Introduction

Introduction:

The incarceration of individuals with behavioral health problems is a national, state, and local crisis. Incarceration due to untreated mental illness illustrates how systems and communities can fail those most in need. Prisons and jails have become de facto mental health treatment centers and police have become de facto mental health crisis first responders. While the deinstitutionalization of state hospitals in the 1970s and 1980s was the appropriate and humane approach to serving and supporting those suffering from mental illness, serious underfunding of the community-based system that was to replace it, has had substantial consequences. Today, law enforcement, the courts, hospitals, social welfare agencies, and community corrections professionals have been on the frontline experiencing how this growing social problem is changing the very nature of their work.

Two million admissions to U.S. jails annually are persons who are experiencing acute mental illness[1]. Of that population, it is estimated that three-quarters have a co-occurring substance use disorder, which is a diagnosis of both a substance use disorder and a serious mental illness. [2] More than 50 percent of inmates in prisons in the year prior to their arrest met criteria for substance dependence or abuse, while that number is nearly 70 percent of those in jails[3]. While roughly 5 percent of the general population has a serious mental illness, and 16 percent have a substance use disorder, those numbers are 9 and 40 percent respectively for probationers and parolees.[4] The National Alliance on Mental Illness (NAMI) estimates that between 25 and 40 percent of all Americans with mental illness will be jailed or incarcerated at some point in their lives.[5]

These numbers are consistent with local jails and prisons who are reporting that the number of incarcerated individuals with mental illness is growing. The California Department of Corrections and Rehabilitation (CDCR) has seen the population with mental health needs, particularly serious ones, grow significantly. In 2006 the mental health population as a percent of the total in custody population was just shy of 19 percent. As of July 2016 that number rose to almost 30 percent.[6] The Public Policy Institute of California (PPIC) also concluded in a recent analysis of California's historic correction reforms that due to shifting the incarceration of most non-serious and non-violent offenders from state prison to county jails, there is now an urgent need for jails to become equipped with mental health beds, rehabilitation and reentry programming.[7]

History and Background:

Too often those with mental illness do not get treatment until they become justice-involved. Seeking to address this, the Council on Mentally Ill Offenders (COMIO) was created and codified in Penal Code Section 6044, which originally set forth a sunset date of December 31, 2006. In 2006 SB 1422 (Chapter 901, Statutes of 2006) eliminated the sunset date.

The Council's primary purpose is to "investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending." In pursuit of that goal, the Council is to:

- Identify strategies for preventing adults and juveniles with mental health needs from becoming offenders,

- Identify strategies for improving the cost-effectiveness of services for adults and juveniles with mental health needs who have a history of offending, and
- Identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt cost-effective approaches for serving adults and juveniles who are likely to offend or who have a history of offending.

The Council must consider strategies that improve service coordination among state and local mental health, criminal justice, and juvenile justice programs. As well as, strategies that improve the ability of adult and juvenile offenders with mental health needs to transition successfully between corrections-based, juvenile-based, and community-based treatment programs.

Penal Code Section 6044(h)(1) requires the Council to "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. The report shall include recommendations for improving the cost-effectiveness of mental health and criminal justice programs."

The Council is comprised of twelve members. Existing law designates as permanent members: the Secretary of CDCR, the Director of the California Department of State Hospitals (DSH), and the Director of the California Department of Health Care Services (DHCS), with the CDCR Secretary serving as the chair. The vice chairperson is selected from the membership.

Other Council members are appointed as follows: three by the Governor, at least one representing mental health; two each by the Senate Rules Committee and the Speaker of the Assembly, each appointing a representative from law enforcement and a representative from mental health; one by the Attorney General; and one by the Chief Justice of the California Supreme Court. Six members of the Council constitute a quorum.

As of this writing, the Council is currently comprised of the following individuals:

- Chairperson: **Scott Kernan,** Secretary, CDCR. The Secretary of CDCR is a statutorily required member and chair of COMIO.
- Vice Chairperson: **Manuel J. Jimenez**, Jr., MA, MFT, former Behavioral Health Director, Alameda County. Mr. Jimenez was appointed to COMIO by Governor Edmund G. Brown Jr. in 2012.
- **Pamela Ahlin**, Director, DSH. The Director of DSH is a statutorily required member of COMIO. Dr. Mark Grabau at times represented Ms. Ahlin on COMIO during 2016.
- **Jessica Cruz**, MPA, Executive Director, NAMI – California. Ms. Cruz was appointed to COMIO by Governor Edmund G. Brown Jr. in 2015.
- **Mack Jenkins**, Retired Chief Probation Officer, San Diego County Probation Department. Mr. Jenkins was appointed to COMIO by Governor Edmund G. Brown Jr. in 2015.
- **Alfred Joshua**, MD, MBA, FAAEM Chief Medical Officer, San Diego County Sheriff's Department. Dr. Joshua was appointed to COMIO by Assembly Speaker Toni G. Atkins in 2015.
- **Jennifer Kent**, Director, DHCS. The Director of DHCS is a statutorily required member of COMIO. Ms. Kent was represented on COMIO by Brenda Grealish.
- **Matthew D. Garcia**, Field Training Officer, Sacramento Police Department. Mr. Garcia was appointed to COMIO by the Senate Rules Committee (chaired by Senator Kevin de León) in 2016.

- **The Honorable Stephen V. Manley**, Santa Clara Superior Court Judge. Judge Manley was appointed to COMIO by Chief Justice Ronald M. George of the California Supreme Court in 2010.
- **David Meyer**, J.D., Clinical Professor/Research Scholar, USC Keck School of Medicine. Mr. Meyer was appointed to COMIO by Assembly Speaker Robert M. Hertzberg in 2002.
- **Lester P. Pincu**, D.CRIM. Dr. Pincu was appointed to COMIO by the Senate Rules Committee (chaired by Senator Kevin de León) in 2015.

Dave Lehman, Retired Probation Chief, Humboldt County and Charles Walters, Ph.D., Retired Assistant Sheriff, Orange County Sheriff-Coroner Department, both long-time COMIO members retired in 2016. COMIO is grateful for their service and dedication to COMIO's mission. Additionally, COMIO was supported by CDCR staff, including COMIO Executive Officer Stephanie Welch, COMIO Program Analyst Michelle Grant, and Norine Occhipinti and Renee Whitehead of the CDCR Office of the Secretary.

2016 Priority Work Areas:

In 2016 COMIO elected to continue the focus on three priority areas identified in 2015 with a few revisions, these include:

- ❖ Sharpening the focus on diversion to identify effective capacity building strategies and resources to support diversion,
- ❖ Broadening the training focus beyond first responders, and
- ❖ Expanding juvenile delinquency prevention to include strategies to support improved services for those who do come in contact with the juvenile justice system.

Obtaining information on each of these priorities took place during COMIO meetings, and Diversion, Training, and Juvenile Justice Committee meetings. COMIO also obtained information by conducting educational site visits, such as to Los Angeles County to talk to implementers and study programs associated with the Office of Diversion and Reentry (ODR) and the Los Angeles County Department of Mental Health (LACDMH). Additionally throughout the year, COMIO staff conducted informational interviews and program visits with criminal justice and behavioral health professionals and organizations across the state (see Appendix B). COMIO supports blending information from research and data with lessons learned from implementers and program participants. Together 15 committee and 6 full Council meetings were held with over 36 presentations from various experts and stakeholders. Materials and resources from all committee and full council meetings can be found on the COMIO website at http://www.cdcr.ca.gov/COMIO/index.html.

Recognizing that not all topics could be explored with the same rigor the annual legislative report for 2016 is organized into three reporting categories:

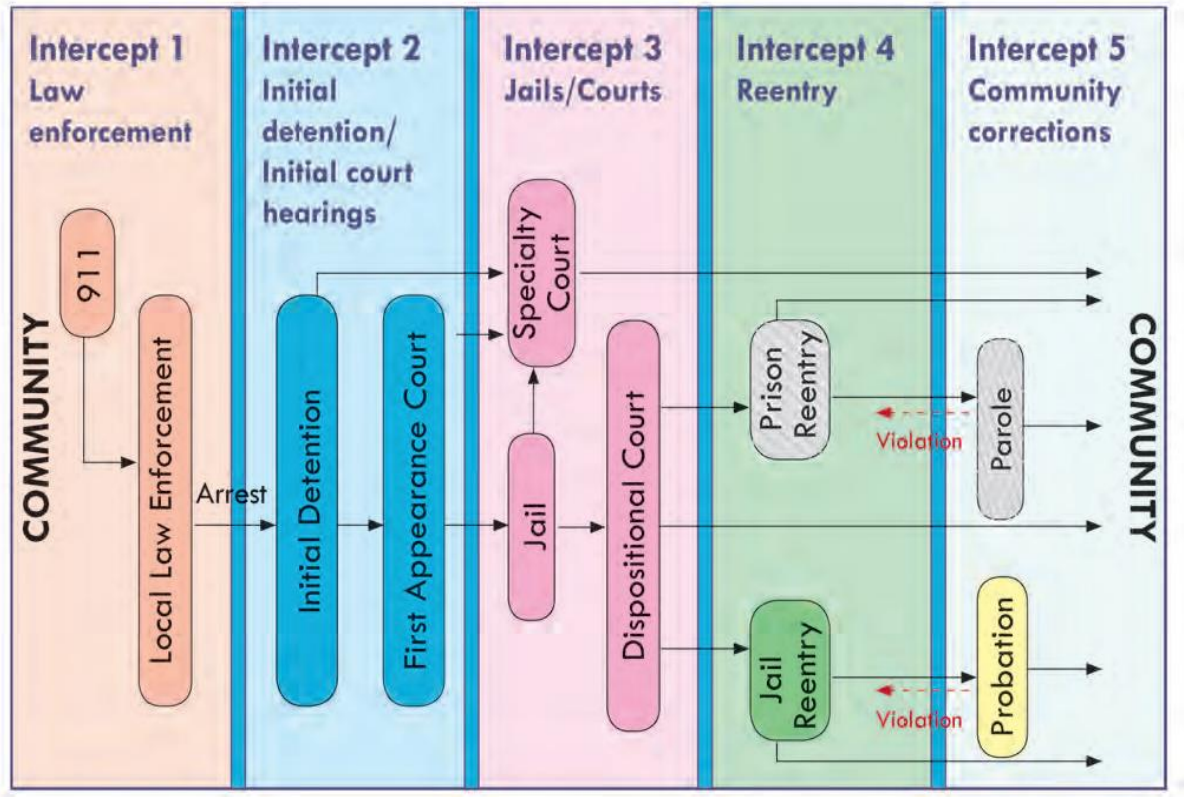
- Investigate – Study the problem and assess challenges,
- Identify – Examine the opportunities present and discover some examples of how, what, and where effective strategies are taking place, and
- Promote – Acknowledge effective strategies that have demonstrated impact.

Each priority area - Diversion, Training, and Juvenile Justice - reports in these three categories in sections two, three, and four of this report.

Foundation of COMIO's Work:

COMIO's work is grounded in support of the "Sequential Intercept Model" 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.[8] 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. The model includes law enforcement and crisis response services, post arrest and disposition options, jail services and alternatives provided through the courts, re-entry services, and community corrections and supports to prevent recidivism. In addition to the usefulness of this model, COMIO advocates that the most effective way to prevent the majority of incarceration among those with mental illness is to have an accessible and varied mental health and social service system that can address issues before individuals ever become justice-involved. For more information see Text Box A and Figure 1.

Figure 1: Sequential Intercept Model



Text Box A

The Five "Intercepts" in the Sequential Intercept Model

1. *Law enforcement and emergency services:*
    a. *Police have become de facto mental health crisis responders, as they are frequently the first to be called to address a person with a mental health emergency. Law enforcement officers frequently report encountering someone having a mental health crisis;*
    b. *Police and Sheriff Departments can work with mental health systems to create mobile crisis teams, staffed by the mental health system but employed by law enforcement, to address crisis in the field;*
    c. *Another option is a team of mental health professionals that is reachable by phone that can assist officers in the field;*
    d. *A third option is a team of police officers that receive additional specialized training to deal with crisis situations directly.*
2. *Post arrest, including initial detention and initial hearing:*
    a. *The first appearance in court is a critical opportunity to divert low-level offenders;*
    b. *Courts may hire mental health professionals to provide consultation, services, and linkage to the community or develop relationships with outside organizations (including county behavioral health) to assess offenders and advise judges about treatment alternatives;*
    c. *Having accessible and appropriate services and housing options to divert individuals is critical, and often missing.*
3. *Post-initial hearings, including jail, courts, forensic evaluations and forensic commitments:*
    a. *Since individuals with mental illness are more likely to stay in jail longer than their general population counterparts, it is essential that they receive proper treatment and services immediately;*
    b. *Collaborative courts, for those selected to participate, have less of an emphasis on incarceration and more of an emphasis on rehabilitation and diversion. There are mental health courts comprised of a team from the district attorney's office, a public defender, probation, and other groups that focus on problem-solving and linking the defendant to community resources and services in lieu of incarceration.*
4. *Reentry from jails, state prisons, and forensic hospitalization:*
    a. *Reentry to the community represents significant opportunities to provide services to prevent recidivism;*
    b. *Ensuring the continuum of care from jails, state prisons, and state hospitals back to the community is an issue that has been receiving increased attention and resources;*
    c. *Preparing the necessary transfer of sensitive information about health and recidivism risks and needs is critical to support a smooth transition;*
    d. *"In Reach" programs aim to engage individuals prior to release, building trusting relationships and conducting assessments to better inform treatment and service plans upon release.*
5. *Community corrections and community support:*
    a. *Be mindful and seek to address the stigma associated with mental illness and justice-involvement that imposes additional barriers to community integration such as limited access to housing, employment, and various social welfare programs and supports;*
    b. *Individuals with mental illness or other behavioral health issues also have recidivism risks that must be addressed along with treatment for psychiatric symptoms;*
    c. *Failure to continue mental health treatment can be grounds for a parole or probation violation and possibly re-incarceration; and*
    d. *Counties and the state could use probation and parole agents trained specifically to handle mental health caseloads.*

Opportunities and Challenges:

Today there is a political climate ready to implement strategies and solutions that can effectively address the swelling number of individuals with mental illness who are incarcerated. The National Association of Counties (NACo), with support from behavioral health and law enforcement organizations, is supporting the ***Stepping Up Initiative***, which is aligning national, state, and local efforts to reduce the incarceration of people with mental illness.[9] Twenty-one California counties are already participating in the initiative, supported by the Bureau of Justice Assistance (BJA), which also supplies technical assistance from the Council on State Governments Justice Center. For more information about the Stepping Up Initiative see Text Box B. Counties are actively assessing and mapping where they can focus and enhance interventions across the intercept model with blended resources, including funds from public safety realignment, the mental health services act, Medi-Cal, federal and state grants, and local county general funds. Even the state budget supplied considerable resources in fiscal year 2016-17 to efforts such as, strengthen rehabilitation and re-entry efforts, law enforcement training, supportive housing development and investments to address poverty such as raising the Supplemental Security Insurance (SSI) Cost-of-Living Adjustment (COLA) for the disabled.

As we seize this opportunity we must also address a critical barrier that COMIO encountered when examining effective strategies in Diversion, Training, and Juvenile Justice - Stigma. COMIO members asked an esteemed researcher studying effective strategies with offenders with mental illness, Dr. Jennifer Skeem of the University of California Berkeley, School of Social Welfare, what the Council should do to have the most meaningful impact, she replied without hesitation:

> *"One of the things that we have been recommending for a long time either at the officer or judicial level is having people ask themselves 'would I be making this decision if not for the mental illness?' If the answer to that question is 'no,' then that means it is time to start unpacking some alternative solutions to the problem. Anybody that is making critical decisions about those facing mental health and/or substance use challenges should be targeted."*

In other words the challenge during this time is to ensure that stigma does not influence the policies and practices that impact individuals with mental health challenges who are, or who are at risk of becoming justice-involved. Myths and misperceptions can reinforce the marginalized status of justice-involved individuals with mental illness, which are far-reaching and can be significantly debilitating. *"Norms and beliefs related to behavioral health, such as the stigma associated with mental illness and substance use disorders, are created and reinforced at multiple levels, including day to day contact with affected individuals, organizational policies and practices, community norms and beliefs, the media and governmental law and policy."*[10] COMIO is committed to challenging this cycle of unfair judgment and resulting behavior. By raising awareness and consciousness, we can work to reduce the stigmas inflicting this population and support recovery and reintegration.

Stigma based policies and practices consistently impede the adoption of effective practices to prevent incarceration and recidivism. How stigma imposes challenges and what can be done to address them is identified below, including recommendations for COMIO to take action in future work.

Text Box B

Stepping Up Initiative

Launched in May 2015, Stepping Up is a national initiative to reduce the number of people in jails with mental illness and co-occurring substance disorders. The initiative is collaboration between NACo, the Council of State Governments (CSG) Justice Center, and the American Psychiatric Foundation (APF), and is supported by the U.S. Justice Department's Bureau of Justice Assistance (BJA). COMIO has endorsed and promoted the initiative here in California.
The initiative encourages a Call to Action for county and state leadership to commit to the completion of the following six actions:

1. *Convene a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people in jails with mental illnesses.*
2. *Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk.*
3. *Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders.*
4. *Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.*
5. *Implement research-based approaches that advance the plan.*
6. *Create a process to track progress using data and information systems, and to report on successes.*

County leaders, national and state associations, criminal justice and behavioral health professionals, state and local policymakers, others with jail authority, and individuals are able to sign on to the Call to Action.

A national summit was held in April 2016 and it has aided in identifying what needs to be done to support counties to effectively implement diversion strategies. In California over twenty counties representing about 60% of the state's average daily jail population are currently participating. Support to stepping up counties includes technical assistance on issues such as data collection and measurement, peer to peer learning and policy analyses to identify places counties need support such as Medi-Cal expansion. A California-specific summit will be taking place in early 2017.

For more information about the Stepping Up Initiative, visit https://stepuptogether.org/.

Finding: Address the challenges stigma presents to building capacity and alternatives to incarceration

Addressing stigma associated with mental illness is essential to ensuring there are alternatives to incarceration in the community, and that those alternatives get appropriate resources and referrals. Most importantly, individuals using those alternatives should be provided equitable opportunities for recovery and community acceptance. Below are a few examples of how myths and misperceptions about mental illness and can influence policies and practices with a potential negative impact.[11]

Ensure alternatives to incarceration

- Myth: Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.
  - Fact: Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems including: biological factors, such as genes, physical illness, injury, or brain chemistry; life experiences, such as trauma or a history of abuse; and family history of mental health problems.
  - Impact: Could lead to policies or reduced investments in mental health services and treatment as an alternative to incarceration because there is no belief that treatment will make any difference.

Support appropriate resources and referrals to alternatives

- Myth: People who have mental illness are more violent and dangerous.
  - Fact: Only 3-5 percent of violent acts can be attributed to people with a serious mental illness. However, 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.
  - Impact: A person with mental illness arrested on theft with no prior history of violence could have a higher bond than a person without mental illness who was arrested for the same crime, or not be considered for a service/treatment diversion program due to fears of violence.

Provide equitable opportunities for recovery and community acceptance

- Myth: People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job.
  - Fact: People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, quality work, and job tenure that is on par with or greater than other employees. When employees with mental health problems receive effective treatment, it can result in: lower total medical costs, increased productivity, lower absenteeism, and decreased disability costs.
  - Impact: Justice-involved individuals with mental illness might not be considered for rehabilitation opportunities, including education and vocational trainings while in custody, upon re-entry, or even prior to incarceration.

The stigma of mental illness is certainly not the only hurdle to building capacity and creating alternatives. This year COMIO investigated the stigma of having a criminal background, which is challenging enough let alone in addition to a mental illness. For the justice-involved person with mental illness, reintegration and a reduction in recidivism seem only possible if there is a conscientious effort to remove the layers of stigma which can be collectively debilitating. While including race, ethnicity, and sexual orientation were not within this years' scope, such an analysis would document an exponential impact. We investigated barriers and solutions in important life domains such as education and training, employment, and social welfare. Below are a few examples. For a more complete analysis see the infographic in Appendix C.

- Education and Training:
  - Barrier: Since 1995 people that are currently in prison or jail have not been allowed to apply for Federal Pell Grants. These grants provide assistance for college that does not have to be repaid. In addition, the American Opportunity Tax Credit which is up to $2,500 per year, comparable to Pell Grants, is denied to those with felony drug convictions.
  - Solution: The US Department of Education launched a Second Chance Pell Grant Pilot Program. Through this pilot program, incarcerated individuals who otherwise meet Title IV eligibility requirements and are eligible for release within the next 5 years could access Pell Grants to pursue postsecondary education and training. The goal is to increase access to high-quality educational opportunities and to help these individuals successfully transition out of prison and back into the classroom or the workforce.[12]
- Employment:
  - Barrier: Having any arrest during one's life decreases employment opportunities more than any other employment stigma, such as long-term unemployment, receipt of public assistance, or having a GED instead of a high school diploma. Beyond that, an estimated 87percent of employers conduct criminal background checks on their applicants.[13]
  - Solution: Assembly Bill (AB) 218 signed by Governor Brown in 2014 prohibits a state or local agency from asking an applicant to disclose information regarding a criminal conviction, except as specified, until the agency has determined the applicant meets the minimum employment qualifications for the position.
- Social Welfare:
  - Barrier: SSI is suspended while incarcerated and payments can be reinstated in the month of release. However, if your confinement lasts for 12 consecutive months or longer, your eligibility will be terminated. Former SSI recipients are not automatically deemed eligible once released, so one must reapply.[14]
  - Solution: SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at-risk of homelessness and have a mental illness, medical impairment, and/or co-occurring substance use disorder. Several counties in California have been trained in SOAR and find it very effective http://soarworks.prainc.com/content/what-soar.

Recommendation 1a. COMIO will continue to support and collaborate with stakeholders to dispel myths about mental illness, justice-involvement, and the prevalence of co-occurring substance use among two-thirds of this population. COMIO can provide information regarding best practices in diversion and be available to provide referrals to experts in the field. Communicate the message that both criminal justice and behavioral health systems have joint responsibilities with shared resources over this population and its diversion from incarceration.

Recommendation 2a. COMIO will use workshops, educational site visits, local outreach, the website and newsletter to further identify and disseminate effective strategies, and to raise awareness to combat stigma-based decision-making.

Recommendation 3a. COMIO will include the Board of Supervisors (BOS), Chief Administrative Officers (CAO), and other decision-makers in educational efforts about people with mental health

and substance use disorders who are justice-involved and the barriers they face due to their criminal background.

Recommendation 4a. COMIO will encourage diversion stakeholders to participate in the local MHSA planning process to encourage that MHSA resources support efforts to prevent and reduce the incarceration of people with mental illness. One of the primary goals of MHSA is to prevent incarceration. Counties already have several efforts underway with MHSA funds. Explore what else can be done, especially through levering other funding opportunities for diversion (e.g. Prop 47 and AB 109).

The challenge of developing capacity and providing community alternatives like housing and supportive services to the justice-involved with mental illness and substance use disorders is so immense that it must be called out above other challenges. "Not in My Backyard" or NIMBY can be defined as "objecting to the siting of something perceived as unpleasant or potentially dangerous in one's neighborhood, such as a landfill or hazardous waste facility, especially while raising no such objections to similar developments elsewhere".[15] NIMBY would be a problem if the population to be housed or provided services was just for the justice-involved or individuals with behavioral health issues but both simultaneously poses tremendous difficulty. In addition, NIMBY also exists as opposition to affordable and supportive housing and according to Disability Rights California (DRC) "has deep roots in fear, racism, classism, ableism, and growing antidevelopment reactions … it is a governance problem, economic problem, and civil rights problem." For more information see Text Box C.

While efforts should be made to ensure that local laws are complying with land use, fair housing and anti-discrimination laws, careful attention should be paid to successfully managing public opposition. The Non-profit Housing Association of Northern California (NPH) has developed a useful guide called *Six Steps to Getting Local Governmental Approval* and these strategies closely mirror recommendations put forth by the National Institute of Corrections (NIC) regarding siting for correctional facilities.[16]

Text Box C

DRC produced policy recommendations for California to address NIMBY in 2014, they include:

- *State and local governments should continue to support efforts to reduce stigma against people with mental illness, such as cities and counties conducting community outreach and training to community development agencies, fair housing, land use and planning staff, section 504 coordinators and others about land use and fair housing rights.*
- *Local governments should facilitate or participate in community discussions regarding zoning approval and communicate that housing providers and perspective tenants have land use and fair housing rights that protect housing developments against NIMBY opposition.*
- *Local governments should ensure that their land use, planning, and zoning efforts, enable supportive housing and discourage NIMBYism, such as, ensuring that their housing elements and consolidated plans are current and approved, that the disability and fair housing assessment and program portions of these planning documents promote and encourage supportive housing, and that changes are made to zoning codes as needed to comply with current and approved housing elements and consolidated plans.*

Recommendation 5a. Promote the implementation of DRC's NIMBY reduction policy recommendations, especially efforts to ensure that local governments are complying with land use/planning, fair housing and anti-discrimination laws. Ensure that people with disabilities are not discriminated against based on their criminal background, and that they receive reasonable accommodations from landlords and municipalities that make land-use decisions.

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[1] Henry J. Steadman, Ph.D., et al. "Prevalence of Serious Mental Illness Among Jail Inmates," (Jun. 2009) *PSYCHIATRIC SERVICES,* pp. 761–765 <http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.6.761> (accessed Nov. 28 2016); and Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers,* (July 1999), U.S. Department of Justice, Office of Justice Programs <http://www.bjs.gov/content/pub/pdf/mhtip.pdf.

[2] Fred Osher, M.D., et al., *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (Sep. 2002) https://www.prainc.com/wp-content/uploads/2015/10/best-practice-approach-community-re-entry-inmates-co-occurring-disorders.pdf.

[3] Mumola, C.; and Karberg, J.C. *Drug Use and Dependence, State and Federal Prisoners, 2004*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2007. Available at http://www.bjs.gov/content/pub/pdf/dudsfp04.pdf

[4] 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. Available at: https://www.ncjrs.gov/pdffiles1/nij/235637.pdf

[5] Ford, M. (2015). America's Largest Mental Health Hospital is a Jail. *The Atlantic.* Available at: http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/

[6] California Department of Corrections and Rehabilitation, Office of Research (2016). 2015 Outcome Evaluation Report, An examination of Offenders Released in 2011-2012. Available at: http://www.cdcr.ca.gov/Adult_Research_Branch/Research_Documents/2015_Outcome_Evaluation_Report_8-25-2016.pdf

[7] Lofstrom, M., Bird, M., and Martin, B. (2016). California's Historic Corrections Reforms. Public Policy Institute of California. Available at: http://www.ppic.org/content/pubs/report/R_916MLR.pdf

[8] 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.

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

[10] National Academy of Sciences (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Available at: https://www.nap.edu/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders

[11] These myths and facts can be reviewed at: https://www.mentalhealth.gov/basics/myths-facts

[12] U.S. Department of Education Launches Second Chance Pell Grant Pilot Program https://www.ed.gov/news/press-releases/us-department-education-launches-second-chance-pell-pilot-program-incarcerated-individuals

[13] Decker, S., Spohn, C., Oritz, N., & Hedberg, E. (2014). Criminal Stigma, Race, Gender, and Employment. National Institute of Justice available at: https://www.ncjrs.gov/pdffiles1/nij/grants/244756.pdf

[14] Social Security Administration (2015). Social Security What Prisoners Need to Know available at: https://www.ssa.gov/pubs/EN-05-10133.pdf

[15] Disability Rights California (2014). Everyone's Neighborhood: Addressing "Not in My Backyard" Opposition to Supportive Housing for People with Disabilities available at: http://www.disabilityrightsca.org/pubs/CM5301.pdf

[16] NPH, Six Steps to Getting Local Government Approvals available at: http://www.hcd.ca.gov/hpd/nimby/six_steps.pdf