon, & Michigan) have developed models to support data-sharing as well as statewide databases to facilitate data-sharing.

Recommendation	Local Action	State Action
		CCJBH can help identify and provide tools and resources to address common concerns from counties including: 1. Lack of knowledge when patient consent is needed to exchange criminal justice or behavioral health information 2. Lack of data systems with required interoperability 3. Lack of approved policies or agreements in place to share and exchange data 4. Lack of staff capacity or training to collect, analyze, or share data.
Step Four: ***Invest in quality data evaluation and research to improve outcomes***	Counties can explore shared costs to develop or improve existing systems that have the capacity to support required interoperability. Counties can explore strategies to leverage resources through administrative costs in partnership with local educational institutions and universities offering in-kind support for evaluation and research.	State agencies and departments have a significant amount of data and can identify ways to make administrative de-identified data more available to research and evaluation entities eager to study best practices to achieve positive public safety and health outcomes. CCJBH can work with evaluation experts to develop a statewide monitoring system for diversion to track trends in incarceration for state policymaking and accountability to taxpayers. The system could assess indicators available in existing datasets like the California Health Interview Survey and the Jail and Juvenile Detention profile surveys to track activities associated with the reduced incarceration of youth and adults with substance use and mental health disorders.

Appendix B

SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model (SIM) pictured below, is a model which identifies five key points of interception for individuals with behavioral health issues, linking them to services and preventing further involvement with the criminal justice system.[i] Several counties have move to using the SIM as a strategic planning tool.



INTERCEPT 0: The goal of this intercept is to connect individuals to treatment before there is a behavioral health crisis, or at the earliest stage of interaction with the criminal justice system. Below are some suggestions from the County Behavioral Health Directors Association of California (CBHDA) regarding what can be done to support building a community-based behavioral health system adequate enough to prevent criminal justice involvement.[ii]

- Expand community-based prevention coalitions that promote environmental approaches to preventing alcohol and drug related problems in the community, as well as individual and primary prevention programs.
- Expand treatment options that prioritize the least restrictive level of care and invest in prevention, alternatives to psychiatric hospitalization, acute crisis needs, inpatient care and post-discharge community based options.
- Expand the crisis continuum to include funding for substance use disorders, detox and recovery services.
- Broaden the use of peers with lived experience and their role in delivering interventions to individuals in a behavioral health crisis.
- Reduce local siting challenges and tackle stigma.

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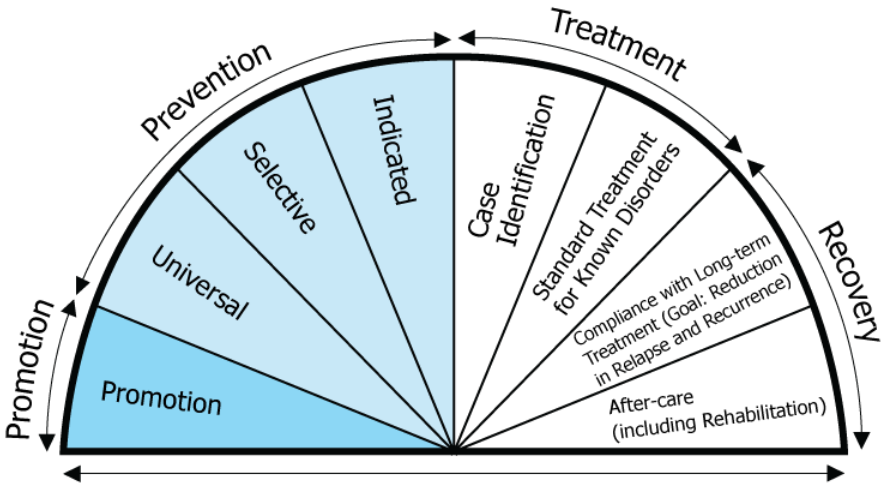
[i] Bowles, Carrie. (2017, August 17). 2017 Highlights. Retrieved from https://www.samhsa.gov/prevention-week/about/2017-highlights

[ii] County Behavioral Health Directors Association of California. (2018, September). CBHDA 2018 Legislative Platform. Retrieved from https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/5b9198394d7a9ccbe86f9067/1536268348282/CBHDA_2018-Legislative-Platform.pdf

Intercept O calls for investments across the behavioral health continuum – promotion, prevention, treatment and recovery.[iii]

INTERCEPT 1: This intercept includes contact with law enforcement, as well as emergency and crisis response.



For example: Crisis Intervention Teams (CIT) are a collaboration between community and local law enforcement, county health services, mental health advocates and mental health consumers. The purpose is to address the needs of mental health consumers who enter the criminal justice system while in crisis.

INTERCEPT 2: In this intercept post-arrest diversion programs are the next opportunity for diversion from an individual going further into the criminal justice system.

For example: Pretrial diversion, which is an informal disposition that involves the referral of individuals, often before arraignment, to rehabilitative programs in lieu of criminal prosecution such as mental health treatment or substance use disorder treatment.

INTERCEPT 3: In this intercept individuals have already entered the criminal justice system and are incarcerated in jail, or on bail waiting to go to court.

For example: Collaborative Courts, are courts that represent a collaboration between judicial supervision and rehabilitation services, where participants are monitored and often receive incentives for their progress.

[iii] Wilson-Buck, Janeen, McCoy, Evelyn F., Noriega-Vasquez, Carla and Reginal, Travis. (2018, October). Retrieved December 1, 2018, from http://www.safetyandjusticechallenge.org/wp-content/uploads/2018/10/2018.10.11_Using-the-SIM_finalized.pdf

INTERCEPT 4: In this intercept individuals have gone through the criminal justice system, or the behavioral health system and have been absent from their community and are now reentering.

- **Principle I:** Upon incarceration, every inmate should be provided an individualized reentry plan tailored to his or her risk of recidivism and programmatic needs.
- **Principle II:** While incarcerated, each inmate should be provided education, employment training, life skills, substance abuse, mental health and other programs that target their criminogenic needs and maximize their likelihood of success upon release.
- **Principle III:** While incarcerated, each inmate should be provided the resources and opportunity to build and maintain family relationships, strengthening the support system available to them upon release.
- **Principle IV:** During transition back to the community, halfway houses and supervised release programs should ensure individualized continuity of care for returning citizens.
- **Principle V:** Before leaving custody, every person should be provided comprehensive reentry-related information and access to resources necessary to succeed in the community.

For example: Community-based organizations that provide connections to services and resources upon reentry such as transitional housing or even a Full Service Partnerships for those with serious mental illness and who are at-risk of homelessness.

INTERCEPT 5: This intercept represents community supervision of individuals whom are either on probation or parole.

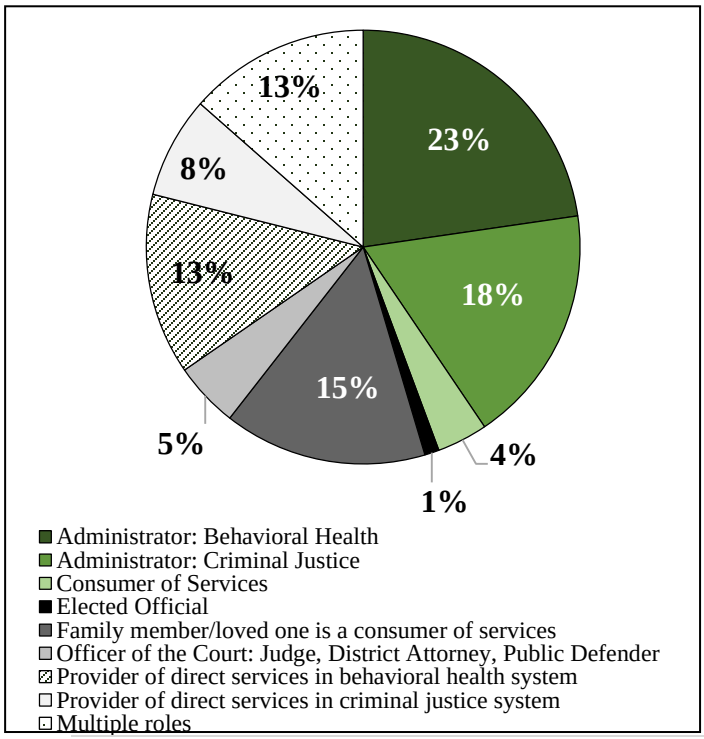
For example: Specialized supervision models combine best practices to address criminogenic risk factors as well as best practices to address behavioral health conditions. With smaller caseloads, integrated service teams from probation/parole and behavioral health work as a team to achieve public safety and health outcomes. These services can be delivered out of the probation or behavioral health system.

CCJBH Annual Statewide Survey
Stakeholder Engagement - Priorities for New Administration

In 2019 the State of California will experience leadership under a newly elected Governor and accompanying administration. In an effort to gather input on what issues should be prioritized and what actions should be taken to further the gains made by the Brown Administration through criminal justice and health care reforms, CCJBH sent out a survey to stakeholders, consumers, and advocates throughout the state.

Of the 189 total respondents, 185 indicated their role. Approximately 13% identified themselves as representing multiple roles such as administrator, provider of services, consumer, or family member of a consumer of services. Among the remaining 86% of respondents, 41% identified as an administrator of either criminal justice or behavioral health services, 15% as a family member or loved one of a consumer, 14% as a provider of behavioral health services, 8% as a provider of criminal justice services, 5% as an officer of the court, 4% as consumers of services, and 1% as an elected officials.

Percent of 2018 CCJBH Survey Respondents by Role (n=185)



> ***"This is not just an issue of state hospitals or state prisons which have too many persons suffering from mental illnesses. This is a crisis situation for the counties, in which persons with mental illnesses live (and die) on the streets or are inappropriately crowding our jails (where their illnesses may get worse, and where they also face a risk of greater mortality). Keeping mentally ill persons in jail because there is no place else for them to receive mental health treatment is unjust."*** *- Survey respondent*

Survey respondents represented all regions of California, with the majority coming from urban communities. Furthermore, 19% of respondents indicated they were formerly incarcerated; while, 81% were not (n=188).

The top three critical issues identified by survey respondents needing to be addressed by the new administration were (n=188):

1. Strengthen responses to people in crisis and develop accessible services as an alternative to jail or hospitalization.
2. Incorporate interventions likely to reduce future crime with substance use and mental health (behavioral health) services.
3. Integrate substance use and mental health disorder treatment so they are more seamless.

Interestingly, both those who were formerly incarcerated (n=36) as well as those with no previous criminal justice involvement (n=152) also identified the need to strengthen responses to people in crisis and develop accessible services as an alternative to jail or hospitalization as the most critical area needing to be addressed by the new administration.

Regarding capacity, the majority of respondents indicated having the lowest capacity for providing funding for infrastructure development, and the highest capacity to integrate substance use and mental health disorder treatment so they are more seamless (n=177). The majority of criminal justice and behavioral health administrators and providers noted two areas where they had the highest capacity to provide support (n=114):

1. Integrating substance use and mental health disorder treatment so they are more seamless
2. Improving care coordination and communication between criminal justice and behavioral health care partners.

"Need to focus on local zoning, policy, and city ordinances that promote NIMBY-ism. The funding and knowledge of what works is there - unfortunately so is the political and social capital of homeowners, developers, and other special interest groups who would rather focus on building housing for the high income market and exclude developing affordable housing for middle and low-income folks and those with substantial barriers and risks (i.e., those with diagnoses of serious mental illness)."

– Behavioral Health Services & Criminal Justice Administrator & Family Member of a consumer of services

We know that the life conditions in which people are born, grow, live, work and age, often referred to as the social determinants of health, impact access and utilization of the services needed to divert individuals from incarceration. When respondents were asked which social determinant or life condition they thought were barriers to accessing services the majority of survey participants indicated poverty as the greatest barrier (n=188). Respondents ranked homelessness and unemployment as the second and third greatest barrier to accessing services, with other barriers such as lack of education, discrimination, and immigration status identified as barriers but not as great for clients.

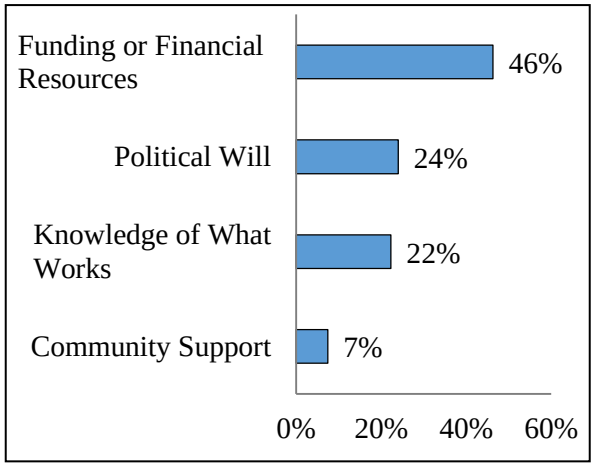
Individuals with substance use and mental health challenges often experience adverse life conditions or social determinants. Survey respondents felt innovative approaches to address varying housing needs, including for those who are homeless was the most pressing action needed to help overcome the negative life conditions that may act as barriers to accessing services, while eliminating barriers to employment, education, and other opportunities due to justice-involvement was the next pressing action to supporting clients in overcoming adverse life conditions/social determinants (n=186).

Criminal justice and behavioral health administrators and providers (n=114), family/consumers (n=35), and those who have been formerly incarcerated (n=36) all said the most effective way to ***prevent, divert, and support successful reentry*** for people with behavioral health issues from incarceration is to invest in programs that improve people's life conditions/social determinants of health (n=189).

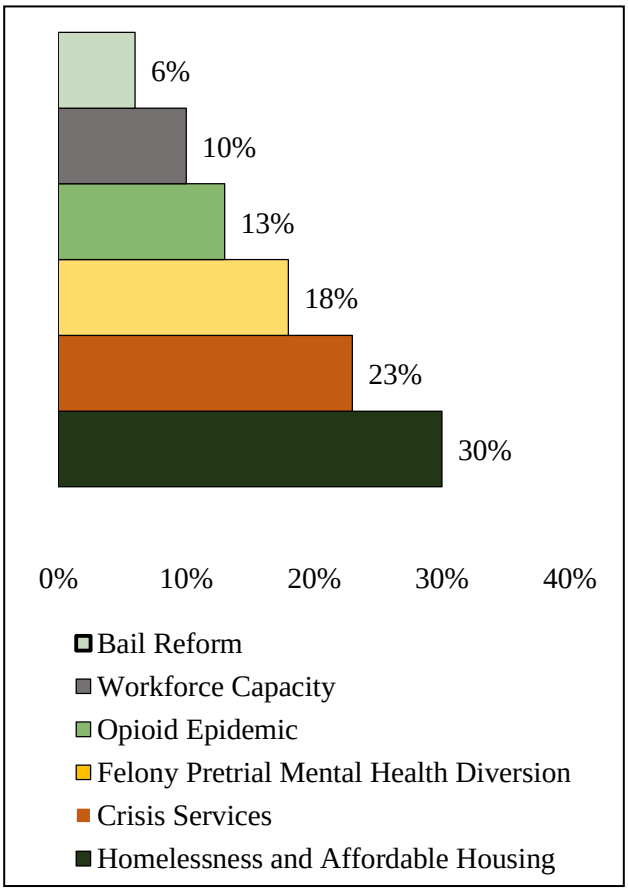
Survey respondents were asked what was most needed in order to support action on critical issues such as providing funding for infrastructure development, strengthening responses to crisis and developing accessible services as an alternative to incarceration or hospitalization, improving care coordination between criminal justice and behavioral health providers, investing in the workforce, incorporating interventions likely to reduce future crime with substance use and mental health services, integrating substance use and mental health disorder treatment, and using data to understand local strengths and challenges, improve outcomes, and determine future investments. Forty-six percent of respondents indicated funding or financial resources were most needed in order to support action on these critical issues, 24% noted political will is most needed, 22% reported knowledge of what works is needed, and 7% indicated community support is what is most needed (n=175).

The most immediate challenging criminal justice and behavioral health policy issue that the new administration is going to have to implement, according to survey respondents is homelessness and affordable housing (30%). Subsequent issues indicated by respondents included crisis services including prevention, stabilization, and residential (23%), felony pretrial mental health diversion, including alternative community programming to reduce the wait-list for incompetent to stand trial (IST) referrals to the DSH (18%), opioid epidemic both in and outside of incarceration (13%), workforce capacity both in number and skill (10%), and bail reform (6%; see graph below).

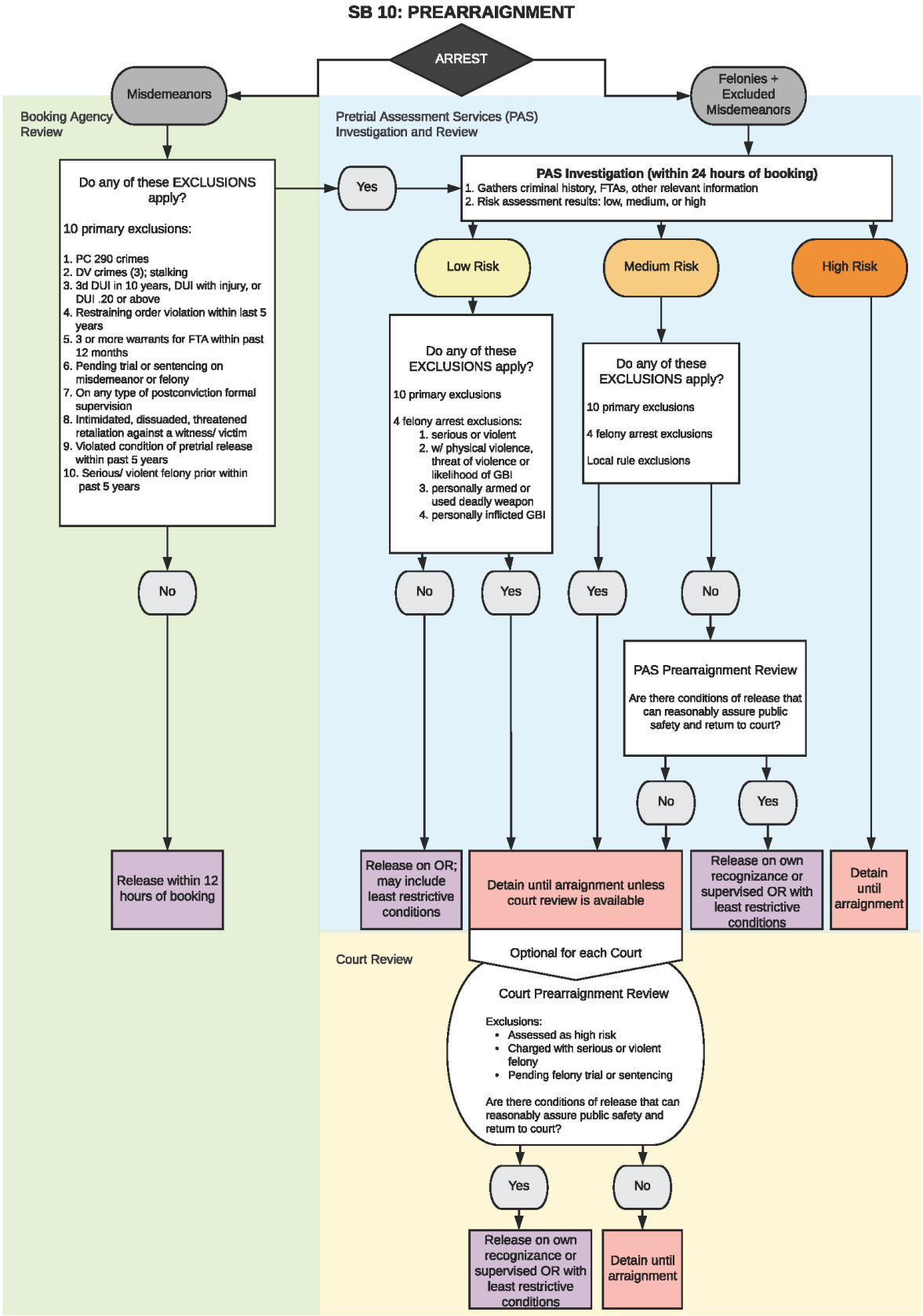
What do you think is most needed to support action on these critical issues? (n=175)



What do you think is the most immediate challenging criminal justice and behavioral health policy issue that the new administration is going to have to implement? (n=178)



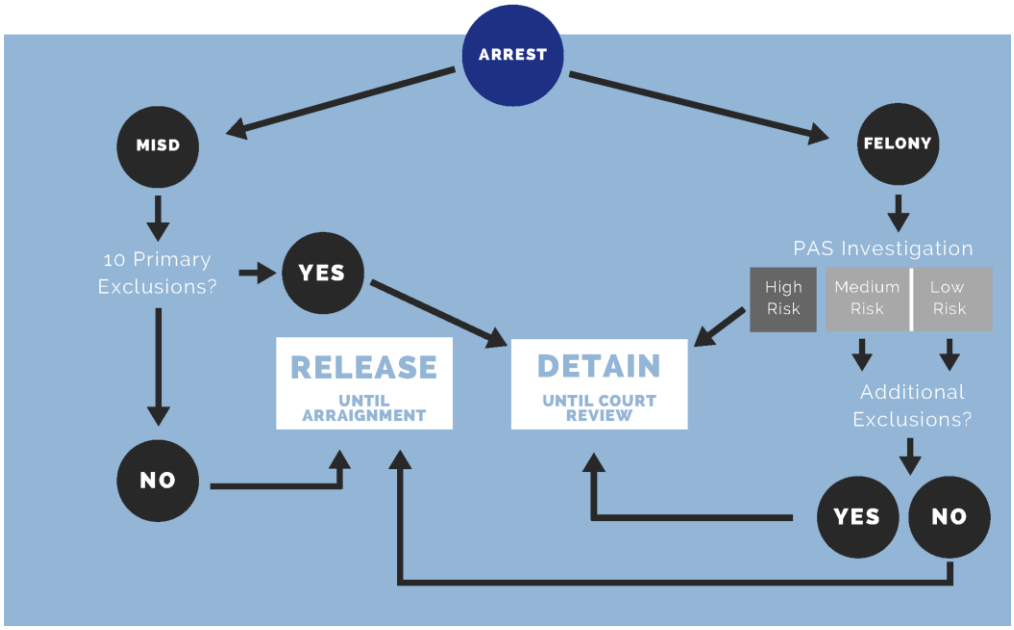
Appendix D


SB 10: PREARRAIGNMENT
ARREST
Misdemeanors
Felonies + Excluded Misdemeanors
Booking Agency Review
Pretrial Assessment Services (PAS) Investigation and Review
Do any of these EXCLUSIONS apply?
10 primary exclusions:
1. PC 290 crimes
2. DV crimes (3); stalking
3. 3d DUI in 10 years, DUI with injury, or DUI .20 or above
4. Restraining order violation within last 5 years
5. 3 or more warrants for FTA within past 12 months
6. Pending trial or sentencing on misdemeanor or felony
7. On any type of postconviction formal supervision
8. Intimidated, dissuaded, threatened retaliation against a witness/ victim
9. Violated condition of pretrial release within past 5 years
10. Serious/ violent felony prior within past 5 years
Yes
PAS Investigation (within 24 hours of booking)
1. Gathers criminal history, FTAs, other relevant information
2. Risk assessment results: low, medium, or high
Low Risk
Medium Risk
High Risk
Do any of these EXCLUSIONS apply?
10 primary exclusions
4 felony arrest exclusions:
1. serious or violent
2. w/ physical violence, threat of violence or likelihood of GBI
3. personally armed or used deadly weapon
4. personally inflicted GBI
Do any of these EXCLUSIONS apply?
10 primary exclusions
4 felony arrest exclusions
Local rule exclusions
No
Yes
Yes
No
PAS Prearraignment Review
Are there conditions of release that can reasonably assure public safety and return to court?
No
Yes
No
Release within 12 hours of booking
Release on OR; may include least restrictive conditions
Detain until arraignment unless court review is available
Release on own recognizance or supervised OR with least restrictive conditions
Detain until arraignment
Court Review
Optional for each Court
Court Prearraignment Review
Exclusions:
• Assessed as high risk
• Charged with serious or violent felony
• Pending felony trial or sentencing
Are there conditions of release that can reasonably assure public safety and return to court?
Yes
No
Release on own recognizance or supervised OR with least restrictive conditions
Detain until arraignment

Appendix E

SB 10 PREARRAIGNMENT

WITHOUT COURT REVIEW



PREARRAIGNMENT WITHOUT COURT REVIEW

PAS Investigation

Pretrial Assessment Services (PAS) investigates within 24 hours of booking

1. Gathers criminal history, failures to appear (FTA), other relevant information
2. Risk assessment results: low, medium, or high

10 Primary Exclusions

1. PC 290 crimes
2. Domestic Violence crimes (3); stalking
3. 3rd DUI in 10 yrs, DUI with injury, or DUI .20 or above
4. Restraining order violation within last 5 yrs
5. 3 or more warrants for FTA within past 12 months
6. Pending trial or sentencing on misdemeanor or felony
7. On any type of postconviction formal supervision
8. Intimidated, dissuaded, threatened retaliation against a witness/ victim
9. Violated condition of pretrial release within past 5 yrs
10. Serious/ violent felony prior within past 5 yrs

Low Risk

If low risk, released on own recognizance (OR) (may include least restrictive conditions) unless the following exclusions apply:

- 10 primary exclusions
- 4 felony arrest exclusions
  1. Pending trial or sentencing in a felony matter
  2. Arrested for a felony with element of physical violence, threat of violence, or likelihood of great bodily injury (GBI)
  3. Arrested for a felony in which personally armed or personally used a deadly weapon or firearm
  4. Arrested for a felony in which personally inflicted GBI

If YES to any exclusions, then detained until arraignment

Medium Risk

If medium risk, released on OR or supervised OR with least restrictive conditions, unless PAS detains after review or the following exclusions apply:

- 10 primary exclusions
- 4 felony arrest exclusions
- Local rule exclusions

If YES to any exclusions, then detained until arraignment

Appendix F

JOINT PUBLIC CORRECTIONAL POLICY ON THE TREATMENT OF OPIOID USE DISORDERS FOR JUSTICE INVOLVED INDIVIDUALS

2018-2

Introduction:

Seventeen to nineteen percent of individuals in America's jail and state prison systems have regularly used heroin or opioids prior to incarceration.[i] While release from jail and prison is associated with a dramatic increase in death from opioid overdose among those with untreated opioid use disorder (OUD), there are considerable data to show that treatment with opioid agonists and partial agonists reduce deaths and improves outcomes for those with opioid use disorders.[ii,iii] Preliminary data suggest that treatment with an opioid antagonist also reduces overdose.[iv] As a result, the 2017 bipartisan Presidential Commission on "Combating Drug Addiction and the Opioid Crisis" has recommended increased usage of medications for addiction treatment (MAT) in correctional settings.[v]

Policy Statement:

The American Correctional Association (ACA) supports the use of evidence-based practices for the treatment of opioid use disorders. ACA and the American Society of Addiction Medicine (ASAM) have developed recommendations specific to the needs of correctional policy makers and healthcare professionals. These recommendations will enable correctional administrators and others, such as community corrections, to provide evidence-based care to those in their custody or under their supervision that have opioid use disorders.

ASAM recently published a document entitled *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*[vi] that includes treatment recommendations specifically for individuals in the justice system. Pharmacotherapy, behavioral health treatment, and support services should be considered for all individuals with OUD that are involved in the justice system.

ACA and ASAM recommend the following for correctional systems and programs:

A. Screening/Prevention

1. Most deaths from overdose occur during the first few days following intake to the correctional facility. Screen all incoming detainees at jails and prisons using screening tools with psychometric reliability and validity that provide useful clinical data to guide the long-term treatment of those with OUD and with co-occurring OUD and mental disorders. Opioid

antagonist (naloxone) should be available within the facility and personnel should be trained on its use.

2. Pre-trial detainees screened upon entry that are found to be participating in an MAT program to treat OUD and who are taking an opioid agonist, partial agonist, or antagonist should be evaluated for continuation of treatment on that medication, or a medication with similar properties. There are effective models for continuing treatment with each of these medications in the justice system.

3. Pre-trial detainees and newly admitted individuals with active substance use disorders who enter with or develop signs and symptoms of withdrawal should be monitored appropriately and should be provided evidence-based medically managed withdrawal ("detox") during the period of withdrawal. Validated withdrawal scales help gauge treatment. Several medications have been shown to improve withdrawal symptoms.

B. Treatment

1. All individuals who arrive into the correctional system who are undergoing opioid use disorder treatment should be evaluated for consideration to continue treatment within the jail or prison system. Individuals who enter the system and are currently on MAT and/or psychosocial treatment should be considered for maintenance on that treatment protocol.

2. Treatment refers to a broad range of primary and supportive services.

3. The standard of care for pregnant women with OUD is MAT and should therefore be offered/continued for all pregnant detainees and incarcerated individuals.

4. All individuals with suspected OUD should be screened for mental health disorders, especially trauma-related disorders, and offered evidence-based treatment for both disorders if appropriate.

5. Ideally, four to six weeks prior to reentry or release, all individuals with a history of OUD should be re-assessed by a trained and licensed clinician to determine whether MAT is medically appropriate for that individual. If clinically appropriate and the individual chooses to receive opioid use disorder treatment, evidence-based options should be offered to the individual.

6. The decision to initiate MAT and the type of MAT treatment should be a joint decision between the provider and individual who has been well informed by the trained and licensed clinician as to appropriateness of the therapy, as well as risks, benefits, and alternatives to this medical therapy. MAT should not be mandated as a condition of release. In choosing among treatment options, the individual and provider will need to consider issues such as community clinic or provider location/accessibility to the individual, insurance access or type and medical/clinical status of the individual.

7. Treatment induction for the individuals who choose treatment for opioid use disorder (MAT) should begin 30 days or more prior to release, when possible.

American Correctional Association

C. Reentry and Community Supervision Considerations

1. All individuals returning to the community who have an OUD should receive education and training regarding unintentional overdose and death. An opioid antagonist (naloxone) overdose kit or prescription and financial means (such as insurance/Medicaid) for obtaining the kit may be given to the individual, along with education regarding its use.

2. When possible, an opioid antagonist (naloxone) and overdose training should include the individual's support system in order to provide knowledge about how to respond to an overdose to those who may be in the individual's presence if an overdose does occur.

3. Immediate appointment to an appropriate clinic or other facility for ongoing treatment for individuals returning to the community with substance use is critical in the treatment of opioid use disorder. As such, ideally the justice involved population's reentry needs should be addressed at least 1 to 2 months prior to release in order to avoid any interruption of treatment.

4. Reentry planning and community supervision should include a collaborative relationship between clinical and parole and/or probation staff including sharing of accurate information regarding MAT.

5. Parole and probation staff should ensure that residence in a community-based halfway house or similar residential facility does not interfere with an individual's treatment of OUD with MAT.

D. Education

1. Scientifically accurate, culturally competent, and non-judgmental training and education regarding the nature of OUD and its treatment should be provided to all justice system personnel including custody officers, counselors, medical personnel, psychologists, community supervision personnel, community residential staff, agency heads and leadership teams.

2. This training should include education about the role of stigma involving substance use disorders and the subtle but very real impact that stigma has on those suffering from substance use disorders and those treating them.

This Joint Public Correctional Policy was unanimously ratified by the American Correctional Association Delegate Assembly at the 2018 Winter Conference in Orlando, FL. on Jan. 9, 2018.

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[i] BJS. (2017, June). Special Report. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009.

[ii] Binswanger IA, Blatchford PJ, Mueller SR, and Stern MF. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. Ann Intern Med 2013 Nov 5; 159(9): 592–600.

[iii] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017;357:j1550

[iv] Lee JD, Friedmann PD, Kinlock TW, et al. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. N Engl J Med 2016;374:1232-42.

[v] https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf

[vi] ASAM. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (ASAM, 2015).

Glossary

AB	Assembly Bill
AB 109	Public Safety Realignment
ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
BJS	Bureau of Justice Statistics
BSCC	Board of State and Community Corrections
CalHPS	California Health Policy Strategies
CBHDA	County Behavioral Health Directors Association
CBO	community-based organizations
CBT	Cognitive-Behavioral Therapy
CCCMS	Correctional Clinical Case Management System
CCJBH	Council on Criminal Justice and Behavioral Health
CDCR	California Department of Corrections and Rehabilitation
CEA	Council on Economic Advisors
CES	Coordinated Entry Systems
CHCF	California Health Care Foundation
CHFFA	California Health Facilities Financing Authority
CHHS	California Health and Human Services Agency
CHW	Community Health Worker
CMS	Centers of Medicare and Medicaid Services
CoC	Continuums of Care
COD	co-occurring mental health and substance use disorder
COMIO	Council on Mentally Ill Offenders
CRTS	Community Residential Treatment Services
CSG	Council on State Governments
CSH	Corporation for Supportive Housing
CSSA	California State Sheriff's Association
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOJ	Department of Justice
DSH	California Department of State Hospitals
ED	emergency departments
EHB	Essential Health Benefits

EOP	Enhanced Outpatient Program
FACT	Forensic Assertive Community Treatment
FFP	federal financial participation
FSP	Full-Service Partnership
FUSE	Frequent Service Enhancement
FY	fiscal year
GAO	Government Accountability Office
HCD	California Department of Housing and Community Development
HCFC	Homeless Coordinating and Financing Council
HEAP	Homeless Emergency Aid Program
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMIS	Homeless Management Information Systems
HUD	U.S. Department of Housing and Urban Development
IDDT	Integrated Dual Disorders Treatment
IHSS	In-Home Supportive Services
IMD	Institutions for Mental Diseases
ISMICC	Interdepartmental Serious Mental Illness Coordinating Committee
IST	Incompetent to Stand Trial
JAMA	Journal of American Medical Association
LAO	Legislative Analysts' Office
MAT	Medication Assisted Treatment
Medi-Cal	California's Medicaid Program
MHC	Mental Health Court
MHPAEA	Mental Health Parity and Addiction Equity Act
MHSA	Mental Health Services Act
MHSOAC	Mental Health Service Oversight and Accountability Commission
NACo	National Association of Counties
NAMI	National Alliance on Mental Illness
NIMBY	Not in My Backyard
NPLH	No Place Like Home
OUD	opioid use disorders
PC	Penal Code
PHA	Public Housing Authority

PHF	Psychiatric Health Facilities
PIT	Point-In-Time
POC	Parole Outpatient Clinic
PPIC	Public Policy Institute of California
RNR	Risk-Need-Responsivity
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SDCB	social determinants of criminal behavior
SDH	social determinants of health
SED	severe emotional disturbance
SES	socioeconomic status
SGF	State General Fund
SMI	serious mental illness
SUD	substance use disorders
USICH	U.S. Interagency Council on Homelessness
VI-SPDAT	Vulnerability Index Service Prioritization Decision Assistance Tool
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
WPC	Whole Person Care

End Notes

[1] "NRRC Facts and Trends". The National Reentry Resource Center, retrieved October 16, 2018 available at: https://csgjusticecenter.org/nrrc/facts-and-trends/

[2] Bronson, J., and Berzofsky, M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012. Bureau of Statistics 2017. Available at: https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[3] Ibid.

[4] Steadman, H. J., F. C. Osher, P. C. Robbins, B. Case, and S. Samuels. —Prevalence of Serious Mental Illness among Jail Inmates. Psychiatric Services 6 (2009): 761–65.

[5] KiDeuk, K., Becker-Cohen, M., & Serakos, M. (2015, March). The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System. Retrieved from https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf

[6] The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation (2014, July). State Prison Health Care Spending. Retrieved from: http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf

[7] State of California 2018-19 Enacted Governors Budget. Available at: http://www.ebudget.ca.gov/2018-19/pdf/Enacted/GovernorsBudget/5210/5225.pdf

[8] Legislative Analysis Office 2017-2018 Budget Analysis available at: http://www.lao.ca.gov/Publications/Report/3578

[9] Mumola, C.J., & Karberg, J.C. (2006, October). Drug Use and Dependence, State and Federal Prisoners, 2004. (NCJ 213530). Retrieved from Bureau of Justice Statistics: http://www.bjs.gov/content/pub/pdf/dudsfp04.pdf

[10] Feucht, T.E., and Gfroerer, Mental and Substance Use Disorders among Adult Men on Probation and Parole: Some Success against a Persistent Challenge (2011), Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Retrieved from: https://www.ncjrs.gov/pdffiles1/nij/235637.pdf

[11] Hammond, Sarah, Mental Health Needs of Juvenile Offenders (June, 2007). National Conference of State Legislatures: The Forum for America's Ideas. Retrieved from: http://www.njjn.org/uploads/digital-library/Mental-Health-Needs-of-Juvenile-Offenders_Hammond-NCSL-6.07.pdf

[12] Child Welfare Practice with Families affected by Parental Incarceration." Children's Bureau, U.S. Department of Health and Human Services, October 2015. Available at https://www.childwelfare.gov/pubPDFs/parental_incarceration.pdf#page=2&view=Overview

[13] "Economic Perspectives on Incarceration and the Criminal Justice System." Executive Office of the President of the United States, 23 April 2016. Available at https://www.prisonpolicy.org/scans/20160423_cea_incarceration_criminal_justice.pdf.

[14] Probation and Parole Systems Marked by High Stakes, Missed Opportunities. Pew Charitable Trusts. Available from: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/09/probation-and-parole-systems-marked-by-high-stakes-missed-opportunities

[15] Gregg D. Caruso. 2017. Public Health and Safety: The Social Determinants of Health and Criminal Behavior. UK: ResearchersLinks Books.

[16] Gregg D. Caruso. 2017. Public Health and Safety: The Social Determinants of Health and Criminal Behavior. UK: ResearchersLinks Books.

[17] Heller, J. (2016, June). A Framework Connecting Criminal Justice and Public Health. Human Impact Partners. Retrieved from: https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health/

[18] Heller, J. (2016, June). A Framework Connecting Criminal Justice and Public Health. Human Impact Partners. Retrieved from: https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health/

[19] James, D.J., and L.E. Glaze. 2006. Mental Health Problems of Prison and Jail Inmates. Washington, DC: Bureau of Justice Statistics. Available online: https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[20] Plotkin, M.R., & Blanford, A.M. (2017, January). Critical Connections Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment they Need – What Policymakers Need to Know about Health Care Coverage. Retrieved from Council of State Governments Justice Center: https://www.bja.gov/publications/Critical-Connections-Full-Report.pdf

[21] Congressional Budget Office. (2017). Cost estimate: American Health Care Act. Retrieved from: http://www.cdcr.ca.gov/COMIO/docs/042017/0406/americanhealthcareact_0.pdf
[22] Wang E.A., White M.C., Jamison R., Goldenson J., Estes M., & Tulsky J.P. (2008) *Discharge planning and continuity of health care: findings from the San Francisco County Jail. American Journal of Public Health. 98* (12), 2182-4.
[23] Dietz, M.D., Lucia, L., Kominski, G.F., Jacobs, K. (2016, December). ACA Repeals in California: Who Stands to Lose? Retrieved from UC Berkeley Center for Labor Research and Education: http://laborcenter.berkeley.edu/aca-repeal-in-california-who-stands-to-lose/
[24] Department of Health Care Services. (2015, September). *Drug Medi-Cal Organized Delivery System Waiver.* Retrieved from: https://www.dhcs.ca.gov/provgovpart/Documents/DMC%20ODS%20FACT%20SHEET.pdf
[25] Lofstrum, M., Bird, M., & Martin, B. (2016, September). California's Historic Corrections Reforms. Retrieved from Public Policy Institute of California: http://www.ppic.org/content/pubs/report/R_916MLR.pdf
[26] Ibid.
[27] Ibid.
[28] California Department of Corrections and Rehabilitation (2018, May). *Proposition 57: Nonviolent Parole Process Frequently Asked Questions.* Retrieved from: https://www.cdcr.ca.gov/proposition57/docs/Prop-57-Final-Regs-Fact-Sheet-May-2018.pdf
[29] Legislative Analyst's Office, "How Much Does It Cost to Incarcerate an Inmate?" (Dec. 2016); Judicial Council of California, "Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report," (Apr. 2011).
[30]Morrissey, J.P., Steadman, H.J., Dalton, K.M., Cuellar, A., Stiles, P., & Cuddeback, G.S. (2006) Medicaid enrollment and mental health service use following release of jail detainees with severe mental illness. Psychiatric Services, 57(6), 809-815.
[31] Mancuso, D., & Felver, B.E.M. (2009, February). Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits. Retrieved from Washington State Department of Social and Health Services Research and Data Analysis Division: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-140.pdf
[32] Munetz, M.R., and Griffin, P.A. (2006). *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*. Psychiatric Services, 57(4): 544-549.
[33] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services*. Retrieved from: https://store.samhsa.gov/product/SMA17-BAROUS-16
[34] California Hospital Association (2016, October). *California Acute Psychiatric Bed Loss*. Retrieved December 18, 2018 available at: https://www.calhospital.org/sites/main/files/file-attachments/psychbeddata.pdf
[35] Charles Holzer & Hoang Nguyen (2017). *Estimation of Need for Mental Health Services* Retrieved from: http://charlesholzer.com
[36] Swanson, J.W., et. al., (2015). *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy*. Annals of Epidemiology v25, 366-376.
[37]D. Webster (2017). *Five Myths About Gun Violence.* The Washington Post. Retrieved from: https://www.washingtonpost.com/outlook/five-myths/five-myths-about-gun-violence/2017/10/06/c4536e44-a9ed-11e7-b3aa-c0e2e1d41e38_story.html?noredirect=on&utm_term=.8ecd69557583
[38] Covered California. *2019 Healthcare Coverage Predictions*. Retrieved from: https://www.healthforcalifornia.com/2019-predictions-health-care-california
[39] California Department of Health Care Services. *Medicaid Mental Health Parity and Addiction Equity Act Compliance Summary*. Retrieved from: https://www.dhcs.ca.gov/formsandpubs/Documents/Parity_Compliance_Plan_9.29.2017.pdf
[40] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services*. Retrieved from: https://store.samhsa.gov/product/SMA17-BAROUS-16

[41] Department of Health and Human Services. (2015, June). *Coverage of Housing-Related Activities and Services for Individuals with Disabilities.* [Letter]. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf
[42] Henry J Kaiser Family Foundation. *Key Questions about Medicaid Payment for Services in Institutions for Mental Disease.* Retrieved from: https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/
[43] Centers for Medicare and Medicaid Services SMD #18-011 (2018, November). *Re: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*. retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
[44] Legislative Analysts' Office (2018) *Rethinking the 1991 Realignment* retrieved from: https://lao.ca.gov/Publications/Report/3886
[45] Ibid.
[46] Peterson, J.K., Kennealy, P.J., & Skeem, J.L. (2014). *How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness*. Law and Human Behavior, Vol 38,439-449.
[47] Cuddleback, G.S., Morrissey, J.P. (2011) *Program planning and staff competencies for forensic assertive community treatment: ACT eligible versus FACT eligible.* Journal of the American Psychiatric Nurses Association 17(1), 90-97.
[48] James, D. J., and Karberg, J. C. (2005). *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002.* Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from: http://www.csdp.org/research/sdatji02.pdf.
[49] Skeem, J.L., Steadman, H.J., & Manchak, S.M. (2015). *Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system.* Psychiatric Services, Vol 66(9), 916-922.
[50] Pope, L., Hopper, K., Davis, C., & Cloud, D. (2016) *First-episode incarceration, creating a recovery-informed framework for integrated mental health and criminal justice responses.* Vera Institute of Justice. Retrieved from: https://www.vera.org/publications/first-episode-incarceration-creating-a-recovery-informed-framework-for-integrated-mental-health-and-criminal-justice-responses
[51] D.A., Andrews, Bonta, J., & Hoge, R.D. (1990). *Classification for effective rehabilitation: rediscovering psychology*. Criminal Justice and Behavior 17(1), 19-52.
[52] For more information about COMPAS visit http://www.cdcr.ca.gov/rehabilitation/docs/FS_COMPAS_Final_4-15-09.pdf
[53] Osher, F., D'Amora, D., Poltkin, M., Jarrett, N., Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery.* Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus project. Retrieved from: https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf
[54] Ibid.
[55] Rotter, M., & Carr, A. (2013). *Reducing criminal recidivism for justice-involved persons with mental illness: risk/needs/responsivity/ and cognitive behavioral interventions.* SAMHSA GAINS center for Behavioral Health and Justice Transformation. Retrieved from: http://forensiccounselor.org/images/file/ReduceCrimRecidMIRiskNeedsResponCogBehavInter.pdf
[56] Golden, L. (2002). Evaluation of the efficacy of a cognitive behavioral program for offenders on probation: Thinking for a change. Retrieved from: https://s3.amazonaws.com/static.nicic.gov/Library/018190.pdf
[57] Little, G.L., & Robinson, K.D. (1988). Moral reconation therapy: A systematic step-by-step treatment system for treatment resistant clients. Psychological Reports, 62, 135–151.
[58] Rotter, M., & Carr, A. (2013). Reducing criminal recidivism for justice-involved persons with mental illness: risk/needs/responsivity/ and cognitive behavioral interventions. SAMHSA GAINS center for Behavioral Health and Justice Transformation. Retrieved from: http://forensiccounselor.org/images/file/ReduceCrimRecidMIRiskNeedsResponCogBehavInter.pdf
[59] Ross, R. R., Fabiano, E. A., & Ewles, C. D. (1988). Reasoning and rehabilitation. International Journal of Offender Therapy and Comparative Criminology, 32, 29–35.
[60] United State Government Accountability Office. (2018, February). *Information on Inmates with Serious Mental Illness and Strategies to Reduce Recidivism (GAO-18-182).* Retrieved from: https://www.gao.gov/products/GAO-18-182

[61] *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. (2012). Retrieved from https://nicic.gov/adults-behavioral-health-needs-under-correctional-supervision-shared-framework-reducing-recidivism
[62] Ibid.
[63] Peters, R.H., Rojas, E., Bartoi, M.G. (2016). *Screening and Assessment of Co-Occurring Disorder in the Justice System*, 3rd Edition. Delmar, NY: SAMHSA's National GAINS Center for Behavioral Health and Justice Transformation.
[64] Peters, R.H., Young, M.S., Rojas, E., Gorey, C. (2017). *Evidence-based Treatment and Supervision Practices for Co-Occurring Mental and Substance Use Disorders in the Criminal Justice System.* The American Journal of Drug and Alcohol Abuse, 43 (4), 475-488.
[65] Ibid.
[66] Ibid.
[67] Cusack K.J., Morrissey J.P., Cuddeback, G.S., Prins, A., Williams, D.M. (2010). *Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial*. Journal of Community Mental Health, 46, 356-363.
[68] Baillargeon, J., Penn, J.V., Knight, K., Horzke, A., Baillargeon, G., Becker, E.A. (2010). *Risk of Re-incarceration Among Prisoners with Co-Occurring Sever Mental Illness and Substance Use Disorders.* Administration and Policy in Mental Health and Mental Health Services, 37, 367-374.
[69] Bureau of Justice Statistics (June 2017). *Special Report: Drug Use, Dependence, and Abuse among State Prisoners and Jail Inmates, 2007-2009.* Retrieved from: https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf
[70] Wattenberg, S.A. and the National Association for Behavioral Healthcare (2018). *Pathways to Care: Treating Opioid and Substance Use Disorders.* Retrieved from: https://www.nabh.org/pathways/
[71] National Institute on Drug Abuse. *What Role Can the Criminal Justice System Play in Addressing Drug Addiction?* Retrieved from: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-role-can-criminal-justice-system-play
[72] U.S. Food and Drug Administration (2018) *Information about Medication-Assisted Treatment.* Available from: https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm
[73] Anthony- North, V., Pope, L.G., Pottinger, S., Sederbaum, I. (March 2018). *Corrections-Based Responses to the Opioid Epidemic: Lessons from the New York State's Overdose Education and Naloxone Distribution Program.* The Vera Institute of Justice. Retrieved from: https://www.vera.org/publications/corrections-responses-to-opioid-epidemic-new-york-state
[74] Wang E.A., Hong, C.S., Shavit, S., Sanders R., Kessell E., & Kushel, M.B. (2012). *Engaging individuals recently released from prison into primary care: a randomized trial.* American Journal of Public Health, 102 (9), 22-9.
[75] Baillargeon, J., Penn, J.V., Knight, K., Horzke, A., Baillargeon, G., Becker, E.A. (2010). *Risk of Reincarceration Among Prisoners with Co-Occurring Sever Mental Illness and Substance Use Disorders.* Administration and Policy in Mental Health and Mental Health Services, 37, 367-374.
[76] Wilderman, C., & Wang, E.A. (2017). *Mass Incarceration, Public Health, and Widening Inequality in the USA.* The Lancet, 389, 1464-1474.
[77] Mallik-Kane, K., & Visher, C.A. (2008, February). *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*. Retrieved from The Urban Institute Justice Policy Center: http://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF
[78] Ibid.
[79] National Association of Counties supported by the Safety and Justice Challenge sponsored by the John D. and Catherine T. MacArthur Foundation. (2017). Coun*ty Roles and Opportunities in Reentry Planning*. Retrieved from: https://www.naco.org/resources/county-roles-and-opportunities-reentry-planning
[80] California Health Care Foundation (2018, August). *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System*. Retrieved from: https://www.chcf.org/publication/medi-cal-addiction-treatment-mainstream/
[81] Ibid.
[82] California Health Care Foundation and the Healthforce Center at UCSF. (2018, February). *California's Current and Future Behavioral Healthcare Workforce.* Retrieved from: https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce

[83] Prison Policy Initiative. (2018, August). *Nowhere to Go: Homelessness Among Formerly Incarcerated People*. Retrieved from: https://www.prisonpolicy.org/reports/housing.html
[84] California Coalition for Youth. (2018, January). *A Call to Action: Prevent and End Youth Homelessness in California.* Retrieved from: https://calyouth.org/wp-content/uploads/2018/01/RHY-Hearing-Paper-January-2018.pdf
[85] U.S. Interagency Council on Homelessness (2016, March). *Connecting People Returning from Incarceration with Housing and Homelessness Assistance*. Retrieved from: https://www.usich.gov/resources/uploads/asset_library/Reentry_Housing_Resource_Tipsheet_Final.pdf
[86] Department of State Hospitals (DSH). (2017). *1370 Admissions Screening Project – Statewide Expansion.* Retrieved from the California Department of Health and Human Services: https://www.chhs.ca.gov/wp-content/uploads/2017/06/IST-Workshop/1370-Project-Final.pdf
[87] Franco, K., Maxwell-Jolly, D., Panush, D. (2018, November). *Criminal Justice System Involvement and Mental Illness among Unsheltered Homeless in California.* California Health Policy Strategies. Retrieved from: http://calhps.com/wp-content/uploads/2018/11/policy-brief-unsheltered-homelessness-11.20.2018.pdf
[88] U.S. Department of Housing and Urban Development. (2016). Retrieved from: https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf
[89] Ibid.
[90] Corporation for Supportive Housing (2015, January). *Improving Communitywide Targeting of Supportive Housing to End Homelessness: The Promise of Coordinated Assessment.* Retrieved from: http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthorughCA_Jan15.pdf
[91] U.S. Interagency Council on Homelessness (2016). *Connecting People Returning from Incarceration with Housing and Homelessness Assistance.* Retrieved from: https://www.usich.gov/resources/uploads/asset_library/Reentry_Housing_Resource_Tipsheet_Final.pdf
[92] Ibid.
[93] U.S. Department of Housing and Urban Development (2018) *Housing First Permanent Supportive Housing.* Available from: https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf
[94] SB 1380 Chapter 847 2016 retrieved from: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1380
[95] Franco, K., Maxwell-Jolly, D., Panush, D. (2018, November). *Criminal Justice System Involvement and Mental Illness among Unsheltered Homeless in California.* California Health Policy Strategies. Retrieved from: http://calhps.com/wp-content/uploads/2018/11/policy-brief-unsheltered-homelessness-11.20.2018.pdf
[96] Haupt, M. (2016, May). "Data is the New Oil" — A Ludicrous Proposition: Natural resources, the question of ownership and the reality of Big Data. Project 2030. Retrieved from: https://medium.com/project-2030/data-is-the-new-oil-a-ludicrous-proposition-1d91bba4f294
[97] Council of State Governments Justice Center. (2017, September). Stepping Up California Efforts. [PowerPoint slides]. Retrieved from: https://sites.cdcr.ca.gov/ccjbh/comio-issue-specific-workshop-92017/
[98] Haneberg, R., Fabelo, T., Osher, F., & Thomspon, M. (2017). Reducing the Number of People with Mental Illness in Jail: Six Questions County Leaders Need to Ask. Stepping Up Initiative. Retrieved from: https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf
[99] CCJBH Council Meeting (2018, January). [Meeting Materials]. Retrieved from: https://sites.cdcr.ca.gov/ccjbh/ccjbh-council-meeting-1-25-18/
[100] Bird, M., Lofstrom, M., Martin, B., Raphael, & S., Nguyen, V. (2018, June). The Impact of Proposition 47 on Crime and Recidivism. Public Policy Institute of California. Retrieved from: https://www.ppic.org/publication/the-impact-of-proposition-47-on-crime-and-recidivism/
[101] Birs, M., Grattet, R., & Nguyen, V. (2017, December). Realignment and Recidivism in California. Public Policy Institute. Retrieved from: https://www.ppic.org/publication/realignment-and-recidivism-in-california/
[102] Haneberg, R., Fabelo, T., Osher, F., & and Thompson, M. Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask (New York: The Council of State Governments Justice Center, forthcoming).
[103] CHHS Open Data. Open Data Portal Terms of Use. Retrieved from: https://data.chhs.ca.gov/pages/terms

[104] Ibid.