COMIO

Council on Mentally Ill Offenders

Building bridges between criminal justice & behavioral health to prevent incarceration

COUNCIL MEMBERS

Scott Kernan, Chair
Secretary, California Department of Corrections and Rehabilitation

Manuel Jimenez, Vice Chair
Former Behavioral Health Director, Alameda County

Pamela Ahlin
Director, California Department of State Hospitals

Jessica Cruz
Executive Director, National Alliance on Mental Illness (NAMI) California

Matthew Garcia
Field Training Officer, Sacramento Police Department

Mack Jenkins
Retired Chief Probation Officer, San Diego County

Alfred Joshua
Chief Medical Officer, San Diego County Sheriff's Department

Jennifer Kent
Director, California Department of Health Care Services

Stephen V. Manley
Santa Clara County Superior Court Judge

David Meyer
Clinical Professor/Research Scholar, USC Keck School of Medicine

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1515 S Street, Suite 502S, Sacramento, CA 95811 • (916) 323-6001 • http://ww.cdcr.ca.gov/COMIO

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

The Council is grateful for the contributions of Professor Lester P. Pincu, a COMIO member since 2015. Dr. Pincu passed this year and he will be remembered for his dedication to public service and, in particular, to addressing the needs of youth who are justice-involved.

COMIO 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 COMIO workshops, meetings, and events. It is your participation that gives our work meaning and value. We are eager to transition into our revised role as the Council on Criminal Justice and Behavioral Health next year and welcome the new partnerships that will result from our expanded duties.

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Executive Summary

EXECUTIVE SUMMARY

Since 2001, California, through the Council on Mentally Ill Offenders (COMIO), has recognized that individuals living with mental illness are at risk of becoming criminally involved without access to support and needed services. As a 12-member Council chaired by the Secretary of the Department of Corrections and Rehabilitation (CDCR), COMIO is charged with *investigating*, *identifying*, and *promoting* cost-effective strategies that will:

- Prevent adults and juveniles with mental health needs from becoming offenders
- Improve services for adults and juveniles with mental health needs who have a history of offending
- Identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt such approaches

2017 PRIORITIES

This year was overshadowed by proposals that would considerably impact California's ability to serve the mental health and substance use treatment needs of individuals at risk of involvement in the justice system. Through the Affordable Care Act (ACA), substantial opportunities, such as Medicaid expansion to low income adults and the inclusion of mental health and substance use treatment as essential health benefits, have allowed California to prevent incarceration and pursue a reduction in recidivism through investments in behavioral health services. The negative consequences that would occur if the ACA was repealed or critical elements dismantled compelled the Council to focus efforts on documenting the need for, and impact of, services provided under Medicaid (Medi-Cal in California). In addition, the Council sought to understand how the administration and delivery of Medi-Cal programs can be improved in the most cost-effective manner.

With incredible assistance from state and county partners who are in the trenches doing the difficult work of building and improving service delivery, the Council has developed the following recommendations:

1. Recommendation: Preserve and protect California's expansion of Medi-Cal and mental health and substance use disorder treatment as essential health benefits. The success of public safety realignment and criminal justice reforms in California is significantly reliant on expanded Medi-Cal eligibility and services, especially behavioral health services. Protecting this expansion is paramount to addressing overcrowded jails and prisons, but more importantly, to serve people with behavioral health needs in the community before they are in crisis or at-risk of incarceration.

2. Recommendation: Mental Health Plans (MHP) and Medi-Cal Managed Care Plans (MCP) are required to provide easy to understand information about benefits and how to access services. Leverage such efforts by assessing for accessibility to various justice partners, providers and service users. Offer recommendations for improvements if needed. Raise awareness about such resources and use dissemination channels that include making the information available on COMIO's website as well as the websites of other justice partners.

3. Recommendation: Support the use of universal screening with reliable and validated tools for mental illness, substance use and/or co-occurring disorders, and criminogenic risk at jail intake and identify strategies to resource such efforts. Doing so will provide valuable information to support diversion, needed services, and improved connections to necessary care.

"Even though the Mental Health Services Act provides great opportunities, Medi-Cal is really the backbone and sustainability is really the key to solving this. The more that people are covered, the more services we can provide."

County Administrator

4. Recommendation: Support the screening of eligibility for health care coverage and other benefits at intake in jails and prison. Identify strategies to resource such screening, either among custody or in partnership or under contract with health and social services staff. Efforts should be consistent with local eligibility screening and determination processes and protocols.

5. Recommendation: Remove the one-year limitation on California's Medi-Cal suspension policy and instead support indefinite suspension so that benefits can be activated immediately upon release to achieve continuity of care. There have been recent legislative proposals regarding this that have yet to be successful. This is likely due to possible costs to the state general fund or concerns about federal approval. Follow-up to determine what the barriers have been and if there are possible resolutions or alternatives. Support policies that are more likely to sustain health care coverage, including the development of a simplified annual redetermination process for those in jail or prison.

6. Recommendation: If capacity within correctional settings for enrollment efforts is limited, priority should go to people with health problems—physical and behavioral. This is another reason it is so important to conduct an effective behavioral health assessment along with assessment of criminogenic risk to ensure those with the greatest needs returning to the community are the most likely to receive health coverage and other benefits.

7. Recommendation: Research what other states are doing through technology to expedite Medicaid eligibility and enrollment such as ease of imposing and lifting suspension status, use of peer educators to support managed care plan selection, and other strategies to expedite access to reimbursable services.

8. Recommendation: The Department of Health Care Services (DHCS), CDCR, and county stakeholders such as behavioral health, social services, probation, and the sheriffs' department can consider the feasibility of a state plan amendment that would establish short-term presumptive eligibility (PE) for those exiting incarceration whose eligibility cannot be determined at the point of release, particularly if they are in need of medical and behavioral health services upon release. The goal is to devise a reasonable strategy where Medi-Cal can support an individual's transition from incarceration to community.

9. Recommendation: Address gaps that exist between eligibility, enrollment, and service access due to an additional process of selecting a local Medi-Cal MCP and completing additional paperwork. Explore strategies where plan selection could be completed simultaneously with eligibility and enrollment processes, for example in small and rural counties that might only have one plan option. Prior to release, individuals can receive support to choose a specific provider within the network of the plan selected.

10. Recommendation: Public safety entities and county MHPs 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. To support these efforts, counties should maximize the identification and use of available federal funding as allowed (e.g., Medi-Cal Administrative Activities, Medi-Cal medical assistance).

11. Recommendation: Over 85 percent of parolees are exiting incarceration as Medi-Cal beneficiaries. Identify mechanisms to ensure that parolees who are Medi-Cal beneficiaries have access to the services they are entitled to either through the Specialty Mental Health System or a Medi-Cal MCP. Such work provides an excellent opportunity to strengthen collaboration between state and local partners.

12. Recommendation: DHCS, in consultation with behavioral health and criminal justice stakeholders, should 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.

13. Recommendation: Maximizing federal reimbursement for parolee mental health care will aid in supplying the resources needed to better address physical and behavioral health needs. The benefits and challenges regarding how to do so most effectively should be thoroughly examined in preparation for 2020 Medi-Cal waiver renewal.

14. Recommendation: Ensure that jails, state prisons, and state hospitals have specific policies in place for enhanced pre-release and discharge planning for individuals who screen and assess at-risk due to serious mental illness (SMI), substance use disorder (SUD), co-occurring disorder (COD), and/or criminogenic needs. Assess how extensively Medi-Cal is being used to support these efforts compared to other funding sources like the MHSA, Realignment, or categorical grant programs. Consider strategies that connect individuals with their service provider prior to release, even if from a state institution. Pre-release and discharge strategies that include individuals with previous incarceration experience have demonstrated effectiveness.

15. Recommendation: Explore the feasibility and mechanics of piloting in jails and/or prisons promising practices to improve continuity of care, including:

    a. Use of community health workers (CHW) and peers for both jail/prison in-reach and community-based service support and system navigation.
    b. Engagement and communication between community supervision (probation and parole) entities and behavioral health service providers to break down myths and misperceptions of roles and responsibilities.
    c. Data-sharing that allows the sharing of health information between criminal justice and behavioral and health partners.
    d. Incentives (including enhanced funding or training and technical assistance) for providers who can specialize in populations who are high-risk and require a specialized skill set to tackle complex conditions (e.g. homelessness, SMI, SUD, COD, criminogenic risks).

16. Recommendation: Considering the risk and crisis in homelessness among the justice-involved population with serious behavioral health needs upon reentry, all efforts to address homelessness and the housing crisis in California should take into consideration the unique needs of this population. Moreover, for the justice-involved population with behavioral health challenges, housing must be linked to services and vice versa.

    a. Maximize the use of Medi-Cal funds for the justice-involved (therefore expanding federal financial participation) including for housing services so that resources saved can be directed towards a variety of housing needs for the reentry population especially for immediate short-term and transitional housing.
    b. Support practices that provide equal opportunities for housing for those being released from institutions such as jails, prisons, juvenile detention, state hospitals, and even parole, such as the *No Place Like Home Initiative*, which will include as part of their target population individuals who are at-risk of chronic homelessness,
    c. Strengthen state-level efforts to combat *Not in My Backyard* (NIMBY) community responses to housing for individuals with behavioral health needs and/or individuals who have been formerly incarcerated. Explore if and how the *Housing Accountability Act* will aid in enforcing the development of appropriate housing for special needs populations who may be experiencing discrimination.

"We need to make it so someone doesn't lose their benefits in jail because we are spending our money on services in jail rather than for reentry and in the community, that does not make any sense"

Peer Provider

17. Recommendation: COMIO should continuously monitor the lessons learned emerging from counties and their partners implementing programs under these initiatives that especially target individuals with justice-involvement or for those returning home from incarceration. Through enhanced pre-release and discharge planning in local jails, CDCR and the Department of State Hospitals (DSH) could have enhanced capacity to directly link appropriate individuals to community-based services prior to release. Disseminate lessons learned across counties and include health, behavioral health, and public safety partners to examine how similar efforts could be adopted locally. Learning from these initiatives should influence decisions about how to change or update Medi-Cal waivers in 2020.

18. Recommendation: Promote the use of peers who have former justice-involvement as an essential provider in the behavioral health workforce. All efforts to expand the use of peers in the workforce should include the formerly incarcerated. Support efforts to establish a statewide certification program equipped with competencies that are effective in meeting the complex needs of the justice-involved population.

19. Recommendation*:* Identify different CHW models being used in California and how they have been effective in behavioral health settings. Explore how to maximize Medi-Cal reimbursement for these services. Ensure that models implemented also consider and address the needs of the justice-involved who have behavioral health needs

20. Recommendation: COMIO should seek to better understand integrated care for co-occurring disorders and effective treatments. Explore the role of SUD counselors in treating the target population and examine how the services they deliver can be reimbursed through Medi-Cal.

21. Recommendation:

    a. Examine effective models to determine strategies for integration of SUD counselors.
    b. Improve understanding of how peers, CHWs, and SUD counselors can work to serve people with co-occurring disorders.
    c. Strengthen collaborative relationships by cross-training Peer Support Specialists, CHWs, and SUD Counselors. Foster the development of a culturally competent workforce that can effectively address the unique needs of the justice-involved population.

22. Recommendation:

    a. Short-term: Assess and document barriers to employment for individuals with justice-involvement. With support from counties, identify effective practices for addressing barriers to employment and disseminate them statewide. Encourage local governments to utilize this untapped resource to build the capacity of their behavioral health workforce.
    b. Long-term: In partnership with counties, strategize to address barriers through policy change.

23. Recommendation: COMIO is well positioned to build upon existing efforts and lead state agencies, departments, advisors, and stakeholders to:

    a. Catalogue existing state and federal efforts in prevention, diversion, and reentry, including the authority and funding provided by different entities.
    b. Identify strengths and barriers in existing efforts including opportunities to improve coordination to address gaps in prevention, diversion and reentry efforts.
    c. Develop a prioritized plan of legislative, regulatory, financial, educational, and training and technical assistance activities for statewide action.
    d. Create a reasonable structure to measure the progress and impact of such activities.

LOOKING AHEAD TO 2018

2017 also represents the final year an Annual Legislative Report will be submitted under the name COMIO. Next year the Council will become the *Council on Criminal Justice and Behavioral Health (CCJBH)*. In September 2017, Governor Edmund J. Brown Jr. signed legislation to amend Penal Code Section 6044, which includes the following:

- Reinforces the importance of the Council's duties and its existence within the California Department of Corrections and Rehabilitation
- Removes outdated and stigmatizing language updating the Council's name and giving the Council an opportunity to inform others about Behavioral Health Services—both Mental Health and Substance-Use disorders
- Includes substance-use disorder challenges within the scope of the Council's work
- Encourages future council member appointments to be individuals who have lived experience in the criminal justice and/or behavioral-health systems

These changes are extremely valuable to the Council in conducting meaningful work that supports the dissemination and adoption of effective practices to reduce the incarceration of individuals with behavioral health issues. In particular, people who are justice-involved and have a mental illness are also more likely to suffer from a substance-use disorder. Addressing both in an integrated manner is difficult but far more effective than addressing one or the other. While it will be challenging to raise awareness of the new name and revised scope of practice, the Council is eager to work on this in 2018. Specifically, the Council intends to draw attention to the need for quality programming and policies that support effective practices for those with co-occurring mental health and substance use disorders.

To follow COMIO's work and to receive information about workshops and meetings, please visit our website at https://sites.cdcr.ca.gov/ccjbh/ and subscribe to our monthly newsletter by emailing comionews@gmail.com.

"COMIO recognizes that mental health issues are far too prevalent in California's criminal justice system. Our role is to promote early intervention for youth and adults with unmet behavioral health needs."

-Secretary Scott Kernan

Introduction

INTRODUCTION

There were several recommendations from the Council on Mentally Ill Offenders (COMIO) 2016 Annual Legislative Report that warranted further action in 2017, including:

- Investigate strategies that prevent crisis and reduce the need for law enforcement responses
- Identify effective pre-trial diversion strategies, especially for those with complex co-occurring mental health and substance use treatment needs
- Develop community-based restoration models for individuals found incompetent to stand trial
- Provide opportunities for law enforcement and community correctional officers to build skills and support their own well-being so they can perform an increasingly demanding job
- Eradicate stigma and eliminate policies that implicitly or explicitly keep individuals with justice-involvement from having equal opportunities and access to housing, employment, and other community services and resources essential to recovery and well-being

The common variable needed to resolve each of these issues is ensuring community based behavioral health care alternatives to incarceration for individuals who are justice-involved or at risk of justice-involvement. In California, an essential resource that funds these alternatives is the Medicaid program, or Medi-Cal. California has been diligent about maximizing health care reform opportunities under the ACA, in particular, opportunities to expand community-based care for special needs populations. Due to the ACA, many of the formerly incarcerated or at-risk of incarceration became eligible for affordable health care services, mainly Medi-Cal services.

When the new federal administration proposed significant changes, if not the full repeal of the ACA, the capacity of Medi-Cal to support alternatives to incarceration became substantially threatened. In response, despite the importance and need for further work on issues identified in 2016, the Council elected to focus efforts in 2017 on better understanding how the current and expanded Medi-Cal program is working to support prevention, diversion, and reentry efforts for individuals experiencing significant behavioral health challenges (mental health and substance use disorders). By understanding the impact of Medi-Cal under the ACA, arguments can be made regarding its value and importance in preventing incarceration and supporting public safety.

CHANGES TO THE AFFORDABLE CARE ACT WITH THE MOST NEGATIVE CONSEQUENCES FOR THE JUSTICE-INVOLVED WITH BEHAVIORAL HEALTH TREATMENT NEEDS

- Elimination of the Medicaid Expansion (3.7 Million Californians)
- Elimination of the 10 Essential Health Benefits—including Mental Health and Substance Use Disorder Treatment
- Elimination of Protections for Pre-existing Conditions
- Elimination of the Entitlement Nature of Medicaid through a Per-Capita Cap
- Elimination of Premium Subsidies
- Elimination of the Individual and Employer Mandates

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
- 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 the following 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.

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 2017.
- 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.

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. The Council currently has two vacancies.

2017 POLICY FOCUS

With the expectation that difficult decisions may have to be made about the future of the ACA and California's Medi-Cal program, including which populations will remain eligible for what types of services, the 2017 COMIO Annual Legislative Report aims to:

1. Document the need and value of behavioral health services for those who are justice-involved or at-risk of involvement.
2. Identify how recent reforms to the criminal justice system have made behavioral health services a public safety issue.
3. Demonstrate that California's implementation of the ACA (such as Medi-Cal expansion) has expanded access to behavioral health services for the previously unserved or underserved justice-involved population.
4. Promote policies and practices, including the use of individuals with lived experience in behavioral health and/or criminal justice settings, which maximize the benefit of behavioral health care for the justice-involved.

In addition, continuing COMIO's support of the *Stepping Up Initiative* and related local activities and technical assistance, the report identifies model programs in six counties, which are working to achieve four critical outcomes that illustrate community behavioral health treatment is reducing incarceration. Those outcomes are reducing jail bookings, reducing time spent in jail, increasing connections to services, and reducing recidivism.

In order to thoroughly complete the report and to develop findings and recommendations the following activities were conducted:

- Quarterly council meetings and informational workshops with experts and fellow stakeholders representing over 40 different speakers and presentations
- Six county visits to multiple programs by staff with on-going follow-up
- A two-day educational site visit hosted by the Council with participation from multiple state and county partners
- Over a dozen key informant interviews
- Statewide online survey with over 350 responses from administrators, providers including peer specialists and community health workers, and service users
- Fact finding at state, local, and national conferences and trainings
- Literature reviews and secondary research

Background research, analysis, findings, and recommendations are organized in this report through the following sections:

- Section A: Maximize Behavioral Health Services for the Justice-Involved or At-Risk of Involvement
- Section B: Support and Expand the Impact People with Lived Experience have on Reducing the Incarceration of Individuals with Behavioral Health Challenges
- Section C: California Counties and Promising Programs to Prevent Incarceration

Section A

SECTION A

BEHAVIORAL HEALTH CARE AND THE JUSTICE-INVOLVED

THE NEED FOR BEHAVIORAL HEALTH CARE SERVICES

FINDING: The consequence of behavioral health needs not being met effectively in the community is costly. For many, if not the majority, correctional facilities provide incarcerated adults with their first access to preventive and chronic care, including treatment for substance use and mental health disorders. 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.

There is ample evidence that the incarceration of individuals with behavioral health problems is a national, state, and local crisis. Approximately 6.7 million individuals or 2.7 percent of the adult population is under correctional supervision on any given day in the United States.[1] This includes individuals in jails and prisons as well as those being supervised on probation and parole in the community. While there are some signs of progress in reducing incarceration, individuals with behavioral health problems remain significantly overrepresented in the criminal justice system. In an analysis produced by the Bureau of Justice Statistics, one in four (26 percent) jail inmates and one in seven (14 percent) prison inmates met the threshold for experiencing psychological distress in the last 30 days.[2] Moreover, 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] The high rates of substance use disorders also significantly burden the system. More than 50 percent of inmates in prisons and nearly 70 percent of those in jail met criteria for substance dependence or abuse in the year prior to their arrest.[4] These challenges follow them home as roughly 9 percent of probationers and parolees have a serious mental illness, and 40 percent have a substance use disorder.[5]

These numbers are fairly consistent with state prisons and local jails 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 October 2017, that number rose to almost 30 percent.[6] From the Legislative Analyst's perspective that number might be even higher as they reported in March of 2017 that one-third (38,000) of the inmate population in state prison were participating in a mental health program.[7] CDCR estimates that the need for psychiatric services will continue to rise in the years to come.[8] In addition, in a recent survey of California Sheriffs, Chief Probation Officers, and County Behavioral Health Directors, 42 out of California's 58 counties reported that the number of people with mental illness in their jails has grown in comparison to five years ago.[9]

The consequence of behavioral health needs not being met effectively in the community is costly. For many, if not the majority, correctional facilities provide incarcerated adults with their first access to preventive and chronic care, including treatment for substance use and mental health disorders.[10] A study by PEW and the MacArthur Foundation found that correctional spending on adults with mental illness alone is 2 to 3 times higher than for those without mental illnesses.[11] In California it costs an average of $71,000 per year to house an inmate so this figure only grows with more significant physical and mental health care needs.[12] Moreover, there are also costs incurred through the State Hospital system where roughly 90 percent of the individuals served are

2 MILLION ADMISSIONS to U.S. jails annually are persons experiencing mental illness. Of these, 3 IN 4 have a diagnosis of BOTH a substance use disorder and a mental illness.

(Feucht & Gfroerer, 2011)

"Of the nearly 10 million people released from correctional facilities each year, as many as 70 percent leaving prison and 90 percent leaving jail were estimated to be uninsured prior to the enactment of the Affordable Health Care Act (ACA).

In Medicaid expansion states, which broaden coverage to all adults who make less than 133 percent of the federal poverty level, as many as 80 to 90 percent of people leaving prisons are eligible for MediCaid."[23]

forensic commitments. In fiscal year (FY) 2017-18, $1.4 billion in State General Fund (SGF) resources were dedicated to State Hospital operations.[13] State correctional systems must provide a constitutional level of health care (including mental health) which is costly and funds must be drawn from the SGF, which also fund health and human services, schools and universities, roads and infrastructure needs, and so on, all of which can be negatively impacted when correctional costs take a great proportion of the budget.

Once incarcerated, people with mental illness stay longer and have higher recidivism rates.[14] In California despite the impact of reforms, the recidivism rate of individuals diagnosed with serious mental illness continues to be the highest among all populations at nearly 52 percent compared to 45 percent for those with no mental health designation.[15] While these costs to the correctional system are concerning, more important but difficult to accurately assess, is the cost to individuals and their families in terms of mental, physical, emotional, and financial losses. In addition, this picture is not complete without thinking about the needs of individuals who are returning home with significant behavioral health needs who will be on community supervision. In FY 2016-17 a total of 34,275 individuals returned to their communities from CDCR. Within that group, 25 percent were identified as having mental health needs ranging from severe to moderate and 55.5 percent as having substance use treatment needs. While those numbers are likely to shift slightly once home due to changing circumstances and stressors, clearly there is a significant need for behavioral health services upon re-entry.[i]

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. During this difficult time, drug use increases and there is a 12-fold increase in the risk of death in the first two weeks after release.[16] 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 substance abuse disorder, which are indirectly linked to recidivism.[17] Some studies show that past incarceration has a clear negative impact on health. Specifically, recently released inmates disproportionately use emergency departments 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.[18]

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.[19] These individuals reported poorer employment noting that health problems interfered with their ability to work and a need for housing assistance.[20] The U.S. Interagency Council on Homelessness assessed that nearly 50,000 people per year enter shelters directly after release from correctional facilities.[21] According to the Corporation for Supportive Housing, about half of the homeless report a history of incarceration, with one-third reporting a mental illness and two-thirds reporting a substance use disorder. In addition, parolees and probationers who are homeless are seven times more likely to recidivate. Of particular concern, a recent analysis by the DSH identified that of individuals found Incompetent to Stand Trail (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 percent to over 83 percent.[22]

The primary barrier to tackling complex health needs, like behavioral health challenges which increase the risk of recidivism, has historically been the large number of people who lack health insurance.

When Medicaid is available, there is ample evidence of cost savings to health and criminal justice budgets. A recent Washington State study showed that during a five year period,

[i] These numbers are provided by the Office of Research within the California Department of Corrections and Rehabilitation in October 2017

"Persons with severe mental illness who have Medicaid upon jail release will make more timely and more extensive use of community-based services than those without such benefits."[28]

substance use treatment for disabled adults provided under Medicaid accompanied a 50 percent reduction in rates of growth in medical and long-term care costs for the justice-involved population.[24] In Colorado, an audit by the state Medicaid program found that while $2.4 million over three years was allocated for substance use services, during its first two fiscal years it had already saved $3.5 million in programs participants' medical costs.[25] As far as reducing criminal justice costs, in another Washington State study the use of publically funded substance use services resulted in 18 percent fewer rearrests in the year following treatment.[26] In addition, a two year study of jail releases in Illinois, Washington, and Florida found that for those with serious mental illnesses, having Medicaid coverage and receiving behavioral health services was associated with a 16 percent reduction in recidivism.[27]

New guidance produced by the Bureau of Justice Assistance (BJA), the National Reentry Resource Center (NRRC), and the Council on State Governments (CSG) Justice Center documents the research that demonstrates the link between health care coverage, increased likelihood to use community-based services, and therefore reduced chances of recidivism.[29] For California, an expansion state, Medi-Cal has become one of the most powerful tools in preventing incarceration and recidivism and therefore a significant instrument in improving public safety. But as the report further contends, that while strides have been made to support recovery, wellness and avoidance of the criminal justice system, state and local governments have struggled to implement policies and practices that increase access to health care coverage and services. The remainder of this section of the report will highlight California's unique opportunity to optimize the existing local landscape despite federal policy uncertainty to support health and public safety.

CALIFORNIA REFORMS TO THE CRIMINAL JUSTICE SYSTEM MADE BEHAVIORAL HEALTH SERVICES A PUBLIC SAFETY ISSUE

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.[30] 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 substance use disorder, 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.

Unfortunately, these efforts began during a time of economic turmoil due to the "great recession" which resulted in billions in state budget deficits that took a weighty toll on local safety net programs. In 2009 Senate Bill (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.[31] But it wasn't until Public Safety Realignment in 2011 (Assembly Bill 109) 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.

With this shift, program and fiscal accountability could be aligned with local needs and priorities. The state provided a revenue stream to counties to support these new responsibilities. While that started small it has grown to over one billion in FY 2016-17.[32] The implementing language for Assembly Bill (AB) 109 required funds to be used for evidenced-based community correctional practices and programs, including rehabilitative services which may include substance use treatment and mental health treatment. Because the AB 109 population has significant behavioral health issues, many local leaders have chosen to dedicate resources to substance use and mental health treatment, in addition to housing and employment services.[33]

"Medi-Cal can't pay for housing and transportation which is what people need the most, especially parolees"

Peer Provider

A series of voter approved ballot initiatives followed the implementation of Public Safety Realignment 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.[34] 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 either returning home or remaining in the county impacted by the policy change were often in need of substance use and mental health treatment. The Safe Neighborhood and School funds established by the initiative uses funds calculated to be saved by the state and issues them to counties, with 65 percent dedicated to support mental health and substance use services.[35] In June 2017 the Board of State and Community Corrections (BSCC) issued roughly $100 million of this fund over a 3-year period to 23 local entities for local treatment and rehabilitation programming.[36] Finally Proposition 57 approved in November of 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.[37]

While these reforms in most cases came attached to resources to support needed community-based rehabilitative services, especially substance use and mental health services, there are significant competing needs locally. Public Safety Realignment funds also must support the increased demands on probation for community supervision and in some cases for sheriff's to ensure jails have appropriate rehabilitative programming and health services. An analysis of the initial realignment implementation plans found substantial variance by county on how funds were spent. Program and service expenditures such as mental health and substance abuse treatment ranged by county from zero to 84 percent with half of the counties directing between 8 and 33 percent of all resources to this category.[38]

Recently, the California Mental Health Planning Council produced a brief that interviewed criminal justice and behavioral health leadership from four diverse counties regarding their perspectives on how realignment implementation has evolved over the past five years. Most respondents noted that as years have passed cross collaboration among county implementers (e.g. probation, sheriff, and behavioral health) has grown and more resources have been directed to behavioral health services recognizing the extensive need. Yet the report noted a, *"resounding request for sufficient funding for programs, and for those programs to include transitional and support services, housing options, and vocational/ educational services."*[39] A specific and current analysis that studies if, and to what extent, investments are being made in treatment programming with AB 109 funding is much needed.

There are some positive signs reported in the July 2017 Annual Report on the Implementation of Community Correctional Partnership (CCP) Plans, which are the local vehicles that document how Public Safety Realignment funds are spent. This includes survey results that find that 38 percent of jurisdictions are working on efforts to improve treatment for offenders with mental illness and 45 percent are working on community or transitional housing.[40] Yet, realigned funds, even if multiplied, could not address the scope and need for justice-involved individuals with complex needs which range from housing and employment to behavioral health treatment. Every need must be strategically addressed by an available and allowable funding source. Which is why maximizing new opportunities under the ACA has been critical to California's public safety goals.

HEALTH CARE REFORM PROVIDES ENHANCED BEHAVIORAL HEALTH SERVICES AND SUPPORTS PUBLIC SAFETY

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.[41] Beginning in 2014 many, if not most, of the formerly incarcerated or at-risk of incarceration became eligible for affordable health care services for the first time. Prior to the ACA approximately nine out of ten individuals who spent time in county jails were uninsured.[42]

The ACA prompted rebuilding California's public health care safety net, including behavioral

health services, which had been acutely impacted during the "great recession" of the late 2000s. This was unfortunate because behavioral health services already had historically suffered from chronic underfunding due to the stigma of mental illness.[43] While the MHSA, a voter initiative that passed in 2004, was intended to expand community-based mental health services beyond existing resources, much of its role until more recently has been to fill deep fractures from depleted state revenue sources for mental health services due to the economic crisis. In addition, until the 2008 passage of the Mental Health Parity and Addiction Equity Act, private health insurance for mental health treatment was far more limited than coverage for medical or surgical benefits.[44] This lack of insurance coverage forced the public system to play the primary role in the delivery of mental health services in the state. Today, aid shoring up the gaping holes in the system is critical, as it is estimated that 5.1 million people or about 18 percent of the adult population in California need mental health care.[45]

In addition to the expansion of eligibility, the ACA established mental health and substance use disorder benefits as services covered as *Essential Health Benefits.* The ACA requires that all insurance plans must cover essential health benefits without annual caps aiming to lessen 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.[46] Coupled with the 2008 MHPAEA, the significance of this cannot be emphasized enough, especially for individuals needing substance use services because the need is not minimal. California's Department of Health Care Services (DHCS) estimates that 13.6 percent of the newly eligible Medi-Cal beneficiaries have a SUD treatment need.[47] 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. In states that expanded Medicaid, the share of people with substance use or mental health disorders who were hospitalized but uninsured fell from roughly 20 to 5 percent.[48]

1. *RECOMMENDATION:* Preserve and protect California's expansion of Medi-Cal and mental health and substance use disorder treatment as essential health benefits. The success of public safety realignment and criminal justice reforms in California is significantly reliant on expanded Medi-Cal eligibility and services, especially behavioral health services. Protecting this expansion is paramount to address overcrowded jails and prisons, but more importantly, to serve people with behavioral health needs in the community before they are in crisis or at-risk of incarceration.

Regardless of justice status there is evidence that Californians are not accessing the mental health and substance use services they need or are entitled to. For example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports that one-third of people with serious mental illness do not receive any treatment.[49] According to the 2015 California Health Interview Survey, 40 percent of individuals who stated they needed help for a mental/emotional and/or substance use issue did not receive treatment.[50] There are clear requirements that MHPs and Medi-Cal MCPs must produce comprehensive beneficiary handbooks that are written in a user-friendly manner and that aim to explain and de-mystify how to access mental health services.[ii] County behavioral health department websites contain a significant array of information yet based on key informant

MEDI-CAL UTILIZATION PROJECT

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, the project aims to study patterns of health care service utilization among former offenders released from CDCR. Considering the high rates of behavioral health needs among the justice-involved population, a better understanding of *if* and *how* these individuals use their health care benefits is needed to inform policy and practice decisions. The Council hopes that findings from this project will:

- Inform and increase understanding among policymakers and program administrators regarding health care utilization of former offenders,
- Provide information to state and county administrators to consider supporting decision-making and improve service delivery to the formerly incarcerated with complex health needs, including behavioral health, and
- For the sub-population of individuals who use a significant amount of resources (e.g. high-utilizers) within this cohort, seek to bend the cost curve by targeting them with interventions.

[ii] How a county complies with this requirement can vary. For some examples please review "the navigator" from Orange County http://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=50069 and the Mental Health Members Handbook from Sacramento County http://www.dhhs.saccounty.net/BHS/Pages/Members-Handbook/GI-Provider-Resources-Members-Handbook-Mental-Health.aspx

interviews and survey data collected by COMIO staff, providers and service-users alike expressed not knowing how to effectively access community-based Medi-Cal mental health services. In other words, it is likely that those needing help that did not receive it may have been caused by a lack of understanding on how to access the system rather than an unavailability or inaccessibility of services.

FINDING: The benefits of behavioral health services are clear but what is less clear is how someone accesses services in the community and what can one expect to receive. Individuals, whether they are administrators, providers, or service-users cannot advocate for the help that is needed without knowing what individuals are lawfully entitled to and what is readily available.

It is not surprising that understanding the public system of behavioral health care is challenging. The governance and funding structure is complex due to 60 years of incorporating new laws and changing roles.[51] Considering Medi-Cal's essential role, especially for a population of newly eligible individuals with justice-involvement, it warrants taking time to outline some basic information regarding funding, governance, and what services a beneficiary can expect to receive as a Medi-Cal beneficiary. In terms of the varying responsibilities among different levels of government, in brief they are:

- Federal: The Centers for Medicare and Medicaid Services (CMS) set standards for Medicaid programs to provide regular oversight and provide federal financial participation to match eligible state and local expenditures
- State: The California Department of Health Care Services (DHCS) provides oversight of the Medi-Cal program, develops California's Medicaid State Plan (*who gets what service and for how long*), and uses waivers to test new ways to improve service delivery
- County: Administers and contracts with providers for mental health and substance use disorder programs for Medi-Cal enrollees

Depending on the severity of the behavioral health condition, Medi-Cal services are either provided by the county Specialty Mental Health Service System for acute impairment or for mild to moderate conditions, through Medi-Cal MCPs or the state fee-for-service system.

While there are several funding sources that support the community-based mental health system, federal funds represent roughly 40 percent of all funding and this has grown due to Medi-Cal expansion. Federal funds reimburse local entities (state/counties) for the Medicaid services they provide. These payments match local spending which is 50 percent for those enrolled prior to 2014. With the ACA, 100 percent of the services provided to individuals enrolled in 2014 through the end of 2016 are covered by the federal government, with locals picking up 5 percent in 2017 and gradually increasing to 10 percent by 2020. In addition, there is a small amount of federal block grant funding available for community-based mental health and substance use treatment under the Substance Abuse and Mental Health Services Administration. As of now, Medi-Cal is an entitlement program with a legal obligation to pay for all medically necessary services and counties cannot set predetermined spending limits for Medi-Cal beneficiaries.[53]

In addition to federal funds, other revenue sources generated from state and local taxes and fees are deposited into the Mental Health Services Fund, 1991 Mental Health Realignment Account, or the 2011 Behavioral Health Subaccount. Together these resources fund the public behavioral health system.[iii] Each funding source comes with its own allowable set of expenditures and requirements. The 1991 realignment revenue was originally intended to fund safety-net services for those without Medi-Cal or for a service that was not Medi-Cal reimbursable, such as inpatient care in a locked long-term facility.

"Medicaid is the single largest payer for community mental health services and also increasingly for substance use treatment"[52]

[iii] While there might be small additional funding available, such as funds from county imposed fees or taxes or grant funds, they do not constitute a significant portion of the overall system's funding. This is also true at the federal level, where there are some small categorical grant programs but they do not represent significant funding sources attached to policy guidance for programs and services like Medicaid. As such, this report focuses only on funding sources that are substantial and not specific to only one county but rather funds that are available to all of California's counties.

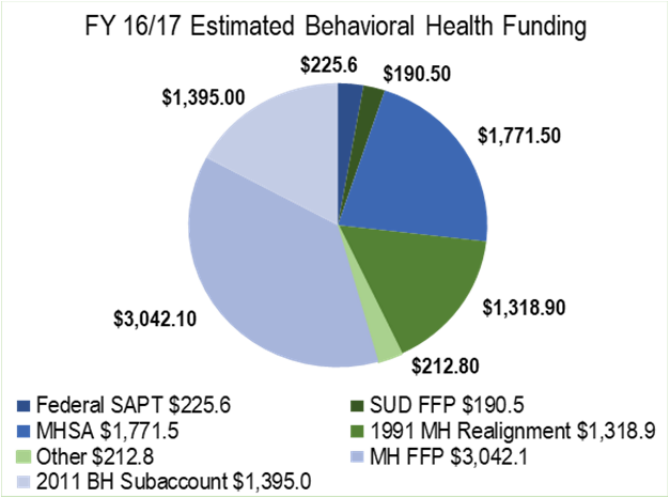
Over time, these funds have been used more and more as match to draw down federal funds for Medi-Cal. 2011 realignment completed the transfer of full responsibility for the delivery of public behavioral health services to the counties with additional resources that now meant counties were administratively and financially responsible for various drug and alcohol treatment programs; the Medi-Cal Mental Health Managed Care Program; and Medi-Cal's Early and Periodic Screening, Diagnosis and Treatment program for children.

MHSA funds provide a flexible source of funding and often are used to fill gaps and pay for individuals or services that other funding sources may not cover, like capital facilities projects, housing, and workforce development. MHSA funds are intended to serve children with serious emotional disturbance (SED) and adults with serious mental illness (SMI), as defined by law, which also specifically mentions that funds should be used to aid the "unserved, underserved, or inappropriately served" such as the homeless, frequent users of hospitals, and those with criminal justice history.[iv] MHSA funds represent a noteworthy amount of resources for the public community-based mental health system but they are not as robust as other funding sources. In 2016, roughly 1.8 billion in revenue came from MHSA, but that was far less than federal funds, which were roughly $3.5 billion, and funds from the realignment accounts combined added up to roughly $2.7 billion (See Figure 1). Moreover, MHSA funds have several restrictions. For example, they cannot pay for care for someone who is in an institution, including mental health services delivered in jails and prisons as well as for services for parolees (Welfare Institutional Code 5813.5 (f)). In addition, since the primary goal of the MHSA is to expand services, there is a maintenance of effort (MOE) clause that requires that the state maintain funding for existing community mental health services. A lawsuit in 2008 found that while the state cannot reduce total funding for mental health services below the amount spent when the initiative was approved by voters (2004), the MHSA MOE does not protect individual programs from elimination.[54]

The various funding sources described above all have an important role to play in understanding *who is eligible* for *what services* under what *set of rules*. For the Medi-Cal service user, what is really important is to understand whether you are part of the Medi-Cal Specialty Mental Health System or the Medi-Cal Mental Health Outpatient System.

"Medi-Cal specialty mental health services are defined as services provided under the waiver to Medi-Cal beneficiaries who meet specified medical necessity criteria."[55]

FIGURE 1: FY 16/17 Estimated Behavioral Health Funding



**Geiss Consulting*

[iv] The complexities of funding California's behavioral health system are vast and beyond the scope of this report. For more information we suggest reviewing a series of helpful documents produced by Harbage Consulting for the California Health Care Foundation, including *A Complex Case: Public Mental Health Delivery and Financing in California* and *The Circle Expands: Understanding Medi-Cal Coverage of Mild to Moderate Mental Health Conditions* both are available at www.chcf.org

The federal government approves and oversees California's Medicaid program—Medi-Cal—to ensure compliance while the state, through the DHCS, oversees local MHPs administered by counties to ensure that Medi-Cal services are accessible, cost-effective, and high quality. Medi-Cal mental health services are provided under the 1915(b) waiver which allows California to create a managed care program for specialty mental health services and this is commonly referred to as the "carve out", which requires Medi-Cal beneficiaries to access specific services through a county-operated Mental Health Plan.

Counties provide mental health services to Medi-Cal beneficiaries who seek services on their own, if the person is on a psychiatric hold (involuntarily), or referred by primary care, law enforcement, county welfare departments, etc. Through an assessment, the MHP determines medical necessity according to California Code of Regulations, Title 9 Section 1820.205 to include:

- Diagnosis (at least 1 of 18 specified by law)
- Impairment (significant or probability for deterioration) in an area of important functioning
- Intervention (availability of services that can address the impairment which would not be responsive to physical health care based treatment, in other words, need for more than non-medication interventions)

Specialty Mental Health Services Covered Under the Waiver:

- Outpatient Services (assessment, service planning, therapy and rehabilitation which is individual or group, collateral which is training or counseling for family members)
- Targeted Case Management
- Medication Support
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services
- Adult Crisis Residential Services
- Psychiatric Hospitalization

MHPs also must provide a toll-free phone number 24 hours per day 7 days per week to inform callers about available services.

As mentioned previously, under the ACA in 2014, Medi-Cal MCPs are now responsible for providing services to support those with mild to moderate behavioral health conditions who do not meet the threshold of severity and impairment required to access the Specialty Mental Health Service System described above. Covered outpatient services include:

- Individual and group psychotherapy
- Psychological testing
- Psychiatric consultation
- Medication management
- Certain supplies and supplements[56]

No longer can MCPs limit services and require treatment authorization for more than two visits. Recognizing that behavioral health challenges can often fluctuate in severity and impairment requiring various levels of service, an individual who needs more intensive services is transferred to the Medi-Cal Specialty Mental Health System. MHPs and MCPs aim to seamlessly move individuals between the systems ensuring adequate levels of service need, which are contractually managed and monitored.

Finally, there are also non-county mental health managed services for behavioral health issues. Federally qualified health centers (FQHCs) and rural health centers (RHCs) have been serving individuals, whether a Medi-Cal beneficiary or not, for quite some time who did not meet the criteria for Medi-Cal Specialty Mental Health Services. After 2014 and the expansion of services to the mild and moderate, FQHCs have played a critical role in providing behavioral health services to Medi-Cal beneficiaries, in particular the formerly justice-involved returning home from incarceration. FQHCs over the years have become leaders in providing integrated physical and behavioral health services, despite payment disincentives. In October 2017, Governor Edmund J. Brown Jr. signed SB 323 (Mitchell) which provides FQHCs and RHCs the ability to provide substance use disorder services by adding the ability for these centers to participate in the Drug Medi-Cal Program. In addition, the legislation declares the intent of the Legislature to authorize an FQHC or RHC to be reimbursed for

"MHPs also are obligated to ensure access to services by having adequate numbers of qualified providers, institutional facilities, and service sites."

(Arnquist & Harbage, 2013)

"There has to be a better way to get people connected to services before they leave jail or prison"

- Peer Provider

Specialty Mental Health Services.[57] This policy can assist in increasing the provider network that MHPs need to support the increasing demand for behavioral health services.

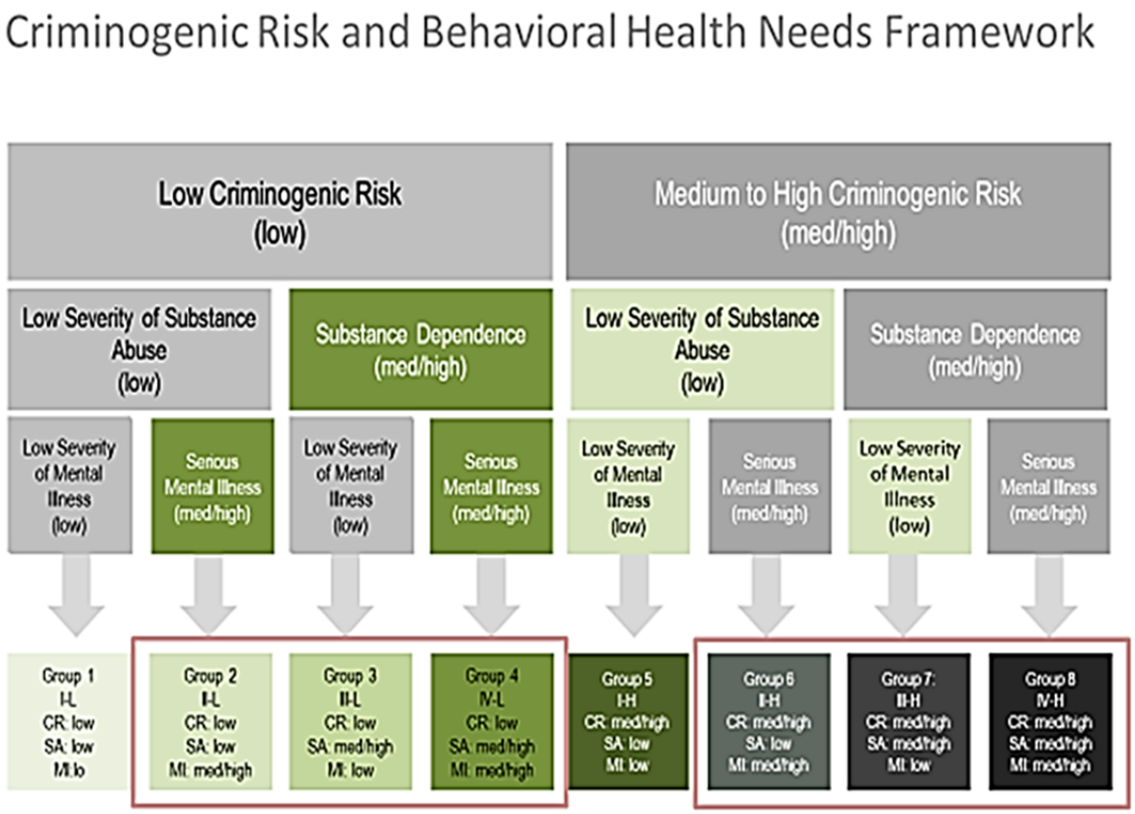
2. *RECOMMENDATION:* MHPs and Medi-Cal MCPs are required to provide easy to understand information about benefits and how to access services. Leverage such efforts by assessing for accessibility to various justice partners, providers and service users. Offer recommendations for improvements if needed. Raise awareness about such resources and use dissemination channels including making the information available on COMIO's website as well as the websites of other justice partners.

WHAT CAN BE DONE TO MAXIMIZE THE BENEFIT OF BEHAVIORAL HEALTH CARE FOR THE JUSTICE-INVOLVED?

Screening and Enrollment

FINDING: Significant improvements have been made to expand the number of Medi-Cal benefits to individuals with behavioral health challenges and justice-involvement or risk of involvement, but more can be done.

FIGURE 2: Criminogenic Risk and Behavioral Health Needs Framework



Source: Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery

"The results of screenings and assessments are used to inform key decisions related to pre-trial release, diversion, discharge planning, and specialized pre-trial and post-conviction community supervision."[59]

The Council strongly supports robust efforts to divert individuals from incarceration, hopefully using that often newly acquired Medi-Cal benefit to access timely and effective behavioral health services in the community. Unfortunately, and as we have discussed in this report and in reports from previous years, the significant lack of community capacity for alternatives to incarceration requires systems to be prepared to explore a variety of options to increase connections to care for those exiting incarceration. Entering jail or prison is the first point where several critical actions can begin to best prepare for high risk and high need individuals to be connected to care, including acquiring the benefits needed to cover the costs of such care.

Universal screenings using valid and reliable instruments can be conducted at booking or intake and throughout the criminal justice continuum to detect substance use disorders, mental illness, co-occurring substance use and mental disorders, and criminogenic risk.[58] The CSG Justice Center, in support of the *Stepping Up Initiative* clearly states the value of such efforts.

"The results of screenings and assessments are used to inform key decisions related to pre-trial release, diversion, discharge planning, and specialized pre-trial and post-conviction community supervision."[59]

Moreover, this information facilitates planning and can initiate the sharing of information across criminal justice and behavioral health entities. For example, the *Stepping Up* report outlines work in Salt Lake County, Utah where beginning in 2015 anyone with class B misdemeanor or higher is screened for mental health, substance abuse, and criminogenic risk at booking. Doing so has allowed the county to establish a baseline of prevalence and, moving forward, supports planning efforts and where to focus resources.

3. *RECOMMENDATION:* Support the use of universal screening with reliable and validated tools for mental illness, substance use and/or co-occurring disorders, and criminogenic risk at jail intake and identify strategies to resource such efforts. Doing so will provide valuable information to support diversion, needed services, and improved connections to necessary care.

Entry into incarceration also provides an opportunity to screen for Medicaid and other benefit eligibility like Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Veterans Administration (VA) benefits. Considering the significant number of uninsured persons in jails, the Public Policy Institute of California (PPIC) concluded,

> *"Enrollment assistance efforts offer the potential to leverage federal and state Medi-Cal resources to improve access to needed physical and behavioral health resources for the re-entry population ... reducing recidivism and the associated cost savings have the potential both to reduce correctional cost burden on counties and to free up resources for additional reentry programming."*[60]

The analysis further states that most counties provide some kind of health insurance enrollment assistance and the cost to do so is covered in various ways including public safety realignment funds, county general funds, and state and federal Medi-Cal administrative funds. CCPs established under public safety realignment, could be an effective place to coordinate aggressive enrollment strategies between correctional and court systems and social services and health systems and set priorities for enrollment. Pre-trial diversion, probation and parole are all points in which Medi-Cal enrollment could be addressed.

The Centers for Medicaid and Medicare Services (CMS) made it clear in State Health Official Letter 16-007 that Medicaid screening and enrollment can take place during incarceration and that state Medicaid agencies must accept applications from inmates during their incarceration and if eligibility is met, must

enroll or renew the enrollment effective before, during or after the period of time spent incarcerated.[61] Yet, although inmates may be enrolled in Medicaid during incarceration the guidance made it clear that Medicaid will not cover the cost of care unless it is for inpatient services.[v] The National Association of Counties continues to urge Congress to pass legislation to ease the inmate exclusion for those who are pre-adjudicated and residing in county jails.[vi]

At CDCR the Division of Adult Parole Operations (DAPO) Transition Case Management Program provides pre-release benefits assistance to all eligible inmates approximately 90 to 120 days prior to release. Through benefit employees under contract they assist with completing applications for Medi-Cal, Social Security, and Veterans benefits. The success rate for Medi-Cal approval is improving moving from 70 percent approved in FY 2015-16 to 86 percent in FY 2016-17.[62] On the other hand, the same level of success has not materialized for Social Security Assistance and Income (SSA/SSI) and VA benefits and the California Rehabilitation Oversight Board has recommended that CDCR further examine the cause of the lower approval rating in the future.[63]

Here are a few additional examples from states that were identified through a collaborative effort by BJA, NRRC, and CSG Justice Center regarding how to connect people exiting jails and prisons to mental health care and substance use treatment.[64]

- In Minnesota a law requires that all individuals be screened at jail intake for enrollment in health care coverage and if someone is already insured he or she must provide necessary insurance information to the sheriff
- The Illinois Department of Corrections established a policy where jail personnel verify benefit status, including health care coverage at intake. If there is not coverage, staff complete screenings to determine eligibility for Medicaid or coverage through the health insurance marketplace. If transferred to prison, this information follows them and records are flagged either already enrolled, in the marketplace, or newly eligible
- In New York City, the Department of Health and Mental Hygiene uses state-funded discharge planning staff to conduct Medicaid screening for all individuals with mental illness and recently expanded this process of eligibility and enrollment to include individuals with substance use disorder and chronic medical conditions

STATE LAWS AND OTHER ACTIONS THAT PROMOTE OR MANDATE APPLICATION ASSISTANCE FOR PEOPLE IN CORRECTIONAL FACILITIES:

- *A 2015 New Mexico law (SB 42)* specifies that for all prisons and jails in the state, people who are not enrolled in Medicaid when their incarceration begins will be allowed to submit a Medicaid application during their incarceration.
- *A 2015 Illinois law (HB 3270)* requires state prisons to provide Medicaid application assistance for those not already insured at 45 days prior to release.
- *A 2015 Indiana law (HEA 1269)* requires sheriff's departments to assist people who are incarcerated for more than 30 days in applying for Medicaid prior to discharge or release from county jail.
- *Under a 2013 memorandum of understanding (MOU)* between the Connecticut Department of Corrections (DOC) and the Department of Social Services (DSS), DSS provides dedicated staff to process Medicaid applications that have been completed by the DOC's discharge planners. The positions are funded by the DOC, the Judicial Branch, and the Department of Mental Health and Addiction Services. Initially, prerelease enrollment efforts focused on people with serious mental illnesses; they have since expanded to include everyone being released.
- *Washington State's Health Care Authority (HCA)* accepts applications for Apple Health benefits (the state's Medicaid benefits) for people who are incarcerated no more than 45 days before the expected release date. To facilitate the timely processing of applications prior to release, interested correctional facilities can sign an MOU with the HCA to define the exact roles and responsibilities of the facility and the HCA and the timeline for the submission and processing of applications. It is unclear just how many states require correctional agencies to provide prerelease assistance with Medicaid applications. States such as New Mexico and Indiana are undertaking universal, system-level approaches to increasing enrollment for people leaving prisons and jails, whereas other states have chosen to authorize staff to check for eligibility and file applications on behalf of consenting individuals without a specific state mandate, leaving the choice of whether and how to provide assistance in the hands of correctional and local officials. Other states require staff to help with applications only in particular prisons or jails.

(Plotkin & Blandford, 2017)

[v] The 2016 Annual Report provides a richer and more detailed summary of 16-007 in addition to recommendations regarding the guidance it has provided, this information can be found at: http://www.cdr.ca.gov/COMIO/docs/2016_Annual_Reprort/Diversion%20Section.pdf

[vi] An inmate of a public institution including correctional institutions. Correctional institutions include state or federal prison, local jails, detention facilities or other penal settings. An important consideration of whether a person is an inmate is his or her ability to exercise personal freedom.

It is common sense that screening for health care coverage and other benefits during incarceration is valuable but doing so is challenging due to the short length of stay in jail and limited resources. According to a 2017 policy brief from the National Association of Counties (NACo) 11.4 million individuals pass through 3,100 local jails each year with an average length of stay of only 23 days.[65] Some report there is even a significant number of individuals that exit jail in less than 48 hours. Therefore, screening at intake, and ideally as part of a behavioral health assessment, is ideal. To support expanded efforts to screen for benefit eligibility, local policymakers are encouraged to examine if and how criminal justice professionals can be given the clearance they need to directly access state data systems regarding Medicaid enrollment status. If not possible, strategize with partners that can, like behavioral health and health care partners and contractors. Final decisions regarding who is doing what should consider who could be reimbursed for such activities.[66]

4. *RECOMMENDATION:* Support screening of eligibility for health care coverage and other benefits at intake in jails and prison and identify strategies to resource such screening, either among custody staff or in partnership or under contract with health and social services staff. Efforts should be consistent with local eligibility screening and determination processes and protocols.

For those who cannot be screened prior to release, some strategies would include providing the individual with information about where they can go to have the process completed in the community. Probation and parole offices should all be equipped to screen for eligibility and assist with enrollment. If someone is staying for a longer period of time, for example those serving sentences in prisons, benefit eligibility may be done at intake or if inpatient services are needed. It is more likely only done prior to release because depending on state policies someone may be terminated from Medicaid after a certain period in time. California state law currently requires that suspension eligibility status can only be maintained for one year and after that a new application is required. But suspension does not have to have a time limit, it can be indefinite. Suspension policies reduce administrative costs, ensure that inpatient care is reimbursed, and expedites the reactivation of benefits upon community reentry supporting continuity of care.

CMS has long encouraged the use of suspension policies and for suspension to be lifted promptly. CMS reaffirms this on the 16-007 letter noting that the state may either suspend the person's eligibility or leave enrollment unaltered or ensure that claims are not approved for excluded services. One way this can be done systematically is by establishing "edits" in the state Medicaid claims processing systems. Edits are automated safeguards that states use through their Medicaid program to prevent improper payments.[67]

Sixteen states now have suspension policies without any time limits. In Arizona suspension agreements are in place for the Department of Corrections, the Department of Juvenile Corrections and 9 of the 15 county jail systems, covering 90 percent of the incarcerated population. Participating jails and prisons send a daily file of bookings and releases electronically to the state Medicaid agency. The agency discontinues capitation payments to the managed care plans and when individuals exit, coverage is reactivated without having to apply. The state Medicaid agency also processes renewals (re-determination) during incarceration.[68]

All states are subject to the federal requirements of redetermination each year with some variance and flexibility on how it is done locally. SAMHSA contends that one of the reasons people who are incarcerated more than a year lost Medicaid eligibility is due to the lack of redetermination paperwork being submitted. California can examine these policies, possibly streamlining and simplifying them to ensure there is capacity for compliance.

5. *RECOMMENDATION:* Remove the one-year limitation on California's Medi-Cal suspension policy and instead, support indefinite suspension so that benefits can be activated immediately upon release to achieve continuity of care. There have been recent legislative proposals regarding this that have yet to be successful. This is likely due to possible costs to the state general fund or concerns about federal approval. Follow-up to determine what the barriers have been, and if there are possible resolutions or alternatives. Support policies that are more likely to sustained health care coverage, including the development of a simplified annual redetermination process for those in jail or prison.

Health Plan Assignment and Access

For many correctional facilities the ultimate goal of these efforts is to secure an insurance card prior to exiting incarceration but having a "card" does not necessarily mean having health care coverage. CDCR has invested considerably in eligibility and enrollment efforts which begin 90 to 120 days prior to release. CDCR submits completed Medi-Cal applications to the county agencies where the person's release is scheduled to take place. Counties try to expedite the process and notify CDCR pre-release staff if additional information is needed or if the Medi-Cal determination

will not be completed prior to release date. For jails how this is done is determined locally, and an entity like a community based agency can be contracted to assist with enrollment but only the county human services agency can make determinations.[vii]

Other states have also committed significant efforts to ensure benefit enrollment. Some examples include:[vii]

- In Ohio, the Department of Rehabilitation of Corrections uses trained peer educators (Peer-to-Peer Medicaid Guides) to not only help with the initial enrollment process but assist throughout the process and provide follow-up. Participants are then connected to a Medicaid Consumer hotline representative through a dedicated phone line and the application is complete in addition to selecting a managed care plan.
- In Connecticut, through an MOU between the Department of Corrections (DOC), the Department of Social Services (DSS) has a dedicated "pre-release entitlement unit" that only processes applications from the DOC. DSS has electronic access to DOC's roster to identify which people are discharged daily, so that DSS can activate a person's Medicaid coverage upon release.
- In Cook County Illinois, enrollment is part of the jail intake process were contractors collect eligibility and coverage information and verify identity through finger-print booking rather than traditional methods like driver's licenses which often are not available. Staff use computers that have access to the jail's information system, the state Department of Human Services' website, the county's application site, and verify zip codes online. As of January 2016, more than 15,000 people had been successfully enrolled since 2013.

Despite these notable efforts, there remains implementation challenges and primary among them is capacity. There are strategies to address capacity shortage in addition to staffing and information technology challenges which California could consider.

6. *RECOMMENDATION:* If capacity within correctional settings for enrollment efforts is limited, priority should go to people with health problems - physical and behavioral. This is another reason why is to so important to conduct an effective behavioral health assessment along with assessment of criminogenic risk to ensure those with the great needs returning to the community are the most likely to receive health coverage and other benefits.

7. *RECOMMENDATION:* Research what other states are doing through technology to expedite Medicaid eligibility and enrollment such as ease of imposing and lifting suspension status, use of peer educators to support managed care plan selection and other strategies to expedite access to reimbursable services.

Some states are looking to authorize correctional agencies as "qualified entities" to employ PE as a method to ensure immediate coverage for those exiting incarceration, especially jails since there is less time to establish eligibility.[69] PE allows for a rapid review of the full Medicaid application and benefits are approved for 30 days, and possibly 30 days longer is the application still has not been approved. PE has often been used in inpatient settings referred to as Hospital Presumptive Eligibility. For example, New Mexico submitted an amended Medicaid state plan in 2013 to allow for PE in its correctional facilities for people leaving who needed post-release medical and behavioral health care.[vii]

8. *RECOMMENDATION:* The Department of Health Care Services (DHCS), CDCR, and county stakeholders like behavioral health, social services, probation and the sheriffs' department can consider the feasibility of a state plan amendment that would establish short-term PE for those exiting incarceration whose eligibility cannot be determined at the point of release, particularly if they are in need of medical and behavioral health services upon release. The goal is to devise a reasonable strategy where Medi-Cal can support an individual's transition from incarceration to community.

"Without Medi-Cal we could not pay for the level of services needed. Before we had to string together county general funds, block grant funds, and find grant money … now we use Medi-Cal. We are looking to figure out how we can use the other funds for housing"

- Provider

[vii] In January 2017 the Bureau of Justice Assistance, the National Reentry Resource Center, and the CSG Justice Center produced a comprehensive report about strategies that connect people exiting jails and prisons to behavioral health treatment. The report titled "Critical Connections" has extensive examples of strategies being used across the country.

According to numbers collected by CDCR's Office of Research of the roughly 34,000 individuals exiting prison in FY 2016-17 nearly 25 percent have a mental health challenge that needs on-going treatment and half of those individuals or (roughly 16,800) are on parole.

An additional challenge is that plan selection is completed after release when a selection packet is mailed to a newly eligible individual. If the application is not completed a plan will be selected for the individual and during the time in which there is no plan, Medi-Cal services can only be reimbursed on a fee-for-service basis which could be a barrier to access. Furthermore, this population often does not end up residing in the community identified during the pre-release process and even if a plan is selected, it may need to be "re-selected" in the community of actual residence.

9. *RECOMMENDATION:* Address gaps that exist between eligibility, enrollment and service access due to an additional process of selecting a local Medi-Cal Managed Care plan and completing additional paperwork. Explore strategies where plan selection could be completed simultaneously with eligibility and enrollment processes, for example in small and rural counties that might only have one plan option. Prior to release individuals can receive support to choose a specific provider within the network of the plan selected.[viii]

Maximizing Federal Reimbursement for Medi-Cal Beneficiaries

FINDING: California and its county partners are not maximizing all opportunities for federal reimbursement for Medi-Cal beneficiaries. Maximizing federal reimbursement can preserve scarce state and local resources for needed, but non-reimbursable, services.

Considering the extensive needs of the justice-involved population with behavioral health issues, using every opportunity to expand financial resources, especially if they come from the federal government under the Medicaid, is a necessity. One area where more federal funds may be accessible is through some of administrative activities. On average 96 percent of Medicaid expenditures cover direct services but the other 4 percent cover administrative expenses. While health, mental health, and social service entities are familiar with Medicaid administrative claiming (MAC) few public safety entities participate in MAC even though they may be eligible and in California that would require partnership with the county MHP. It is important to note that federal funds can only be accessed when state or local funds (i.e. Realignment, MHSA, County General Fund) are used as match, or a Certified Public Expenditure. This ensures that "federal funds" are not being used to match other federal funds.

Based on an issue paper presented by Community Oriented Correctional Health Services (COCHS) to the Council earlier this year, the following activities are eligible for reimbursement:

- Referral, coordination and monitoring such as a probation officer monitoring his clients progress in a substance use treatment program
- Medicaid outreach such as helping a client schedule a doctor's appointment
- Arranging transportation to Medicaid services
- Medicaid eligibility intake, such as helping a client fill out a Medicaid application[70]

Policy changes here in California have also provided more opportunities to draw down federal funds for transportation costs, which are often cited as costly barriers to access to care. AB 2394 amended Welfare and Institutions Code Section 14132 so that as of July 1, 2017 MCPs must provide Non-Medical Transportation services subject to utilization controls and permissible time and distance standards so that MCP members can obtain Medi-Cal medical, dental, mental health and substance use disorder services.[71] Carved out Specialty Mental Health and Substance Use Disorders services also have to comply with these rules as of October 2017.

10. *RECOMMENDATION:* Public safety entities and county Mental Health Plans (MHP) 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. To support these efforts, counties should maximize the identification and use of available federal funding, as allowed (e.g., Medi-Cal Administrative Activities, Medi-Cal medical assistance).

[viii] It is important to note that securing other benefits like SSI/SSDI, VA, Calfresh, etc., are all important but this report focuses specifically on Medicaid/Medi-Cal

"We have the capacity to serve the parents of children in our care thanks to the Medi-Cal expansion. These are the individuals we were not able to serve previously."

-Provider

One of the best opportunities to capitalize on federal funds is to maximize federal reimbursement for parolee behavioral health services. As discussed previously, the Medicaid expansion created tremendous opportunities for access to behavioral health care and these opportunities are still quite new with lessons being learned daily regarding how to further the impact of the ACA. Prior to the ACA many, if not most, individuals returning home from incarceration were not eligible for Medi-Cal unless significantly impaired with a severe mental illness and qualifying for social security income (SSI). As a result a small number of individuals were eligible for county-delivered specialty mental health services. In addition, prior to recent criminal justice reforms, parole violators were a state responsibility and incentives were aligned for investments in mental health care with the goal of reducing recidivism. Today that is a very different picture with counties responsible for 50 percent share of cost for individuals eligible prior to 2014 and only 5 percent growing to 10 percent share of cost by 2020 for Medi-Cal beneficiaries enrolled after 2014. There is still a local share of cost for Medi-Cal service, recall that responsibility for behavioral health services has been completely realigned to the counties, and with ACA this share is reduced. Yet, for the time the vast majority of the justice-involved population coming home are entitled to the federal government covering the near majority of necessary health costs.

11. *RECOMMENDATION:* Over 85 percent of parolees are exiting incarceration as Medi-Cal beneficiaries. Identify mechanisms to ensure that parolees who are Medi-Cal beneficiaries have access to the services they are entitled to either through the Specialty Mental Health System or a Medi-Cal Managed Care Plan. Such work provides an excellent opportunity to strengthen collaboration between state and local partners.

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 often used to provide the match. The Medi-Cal expansion has complicated understanding how to comply with the MHSA parolee exclusion. Full Service Partnership (FSP)s 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.

12. *RECOMMENDATION*: DHCS, in consultation with behavioral health and criminal justice stakeholders, should 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.

Despite the Medi-Cal beneficiary status of parolees, the majority with mental health challenges receive services through state funded programs administered by CDCR. The mental health continuum of care developed by CDCR has functioned as a lifeline to the many individuals statewide that rely on such services, but capacity is small. According to numbers collected by CDCR's Office of Research of the roughly 34,000 individuals exiting prison in FY 2016-17 nearly 25 percent have a mental health challenge that needs on-going treatment and half of those individuals or (roughly 16,800) are on parole. Considering the entitlement Medi-Cal beneficiaries have to mental health and substance use treatment in the community, re-thinking how to maximize financial resources (federal, state, and local) for programs in this continuum is warranted.[ix]

[ix] It should be noted that there ae significant community programs for those experiencing substance use disorders administered by CDCR. It is currently not the scope of this annual report to include an in-depth analysis of these programs but it should be noted that similar to mental health care, substance use treatment is available to MediCal beneficiaries and strategies to maximize federal reimbursement should also be employed.

Currently, the state invests about $31.5 million in parolee mental health care in the community through three major programs:[72]

- *Parole Outpatient Clinics (POCs)* $16.5 million: POCs are staffed with psychiatrists, psychologists, and social workers who are available to assist parolees with community reintegration. POC provides services including the evaluation of mental illness, medication management, individual therapy, group therapy, crisis intervention, and case management. In addition, POC staff collaborates with Integrated Services for Mentally Ill Parolees (ISMIP) providers, connecting eligible parolees with mental illness to additional outpatient services.
- *Integrated Services for Mentally Ill Parolees* $12.3 million: The ISMIP Program provides comprehensive mental health and support services, including housing subsidies, to parolees who suffer from severe mental illness and are at risk for homelessness.
- *Case Management Reentry Program (CMRP)* $2.7 million: The CMRP is for offenders who are likely to benefit from a case management reentry strategy designed to address mental disorders, developmental disabilities, homelessness, and joblessness while serving a term of parole.

There is considerable confusion regarding who is eligible for what services and who is responsible for paying for them – see recommendations 2, 10, 11, and 12. During the Council's time talking to local administrators this year, there would be one county/provider willing to serve parolees on Medi-Cal while another county/provider would have concerns about a lack of capacity to do so. Capacity deficits were not simply financial but rather ranged from workforce, to a lack of facilities, to concerns about staff not having the appropriate skill set to serve the population. Above all there was clear acknowledgment that improvements needed to be made fairly urgently. These include the ability to draw down federal funds but also the need for continued state support for services and activities, especially those not traditionally funded by Medi-Cal including housing, workforce development, technology infrastructure, and facilities. In short, to address tremendous need and avoid recidivism (including individuals found incompetent to stand trial and sent to State Hospitals), homelessness and hospitalizations, state and local partners must leverage existing capacities while still maximizing federal, state and local funds.

13. *RECOMMENDATION:* Maximizing federal reimbursement for parolee mental health care will aid in supplying the resources needed to better address physical and behavioral health needs. The benefits and challenges regarding how to do so most effectively should be thoroughly examined in preparation for 2020 Medi-Cal waiver renewal.

Connections to Care

FINDING: Connections to care are fragmented and disjointed for a variety of reasons ranging from a lack of resources, *especially housing*, to complications with data-sharing to low capacity to navigate complex community health and service systems.

"Health insurance alone is not sufficient to effectively link people released from incarceration to community-based care"[73]

Efforts are needed to educate individuals about entitlements to behavioral health benefits and increase eligibility. Enrollment does not automatically transfer to increased health care consumption when individuals return home. One study found, that despite improvements in Medicaid coverage among the justice-involved population, *"persistently high un-insurance rates, lack of care coordination, and poor access to high quality behavioral health treatment remain critical public health issues given the high rate of mental health and substance use disorders among justice-involved individuals."*[74]

"Correctional partners are critical in achieving positive health outcomes for individuals returning from incarceration, but to date, health systems face challenges in forging these partnerships. Lack of discharge planning services from prisons and little access to correctional medical records creates significant challenges in caring for sick individuals in the community who are recently released from incarceration".

Dr. Shira Shavit, Executive Director, Transitions Clinic Network

Many people leaving prisons and jails have behavioral health disorders, frequently combined with physical illness, that need to be addressed within the context of a comprehensive reentry plan – a plan that builds on correctional agencies investment in an individual's treatment during incarceration. The APIC (Assess, Plan, Identify, Coordinate) Model provides guidance for behavioral health, criminal justice system, and community stakeholders to work collaboratively across systems to design and implement evidence-based programming to forward the dual goals of individual recovery and risk reduction.

(Osher, Steadman, & Barr, 2002)

ASSESS the individual's clinical and social needs and public safety risk.

GUIDELINE I

Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

GUIDELINE II

For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on:

- Basic demographics and pathways to criminal involvement
- Clinical needs
- Strengths and protective factors
- Public safety risks and needs

PLAN for the treatment and services required to address the individual's needs, both in custody and upon reentry.

GUIDELINE III

Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process to:

- Determine appropriate level of treatment
- Identify and target individuals' multiple criminogenic needs
- Address aspects of disorders that affect function
- Develop strategies for integrating appropriate recovery support services into service delivery models
- Acknowledge dosage of treatment as an important factor in recidivism reduction

GUIDELINE IV

Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

IDENTIFY the required community and correctional programs responsible for post-release services.

GUIDELINE V

Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings

GUIDELINE VI

Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages for post-release treatment and supervision agencies.

COORDINATE the transition plan to ensure implementation and avoid gaps in care with community-based services.

GUIDELINE VII

Support adherence to treatment plans and supervision conditions through coordinated strategies to:

- Maintain a "firm but fair" relationship style
- Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions

GUIDELINE VIII

Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.

GUIDELINE IX

Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with co-occurring disorders who are involved in the criminal justice system.

GUIDELINE X

Collect and analyze data to evaluate program performance, identify gaps in performance, and plan for long-term sustainability.

Research demonstrates that there are key ingredients to successfully link justice-involved individuals to community-based care:

- Use clinically effective treatments and strategies,
- Supply access to behavioral health services which can be cost-effective and result in overall medical cost savings, and
- Engage people in health care immediately upon release, which may play a role in reducing recidivism, especially with people with behavioral health needs.[75]

Engagement does not need to wait until someone is home but rather begin as part of the pre-release and discharge planning process. Lessons can be learned for behavioral health service delivery from efforts to support individuals returning home with serious medical conditions. Project Bridge in Rhode Island sends personnel into the correctional setting before HIV infected individuals are released and links them to hospital based clinics. Intensive case management services after release are used and have been much more successful at retention in post-release services than a standard referral process.[76] Another example is the Transitions Clinic Network, which *"is a consortium of primary care clinics that aim to increase access to health care services, improve health, and reduce recidivism among high-risk, chronically ill people recently released from prison"*.[77]

The model provides transitional and primary care with case management and linkages to clinics located in neighborhoods with high concentrations of formerly incarcerated individuals, use of physicians who have worked with this population, and most importantly trained and employed formerly incarcerated individuals as community health workers. One study demonstrated that participants randomly assigned to TCN had 50 percent fewer emergency department visits during the first 12 months post incarceration over standard safety-net community health centers with over a $900.00 per patient cost-savings per year.[78]

TCN staff aim to conduct discharge planning while individuals are still incarcerated which facilitates engagement but also medical record and information exchange. Ideally a comprehensive referral from a correctional partner would identify individuals who have chronic health conditions, including behavioral health, in enough time prior to release to create a care transition plan with the aid of a community health worker. Such a plan includes determining reentry services, scheduling medical appointments, and obtaining medical records. While care coordination varies by correctional facility, the goal is always to engage the individuals in care as soon as possible upon release.[79] Community health workers serve as the primary engagement agent meeting with individuals during clinic visits and helping with the challenges of reentry such as finding housing and employment, navigating the probation or parole system, and dealing with legal issues.

"They use their personal experience with incarceration to educate the health care team about the patient's challenges, facilitate patient-provider communication, and help patients navigate the medical system and build trust in it".[80]

Moreover, as shared in a presentation to the Council, the emotional support and mentorship community health workers bring is the "special sauce" of the TCN model.[x]

Other analyses from similar models have identified effective strategies to keep individuals who need treatment for chronic medical conditions post incarceration retained in services, include developing:

- New staff competencies that require understanding and addressing the complex interrelated needs of the justice-involved including health, legal, social, and economic needs,
- Robust collaboration between correctional professionals, health plans, and community providers to break down barriers to support services linkage, and
- Strategies to address the lack of functional information exchange between justice settings and community based health care systems. [82]

Like the results from the TCN model regarding exiting prison, there is research that demonstrates similar effectiveness when exiting jail. For example, the Jail In-Reach Project in Texas which targets individuals with frequent jail admissions who are diagnosed with a behavioral health disorder (SMI, SUD or COD) and who are homeless or at risk of homelessness at discharge found that targeted efforts at high risk populations coupled with intensive planning and services significantly improves outcomes.[83] Elements of the model include early pre-release planning, involving clients in designing their treatment plan which includes medical and behavioral health services, activation of social services (housing, job training and life skills counseling) and a direct daytime release to a service provider/case manager. The direct release is critical as 86 percent of the participants that opted for direct release were successfully linked to services while only 28 percent were linked if they opted for self-release, which also were often in the middle of the night.[84] Those who were engaged in services after release had arrest rates that were 36 percent lower compared to the year prior and the total annual criminal charges for each participant also reduced by 56 percent during the year after contact with the programs.[85]

It is not surprising, and quite positive, that pre-release and discharge planning coordination efforts are more common at the local level but resourcing these efforts remains a challenge. In work the CSG Justice Center conducted on behalf of Franklin County Ohio, CSG offers suggestions on how Medicaid funds might be able to assist with jail "in-reach" programming and support continuity of care. In addition to establishing Medicaid eligibility and conducting enrollment efforts, they recommend instituting a permanent jail liaison team that supports the smooth transition of the individual exiting jail to community services by making appointments prior to release and then continuing to provide connections to care and services in the community for upwards of 30 months.[86] Several California counties are doing innovative work with jails in pre-release and discharge planning, but it is much more likely supported with MHSA funds or funds from non-sustainable categorical grants like the Mentally Ill Offender Crime Reduction (MIOCR) Grant Program. How extensively Medi-Cal is being used to bolster pre-release, discharge and continuity of care efforts should be further examined.

In a recent analysis of the TCN model several findings are instructive for policymakers when thinking about meeting the needs of the reentry population with chronic health conditions.

- The target population has significant complex health needs with 85.2 percent reporting a chronic physical health condition, 52.7 percent reporting being diagnosed with a mental health condition, and 49.9 percent reporting being diagnosed with a substance use disorder.
- Substantial help is needed to meet basic needs from unemployment to food insecurity, but this is challenging because the type of conviction can exclude access to benefit assistance.
- Poor care coordination exists between prison and community health care systems possibly resulting from the absence of health-focused discharge planning but also due to the remoteness of prisons, lack of reimbursement for outreach activities by community health workers, and lack of electronic health records or methods to exchange health information[81]

[x] TCN was honored with COMIO's Best Practices Award for 2017 because their model demonstrates the following components: Collaborative working relationships with community-based organizations that serve individuals who have been incarcerated in addition to health and correctional partners; commitment to evidence-based practices, monitoring fidelity and measuring outcomes, as well as dissemination of lessons learned through publications; and most importantly, making a difference in the lives of those who need services and support. The use of individuals who have previous justice - involvement as community health workers provides expertise in system navigation but also delivers mentorship and emotional support.

14. *RECOMMENDATION:* Ensure that jails, state prisons, and state hospitals have specific policies in place for enhanced pre-release and discharge planning for individuals who screen and assess at-risk due to serious mental illness (SMI), substance use disorder (SUD), co-occurring disorder (COD), and/or criminogenic needs. Assess how extensively Medi-Cal is being used to support these efforts compared to other funding sources like the MHSA, Realignment, or categorical grant programs. Consider strategies that connect individuals with their service provider prior to release, even if from a state institution. Pre-release and discharge strategies that include individuals with previous incarceration experience have demonstrated effectiveness.

15. *RECOMMENDATION:* Explore the feasibility and mechanics of piloting in jails and/or prisons promising practices to improve continuity of care, including:

    a. Use of community health workers and peers for both jail/prison in-reach and community-based service support and navigation.
    b. Engagement and communication between community supervision (probation and parole) entities and behavioral health service providers to break down myths and misperceptions of roles and responsibilities.
    c. Data-sharing that allows the sharing of health information between criminal justice and behavioral and health partners.
    d. Incentives (including enhanced funding or training and technical assistance) for providers who can specialize in populations who are high-risk and require a specialized skill set to tackle complex conditions (e.g. homeless, SMI, SUD, criminogenic needs).

It would be an oversight when discussing effective connections to care without emphasizing the importance of having a full continuum of housing options available and affordable for individuals with serious behavioral health challenges returning home. *Housing First* models are increasingly promoted as a best practice including individuals with behavioral health challenges who have been justice-involved.

The four standard *Housing First* models 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 Rehousing – 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 needs

The 2016 COMIO annual report identified challenges with obtaining appropriate and affordable housing, as well as, strategies counties used to address what was described as the principal barrier to effectively serving the justice-involved with behavioral health issues. The report also briefly discussed the challenges of purchasing costly land or buildings to refurbish for treatment facilities such as sobering centers, residential treatment, and crisis stabilization centers. For purposes of the 2017 annual report housing issues related to the objective of ensuring access to behavioral health care for the justice-involved will be examined.

According to the U.S. Department of Housing and Urban Development (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."[87]

A recent report assessing community responses nationwide to the impact of untreated behavioral health issues, found that there was a lack of understanding regarding how Medicaid can be used to support housing for beneficiaries.[88] By law, Medicaid cannot cover rent (room and board), but states like California have chosen to cover some housing-related services through approved waivers. These can include transition services, housing and tenancy sustaining services, and housing-related collaborative activities. Considering California's embrace of *Housing First* models[xi] and the evidence-base backing supportive housing, it is necessary to better understand how Medicaid can be used to resource supportive housing efforts.

In June 2015, CMS issued an information bulletin which clarifies how Medicaid can be used for housing related services.[90] This was significant because doing so acknowledged that addressing housing needs is critical to meeting the objectives of the Medicaid program. CMS identified three types of housing services that are reimbursable under Medicaid, they include:

- Individual Housing Transition Services: assist in moving an individual from an institution to community-based housing and include housing assessments, developing a housing plan including crisis planning if housing is lost, completing applications, and assisting in one-time housing acquisition such as moving assistance,
- Individual Housing Tenancy Sustaining Services: aid in maintaining housing through services like education and training on tenant's and landlord's rights and responsibilities and help in resolving disputes that could lead to loss of housing, and
- State-Level Housing Services: strategic and collaborative efforts to identify and secure housing such as the development of agreements with local housing and community development agencies to increase housing or to participate in planning processes.[91]

Counties are developing skill sets to maximize the Med-Cal dollars for supporting housing services for the justice-involved with behavioral health issues. For example, as part of the Jail Diversion Initiative Santa Clara County's Office of Supportive Housing is expanding services for permanent supportive housing through programs like "Project Welcome Home" which serves chronically homeless persons who are high-utilizers of county safety net services by leveraging Medi-Cal for services which enables local resources for housing to go further. In addition, participants can be in the program without having to be in a FSP, which has been helpful considering the significant demands for those program slots. In Los Angeles the Office of Diversion and Reentry (ODR) which is housed within the Department of Health Service (DHS) has a housing program that works to provide services to meet a variety of different needs among those participating in diversion programs from immediate interim housing upon jail release, to permanent supportive housing, to ongoing housing retention services and support in obtaining rental subsidy payments.[92]

"Historically housing programs have financed the housing and health-related programs were provided with a combination of rental income and private foundation grants, or with funding provided by the Federal Department of Housing and Urban Development (HUD). However, state Medicaid programs also have substantial flexibility to cover certain housing-related services and activities ... Medicaid and housing programs could be effective partners."[89]

As Medi-Cal beneficiaries, individuals with justice-involvement optimally would have equal opportunities to access housing services and supports but often doing so can be a challenge due to formal restrictions on the housing side. Some recent progress has been made, for example HUD issued Notice PIH 2015-19/H 2015-10 to inform Public Housing Authorities (PHA) and owners of other federally assisted housing that arrest records may not be the basis for denying admission, terminating assistance or evicting tenants.[93,xii] Yet HUD's definition of homelessness, which is often used to determine program eligibility by state and local administrators, remains a clear barrier for the justice-involved. While exiting incarceration is included in the definition because jails, prisons, state hospitals, and juvenile detention centers are considered institutions, to qualify the individual had to be homeless prior to institutionalization and can only be institutionalized for 90 days or less.[94] If you are "institutionalized" for more than 90 days that is considered a "break" in homelessness and advocates

[xi] *Please see the COMIO 2016 Annual* Report
[xii] More examples can be reviewed from the 2016 COMIO Annual Report

"We have a project for expansion but the NIMBYism, we can't get anyone to site us. So we have the resources just no place to provide them"

County Administrator

argue that such "limited definitions serve to ration services to ex-offenders who find themselves homeless upon release but are determined ineligibility for emergency housing assistance."[95] To overcome some of these barriers, the US Interagency Council on Homelessness recommends strong coordination between criminal justice and housing service providers and specifically recommends that criminal justice resources be used to support immediate housing options like short-term rental assistance and rapid rehousing programs while housing and health providers direct resources towards long-term solutions like permanent supportive housing.[96]

The California Department of Housing and Community Development (HCD), is responsible for implementing the *No Place Like Home Initiative*, which will develop permanent supportive housing for the individuals with serious mental illness (SMI) or children and adolescents with serious emotional disturbance (SED). HCD has been working diligently with advisors and stakeholders to create guidelines inclusive of the justice-involved with behavioral health needs.

In addition to individuals who are homeless or chronically homeless, individuals at-risk of chronic homelessness are eligible. In this case, no matter the length of institutionalization, individuals can be eligible upon release or discharge as long as they were homeless prior to admission.[97]

While this still poses a challenge for those who are at-risk of homeless upon release, it does provide long-term supportive housing for those most in need (including those with justice-involvement), and reinforces the necessity for criminal justice partners to prioritize their housing resources for immediate shelter and housing options during the transition back to the community.

Such progress is positive, but efforts to address homelessness as well as ensure equal opportunities and access to housing, behavioral health services must include strengthened enforcement of existing legal protections, and an examination of whether additional protections from *Not in My Backyard (NIMBY)* efforts are needed. Unfortunately, community resistance of individuals with criminal backgrounds, especially those with mental health and substance use disorders, have not noticeably improved and with housing become scarce and land more expensive, attitudes might even be worse now than they were a decade ago. As such, strategies to combat NIMBYism focus on protecting individual rights and upholding the law.

California has the highest rate of chronic homelessness in the country at 36 percent, with 21 percent of the national homeless population, of which a fifth are individuals with mental illness[xiii]

In September 2017 Governor Edmund J. Brown Jr. signed a package of bills to address California's Housing Crisis. Among them, the Housing Accountability Act (65598.5 of the Government Code) was amended to stop local governments from subjectively rejecting development projects that comply with their existing zoning and land use policies. The amendments will "increase the burden of proof cities and counties must meet to deny housing projects; award damages to developers if local governments act in bad faith; and require courts to fine cities and counties for not complying with the Housing Accountability Act".[98,xiv]

Overall there is promise that these changes will help protect marginalized populations against discrimination, but the changes still require those negatively impacted to know and assert their rights in addition to enhanced resources to effectively monitor compliance with the law.

16. *RECOMMENDATION:* Considering the risk and crisis in homelessness among the justice-involved population with serious behavioral health needs upon reentry, all efforts to address homelessness and the housing crisis in California should take into consideration the unique needs of this population. Moreover, for the justice-involved population with behavioral health challenges, housing must be linked to services and vice versa.

    a. Maximize the use of Medi-Cal funds for the justice-involved (therefore expanding federal financial participation) including housing services so that resources saved can be directed towards a variety of housing needs for the reentry population especially for immediate short-term and transitional housing.
    b. Support practices that provide equal opportunities for housing for those being released from institutions such as jails, prisons, juvenile detention, state hospitals and even parole such as the *No Place Like Home Initiative* which will include individuals who are at-risk of chronic homelessness as part of their target population.
    c. Strengthen state-level efforts to combat *Not in My Backyard* (NIMBY) community responses for housing for individuals with behavioral health needs and/or individuals who have been formerly incarcerated. Explore if and how the *Housing Accountability Act* will aid in enforcing the development of appropriate housing for special needs populations who may be experiencing discrimination.

[xiii] Information shared by the Corporation for Supportive Housing presented to the Homeless Coordinating and Financing Council on October 10, 2017.
[xiv] Please review Everyone's Neighborhood: Addressing "Not in My Backyard" Opposition to Supportive Housing for People with Mental Disabilities" by Disability Rights California at: http://ww.disabilityrightsca.org/pubs/CM5301.pdf

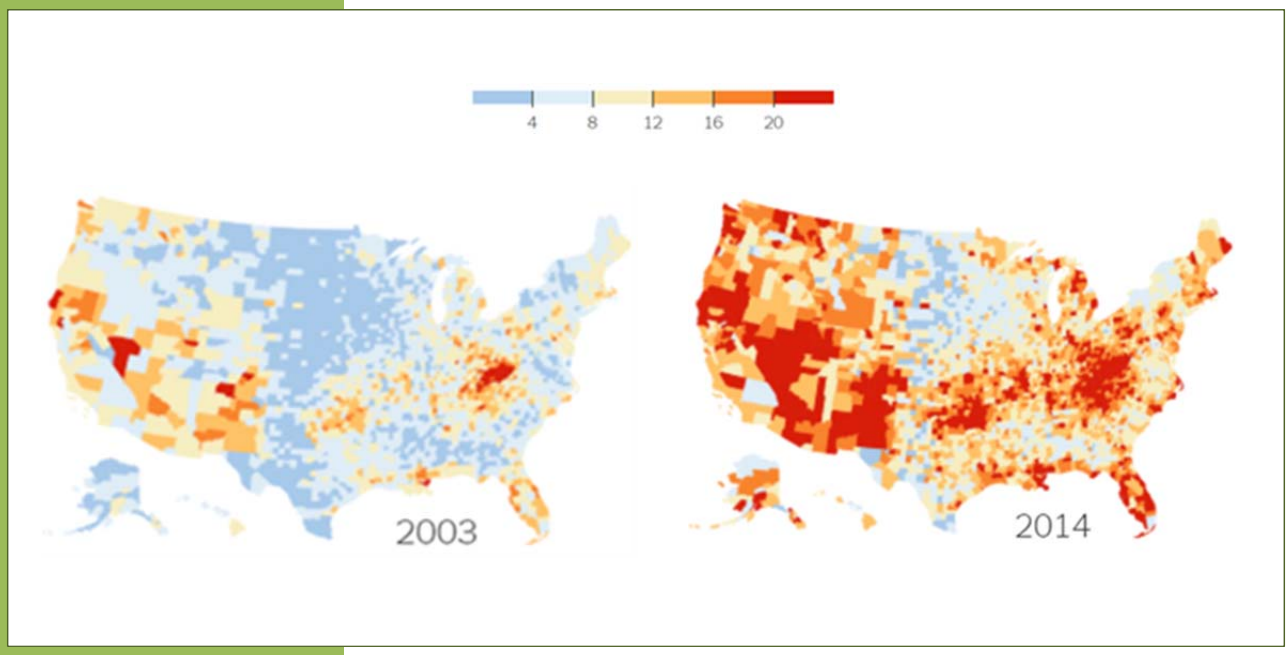
Medi-Cal expansion has made it possible to help people struggling with addiction and sobriety.

Provider

CALIFORNIA'S OPPORTUNITY TO DESIGN WHAT WORKS FOR THE JUSTICE-INVOLVED WITH SIGNIFICANT BEHAVIORAL HEALTH CHALLENGES

In 2020 California's five-year Section 1115 waiver will be up for renewal and the time has come to consider strategies that can expand community-based care for the justice-involved with significant behavioral health needs. This may include suggesting changes to how the Medi-Cal program is administered. Recently many counties have been working to expand services to the justice-involved population through the roll out of the Drug Medi-Cal Organized Delivery System (DMC-ODS) and the Whole Person Care (WPC) Pilot Program, which are components of the current 1115 waiver. Identifying what has been accomplished to date and what has been learned during that process can be instructive regarding what needs to be improved moving forward, including issues that may need to be addressed through amendments to the Medi-Cal program including the 1915(b) Medi-Cal Specialty Mental Health Services waiver.

FIGURE 3: Number of Overdose Deaths per 100,000 2003 versus 2014



Drug Medi-Cal Organized Delivery System (DMC-ODS)

According to the Centers for Disease Control and Prevention, 78 percent of violent crimes and 77 percent of property crimes involve drugs and/or alcohol.[99] Additionally, 74 percent of the deaths that occur two weeks after release from incarceration are due to overdoses.[100] Criminal justice and behavioral health experts have long recognized the value evidenced-informed practices have for individuals with SUD treatment needs who are involved in the justice system. According to CDCR, individuals who complete both in-prison SUD treatment as well as community-based SUD aftercare, have much lower rates of recidivism than those who do not, 29.2 percent compared to 46.1 percent.[101] The ACA has provided significant opportunities to expand substance use treatment services. California has been hard at work developing and implementing the DMC-ODS pilot program and is the first state to use the 1115 waiver to expand SUD services.

Counties that opt into the pilot must provide a continuum of services to all eligible beneficiaries based on the ASAM criteria that includes (See Figure 4):

- Early Intervention (overseen through the managed care system)
- Outpatient Services
- Intensive Outpatient Services
- Short-Term Residential Services (up to 90 days with no facility bed limit)
- Withdrawal management
- Opioid/Narcotic Treatment Program Services
- Recovery Services
- Case Management
- Physician Consultation
- Optional services include additional Medication Assisted Treatment, Partial Hospitalization, and Recovery Residences[102]

FIGURE 4: Standard DMC-ODS Benefits

Standard DMC Benefits (available to beneficiaries in all counties)	Pilot Benefits (only available to beneficiaries in pilot counties)
Outpatient Drug Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment (oral for opioid dependence or with TAR for other)	Naltrexone Treatment (oral for opioid dependence or with TAR for other)
Narcotic Treatment Program (methadone)	Narcotic Treatment Program (methadone + additional medications)
Perinatal Residential SUD Services (limited by IMD exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal)
Detoxification in a Hospital (with a TAR)	Withdrawal Management (at least one level)
	Recovery Services
	Case Management
	Physician Consultation
	Partial Hospitalization (Optional)
	Additional Medication Assisted Treatment (Optional)

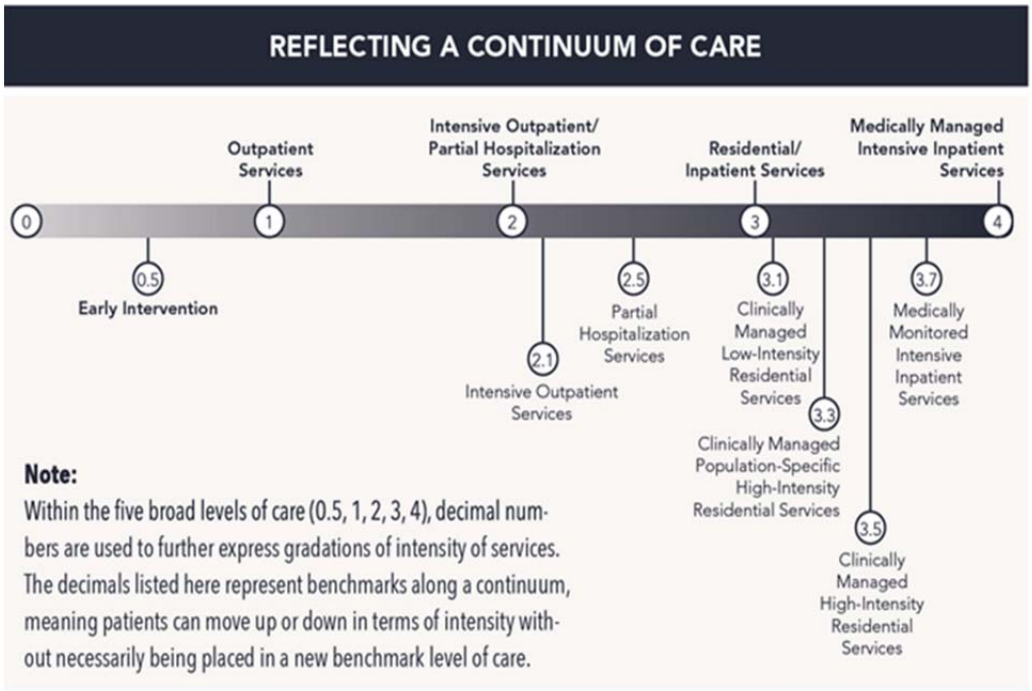
FIGURE 5: County DMC-ODS Status Report as of September 2017

County	Live Date	County	County	County
1. Riverside	2/1/17	13. Alameda	25. Merced	36. Stanislaus
2. San Mateo	2/1/17	14. Ventura	26. Sacramento	37. San Joaquin
3. Marin	4/1/17	15. Kern	27-34. Partnership:	38. El Dorado
4. Santa Clara	6/15/17	16. Orange	Humboldt	39. Tulare
5. Contra Costa	6/30/17	17. Yolo	Trinity	40. Kings
6. Los Angeles	7/1/17	18. Imperial	Mendocino	
7. San Francisco	7/1/17	19. San Bernardino	Lassen	
8. Santa Cruz	10/01/17	20. Santa Barbara	Modoc	
9. Sonoma	10/1/17	21. San Benito	Shasta	
10. Monterey		22. Placer	Siskiyou	
11. Napa		23. Fresno	Solano	
12. SLO		24. San Diego	35. Nevada	

Critical elements of the DMC-ODS include (See Figure 6):

- A continuum of care modelled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment service
- Increases local control and accountability with greater administrative oversight
- Creates utilization controls to improve care and efficient use of resources
- Increases program oversight and accountability
- Provides more intensive services to the criminal justice population which are harder to treat
- Requires evidence-based practices in substance use treatment
- Increases coordination with other systems of care including physical and mental health

FIGURE 6: Continuum of Care



To access this developing enhanced continuum of care a Medi-Cal beneficiary must meet medical necessity based on the presence of one DSM diagnosis for substance-related and addictive disorders (with the exception of tobacco) and meet the ASAM criteria definition of medically necessity. Beneficiaries will be screened using ASAM's multi-dimensional diagnostic criteria, and then placed into a corresponding level of care. The levels of care reflect both the intensity of a needed service as well as the type of service needed to address that intensity with the expectation that individuals will move across different levels as they journey through treatment, recovery, relapse, and so on.

There are no age restrictions to be eligible for the services but an individual must reside in a county that has opted into the pilot. As of September 2017 40 counties have submitted implementation plans covering over 97 percent of the population of California with nearly 45 percent eligible for DMC-ODS services.[103] Nine counties are providing services, another 11 are likely to have begun services by the time this report is published in December of 2017 and another 20 are under development. (See Figure 5). The University of California, Los Angeles Integrated Substance Abuse Programs will be the evaluator of this effort and focus on four areas: 1) access to care, 2) quality of care, 3) cost and 4) integration and coordination of SUD care both within the SUD system but also with medical and mental health service systems. The evaluation will also be looking at recidivism rates and the effect the DMC-ODS waiver has across systems, including criminal justice.[104]

Based on projections available in county DMC-ODS implementation plans as of October 2017, 17 percent of the population to be served in 2016-17 was projected to be referred by the criminal justice system totaling nearly 40,000. In addition, and not surprisingly, 22 percent (roughly 50,000) of the projected population will have co-occurring treatment needs. While these numbers are projections and could be considerably variable, they illustrate the possibilities to reach individuals with justice-involvement with SUD and COD services under Medi-Cal. In discussions with DHCS and counties regarding implementation this early in the process, there are many things that were expected such as the challenge of the substantial redesign of the SUD delivery system and statewide. In addition, the lack of programs that can effectively address complex co-occurring mental health and substance use disorders was a concern in all of the counties COMIO spoke with. Less expected but just as challenging, included the lack of existing residential treatment and detoxification capacity and the extraordinary community resistance to expanding such treatment services coupled with the low availability of ASAM-certified providers. Despite the hurdles, a range of innovative services are being implemented and developed by counties and their provider partners.

Many of these innovations target individuals who are justice-involved, some examples include:

- San Mateo County has designed a continuum of re-entry services and coordinated a one stop multi-disciplinary case management approach for the eligible population, which include mobile health and outreach services
- Riverside County has eight different recovery residence providers that serve the probation population
- San Luis Obispo County offers a continuum of care services for justice-involved individuals who are participants in court ordered treatment programs
- Orange County is providing Vivitrol to DHCS certified contract outpatient providers to probation participants with or without Medi-Cal and to probation and parolees who are on Medi-Cal. The county further notes that over 80 percent of beneficiaries are or have been involved with the criminal justice system[105]

Probably the most unexpected variable has been to roll out the DMC-ODS in the midst of the national opioid epidemic. Between 1999 and 2015 over 560,000 people in the country died from a drug overdose and in 2015 nearly two-thirds were linked to opioids.[106] How this epidemic has impacted California and its diverse communities differently is beyond the scope of this report but what is known is that individuals suffering from opioid addiction are increasingly interacting with our criminal justice system. From 2002-2012 San Diego County reported a twofold increase in arrestees on opioids and in Sacramento County arrestees on opioids rose from 3 percent in 2000 to 18 percent in 2013.[107]

With access to supportive services "*people turn their lives around*," one provider stated, and explained that one man, who had been in and out of prison his entire life, was successful after receiving mental health services and still access services as an alumnus of the program. Now, off probation, he still accesses services and has said he "*never thought [he] would be here, [he] thought [he'd] be imprisoned forever*."

- *Provider*

"If anything happened to Medi-Cal it would be devastating. Right now, we just have a band-aid where stiches are needed."

Peer Provider/ Community Health Worker

Considering how much the crisis has grown these numbers likely do not reflect the current number of individuals who are incarcerated who need treatment and are at high risk of overdosing upon community reentry. The California Health Care Foundation reported during a recent seminar that in California nearly 2,000 people died of an opioid overdose in each of the last two years.[xv] One additional resource to address capacity to treat individuals with opioid addiction will be California's Medication Assisted Treatment (MAT) Expansion Project funded by a SAMHSA grant as part of the implementation of the 21st Century Cures Act. The grant will leverage 1115 DMC-ODS efforts and focus on populations with limited MAT access on populations with limited MAT access including rural areas, American Indian and Native Alaskan tribal communities as well as provide statewide access to buprenorphine.

Regardless of the challenges, all of the counties the Council worked with this year believe that the DMC-ODS is essential to addressing the SUD, and in particular, the COD needs of individuals with justice-involvement. The DMC-ODS will provide more opportunities to conduct thorough assessments to support prevention and diversion and support community alternatives to incarceration, especially residential treatment. Future reports, especially considering the recent inclusion of substance use and co-occurring disorders within the scope of work of the Council, should focus specifically on how the DMC-ODS may assist in developing effective integrated models to address co-occurring disorders.

Whole Person Care Pilot Program

A second critical element of the waiver that has the ability to create effective interventions for individuals with behavioral health needs who are justice-involved is the Whole Person Care (WPC) Pilot Program. Pilot programs will have up to $3 billion in funds ($1.5 billion in federal Medicaid match) over 5 years to identify high-risk, high-utilizing Medi-Cal beneficiaries, such as individuals with complex needs like mental illness and substance use disorder who are also at risk of experiencing homelessness due to release from institutions, like jails and prisons.

FIGURE 7: Application of Whole Person Care in California Stats as of June 2017

DHCS	Whole Person Care Pilot		
Lead Entity	**Legacy, Expansion, or New**	**Estimated 5-year Beneficiary Count**	**Total 5-Year Budget**
Alameda County Health Care Services Agency	Legacy	20,000	$283,453,400
City of Sacramento	New	4,386	$64,078,680
Contra Costa Health Services	Legacy	52,500	$203,958,160
County of Marin, Department of Health and Human Services	New	3,516	$20,000,000
County of Orange, Health Care Agency	Expansion	9,303	$31,066,860
County of San Diego, Health and Human Services Agency	Legacy	1,049	$43,619,950
County of Santa Cruz, Health Services Agency	New	1,000	$20,892,336
County of Sonoma, Department of Health Services Behavioral Health Division	New	3,040	$16,704,136
Kern Medical Center	Legacy	2,000	$157,346,500
Kings County Human Services Agency	New	790	$12,848,360
Los Angeles County Department of Health Services	Expansion	154,044	$1,260,352,362
Mendocino County Health and Human Services Agency	New	600	$10,804,720
Monterey County Health Department	Expansion	500	$34,035,672
Napa County	Expansion	800	$22,921,433
Placer County Health and Human Services Department	Legacy	450	$20,126,290
Riverside University Health System - Behavioral Health	Legacy	38,000	$35,386,995
San Bernardino County - Arrowhead Regional Medical Center	Legacy	2,000	$24,537,000
San Francisco Department of Public Health	Expansion	16,954	$161,750,000
San Joaquin County Health Care Services Agency	Expansion	2,255	$18,365,004
San Mateo County Health System	Legacy	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	Expansion	10,000	$250,191,859
Small County Whole Person Care Collaborative	New	427	$10,362,176
Shasta County Health and Human Services Agency	Legacy	600	$19,403,550
Solano County Health & Social Services	Legacy	250	$4,667,010
Ventura County Health Care Agency	Expansion	2,280	$107,759,837

Legacy – Whole Person Care Pilots approved for implementation for January 1, 2017.
Expansion – Whole Person Care Pilots originally approved for implementation for January 1, 2017, and approved for expansion beginning July 1, 2017.
New – Whole Person Care Pilots approved for implementation for July 1, 2017

[xv] Resources from the November 27th 2017 Seminar available at: http://www.chcf.org/cosn

The pilots will test how comprehensive, coordinated, and integrated services can lead to reduced spending with better health outcomes. Of interest to the Council, the WPC pilots offer an opportunity to examine and improve coordination between criminal justice and behavioral health partners as individuals transition from incarceration to community-based services and supports.

Potential services for those enrolled include:

- Health services – physical, mental health, and substance use disorder,
- Care coordination –system navigators, medication management support, transition from jail to home,
- Stabilization services – support homeless or at risk of homelessness populations to obtain housing and provide tenancy supports and establish a flexible housing pool to take saving and use them for non-Federal Financial Participation reimbursable needs like rental subsidies, and
- Other – transportation, benefit establishment, SSI advocacy, educational and vocational training.

At this point in time DHCS has awarded all of the available WPC pilot funds and the majority of state's population will be reached by participating counties (See Figure 7 chart of application stats June 2017). Individuals who are on community supervision or returning home from jail or prison are often overrepresented in the populations targeted by the pilot – homeless or at risk of homelessness, frequent users of emergency departments or hospitals, individuals with co-occurring SUD and SMI conditions, individuals exiting institutional settings, and high-utilizers with two or more chronic health conditions. As result, even though there are several counties who have designed WPC pilots to target the reentry population, DHCS estimates that at minimum 13 counties will actively be engaging the justice-involved population and in reality, most of the participating counties at some point will be working with justice-involved populations.[108, xvi]

Regardless of the specific target population, across all WPC pilots there are similarities in approaches and investments. First, housing is often cited as the most difficult hurdle to clear to effectively deliver behavioral health services and the majority of WPC pilots are targeting populations that are homeless or at risk of homelessness, especially after acute illness or institutionalization, including incarceration. While WPC funds cannot be used to directly pay for rent (recall this is a Medicaid exclusion), there are a variety of strategies being used to support housing access and retention.

For example, the following are being used in Alameda County:

- Housing and Tenancy Sustaining Services (e.g. help identifying housing, move in assistance like security deposits)
- Skilled Nursing Facility Housing Transition Programs (assistance locating more independent community settings)
- Street Outreach (engagement with unsheltered chronically homeless individuals)
- Community Living Facilities Quality Improvement (create a database of available units, create housing standards and provide certifications, and provide training to operators, residents and the community)
- Housing Education and Legal Assistance Program (create legal services dedicated to housing, toll free number for Medi-Cal beneficiaries looking for housing, and housing education workshops)[109]

[xvi] These counties include Alameda, Contra Costa, Kern, Los Angeles, Marin, Mendocino, Placer, Riverside, San Diego, San Mateo, Santa Clara, Santa Cruz, and he small county regional collaborative of Mariposa, Plumas, and San Benito counties.

A second consistent element among the pilots is the use of peer support specialists, system navigators, or community health workers who often have former experience being incarcerated, homeless, and/or struggling with substance use and mental health disorders. These individuals can model recovery and provide emotional support in addition to expertise in health and wellness as well as knowledge of various services and programs available in the surrounding community. For example, according to Los Angeles County's WPC pilot application community health workers under the supervision and support of a social worker provide a variety of critical services, including:

DUTIES OF COMMUNITY HEALTH WORKERS: LA COUNTY WPC

- Peer mentorship in the re-entry process and positive social support to reduce associations with prior associates that have been demonstrated to increase recidivism rates
- Attend medical, mental health, and addictions counseling and medication-assisted therapy visits, when appropriate, working closely with primary care and behavioral health teams to ensure that the client's issues are addressed
- Transportation from jail to their post-release home and to and from medical visits
- Home visits and medication reviews
- Health coaching, chronic disease self-management support and harm reduction
- Support medication adherence
- Set and track health care goals around smoking, exercise and diet
- Ensure that appropriate connections to support and enabling services occurs adequately to maintain the client in the community
- Assist with establishment and maintenance of non-SSI/SSDI benefits to which the client is eligible
- Work closely with housing specialists (e.g. move-in readiness and assistance) and legal assistants, as necessary
- Support criminal justice navigation, such as assistance in making scheduled court appearances, parole, and/or probation appointments
- Assist with connections to legal aid for issues such as child support and restitution
- Assist with coordination of other activities as needed to support re-integration with the client's families and communities (e.g. tattoo removal, family counseling, parenting education, education and vocational training) in partnership with WPC-LA regional partners and community-based organizations
- Navigating to community-based re-entry organizations (e.g., Los Angeles Regional Re-entry Partnership entities) to address additional social determinants of health such as education, employment, food security, and family reunification

"We have a big impact on making someone who has just come home comfortable, and help to break down the stigma towards mental health treatment and law enforcement"

-Peer Provider

A third area of similarity includes efforts to develop data collection and data sharing capabilities across participating entities, which includes partnering Managed Care Plans (MCPs). The MCPs can provide needed basic information to identify who is eligible, and can request information that is available within the data system that is helpful such as utilization and enrollment. According to an analysis of the plans conducted by Harbage Consulting earlier this year, all pilots are using WPC funds to expand existing data sharing frameworks that can enable health care providers, care coordinators and social service providers to share data and communicate effectively. Whether or not and how any of these efforts include the exchange of health information between criminal justice and health partners should be analyzed.

The types of projects being implemented includes:

- Health Information Exchanges
- Patient Population Software
- Data Warehouses
- Case Management Software
- Newly Designed Data Sharing Systems
- Collecting and Sharing Real Time Data[110]

Based on conversations with several counties and preliminary scans of WPC pilot plans, those working with the reentry population typically do so post-release but aim to start the care coordination process while the person is still incarcerated. As this report has documented, doing so is a best practice. For example, while there are multiple entry points into LA County's WPC pilot component for the justice-involved who are high-risk, one set of services will be targeted "pre-release" from custody for those that are projected to leave LA County Jail within 90 days. The plan also calls for working with CDCR up to 180 days prior to release, which is when the state begins its pre-release planning processes. This makes good sense considering that in FY 2016-17 over 9,600 individuals returned to LA County from prison, 46 percent on post-release community supervision and 54 percent on parole. Of this group, 25 percent was diagnosed with a mental health treatment need, 5 percent which were severe and disabling, and 49 percent were identified as having a substance use treatment need.[111] CDCR is responding to this request and sees enormous value in working to identify appropriate candidates for the pilot such as those with serious mental illness, and a co-occurring chronic medical condition or substance use disorder, who may also be at risk of homelessness. If an effective pre-release planning process can be put in place it certainly would seem appropriate to use it for other counties in the warm handoff process that are interested in having this information about returning community members who are at high risk of being costly to their Medi-Cal and local criminal justice programs.

17. *RECOMMENDATION:*
    COMIO will continuously monitor counties and their partners implementing programs under these initiatives that especially target individuals with justice-involvement or for those returning home from incarceration.

    a. Adopt enhanced pre-release and discharge planning in local jails, CDCR, and DSH, developing the capacity to directly link appropriate individuals to community-based services prior to release.
    b. Disseminate lessons learned across counties and include health, behavioral health, and public safety partners to examine how similar efforts could be adopted locally.
    c. Apply lessons learned from these initiatives to make decisions about how to change or update Medi-Cal waivers in 2020.

COMIO Statewide Survey – The Impact of Medi-Cal Expansion on Behavioral Health Services for the Justice-Involved

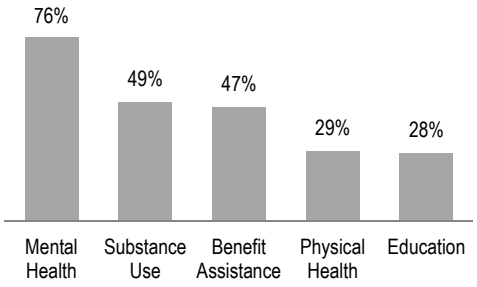
COMIO developed an online survey, with questions based on key informant interviews with administrators, providers (licensed, peers, family members, and community health workers), advocates and service users. Interviews and surveys were initiated in an effort to gain insight regarding the impact of:

- Expansion of Medi-Cal services, under the Affordable Care Act
- Services provided by peer providers, community workers and family advocates
- What is and is not working, service utilization, and satisfaction

There were 352 survey respondents from all over the state.

Administrators and providers were asked which services their agency has the most capacity to provide; the top five services indicated by respondents were mental health, substance use services, benefit assistance, physical health, and education (Figure 8).

FIGURE 8: Most Capacity to Provide (n= 211)



Survey respondents were asked what they think most improves access to services. Administrators and providers listed peer support/mentoring, transportation, housing, assistance with accessing benefits (e.g., general assistance, SSI, veterans), and cultural competency as the top five (Figure 9).

FIGURE 9: Most Improves Access to Services (n=195)

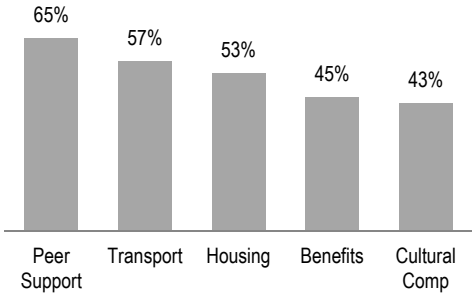
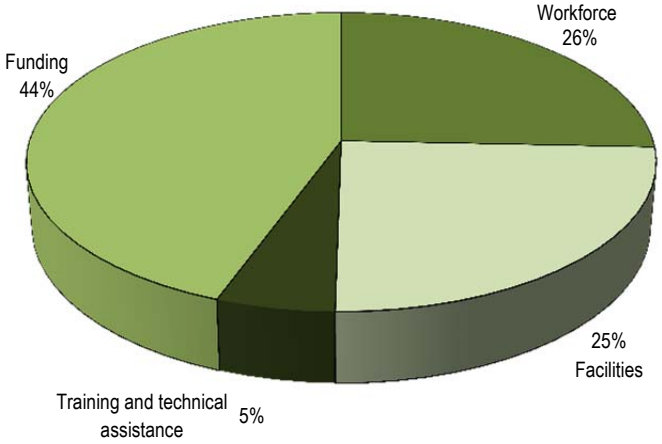


FIGURE 10: Biggest Challenge to Providing Behavioral Health Needs (n=190)

In addition, the biggest challenge for agencies to provide people with behavioral health needs were funding (44%), workforce (26%), facilities (25%), and training and technical assistance (5%) (Figure 10).



One key informant interview participant noted that the Medi-Cal expansion has "*helped parolees to get help they need but the services aren't really designed to meet the needs … people have significant trauma and need more than brief treatments.*"

Endnotes

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Section B

"Long wait times for appointments and crowded clinics can be frustrating and overwhelming. We need to invest in the workforce"

Peer Provider

SECTION B

BUILDING THE CAPACITY OF THE BEHAVIORAL HEALTH WORKFORCE TO REDUCE THE INCARCERATION OF INDIVIDUALS WITH BEHAVIORAL HEALTH CHALLENGES

FINDING: California is lacking a cost-effective and evidence-based statewide peer support model for prevention, diversion, and reentry programming to reduce recidivism and prevent incarceration among individuals with mental illness.

In 2016, COMIO's 15th Annual Report investigated the use of peer support in reducing incarceration and promoting recovery for individuals with mental illness and substance use disorders.[xvii] The report provided recommendations that encouraged the exploration of potential funding sources for providing care that is recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed. In 2017, the Council examined how various models utilize people with lived experience to effectively prevent or divert individuals from incarceration who have behavioral health challenges to reduce recidivism among this population. The Council specifically looked for models that provided these services and were reimbursable through a sustainable funding source such as Medi-Cal. The models explored included peer provider and community health worker models. The following section will discuss findings regarding the ability of these models to reduce the incarceration of individuals with behavioral health challenges in a cost-effective manner.

There is potential for Medicaid reimbursement to be a significant funding source for peer support services. A letter written by CMS in 2007 to state Medicaid directors discussed the importance and evidence-base of peer support services and how they could be Medicaid-reimbursable.[112]

"*CMS recognizes that the experience of peer support providers, as consumers of behavioral health care services, can be an important component in a State's delivery of effective treatment.*"[113]

The letter identified three methods for states to fund peer support services:[114]

1. Section 1905(a)(13) of the Social Security Act, also known as the "rehab option" which allows States to add new services through amendments to their Medicaid State Plans.
2. The 1915 (b) Waiver Authority which is the primary vehicle to develop Medicaid managed care organizations that receive capitated payments from states to pay for a group of beneficiaries and the alternative proposed in the waiver must be budget-neutral.
3. The 1915 (c) Waiver Authority, which allows states to deliver Homes and Community Based Services, including behavioral health services for individuals who are at risk of institutionalization and the alternative proposed in the waiver must also be budget-neutral.

According to COCHS in a recent issue brief, many states that fund peer services with Medicaid do so through the "rehab option". COCHS identifies two benefits of this approach, including no requirement to meet budget neutrality and a less stringent review process. Peer services are Medicaid reimbursable under the "rehab option" if clients have a diagnosed behavioral health disorder that meets medical necessity. The providers do not have to hold professional degrees or licenses and the services provided do not necessarily need to be clinical but the peer staff must be supervised by a licensed health professional such as a licensed clinical social worker.

"*States define the scope, duration, and limitation of services, as well as medical necessity and provider certification criteria, in their Medicaid State Plans.*"[115]

California's State Plan is currently using this method, but the extent to which this approach is the most effective at drawing down federal Medicaid funds should be further explored to ensure optimal support for service delivery models that use individuals who have lived experience in the behavioral health and criminal justice systems.

[xvii] To view the 15th Annual Report, visit https://sites.cdcr.ca.gov/ccjbh/publications

Individuals with lived experience are used to support the well-being and community reintegration of the justice-involved. The use of mentors in a reentry setting to improve reintegration into the community after release from jail or prison has been commonplace for many years. A mentor is a positive role model who provides support to their mentee both emotionally and practically. They may help the mentee set goals or address needs such as housing, employment, and financial services.[116] Building upon the mentor model, peer providers have a shared experience with their client that affects the way they provide services. Peer support has been used for decades in behavioral health settings and has an evidence-base for supporting efforts in recovery. Recovery is "*a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential*."[117]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), a peer support specialist is "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience*."[118]

For peers working with individuals with substance use disorders, SAMHSA defines peer recovery support *as "a set of nonclinical, peer-based activities that engage, educate, and support individuals so that they can make life changes that are necessary to recover from substance use disorder."*[119]

The use of peer support specialists in recovery may promote faster connections to care and community resources, more opportunities for diversion, and reduced recidivism.[120]

Over the past decade, there has been an increase in research supporting the use of peers in correctional settings to improve the transition from jails and prisons to the community for formerly incarcerated individuals who have behavioral health issues. These *forensic* peer specialists have a unique connection to the community they serve through their lived experience of justice system involvement. Forensic peer provider models are growing in number and preliminary evaluation of these models has shown increased rates of connection to services and reduced rates of recidivism. Generally, peer specialists are paired with clients who have lived experience that is similar to their own. This allows them to provide a more closely tied model of recovery for their client and to guide them on their path to recovery prior to and upon release.

> "*Forensic peer specialists embody the potential for recover for people who confront the dual stigmas associated with serious mental illnesses and criminal justice system involvement*."[121]

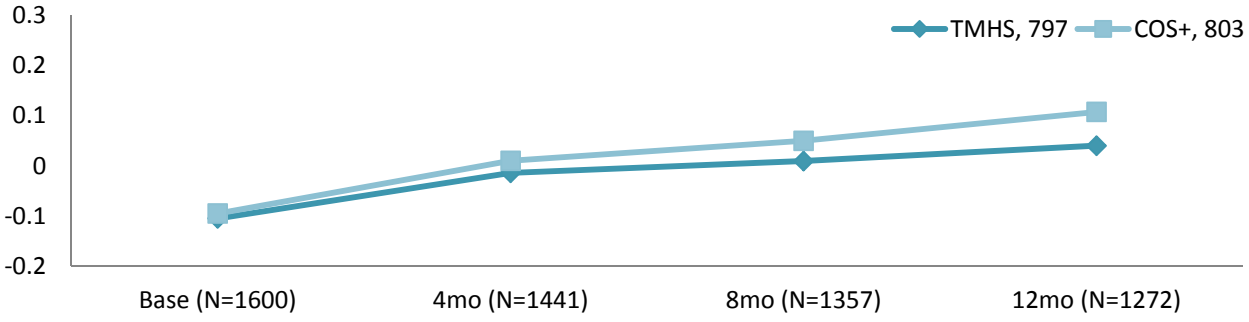
A national ten-year study sponsored by SAMHSA regarding eight consumer-operated service programs (COSPs) provides evidence of the effectiveness of using mentors and peers in behavioral health settings. A COSP is *a "peer-run self-help organization, administratively controlled and operated by mental health consumers."*[122] The study demonstrates that participants who received both traditional mental health services and peer services experienced *"significant gains in hope, self-efficacy, empowerment, goal attainment and meaning of life, in comparison to those her were offered traditional mental health services only."*[123] (See Figure 12)

Well-being is a key factor in the resiliency of psychologically vulnerable populations and therefore was chosen as an outcome measure for this study.[124] A composite of established scales that assesses hope, empowerment, meaning of life, self-efficacy, and goal attainment was used to measure the well-being of over 1600 of the adults who participated in the study.

An additional example of a program with promising outcomes is Peers Reach Out Supporting Peers to Embrace Recovery (PROSPER). PROSPER is a strength-based recovery maintenance program that uses peer

FIGURE 12:

Change in Well-Being Over Time: Consumer-Operated Service Programs (COSP) versus Traditional Mental Health Services (TMHS)[125]



support to address recovery and reentry. The target population for the program includes individuals who have former justice-involvement and are recovering from a substance use disorder, and their family members, most of whom reside in Central and South-Central Los Angeles. A one-year study examined the effectiveness of PROSPER's peer support services in treating substance use disorders and the findings documented significant changes. Over five hundred people participated in the study and outcomes measured self-efficacy, perceived social support, perceived stress, and quality of life. Although these measures are not directly related to recovery, participants experienced a more culturally appropriate peer-to-peer recovery community that resulted in more positive outcomes.[126]

Considering the potential impact of peer support services, administrators are using peer support specialists to play pertinent roles at each of the six intercepts (Intercepts 0 – 5) of the Sequential Intercept Model (SIM)[xviii] (Figure 13). Below are examples of peer roles at each intercept.[127]

Intercept 0

- Perform outreach to engage the target population
  - Example: being part of an Assertive Community Treatment team, a mobile crisis team, or operating crisis lines

Intercept 1

- Participate in Crisis Intervention Teams alongside law enforcement
- Follow-up with those individuals who are at risk for further justice-involvement and/or hospitalization

Intercept 2

- Provide guidance to individuals who are going through arrest, detention, and arraignment
- Give a sense of comfort and hope for their clients who may be struggling to understand and cope with the hearing process

Intercept 3

- Participate in treatment court teams and Forensic Assertive Community Treatment (FACT) teams
- Facilitate support groups within jails and prisons

Peers in a Forensic Assertive Community Treatment team[128]

The San Jose Forensic Assertive Community Treatment (FACT) program is part of SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). FACT has been found to be a promising program for "reducing criminal and delinquent behavior" as well as improving mental health and/or substance use treatment. San Jose's FACT program uses a multidisciplinary team which includes peer recovery specialists and provides clients with behavioral health services as well as support for housing, employment assistance, and benefits applications. The evaluation of this program included participation from 134 inmates from the Santa Clara County Jail in San Jose, California. The program participants were incarcerated for non-serious, non-violent offenses, and had been diagnosed with a major mental disorder. Of the 134 participants, 62 were part of the control group and 72 were part of the intervention group. The intervention group was found to have more outpatient visits, fewer days of hospitalization, and fewer jail bookings between months 13 to 24 than the usual-care control group.

[xviii] Developed by Mark R. Munetz, MD and Patricia A. Griffin, PhD, the Sequential Intercept Model (SIM) "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". For more information about the SIM, see COMIO's 15th Annual Report.

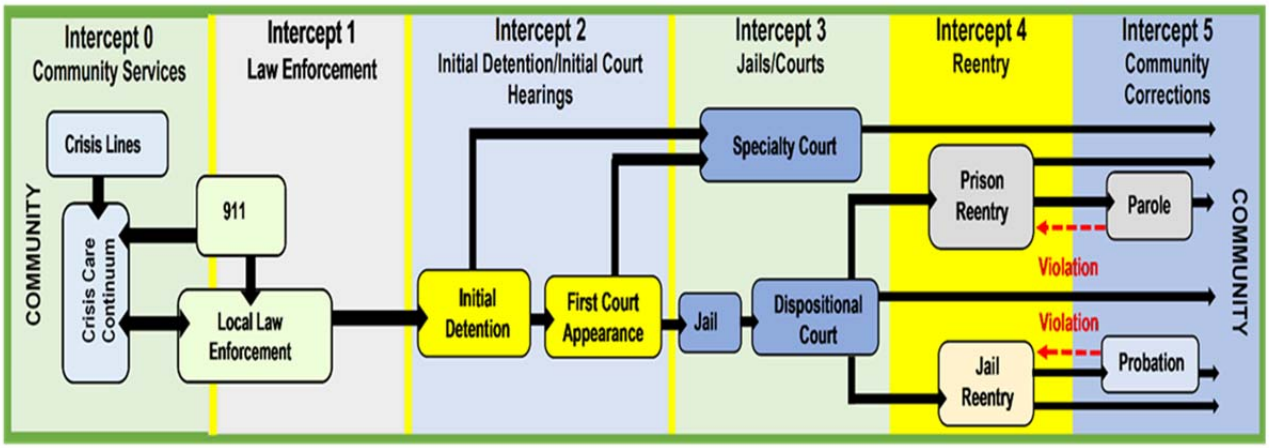
Intercept 4

- System navigation, treatment planning, and case management
- Reduce recidivism by assisting with a warm handoff from the institution to community supervision and community resources

Intercept 5

- Help clients understand the provisions and conditions of their parole or probation while assisting with recovery and system navigation (SAMHSA, 2017)

FIGURE 13: Sequential Intercept Model



Although many county behavioral health departments employ peer providers, often through contractors, the State of California does not provide practice guidelines or standardized training. According to a presentation to COMIO by the California Association of Mental Health Peer Run Organizations (CAMHPRO), many counties also do not allow peers to bill Medi-Cal for the services they provide. In order to bill Medi-Cal for these services, CMS requires the establishment of a statewide plan to:

- Train and certify Peer Providers
- Address the supervision of Peer Providers
- Ensure care coordination in the context of a comprehensive and individualized plan of care with goals[129]

Current Medi-Cal provisions allow reimbursement for services related to rehabilitation and case management, services peers provide, but local behavioral health systems can apply more stringent guidelines than those given by the state. There are counties that allow billing to Medi-Cal for services delivered by peer support specialists however, at least 25 percent of billing ability is lost because current codes do not cover all services provided by peers.[130] Many believe that by establishing statewide certification for peers, more of these services would be billable for Medi-Cal reimbursement, making the use of peer providers more cost-effective.

Presently, 42 states and D.C. have state certification in place for peer specialists, and four states are in the process of developing protocols for state certification, primarily to allow peer services to be billed to Medicaid. Below are examples of states which have state certification for peers and therefore peer services are Medicaid billable.[xix]

Oregon:

- Has a Medicaid billing code for self-help/peer support
- Defines peer delivered services *as "an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable"*

Georgia:

- Has a Medicaid billing code specifically for peer support
- Includes *"activities provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible"*

Michigan:

- Has Medicaid service codes for peer-directed and –operated support services
- Acknowledges that "*because of their life experience, Peer Support Specialists provide expertise that professional disciplines cannot replicate"*

Kansas:

- Has Medicaid billing codes for individual and group peer support
- Aims to *"help the member to develop a network for information and support from others who have been through similar experiences," and "assist the member with regaining the ability to make independent choices and to take a proactive role in treatment, including discussion questions or concerns about medications, diagnoses or treatment approaches with the treating clinician"*

CERTIFICATION OF PEERS SERVES SEVERAL PURPOSES:[131]

- Establishes a standard of practice
- Legitimizes the role by establishing recognized standards of practice and a code of ethics
- Provides peer support employees with a professional voice
- Qualifies services for federal financial participation of at least 50%
- Allows for portability from one county to another

In 2015, SAMHSA identified 62 core competencies for peer workers in behavioral health services to be used for all forms of peer support.[xx] The competencies provided do not constitute an exhaustive list but offer a foundation which can be modified for different settings or target populations.

Other organizations, some within the state of California, are working to establish core competencies for peers in behavioral health and correctional settings which could potentially serve as the basis for a statewide model for peer certification.

The core competencies are organized into the following categories:[132]

- Engage peers in collaborative and caring relationships
- Provide support
- Share lived experiences of recovery
- Personalize peer support
- Support recovery planning
- Link to resources, services, and supports
- Provide information about skills related to health, wellness, and recovery
- Help peers to manage crises
- Value communication
- Support collaboration and teamwork
- Promote leadership and advocacy
- Promote growth and development

[xix] Gathered from PowerPoint presentation given by California Association of Mental Health Peer Run Organizations (CAMHPRO) on April 14, 2016 as an update on peer certification bill SB 614. To view presentation slides visit: https://camphro.files.wordpress.com/2016/03/peer-certification-slides.pdf.
[xx] For full list of core competencies, visit: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf

18. *RECOMMENDATION:* Promote the use of peers who are formerly justice-involved as an essential provider in the behavioral health workforce. Examine strategies to maximize Medi-Cal reimbursement for peer-delivered services. Use core competencies for a statewide peer certification program. Support efforts to establish a statewide certification program equipped with competencies that are effective in meeting the complex needs of the justice-involved population. All efforts to expand the use of peers in the workforce should include the formerly incarcerated.

Another model for expanding the behavioral health care workforce is that of the Community Health Worker (CHW).

FINDING: CHWs are often used to bridge the gap between community members and health care services. The CHW model has been used in different settings, including justice settings, to strengthen connections to health care services and general assistance benefits for clients who have complex needs.

CHWs are often used in the health care field as a link between clients, community resources, and health care services. CHWs come from the communities they serve, making them a more trustworthy and reliable resource for clients with complex behavioral health needs.

The connection that CHWs hold with members of their community enables them to provide more culturally competent services than providers who come from outside of the community. To be culturally competent, services must be responsive to the diverse health beliefs and practices of the population and meet the cultural and linguistic needs of the group served.[134] There are several different working titles for CHWs, but generally the services provided remain the same. There is some variation between work settings for CHWs with more specific titles, but Community Health Worker can be used as an umbrella term. In some cases, even peer support specialists have been included under the CHW umbrella.[135] Depending on the facility where they work, CHWs may or may not be required to complete an educational or certification program.

City College of San Francisco (CCSF) has a CHW certificate program with core competencies for CHWs within the curriculum. Using grant funds from Center for Medicare and Medicaid Innovations , CCSF developed an online version of the Post Prison Health Worker Certificate program. The curriculum for both the online and campus-based programs includes 20 units of study, including the core courses from the CCSF Community Health Worker Certificate. The program also includes training on the health impacts of incarceration and chronic disease management. The textbook used in the program, Foundations for Community Health Workers, was written by faculty along with CHW graduates. Students participating in the certificate program online are required to complete assignments such as shadowing colleagues at work, working with clients to develop Action Plans for the management of chronic health conditions, and developing and providing a community-based training.[xxi]

The use of CHWs in reentry has been shown to reduce recidivism among those with a history of justice-involvement.[136] Integrating correctional and community health care for formerly incarcerated people who are eligible for medicaid. An analysis of a program within the Michigan Prisoner Reentry Initiative that used CHWs to assist clients in reentry showed reduced rates of recidivism for participants who had been on parole for two years.[xxii] Only 22 percent of the 2,400 program participants in 2012 had new involvement with the criminal justice system compared to 46 percent of partcipants in 2007 when the initiative began.[137]

In California, some Medicaid Administrative Claiming (MAC) reimbursement is allowed for services that assist an inmate with enrollment in Medi-Cal up to 30 days prior to their release. MAC reimbursement can therefore be applicable to some reentry services provided by peer support specialists or community health workers.[138]

The American Public Health Association defines a Community Health Worker (CHW) as:

"…a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[133]

[xxi] To view the full requirements of the CCSF Post-Prison Health Worker Certificate Program visit: http://www.ccsf.edu/en/educational-programs/school-and-departments/school-of-health-and-physical-education/health-education-and-community-health-studies0/CommunityHealthWorkerCertificate/Post-Prison-Health-Worker-Specialty-Certificate-of-Achievement.html.

[xxii] The Michigan Prisoner Reentry initiative is "a statewide coordinated program that helps recently released prisoners access community-based health care and social services" (Sartorius and Woodbury, 2013).

Example of the CHW Model: Transitions Clinic Network (TCN)[139]

"[CHWs] are a vital member of the healthcare team, connecting patients with health and social services through outreach, educational, and advocacy efforts. CHWs act as cultural liaisons to ensure the provision of culturally relevant health services. They work both in the community and clinical setting, bridging the healthcare gap for the sickest and most vulnerable patients."

The Transitions Clinic Network serves individuals with chronic diseased who have recently been released from prison. The network is comprised of 17 clinics across the country, including Puerto Rico, six of which are in California, and all of which employ community health workers. TCN assists with re-integration into communities post-release and only hires CHWs who have a history of involvement with the justice system. All CHWs at TCN complete CCSF's Post Prison Health Worker Certificate Program. Those who work for a TCN outside of San Francisco, California complete their certificate through this online program.

19. *RECOMMENDATION:* Identify different CHW models being used in California and how they have been effective in behavioral health settings. Explore how maximize Medi-Cal reimbursement for these services. Ensure that models implemented also consider and address the needs of the justice-involved who have behavioral health needs.

FINDING: Many individuals who are justice-involved have a co-occurring mental illness and substance use disorder. Screening, assessment, and treatment of co-occurring disorders can be performed through integrated care. In 2017, Penal Code Section 6044 was amended and directed the Council to include individuals who receive medically necessary substance use disorder services as part of the Council's target population beginning in January 2018.

The Council has previously reported on the prevalence of COD among justice-involved individuals, calling for an examination of best practices to divert these individuals from jails and prisons. In addition, the Council identified the need for core competencies to provide integrated correctional and behavioral health care services. Because the presence of a COD greatly increases the risk of recidivism, coupled with the Council's newly expanded responsibilities to include substance use disorders within scope of practice, strengthening what is known to be effective treatment options for COD is paramount in the near future.

One example of a program which supports individuals with COD is the Friends Connection (FC) program in Southeastern Pennsylvania. Program clients have a history of frequent, long-term hospitalizations due to behavioral health challenges. Program staff include paid peers who are paired with clients they meet with regularly. To be hired, peer staff must be successfully coping with their mental illness and have abstained from drug and alcohol use for at least three years. A study of the Friends Connection program examined the number of days participants remained in the community before re-hospitalization over a three-year period compared to individuals with COD who did not participate in the program. The results of the study showed a statistically significant difference in hospitalization between the two groups. Nearly 38 percent of individuals in the FC program went through the full three years without any hospitalizations compared to only 27 percent among those who did not participate in the FC group.[140]

"The presence of co-occurring disorders is consistently found to adversely impact illness course, treatment response, psychosocial functioning, and is a key predictor of rehospitalizations, a major contributor to higher costs of care. Peer support programs hold promise for significantly reducing rehospitalizations."[141]

Marin County provides a local example of peers working to treat COD. In April 2017 Cesar Lagleva, LCSW, presented to the Council on his work as Ethnic Services and Training Manager for Marin County Behavioral Health and Recovery Services (BHRS).

Lagleva provided an overview of the Marin County BHRS Workforce Education and Training (WET) Program which is intended to *"develop a workforce that is culturally competent, linguistically and culturally reflective of the communities that are served, and able to offer integrated treatment for co-occurring disorders."*[142]

As part of this vocational training program, referred to as COPE (Co-Occurring Peer Education Program), Marin County residents who have lived experience with the behavioral health, criminal justice, and/or child welfare systems receive scholarships to pay for training to become certified as a mental health peer specialist, drug and alcohol counselor, or domestic violence counselor. From 2015-2016 COPE awarded drug and alcohol counselor certifications to thirty-five individuals and mental health peer specialist certifications to four individuals with lived experience. Thirty-nine graduates subsequently found volunteer, internship, or paid employment within the Marin County BHRS system. Lagleva recommended the promotion of peer specialist, drug and alcohol, and domestic violence counselors with lived experience as equal professional partners within multi-disciplinary team settings.[143]

Similar to a peer support specialists, peer recovery support providers (PRSP), or peer recovery coaches, can be used to augment recovery activities or formal substance use disorder treatment. PRSPs draw on their own lived experiences with recovery, creating a mutually beneficial relationship that supports the intervention's success.[144] Although some training is required, PRSP's differ from traditional professional counselors in that they do not need an advanced degree. Instead PRSP's use their shared experience to

"act as a recovery catalyst who serves to motivate and empower the individual…"[145]

In addition to providing emotional, motivational and instrumental support, PRSPs monitor treatment plan compliance, act as a referral source, and help with service coordination and case management.[146] PRSPs work with individuals to gain self-empowerment, employment, housing, and improved relationships while decreasing substance use, social isolation, and criminal justice-involvement.[147,148,149]

Although studies have shown the utility of PRSPs, there continues to be a need for more research regarding how PRSPs can be better incorporated into mental health service delivery, especially for those with co-occurring disorders.

20. *RECOMMENDATION:* The Council on Mentally Ill Offenders should seek to better understand integrated care and effective treatments for co-occurring disorders. Explore the role of SUD counselors in treating the target population and examine how the services delivered can be reimbursed through Medi-Cal.

The significant barriers faced by individuals with a history of involvement with the Criminal Justice system who are reintegrating back into their community are compounded by the presence of behavioral health challenges, including co-occurring disorders. Through COMIO's engagement with community health workers, peer support specialists, law enforcement, and consumers, it has become clear that navigating public systems upon release from jail or prison can be a daunting task. Peer support specialists, PRSPs, and CHWs can assist with this difficult transition.

FINDING: Specially trained peer providers, including CHWs, are needed to serve the target population due to their complex needs. There is emerging evidence that effective models exist in California but these models are not being implemented statewide.

This report shows that there is a need for peer support specialists, CHWs, and PRSPs with lived experience in the behavioral health workforce, including those who are justice-involved. A preliminary assessment shows there are several existing models, which address the needs of the target population, some of which are housed within California. The models described below are examples of some of the programs the Council interacted with this year.

PEERS

- Riverside University Health System – Behavioral Health (Riverside County)[xxiii]
  - The Navigation Center (formerly the Recovery Learning Center), employs peer support specialists who have lived experience in the behavioral health system, justice system, or both
  - Provides mental health services with consumer staff being the center of the delivery model
  - Uses Recovery International (RI) training program to train peer staff

- Peer Advisory and Advocacy Team (San Luis Obispo County)[150]
  - Created in partnership with Transitions-Mental Health Association, the San Luis Obispo County Behavioral Health Department, and the community
  - Provides informational forums, public service announcements, and unique educational opportunities via e-learning, classroom instruction, and field training for individuals with lived experience with mental illness
  - *"Supports individuals living with mental illness while offering a voice for peers as custodians of their trust"*

CHWs

Los Angeles County's WPC Pilot utilizes community health workers including the training and integration of CHWs into their service team. As part of this pilot, CHWs have many duties including participation in care coordination, re-entry planning and system navigation, to address the complex needs of clients in partnership with their primary care and behavioral health teams.[151] Below are some examples of the day-to-day work of CHWs in LA County's WPC pilot:[xxiv]

- Create a catalogue of local resources by various communities
- Coordinate with families, parole, and probation for case management
- Assist clients with job placement and job fairs
- Assist clients with enrolling in health coverage and general assistance

HYBRID MODEL

- Marin County Behavioral Health and Recovery Services[152]
  - Workforce Education and Training (WET) Program 2017-2020
  - Referred to as COPE (Co-Occurring Peer Education Program)
  - Seeks to develop a workforce that is reflective of the communities that are served and offer integrated treatment for co-occurring disorders
  - WET Scholarship Vocational Training Program helps fund training for county residents with lived experience county residents for certification as a mental health peer specialist, drug and alcohol counselor, or domestic violence counselor
  - Most program graduates find volunteer, internship, or paid employment within Marin's behavioral health care agencies

[xxiii] Conversation between Navigation Center staff and COMIO staff.
[xxiv] Focus group with Los Angeles County Whole Person Care (WPC) Pilot and COMIO staff.

In order to continue progress toward the goals of diverting individuals with behavioral health challenges from the criminal justice system, increasing connections to care, and reducing recidivism, models such as these must be further examined and evaluated for effectiveness. Each model—peer support specialists, community health workers, and peer recovery support providers—has strengths for treating the target population. Marin County's COPE program provides training for peers in both mental health and alcohol and drug counseling. This allows graduates the opportunity to successfully work with an integrated care team and address treatment needs for CODs. In moving toward statewide peer certification and increased use of CHWs, models that include SUD treatment should be prioritized due to the high number of individuals involved in the criminal justice system who are diagnosed with co-occurring disorders.

21. *RECOMMENDATION:*

a. Examine effective models to determine strategies for integration of SUD counselors.
b. Improve understanding of how peers, CHWs, and SUD counselors can work to serve people with co-occurring disorders.
c. Strengthen collaborative relationships by cross-training Peer Support Specialists, CHWs, and SUD Counselors. Foster the development of a culturally competent workforce who can effectively address the unique needs of the justice-involved population.

FINDING: There are significant barriers to employment for individuals who have a history of justice-involvement. These barriers also exist in county behavioral health systems.

Regardless of progress in building the capacity of the behavioral health care workforce, there are additional barriers to successful reintegration into the community post-release. Obtaining steady income is often a challenge in reentry especially due to the stigma of justice-involvement. When developing a statewide peer certification program, the barriers to employment that peers with lived experience and their clients face must be addressed. For individuals with prior justice-involvement, there are many barriers to reintegration into the community. Some may argue that one of the most significant of these barriers is the inability to find stable employment.

A study done by the National Institute of Justice showed that employers were 22 percent less likely to give a positive response (i.e. asking for an interview, second interview, or offering a job) to applicants who were formerly incarcerated than to applicants with no history of involvement with the criminal justice system. The study also demonstrated disparities in positive employer responses related to the race/ethnicity of the applicants. Results showed that employers responded better to White applicants with former justice-involvement than to African American or Hispanic applicants with no history of justice-involvement.[154]

Individuals who have lived experience in both the criminal justice and behavioral health systems face further discrimination when seeking employment. According to research from Texas Tech University, employer bias is an obstacle for persons with mental illness with and without criminal justice-involvement.[155] An evaluation of the bias toward job applicants who either had a known psychiatric and/or criminal history or neither, demonstrated that candidates who had a mental illness or a history of justice-involvement were considered less favorable by employers. Furthermore, applicants with both a mental illness and justice-involvement were considered the least acceptable.[156] Other factors considered to create obstacles for this population can be "*deficits in interpersonal skills, cognitive abilities, training or formal education, and stable work histories.*"[157]

In the case of peer support specialists, PRSPs, and CHWs, there is often a lack of acceptance from their colleagues due to the lack of standardized training or professional licenses for these roles. Therefore, individuals who have lived experience still face stigma in the workplace even after being offered a position. There is often tension between peers and other types of providers both because of stigma and disagreement or misunderstanding of recovery-oriented models that peers are trained to employ versus more traditional models of treatment. Instituting statewide peer certification could alleviate some of these issues, giving individuals with lived experience a more professional voice in the workforce.[158]

"Although the benefits of employment may be more critical to the lives of returning prisoners, one of the collateral consequences of incarceration is the stigma that results from imprisonment, which negatively affects the likelihood of securing employment" [153]

Individuals released from prison encounter a number of obstacles in their search for employment, including the reluctance of potential employers to hire ex-prisoners... although ex-offenders knew employment was important for their success and were optimistic about their prospects, their post-release employment rates remained low... ex-prisoners find fewer jobs and lower paying jobs. [159]

In addition to the barriers that individuals face in attempting to secure employment and financial stability, there are barriers that can prevent entities from being able to hire qualified individuals because of a criminal background. About 87 percent of employers conduct criminal background checks as part of their screening process for applicants.[160] These background checks can rule out quality candidates who are both qualified and driven. In 2008, the Center for Economic Policy Research determined that as many as 1.7 million workers were overlooked for positions because of their former justice-involvement. This loss of potential employees accounts for a 0.9 percentage-point reduction in the nation's employment rate and a reduction of $65 billion per year in gross domestic product for the United States.[161]

In recent years policies in California have attempted to aid in reducing the impact a criminal background in obtaining employment. For example, Section 12952 was added to the California Government Code in 2017 to prohibit employers from requesting information about a job applicant's conviction history prior to a conditional offer of employment, and sets requirements regarding the consideration of conviction histories in employment decisions. Although removing questions about convictions from employment applications creates less of a deterrent for applicants who are formerly justice-involved, it does not remove all barriers to employment. While progress is being made, there is much more that can be done to support the employment of individuals with lived experience in the behavioral health and criminal justice systems and ensure that they can assist in expanding an effective behavioral health workforce.

22. *RECOMMENDATION:*

a. Short-term: Assess and document barriers to employment for individuals with justice-involvement. With support from counties, identify effective practices for addressing barriers to employment and disseminate them statewide. Encourage local governments to utilize this untapped resource to build the capacity of their behavioral health workforce.
b. Long-term: In partnership with counties, strategize to address barriers through policy change.

"*It is hard enough to find a livable wage here in California, but to be disadvantaged because of something you did in your past, but you are in recovery today, and you can give back and help others, that does not seem fair*"

-Peer Provider

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Section C

SECTION C

CALIFORNIA COUNTIES AND PROMISING PROGRAMS TO PREVENT INCARCERATION

The Council continues support of activities being led by the *Stepping Up Initiative* which kicked-off 2017 with a California Summit where hundreds of leaders across the state gathered to learn how to strategically assess, plan, implement, and measure effective policies and programs to keep individuals with mental illness from incarceration. Organizers shared some of their conclusions based on their cumulative expertise as to why, after a decade of investments in diversion, counties are still not seeing reductions in the incarceration of people with mental illness, they include:

- Insufficient data as a barrier to identifying the target population and to informing efforts to develop a system-wise response,
- Program design and implementation are not evidenced based, and
- Initiatives are most often small in scale and outcomes and impact are not measured.[162]

The organizers urged county leaders to use four key measures to determine whether or not investments in community based services and supervision for people with mental illnesses are reaping benefits, they include:

- Reducing the number of people with mental illness booked into jail,
- Reducing the length of time people with mental illnesses remain in jail,
- Increasing connections to treatment and other needed services, and
- Reducing recidivism.[163]

Capacity is needed so that the right data can be collected, analyzed, and used to inform policymakers and administrators on where to make what types of investments (e.g. programs, facilities, workforce, training, evaluation, technology, etc.). The good news is that the vast majority of California counties, who collectively represent over three-quarters of the population, have passed resolutions to support the initiative. Often with assistance from *Stepping Up Initiative* staff, many have already begun or completed substantial planning efforts based on sequential intercept mapping (SMI)[xxv]. Some counties are exploring ways to roll out universal screening and assessment processes, which can help support the ability to measure these four outcomes, including some of the counties the Council worked with this year.

For 2017, the Council identified six counties that are distinct from each other to better understand the impact of Medi-Cal expansion and how individuals with lived experience can effectively be used in the delivery of behavioral health services for those with justice-involvement.[xxvi] In addition, this section of the report identifies key programs in each of the six counties that demonstrate promise or that has already succeeded at one or more of the four key outcomes identified by the *Stepping Up Initiative* as outcomes that can document a return on investment in community-based services or supervision alternatives to incarceration.

[xxv] To learn more about SMI review the COMIO 2016 Annual Report https://sites.cdcr.ca.gov/ccjbh/publications/ or the SAMHSA GAINS Center website https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts

[xxvi] Fresno, Orange, Riverside, San Luis Obispo, San Mateo, and Santa Clara were selected this year because each was in a different stage of planning and investments in prevention, diversion and reentry programming. In addition, these counties, like many, were in the middle of rolling out the DMC-ODS, implementing WPC pilots, and had made significant or enhanced investments in employing peers and community health workers to work with individuals who were justice-involved. Unfortunately, the Council was not able to include a small county in the cohort but looks forward to doing so next year.

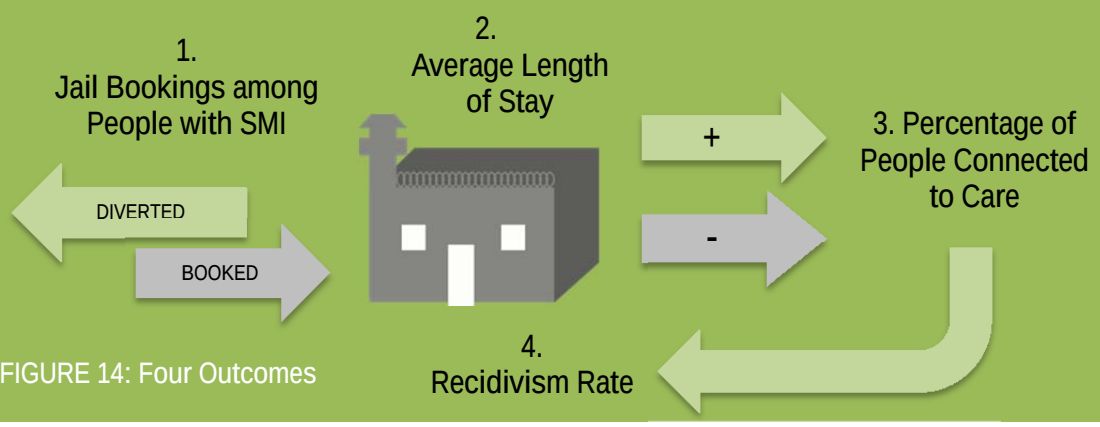

FIGURE 14: Four Outcomes

OUTCOME ONE: Reducing the number of people with mental illness booked into jail

One of the best methods to reduce the number of people with mental illness from being booked into jail is to provide the right kind of help at the right time, or the presence of a healthy, culturally responsive and accessible community-based behavioral health system of care. Using diversion terminology in sequential intercept mapping, which would be intercept zero and what systems strive to have the capacity to provide. At the April Council meeting a seasoned member of the Los Angeles Police Department's Mental Health Emergency Outreach Bureau, who has been leading crisis intervention training (CIT) for law enforcement and first responders for nearly a decade, spoke about the need to look beyond CIT. The lieutenant explained that police officers are sworn to protect public safety and they come to the scene with that mindset. He posed an important series of questions to the Council members and audience.

- Why are the police the primary responders to mental health crisis calls?
- Who else could respond that is better equipped to offer help?
- What are we doing to train and empower individuals, not police, to prevent crisis in the first place?

RIVERSIDE COUNTY

In Riverside County there are robust CIT efforts and in fiscal year 2015-16 nearly 800 law enforcement personnel ranging from officers to dispatchers to chaplains received training. More recently that number has grown exponentially to nearly 2000 and includes correctional and custody staff[xxvii]. The Consumer Affairs and Family Advocate (FA) programs are very involved in delivering CIT but the county is also investing in preventing crisis through training and empowering individuals with lived experience to respond to crisis. Both strategies aid in reducing the number of individuals booked into jail.

The Riverside University Health System Behavioral Health Division has demonstrated significant leadership in peer employment and training opportunities and now funds well over two hundred peer positions, many of whom have additional lived experienced in the justice system and who work in programs serving that population.[164] Particularly noteworthy, in 2016 the Office of Consumer Affairs implemented a consumer resources help line called the Peer Navigation Line (PNL)[xxviii]. Trained peers take calls from the public and help the caller by listening to concerns, identifying where possible resources may be located, and helping guide the caller on how to access resources. Staff is doing community outreach to raise awareness about the help line and a current peer program is being adapted into a "Navigation Center". Building upon the value of peers to "navigate" services, the Navigation Center is a hub for

[xxvii] Information provided in key informant interviews with staff
[xxviii] Visit the Office of Consumer Affairs Website at: http://www.rcdmh.org/ca

"I can give the family a voice in the courtroom, that is so important. I teach the family how to navigate the system and what options are available."

-Family Advocate

resource education where peer specialists (called peer navigators) help consumers problem solve barriers to services, including transportation.

The Center's approach to care includes:

- A team of peer support navigators who help make connections to mental health programs,
- A discharge clinic to address medication needs within 7 days of inpatient discharge, and
- A welcoming space to strengthen informal support systems.[165]

In addition to efforts to prevent crisis, Riverside County is also training peers to respond and support crisis programming. Transitions between levels of care can be stressful experiences and support from someone who has had similar experiences is comforting but also an effective engagement intervention. As noted in the Riverside MHSA three-year plan,

"Anecdotal reports from inpatient care providers report that feeling 'lost' at entering our service system is a primary reason that many consumers do not follow up with a mental health program after leaving the hospital"

Peer navigators are trained to work in inpatient environments, crisis stabilization units, and crisis residential treatment facilities. They offer emotional support as well as essential system navigation post-crisis to support relapse prevention and continuity of care. The use of peers in this manner was evident to various extents in all six counties the Council studied in 2017.

The county has made similar investments in the FA program that may seem less directly linked to preventing crisis and jail bookings, but certainly provides essential resources to prevent incarceration, especially recidivism. The program provides assistance to adult family members coping with understanding mental illness through education, information, and support. The program further helps families navigate the complex mental health, and if needed, criminal justice systems. While the program does a substantial amount of training, much of it is tailored to the needs of diverse racial and ethnic communities. What the Council found unique was the extensive support provided to families with loved ones in the justice system.[xxix]

Families often call in distress and want information about what to do if their loved one has been arrested. The FA program has developed an educational series on justice and mental health issues including what to do if a loved one is booked into jail or how to navigate the conservatorship process. The FA program uses forensic senior behavioral health peer specialists to do outreach in mental health courts, veteran's mental health courts, juvenile detention, the office of the public guardian, and long-term care programs to aid in understanding these complex systems and to offer hope and support. Family advocates are an essential part of the behavioral health court team bridging gaps between the family, district attorney, public defender, judge, and behavioral health care staff. There are over thirty family advocate staff working with the courts and jails as their primary focus. Families engaged in the courtroom or jail setting are encouraged to participate in educational training so that when their loved one comes home they are better equipped to support his or her recovery and wellness with goals of preventing relapse and recidivism.

SAN MATEO COUNTY

Crisis services are a continuum of services that stabilize and improve psychological distress and engage individuals in the type of services needed to address the problem that led to the crisis.[166] This continuum includes 23-hour crisis stabilization units, short-term crisis residential

[xxix] Visit the Family Advocate Program's website at: http://www.rcdmh.org/fap

services, mobile crisis services, 24/7 crisis lines, warm lines, advance directives, and peer crisis services. Such a robust scope of services can be influential in diverting individuals with behavioral health issues from incarceration but it is difficult for a county to develop such a continuum, especially smaller counties. Despite challenges for over a decade, San Mateo County has had many elements of this continuum and is currently developing more capacity. Below are four elements of the crisis continuum that have strengthened the county's ability to support diversion efforts.[xxx]

1. *CRISIS INTERVENTION TRAINING (CIT)* is a collaboration between the Sheriff's Office, BHRS, and NAMI for over the last 10 years serving 160 students per year and reaching all law enforcement jurisdictions in the county, including dispatch staff. The 40 hour courses have been adapted to include additional learning modalities about specialty populations such as diverse racial and ethnic groups. In addition, outreach is conducted by training staff to better understand what the needs of the community are and to continuously update the training. Future activities include "reverse CIT" which is for community members and providers to have a better understanding of the perspectives of law enforcement, course tailored for supervisors and courses focused on responding to youth in crisis.
2. *SAN MATEO ASSESSMENT AND REFERRAL TEAM (SMART)* is a collaboration between emergency medical services (EMS) and BHRS for over the last 10 years with the goal of providing a service to the community that can either provide an alternative to being transported to the hospital, jail or released at the scene. These alternatives include the sobering center, veterans' services, or other outpatient services. Medics selected for SMART have completed CIT and an additional 80 hours of specialized training. When 911 is called law enforcement can dispatch SMART. The medic can issue a 5150 hold but it is more likely they will consult a clinician or Psychiatric Emergency Services (PES) to determine another destination where the individuals can receive appropriate help if needed.
3. *PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT)* is another partnership between the Sheriff's Office and BRHS and has many responsibilities including providing consultation to law enforcement in the field and to support the diversion of clients from acute involuntary placement. The team trains law enforcement in crisis intervention techniques and also provides case management support for individuals who come in contact with law enforcement more regularly, such as individuals experiencing homelessness and substance use disorders. The PERT team visits all individuals 24 hours post a 5150 hold and does on-going outreach to individuals with mental illness in the community, seeking to reduce recidivism among offenders with mental illness.
4. *FAMILY ASSERTIVE SUPPORT TEAM (FAST)* started in 2013 as a response to families who would call in distress over a loved one but did not want to, or feel it was necessary, to involve law enforcement. FAST is an in-home outreach service that offers assessment, consultation, and support services to adults and their families living with significant mental health challenges. FAST consist of a therapist, family partners and a peer counselor who supports recovery but also works to prevent future crisis situations.

To facilitate quality improvement all four programs along the crisis continuum meet regularly to identify gaps in the system and strategize about partnerships with other services providers coming in contact with similar populations such as homeless and social services.

[xxx] Information about these four programs were presented during the July Educational Site Visit to San Mateo and Santa Clara counties. Materials are available at: https://sites.cdcr.ca.gov/ccjbh/1343-2/

Consistent definitions of mental illness and substance use disorder should be used among criminal justice and behavioral health systems to *"ensure that all systems are using the same measure to consistently identify the population that is the target for alternative services"*, such as the mental health court.[168]

OUTCOME TWO: ***Reducing the length of time people with mental illnesses remain in jail***

If it is the case that an individual is booked into jail, there are actions that can reduce the length of stay. As discussed previously (see page 18, recommendation 3) screening for mental illness and substance use disorder should be conducted on anyone booked into jail, in addition to follow-up assessments for those that screen positive. In addition, a person's risk of flight and risk of reoffending while awaiting court action should conducted so that all the information needed to determine readiness for diversion at pre-trail is available.[167] Screenings and assessments give jail administrators the information they need to appropriately plan and serve their population. Consistent definitions of mental illness and substance use disorder should be used among criminal justice and behavioral health systems to *"ensure that all systems are using the same measure to consistently identify the population that is the target for alternative services"*, such as the mental health court.[168] Currently there are efforts in California supported through technical assistance from the *Stepping Up Initiative* team to develop, with the help of local criminal justice and behavioral health experts and leaders, guidance and direction on using a shared definition of serious mental illness.

SAN LUIS OBISPO COUNTY

In San Luis Obispo County, the Behavioral Health Treatment Collaborative Court (BHTCC), through additional resources provided by a MIOCR Grant, has been able to add arraignment screenings by behavioral health clinicians to screen offenders with mental illness as early as their first appearance in court. This is unique because the request for a screening can come from any judge during arraignment if he or she believes the individual might be a good candidate for diversion. This method can facilitate earlier diversion from jail, possibly reducing the length of stay more than a traditional behavioral health treatment court. Once a screening identifies a candidate for diversion, a more thorough assessment can be provided by the BHTCC staff.

Through a collaborative process involving staff from behavioral health, probation, and the offices of the district attorney and public defender, admission into the program can take place immediately. If alternative services are available that day, for example a forensic full-service partnership slot or residential treatment, the diversion court candidate may be released and escorted to the available service. Peer support specialists from Transitions Mental Health Association, many with former experience in the justice system, play a vital role in engaging the new court program participant in services.[xxxi] The peer often transports the individual from jail to services or helps the individual navigate services once in the community. Peer support specialists also do outreach and engagement in the jail setting to encourage those who may have screened positive but weren't ready for diversion to

[xxxi] To learn more about Transitions programs, please visit: https://www.t-mha.org/community-programs.php

reconsider services as an alternative to jail. In addition, peers lead a variety of educational and support groups available to program participants.

Some of the accomplishments of the county's first year of the MIOCR grant programming includes:

- Serving over twice as many individuals as projected (for a total of 141),
- In-custody treatment for the SMI population has been established and groups and individual treatment sessions are conducted regularly, and
- Partners such as the courts, attorneys, and probation have been successfully educated regarding the dynamic needs of individuals with SMI and some of the treatment options in the community.[xxxii]

SANTA CLARA COUNTY

Earlier this year Santa Clara County launched the Community Awaiting Placement Supervision (CAPS) pilot which is a collaboration among the Sheriff's Department, Probation, Pre-trial Services, Reentry Services, Behavioral Health Services, Custody Health, and the Office of Supportive Housing. The team works with the courts, district attorneys and public defenders, state correctional partners, and treatment providers to facilitate the release of individuals on the Jail Assessment Coordinator (JAC) list.[169] The primary purpose is to place individuals suited for community supervision in treatment rather than remaining in jail. Preliminary results demonstrate that individuals on this list have a high need for mental health, substance use and housing services. For example, after just months in operation 76 of the 93 program participants were connected to mental health treatment and nearly all of those individuals are still in treatment.[170]

Behavioral Health Services has developed a protocol in partnership with the Behavioral Health Treatment Court where a provider delivers "in-reach" services during custody to develop a therapeutic alliance, encouraging medication compliance, and conducting acute interventions to stabilize the client before the transition to the community. If the individual is homeless, he or she is assessed using the standard triage assessment survey tool in the county—the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT)—which prioritizes who receives what kind of housing assistance in the county based on who has the greatest need. Of the preliminary CAPS cohort of 93 individuals, 35 were identified as being appropriate for permanent supportive housing (PSH) while 24 were identified for rapid-rehousing. Each CAPS client is routed through the reentry resource center and is provided with transportation assistance to fill medications and participate in treatment and services. The CAPS team makes contact with individuals several times per week depending on level of risk and need.

As of August 1, 2017, 520 individuals in custody where set of appear in the Adult Treatment Court and many of these clients potentially would be placed on the JAC list and also could be eligible for the CAPS program. As a solution to reducing to the size of the JAC list and placing more individuals who need treatment and services under community supervision rather than incarceration, staff is hoping to expand the CAPS program and to add designated shelter beds for the CAPS team to utilize when clients are in need of temporary housing.

All of the counties the Council engaged with this year expressed strong interest in increasing capacity for pre-trial diversion options. Making those options possible is not easy or simple. It requires investments across criminal justice and behavioral health systems including screening and assessments in jails, housing and community-based services, in addition to a political environment that is supportive of community supervision and treatment rather than incarceration. Many county representatives from judges to probation to mental health contract providers expressed frustration over challenges in creating community alternatives to incarceration due to NIMBYism for projects like sobering and restoration centers, residential treatment, and permanent supportive housing. While the process to develop community alternatives to incarceration has been slower than anticipated, counties remain vigilantly committed to pursuing and implementing projects.

Despite challenges in expanding pre-trial diversion options, all counties studied this year have grown and continue to make investments in specialty courts, like Santa Clara County's Adult Treatment Court programs. For over twenty years these court programs have served individuals with complex mental health challenges, substance use disorders, or both. Today the collaborative court model has been expanded to include, among others, a Veteran Treatment Court, Parole Reentry Court, Developmentally Disabled Court, and Incompetent to Stand Trial (IST) Treatment Court. In the Adult Treatment Court for individuals with behavioral health challenges over the course of one year (Jan 2016-Feb 2017) 76 percent of the participants completed the program.

[xxxii] During staff's site visit August 17, 2017, San Luis Obispo County staff shared results from their MIOCR rant reporting to BSCC.

The primary purpose of these courts is to provide individuals with complex behavioral health needs judicially supervised treatment as an alternative to incarceration, elements include:

- Supervision and case management,
- Interventions aimed at reducing high-risk behaviors,
- Assistance with vocational, educational, employment, mental and physical health care needs through community partnerships,
- Maintenance of a cohesive, multidisciplinary team to assist participants with life changing behaviors
- Administration of random drug and alcohol testing to encourage reduced substance use, and
- Preforming regular evaluations to promote effective practices.[xxxiii]

OUTCOME THREE: *Increasing connections to treatment and other needed services*

The challenges and benefits associated with connecting individuals with justice-involvement and behavioral health challenges to the right treatment and services are well documented in this report. Observations of efforts to increase these connections to avoid incarceration or promote diversion at the local level include prevention and reentry services because investments in both are interdependent. Both of the examples that follow highlight the value of making services more accessible as the key to increasing the likelihood of connections to care.

FRESNO COUNTY

In an effort to streamline processes and ensure that all individuals that need behavioral health care know how to access the right care at the right time and place, Fresno County's Department of Behavioral Health (DBH) developed the Multi-Agency Access Program (MAP). This preventive systems such as physical health, criminal justice including courts and probation, schools and other service delivery organizations so that access to care is significantly increased and health and wellness is improved.[xxxiv] The new program provides individuals with a single point of entry to access linkages (not just referrals) to behavioral health, social services, health services, and housing programs. Multiple "Map Points", which are, contract service providers, are strategically and geographic located where there is a large flow of underserved and unserved populations with high needs, such as individuals who have criminal justice-involvement. MAP is available to all people living in Fresno County and is offered in several languages.

Map Point providers across various systems participate in this as a collaborative and provide the following:

- A screening using a universal screening tool developed by the DBH called the *Community Screening Tool*—other assessment tools such as the VI-SPDAT are utilized
- The *Community Screening Tool* identifies needs in several domains representing all aspects of the client's life such as mental health, housing, medical and social services, etc.
- Navigators develop a service and linkage plan for clients and or families and monitor for successful linkage to each
- Navigators assist clients in obtaining documents such as identification cards, social security cards, birth certificate, immigration related or other documents needed to access public benefits and housing programs
- Transportation is provided to support the warm handoff and successful linkage to needed services
- Advocacy is provided to clients needing to maintain housing and their utilities

[xxxiii] Information was presented as part of the July Educational Site Visit and can be found on the COMIO website at: https://sites.cdcr.ca.gov/ccjbh/1343-2/
[xxxiv] Information provided by Fresno County in the program overview of the solicitation for MAP contract agencies.

Currently three providers are participating in the program with eight stationary "MAP points" in addition to a mobile unit with capacity to reach rural communities. The screening tool is operative and available for navigators to use at the map points and it is being further enhanced with features that would allow navigators to more effectively assist clients such as tracking activities and case management and assistance with additional service linkages.[171] According to very preliminary data in the first quarter of 2017, the overwhelming reason for coming to a MAP point (76 percent of participants) was for assistance with housing.[172] Currently the MAP collaborative is working with law enforcement and the courts to assist in clearing outstanding warrants and to support success in meeting supervision requirements which can facilitate access to housing and employment. The County is also exploring if and how information from the screening tool, or associated data, can aid law enforcement in identifying persons with behavioral health conditions they come in contact with to promote diversion from incarceration.

SANTA CLARA COUNTY

While providing access to the right kinds of services may be associated with decreased risk in incarceration, providing similar access upon release from incarceration can reduce recidivism. Valley Homeless Healthcare Program (VHHP) provides comprehensive healthcare services to the homeless population of Santa Clara County. Overall the program provides medical care to more than 7,000 homeless patients each year. Their staff of 35 is composed of physicians, nurses, mental health experts, and outreach workers who care for Santa Clara County's homeless through walk-in clinics and a mobile unit that travels once a week to local homeless encampments.

As part of this program, the mobile health unit that is equipped with medical staff, including a psychiatrist, can be found twice per week at the Santa Clara County Reentry Resource Center located across from the county jail. The unit provides an array of services to both probationers and parolees. Staff at the program estimate that about a third of the homeless population they serve have a mental illness and nearly two-thirds have previous or current justice-involvement. The mobile unit alone estimates about 2500 visits per year of which half involve clients with mental health needs. In addition, the program reports a 70 percent success rate at connecting individuals to on-going primary care services. [xxxv]

The reasons for success reported by staff include the ability to work with custody clinicians to support a smooth transition back to the community, including transferring and integrating health data. Of particular interest to COMIO, VHHP relies on a network of community health workers to do outreach and engagement (including in the jails), system navigation, health education and peer counseling to support successful health outcomes and to keep individuals from returning to incarceration or hospitalization. Many if not most of this uniquely skilled group of individuals have been formerly incarcerated themselves and understand the specific challenges of reentry and recovery. Moreover they literally support connections to care as system navigators who physically transport and accompany individuals to appointments and aid in signing up for needed benefits, etc.

[xxxv] Comments made from a panel of staff at the July 19th Educational Site Visit to Santa Clara County.

"A client with a 20-year history of substance abuse and criminal justice-involvement was able to receive 90 days of residential treatment because of the Drug Medi-Cal Waiver. Now he has a job, has reestablished relationships with his family, and is going to college to get his degree."

-Provider, sharing a success story

OUTCOME FOUR: *Reducing recidivism*

All six counties had community-based behavioral health treatment programs either fully or partially dedicated to serving individuals with justice-involvement. These primarily came in the form of full service partnership (FSP) programs in which one of the primary goals is to reduce arrests and time spent in jail. While the FSP program, often referred to as a *forensic* FSP, may have begun as an MHSA program, there is promising evidence that in some counties these programs are growing because of increased federal funds under Medi-Cal or funds dedicated to *forensic* FSPs under the direction of the CCP (who oversee public safety realignment funds). For example, in reviewing Santa Clara County's Behavioral Health Services Department work plan update to the Jail Diversion and Behavioral Health Subcommittee of the Re-entry Network, *forensic* FSP slots were proposed to be increased by 20 in order to take more referrals and reduce the length of stay in jail. The proposed resources for this expansion include Medi-Cal and county general fund, not MHSA funds. Possibly this was designed to ensure parolees would not be excluded. In addition, 50 slots for post-custody clients are being added to the 120-day Intensive Outpatient Service Team using primarily Medi-Cal revenue with additional support from MHSA and county general fund.[173] Increasing the ability to achieve a reduction in recidivism is not necessarily about what MHSA programs are doing or what AB 109 programs are doing but collectively how are counties maximizing resources, and in particular leveraging Medi-Cal, from multiple funding sources to implement programs that can reduce recidivism. Moreover, the Council would encourage that such efforts would include parolees particularly since many recidivate to local jails and not state prison.

ORANGE COUNTY

While FSPs may be resourced differently county by county, there is growing evidence that it is a model that works well for those with complex health conditions and justice-involvement. Among them is Orange County's *Whatever it Takes* (WIT) Court and FSP provided by The Telecare Corporation which has contracts in several counties and CDCR. WIT is a voluntary program for non-violent offenders who have a mental illness and are underserved or unserved and who may be homeless or at risk of homelessness. The program offers a final opportunity to receive services in the community rather than jail and helps an individual comply with requirements set by the courts and a treatment plan designed in collaboration with probation, the district attorney, the public defender, behavioral health, and the program participant.[174] Through a multidisciplinary team skilled in drug and alcohol, housing, and employment and vocational services, in addition to mental health, participants experience a *whatever it takes* approach to avoiding re-incarceration, hospitalization, and homelessness. Specialized probation officers with enhanced training and reduced caseloads due to the intensity of the needs of participants are an essential component of the program. Services and supports include:

- Outreach and engagement
- Community-based wrap around services
- Intensive case management
- Money management/representative payee
- 24/7 availability
- Housing support
- Medication support and education
- Co-occurring recovery treatment
- Vocational and educational services
- Linkage to financial benefits

According to outcomes reported in the Orange County MHSA Three-Year Plan in FY 15/16, the WIT program achieved a 94 percent reduction in days spent in jail for participants who were enrolled in the program. Program costs under the MHSA plan are directed at items that are not likely reimbursable under Medi-Cal, for example enhanced probation staff and training for the Mental Health Collaborative Courts.[175]

Areas of quality improvement identified by Telecare include reducing the rate of relapse for those with COD and increasing financial independence. Developing effective treatment for the co-occurring population with justice-involvement was a reported challenge in all counties the Council interacted with this year. Currently 100 percent of the WIT participants have COD and residential treatment referrals have skyrocketed. This trend prompted Telecare to develop a program specific to those at high risk of relapse as an alternative to residential treatment—Co-Occurring Program Extension (COPE). Additional treatment includes programming specific to SUD including evidence-based practices such as Cognitive Behavioral Therapy, Dialectal Behavioral Therapy, Moral Recognition Therapy, trauma focused therapists, random urine screening, and identifying triggers of relapse. Preliminary results are

promising, demonstrating that COPE is more successful in engaging participants in substance use treatment without incurring high costs and struggling with the lack of availability of residential treatment beds. Public administrators note that more work needs to be done to improve retention and program completion rates.[xxxvi]

[xxxvi] Preliminary results were shared with staff via email communication in November 2017.

Endnotes

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Future Directions

FUTURE DIRECTIONS

FINDING: Although federal, state and local partners have invested significantly in this issue, the state lacks a coordinated, strategic approach that leverages the authority and resources across state government to maximize the prevention and diversion of individuals with mental illness and substance use disorders from the criminal justice system. This includes effective reentry strategies tailored to meet the needs of individuals with serious mental illness, substance use disorder, co-occurring disorders, and/or high criminogenic risk factors who have specialized needs. In addition, continuity of care between state and local criminal justice and behavioral health systems is fragmented and perpetuates negative consequences such as recidivism, homelessness, and hospitalization.

Over the course of 2017, and particularly through the Council's in-depth work with six counties, it became clear that more could be done at the state level to support local success in prevention, diversion and reentry. Several statewide entities in recent years have conducted comprehensive efforts to identify what needs to be done to effectively reduce the incarceration of individuals with mental illness including the Judicial Council's Mental Health Issues Implementation Task Force and the Mental Health Services Oversight and Accountability Commission's (MHSOAC) Subcommittee on Criminal Justice and Mental Health. These efforts, in addition to the work of the Council and several others, can be built upon to synthesize and prioritized future state action. As counties undergo sequential intercept mapping to identify gaps in services and propose solutions, the state can also tactfully identify if there are policies and practices that warrant revision to support local goals. Several of the recommendations in this report and the work of others identify actions that the state can take such as addressing NIMBYism or maximizing federal reimbursement for Medi-Cal beneficiaries with justice-involvement, but a more strategic and systemic process is needed. Doing so now can also assist new state leadership that must follow in footsteps of the Brown Administration which invested significant time and resources into reforming criminal justice and health care systems. Guidance that is collaborative and comprehensive can serve as a useful transition tool, documenting current progress and mapping necessary next steps to sustain achievements and further push California forward as a leader in effective prevention, diversion, and reentry policies and programs for individuals with behavioral health challenges.

23. *RECOMMENDATION:* COMIO is well positioned to build upon existing efforts and lead state agencies, departments, advisors, and stakeholders to:

    a. Catalogue existing state and federal efforts in prevention, diversion, and reentry, including the authority and funding provided by different entities,
    b. Identify strengths and barriers in existing efforts including opportunities to improve coordination to address gaps in prevention, diversion and reentry efforts,
    c. Develop a prioritized plan of legislative, regulatory, financial, educational, and training and technical assistance activities for statewide action, and
    d. Create a reasonable structure to measure the progress and impact of such activities.

Such a plan would echo and reinforce local planning processes underway and ensure that state resources are prioritized to achieve shared measurable objectives with county partners.

Appendix A

Appendix A

Research Scientist III started with COMIO February 2017 – Highlights of Activities Completed

I. Medi-Cal utilization research project
   a. Executed a Memorandum of Understanding between CDCR and DHCS to permit a Research Scientist III to work within both departments to lead the Medi-Cal utilization project.
   b. Executed a DU) between CDCR and DHCS allowing the use of CDCR data by the Research Scientist III to be linked to DHCS data systems.
      1. Example of CDCR data variables included in the DUA (Data Use Agreement)
         i. Admission and release date
         ii. Mental health designation
         iii. CSRA (California Static Risk Assessment) score
         iv. Substance abuse need assessment
         v. Demographics
      2. Example of DHCS data variables linked to CDCR data include
         i. Program code
         ii. Health Plan code
         iii. ICD-9 and ICD-10 diagnosis codes
         iv. Procedure codes
         v. Location of services received
   c. Next steps, conduct analyses to answer core project goals including:
      1. Inform and increase understanding among policymakers and program administrators regarding health care utilization of former offenders and implications.
      2. Provide information to state and county administrators to consider supporting decision-making and improve service delivery to the formerly incarcerated with complex health needs, including behavioral health.
      3. For the sub-population of individuals who use a significant amount of resources (e.g. super-utilizers) within this cohort, seek to bend the cost curve by targeting them with interventions.

II. Coordination of the Criminal Justice and Behavioral Health Data Workgroup (CJBHW). CJBHW is a statewide workgroup whose mission is to collaborate and discuss findings from research studies at the state and county level that incorporate data from justice-involved individuals and behavioral health factors. The group discusses ways findings and data from various studies can be leveraged to advance policy recommendations for the justice population in California.

III. Planned and facilitated COMIO's September Data workshop which focused on exploring available data collection and sharing strategies and challenges in their implementation related to the justice-involved population with behavioral health needs.

Appendix B

Appendix B

COMIO
Council on Mentally Ill Offenders

Building bridges between criminal justice & behavioral health to prevent incarceration

HOMELESSNESS, MENTAL ILLNESS & JUSTICE-INVOLVEMENT

According to Corporation for Supportive Housing (CSH), **one-third of those who are homeless experience a mental illness,** and **two-thirds report substance use disorders.**

- The impact of homeless on Californians with behavioral health challenges, justice
- Homeless parolees and probationers are **seven times more likely to recidivate.**
- In California, medical costs make up the largest share of costs for those who experience homelessness. **Each homeless person costs** Medi-Cal over $21,500 per year and those with substance use disorders average $60,000. For those who are chronically homeless, this number can rise to over $100,000.
- While the percentage of those experiencing **chronic homelessness** has decreased by 10% in the United States from 2013 – 2016, in California homelessness has **increased by 13%.**

California has the highest rate of chronic homelessness in the country at 36 percent, with 21 percent of the national homeless population, of which a fifth are individuals with mental illness

Those experiencing chronic homelessness in California have high mortality rates, dying, on average, 25 - 30 years earlier than their housed counterparts

HOMELESSNESS & HEALTH ISSUES

- **Behavioral health issues** such as depression or alcoholism often **develop or are made worse** in such difficult situations, especially if there is no solution in sight.
- **Common conditions** such as high blood pressure, diabetes, and asthma **become worse** because there is no safe place to store medications or treatments properly.
- **Maintaining a healthy diet is difficult** in soup kitchens and shelters as the meals are usually high in salt, sugars, and that lack nutritional value.
- **Injuries** that result from violence or accidents **do not heal properly** because cleanliness and sanitation is difficult, and getting proper rest and recuperation isn't possible on the street or in shelters.
- **Minor issues** such as cuts or common colds easily **develop into large problems** such as infections or pneumonia.

Conditions among people who are homeless are frequently co-occurring, with a complex mix of severe physical, psychiatric, substance use, and social problems. High stress, unhealthy and dangerous environments, and an inability to control food intake often result in visits to emergency rooms and hospitalization which worsens overall health.

COUNCIL MEMBERS

Scott Kernan, Chair
Secretary, California Department of Corrections and Rehabilitation

Manuel Jimenez, Vice Chair
Former Behavioral Health Director, Alameda County

Pamela Ahlin
Director, California Department of State Hospitals

Jessica Cruz
Executive Director, National Alliance on Mental Illness California

Matthew Garcia
Field Training Officer, Sacramento Police Department

Mack Jenkins
Retired Chief Probation Officer, San Diego County

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David Meyer
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STRATEGIES TO TACKLE HOMELESSNESS

- **Housing First:** Under Housing First, those experiencing homelessness **should be connected to permanent housing as soon as possible** and barriers to accessing housing should be removed.
  - Opportunities for Housing First initiatives must not exclude people based on justice status, explicitly or implicitly.
  - Four standard Housing First models include:
    - Emergency Shelter: short-term (ideally less than 30 days)
    - Rapid Rehousing: medium-term (no limit on stay)
    - Transitional Housing: medium-term (limited stay)
    - Permanent Supportive Housing: long-term (no limit on stay)
    - Residential Treatment: treatment model (length of stay depends on need)
  - **SB 1380:** Requires all State housing programs to **adopt "core components" of Housing First**, which are: low barrier access to housing, voluntary services tailored to tenant needs rather than tailored to the program, and lease protections for tenants.
- **Ensure people exiting incarceration are eligible and have access to housing.**
  - The use of the definition "chronic homelessness" could exclude individuals returning home. The inclusion of "at risk" of chronic homelessness should be included in Housing and Community Development programs and initiatives.
  - HUD will require local **homeless Continuum of Care (CoCs)** planning bodies to have **Coordinated Entry Systems (CES)** by January 2018. CES is intended to be a more collaborative, comprehensive approach to working with those who are in need of housing. Justice involvement should be prioritized as a risk factor in CESs.
- **Combat NIMBYism**, "Not in My Back Yard": the resistance of unwanted development in one's locality.
  - Strengthen state-level efforts to combat NIMBY community responses for housing for individuals with behavioral health needs and/or individuals who have been formerly incarcerated. Explore if and how the Housing Accountability Act will aid in enforcing the development of appropriate housing for special needs populations who may be experiencing discrimination.
- **Housing Rights: Educate the Public Housing Authority and Californians**
  - Arrest records cannot be the basis for denying admission, terminating assistance or evicting tenants.
  - Support Californians in knowing their rights to housing and filing grievances when they are denied.
- **Housing and service providers could further explore opportunities to expand group housing options as an alternative to single family units.** Group housing not only could be more accessible and affordable but might be a better fit for individuals with behavioral health challenges.

"There is a need for safe and affordable housing in a very expensive housing market with little vacancy."

Survey Respondent, Provider

https://sites.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/4/2017/12/COMIO-Homelessness-and-Justice-Involvement-Factsheet-Revised.pdf

COMIO
Council on Mentally Ill Offenders

Building bridges between criminal justice & behavioral health to prevent incarceration

BEHAVIORAL HEALTH CARE AND THE JUSTICE-INVOLVED: WHY IT IS SO IMPORTANT?

In fiscal year 2015-16 a total of **35,098 individuals** returned to their communities from the California Department of Corrections and Rehabilitation (CDCR). Within that group, **23.1 percent** were identified by CDCR as having mental health needs ranging from severe to moderate and **57.7 percent** as having substance use treatment needs. While those numbers are likely to shift slightly once home due to changing circumstances and stressors, clearly there is a significant need for behavioral health services upon re-entry.

The consequence of behavioral health needs 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** (Kim, Becker-Cohen, & Serakos, 2015). A study by PEW and the MacArthur Foundation (2014) found that **correctional spending on adults with mental illness alone is two to three times higher than for those without mental illnesses**.

- ✓ **The number of prisoners with mental illness in California is on the rise:** while the overall state prison population has decreased dramatically, the number of prisoners with mental illness continues to climb and is expected to grow in the years ahead. Over the past decade, the percentage of state prisoners with mental illness had increased by 77 percent (Stanford Justice Advocacy Project).
- ✓ **Defendants with mental illness receive longer prison sentences:** On average, prisoners with mental illness in California receive sentences that are 12 percent longer than prisoners convicted of the same crimes but without mental health diagnoses (Stanford Justice Advocacy Project).

Released inmates have high rates of poverty, unemployment, and ultimately homelessness – wreaking havoc on health status

- ✓ A survey of over 1000 returning offenders from prisons found that **4 in 10 men** and **6 in 10 women** reported a combination of physical health, mental health, and substance abuse conditions
- ✓ These individuals reported poorer employment noting that health problems interfered with their ability to work, and reported a need for housing assistance

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 substance abuse disorder, which are indirectly linked to recidivism

Public safety is a health issue – health issues are a public safety issue

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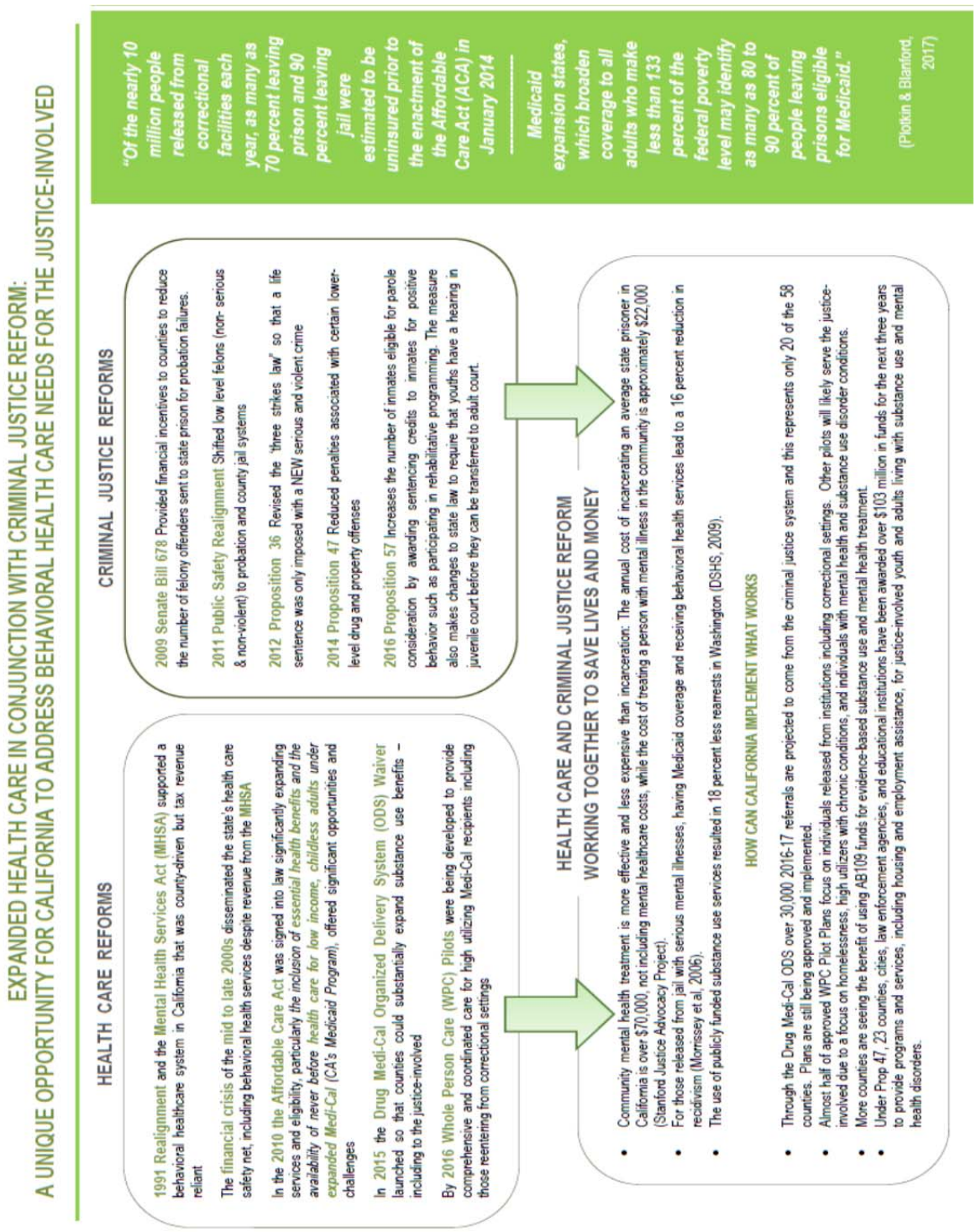

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COMIO
Council on Mentally Ill Offenders

Building bridges between criminal justice & behavioral health to prevent incarceration

WHAT WE DO

Since 2001 California, through the Council on Mentally Ill Offenders (COMIO), has recognized that individuals living with mental illness are at risk of becoming criminally involved without access to support and needed services. As a 12-member council chaired by the Secretary of the Department of Corrections and Rehabilitation (CDCR), COMIO is charged with investigating, identifying, and promoting cost-effective strategies that:

- Prevent criminal involvement
- Improve behavioral health services
- Encourage state and local criminal justice and behavioral health systems to work collaboratively

DIVERSION

When programs divert individuals with mental illness (and often co-occurring substance use disorders) away from incarceration by providing links to community-based treatment and support services. Individual's avoid arrest or spend significantly reduced time incarcerated on the current charge or violations of probation resulting from previous charges.

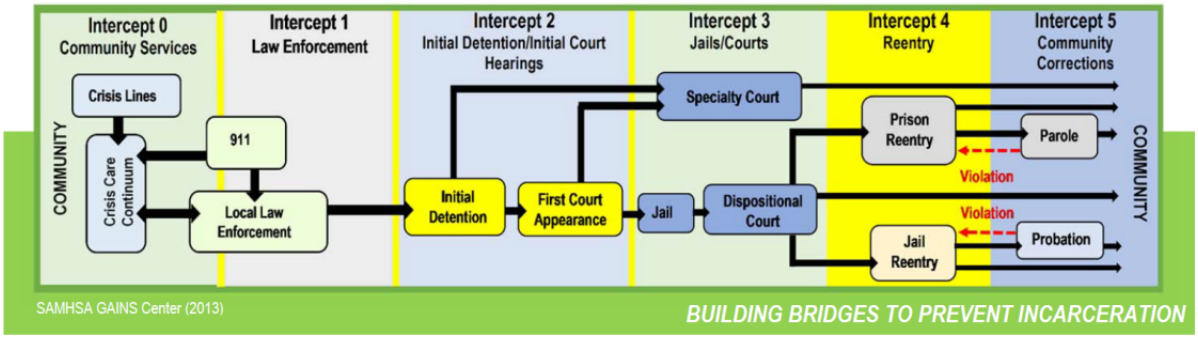
The **SEQUENTIAL INTERCEPT MODEL** helps administrators plan how to reduce the over-representation of people with mental illness in the criminal justice system. The model outlines sequential points at which a person with mental illness can be "intercepted" and diverted from going further into the criminal justice system. The goal is for people to be intercepted as early in the process as possible, leading to fewer people entering the criminal justice system.

WHY DIVERSION

- **2 MILLION ADMISSIONS** to U.S. jails annually are persons experiencing mental illness. Of these, **3 IN 4** have a diagnosis of **BOTH** a substance use disorder and a mental illness (Steadman et al, 2009).

- More than **fifty percent** of inmates in prison and nearly **seventy percent** of those in jail met criteria for substance dependence in the year prior to their arrest (Mumola & Karberg, 2004).
- Once incarcerated, these individuals stay longer and correctional spending on adults with mental illness is two to three times higher than for others (Stanford Justice Advocacy Project, 2017).
- Challenges follow them home, as nearly **ten percent** of probationers and parolees have a serious mental illness, and **forty percent** have a substance use disorder (Feucht & Gfroerer, 2011).
- Individuals with behavioral health challenges have higher rates of recidivism *(e.g. over **sixty percent** of individuals with the most serious mental illnesses return to prison in California within **three years**)* (CDCR Outcome Report, 2015).

SEQUENTIAL INTERCEPT MODEL



SAMHSA GAINS Center (2013)

BUILDING BRIDGES TO PREVENT INCARCERATION

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CHALLENGES

Diversion practices are fairly new and we are starting to learn what works. Currently there is a need to better use screening and assessment tools for mental health, substance use disorders, and recidivism risk. Doing so can prioritize need and risk with the right services and interventions. The lack of co-occurring services (those offered to individuals with both a mental illness and substance use disorder) is a particular concern.

Addressing **STIGMA** is essential to ensuring more equitable practices in both the criminal justice and behavioral health systems. Because of stigma toward the justice-involved, former offenders reentering society face major challenges in each of the areas in the visual to the right (housing, education and training, employment, and social welfare).

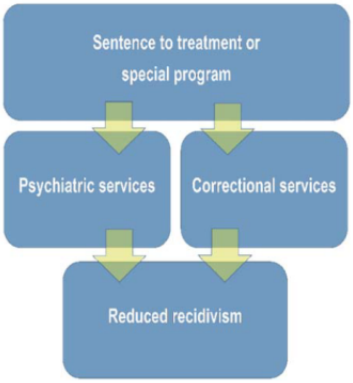
For the justice-involved person with mental illness, reintegration and a reduction in recidivism is only possible if we begin to remove the layers of stigma which collectively are crippling.

IMPLEMENTING EFFECTIVE PRACTICES

Often it is believed that more community mental health services will reduce recidivism, but this is not well supported by research. 'Untreated mental illness' alone does not strongly predict criminal behavior (Skeem et al, 2013).

- Symptoms rarely cause crime
- Psychiatric services rarely reduce crime

WHAT WORKS



ON THE HORIZON

- Preserve and protect California's expansion of health care services for the justice involved – **it is a public safety and public health issue.**
  - Preserve and maximize Medi-Cal (Medicaid) expansion to address mental health and substance use disorder needs.
- Prevent crisis don't just respond to it.
  - Empowering peers, families, suicide prevention hotlines, and other community members to do outreach and engagement.
- Remain vigilant in eradicating discriminatory policies impacting the justice-involved.
- Integrate data systems between criminal justice and behavioral health systems.
  - Individuals who are justice-involved are among the most costly healthcare users so it is necessary to develop strategies to share information to target limited resources and monitor outcomes.
- Address the high cost and lack of accessibility to affordable housing.
- Review and revise bail and pre-trial detention policies that have a disproportional impact on individuals with mental illness.

"COMIO recognizes that mental health issues are far too prevalent in California's criminal justice system. Our role is to promote early intervention for youth and adults with unmet behavioral health needs."

- Secretary Scott Kernan

https://sites.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/4/2017/12/COMIO-General-Factsheet-Revised.pdf

CONNECTIONS TO CARE

There are numerous reasons why there are challenges for justice-involved individuals to be connected to care. We do not have the capacity to serve those with behavioral health issues in the community due to:

- Lack of capacity in the workforce to provide services
- Lack of facilities to provide treatment
- Cumulative reduction in overall spending for behavioral health services

Nearly **1.3 million** people with mental illness are incarcerated in state and federal jails and prisons – compared to only about 70,000 people being served in psychiatric hospitals (Department of Justice, 2013).

The Journal of the American Medical Association reported that there were **22 psychiatric beds for every 100,000 people in the United States.** In addition, from 1998 to 2013, as the number of psychiatric beds fell from 34 to 22 per 100,000, the suicide rate increased by 24 percent to 13 per 100,000, significantly more than in other developed nations. In this most advanced of nations, there were 42,773 suicide deaths in 2014, up from 29,199 in 1999.

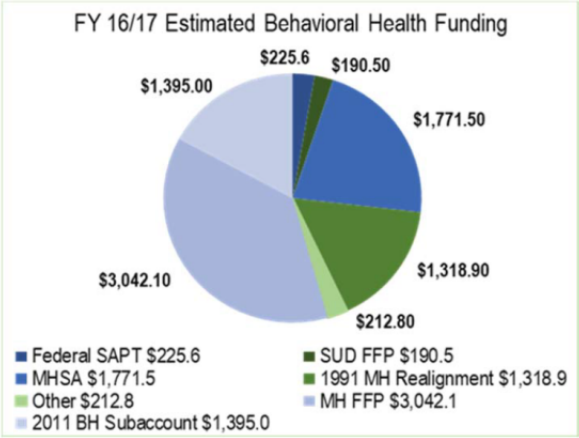
Around the country, state psychiatric hospital beds are in short supply and their numbers are declining. Advocates suggest at least 40 beds for every 100,000 people.

California, as of June 2016, had 15.1 beds per 100,000

(Treatment Advocacy Center)

"The inclusion of behavioral health services which are covered by health insurance means people will have greater access to the help that they need. But right now, 55 percent of U.S. counties do not have any practicing behavioral health workers and 77 percent reported unmet behavioral health needs. It's clear our robust effort in promoting relevant professions, building skills, and making sure that communities in need have support will have a positive effect on many."

- *Anne Herron, SAMHSA*



*Geiss Consulting

In state prison, prevalence of serious mental illness is 3 to 4 times higher than in the community.

Many people leaving prisons and jails have behavioral health disorders, frequently combined with physical illness, that need to be addressed within the context of a comprehensive reentry plan – a plan that builds on correctional agencies investment in an individual's treatment during incarceration. **The APIC (Assess, Plan, Identify, Coordinate) Model** (Osher, Steadman, & Barr, 2002) provides guidance for behavioral health, criminal justice system, and community stakeholders to work collaboratively across systems to design and implement evidence-based programming to forward the dual goals of individual recovery and risk reduction.

ASSESS the individual's clinical and social needs and public safety risk.

GUIDELINE I

Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

GUIDELINE II

For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on

- Basic demographics and pathways to criminal involvement
- Clinical needs
- Strengths and protective factors
- Public safety risks and needs

PLAN for the treatment and services required to address the individual's needs, both in custody and upon reentry.

GUIDELINE III

Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process

- Determine appropriate level of treatment
- Identify and target individuals' multiple criminogenic needs
- Address aspects of disorders that affect function
- Develop strategies for integrating appropriate recovery support services into service delivery models
- Acknowledge dosage of treatment as an important factor in recidivism reduction

GUIDELINE IV

Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

IDENTIFY required community and correctional programs responsible for post-release services.

GUIDELINE V

Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings

GUIDELINE VI

Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages for post-release treatment and supervision agencies.

COORDINATE the transition plan to ensure implementation and avoid gaps in care with community-based services.

GUIDELINE VII

Support adherence to treatment plans and supervision conditions through coordinated strategies

- Maintain a "firm but fair" relationship style
- Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions

GUIDELINE VIII

Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals

GUIDELINE IX

Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with co-occurring disorders who are involved in the criminal justice system

GUIDELINE X

Collect and analyze data to evaluate program performance, identify gaps in performance and plan for long-term sustainability.

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https://sites.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/4/2017/12/COMIO-Connections-to-Care-Factsheet-Revised.pdf

Appendix C

Appendix C

2017 COMIO Stakeholder Engagement Log

January	Participated in the following: • No Place Like Home Workshop hosted by the Department of Housing and Community Development (DHCD) • Collaboration meeting with BSCC • Developing Partnerships: "Crisis Intervention Team Officers and Providers" crisis intervention team collaboration hosted SAMHSA • Presenter at the Stepping Up Initiative: The California Summit hosted by CSG Justice Center and state partners: County Behavioral Health Directors Association (CBHDA), California State Sheriffs' Association, Chief Probation Officers of California, California State Association of Counties (CSAC), CBHDA, and Mental Health Services Oversight and Accountability Commission (MHSOAC) • COMIO, DAPO, Division of Rehabilitative Programs and California Correctional Health Care Services (CCHCS) staff to staff meeting with CBHDA Site Visit • California State Prison, San Quentin
February	Participated in the following: • Share Project National Training and Grant Retreat; project of Dr. Emily Wang, MD, MAS, Associate Professor at the Yale School of Medicine and Co-Founder of TCN • Leading the Way Coalition Meeting led by California Hospital Association (CHA) and NAMI • MHSOAC Forum on Triage Services • BSCC Strategic Planning Meeting • Steinberg Institute Policy Summit • Mental Health Care collaboration meeting with Office of Health Equity • Invited speaker at the National Association of County Behavioral Health and Developmental Disability 2017 Legislative and Policy Conference in Washington, DC COMIO Workshop - Protecting California's Investments in Medi-Cal Expansion for the Justice-Involved • Guest Speaker ➢ Mary Adér, Deputy Director, Legislative Affairs, CBHDA COMIO Council Meeting • Update on the Whole Person Care Pilot ➢ Dr. Clemens Hong, Medical Director, Community Health Improvements, Los Angeles County Department of Health Services • Update on State Budget and Administration Priorities for 2017-18 ➢ Diane Cummins, Special Advisor to the Governor, State and Local Realignment, California Department of Finance • Policy Priorities from COMIO Key Partners ➢ Kathleen Howard, Executive Director, BSCC ➢ Kirsten Barlow, Executive Director, CBHDA ➢ Darby Kernan, Legislative Representative, CSAC ➢ Ashley Mills, Senior Researcher, MHSOAC ➢ Carrie Zoller, Supervising Attorney, Center for Families, Children and the Courts, Operations and Programs Division, Judicial Council of California ➢ Arley Lindberg, Analyst, Criminal Justice Services, Operations and Programs Division, Judicial Council of California • CDCR Presentations on Behavioral Health Services ➢ Lisa Heintz, Chief Clinical Program Administrator, DAPO, CDCR ➢ Jay Virbel, Director, DRP, CDCR

March	Participated in the following: • CMHPC WET Summit • 42nd Annual Conference California Forensic Mental Health Association Conference San Francisco Site Visit • Parole Outpatient Clinic • Southeast Health Center, a TCN Site
April	Participated in the following: • Attended the Parole Resource Fair COMIO Workshop - How Lived Experience Can Prevent Crisis and Incarceration and Promote Recovery and Wellness • Guest Speakers ➢ Heidi Strunk, Advocacy Coordinator, CAMHPRO ➢ Steven Kite and Beth Wolf, NAMI - California ➢ Kevin Grant, Kevin Grant Consulting COMIO Council Meeting • Transitions Clinic Network Model - "Transitions Clinic Network: Working to Improve the Health Care System in Partnership with Justice-Involved Individuals" ➢ Dr. Shira Shavit, MD, Executive Director, TCN • Preventing Crisis - "Beyond CIT: The Next Level of Crisis Response and Prevention" ➢ Brain Bixler, Lieutenant II, Officer in Charge, Crisis Response Support Section, Detective Support and Vice Division, Los Angeles Police Department • Key Policy Priorities for 2017 ➢ Cory Salzillo, Legislative Director, CHA • Maximizing Medi-Cal to Serve the Justice-Involved ➢ Daniel Mistak, General Counsel, COCHS • Peers as Partners in Recovery, Wellness and Reentry ➢ Cesar Lagleva, LCSW, Ethnic Services and Training Manager, BHRS, Marin County Health and Human Services ➢ Connie Learson, Peer Specialist, BHRS, Marin County Health and Human Services
May	Participated in the following: • Presented at a CCHCS Mental Health Chiefs meeting • Provided comments to DHCD No Place Like Home Advisory Committee • Hosted an information table at Mental Health Advocacy Day at the State Capitol
June	Participated in the following: • Attended the CBHDA Criminal Justice Task Force Meeting with Jerry E. Powers, Director, DAPO, CDCR • Attended a quarterly Stepping Up planning committee meeting Riverside County Site Visit • Program Visits: ➢ Riverside University Health System - Behavioral Health Programs (Peer and Family, Crisis Services, Court Programs) ➢ Integrated Services for Mentally Ill Parolees Program Site Orange County Site Visit • Program Visits: ➢ Opportunity Knocks Program ➢ Whatever it Takes Full Service Partnership/Telecare

July	COMIO Educational Site Visit - Santa Clara, California Presentations: • Overview of Santa Clara County Diversion Efforts • Stepping Up Initiative Update • Pre-Trial and Collaborative Courts Overview • National Alliance for Mental Illness Santa Clara • Reentry Services and Mobile Health Clinic • San Mateo County Diversion Efforts and Drug Medical Organized Delivery System Implementation • Santa Clara County Housing Initiatives and Infrastructure Investments • Role of Faith Based Services in Reentry Program Visits: • Behavioral Health Courtroom and Court Services Observation • Reentry Resource Services Center and Mobile Health Clinic • Momentum Crisis Stabilization and Crisis Residential Facilities
August	Participated in the following: • 2017 National Forum on Criminal Justice in Long Beach hosted by The National Criminal Justice Association • Leading the Way Coalition Meeting led by CHA and NAMI • Presenter at the 2017 NAMI Conference, "What works: Preventing Crisis, Incarceration, and Recidivism" San Luis Obispo Site Visit • Presentations: ➢ Jail Treatment Services ➢ Behavioral Health Treatment Collaborative Court - Client Focus Groups ➢ Q & A with staff at Transitions Mental Health Association • Program Visits: ➢ Court House ♦ Pre-Trial Court Mental Health Screening ♦ Behavioral Health Treatment Collaborative Court ➢ Psychiatric Health Facility Tour ➢ Atascadero State Hospital Site Visit Fresno Site Visit • Presentations: ➢ Correctional Behavioral Health, Care Coordination/ Discharge Planning/Re-Entry ➢ AB109 Treatment Programming, Turning Point Community Programs ➢ MAP ➢ CIT Work Group ➢ Collaborative Treatment Courts
September	Participated in the following: • Panel Presenter - Strengthening Partnerships to Benefit Children, Youth, and Young adults at the 2017 Behavioral Health Policy Forum hosted by CBHDA • Presented to Kaiser Permanente Community Foundation Mental Health team meeting • Presenter at the Board of Parole Hearings Board Meeting County of Los Angeles Site Visit ➢ Met with WPC - Los Angeles (Implementation Team ➢ Met with LA County Department of Mental Health

	➢ Met with Los Angeles County ODR COMIO Data and Research Workshop • State Health Information Guidance, sharing patient health information by behavioral health facilities with law enforcement ➢ Elaine Scordakis, Assistant Director, California Office of Health Information Integrity (CalOHII) ➢ Rick Lytle, Consultant, CalOHII • Evaluation of the Mental Illness Response Program, (MIRP) ➢ Officer Gordon Shake, California Highway Patrol (CHP), MIRP ➢ Linda Tomasello, Senior Associate Analyst, CHP, MIRP, CHP Academy • Mentally Ill Offender Crime Reduction, MIOCR Grant Panel ➢ Helene Zentner, Field Representative, BSCC ➢ Kelly Glossup, LCSW, Youth and Family Services Manager, Alameda Co. Sheriff's Office ➢ Danielle Toussaint, PhD, Director, Research & Evaluation ➢ Hatchuel Tabernik & Associates, Alameda County Evaluator • Understanding and Improving Key Measures to Reduce the Number of People with Mental Illnesses in Jail: Stepping up California Efforts ➢ Deanna Adams, Senior Policy Analyst, CSG Justice Center • Elizabeth Siggins, Project Consultant, CSG Justice Center • Criminal Justice and Behavioral Health data Workgroup Planning session COMIO Council Meeting • NPLH Initiative and Homeless Coordinating and Financing Council - Status Update ➢ Zachary Olmstead, Deputy Director, Housing Policy Development • MHSOAC Criminal Justice and Mental Health Project Update ➢ Toby Ewing, Executive Director, MHSOAC ➢ Ashely Mills, Senior Researcher, MHSOAC • Proposition 47, Law Enforcement Assisted Diversion, MIOCR and other BSCC Grants Update ➢ Mary Jolls, Deputy Director, Corrections Planning and Grant Programs, BSCC ➢ Helene Zentner, Field Representative, BSCC • Substance Use Disorder Program Implementation at California Department of Corrections and Rehabilitation - Status Update ➢ Kevin Hoffman, Deputy Director, Rehabilitative Programs, CDCR • Medication Assisted Treatment and Substance Use Disorders ➢ Dr. Shannon Robinson, Senior Psychiatrist, Statewide Telepsychiatry Program, CDCR • Maximizing Medi-Cal for the Justice-Involved Population - Department of Health Care Services ➢ Drug Medi-Cal Organized Delivery System ♦ Michele Wong, Assistant Division Chief, SUD Compliance Division, DHCS WPC Pilots - Status Update and Justice-involved Populations ♦ Brian Hansen, Health Program Specialist II, Health Care Delivery Systems, DHCS • Efforts to Reduce Recidivism - Yolo County Health and Human Services ➢ Karen Larsen, LMFT, Director, Yolo County Health and Human Services Agency
October	Participated in the following: • Attended as a Council Member to the 1st Homeless Coordinating and Financing Council Meeting • Hosted Statewide Demonstration Training of the Canadian Curriculum *"Road to Mental Readiness"*

November	Participated in the following: • Words to Deeds Conference • Collaborative meeting with COMIO and California Health Facilities Financing Authority COMIO Legislative Meeting • Presenting Findings and Recommendations for COMIO Annual Legislative Report • Board Presentation of Promising Program Awards ➢ Fresno County - Multi-Agency Access Program ➢ Orange County - Opportunity Knocks and Telecare's Whatever it Takes ➢ Riverside County - Riverside Family Advocate Program Consumer Affairs Program ➢ San Luis Obispo - County Behavioral Health Treatment Collaborative Court ➢ San Mateo County - Continuum of Care ➢ Santa Clara County - Valley Homeless Healthcare Program • Board Presentation of COMIO Best Practices Award ➢ Transitions Clinic Network

Glossary

GLOSSARY

AB	Assembly Bill
ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
BHRS	Behavioral Health and Recovery Services
BHTCC	Behavioral Health Treatment Collaborative Court
BJA	Bureau of Justice Assistance
BSCC	Board of State and Community Corrections
CalOHII	California Office of Health Information Integrity
CAMHPRO	California Association of Mental Health and Peer run Organizations
CAPS	Community Awaiting Placement Supervision
CBHDA	County Behavioral Health Directors Association
CCHCS	California Correctional Health Care Services
CCJBH	Council on Criminal Justice and Behavioral Health
CCP	Community Correctional Partnerships
CCSF	City College of San Francisco
CDCR	California Department of Corrections and Rehabilitation
CHA	California Hospital Association
CHP	California Highway Patrol
CHW	Community Health Workers
CIT	Crisis Intervention Training
CJBHW	Criminal Justice and Behavioral Health Data Workgroup
CMRP	Case Management Reentry Program
CMS	Centers of Medicare and Medicaid Services
COCHS	Community Oriented Correctional Health Services
COD	Co-occurring disorder
COMIO	Council on Mentally Ill Offenders
COPE	Co-Occurring Peer Education Program
COSP	Consumer-operated service programs
CSG	Council on State Governments
CSRA	California Static Risk Assessment
DAPO	Division of Adult Parole Operations
DBH	Department of Behavioral Health

DHCD	Department of Housing and Community Development
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOC	Department of Corrections
DSH	California Department of State Hospitals
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSS	Department of Social Services
DUA	Data Use Agreement
FA	Family Advocate
FACT	Forensic Assertive Community Treatment
FAST	Family Assertive Support Team
FC	Friends Connection
FQHC	Federally qualified health centers
FSP	Full-Service Partnership
FY	fiscal year
HCA	Health Care Authority (Washington State)
HCD	California Department of Housing and Community Development
HUD	U.S. Department of Housing and Urban Development
ISMIP	Integrated Services for Mentally Ill Parolees
IST	Incompetent to Stand Trial
JAC	Jail Assessment Coordinator
MAC	Medicaid administrative claiming
MAP	Multi-Agency Access Program
MCP	Managed Care Plans
MHP	Mental Health Plans
MHSA	Mental Health Services Act
MHSOAC	Mental Health Service Oversight and Accountability Commission
MIOCR	Mentally Ill Offender Crime Reduction
MIRP	Mental Illness Response Program
MOE	maintenance of effort
NACo	National Association of Counties
NAMI	National Alliance on Mental Illness
NIMBY	Not in My Backyard
NPLH	No Place Like Home Initiative
NREPP	National Registry of Evidence-Based Programs and Practices

NRRC	National Reentry Resource Center
ODR	Office of Diversion and Reentry
PE	presumptive eligibility
PERT	Psychiatric Emergency Response Team
PHA	Public Housing Authorities
POC	Parole Outpatient Clinics
PPIC	Public Policy Institute of California
PROSPER	Peers Reach Out Supporting Peers to Embrace Recovery
PRSP	peer recovery support providers
PSH	Permanent Supportive Housing
RHC	Rural health centers
RI	Recovery International
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SED	serious emotional disturbance
SGF	State General Fund
SMART	System wide Mental Assessment Response Team
SMI	serious mental illness
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Insurance
TMHS	Traditional Mental Health Services
VA	Veterans Administration
VHHP	Valley Homeless Healthcare Program
VI-SPDAT	Vulnerability Index Service Prioritization Decision Assistance Tool
WET	Workforce Education and Training
WIT	Whatever it Takes
WPC	Whole Person Care