



CCJBH
Council on Criminal Justice and Behavioral Health

Building bridges to prevent incarceration



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Executive Summary

The Council on Criminal Justice and Behavioral Health (CCJBH) is a 12-member council chaired by the Secretary of the California Department of Corrections and Rehabilitation (CDCR) and is comprised of the Department of State Hospitals (DSH), the Department of Health Care Services (DHCS) and appointed expert representatives from the criminal justice and behavioral health fields such as probation, court officers and mental health care professionals. CCJBH serves as a resource to assist and advise the administration and legislature on best practices to reduce the incarceration of youth and adults with mental illness and substance use disorders (SUDs) with a focus on prevention, diversion and re-entry strategies.

The Council on Criminal Justice and Behavioral Health Council Members

Chairperson: Ralph M. Diaz, *Secretary*, California Department of Corrections and Rehabilitation. The Secretary of CDCR is at times represented by Diana Toche, DDS, *Undersecretary*, CCHS

Vice Chair: Richard Figueroa, *Director (A)*, Department of Health Care Services. The Director of DHCS is represented by Brenda Grealish, *Chief*, DHCS.

Stephanie Clendenin, *Director*, Department of State Hospitals. The Department of State Hospitals is at times represented by Mark Grabau, PsyD, *Chief Psychologist*, DSH or Katherine Warburton, DO, *Medical Director*, DSH.

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

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

Tony Hobson, Ph.D., *Behavioral Health Director*, Plumas County. Mr. Hobson was appointed to CCJBH by Governor Jerry Brown, 2018.

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

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

Danitza Pantoja, PsyD, *Coordinator of Psychological Services for the Antelope Valley Union High School District*. Ms. Pantoja was appointed to CCJBH by Speaker Anthony Rendon in 2019.

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

Last year CCJBH encouraged the administration to focus on strengthening services and support for individuals with complex needs who are vulnerable and at-risk of incarceration, homelessness, hospitalization and other negative outcomes. Exceeding the Council's expectations, the administration

has publically committed to *Transforming the Behavioral Health System*, which is evident in the proposed Medi-Cal Healthier California for All Initiative under development at DHCS which proposes to:

“Address many of the complex challenges facing California’s most vulnerable residents, such as homelessness, insufficient behavioral health care services, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs and the growing aging population.”ⁱ

In addition to the substantial reimagining of what Medi-Cal can achieve, the administration, through the Homeless Coordinating and Financing Council (HCFC), has expressed a sincere interest in better understanding and addressing the challenges of securing housing for individuals who are justice-involved with behavioral health issues. CCJBH dedicated significant time to this policy issue this year and has produced a separate policy brief with recommendations to consider for the administration and legislature. While there is more work underway for 2020, current recommendations can support the upcoming development of a State Plan to Address Homelessness by the HCFC. For a detailed analysis and to review recommendations for both state and local actions to improve housing outcomes for the justice-involved with behavioral health issues, please review CCJBH’s policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.ⁱⁱ

Issues affecting children and youth involved in the juvenile justice system are also a top priority for the administration. The Division of Juvenile Justice at CDCR is transitioning to the newly-established Department of Youth and Community Restoration within the California Health and Human Services Agency (CHHS). In addition, the administration has expressed a strong commitment to prevention. Of specific interest to CCJBH is the fact that youth who have experienced high numbers of Adverse Childhood Experiences (ACEs) are more likely to be involved with the criminal justice system as youth and adults. This year, the enacted state budget allocated nearly \$100 million in federal and state funds to implementing developmental and trauma screenings for youth and adults in the Medi-Cal program. Implementing these screenings is a first-in-the-nation statewide effort led by the California Office of the Surgeon General, in partnership with DHCS, which seeks to reduce ACEs and toxic stress by half in one generation. Increased screenings will help to direct early interventions that help keep youth out of the criminal justice system.

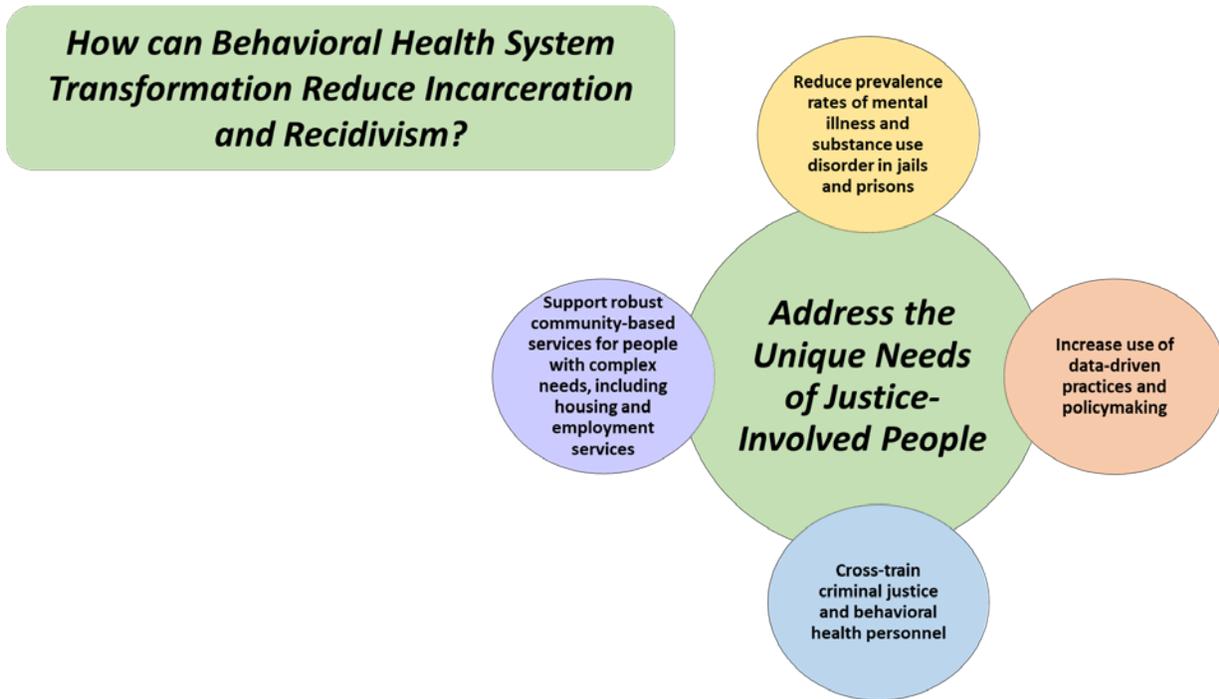
The 2019 CCJBH annual report provides eighteen findings and recommendations specific to those with complex needs, including individuals in the juvenile justice system and those who are experiencing homelessness. In addition, CCJBH embarked on several new projects for the first time and this work has proven to provide additional insight on best practices to reduce incarceration, including recidivism. Project activities are described in the *Project Update* section of the report that also includes identified next steps for 2020 in the following project areas:

- Data-Driven Practices and Policymaking,
- Making the Case for Diversion and Supporting the Implementation of Pre-Trial Diversion, and
- Lived Experience Contracts, including Initial Results from the Community Engagement Process.

ⁱ The Medi-Cal Healthier California for All proposal, various documents and information about workgroups and other forms of engagement are available at: <https://www.dhcs.ca.gov/provgovpart/pages/medi-calhealthiercaforall>.

ⁱⁱ Please visit <https://www.cdcr.ca.gov/ccjbh/> to view *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges* in its’ entirety.

Figure 1



As we look towards 2020, there is tremendous opportunity ahead to support *Behavioral Health System Transformation* (see **Figure 1**). In addition to Medi-Cal Healthier California for All, efforts are underway to explore whether or not amendments should be made to the Mental Health Services Act (MHSA), including exploring more impactful ways to serve individuals who are system-involved (justice and foster care) and those experiencing homelessness. One way to drive change is to have aspirational but achievable targets for progress created and monitored at the state-level. To support this, CCJBH has identified four visionary but measurable goals for policymaking partners to consider as we enter a new decade of progress (see **Table 1**). Each of the following goals indicate the ways that criminal justice and behavioral health partners can meet the unique needs of justice-involved people.

**CCJBH Encourages Investments and Policies that Achieve the
Following Goals by 2025**

Table 1:

Goal #1: The prevalence rate of mental illness and substance use disorders (SUDs) in jails and prisons should be similar, if not equal to, the prevalence rate of mental illness and SUDs in the community.		
<u>Outcome</u> Improvement in aligning prevalence rates	<u>Strategies</u> Significant investments in diversion to community treatment, services and housing alternatives to jails, juvenile halls and prisons	<u>Indicators of Progress</u> Fewer arrests and shorter length of stay for individuals with mental illness and SUDs Increased Pre-Trial Diversion to community treatment and services Universal screening in jails for mental illness and SUDs
Goal #2: Community-based services, particularly residential, are robust enough to meet demand starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges.		
<u>Outcome</u> Increase in residential and community service capacity	<u>Strategies</u> Implement and fund proposals in Medi-Cal Healthier California for All especially enhanced care management and behavioral health proposals Support the expansion of recovery housing Invest in a comprehensive substance use treatment continuum Increase the effectiveness of MHSA to effectively serve the justice-involved population with both diversion and re-entry strategies	<u>Indicators of Progress</u> Increase number of Adult Residential Facilities, including Recovery housing and Shared housing models Increase in referrals to community-based services from system partners Fewer emergency room visits and lower death rates

Goal #3: Through consistent dedication to workforce development, quality education and training, and on-going technical assistance to an array of service providers and partners, Californians benefit from professionals having core competencies that provide effective integrated correctional and behavioral health services to achieve recovery and reduced recidivism.

<u>Outcome</u>	<u>Strategies</u>	<u>Indicators of Progress</u>
<p>Increase cross training for all community corrections, court, and enforcement staff with regards to behavioral health issues and strategies</p>	<p>Update educational curriculum and training requirements to ensure teaching cross system skills, including field placements and continuing education</p> <p>Financially reward individuals with dual system expertise</p>	<p>Data collection on the credentials and experience of law enforcement, community corrections, court officers and behavioral health personnel</p> <p>Increased training completed through continuing education courses across professions</p> <p>Positive perception of law enforcement and community corrections personnel by behavioral health system partners and vice versa</p>

Goal #4: Through state leadership to support data-driven practices and policy-making among criminal justice and behavioral health systems, continuity of care and desired public safety and health outcomes improve significantly.

<u>Outcome</u>	<u>Strategies</u>	<u>Indicators of Progress</u>
<p>Increase local jurisdictions usage of Department of Justice Data to inform budget decisions</p>	<p>Provide guidance and confidence to support data-sharing and change policies that hinder care coordination, research and evaluation</p> <p>Provide incentives (training, resources, sophisticated analysis that cannot efficiently be done locally) to increase the quality of data collection and reporting from the local level</p>	<p>Collection and analysis of baseline data at the state and county levels</p> <p>Increased staff capacity to identify data-driven areas for improvement and incorporate recommendations</p> <p>Increased number of functional data sharing agreements between correctional and behavioral health systems</p>

A. Investing in Services for Individuals with Complex Needs

The federal Healthy People 2020 Initiative mentions incarceration as a social determinant of health,¹ and justice-involved people have a variety of complex needs. For example, justice-involved people are more likely to have experienced childhood trauma,² and incarceration can amplify the negative effects of these early-life challenges to worsen mental health.³ Homelessness is much more common among justice-involved people than in the general population,⁴ and rates of housing insecurity are very high among people released from prison.⁵ Meeting health and housing needs can help to reduce length of stay in a prison or jail,⁶ and many justice-involved people access health and housing services through Medi-Cal. While expanded eligibility under the Affordable Care Act (ACA) was an important first step in broadening access to care, recent reforms to Medi-Cal further expand opportunities to improve quality of care and support the successful integration of justice-involved people into society. High quality, accessible Medi-Cal services are critical to reducing incarceration and improving outcomes.

Overview of Whole Person Care and Update

In efforts to respond to poor health outcomes, avoidable medical costs and high utilizers of services with a robust alternative payment methodology and better integration of care, California made changes to its Medicaid (known as Medi-Cal) program through a waiver, known as California's Section 1115 Medicaid waiver, approved December 30, 2015 and effective through December 31, 2020. This is one of two ways to make changes to the public health insurance program that is federally funded through Title XIX of the Social Security Act by the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS). Medi-Cal waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under traditional Medicaid rules. California's Section 1115 Medicaid waiver, Medi-Cal 2020, included a \$3 billion pilot program to improve care for Medi-Cal beneficiaries by supporting local efforts that embrace the Whole Person Care (WPC) philosophy.

In 2017, DHCS launched the WPC pilot program in recognition that the best way to care for people with complex needs is to consider their full spectrum of needs – health, behavioral health, and social services. The anticipated outcomes of the program are to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. The pilot program concludes December 31, 2020. According to the *Whole Person Care: A Mid-Point Check-In* report, many pilot sites have already demonstrated how an integrated, patient-centered care helps to address patients' holistic needs. As CCJBH has noted in previous annual reports, this approach is a best practice to addressing justice-involved individuals with complex behavioral health needs, which requires comprehensive and coordinated services post-release from incarceration. To learn more about each WPC site, including enrollment strategies, program design, services provided, data collection, and the mid-point outcomes, check out DHCS' Whole Person Care Websiteⁱⁱⁱ and the *Whole Person Care: A Mid-Point Check-In* Report.^{iv}

ⁱⁱⁱ Department of Health Care Services, Whole Person Care Website, <https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

^{iv} *Whole Person Care: A Mid-Point Check-In Report*, https://www.dhcs.ca.gov/services/Documents/Harbage_WPC_MidPointPaper.pdf

The report also provides insight into WPC program implementation and discusses accomplishments and current challenges. While each WPC pilot differs in size, target populations, and interventions based on community needs, priorities, and resources, common elements attributing to successful outcomes include:

- Community Health Workers (CHWs): Key team members to assist with improving outreach and care coordination services to WPC enrollees,
- Service Navigation Centers/Support: Information hubs to help enrollees connect to services,
- Re-entry Transitions: Pilots focusing on the re-entry population work closely with corrections departments, probation, courts, and the local county jail system to improve transitions when people are released from jail,
- Housing Supportive Services: Providing tenancy support to help WPC enrollees find housing placements and stay in their new homes for long term,
- Medical Respite/Recuperative: Helping homeless enrollees who are too sick to be on the street, but not sick enough to be admitted to the hospital, and
- Sobering Centers: Providing a safe recovery space for intoxicated people who are homeless.

An example of a successful WPC program with the essential elements is the Re-entry Intensive Case Management Services (RICMS) program run by Amity Foundation in Los Angeles, California. This pilot program is one of the nine pilots servicing the justice-involved population and has been operating for the past two years. They have provided services to over 350 program participants in the areas of social services, housing, healthcare, substance use counseling, legal services, and employment. The premise of their program is linking program members to services through a warm handoff approach to organizations and services within the community. A defining characteristic attributable to the success of their program is utilizing personnel with lived experience (i.e. credible messengers, peer support specialists) to provide insights on recovery and support program participants.^v

A major success of the WPC program has been the development of both intragovernmental and external partnerships. Through the mission of the program and the resources dedicated to building care, lines of communication were created, and partnerships begun or strengthened.⁷ Below is a summary of the contributing elements of success.

- WPC has provided voluntary counties the opportunity to address the needs of Medi-Cal beneficiaries who have historically fallen through the safety net by assisting with creating pathways to collaboration.
- WPC has provided more coordinated services to enrollees accredited to the use of an interdisciplinary care coordination team, including CHWs and peer support specialist, for their ability to meet goals.
- WPC pilots developed innovative methods for finding appropriate staff to fit the unique WPC roles through modifying traditional job descriptions to attract applicants with relevant “lived

^v Labrada, G. (2019, December 02). Personal Interview

experience” (people who have experienced homelessness, incarceration, or are in recovery) and creating pathways to advance career opportunities such as management roles for CHWs.

Just as any program trial period, there are successes, challenges, and lessons learned. The WPC pilots faced challenges when it came to developing data-sharing agreements. Those that have successfully navigated this process describe having the ability to share and act on enrollee health data as key to success. Still, many pilots face different interpretations among county counsels, health plans, and other partners. On the technical side, different groups often use different information technology platforms. Developing interoperable platforms that could work across all partners can be prohibitively expensive. Another challenge, which many of the pilots focused on was connecting WPC enrollees to housing. Although housing is one of the most innovative aspects of the WPC program it is most challenging because federal rules do not allow funding to be used for purchasing or renting housing units. However, it can be used for tenancy support services such as; individuals outreach and assessment; tenant and landlord training and coaching; partnering with community-based organizations (CBOs) to secure housing for target population; and funds for security deposit and first month’s rent.⁸

Despite challenges and barriers, some states such as New York have used aspects of the ACA and other health care reforms to integrate housing and health services for vulnerable populations. In New York State, under executive order, a Medicaid Redesign Team (MRT) developed a plan for improving the quality of care and reduce escalating health care costs in the state’s Medicaid program. The solution was the MRT Supportive Housing Initiative in which, vulnerable populations are connected to healthcare, housing, and related supports through a multipronged approach known as Medicaid Health Homes. Not only did this comprehensive, integrated model of care address the needs of the individuals with complex needs, it was also cost effective. The savings happened through MRT reforms that included a global spending cap on state Medicaid expenditures, two percent Medicaid rate cut to all services, and the implementation of Medicaid Health Homes. The state portion of Medicaid savings generated by the MRT reform was invested in supportive housing and rental subsidies.⁹

New York has one of the largest Medicaid programs in the country, and its sweeping redesign efforts have produced substantial savings, allowing the state to alternatively invest \$503 million into its supportive housing programs since 2011. In July 2015, CMS approved the New York State Roadmap for Medicaid Payment Reform, which outlined plans to move 80 to 90 percent of managed care payments to providers from fee-for-service to value based payments (VBP) by 2020.¹⁰ As part of the payment reform, the state envisions that VBPs will incentivize providers to address social determinants of health (SDOH), and it is exploring ways to capture savings that will accrue in other public sectors from social determinant interventions such as reduced recidivism. California is moving in the same direction. Recognizing the need for housing support services for populations with complex needs, the California 2019 Budget Act invested \$20 million one-time funding to encourage additional counties to initiate WPC-like programs, while also investing \$100 million, one-time for active WPC pilot programs to provide housing services. The two reports listed below share some enrollment and demographic information on the target populations including the re-entry population:

- [Whole Person Care Pilot Program Challenges, Lessons Learned, and Successes: January 2017-January 2018^{vi}](#)
- [Whole Person Care Enrollment and Demographics Report: January 2017-June 2018^{vii}](#)

Not only is it time to renew the Section 1115 Medicaid waiver, it is time to thoroughly examine how promising and effective pilot programs like WPC, can be brought to scale so that all Californians with complex care needs receiving Medi-Cal services can have access to what is known to work best. DHCS is leading the task by rolling out the Medi-Cal Healthier California for All initiative that will implement a broad delivery system and program and payment reform by implementing overarching policy changes across the Medi-Cal delivery systems. Medi-Cal Healthier California for All recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach through Medi-Cal that target SDOH and reduce health disparities and inequities. The overarching goals of Medi-Cal Healthier California for All are to identify and manage member risk and need through WPC approaches and addressing SDOH through:

1. Moving Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
2. Improving quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

These goals align with and advance several key priorities of the administration. The initiative also establishes a foundation where investments and programs within Medicaid can easily do the following:

- Integrate, complement and catalyze the administration’s plan to address homelessness,
- Support justice systems reforms for youth and adults who have significant health issues,
- Build a platform for vastly more integrated systems of care and move toward a level of standardization, and
- Streamline administration required as California explores single payer principles through the Healthy California for All Commission.

Medi-Cal Healthier California for All will advance a number of existing Medi-Cal efforts such as WPC and Health Homes Programs, the prescription drug executive order, improve screenings for kids, and expand the use of value-based payments across systems, including in behavioral health and long-term care.¹¹

Table 2 provides an overview of the impact Medi-Cal Healthier California for All could have on CCJBH’s target population if enacted and funded as proposed: (the Medi-Cal Healthier California for All proposal addresses seven target populations in all)

^{vi} Whole Person Care (WPC) Pilot Program Challenges, Lessons Learned, and Successes: January 2017-June 2018 is available at https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC_Documents/WPC_UCLA_Evaluation_Narrative_Report_to_Jun18.pdf

^{vii} Whole Person Care Enrollment and Demographics Report: January 2017-June 2018 is available at https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC_Documents/WPC_%20UCLA_Evaluation_Enrollment_Report_to_Jun18.pdf

Table 2:

High Utilizers (top 5%)	It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. Medi-Cal Healthier California for All proposes enhanced care management (ECM) and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary WPC approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.
Behavioral Health	Medi-Cal Healthier California for All’s behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder (SUD) services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in Medi-Cal Healthier California for All simplify administration of, eligibility for, and access to integrated behavioral health care.
Homelessness and Housing	Build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.
Justice-Involved	The Medi-Cal pre-release application mandate, ECM and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Critical Proposals Impacting the Justice-Involved Population

Throughout 2019 and 2020, DHCS will conduct extensive stakeholder engagement and CCJBH will actively participate, including as a member of the behavioral health workgroup. The ECM workgroup is charged with establishing a statewide ECM benefit that will provide a whole-person approach to care that addresses the needs of high-need Medi-Cal beneficiaries enrolled in managed care health plans (MCPs) through intensive and comprehensive care management services. The ECM benefit will replace the current WPC management pilots in January 2021 and under the renewed Medicaid Section 1115 waiver. CCJBH’s target population is identified amongst the high need Medi-Cal beneficiaries this benefit targets. Below is a summary of the target populations for the ECM benefit that CCJBH services.¹²

Target populations for this service include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance or SUD with co-occurring chronic health conditions
- Individuals at risk for institutionalization, eligible for long-term care
- **Individuals transitioning from incarceration**
- Individuals experiencing chronic homelessness or at risk of becoming homeless

Creating a statewide ECM benefit with required target populations is consistent with the Medi-Cal Healthier California for All objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels.

Coordinated Services and Supports for Successful Transition

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs are met like housing, transportation, and overall integration back into the community. Studies have shown, such coordinated activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail.

Medi-Cal beneficiaries are enrolled in MCPs. These plans will be required to submit an ECM model of care proposal for individuals transitioning from incarceration, to DHCS by January 2023. Re-entry transitions involve working closely with corrections departments, including probation, courts, and the local county jail system to ensure connections to care once individuals are released from jail.¹³ While there is some infrastructure in place for this ECM target population due to WPC pilots, these type of arrangements take significant coordination between the managed care plan, counties, sheriff, probation and other key stakeholders. CCJBH welcomes supporting DHCS in connecting with these partners locally to identify existing best practices, lessons learned from existing efforts in this area, and feasibly future strategies to support Medi-Cal Healthier California for All's goals.

Pre-Release Medi-Cal Enrollment

To complement the ECM program model, DHCS is proposing to mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022. The proposed mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration aims to ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.¹⁴ CCJBH has long advocated for a universal screening at booking for mental health and SUDs, criminogenic risk and even Medi-Cal eligibility. Today adding housing status and need to that list may be warranted. Universal screenings with follow-up timely assessments are one of the most effective ways to support diversion to community alternatives, appropriate care during incarceration, and effective planning for

re-entry.^{viii} These factors can be examined when exploring at what point in the process it is most feasible to initiate the proposed inmate pre-release Medi-Cal application process.

Warm Handoff Approaches

Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments where the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. This would further align California counties with Substance Abuse and Mental Health Services Administration (SAMHSA) best practices regarding the facilitation of continuity of care between county jails and post-release treatment providers.¹⁵ One precondition to a warm-handoff is regular data-sharing between county jails and county behavioral health providers, which may be facilitated by the pre-release application process discussed above. However, successful ongoing data sharing is a challenge and CCJBH recommends that counties prioritize the establishment of Data Sharing Agreements in addition to collection of a comprehensive array of measures that permit evaluation of policy success.

DHCS may seek to leverage provisions of the federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act which was signed into law on October 24, 2018. The SUPPORT Act may facilitate ECM for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. Within a year of enactment, the CMS were required to release guidance on this issue to State Medicaid Directors based on best practices recommendations generated by a stakeholder workgroup. As a means of improving the quality of care delivered to justice-involved people, CCJBH encourages prompt attention to the development of this guidance as well as to the implementation of this guidance once issued.

To continue and transition the work done under WPC, DHCS is proposing to implement in lieu of services.¹⁶ In lieu of services are flexible wrap-around services that a MCP will integrate into its population health strategy as a means of filling gaps in existing state, federal or community efforts to address the SDOH. This change can empower justice-involved Medi-Cal beneficiaries to access housing support services, sobering centers, and other community-based wrap-around services that facilitate successful re-entry. Justice-involved people who access in lieu of services may not need to utilize higher-cost, more intensive services such as hospital or skilled nursing facilities or may utilize such services at lower rates. The use of in lieu of services is voluntary to both beneficiaries and Medi-Cal managed care plans, and CCJBH encourages all counties to continue providing housing support services and behavioral health services or to begin providing such services to justice-involved people. If in lieu of services are consistently offered statewide, justice-involved people will be able to access a uniform array of support services no matter which county they live in.

Mental Health Services Act funds and Justice-Involved Population

Resources proposed in Medi-Cal Healthier California for All, as well as new resources made possible by recent changes to the MHSa, can support diversion programs so that vulnerable people with serious medical or behavioral health conditions are better able to avoid incarceration and are provided with

^{viii} For more information about best practices for screening and assessments in jails please review the 16th Annual CCJBH/COMIO report pages 17 – 21 which describe best practices in screening and enrollment strategies and can found at: <https://www.cdcr.ca.gov/ccjbh/publications/>

support in their communities. Medi-Cal Healthier California for All proposes to give Medi-Cal MCPs the opportunity to contract with county and non-profit entities that provide pre- or post-booking diversion options, including behavioral health services, treatment for criminogenic risks and needs, care coordination, and treatment planning to ensure successful re-entry.¹⁷ In addition, Senate Bill (SB) 389 (Hertzberg) went into effect on August 30, 2019 and authorizes counties to use MHSA funds to provide services to individuals who are participating in a pre-sentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision, or mandatory supervision.

Medi-Cal Healthier California for All Proposal - Behavioral Health

The Medi-Cal Healthier California for All proposal also aims to improve service delivery and outcomes for individuals with co-occurring disorders (behavioral health needs and SUDs). The complex needs of those who have co-occurring disorders presents significant challenges for communities, counties, and treatment providers throughout the state. This population consumes a tremendous amount of criminal justice, public health and other community resources cycling between systems and not getting the treatment they need.

Across the country, as well as locally, individuals with co-occurring mental health and substance abuse disorders (COD) are one of the most common groups seeking behavioral health services. Often there is inadequate access to community services that results in frequent use of other county services such as criminal justice, health care, child protective, and homeless shelter services. These individuals present a variety of complex challenges across the continuum of the justice system including aggressive interactions with law enforcement, lack of program participation in jails and prisons, and often are the recipients of inadequate supplies of psychotropic medications or re-entry services when released, leading to a rapid reoccurrence of acute psychiatric symptoms.¹⁸ They also face a system of community-based services that are fragmented or exclude some of the most vulnerable individuals, including those on parole. “Many community-based mental health and rehabilitation programs are simply unwilling to provide services for those with the ‘triple stigma’ of dual diagnosis and a criminal history.”¹⁹

The Medi-Cal Healthier California for All proposal depicts a fundamental shift in how Californians (adults and children) will access mental health and SUD services including administration of, eligibility for, and access to integrated behavioral health care. Specifically as it relates to improvements in the delivery of behavioral health care services, Medi-Cal Healthier California for All strives to:

- Keep all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care.
- Provide opportunities to better coordinate medical, behavioral health and non-clinical social services keeping some of California’s most acute and vulnerable individuals with serious medical and behavioral health conditions out of jail/prison.
- Provide the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail by applying knowledge gained through the WPC and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots.
- Help individuals prior to and upon release from county jails, which also lays the foundation to further diversion and re-entry efforts and better support other forensic populations.

Medical Necessity

One of the elements in the Medi-Cal Healthier for All proposal seeks to modify the medical necessity criteria for mental health and SUD treatment services to align with state and federal requirements and clearly delineates and standardizes the benefit statewide. The current medical necessity criteria is outdated and lacks clarity, creating confusion and misinterpretation for providers and consumers alike.

The current medical necessity criteria for both mental health and SUD services requires individuals meet program specific requirements to be eligible for such services. The existing medical necessity criteria includes three components: covered diagnoses, functional impairment, and intervention criteria.^{ix} These three components represent two distinct concepts: 1) whether a beneficiary meets eligibility criteria for a certain level of care (i.e., covered diagnoses and functional impairment); and, 2) whether the services are medically necessary (i.e., intervention criteria).

One of the challenges for justice-involved individuals is that often times during the assessment process for behavioral health and/or SUD services, individuals do not always express information related to the questions that validates meeting the necessary criteria. Sometimes a diagnosis cannot be made with the information provided but the individual is presenting with a functional impairment (treatment need) that could be addressed through interventions (services). This leaves providers reluctant to provide treatment services to someone without a defined diagnosis unless the county has a system to provide services using other funds. The Medi-Cal Healthier California for All proposal aims to shift the focus from diagnosis to level of impairment rather than continuing to let diagnoses drive delivery system and funding decisions. It will allow counties to provide and be paid for treatment services to meet a current mental health and/or SUD need prior to the provider determining whether there is a covered diagnosis.

Currently within the DMC-ODS, medical necessity for substance use treatment is determined by the completion of an assessment using the American Society of Addiction Medicine (ASAM) criteria. The ASAM criteria is the most widely used comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.²⁰ The existing DMC-ODS rules can limit the counties' ability to be reimbursed for services that are provided prior to the completion of an assessment based on the ASAM criteria.

Initial and ongoing treatment planning assessments are completed using the ASAM placement criteria but individuals being released from incarceration are often not eligible for residential treatment due to how the questions/criteria are designed. The current criteria standard is not relevant or sensitive to the needs of incarcerated populations upon discharge because it seeks to identify current status by asking questions related to the last 2 days or 30 days as it pertains to drug/alcohol use and housing status. These questions do not account for how the incarcerated condition affects these answers and resulting determinations. Modifications can be made to the ASAM placement criteria that would be more appropriate for incarcerated individuals and individuals exiting state and local incarceration to support transitions from incarceration into the appropriate level of services on the continuum of care.

^{ix} 1) Diagnosis – one or more of the specified Diagnostic and Statistical Manual of Mental Disorders; 2) Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won't progress appropriately; 3) Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment.

ASAM assessments are conducted throughout the treatment continuum to ensure the individual is in the appropriate level of services. ASAM placement criteria determines where on a continuum of care an individual should receive services. This allows patients to “step-up” or “step-down” to match treatment intensity with their treatment needs. Recovery housing or recovery residences are typically the transition point between inpatient rehabilitation facilities and a home-based, outpatient care system. Many times this is the level of care that individuals exiting incarceration need. These residential environments provide safe housing and supportive, structured living conditions that are in great demand, but capacity is decreasing due to rising housing and operational costs as well as increased need and demand. There is a need for more recovery housing throughout the state to effectively implement a continuum of care. More information about best practices in housing for the justice-involved population can be found in the *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges* section of this report.

Often times during the initial ASAM assessment the individual may be diagnosed with only SUD and be placed in a SUD treatment program where, after more information is received, it is determined there is a mental health treatment need. Unfortunately, community treatment systems providing services to individuals with CODs are siloed systems that are difficult to navigate. Current best practices are programs that create a single access point providing mental health and SUD treatment services for different levels of care. These programs leverage multiple funding streams and have multi-disciplinary staff providing integrated treatment for mild, moderate, and severe diagnoses in a continuum of care environment.

Integrated Behavioral Health

The Medi-Cal Healthier California for All proposal seeks to administratively integrate mental health and SUD services into one behavioral health managed care program with the goal to improve outcomes through coordinated treatment across the continuum of care. Research indicates that approximately 50% of individuals who have a SMI have a co-occurring SUD and that those individuals benefit from integrated treatment.^{21, 22} While the information on knowledge and practice are widely available and growing, the expansion of integrated services has been challenged by providing services in two separate systems. Mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Individuals with co-occurring mental health and SUD service needs must navigate multiple systems to access care.

In a typical treatment program, even if services are co-located, a client with COD is likely screened and assessed by two or more staff members using two or more assessment tools. This information is then housed in two separate administrative records and processed through two separate state systems. Confidentiality regulations require a client to give permission for the sharing of information, which is usually done using multiple release of information documents that are specific to each program. These elements lead to different philosophies and approaches, in addition to unnecessary time spent for compliance with guidelines and/or regulations. Integrated case conferencing and treatment plans are not normally practiced, frequently resulting in competing treatment plans, as well as fragmented and incomplete continuing care plans. Researchers, planners, and policymakers have consistently identified that treatments aimed at addressing both disorders at the same time are generally more effective than dealing with one disorder at a time.²³

Another element of the Medi-Cal Healthier California for All proposal seeks to improve the DMC-ODS by exploring opportunities to improve the SUD managed care program based on experience from the first several years of implementation. DMC-ODS was created by the Medicaid 1915(b) waiver and significantly expanded the delivery system for SUD treatment in the community by creating a comprehensive SUD managed care program. Currently 30 counties administer the SUD managed care program, covering 93 percent of the Medi-Cal population. The remaining 28 counties provide less robust SUD treatment services through the fee-for-service delivery system. Eight of these counties are working with a local Medi-Cal managed care plan to implement an alternative regional model for SUD managed care.²⁴

DMC-ODS is addressing the opioid crisis by expanding the ability to provide Medication Assisted Treatment (MAT) in treating alcohol and opioid use disorders (OUD). MAT is a major component of many SUD treatment programs and is primarily used to address opioid and alcohol use. OUD has become a national epidemic that has caused record numbers of overdose-related deaths each year, a total that exceeded 72,000 in 2017.²⁵

Statistics have shown that individuals with CODs in the criminal justice system often have more than one mental disorder and have a history of abusing multiple substances.²⁶ One of the most common drugs used in California is methamphetamine, especially among individuals with mental health challenges but there currently is no medication to assist with treatment. Some studies have tested a variety of medicinal interventions including antidepressants and medicines designed for attention deficit disorders that have shown promising results, but currently none are approved by the Food and Drug Administration. There are other methods of treatment for methamphetamine use such as contingency management, which utilizes positive reinforcement and incentives as external motivators to promote adherence to program rules or treatment plans. Also, harm reduction techniques have proven to be an effective strategy when adopted by treatment programs. These methods can be incorporated into an integrated delivery system to help combat methamphetamine use.

Integrated Substance Use Disorder Treatment within CDCR

In line with tenets from the Medi-Cal Healthier California for All proposal, CDCR and California Correctional Health Care Services (CCHCS) recognizes its role in ensuring that its large population of complex patients receive comprehensive integrated care for successful health care outcomes and effective community re-entry, which includes SUD treatment. The estimated prevalence for SUD including but not limited to alcohol, opioids, and methamphetamines among CDCR's population is approximately 70 percent, or 86,800 patients.²⁷ An analysis of over 60,000 Texas inmates showed that individuals with CODs had a substantially higher risk of multiple incarcerations in the five years post-release than individuals with just a mental illness or a SUD alone.²⁸

CDCR and CCHCS are working to establish ambitious system change through the Integrated Substance Use Disorder Treatment (ISUDT) program for the state's prison population that will address a person's needs for SUDs from entry into prison to release from prison. The ISUDT project began in fiscal year (FY) 2019-20 with 280.2 allocated positions and \$71.3 million State General Fund (SGF) with an additional 150.8 positions and a total of \$161.9 million SGF in FY 2020-21. The project scope encompasses establishment of the necessary infrastructure and resources to successfully implement the ISUDT statewide including: 1) hiring and training staff; 2) contracting with sufficient numbers of qualified

counselors; 3) using standardized evidence-based curriculum for behavioral group therapy; 4) obtaining adequate supportive prison housing arrangements; 5) ensuring adequate clinical and programming space; 6) delivering MAT; and 7) providing comprehensive transition services. The project began planning and implementation August 2019 and has projected to be in full implementation by June 30, 2020. The program will be implemented statewide and focus on three patient populations at higher clinical risk for SUD related harm including: 1) patients entering prison prescribed MAT; 2) patients already in CDCR who have one or more events indicative of high risk behavior, and 3) individuals preparing to leave prison within 15-18 months.

This cross-divisional collaborative effort will provide access to both behavioral health treatment and MAT for SUD while individuals are incarcerated, and then effectively link them to community resources upon release. The ISUDT program implements a methodology to screen, risk stratify, and connect patients to relevant care similar to that available in the community. Doing so assures that the levels of care offered in the prison system will align and dovetail with continuing services available to patients as they are released. Not only does the ISUDT program have the potential to reduce risk for overdose but also recidivism by increasing functions such as maintaining employment, procuring stable housing, and successfully reintegrating into their communities.

Transitions Workgroup

To achieve a smooth and successful transition back to communities will require communication, coordination, and collaboration between institutions and community service providers. The success of the ISUDT will require dedicated coordination efforts between CCHCS, CDCR, and county partners. CCJBH is spearheading a collaborative workgroup with these partners to help support this coordination through the *Transitions Workgroup*. This workgroup includes CCJBH, County Behavioral Health Directors Association (CBHDA), and representatives from divisions within CDCR like rehabilitation, parole, and correctional health care services. The intimate workgroup of staff experts focus on system improvements and continuity of care, including:

- Improving communication between systems,
- Breaking down barriers to care,
- Supporting a warm handoff for individuals transitioning between state and county facilities who have an identified behavioral health need and need continuity of care, and
- Working to effectively implement SB 389 (Hertzberg).

CCJBH will seek to expand participation in the workgroup to include probation, sheriffs, and others in 2020.

Findings and Recommendations

Finding One: WPC Pilots are part of the current Medi-Cal system and provide intensive wrap-around services, including housing (with limited state resources), for individuals with complex needs such as the re-entry population. These models of care have demonstrated promise, and are part of a comprehensive set of proposals that make up DHCS' Medi-Cal Healthier California for All. In addition to the overarching population health approach and addressing social determinants, two proposals specifically relevant to CCJBH's target population include adding a new ECM benefit designed to focus on critical populations

that are high-cost and high-need, as well as behavioral health payment reform and delivery system transformation, and a Medi-Cal pre-release mandate.

Recommendation One:

- A. CCJBH can more actively engage in the current implementation of WPC pilots, of which nine of the twenty-five pilot counties are focusing on the re-entry population. For example, CCJBH can help to identify lessons learned, successes, and challenges, including a need for additional training or support for continued and expanded work with the re-entry population. Counties like Los Angeles and Riverside have been serving individuals returning home from state prison, and CCJBH can learn from those experiences to understand how to improve the warm hand-off and transition to community-based services to inform efforts in this area, including in support of ISUDT and implementation of SB 389 (Hertzberg).
- B. CCJBH will participate as an active stakeholder in the Medi-Cal Healthier California for All initiative through representation on the Behavioral Health Workgroup. The most pressing issue will be the Medi-Cal Waiver Renewal. CCJBH has developed several previous recommendations in this area with the goal of maximizing the impact of Medi-Cal for the justice-involved. CCJBH will participate with this goal in mind and commit to seeking and sharing expert input from the field with the workgroup.

Finding Two: Beginning January 1, 2020 with the passage of SB 389 (Hertzberg), funds from the MHSA, consistent with an approved local MHSA plan, can now be used to provide services to persons who are participating in a pre-sentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision or mandatory supervision. This policy change means that justice-involved people experiencing mental health challenges, including SMI, can now be treated equitably and are more likely to be successful as they leave state incarceration and experience re-entry and re-integration. CDCR, and specialty providers, have expertise working with this population and can be a resource to identify strategies for addressing needs and coordinating efforts to leverage services and supports for this high-need, high-risk population.

Recommendation Two: CCJBH can actively work with CBHDA, CDCR, Chief Probation Officers of California (CPOC) and other relevant stakeholders and partners on ways to implement SB 389 (Hertzberg) successfully by helping to facilitate consistent local planning processes, leveraging existing systems and capacities, and using state and local funding in a way that can best leverage federal match.

Finding Three: The DMC-ODS utilizes the ASAM placement criteria, but these criteria are not relevant or sensitive to the needs of incarcerated populations upon discharge.

Recommendation Three: Modify the ASAM placement criteria to be more appropriate for incarcerated individuals and individuals exiting state and local incarceration. The state, through DHCS Medi-Cal Healthier California for All Initiative, can work with experts to develop an assessment that can be used in both state and local systems.

Finding Four: MAT is primarily used to address opioid and alcohol use, but methamphetamine is commonly used in California, especially among individuals with mental health challenges.

Recommendation Four: Promote best practices in treatment for methamphetamine use such as contingency management, which utilizes positive reinforcement and incentives as external motivators to promote adherence to program rules or treatment plans.

Finding Five: Communication, coordination, and collaboration between institutions and community service providers needs improvement.

Recommendation Five: CCJBH should continue and strengthen investments in the *Transitions Workgroup* with CBHDA that also includes representatives from divisions within CDCR like rehabilitation, parole, and correctional health services. The intimate workgroup of staff experts focuses on system improvements and continuity of care, and its goals are to 1) improve communication between systems, 2) break down barriers to care, and 3) support a warm handoff for individuals transitioning between state and county facilities who have an identified behavioral health need and need continuity of care. CCJBH will seek to expand participation in the workgroup to include probation and sheriffs.

Finding Six: Community treatment systems providing services to individuals with co-occurring disorders (mental health and SUD) are siloed systems that are difficult to navigate.

Recommendation Six: Promote best practices such as programs that create a single access point providing mental health and SUD treatment services for different levels of care. These programs would leverage multiple funding streams and have multi-disciplinary staff providing a treatment for mild, moderate, and severe diagnoses in a continuum of care environment. Support Medi-Cal Healthier California for All's goal to make necessary state and county changes to enable mental health and SUD services through a single contract.

Finding Seven: Residential SUD treatment services provide a continuum of care that allows patients to “step-up” or “step-down” to match treatment intensity with their treatment needs. Recovery housing or recovery residences are typically the transition point between inpatient rehabilitation facilities and a home-based, outpatient care system, but many times this is the level of care that individuals exiting incarceration need. These residential environments provide safe housing and supportive, structured living conditions that are in great demand, but capacity is decreasing due to rising housing and operational costs as well as increased need and demand. There is a need for more recovery housing.

Recommendation Seven: See policy recommendation in the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.^x

Finding Eight: CDCR and CCHCS are implementing an Integrated Substance Use Disorder Treatment (ISUDT) program for the state prison population. This represents a significant investment in enhancing programs at all stages, from entry into prison to release. The new ISUDT program will treat SUD as a chronic medical condition, reduce fatalities associated with it, and improve the rehabilitative environment.

Recommendation Eight: CCJBH will support the implementation of ISUDT, as appropriate, by fostering coordination and collaboration between state and local implementers and sharing

^x Please visit <https://www.cdcr.ca.gov/ccjbh/publications/> to view *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.

information about the initiative and its impact in local communities via the Transitions Workgroup.

Next steps

1. CCJBH will actively work with CBHDA, CDCR, Chief Probation Officers of California and other relevant stakeholders and partners through the *Transitions Workgroup* and other opportunities to improve the warm handoff for individuals with behavioral health issues returning home, including the roll out of ISUDT and the implementation SB 389 (Hertzberg) successfully.
2. CCJBH will actively work with criminal justice partners and behavioral health experts and participate in the Medi-Cal Healthier California for All process by providing or acquiring subject matter expertise from the field on proposals that affect justice-involved populations with complex care needs like those with COD.

B. Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges

Background

California's housing and homelessness crisis is the leading political and humanitarian issue of the day. Californians name homelessness (15%), jobs and the economy (15%) as the most important issues facing the state today; followed by housing costs and availability (11%), according to a September 2019 survey conducted by the Public Policy Institute of California (PPIC).²⁹ The 2019 Point-In-Time (PIT)^{xi} count released by the United States Department of Housing and Urban Development (HUD) indicates there are 151,278 homeless individuals in California, a nearly 15% increase since 2017.³⁰

The housing story is more complicated than the overall statewide increase. While communities with known high rates of homelessness like Los Angeles and San Francisco report increases similar to the estimated statewide average, some Continuum of Cares (CoCs)^{xii} such as Stockton/San Joaquin County report dramatic increases of nearly 70% in two years. Traditionally "affordable" central and inland valley communities also report significant increases. Many argue that PIT counts substantially underreport the numbers for a variety of reasons, including "the count is during the winter early in the morning, when it's harder to actually find folks because they're seeking some sort of refuge or they want to stay out of sight in general for their own safety."³¹

Communities are re-examining policies to determine whether they are helping to solve or contribute to the crisis. In September, the California State Association of Counties (CSAC) and 33 local governments submitted an amicus brief requesting the Supreme Court hear an appeal of *Martin v. City of Boise*, which found that municipalities cannot punish people for sleeping on the streets, if there are no available shelter beds.³² The brief noted that the "*Boise* decision is ill-defined and unworkable, threatening to

^{xi} The Point-in-Time count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night.

^{xii} Continuums of Care are local community planning bodies that make decisions about funding priorities and consist of stakeholders (i.e. non-profits, business leaders, local government officials and law enforcement) committed to ending homelessness.

derail local and regional efforts to end homelessness, and preventing law enforcement officials from ensuring the public health and safety of communities.”³³ On the other hand, advocates fear undoing the ruling will lead to increased criminalization of the homeless. Reaching forward are new policies like SB 40 (Chapter 467, Statutes of 2019), which builds on legislation passed last year. The new policy pilots a “housing conservatorship” procedure for a person who is incapable of caring for his/her health and well-being due to SMI and SUD. The procedure may base a decision on evidence of multiple previous involuntary holds during the previous year.³⁴ Currently, a debate on how to best “compel” individuals, in this case, to involuntarily accept treatment and come off the streets is underway.

State Leadership is Steering the Course Towards Change

Housing affordability is central to the administration’s broader “California for All” agenda. The 2019-20 enacted state budget includes \$1.7 billion to support the development of new affordable housing. Dozens of signed legislation is now in place to spur housing production, including incentives to local government to enforce sanctions on development that is out of compliance with state housing laws. The administration is calling on both public and private, state, and local, to participate in developing solutions with the administration. The Governor met with business leaders and philanthropists to discuss the important role the private sector must play in resolving the affordability crisis highlighting recent commitments made by Apple, Facebook, and Google.³⁵ Furthermore, an executive order creates an inventory of all excess state land and launched partnerships with six California cities to develop affordable housing.³⁶

While affordable housing is critical to long-term solutions to homelessness, now is the time for immediate solutions. The administration dedicated another \$1 billion to the issue broadly, including efforts to support local governments with establishing emergency shelters/navigation centers, as well as resources to support increased access to legal assistance for eviction prevention and Supplemental Security Income (SSI) advocacy.^{xiii} In a letter from the Governor to his newly established Council of Regional Homeless Advisors, he states, “The Council must identify public policy changes and best practices for local communities to spend the major infusion of state dollars to address the problem of street homelessness by providing immediate emergency shelter and services.”³⁷ In addition, the letter clarifies priorities in need of short and long-term solutions regarding how the state can collaborate with local communities and the private sector, those priorities are: 1) end street homelessness 2) break down barriers to building more housing and 3) get more people into treatment.³⁸

The Governor’s directions identify how CCJBH can aid the administration with strategies to improve housing outcomes for justice-involved individuals living with behavioral health issues. The 2018 CCJBH Legislative Report urged that any efforts to address homelessness and the housing crisis must consider the impact on people with justice involvement and behavioral health challenges and outlined several recommendations. This year CCJBH discussed revisions to the recommendations with over 100 experts in the field, representative of systems and service partners working to improve housing outcomes for the justice-involved with behavioral health issues. These experts include, but are not limited to county health and behavioral health, continuum of cares, probation, officers of the court, law enforcement, social service providers, and most notably, individuals with lived experience in the intersection of

^{xiii} To review a summary of key provisions in the 2019-20 signed State Budget to address homelessness see Appendix C.

behavioral health, criminal justice, and homelessness. Through statewide in-person workshops with experts, key informant interviews, face-to-face meetings, research on critical issues and best practices, CCJBH developed recommendations for state and local action to improve housing outcomes for the justice-involved with behavioral health issues for policy-makers' consideration during this critical time. These detailed recommendations for state and local action can be reviewed in detail in the CCJBH policy brief, *Improve Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.³⁹

Recognizing the Link between Behavioral Health, Criminal Justice Involvement, and Homelessness

When addressing housing, it is essential to articulate the interconnections of behavioral health, criminal justice involvement, and homelessness. It does not matter which issue came first for an individual (i.e. criminal justice involvement, heightened mental health or SUD challenges, or loss of employment leading to homelessness). Each issue plays a role and often together with a multiplying effect on negative outcomes. Each of these issues need equal attention and dedicated solutions. Recognizing the reciprocity between these issues is essential to improving sustainable housing outcomes for this uniquely challenged population.

There is an overrepresentation of individuals with behavioral health issues in the criminal justice system. In one study of more than 20,000 adults entering five local jails, researchers documented SMI's in 14.5% of the men and 31% of the women, which taken together, comprise 16.9% of those studied—rates above three to six times those found in the general population.⁴⁰ Here in California, CDCR reports that 29% of the population has a SMI, and 31% of the admitted population has a mental health condition.^{xiv} The estimated prevalence of SUDs, including alcohol, opioids, and methamphetamines among CDCR's population is approximately 70%.⁴¹ The Board of State and Community Corrections (BSCC) estimates a prevalence rate of 27% of the jail population is living with SMI based on the most currently available data. For individuals returning home from state incarceration, roughly 32% (including 7.6% designated as Enhanced Outpatient Program and 24.5% as Correctional Clinical Case Management System patients) are identified with mental health treatment needs.⁴²

Data from the Bureau of Justice Statistics (BJS) indicates that formerly incarcerated people are almost 10 times more likely to be homeless than the general public, and this figure jumps to 20 times more likely if the individual has a mental illness. Data further shows that nearly 15% report homelessness before admission into prison.⁴³ Men, and specifically formerly incarcerated African American men, have much higher rates of unsheltered homelessness, and rates of marginal housing are 3 times higher than that of the homeless with no history of justice-involvement.⁴⁴ The U.S. Interagency Council on Homelessness (USICH) assessed that nearly 50,000 people per year enter shelters directly after release from correctional facilities.⁴⁵ One study found that the first 30 days after release from prison or jail is the time

^{xiv} *Correctional Clinical Case Management System*: A system utilized by CDCR that facilitates mental health care by linking offenders to needed services. Offenders receiving these services are housed within the general population and participate in outpatient services including individual counseling, crisis intervention, medication review, group therapy, social skills training, clinical discharge, and pre-release planning.

Enhanced Outpatient Program: Provides the most intensive level of outpatient mental health care, including separate housing, weekly structured clinical activity, bi-weekly clinical contacts and enhanced nursing services, for offenders with mental illness who have difficulty adjusting to a general population setting, but do not need 24-hour inpatient care.

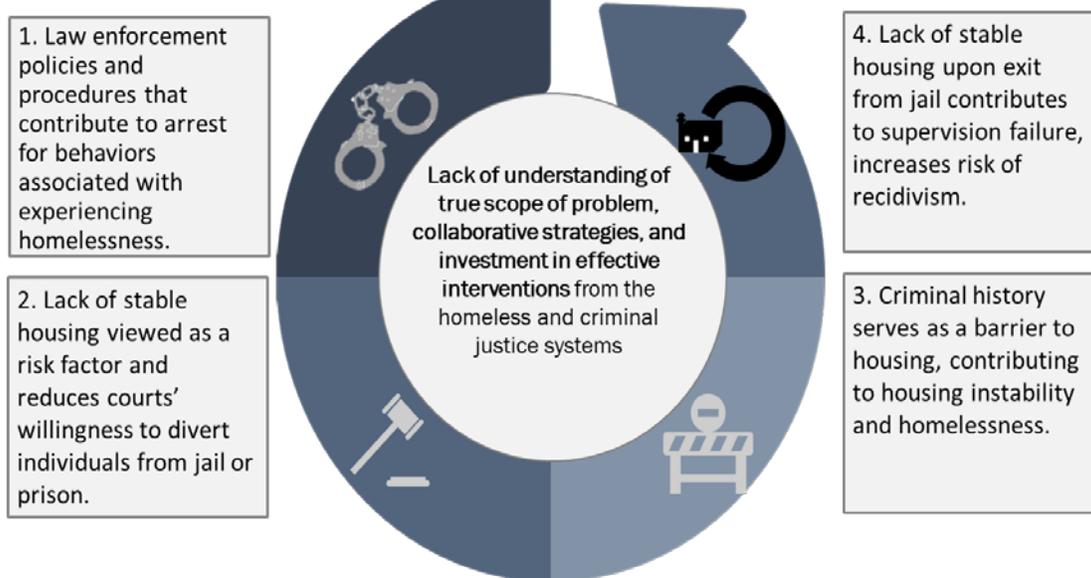
when people are most likely to experience homelessness.⁴⁶ Besides, not only are people leaving jails and prisons at risk of homelessness, they are also more likely to be homeless for longer periods.⁴⁷

HUD's 2019 PIT count indicates that 151,278 Californians are homeless,⁴⁸ with over 34,942 suffering from "severe mental illness," and another 26,410 with "chronic substance use."⁴⁹ HUD does not systemically collect justice status with the PIT count. More details on the importance of the inclusion of justice status with homelessness data is discussed in the CCJBH policy brief, *Improve Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*. A California Health Policy Strategies (CalHPS) brief correlates the statewide number of unsheltered homeless individuals, with those who report histories of mental health issues or illness and justice involvement. CalHPS's brief looks at PIT counts from 2017 and 2018 and other surveys from the three most populous counties in the state - Los Angeles, Orange and San Diego. The results include the following key findings for unsheltered adults:

- 26% increase in the number of unsheltered homeless individuals in the 5 years from 2013 to 2017,
- 70% report a history of incarceration,
- 28% report a recent release from jail or prison,
- 13% report being presently under community supervision, probation or parole,
- 32% report both having "mental health issues" and being formerly incarcerated, and
- 15% report both a "serious mental illness" and being formerly incarcerated.

National data shows that the number of Americans caught in a revolving door between the streets, shelters, and jails may reach the tens of thousands, and anywhere from 25 to 50% of people experiencing homelessness have a history of incarceration. According to the USICH, "homelessness may be both a cause and consequence of incarceration."⁵⁰ At the local level, the link between housing instability and criminal involvement is a cyclical relationship, clearly depicted in **Figure 2** created by the Council on State Governments Justice Center:^{xv}

Figure 2

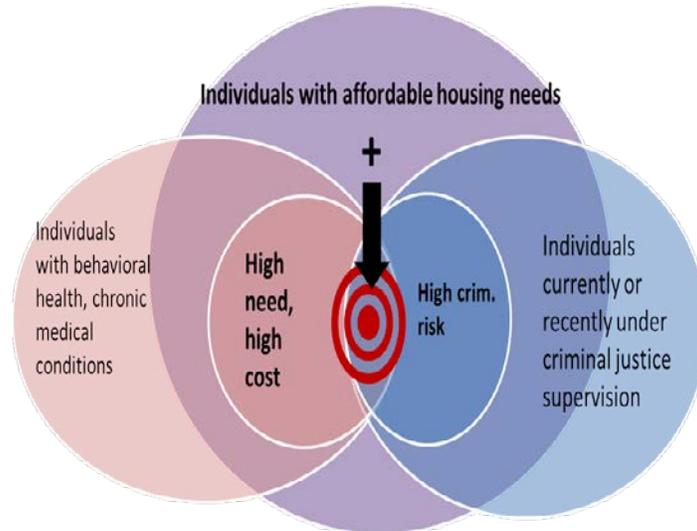


^{xv} Presented by Liz Buck and Hallie Fader-Towe of the CSG Justice Center as part of the CCJBH Legislative Briefing in January 2019. Presentation materials can be found at: <https://www.cdcr.ca.gov/ccjbh/2019/01/11/ccjbh-informational-briefing-jan-23-2019/>

1. Law enforcement policies and practices criminalize behaviors associated with homelessness,
2. Lack of housing is a known risk factor and has reduced courts' willingness to divert individuals from jail or prison,
3. Criminal history serves as a barrier to housing, contributing to housing instability, and
4. Lack of stable housing upon exit from jail contributes to supervision failure, which increases the risk of recidivism.

Specifically, individuals returning from long periods of incarceration have high rates of poverty, unemployment, and ultimately, homelessness – wreaking havoc on health status. **Figure 3** represents some of the high risk and needs of this population.

Figure 3



Adjusting to re-entry into the community from incarceration is marked by significant stress with conflicting priorities, as a result, seeking needed health care, especially behavioral health care is often not a priority. During this difficult transition, released inmate drug use increases and the risk of death in the first two weeks after release increases 12-fold.⁵¹ 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 disorders, which indirectly links to recidivism.⁵² 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 may link to high rates of mental illness that impose obstacles and interfere with one's ability to follow through with accessing timely care, let alone to establish and maintain housing.⁵³

Addressing the Unique Housing Needs of Individuals Experiencing Behavioral Health Challenges and Justice Involvement

“Homelessness may be both a cause and consequence of incarceration, particularly for those persons with mental health or substance use disorders, because an arrest and involvement in the criminal justice system can destabilize employment, housing, social ties and connections to health care and treatment services. People who have been involved in the criminal justice system often face significant barriers to future employment and housing opportunities.”⁵⁴

– The U.S. Interagency Council on Homelessness (USICH)

If California’s efforts are successful in tackling the housing and homelessness crisis, the unique housing needs of individuals experiencing behavioral health challenges and justice involvement must be adequately addressed across multiple systems (see **Figure 4**).

Figure 4



CCJBH encourages consideration of the “drivers” of homelessness strategies, when policy makers are developing solutions. The “drivers” listed below are significantly and disproportionately experienced by individuals in the intersection of behavioral health and justice systems:

- Poverty
- Lack of Education and Employment Opportunities
- Disability/ Poor Health (Behavioral Health)
- Marginalization
- Disenfranchisement
- Discrimination (Racism)
- Trauma

“There are as many reasons for homelessness as there are people sleeping on our sidewalks and that means we need a wide range of approaches to solving the problem, aimed at addressing the needs of individuals. We simply can’t force all homeless people into a relatively narrow set of solutions.”⁵⁵

Findings and Recommendations

Below are general housing strategies, findings and recommendations which can be reviewed in more detail in the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.

Strategy One: Support the Expansion of Housing and Housing Assistance Options

Finding Nine: California’s housing and homelessness crisis is unprecedented, calling for emergency, short, medium and long-term solutions that are inclusive of the unique needs of individuals with justice involvement and behavioral health challenges.

Recommendation Nine: Support the expansion of housing and housing assistance options with an “all hands on deck” approach.

Strategy Two: Support Housing Best Practices for the Justice-Involved with Behavioral Health Challenges

Finding Ten: There is research to document the effectiveness of *Housing First* principles put into practice, especially when serving individuals with SMI, who are experiencing chronic homelessness, and who have histories of justice involvement. There is far less definitive research with a focus on best practices to address the needs of individuals, who are justice-involved with various behavioral health challenges, especially SUDs. Traditionally, providing housing services to prevent homelessness is not the role of community supervision. Affordable housing is associated with improved public safety and health outcomes; and yet probation and parole are not adequately resourced to prevent homelessness as part of the community supervisory role.

Recommendation Ten: Increase understanding and adoption of *Housing First* principles that help an individual to be successful while under supervision, court-ordered treatment, or other forms of alternative custody. Explore and examine various models that can obtain similar results, but are sensitive to the unique needs and wishes of individuals returning after long periods of incarceration and/or who live to achieve a substance-free lifestyle.

Strategy Three: Commit to Addressing Underlining Poverty

Finding Eleven: Individuals experiencing significant behavioral health challenges and justice-involvement are likely experiencing extreme poverty, in addition to stigma and discrimination. These individuals are often overlooked when it comes to vocational training or educational opportunities due to their perceived cognitive limitations. For those who are most vulnerable, making a livable wage or gaining adequate financial assistance due to a disability is critical to sustaining housing or preventing homelessness.

Recommendation Eleven: Commit to addressing underlining poverty as an essential strategy to solve and prevent future homelessness among individuals experiencing behavioral health challenges who are justice-involved. For those with disabling mental illness, consider ways to fill the gaps between the cost of living and what benefits cover. Invest in employment, education, and training grounded in best practices, as well as aid in achieving a livable wage that provides equal opportunities for everyone to participate in society.

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

Finding Twelve: The lack of available and accurate data regarding who is experiencing housing insecurity and homelessness among individuals, who are currently or formerly justice-involved with behavioral health challenges, makes it more difficult to address their needs.

Recommendation Twelve: Invest in uniform quality data collection that includes data-entry fields to indicate justice status, analysis and report efforts to understand the needs and gaps in services and to inform on the impact of strategies and investments on target populations. Data analysis can track progress on benchmarks to achieve equitable housing assistance opportunities for people who are justice-involved and experiencing behavioral health challenges. The reports will provide information on comprehensive statewide strategies to combat housing discrimination.

Strategy Five: Link the Criminal Justice System to the Homeless Crisis Response System and Facilitate Coordination, Collaboration, and Commitment Among System and Service Partners

Finding Thirteen: There are significant barriers for transitioning individuals exiting incarceration to critical services and supports, especially housing. Not only are there barriers due to policies that may or may not be within the state's ability to change, but also, there is a lack of necessary infrastructure, especially in the coordinated entry system, to support state-local partnerships and empower on-the-ground leveraging of resources.

Recommendation Thirteen: Link the criminal justice system to the homeless crisis response system to facilitate coordination, collaboration, and commitment among systems and service partners at the state level, the local level, and between the state and local levels.

For an expanded version of Strategies to Improve Housing Outcomes for the Justice-Involved with Behavioral Issues, please see Appendix B.

Next Steps

1. CCJBH will widely disseminate the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges* to the administration, legislature, local leaders, implementers, and stakeholders and continue this work in 2020.
2. CCJBH will be partnering with the CSG Justice Center next year through support from the Melville Charitable Trust, the largest foundation in the U.S. dedicated to ending homelessness, to further vet, study and operationalize the recommended state and local actions shared in the policy brief.
3. CCJBH can work with policymakers to find as many opportunities as possible to listen and learn from those who have experience in the intersection of homelessness, criminal justice, and behavioral health.

C. Juvenile Justice

Juvenile justice systems across the state are disproportionately filled with youth with behavioral health disorders. Youth with behavioral health needs are higher at all points of the juvenile justice system than youth in the general population and the percentage of youth with behavioral health disorders is greatest at the point of secure confinement after trial.⁵⁶ These youth likely engage in the juvenile justice system because 1) They have limited access to treatment in the community 2) Systems of care lack necessary coordination and collaboration 3) Training and assessments are needed to identify disorders.⁵⁷

Some research estimates that 75 to 93% of youth entering the justice system each year have experienced some degree of trauma.⁵⁸ Most youth detained have been exposed to trauma in the form of community and family violence.⁵⁹ Children of incarcerated parents (CIP) are three times more likely than non-CIP to become justice-involved. Youth that are dually involved in the child welfare and juvenile justice systems, known as “Crossover Youth,” are disproportionately youth of color and girls. LGBTQ youth are estimated to only make up 5 to 7% of the nation’s youth, while they represent 13 to 15% of youth in the juvenile justice system. Each of these disparities increase the prevalence of youth with behavioral health needs in the juvenile justice system. These unmet needs such as mental health and SUDs, behavioral challenges, untreated trauma and challenges with family are likely root causes leading to arrests and involvement with the juvenile justice system. CCJBH’s aim to reduce the number of youth with behavioral health complex needs in the juvenile justice systems, by promoting a focus on prevention, diversion and re-entry strategies.

California has been a leader in juvenile justice system reform through a series of policy changes that have lowered the number of youth detained and changed the composition of the California Department of Corrections and Rehabilitation (CDCR) and Division of Juvenile Justice (DJJ). In the mid-1990s, the state began to shift responsibility for juvenile offenders to the counties, initially to reduce state costs. A 2007 reform permitted counties to commit only the most serious offenders to state facilities. Between 2007 and 2013, the year-end number of juvenile offenders in DJJ institutions and camps fell from 2,115 to 659. Currently, DJJ’s population represents less than one percent of the 225,000 youth that are arrested each year in California. Youth with the most serious criminogenic behaviors, complex and intense treatment needs are detained at DJJ up to the age of 25 and are provided with an education and treatment program using an integrated behavior treatment model framework.^{xvi}

There are two juvenile justice system formats with different frameworks: the welfare model and the justice model. The welfare model focuses on the needs of the child, diagnosis, treatment, and evidence based procedures. Whereas, the justice model emphasizes accountability, consequences and procedural formality.⁶⁰ In January 2019, the administration announced that it would move the Division of Juvenile Justice from the Department of Corrections and Rehabilitation to the CHHS, stating “Juvenile justice should be about helping kids imagine and pursue new lives... The system should be helping these kids unpack trauma and adverse experiences many have suffered.” This is promising for youth with behavioral health needs in the juvenile justice system because these youth decompensate when detained and untreated. CCJBH promotes programs and policies that, whenever safe and appropriate, divert youth to community-based, wraparound services. The enacted 2019-20 state budget establish the Department of Youth and Community Restoration within the CHHS. This agency is tasked with the administration and oversight of state and federal programs for health care, social services, public assistance and rehabilitation. The new department will oversee the youth that are in state custody and provide social services supports. This move by the administration is consistent and builds upon the work the legislature has been doing since 2004.

During this time, California has adopted significant policies to address ineffective youth justice policies. While reforms have decreased the number of detained youth, high concentration of youth with behavioral health needs within the juvenile justice system remain.⁶¹ Most juvenile offenders today are

^{xvi} California Department of Corrections and Rehabilitation, Division of Juvenile Justice, <https://www.cdcr.ca.gov/juvenile-justice/>

committed to county facilities in their home communities where they can be closer to their families and local social services that are vital to rehabilitation. According to the National Association of Counties (NACo), counties are encouraged to support youth with behavioral health needs in the juvenile justice system because research has shown that these youth can be safely, effectively and more cost-efficiently treated in community settings. The annual cost of incarcerating a youth in the juvenile hall in California has doubled since 2011. California taxpayers spent an average of \$284,700 in 2018 and as high as \$400,000 per youth per year in Bay Area counties according to county-level data from the BSCC.^{62,63} Whereas, evidenced-based services provided in the community have been proven to reduce recidivism by more than 20% and provide upwards of \$10 worth of benefits for every \$1 spent.^{xvii} Considering the costs, both financially and socially, consideration of possible alternative approaches at every opportunity, while maintaining public safety, to divert youth with behavioral health needs out of the juvenile justice system is important.

Activities and Promising Practices

CCJBH hosted a statewide Juvenile Justice Roundtable to hear from experts in the field at the intersection of justice and behavioral health systems, to identify the critical issues impacting the juvenile justice system and the best practice models that are effective for this population.

The Roundtable consisted of three panel discussions addressing California’s juvenile justice system and critical issues, youth homelessness and the correlations with juvenile justice, a first-hand perspective from youth with lived experience and a presentation on the link between Adverse Childhood Experience (ACE) scores among probation youth. Findings are summarized in **Table 3** below.

Table 3:

Understanding Today’s Juvenile Justice System in California what are the Critical Issues?		
<i>Critical Issues</i>	<i>Recommendations</i>	<i>Promising Practices</i>
Probation departments are proponents of diversion programs. Not every county has CBOs to partner with or programs to divert youth to.		Community partnerships with CBOs that can meet the needs of youth with behavioral challenges and provide wraparound services.
There is little data available to explain why the number of incarcerated youth in California is declining and the attributed best practices.	Research is needed to address the declining number of incarcerated youth and identify the best practice models.	

^{xvii} Justice Policy Institute. The Costs of Confinement: Why Good Juvenile Justice Polices Make Good Fiscal Sense. Available at http://www.justicepolicy.org/images/upload/09_05_rep_costsofconfinement_jj_ps.pdf

Youth and Young adult Homelessness and the Correlation to Juvenile Justice.		
Critical Issues	Recommendations	Promising Practices
Roughly 2/3 of California’s counties have no programs or shelters specifically designed to serve youth. Homeless youth are more likely involved in the juvenile justice system for quality of life crimes.	Establish youth shelters throughout California to address youth homelessness that is segregated by gender and age groups.	Youth drop in centers that assists with shelter, resources and support services. <i>Edgewood Drop in Center in San Bruno, CA^{xviii} and Bill Wilson Center in Santa Clara, CA^{xix} are examples of centers for youth providing services.</i>
Youth homelessness is minimally funded in California. Most funding opportunities are one time funding sources.	Support youth homeless programs with longer funding cycles to sustain programs.	
Youth Voice		
Critical Issues	Recommendations	Promising Practices
Youth with incarcerated parents become over labeled as at-risk, involuntarily placed in programs, heavily monitored (teachers, counselors or staff members), and lack support services. Being involved with the justice system has lasting effects on youth (e.g. financial, housing, stability, education, and family relationships).		Youth peer run groups with safe spaces to express concerns freely, with supportive adult leaders. <i>California Youth Connection (CYC)^{xx} and Community Works^{xxi} are youth led organizations that empower youth and provide pathways to express themselves and lend their voice to issues impacting youth.</i>
Visiting incarcerated parents is difficult and can even be traumatizing due to barriers (e.g. distance to facility, required paperwork, wait times, declined visits and no physical contact between parent and child).	Training opportunities that address best practice approaches for children and youth visits within the California State Prison system.	

^{xviii} Edgewood, Drop-in Center, San Bruno, California <https://edgewood.org/drop-in-centers/>

^{xix} Bill Wilson Center, Drop-in Center, Santa Clara, California <https://www.billwilsoncenter.org/services/all/drop.html>

^{xx} California Youth Connection is a youth-led organizations whose aim is to develop leaders who empower each other and their communities to transform the foster care system through legislative policy and practice change.

^{xxi} Community Works is an organization that engages youth and adults in arts, education and restorative justice programs that interrupt and heal the far reaching impact of incarceration and violence empowering individuals, families and communities.

Adverse Childhood Experiences (ACE) Scores Among Probation Youth		
<i>Critical Issues</i>	<i>Recommendations</i>	<i>Promising Practices</i>
Adverse Childhood Experience Scores (ACEs) of 4 or greater have a strong correlation between negative health and mental health outcomes in adulthood. High ACE scores in youth correlate with recidivism.		The administration established the <i>Early Childhood Policy Council</i> and advisory committee, Chaired by California’s Surgeon General, Dr. Nadine Burke Harris, November 2019, to develop a plan for early learning and care. Leaders from across the state in social services, child care and child trauma are amongst the 20 appointed members of the Council. The objective is to ensure that all children in California have the critical foundation they need for healthy development and learning in the earliest years. This expands children’s access to quality education, health care and invests in parents so they invest in their children. Early intervention improves outcomes.
Toxic stress responses effect behaviors, the body, and brain.	Implement approaches that avoid causing toxic stress responses when supervising incarcerated youth or adults.	
Most youth have their first touch with the juvenile justice system between the ages of 13 and 14. The leading causes of delinquency are peers, family, and trauma.	Design interventions and programs targeting children 5 -10 years of age.	

From the outcomes of the Roundtable, CCJBH developed a survey sent to criminal justice partners, community based organizations representing youth with lived experience, homeless youth, crossover youth, and state agency leaders, to help clarify and capture additional input on critical issues pertaining to youth with behavioral health needs in the juvenile justice system at the state and local levels, best practice models for addressing these needs, and outcomes the state should achieve for this population. The survey closed on July 31, 2019. Sixty five percent of the participants responded to the survey. When asked if participants felt that California was meeting the standards in employing best practices in the juvenile justice system for youth with behavioral health needs, 94% of the participants responded that there was a need for improvements.

Critical Issues

- Access to behavioral health services in the community without a referral
- Over-incarceration of youth with behavioral health needs
- Uniform opportunities for diversion
- Sustainable program funding
- Need for more supportive housing
- Housing and employment barriers
- School suspension and expulsion rates
- No behavioral health treatment in detention centers
- Behavioral health workforce shortage
- Short-Term Residential Therapeutic Programs (STRTPs)^{xxii}

CCJBH asked participants how could the Council help improve the juvenile justice system and promote best practices. Respondents replied:

- Host forums that feature juvenile justice issues for education and awareness
- Provide a platform to hear from providers and youth
- Engage system-impacted youth
- Feature innovative approaches to juvenile justice as a public mental health issue
- Share information with the legislature on emerging juvenile justice issues
- Partner with families, youth and communities to identify solutions through facilitated forums with state leadership to support consistency across counties that emphasize treatment, community support and school support over incarceration

Based on CCJBH's findings through research and information-gathering CCJBH has developed policy recommendations that will inform the work of the Council in 2020.

Findings and Recommendations

Finding Fourteen: While there has been a decline in the overall population of youth confined in local Juvenile Detention Centers statewide, youth with mental health needs and SUDs make up a significant percentage of those who remain. The specific factors that explain the decline in overall population yet continued overrepresentation of youth with serious behavioral health needs are unknown.

Recommendation Fourteen:

- A. Analyze available data and trends to examine the causes and effects of the declining population and remaining concentration of youth with serious behavioral health needs in the Juvenile Detention Centers statewide.
- B. If data is not available to review, CCJBH can develop a survey (distributed statewide) to assess what factors local implementers and stakeholders attribute to the decline and

^{xxii} Short-Term Residential Therapeutic Programs (STRTPs) provide an integrated treatment model of 24-hour specialized intensive care and supervision. These residential facilities utilize trauma-informed and culturally relevant practices to provide core services and supports needed by youth in foster care.

concentration of the population. Specifically, CCJBH can explore how youth with behavioral health needs have been impacted and what were the opportunities for diversion.

Finding Fifteen: It can be difficult for youth to visit parents or family members who are incarcerated. There are many challenges and barriers such as the distance to facility, required paperwork, wait times, and lack of physical contact between parent and child. Children and family members can be turned away for small infractions such as improper clothing or a name on a school ID that differs slightly from the full name on a birth certificate. A missed opportunity to meet with a parent or family member can be upsetting. Families are critical to rehabilitation and accessibility to visitation can facilitate continued family engagement.

Recommendation Fifteen: CCJBH can study best practice approaches for children and youth visiting parents or family in the California State Prison system and position CDCR as a resource by exploring improved strategies, such as training regarding effective methods to approach and handle youth and children in a correctional setting, proper identification for youth and children for visits and strategies for promoting family visits from youth and children as a therapeutic healing process that may lead to breaking the cycle of generational incarceration.

Finding Sixteen: Adverse Childhood Experience Scores (ACEs) of 4 or more have a strong correlation between negative physical and mental health outcomes in adulthood. The higher the score, the more issues that relate to health, mental health, behavior changes, and justice involvement. There is no difference between genders. Children/Youth with ACE scores of 8, 9, and 10 are more likely to become incarcerated adults. The first touch point with the juvenile justice system for youth is between the ages of 13 and 14.

Recommendation Sixteen:

- A. CCJBH can research, study and seek to support the work of the California Surgeon General and the California Department of Education regarding ACEs and preventative programs to mitigate or divert youth with high ACEs from becoming justice-involved.
- B. CCJBH can research if foster youth and probation youth have parallel high ACEs and what services available to foster youth are effective, which can help to determine how both youth populations with similar needs can experience improved outcomes.
- C. CCJBH can research if there are court appointed advocates for youth with behavioral health needs, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.

Finding Seventeen: CCJBH distributed a survey statewide to learn about best practice approaches in juvenile justice systems for youth with behavioral health needs. CCJBH asked participants to make suggestions regarding how CCJBH can help improve the juvenile justice system and promote best practices.

Recommendation Seventeen: CCJBH can continue to host forums that feature juvenile justice issues. Objectives could include providing a platform to hear from providers, youth and engaging

more system-impacted youth; feature innovative approaches to juvenile justice as a public mental health issue; share information with the legislature on emerging juvenile justice issues; and partner with families, youth and communities to identify solutions through facilitated forums with state leadership to support consistency across counties that emphasize treatment, community support and school support over incarceration.

Finding Eighteen: There is a high prevalence of youth with behavioral health needs arrested each year that fill local juvenile halls. Sometimes these youth enter a juvenile justice system ill equipped to assist them. Without treatment, youth may continue on a path of delinquency and onto offenses that may lead them to adult corrections. The courts recognize that most youth that have been arrested and come before them are in need of treatment rather than detainment. Screening and assessments are vital to addressing mental health treatment needs of youth in the juvenile justice system.

Recommendation Eighteen:

- A. To better understand high-end service capacity alternatives for youth, CCJBH can conduct, in partnership with key stakeholders and providers, an assessment of residential treatment capacity for juveniles as an alternative to juvenile hall.
- B. CCJBH will explore and research existing law enforcement protocols for arresting youth in California with the intention of identifying their pre-charge diversion, treatment, and crisis support services procedures as alternative options.
- C. CCJBH will bring awareness to our law enforcement, behavioral health, Judicial, and community partners on pre-charge diversion, treatment, and crisis support services for youth known to have or assessed as having behavioral health needs as alternative options.
- D. CCJBH can research if there are clinical coordinators present in juvenile court rooms, who can provide guidance to judges and probation staff about juvenile mental health evaluation and community-based treatment, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.

Next Steps

- 1. CCJBH will seek opportunities to research, study, support, and collaborate with key stakeholders and state agencies such as the Health and Human Services Agency, Department of Education, Department of Public Health, and the BSCC to forward progressive Juvenile Justice policies.
- 2. CCJBH Juvenile Justice Workgroup committee made up of CCJBH Councilmembers will select one to two specific activities for the council to conduct during 2020 that align with the findings and policy recommendations.

CCJBH can continue to serve in the capacity as a resource in working with key stakeholders around youth diversion promising practices.

D. Project Report Updates

Data-Driven Practices and Policymaking

CCJBH works to implement data-driven practices and policymaking among criminal justice and behavioral health systems to ensure continuity of care and improve public safety and health outcomes. While all of CCJBH's work is inspired by these principles, two of its projects in particular support data-driven policymaking at the intersection of criminal justice and behavioral health. These projects facilitate partnerships between CCJBH and other departments to advance statewide data management, data sharing, outcomes reporting, and evaluation efforts.

CDCR-DHCS Medi-Cal Utilization Project

Overview

Because the justice-involved population can be difficult to reach after they leave prison, correctional agencies have a unique role in improving access to health care. CCJBH has partnered with DHCS to conduct the CDCR-DHCS Medi-Cal Utilization Project, which shares data and information about possibilities for supporting justice-involved people through community-based behavioral health services. By documenting trends and identifying gaps in service provision, the project aims to improve the quality of behavioral health care and ensure that justice-involved people are able to access care as needed. Findings from the project inform the development of interventions that reduce recidivism associated with unmet behavioral health needs. The project reflects a broad statewide movement toward meeting shared goals by analyzing data linked across departments.

Activity and Outcomes

CCJBH currently has access to data on Medi-Cal claims for people released from CDCR facilities in 2016. These constitute baseline data, which are important in evaluating the effect of subsequent policy changes.⁶⁴ CCJBH has analyzed these data to better understand patterns of specialty mental health service utilization among justice-involved people eligible for Medi-Cal ("justice-involved eligibles"). People who access specialty mental health services meet medical necessity criteria and have higher levels of mental health need relative to people with mild-to-moderate need.⁶⁵

The goal of this analysis was to determine whether justice-involved people who received timely non-crisis services accessed crisis services at lower rates. There is consensus that service providers have a responsibility to prevent crisis among people with behavioral health need, and crisis stabilization services have emerged as a preferred alternative to other types of emergency services.⁶⁶ There is also interest in crisis stabilization services among law enforcement agencies: police departments have increasingly partnered with the community-based mental health system to provide access to crisis services, including to avoid incarceration.⁶⁷

Of non-crisis specialty mental health services, justice-involved eligibles most commonly accessed therapy, medication services, and case management. CCJBH reports on these services in accordance with DHCS guidelines published in the Performance Outcomes System Measures Catalog.⁶⁸ While there are other types of non-crisis specialty mental health services, CCJBH has chosen the most common types of services for ease of presentation. Therapy and Other Service Activities include assessment, plan development, therapy, rehabilitation, and training of people who support the justice-involved service

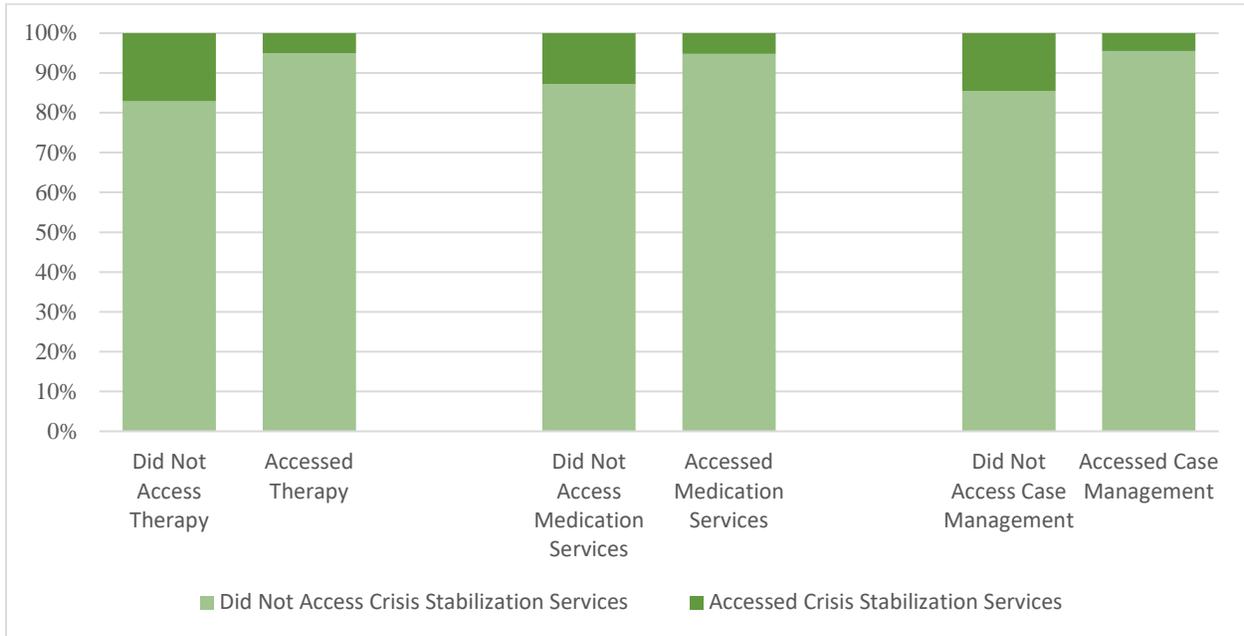
recipient. Medication Support Services include prescribing, administering, dispensing, and monitoring psychiatric medications. Targeted Case Management Services assist service recipients in accessing needed medical, educational, social, vocational, rehabilitative, or other community services. Justice-involved eligibles were considered to have accessed non-crisis services within 30 days of release if there was a paid Medi-Cal claim for any of the three listed categories of services 30 or fewer days after their release date during calendar year 2016. Justice-involved eligibles were considered to have accessed crisis stabilization services 31 days or more post-release if there was a paid Medi-Cal claim for a crisis stabilization service after 31 days of their release during calendar year 2016. Crisis Stabilization Services reflect that a service recipient requires more timely response than a regularly scheduled visit and include emergency and urgent care services.⁶⁹ While Crisis Stabilization is a broad category that includes services such as short-term crisis residential facilities in addition to therapy and medication, it meaningfully reflects an urgent need for mental health services among people in crisis.

In the below table and graph, findings from the Medi-Cal Utilization Project document that justice-involved eligibles who did not access the included non-crisis services within the first 30 days of release from a CDCR facility were more likely to require crisis stabilization services 31 days or more post-release. Without access to non-crisis services, approximately 15% of justice-involved eligibles required crisis stabilization services in 2016. However, with access to non-crisis services, only approximately five percent of justice-involved eligibles required crisis stabilization services in 2016. This estimated difference likely represents an undercount of all justice-involved people who required crisis services, because only a subset of people who sought services in emergency rooms or who were hospitalized for unmet behavioral health need were referred to crisis stabilization services. People who experienced mental health crises but did not have a paid Medi-Cal claim for crisis stabilization services are not reflected in these estimates.

Justice-Involved People Who Received Non-Crisis Medi-Cal Specialty Mental Health Services Required Crisis Stabilization at Lower Rates (CY 2016)

	Crisis Stabilization 31+ Days Post-Release					
	No		Yes		Total Non-Crisis	
No Therapy < 30 Days Post-Release	1,258	83%	260	17%	1,518	100%
Therapy < 30 Days Post-Release	1,217	95%	65	5%	1,282	100%
No Medication Services < 30 Days Post-Release	2,054	87%	302	13%	2,356	100%
Medication Services < 30 Days Post-Release	421	95%	23	5%	444	100%
No Case Management < 30 Days Post-Release	1,690	85%	288	15%	1,978	100%
Case Management < 30 Days Post-Release	785	95%	37	5%	822	100%
Crisis Stabilization 31+ Days Post-Release	2,475		325		2,800	

Justice-Involved People Who Received Non-Crisis Medi-Cal Specialty Mental Health Services Required Crisis Stabilization at Lower Rates (CY 2016) Con't



Research and Best Practices

The Medicaid expansion under the ACA provided a unique opportunity to intervene in the challenged health trajectories of justice-involved people, as it expanded coverage to single, childless adults: a category into which justice-involved people often fall. Simultaneously, recent criminal justice reforms have moved larger numbers of justice-involved people out of custodial facilities and onto community supervision. Treating behavioral health conditions in the community rather than in correctional facilities has become increasingly accepted as a best practice, and “policymakers are beginning to see incarceration less as a barrier to care and more as an opportunity to manage orderly transitions in care.”⁷⁰ CDCR has acted to implement best practices related to care coordination by strengthening the “warm handoff” by which additional support for Medi-Cal enrollment is provided at release. CDCR is also undertaking an extensive overhaul of its Integrated Substance Use Disorder Treatment Program in FY 2019-20 to incorporate greater access to Medication-Assisted Treatment. This brings CDCR into greater alignment with SAMHSA best practices with regard to transitioning justice-involved people from custody to the community.⁷¹

In both the criminal justice and health care contexts, there has been increased emphasis on data-informed policies and regular evaluation of program performance as best practices. Data have historically been used for a variety of purposes within state departments, such as reporting on the number of people that programs serve, but there is increasing emphasis on data analysis to better understand policy effectiveness, improve business practices, and ensure that state investments produce results. One particularly relevant shift related to criminal justice data was the 2019 passage of Assembly Bill (AB) 1331 (Bonta), which required reporting of criminal identification and information numbers as well as incident and court numbers. This change facilitates better-quality data linkage and consistent

updating of arrest and court records. AB 1331 also changed the regulations governing access to criminal history information, which expands access to data for research.

Next Steps/Deliverables

The Medi-Cal Utilization Project will continue describing access to and utilization of health care services. Below are activities to complete in 2020:

1. Findings will be shared broadly via quarterly factsheets beginning in March, which can empower decision-makers at the state level to make data-informed choices within shifting policy and regulatory contexts. CCJBH anticipates a factsheet that will describe patterns of mental health and substance abuse disorder service utilization post-release.
2. Findings will also be shared with county stakeholders through the dissemination of de-identified datasets that provide information at the county level via public sharing on the CHHS Open Data Portal. Examples of information that will be provided include the number of people returning to counties with designations of mental health or substance use need. This information can assist county criminal justice officials and county behavioral health directors as they meet the needs of justice-involved people.

Academic and policy researchers, as well as government-based researchers in other states, have increasingly recognized the importance of behavioral health treatment for justice-involved people. CCJBH will communicate its findings to other organizations in this nationwide movement and advocate for the use of a public health framework in supporting justice-involved people.

The CHHS CDCR/CCHCS Inter-Agency Data Exchange Agreement will facilitate the flow of data and information about justice-involved people with behavioral health need. While data have already been shared across agencies for diverse purposes, many more efforts like the Medi-Cal Utilization Project are necessary to improve outcomes for high-cost, high-need populations by improving the delivery of social services for justice-involved people who interact with multiple state systems. For example, analyses facilitated by the Inter-Agency Data Sharing Agreement can enhance the quality of housing-related services that justice-involved people access and shed light on additional ways that criminal justice and behavioral health partners can help to address housing need. CCJBH anticipates that the CHHS CDCR/CCHCS Inter-Agency Data Exchange Agreement will be finalized in the near future.

State Administrative Data Framework

Overview

Supporting the adoption of best practices in community supervision and behavioral health care can help to reduce recidivism, improve health and housing outcomes, and integrate justice-involved people into society. CCJBH will develop and use a state administrative data framework to support action that will reduce incarceration and support diversion of people with behavioral health need to community-based services. The framework will be used to measure progress and outcomes at the state level to inform where investments should be sustained, increased, or decreased. The state administrative data framework can help stakeholders better understand how to prevent criminal justice involvement and develop systematic eligibility criteria for diversion to non-custodial, community-based services. Using

the framework, CCJBH will supply information to stakeholders from behavioral health and criminal justice systems at the state and local levels.

Activity and Outcomes

To embark on these efforts, CCJBH obtained \$400,000 to be encumbered in a deliverables-based contract determined by a competitive bidding process. An RFP for the framework is under development, and selection of a contractor will take place by June 30, 2020. CCJBH is expanding staff capacity for communicating with contractors and for populating and updating the framework by filling two positions by January 2020. All deliverables shall be completed by December 2022.

Research and Best Practices

Behavioral health is a responsivity factor, and justice-involved people whose behavioral health needs are met will successfully reintegrate into society.⁷² As criminal justice and behavioral health providers work more closely to address behavioral health need among justice-involved people, research can inform the development of collaborative and cost-effective strategies that capitalize on the strengths that partners bring to the table. For example, the criminal justice system can be conceptualized as a system of last resort that provides individualized and coordinated care based on appropriate screening and treatment.⁷³ Research can also document a need for additional resources, for instance so that systems can better stabilize patients and support their recovery.

Research can identify successful interventions as well as opportunities for improvement. There is a wide degree of variation in program types, and research and evaluation can point to strategies for state and local systems to build effective and sustainable models of care. Evaluation efforts are often at the local and program levels, even though state-level policy and funding priorities set the stage for local practices. As a recently published RAND evaluation notes, “[a]lthough an influx of funding might be required to meet the demand for community-based and institution-based mental health and supportive services, a systemic view of how current dollars are spent could identify opportunities for greater returns.”⁷⁴

Next Steps/Deliverables

Considering points of intervention ranging from crisis response to community correctional programs, the awarded contractor in 2020 will develop a statewide framework capable of monitoring trends, identifying gaps, and recommending priorities for CCJBH and policymakers. The framework will consist of:

1. California-specific, statewide, regularly updated data that can be used to monitor rates of incarceration and recidivism among individuals with mental illness and SUDs, as well as potential research questions that can feasibly be answered using those datasets. For example, some datasets may be comparable to other datasets with regard to their levels of aggregation while others may not be.
2. This inventory will also denote the data, research, and evaluation efforts/responsibilities of critical stakeholders and partners at the intersection of criminal justice and behavioral health including but not limited to; law enforcement, corrections and community corrections, the courts, and behavioral health administrators and providers.

- As part of the work product, the contractor will provide recommendations to CCJBH about the staff capacity needed to populate the framework.

Making the Case for Diversion and Supporting the Implementation of Pre-Trial Diversion

Overview

Diversion programs serve as an off-ramp from criminal justice to the community and have become a key strategy for reducing incarceration and recidivism among individuals living with behavioral health conditions throughout the United States. For example, a study conducted by the Center for Health and Justice at TASC, in Hennepin County, Minnesota reported a 34% reduction in recidivism for individuals who graduated a diversion program.⁷⁵ California’s health budget trailer bill, AB 1810, created new opportunities for diversion for individuals living with mental illness. AB 1810 and SB 215 (Chaptered 1005, Statutes of 2018) amended Penal Code Sections 1001.35-1001.36 to create a pathway for courts to authorize Pre-Trial Diversion for individuals with serious mental disorders who committed certain felony or misdemeanor crimes. Additionally, AB 1810 established Welfare and Institutions Code (WIC) 4361 which allows a funding opportunity for Department of State Hospitals (DSH) to contract with counties to support a specific target population of individuals with serious mental health illness who have the potential to be or are deemed Incompetent to Stand Trial (IST) on felony charges.^{xxiii}

Diversion of Individuals with Mental Disorders	IST Diversion Program (\$100M)
Penal Code 1001.35 – 1001.36	Welfare and Institutions Code 4361
Felony and Misdemeanors	IST on felony charges or potential to be found IST on felony charges
DM diagnosis, excluding antisocial personality disorder, and pedophilia	Schizophrenia, Schizoaffective Disorder or Bipolar Disorder

https://www.dsh.ca.gov/Treatment/docs/IST_Diversion_Slides.pdf

In fiscal year 2018-19 CCJBH was awarded \$150,000 per year for 3 years to support the implementation of AB 1810 or Pre-Trial Mental Health Diversion. The legislation specifically directed CCJBH to provide consultation to DSH to implement the DSH Diversion Program, which focuses on felony Pre-Trial Diversion for individuals at risk of being deemed incompetent to stand trial who are experiencing severe mental illness and who may be homeless or at risk of homelessness.

Activity and Outcomes

CCJBH has been supporting DSH with a variety of responsibilities including developing and scoring county proposals, reviewing scopes of work, and acquiring or delivering technical assistance to the counties. Through a limited scope training contract with the Council on State Governments Justice Center (CSG), CCJBH is supplying a variety of training to counties including topics such as successful planning and implementation, sustainability, housing, and case planning through the end of 2019. This

^{xxiii} The text for AB 1810 and SB 215 can be referenced at the following links:

AB 1810: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1810

SB 215: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB215

contract will be renewed through June 2020 and will focus on bringing key local diversion leadership (i.e. Judges, District Attorneys, Public Defenders, and County Behavioral Health Directors) together to work through policy and practice implementation issues.

In addition, CCJBH and DSH were successful in obtaining technical assistance from the SAMHSA GAINS Center in which counties participate in a 2-day training with subject matter experts provided by SAMHSA. CCJBH, DSH, and CBHDA representing the counties also met with these subject matter experts to discuss future training needs and identify potential paths forward for future training opportunities to support the counties. In addition, DHCS, through a contract with the California Institute for Behavioral Health Solutions (CIBHS), will also be a partner in supplying the technical assistance necessary for program success.

During the analysis led by experts from the SAMHSA GAINS Center, it was determined that within existing resources the following areas would be priority:

- DHCS – Develop a Criminal Justice Informed Workforce (through contract with CIBHS)
- DSH – Improve DSH Pre-Trial Felony Mental Health Diversion Program Implementation
- CCJBH – Ensure Broader Mental Health Diversion Implementation and Statewide Policy Success

The partnership with DSH, CBHDA, and DHCS via CIBHS has been collaborative and productive. All entities recognize that the on-going training and technical assistance needs in this area are vast, as documented by several entities including CCJBH, the Judicial Council and the Mental Health Services Oversight and Accountability Commission. For CCJBH, there is now more clarity regarding where to invest and leverage remaining resources in order to champion diversion and support long-term system change.

On November 7, 2019, CCJBH partnered with Words to Deeds (W2D), a project of the Forensic Mental Health Association of California, and held the “W2D Outcomes Matter: Diversion that Works!” Summit. More than 100 leaders and stakeholders gathered in Sacramento to discuss diversion in California and learned what successful diversion looks like in other parts of the country, featuring Honorable Judge Nan Waller, from the State of Oregon and Miriam Popper, Executive Director for Diversion Initiatives in the State of New York.^{xxiv}

Research and Best Practices

To champion diversion, CCJBH is listening to and learning from various perspectives in the field. More importantly, this process specifically includes hearing from individuals with lived experience and their current experience with diversion efforts. Once this process is completed the information gathered can be coupled with research and evaluation on known effective practices so CCJBH can help inform state policy and support local implementation success.

There is significant evidence to document the effectiveness of a variety of forms of diversion, including Pre-Trial Diversion similar to AB 1810. According to CSG Justice Center, in a study of 3 pre-booking and 3 post booking diversion programs for people with SMI and COD jail diversion ‘works’ by:

^{xxiv} A summary report and materials from the Outcomes Matter: Diversion that Works! summit, can be accessed at the following link: <https://www.fmhac.org/w2d-2019-conference.html#/>

- Reducing time spent in jail,
- Increasing public safety,
- Linking people to community-based services, and
- Reducing criminal justice costs^{xxv}

In New York City, the Mayor’s Office of Criminal Justice has implemented Alternative to Detention (ATD) and Alternative to Incarceration (ATI) programs. The number of people in custody has fallen dramatically in recent years, due in large part, to the expansion of diversion programs that allow defendants to wait for trial in the community and/or ATI programs that divert people into supportive community-based services rather than imposing a jail sentence.⁷⁶ Elements of pre-trial programming that New York City has identified as effective and proven to their success include:

- Supporting treatment instead of mandating it,
- Incorporating peer consultants with lived experience,
- Connecting programs to community mental health for expedited referrals,
- Investing in data to maintain trust in the programs, and
- Using the least restrictive options possible when implementing diversion.⁷⁷

Resources and Best Practices for Diversion	
<u>POLICY GUIDES WITH RESEARCH SUMMARIES</u>	The Council of State Governments Justice Center, Practical Considerations Related to Release and Sentencing for Defendants Who Have Behavioral Health Needs: Judicial Guide (New York, The CSG Justice Center, 2017), available online at: https://csgjusticecenter.org/courts/publications/practical-considerations-related-to-release-and-sentencing-for-defendants-who-have-behavioral-health-needs-a-judicial-guide/
	Hallie Fader-Towe and Fred C. Osher, Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements (New York: The Council of State Governments Justice Center, 2015), available online at: https://csgjusticecenter.org/courts/publications/improving-responses-to-people-with-mental-illnesses-at-the-pretrial-stage-essential-elements
	National Center for State Courts, “Effective Court Responses to Persons with Mental Disorders.” September 2018. https://www.ncsc.org/~/_media/Files/PDF/Topics/Criminal/Effective-Court-Responses-Mental-Disorders.ashx
<u>RESEARCH</u>	Steadman, Henry J., and Michelle Naples. “Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders.” Behavioral Sciences & the Law 23, no. 2 (2005): 163–70.

^{xxv} Hallie Fader-Towe, “Making the Case for Diversion” (PowerPoint presentation, Words to Deeds Conference, Sacramento, CA, November 7, 2019). Available online at: https://www.fmhac.org/uploads/1/2/4/4/124447122/w2d_xiii_fader-towe_making_the_case_for_diversion_11_07_2019_final_for_posting.pdf

	Landess, Jacqueline, and Brian Holyda. 2017. "Mental Health Courts and Forensic Assertive Community Treatment Teams as Correctional Diversion Programs." Behavioral Sciences & the Law 35 (5/6): 501–11. (Good research summary)
SPECIFIC PROGRAMS	CT ASIST Program (CT). Frisman, Linda K., Hsiu-Ju, Elena T. Rodis, Joseph Grzelak, Michael Aiello, and Hsiu-Ju Lin. 2017. "Evaluation of CT's ASIST Program: Specialized Services to Divert Higher Risk Defendants." Behavioral Sciences & the Law 35 (5/6): 550-61.
	The Nathaniel Project/Nathaniel ACT (NYC). National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). The Nathaniel Project: An alternative to incarceration program for people with serious mental illness who have committed felony offenses. Program Brief Series. Delmar, NY: Author. Available online at: http://www.antonioacasella.eu/archipsy/nathaniel_project_2002-2005.pdf . For Nathaniel ACT today see https://www.cases.org/programs/nathaniel-act/

Further research by the CSG Justice Center found:

- The general public over-values the risk of people with mental illnesses, and
- Diversion of people with behavioral health needs can reduce jail days, justice costs and recidivism, and increase connections with treatment.

"[r]isk cannot be eliminated but can be mitigated by programs that, assertively offer quality case management, respond to people's treatment needs, respond to people's needs for support like occupation and housing, treat people with respect and hope in a culturally appropriate way, build skills and ways of thinking that discourage criminal behavior and do constant stakeholder, public and media engagement to collect outcome data."^{xxvi}

There is substantial energy and a shared understanding among key state and local policy-makers that a comprehensive set of strategies across multiple systems is needed to reduce the incarceration of individuals with behavioral health issues. Pre-Trial Diversion is one of those strategies but increased knowledge of effective practices coupled with dedicated community resources as an alternative to incarceration is critical.

CCJBH is committed to using research and best practices to "make the case for diversion." While implementing substantial policy change such as AB 1810, can be difficult and require significant cross system collaboration, trust, and resources over time result in an investment with the potential to pay for itself and improve the well-being of individuals, families, and communities. CCJBH is exploring, with input and direction from local diversion leadership, how best to make the case for diversion in

^{xxvi} Hallie Fader-Towe, "Making the Case for Diversion" (PowerPoint presentation, Words to Deeds Conference, Sacramento, CA, November 7, 2019). Available online at: https://www.fmhac.org/uploads/1/2/4/4/124447122/w2d_xiii_fader-towe_making_the_case_for_diversion_11_07_2019_final_for_posting.pdf

California. CCJBH will continue to provide on-going consultation with counties, working towards successful implementation.

Next Steps/Deliverables

Next steps in *making the case for diversion* is for CCJBH to develop a Request for Proposals (RFP) for consultation, training, and policy recommendations with objectives including:

1. *Making the Case for Diversion* with partners in critical roles and leadership such as District Attorneys, Judges, and other local elected officials. Sample deliverables include trainings, toolkits, webinars, etc., and
2. *Listening and Learning from Local Experts* to maximum program impact and effectiveness. As part of this process CCJBH will weigh the value of bringing together a state-level advisory committee, to include representatives of the various partners in diversion in order to find common ground, seek resolutions and propose recommendations to strengthen the effectiveness and sustainable impact of AB 1810. Sample deliverables include a final set of policy recommendations with identified next steps to support expanded mental health diversion best practices statewide.

Lived Experience Contract(s) Project Update

Overview

The 2018-19 enacted state budget provided CCJBH with an ongoing allocation of MHSAs funds to administer stakeholder contracts for activities that reduce the involvement of individuals with behavioral health needs in the criminal justice system. Funding was provided for one position and \$670,000 in contract funds. MHSAs include the specific instruction that the state consider the perspective and experience of those who will be affected and supported by its funding when determining how to utilize MHSAs funding.

Activity and Outcomes

Following the spirit of MHSAs, CCJBH partnered with California State University, Sacramento to embark on a statewide community engagement process to elicit input from diverse stakeholders including consumers, family members, administrators, providers, and other subject matter experts, especially those with lived experience, to provide their first-hand perspectives on how the funding could best serve its intended purposes. CCJBH convened a workgroup of diverse professionals, representative of the stakeholder constituencies for this project, to serve as subject matter experts to help design and guide the process.

The community engagement process was designed to include a variety of components that provide a unique effort to gather feedback from diverse stakeholders. A kick-off event in June 2019 invited policy makers, program administrators, and individuals with lived experience to provide their input on the planned process. Following the kick-off event, there were 9 informant interviews, a literature review, 6 focused listening sessions, and 5 regional forums.

The information gathered during the community engagement process helped define the criteria and elements that will be included in RFPs that allow organizations to submit proposals as part of a

competitive bidding process for contracting with the State of California. In addition to the community engagement process, CCJBH staff met with other state departments who had similar funding and projects to learn best practices and scope of their current programs to ensure effective administrative processing of this RFP but to also not duplicate activities.

Research and Best Practices

The final report from the community engagement process is not anticipated until January 2020, but the preliminary findings are included below. Input from over 300 diverse stakeholders was received during the community engagement process. Invitations were widely disseminated utilizing extensive networks for partners from both systems including government entities, community based organizations, and the general public. Participants representing these sectors included individuals with lived experience, family members, peer support specialists (advocates), judicial partners, law enforcement, probation, parole, SUD and behavioral health treatment providers, program administrators, etc. Participants were various ethnicities, socioeconomic levels, and were representative of the community. Events were held in urban and rural locations and included focused listening sessions for the following subpopulations: women, transitional aged youth, people of color, substance users, family members, and individuals facing housing insecurity.

Questions asked during the regional forums were:

- What works best? Given your experience, what efforts have been successful in supporting individuals with behavioral and mental health issues who are involved with the criminal justice system?
- Where do you see the most needs? Given your experience, where do you see the most need and opportunity for change?
- How should this limited funding be spent to achieve the most impact? How should success be defined?

Key common themes that were identified throughout the regions were (or include):

- Extend continuity of care,
- Increase opportunities for peer support,
- Expand existing local capacity,
- Develop and carry out outreach and education, and
- Promote collaboration and information sharing.

A review of the literature revealed that best practices dictate that improved outcomes include the following:

- Training and education opportunities,
- Building organizational capacity,
- Building local advocacy capacity,
- Building partnerships across systems, and
- Promoting common language across systems.

The review of existing best practices and available research suggests that strategies implemented to address the intersection of criminal justice and behavioral health systems should include activities that

impact these systems at both the state and local levels since each plays a distinct role. Engagement at the state-level will allow activities to impact state policies, legislative priorities, and collaboration among state partners. Engagement at the local level will allow activities to occur in local communities and impact behavioral health services and priorities where they are determined. CCJBH strives to develop collaboration between the two efforts for collective impact. This project was designed to solicit innovative proposals that generate meaningful input from individuals with lived experience, effective methods to elevate and disseminate that input to educate and raise awareness among stakeholders, and defined activities that facilitate collaborative approaches to engage in active dialogue with decision makers that focus on recommendations, strategies, and solutions that can be applied within systems at the local and state level.

Applying this information, the RFP deliverables will not describe specific tasks, but rather broad categories to allow organizations the ability to submit unique proposals that address their specific community needs. Organizations throughout the state will have the ability to submit proposals that document their specific community needs, develop goals and activities to address those needs, and identify outcome measures that will show the impact of those efforts.

Some example activities might include the following efforts:

- Reducing stigma,
- Increasing community awareness of the facts related to both criminal justice and behavioral health,
- Increasing stakeholder engagement,
- Improving cross-sector collaboration, and/or
- Training consumers, families, and community members as advocates.

The RFP framework consists of a state-level contractor and up to five local level contractors (one for each behavioral health region). The state-level contractor will conduct outreach, awareness, and education activities at the state level but will also develop collateral materials and provide technical assistance to the local level contractors. The local level contractors will conduct outreach, awareness, and education activities at the local level implementing the activities from their unique proposals. CCJBH envisions a collaborative relationship among the contractors and consistent messaging and materials.

Next Steps/Deliverables

1. The RFP is in development and the Council is anticipated to vote on the final scope of work for the contracts at the February 2020 council meeting.
2. CCJBH will conduct a competitive bidding process to award the contract funds which are anticipated to be awarded in June 2020.
3. CCJBH will host a summit and report to the Council about the community engagement process, showcase information learned, and highlight the winning proposals and contractors.
4. CCJBH will monitor the contracts, analyze quarterly progress reports, and establish a methodology to provide an evaluation of outcome measures. The outcome measures will be analyzed and information applied to future funding opportunities.

Appendix A

CCJBH Annual Legislative Report Findings and Recommendations

December 2019

Investing in Services for Individuals with Complex Needs

Finding One: Whole Person Care (WPC) pilots are part of the current Medi-Cal system and provide intensive wrap-around services, including housing (with limited state resources), for individuals with complex needs such as the re-entry population. These models of care have demonstrated promise, and are part of a comprehensive set of proposals that make up the Department of Health Care Services' (DHCS) California Advancing and Innovating Medi-Cal (Medi-Cal Healthier California for All). In addition to the overarching population health approach and addressing social determinants, two proposals specifically relevant to the Council on Criminal Justice and Behavioral Health's (CCJBH) target population include adding a new enhanced care management benefit designed to focus on critical populations that are high-cost and high-need, as well as behavioral health payment reform and delivery system transformation, and a Medi-Cal pre-release application mandate.

Recommendation One:

- A. CCJBH can more actively engage in the current implementation of WPC pilots, of which nine of the twenty-five pilot counties are focusing on the re-entry population. For example, CCJBH can help to identify lessons learned, successes, and challenges, including a need for additional training or support for continued and expanded work with the re-entry population. Counties like Los Angeles and Riverside have been serving individuals returning home from state prison, and CCJBH can learn from those experiences to understand how to improve the warm hand-off and transition to community-based services to inform efforts in this area, including in support of Integrated Substance Use Disorder Treatment (ISUDT) and implementation SB 389 (Hertzberg).
- B. CCJBH will participate as an active stakeholder in the Medi-Cal Healthier California for All initiative through representation on the Behavioral Health Workgroup. The most pressing issue will be the Medi-Cal Waiver Renewal. CCJBH has developed several previous recommendations in this area with the goal of maximizing the impact of Medi-Cal for the justice-involved. CCJBH will participate with this goal in mind and commit to seeking and sharing expert input from the field with the workgroup.

Finding Two: Beginning January 1, 2020 with the passage of SB 389 (Hertzberg), funds from the Mental Health Services Administration (MHSA), consistent with an approved local MHSA plan, can now be used to provide services to persons who are participating in a pre-sentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision or mandatory supervision. This policy change means that justice-involved people experiencing mental health challenges, including Serious Mental Illness (SMI), can now be treated equitably and are more likely to be successful as they leave state incarceration and experience re-entry and re-integration. The California Department of Corrections and Rehabilitation (CDCR), and specialty providers, have expertise working

with this population and can be a resource to identify strategies for addressing needs and coordinating efforts to leverage services and supports for this high-need, high-risk population.

Recommendation Two: CCJBH can actively work with the County Behavioral Health Directors Association (CBHDA), CDCR, CPOC and other relevant stakeholders and partners on ways to implement SB 389 (Hertzberg) successfully by helping to facilitate consistent local planning processes, leveraging existing systems and capacities, and using state and local funding in a way that can best leverage federal match.

Finding Three: The Drug Medical-Cal Organized Delivery System (DMC-ODS) utilizes the American Society of Addiction Medicine (ASAM) placement criteria, but these criteria are not relevant or sensitive to the needs of incarcerated populations upon discharge.

Recommendation Three: Modify the ASAM placement criteria to be more appropriate for incarcerated individuals and individuals exiting state and local incarceration. The state, through the DHCS Medi-Cal Healthier California for All Initiative, can work with experts to develop an assessment that can be used in both state and local systems.

Finding Four: Medication Assisted Treatment is primarily used to address opioid and alcohol use, but methamphetamine is commonly used in California, especially among individuals with mental health challenges.

Recommendation Four: Promote best practices in treatment for methamphetamine use such as contingency management, which utilizes positive reinforcement and incentives as external motivators to promote adherence to program rules or treatment plans.

Finding Five: Communication, coordination, and collaboration between institutions and community service provider needs improvement.

Recommendation Five: CCJBH should continue and strengthen investments in the *Transitions Workgroup* with CBHDA that also includes representatives from divisions within CDCR like rehabilitation, parole, and correctional health services. The intimate workgroup of staff experts focuses on system improvements and continuity of care, and its goals are to 1) improve communication between systems, 2) break down barriers to care, and 3) support a warm handoff for individuals transitioning between state and county facilities who have an identified behavioral health need and need continuity of care. CCJBH will seek to expand participation in the workgroup to include probation and sheriffs.

Finding Six: Community treatment systems providing services to individuals with co-occurring disorders (mental health and SUD) are siloed systems that are difficult to navigate.

Recommendation Six: Promote best practices such as programs that create a single access point providing mental health and substance use disorder (SUD) treatment services for different levels of care. These programs would leverage multiple funding streams and have multi-disciplinary staff providing a treatment for mild, moderate, and severe diagnoses in a continuum of care environment. Support Medi-Cal Healthier California for All's goal to make necessary state and county changes to enable mental health and SUD services through a single contract.

Finding Seven: Residential SUD treatment services provide a continuum of care that allows patients to “step-up” or “step-down” to match treatment intensity with their treatment needs. Recovery housing or recovery residences are typically the transition point between inpatient rehabilitation facilities and a home-based, outpatient care system, but many times this is the level of care that individuals exiting incarceration need. These residential environments provide safe housing and supportive, structured living conditions that are in great demand, but capacity is decreasing due to rising housing and operational costs as well as increased need and demand. There is a need for more recovery housing.

Recommendation Seven: See policy recommendation in the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.

Finding Eight: CDCR and CCHCS are implementing an ISUDT program for the state prison population. This represents a significant investment in enhancing programs at all stages, from entry into prison to release. The new ISUDT program will treat SUD as a chronic medical condition, reduce fatalities associated with it, and improve the rehabilitative environment.

Recommendation Eight: CCJBH will support the implementation of ISUDT, as appropriate, by fostering coordination and collaboration between state and local implementers and sharing information about the initiative and its impact in local communities via the Transitions Workgroup.

Next Steps

1. CCJBH will actively work with CBHDA, CDCR, CPOC and other relevant stakeholders and partners through the *Transitions Workgroup* and other opportunities to improve the warm handoff for individuals with behavioral health issues returning home, including the roll out of ISUDT and the implementation of SB 389 (Hertzberg) successfully.
2. CCJBH will actively work with criminal justice partners and behavioral health experts and participate in the Medi-Cal Healthier California for All process by providing or acquiring subject matter expertise from the field on proposals that affect justice-involved populations with complex care needs like those with COD.

Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges

Finding Nine: California’s housing and homelessness crisis is unprecedented, calling for emergency, short, medium, and long-term solutions that are inclusive of the unique needs of individuals with justice involvement and behavioral health challenges.

Recommendation Nine: Support the expansion of housing and housing assistance options with an “all hands on deck” approach.

Finding Ten: There is research to document the effectiveness of *Housing First* principles put into practice, especially when serving individuals with SMI, who are experiencing chronic homelessness, and who have histories of justice involvement. There is far less definitive research with a focus on best practices to address the needs of individuals, who are justice-involved with various behavioral health challenges, especially SUDs. Traditionally, providing housing services to prevent homelessness is not the role of community supervision. Affordable housing is associated with improved public safety and health

outcomes; and yet probation and parole are not adequately resourced to prevent homelessness as part of the community supervisory role.

Recommendation Ten: Increase understanding and adoption of *Housing First* principles that help an individual to be successful while under supervision, court-ordered treatment, or other forms of alternative custody. Explore and examine various models that can obtain similar results, but are sensitive to the unique needs and wishes of individuals returning after long periods of incarceration and/or who live to achieve a substance-free lifestyle.

Finding Eleven: Individuals, experiencing significant behavioral health challenges and justice-involvement, are likely experiencing extreme poverty, in addition to stigma and discrimination. These individuals are often overlooked when it comes to vocational training or educational opportunities due to their perceived cognitive limitations. For those who are most vulnerable, making a livable wage or gaining adequate financial assistance due to a disability is critical to sustaining housing or preventing homelessness.

Recommendation Eleven: Commit to addressing underlining poverty as an essential strategy to solve and prevent future homelessness among individuals experiencing behavioral health challenges who are justice-involved. For those with disabling mental illness, consider ways to fill the gaps between the cost of living and what benefits cover. Invest in employment, education, and training grounded in best practices, as well as aid in achieving a livable wage that provides equal opportunities for everyone to participate in society.

Finding Twelve: The lack of available and accurate data regarding who is experiencing housing insecurity and homelessness among individuals, who are currently or formerly justice-involved with behavioral health challenges, makes it more difficult to address their needs.

Recommendation Twelve: Invest in uniform quality data collection, analysis and report efforts to understand the needs and gaps in services and to inform on the impact of strategies and investments on target populations. Data analysis can track progress on benchmarks to achieve equitable housing assistance opportunities for people who are justice-involved and experiencing behavioral health challenges. The reports will provide information on comprehensive statewide strategies to combat housing discrimination.

Finding Thirteen: There are significant barriers for transitioning individuals exiting incarceration to critical services and supports, especially housing. Not only are there barriers due to policies that may or may not be within the state's ability to change, but also, there is a lack of necessary infrastructure to support state-local partnerships and empower on-the-ground leveraging of resources.

Recommendation Thirteen: Link the criminal justice system to the homeless crisis response system to facilitate coordination, collaboration, and commitment among systems and service partners at the state level, the local level, and between the state and local levels.

Next Steps

1. CCJBH will widely disseminate the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges* with administration, the legislature, local leaders, implementers, and advocates to continue this work in 2020 and beyond.

2. CCJBH will be partnering with the Council of State Governments Justice Center next year through support from the Melville Charitable Trust, the largest foundation in the U.S. dedicated to ending homelessness, to further vet, study and operationalize the recommended state and local actions we have shared in the CCJBH policy brief *Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges*.
3. CCJBH will work with policymakers to find as many opportunities as possible to listen and learn from those who have experience in the intersection of homelessness, criminal justice, and behavioral health.

Juvenile Justice

Finding Fourteen: While there has been a decline in the overall population of youth confined in local Juvenile Detention Centers statewide, youth with mental health needs and SUDs make up a significant percentage of those who remain. The specific factors that explain the decline in overall population yet continued overrepresentation of youth with serious behavioral health needs are unknown.

Recommendation Fourteen:

- A. Analyze available data and trends to examine the causes and effects of the declining population and remaining concentration of youth with serious behavioral health needs in the Juvenile Detention Centers statewide.
- B. If data is not available to review, CCJBH shall develop a survey (distributed statewide) to assess what factors local implementers and stakeholders attribute to the decline and concentration of the population. Specifically, CCJBH will explore how youth with behavioral health needs have been impacted and what were the opportunities for diversion.

Finding Fifteen: It can be difficult for youth to visit parents or family members who are incarcerated. There are many challenges and barriers such as the distance to facility, required paperwork, wait times, and lack of physical contact between parent and child. Children and family members can be turned away for small infractions such as improper clothing or a name on a school ID that differs slightly from the full name on a birth certificate. A missed opportunity to meet with a parent or family member can be upsetting. Families are critical to rehabilitation and accessibility to visitation can facilitate continued family engagement.

Recommendation Fifteen: CCJBH can study best practice approaches for children and youth visiting parents or family in the California State Prison system and position CDCR as a resource by exploring improved strategies, such as training regarding effective methods to approach and handle youth and children in a correctional setting, proper identification for youth and children for visits and strategies for promoting family visits from youth and children as a therapeutic healing process that may lead to breaking the cycle of generational incarceration.

Finding Sixteen: Adverse Childhood Experience Scores (ACEs) of 4 or more have a strong correlation between negative physical and mental health outcomes in adulthood. The higher the score, the more issues that relate to health, mental health, behavior changes, and justice involvement. There is no difference between genders. Children/Youth with ACE scores of 8, 9, and 10 are more likely to become

incarcerated adults. The first touch point with the juvenile justice system for youth is between the ages of 13 and 14.

Recommendation Sixteen:

- A. CCJBH can research, study and seek to support the work of the California Surgeon General and the California Department of Education regarding ACEs and preventative programs to mitigate or divert youth with high ACEs from becoming justice-involved.
- B. CCJBH can research if foster youth and probation youth have parallel high ACEs and what services available to foster youth are effective, which can help to determine how both youth populations with similar needs can experience improved outcomes.
- C. CCJBH can research if there are court appointed advocates for youth with behavioral health needs, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.

Finding Seventeen: CCJBH distributed a survey statewide to learn about best practice approaches in juvenile justice systems for youth with behavioral health needs. CCJBH asked participants to make suggestions regarding how CCJBH can help improve the juvenile justice system and promote best practices.

Recommendation Seventeen: CCJBH can continue to host forums that feature juvenile justice issues. Objectives could include providing a platform to hear from providers, youth and engaging more system-impacted youth; feature innovative approaches to juvenile justice as a public mental health issue; share information with the legislature on emerging juvenile justice issues; and partner with families, youth and communities to identify solutions through facilitated forums with state leadership to support consistency across counties that emphasize treatment, community support and school support over incarceration.

Finding Eighteen: There is a high prevalence of youth with behavioral health needs arrested each year that fill the local juvenile halls. Sometimes these youth enter a juvenile justice system ill equipped to assist them. Without treatment, youth may continue on a path of delinquency and onto offenses that may lead them to adult corrections. The courts recognize that most youth that have been arrested and come before them are in need of treatment rather than detainment. Screening and assessments are vital to addressing mental health treatment needs of youth in the juvenile justice system.

Recommendation Eighteen:

- A. To better understand high-end service capacity alternatives for youth, CCJBH can conduct, in partnership with key stakeholders and providers, an assessment of residential treatment capacity for juveniles as an alternative to juvenile hall.
- B. CCJBH will explore and research existing law enforcement protocols for arresting youth in California with the intention of identifying their pre-charge diversion, treatment and crisis support services procedures as alternative options.

- C. CCJBH will bring awareness to our law enforcement, behavioral health, Judicial, and community partners on pre-charge diversion, treatment, and crisis support services for youth known to have or assessed as having behavioral health needs as alternative options.
- D. CCJBH can research if there are clinical coordinators present in juvenile court rooms, who can provide guidance to judges and probation staff about juvenile mental health evaluation and community-based treatment, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.

Next Steps

1. CCJBH will seek opportunities to research, study, support, and collaborate with key stakeholders and state agencies such as; the Health and Human Services Agency, Department of Education, Department of Public Health and the BSCC to forward progressive Juvenile Justice policies.
2. CCJBH Juvenile Justice Workgroup committee made up of CCJBH Councilmembers will select one to two specific activities for the council to conduct during 2020 that align with the findings and policy recommendations.
3. CCJBH will continue to serve in the capacity as a resource in working with key stakeholders around youth diversion promising practices.

Appendix B

Strategies to Improve Housing Outcomes for the Justice-Involved with Behavioral Issues

Strategy One: Support the Expansion of Housing and Housing Assistance Options

Local Action	State Action
<p>Within the parameters of preventing the most vulnerable individuals from homelessness, counties and cities can explore if and how to utilize one-time state funds to address homelessness and the housing crisis. Local government can explore the gaps in operating costs of Adult Residential Facilities (ARFs) treating those with serious mental illness (SMI).</p>	<p>Adult Residential Facilities (ARFs), also known as Board and Care Facilities, and Residential Care Facilities for the Elderly (RCFEs), when appropriately administered and adequately financed, serve the essential role of buffering the most vulnerable individuals experiencing severe mental illness from homelessness. Moreover, ARFs provide a community-based alternative to more costly hospital and institutional settings. Currently board and care costs are high when reimbursement rates are low (\$1058.37 per month). Licensure is burdensome and time-consuming; in the current housing market, the incentive is to sell properties, rather than to invest in them: subsequently, 100s of beds statewide disappear annually.</p> <p>As part of the state’s ongoing comprehensive plan addressing homelessness and the affordability crisis, the state can evaluate and consider the following recommendations concerning ARFs developed by a coalition of county human services and behavioral health programs:</p> <ul style="list-style-type: none"> • One-time statewide investment to stabilize and prevent the loss of additional board and care facilities and begin rebuilding capacity. • Streamline regulations to ease the burden on board and care operators. • Establish a sustainable rate and program structure that maximizes federal funding to support the long-term viability of board and care facilities, explore potentially leveraging Federal Financial Participation through a Medi-Cal

Local Action	State Action
<p>Counties are encouraged to apply for capital development funding to develop permanent supportive housing for people with SMI who are experiencing, or at risk of chronic homelessness. Funding sources could include programs administered by the California Housing and Community Development (HCD), California Veteran Affairs (CalVet), California Tax Credit Allocation Committee (TCAC), California Housing Finance Agency (CalHFA), and the Department of Health Care Services (DHCS).</p> <ul style="list-style-type: none"> • No Place Like Home Program / HCD • Veterans Housing and Homelessness Prevention Program / HCD, CalVet, CalHFA • Multifamily Housing Program-Supportive Housing / HCD • Low-Income Housing Tax Credit Program / TCAC • Whole Person Care Pilots / DHCS 	<p>1915(c) Home and Community Based Services Waiver.</p> <p>The state can explore how to simplify the processes counties, cities, and local providers must undergo while applying for a wide range of state-funded programs. With the aim of reducing local costs so that more funds remain available for housing, rather than administration.</p> <p>CCJBH can guide in optimizing Medi-Cal resources. Savings on healthcare, including by parole and probation, open resources for redirection towards housing the reentry population ranging from transitional and rental assistance to permanent supportive housing.</p>
<p>The state passed several pieces of legislation in 2019 to assist county and city governments with addressing homelessness, particularly by removing regulatory barriers. While the state can provide these new “tools” to fight homelessness, expand proven programs, and speed up re-housing, it is essential to raise local awareness and support local adoption. Below are a few of the most pertinent tools for local communities to consider.</p> <ul style="list-style-type: none"> • AB 139 (Emergency Shelter and Housing Element) • AB 761 (Temporary Shelter/Military Department) • AB 1397 (Local Planning: Housing Element/Inventory of Land for Residential Development) • AB 1482 (Tenant Protection Act/Rent Control) • AB 1515 (Planning and Zoning Protections) • AB 2162 (Planning and Zoning; Housing Development/Supportive Housing) • SB 211 (Emergency Shelter/ CalTRANS) • SB 330 (Housing Crisis Act of 2019) 	<p>The Adult Reentry Grant Program administered by the Board of State and Community Corrections (BSCC) provided nearly \$83 million in state grants for rental assistance, capital improvements, and resources to support the warm hand-off from state incarceration. These funds went directly to non-profit community-based organizations (CBO) through a competitive process. While individuals returning from state incarceration to homelessness should be equally eligible for local programs, the reality is that there are still barriers due to federal regulation and policy. Until federal policy (U.S. Department of Housing and Urban Development/HUD) changes, housing support for individuals who are returning after an incarceration of more than 90 days will have to come from flexible state and local funds.</p> <ul style="list-style-type: none"> • Examine the viability of sustainably funding the Adult Reentry Grant Program for CBOs (and possibly directly with counties especially in smaller/rural communities) with a

Local Action	State Action
<ul style="list-style-type: none"> • SB 450 (California Environmental Quality Act Exemption: Supportive and Transitional Housing/Motel Conversion) • SB 744 (Planning and Zoning: California Environmental Quality Act: Permanent Supportive Housing) 	<p>revised focus on “do whatever it takes” housing, service navigation, and warm hand-off supports including benefits assistance, substance use and mental health services, family reunification, vocational training, and employment supports.</p> <ul style="list-style-type: none"> • Examine the role, capacity, and necessary resources for parole and probation to provide transitional housing and service navigation in the first 30-60-90-120 + days post-release; or, until local agencies can enter those coming home to coordinated entry, and other systems of care, especially those provided by local CBOs and/or possibly with counties directly.
<p>Counties can consider how best to implement SB 389, which lifts the ban on using the Mental Health Services Act (MHSA) funds for services to parolees. Specifically, it authorizes counties consistent with the local community planning process, to use MHSA funding to provide services to persons participating in a pre-sentencing or post-sentencing diversion programs, or who are on parole, probation, post-release community supervision, or mandatory supervision. It can also provide housing supports for parolees with SMI who are experiencing or at risk of homelessness.</p>	<p>DHCS can update the Mental Health and Substance Use Disorder Services Information Notice 19-007 to include clarity on the implementation of SB 389 and offer counties technical assistance and support for implementation activities.</p>

Strategy Two: Support Housing Best Practices for the Justice-Involved with Behavioral Health Challenges

Local Action	State Action
<p>The first step in achieving the implementation of best practices is for local service/system partners from housing, social services, behavioral health, and criminal justice to have a better understanding of each other.</p> <p>Criminal Justice partners can reach out to Continuums of Care (CoC) to learn more about <i>Housing First</i> and various effective models across the housing continuum (i.e. emergency shelters, rapid rehousing, transitional housing, permanent supportive housing, and residential treatment) and</p>	<p>In addition to opportunities available with Homeless Housing Assistance Program (HHAP) funding, consider the value of continuous state support to strengthen CoCs, including for infrastructure and capacity building such as training and technical assistance, data collection, cross-system collaboration, program and policy development, and strategic planning.</p> <p>As part of state technical assistance efforts, create a small/rural county-specific</p>

Local Action	State Action
<p>which ones are the most effective for those being released from jails, prisons, and state hospitals.</p>	<p>implementation guideline for housing and housing best practices.</p>
<p>CoCs and housing partners can collaborate with criminal justice and behavioral health partners to understand the role of community supervision and court-ordered treatment and supervision. Locals can consider assigning criminal justice liaisons to local housing planning efforts.</p>	<p>State-supported housing programs should encourage using community engagement strategies that include persons with lived experience (e.g., homelessness, criminal justice, and behavioral health system involvement) to develop, determine, and implement housing strategies and services. The state can consider incentivizing the use of peers as providers; especially, as housing navigators, service coordinators, and recovery coaches in supportive housing, shared housing, and recovery housing models.</p>
<p>When using recovery housing locally for placement, here are a few elements that should be present:</p> <ul style="list-style-type: none"> • Inclusive and supportive of Medication Assisted Treatment (MAT), including the availability of peers with MAT experience to support residents on MAT. • Utilization of appropriately trained peers, coupled with a house culture that is grounded in fostering mutual support and investing in recovery. • Policies and practices that recognize that lapse/relapse is part of the recovery process, and there is a level of training and professionalism within the house staff to recognize and refer to a higher level of care. 	<p>California’s <i>Housing First</i> requirements should be inclusive of recovery housing as long as it is the individual’s choice. The Substance Abuse and Mental Health Services Administration identifies recovery housing as a best practice in serving those with substance use disorders, particularly within the first 12 months of recovery. Considering many individuals return from incarceration with the primary goal of a substance-free lifestyle, recovery housing should be available.</p>
<p>Similar to LA County’s Bridge Housing Model, local administrators can consider providing an enhanced subsidy to housing providers of abstinence-based peer-supported recovery residences, facilitating more intensive therapeutic services to individuals who are concurrently in outpatient services, including intensive outpatient, MAT, and outpatient withdrawal management.</p>	<p>CCJBH can work with the Homeless Coordinating and Financing Council to ensure that required conditions of court-ordered treatment, parole, and probation can co-exist as applicable with <i>Housing First</i> requirements and best practices.</p> <p>CCJBH can identify, in collaboration with local criminal justice partners and CoCs, what additional guidance, training, and technical assistance is needed to apply guiding principles of <i>Housing First</i> for individuals who also have to comply with supervision requirements.</p> <p><i>Housing First</i> requirements should take into consideration the reality of limited housing</p>

Local Action	State Action
	stock. Additionally, the temporary nature of community supervision creates challenges regarding how to achieve permanent housing that warrant further exploration and creative adaptation.
Many counties have or are implementing jail in-reach programs to support a seamless transition home for individuals with complex physical and behavioral health conditions. Consider including a housing assessment processes to initiate possible future placements for those who will be exiting to homelessness.	As part of the California Medi-Cal Healthier California for All Initiative multi-year Department of Health Care Services (DHCS) initiative, examine ways in which Medi-Cal can more comprehensively support best practices in care coordination efforts for complex populations who are justice-involved and experiencing homelessness.

Strategy Three: Commit to Addressing Underlying Poverty

Local Action	State Action
The 2019-20 budget provides \$25 million in ongoing funding for the Housing and Disability Advocacy Program (HDAP), which provides funding to counties for advocacy programs to establish Supplemental Security Income (SSI) eligibility for people with disabilities. Locals can use these funds to support targeted efforts to reach potentially eligible jail inmates and assist in their reentry. These application processes can take a significant amount of time, and in the interim, locals can explore other temporary or transitional housing resources for this population.	<p>Strengthening safety net programs that intend to support and protect individuals and families from severe poverty, is feasible in the current California economy.</p> <ul style="list-style-type: none"> • Repair cuts to Supplemental Security Income/State Supplemental Payment (SSI/SSP made during the recession roughly ten years ago, which has resulted in the maximum SSI/SSP grant for an individual be just \$932 per month (89.5% of the poverty line). If fully adjusted for inflation, the CA Budget and Policy Center estimates that the grant amount today would be equal to \$1,478 per month. Grants can be significantly improved to help disabled and elderly individuals afford housing if the annual state COLA were reimplemented. • Continue to increase CalWORKS grants to address deep end poverty. Similar to SSI/SSP grants, CalWORKS grants have not kept up with the cost of living, especially rent. • Consider a state-level flexible housing fund to act as a safety net for families who want to help with housing, but they are also suffering from rent

Local Action	State Action
	<p>burdens. The additional limited-time resources can aid in helping family members house their loved ones returning from incarceration.</p>
<p>Coordinating available social services on a local level is critical. In addition to focusing on immediate housing/shelter and access to services for behavioral health conditions, connect individuals to CalFresh, General Assistance, CalWORKs, etc., if appropriate.</p> <p>While the state requires counties to offer General Assistance or General Relief (GA/GR) Programs to indigent adults, administration rests with the counties. As a result, benefits, payment levels, and eligibility requirements vary among the 58 counties. Individuals exiting incarceration often do not have the necessary documentation to apply and secure benefits.</p> <p>Local communities are encouraged to explore flexible strategies to support access to GA/GR programs while individuals are taking the necessary steps to establish and acquire necessary documentation.</p>	<p>Having a livable wage is essential to sustained housing, improved health, and reduced risk of recidivism. It is not achievable without both education and training, as well as equal opportunities and protections despite justice-involvement.</p> <ul style="list-style-type: none"> • Safety net programs like CalWORKS should provide vocational training by known best practices, including educational programs that provide skills that are in demand and compensated well, such as technology and health care. • The state could invest in or provide incentives to reentry programs to focus on improving job readiness for high-risk populations by integrating cognitive-behavioral interventions into employment programs.
<p>Support legal service providers who can contribute to reducing homelessness among the justice-involved including:</p> <ul style="list-style-type: none"> • Help mitigate the impact of a criminal records by correcting errors, help address outstanding fines and court costs, obtaining expungements or sealing records, • Help resolve errors by removing inaccurate items from credit records, and • Provide guidance on disclosure of one’s criminal background during the employment process, especially in light of new legislation passed in 2019 <p>Supply assistance and advocacy in obtaining public benefits such as Medi-Cal, SSI/SSDI, CalWORKs, CalFresh, GA/GR, and aid in appeal processes as needed.</p>	<p>Strengthen efforts to support the enforcement of the Fair Chance Act (effective January 2018) making it illegal for most employers to ask about a criminal record before making a job offer. AB 1076 (Ting) commences in January 2021, will use technology to automate record clearance for those already entitled to relief under existing laws. CCJBH could support enhanced public awareness efforts to increase knowledge of these significant changes. Building on this, identify possible future actions the state can take to ensure equitable employment opportunities for individuals with criminal records.</p>
<p>Commit to supporting employment opportunities for all reentry populations, including individuals with substance use disorders and mental health challenges. By integrating cognitive-behavioral</p>	<p>Continue support for the Prison to Employment Initiative, which is a grant program to improve labor market outcomes by creating a systemic and on-going</p>

Local Action	State Action
<p>interventions into employment programs and collaborating with substance use and mental health service providers, job readiness can improve among individuals also struggling with complex behavioral health conditions.</p>	<p>partnership between rehabilitation programs within the California Department of Corrections and Rehabilitation (CDCR) and California’s workforce system.</p>
<p>Counties and/or cities can take a leadership role in hiring people with criminal backgrounds. Provide guidance and incentives to local departments and contractors who also do so.</p>	<p>The state can take a leadership role in hiring people with criminal backgrounds. Provide guidance and incentives to state entities, departments, and contractors who also do so.</p>

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

Local Action	State Action
<p>Local communities can work to prioritize limited resources to help gain a better understanding of who is homeless and why. Local CoCs need guidance and support (including resources) to collect appropriate information about justice status (i.e., active probation vs. parole, recently released from jail vs. prison, prior justice involvement, etc.). Agencies can implement this during the Point in Time (PIT) counts to help clarify a more equitable plan, while providing assistance and supporting coordination efforts with criminal justice partners. All of this information should be collected uniformly across CoCs to facilitate statewide analysis.</p>	<p>AB 1331 (Bonta) is a good start to improving the quality of criminal justice data by establishing reporting requirements across the system and clarifying existing laws regarding access to data.</p> <p>Future efforts to vigorously examine data, similar to the CCJBH Medi-Cal Utilization Project, can use this data to increase knowledge regarding links between criminal justice, behavioral health, homelessness, etc.</p>
<p>Communities must be adequately resourced to coordinate a comprehensive set of strategies that collect information and data from places working with people who are experiencing homelessness, including jails, prisons, state hospitals, juvenile detention facilities, and courts.</p>	<p>Similar to federal requirements under HUD for CoCs to receive funding, provide comprehensive state guidance (possibly through HCFC), to state programs on how to consistently collect information on housing status. Provide definitions for state programs to use when collecting this information (i.e., sheltered vs. unsheltered) and recommendations regarding the timing of data collection (i.e. upon enrollment in a program, dis-enrollment, every six months, etc.). Every department participating in the HCFC should be using the same definitions to collect and report housing status.</p>
<p>Homeless Management Information Systems (HMIS) and other data sources should build and maintain information about people experiencing homelessness and their outcomes, including justice</p>	<p>CCJBH will participate in the development of the Statewide HMIS, seeking the inclusion of justice status with appropriate specificity so that personal information is protected.</p>

Local Action	State Action
<p>and behavioral health system involvement. Aggregate HMIS data used responsibly for planning and evaluation purposes can increase understanding of the extent and nature of homelessness over time. Specifically, a HMIS can produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.</p>	<p>Consider justice-involvement as a variable in evaluation and planning efforts, potentially documenting the need for increased access to housing and housing assistance for the justice-involved.</p>
<p>Local jurisdictions should encourage developers to site permanent supportive housing in by-right zones where multifamily and mixed-use development is permitted. Also, local jurisdictions can modify their land-use policies to accommodate higher densities of rental and for-sale housing.</p>	<p>Data integration is paramount to care coordination and monitoring program impact and performance. Conduct a comprehensive assessment of regulatory barriers to data-sharing practices between criminal justice, behavioral health, and housing/social systems. Identify implementation solutions at the state level to remove barriers and/or provide guidance on allowable data-sharing strategies locally that work within existing federal/ state limitations.</p>
<p>Improve access to local Public Housing Authority (PHA) resources for individuals who have convictions by modifying standards of admission/screening, examples include:</p> <ul style="list-style-type: none"> • Shorten the length of time that a review of a conviction or public safety concerns consideration, • Use individualized assessments and allow explanations for special circumstances, eliminating all provisions that screen applicants out of the Housing Choice Voucher (Section 8) and Public Housing programs due to probation or parole status, and • Direct the PHA to prioritize people who are justice-involved and have behavioral health or serious health needs for Section 8 or other public housing. 	<p>In 2019 several pieces of legislation were passed to protect individuals from housing discrimination, particularly evictions. The state can consider ways to support local jurisdictions to raise awareness and enforce these new policies</p> <ul style="list-style-type: none"> • AB 1110 (90-day Notification of Rent Increases) • AB 1399 (Protection Landlord Withdrawal of Accommodations) • SB 329 (Protection Landlord Discrimination of Sec. 8 Housing) • SB 644 (Active Military Personnel Lowered Security Deposits)
<p>Support legal service providers who can contribute to reducing homelessness among the justice-involved, including:</p> <ul style="list-style-type: none"> • Legal representation in housing court or mediation, and to resolve problems and prevent unlawful evictions in government-subsidized or private housing, 	<p>CCBJH can support the HCFC to inform local communities of these new protections and consider various ways to increase Californians' knowledge of housing rights and how to file grievances when they are denied. Widely disseminate available resources from the California Department of Fair Employment and</p>

Local Action	State Action
<ul style="list-style-type: none"> • Educate landlords on their rights and responsibilities through local information sessions or rental housing associations and published materials, • Educate tenants dispelling myths and supporting their assertion of rights such as to a reasonable accommodation, and • Provide legal representation within homelessness assistance programs through on-site services or support to coordinate pro bono efforts and enhanced legal service relationships for individuals experiencing homelessness. 	<p>Housing at https://www.dfeh.ca.gov/Housing/.</p> <p>CCJBH can support the HCFC to monitor local and state efforts that reduce the criminalization of homelessness for people with behavioral health issues, report on trends, and identify best practices.</p> <p>Housing and Community Development (HCD) Department should incentivize permanent supportive housing projects by streamlining approval.</p>
<p>State associations that represent local government such as the California State Association of Counties (CSAC) and California League of Cities can support the implementation of a State NIMBY Reduction Plan by providing technical assistance on everything from legal strategies to social marketing. Identify communities and projects that have been successful in establishing housing and share lessons learned across counties. Identify best practices to organize and empower volunteers/citizens and people with lived experience to share their voices and influence social norms.</p>	<p>Develop a comprehensive multi-year state plan to address NIMBYism, which includes strategies to combat the additional stigma and discrimination experienced by individuals with behavioral health needs and/or former incarceration.</p>
	<p>Consider implementing a pilot grant program based on the Opening Doors to Public Housing Initiative launched by the Vera Institute for Justice of which one of the primary goals is to promote collaboration between public housing authorities, law enforcement agencies, and other criminal justice stakeholders as a means of effectively reducing crime and improving reentry outcomes. San Diego is one of the current federal pilots. Lessons learned from San Diego can be used to help create guidance and suggestions statewide for local implementation.</p>

Strategy Five: Link the Criminal Justice System to the Homeless Crisis Response System and Facilitate Coordination, Collaboration, and Commitment among System and Service Partners

Local Action	State Action
<p>Local communities can use one-time state funds to invest in and strengthen coordinated entry processes. Coordinated entry is a process at the local level to ensure that people experiencing a housing crisis are assessed, referred, and connected to appropriate housing based on need. While Coordinated Entry Systems (CES) are working to provide the right kind of help to people at the right time, they are not designed or resourced to address state priorities. In addition, the scope and complexity of needs presented locally is often overwhelming the systems that are just now becoming functional.</p>	<p>Coordinated entry systems operate at the local level, but there are actions the state can take to improve operations and be more inclusive of justice-involved populations:</p> <ul style="list-style-type: none"> • Identify and disseminate best practices in the application of CES with criminal justice referral entities, and • Provide guidance to criminal justice partners on how to define homelessness and align definitions with state and local practices so that individuals exiting incarceration, or who are on community supervision, are better positioned during the assessment process. For example, jails and prisons could collect housing status data before incarceration to establish a history of homelessness. Pertinent housing history information can be provided to locals when individuals transition to parole or probation.
<p>Establish a CES access point to assess individuals exiting state and local incarceration. Partners in CES should include criminal justice – probation, parole, sheriffs/jail administrators, and the courts. Provide adequate training to criminal justice partners regarding how to use assessments and refer/link to CES.</p>	<p>The Homeless Coordinating and Financing Council (HCFC) should expand the homelessness definition beyond CFR 24 Section 578.3 for all programs that receive state funding.</p> <p>The expanded definition should include an individual or family that is exiting an institution where he or she has resided for more than 90 days and who resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.</p>
<p>Counties/Cities (CoCs) who use the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) or another tool should include justice status as part of the assessment, such as the Justice Discharge VI-SPDAT. Similar to the above, provide adequate training to criminal partners so they are</p>	<p>The HCFC, in partnership with local experts, can lead a workgroup to study strategies to improve the vulnerability assessment of individuals who are justice-involved and living with mental illness and substance use disorders to be more sensitive and relevant to the circumstances of someone who has been in an institution. HCFC can consider the</p>

Local Action	State Action
<p>equipped to assess with the Justice Discharge VI-SPDAT and refer/link to CES.</p>	<p>effectiveness and feasibility of one tool/assessment used statewide. The recommendations from the workgroup can also get disseminated widely.</p>
<p>Resources are so limited and needs are so great that locally, it will take coordination, collaboration, and commitment across a wide variety of systems. Criminal justice, behavioral health, social services, and housing providers are all essential in combating homelessness among the most vulnerable justice-involved individuals. Each system/service partner can examine what they can contribute (i.e. workforce, facilities, resources, etc.) to improving the situation. Regional forums or trainings can provide opportunities for peer learning across these system partners to support innovative problem-solving.</p>	<p>The Homeless Housing Assistance Program (HHAP) is a statewide one-time funding opportunity of \$650 million in block grants for local jurisdictions to support regional coordination and expand and/or develop local capacity to address immediate homelessness challenges. Support local implementers working to successfully use this opportunity to facilitate coordination, collaboration, and commitment between housing providers, behavioral health, and criminal justice partners, such as:</p> <ul style="list-style-type: none"> • Operationalize and provide examples of effective models of multi-system and potentially multi-jurisdictional coordination, collaboration, and commitment, and • As informed by criminal justice and behavioral health system partners, provide examples of the roles these systems can play in improving housing outcomes.
<p>CCJBH, in collaboration with other state departments and counties, can develop examples for local consideration of how non-housing dedicated funding like Public Safety Realignment (AB 109), the Mental Health Services Act (MHSA), Proposition 47 and other resources can be used locally for housing services and supports for the justice-involved with behavioral health challenges.</p>	<p>Future state funding opportunities should consider the following:</p> <ul style="list-style-type: none"> • Provide resources to improve data-informed decision-making including improving strategic planning, data collection, infrastructure, establishing legal/data use agreements, training and on-going coordination, • Require percentage set-asides for priority populations such as youth, but allow the local or regional jurisdiction to determine the priority based on local needs including targeting the justice-involved, behavioral health, older adult populations, • Require awardees to document/describe all collaborations

Local Action	State Action
	<p>with community and systems partners, most importantly individuals with lived experience (former incarceration, homelessness, and behavioral health challenges), and</p> <ul style="list-style-type: none"> • Provide resources directly to criminal justice partners (parole, probation, the courts, and others as appropriate) to ensure opportunities for diversion and alternative community placements as well as to support individuals under their jurisdiction in successful reentry and the transition home.

Appendix C

2019-20 Enacted California State Budget Components - Homelessness

Budget Allocation:	Purpose:
<p>\$650 Million</p> <ul style="list-style-type: none"> • \$275 Most Populous Cities • \$175 Counties • \$190 COC's • \$10 million for the City of Palm Springs 	<p><i>Emergency Funds:</i> Meant to fund construction and expansion of emergency shelters and navigation centers, rapid rehousing, permanent supportive housing, job programs and for innovative projects like hotel/motel conversions.</p>
<p>\$331.5 Million to Temporary Assistance to Needy Families Block Grants</p>	<p>These block grants in the CA Work Opportunity and Responsibility to Kids Program will assist low-income families with paying for housing, food and other necessities.</p>
<p>\$150 Million Mental Health Care Workforce</p>	<p><i>Healthcare Expansion and Retention:</i> Due to an ongoing shortage of mental health professionals in the state's public health system, the budget provides for a fund to assist in hiring and in retaining those already working in the system.</p>
<p>\$120 Million WPC's</p> <ul style="list-style-type: none"> • \$100 Million in housing support • \$20 Million to help counties establish new programs. 	<p><i>Expansion of the Whole Person Care (WPC's) program:</i> WPC's are meant to combine the care of individuals with complex medical cases in a wrap-around health, behavioral health, and housing services program aimed at preventing homelessness</p>
<p>\$52.9 million Student Rapid Rehousing and Basic Needs</p> <p>Rapid Rehousing:</p> <ul style="list-style-type: none"> • \$6.5 million ongoing for CA State University (CSU) • \$3.5 million ongoing for University of CA (UC) • \$9 million ongoing for CA Community Colleges (CCC)s <p>Basic Needs:</p> <ul style="list-style-type: none"> • \$15 million one-time for CA State University (CSU) • \$15 million ongoing for University of CA (UC) • \$3.9 million one-time for CA Community Colleges (CCC)s 	<p>For assistance in Rapid-Rehousing efforts, originally developed under HUD, these programs help address searching for, and securing housing; in addition to providing for students basic needs.</p>

Budget Allocation:	Purpose:
\$25 Million Bringing Families Home Program (BFH)	Bringing Families Home aims to help reduce the number of families in the child welfare system experiencing homelessness, increasing family reunification, and preventing foster care placements. Funds awarded to counties are matched by the receiving counties effectively doubling the amount of money available.
\$25 Million Housing and Disability Advocacy Program	Applying for disability benefits is cumbersome and time consuming. Advocacy programs aim to help homeless and disabled individuals apply for a capture monthly basic needs funding through the Social Security Administration.
\$20 Million Eviction Assistance	Newly passed renter protections highlight the ongoing issues California renters face with regard to evictions. The funding is designed to provide low-income tenants with legal assistance to prevent adverse effects stemming from eviction.
\$14.7 Million CalWORKS	The Homeless Assistance Program is temporary aid designed to cover hotel expenses for up to 16 days, once every calendar year. In addition, the program can also assist in paying security deposits and last month's rent when a family is at risk of being evicted.

For more information visit:

<http://www.ebudget.ca.gov/201920/pdf/Enacted/BudgetSummary/Homelessness.pdf>

Glossary

AB	Assembly Bill
AB 109	Public Safety Realignment
ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
BJS	Bureau of Justice Statistics
BSCC	Board of State and Community Corrections
CalHPS	California Health Policy Strategies
CBHDA	County Behavioral Health Directors Association
CBO	community-based organizations
CCCMS	Correctional Clinical Case Management System
CCJBH	Council on Criminal Justice and Behavioral Health
CDCR	California Department of Corrections and Rehabilitation
CES	Coordinated Entry Systems
CHHS	California Health and Human Services Agency
CHW	Community Health Worker
CMS	Centers of Medicare and Medicaid Services
CoC	Continuums of Care
COD	co-occurring mental health and substance use disorder
COMIO	Council on Mentally Ill Offenders
CSG	Council on State Governments
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSH	California Department of State Hospitals
EOP	Enhanced Outpatient Program
FY	fiscal year
HCD	California Department of Housing and Community Development
HCFC	Homeless Coordinating and Financing Council
HEAP	Homeless Emergency Aid Program
HHS	U.S. Department of Health and Human Services
HMIS	Homeless Management Information Systems
HUD	U.S. Department of Housing and Urban Development
IST	Incompetent to Stand Trial
MAT	Medication Assisted Treatment

MCP	Managed Care Health Plan
Medi-Cal	California's Medicaid Program
MHSA	Mental Health Services Act
MRT	Medicaid Redesign Team
NACo	National Association of Counties
NAMI	National Alliance on Mental Illness
NIMBY	Not in My Backyard
NPLH	No Place Like Home
OD	opioid use disorders
PC	Penal Code
PHA	Public Housing Authority
PIT	Point-In-Time
POC	Parole Outpatient Clinic
PPIC	Public Policy Institute of California
RNR	Risk-Need-Responsivity
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SDOH	social determinants of health
SGF	State General Fund
SMI	serious mental illness
SUD	substance use disorders
USICH	U.S. Interagency Council on Homelessness
VI-SPDAT	Vulnerability Index Service Prioritization Decision Assistance Tool
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
WPC	Whole Person Care

End Notes

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