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Successful Reentry/Transition from the California Department of Corrections and Rehabilitation: Identification of Barriers and Solutions to Address Them

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Description of Barriers to Reentry, Solutions, Strategy, and Responsible Entities

SB 369 (Hertzberg) was introduced in the 2019 Legislative Session and was passed by both houses, but vetoed by the Governor. SB 369 would have established the California Reentry Commission. Noting a "shared commitment to supporting successful reentry for persons returning to the community from prison," the Governor's veto message of SB 369 required the California Department of Corrections and Rehabilitation (CDCR) and CDCR's Council on Criminal Justice and Behavioral Health to work with stakeholders to identify barriers to successful reentry and strategies to overcome those barriers.

Multiple divisions within CDCR and the California Department of Correctional Health Care Services (CCHCS) have roles in successful reentry (also called transition) from prison. Responsibilities are as follows:

- The Division of Adult Parole Operations (DAPO) is responsible for protecting the community by enabling parole agents to have an active part in the local community's public safety plans. DAPO are the catalysts for change in the way communities deal with crime and reintegration. DAPO encourages and assists individuals with their community reintegration while providing a range of programs and services that offer the opportunity for change. Prior to release from a CDCR institution, DAPO guides the prerelease process and collaboratively develops reentry case plans, and manages the Transitional Case Management Program, which utilizes contracted benefits workers in all adult prisons to apply for federal and state benefit entitlements prior to an inmate's return to the community. Benefits applied for include Medi-Cal, Social Security and Veteran's Affairs coverage, and this service is available to all releasing inmates, not just those releasing to parole supervision. Upon release, DAPO assists each individual with obtaining reentry resources and rehabilitative programs in the community. DAPO is committed to working closely with our community partners and advocating for the needs of those on parole supervision. DAPO's Behavioral Health Reintegration (BHR) program provides gap services and psychosocial support services for parolees reintegrating into county mental health and substance use disorder treatment programs. BHR employs licensed mental health professionals located in parole units throughout the state. DAPO's presence in the community enables visibility and accessibility in an effort to reduce recidivism and enhance community safety.
- The Division of Rehabilitative Programs (DRP), through its Community Reentry Services section, provides comprehensive post-release rehabilitative programs and services located in communities throughout the State of California delivered through residential, outpatient,

reentry and recovery housing, and day reporting centers. DRP also provides Alcohol and Other Drug (AOD) Counselors for the Integrated Substance Use Disorder Treatment Program. DRP provides these services through multiple contracts with Non-Profit Treatment Providers.

- The Statewide Mental Health Program (SMHP) provides mental health services via the Mental Health Services Delivery System (MHSDS) to individuals incarcerated within CDCR. The MHSDS includes various levels of care ranging from independent outpatient services to acute psychiatric inpatient care. A component of the SMHP is the Statewide Pre-Release Program which provides supportive pre-release services specifically to individuals within the MHSDS. Prior to release, mental health pre-release assessments are conducted to identify case factors requiring specific attention for transition of care. Upon discovery of various concerning case factors, mental health clinicians initiate outreach to various CDCR and community stakeholders to discuss continuity of care and other key concerns related to transition from prison to the community. In conjunction, for individuals releasing to Post-Release Community Supervision, mental health records are shared with county behavioral health departments. For those transitioning to supervision under DAPO, and connected to BHR services upon release, institutional mental health records can be accessed directly by CDCR BHR clinicians. For individuals releasing from inpatient psychiatric programs, Coordinated Clinical Assessment Team meetings are held with various entities to discuss pre-release plans and support a smooth transition for this highly vulnerable population. The pre-release services provided within the MHSDS are continuously improving as relationships develop and grow with numerous stakeholders and community partners.
- The Integrated Substance Use Disorder Treatment (ISUDT) Program requires active involvement of nearly all business areas within CDCR and CCHCS in order to provide timely and effective, evidence-based treatment and transitions to incarcerated individuals afflicted with substance use disorder with the long-term goals of reducing substance use disorder related morbidity and mortality, and recidivism. The project is implemented statewide and focuses on three patient populations at higher clinical risk for substance use disorder related harm including: 1) patients entering prison prescribed Medication Assisted Treatment (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. Primary project areas include, but are not limited to: 1) Intake, 2) Cognitive Behavioral Interventions, 3) Medication Assisted Treatment, 4) Enhanced Pre-Release Planning, and 5) Transition Services.
- Established by CA Penal Code Section 6044(a), 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 reentry strategies.

The purpose of this document is to comprehensively capture barriers to reentry and potential solutions. Thus far, this draft document reflects input from the criminal justice system, community-based service

providers, and individuals who have lived experience in the criminal justice system. It inventories barriers to successful reentry, solutions, strategy, and responsible entities. The draft table below will form the basis of a final report for submission to the Governor's Office that will serve to fulfill the directive set forth in the veto message. Once the barriers and potential solutions/strategies are documented, they will be analyzed and an Action Plan will be developed that takes into consideration existing and potential resources.

For clarity of presentation, barriers to reentry are listed separately even though many of the barriers are interrelated. People who return home with limited family support, for example, may not be able to live with their family members or rely on them for other basic needs. Those returning home with behavioral health needs may have difficulty managing those conditions in the community, which reduces their ability to maintain employment and housing.

Similar terms could have different meanings in different systems. Two such terms have already been identified: "case management" and "treatment." Sample definitions from the criminal justice system are as follows:

- DAPO/DRP define case management as "an individualized supervision plan that assesses the parolee's needs, changing case factors, risks, and case dynamics for a successful reentry. Case management includes assessing and linking parolees to such services in the community."
- ISUDT defines case management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's comprehensive needs." ISUDT defines treatment as "*medical* care or care given to a patient/program participant for an illness or injury."

Sample definitions from the community behavioral health system are as follows:

- A definition of case management used by the Drug Medi-Cal Organized Delivery System in the Standard Terms and Conditions (STCs) is "a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services."
- For the purpose of delivering Medi-Cal Specialty Mental Health Services, Targeted Case Management is defined as "services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development."
- Through the Medi-Cal Managed Care System, Basic Case Management Services include assessment, identification of appropriate providers and facilities, communication, education, and referral. Complex Case Management Services include "management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team; intense coordination of resources to ensure the member regains optimal health or improved functionality; development of care plans specific to individual needs and updating of these plans at least annually; and assessment of transitional needs of members in and out of Complex Case Management Services."

Additional terms and definitions will be identified through the public stakeholder process.

Note: SB 369 legislative advocates expressed continued interest in centralized planning through a statewide reentry commission or state-level Office of Reentry composed of experts, impacted individuals, and representatives from all involved agencies to serve as a convener of stakeholders and facilitate service delivery coordination. Along this line, an additional idea was submitted to create an oversight board, exclusively and solely community based excluding any law enforcement and/or legal system personnel, which would oversee the implementation of policy changes and funding that impact the incarcerated population.

#	Barrier	Description	Potential Solution(s)	Potential Strategy	Potentially Impacted Entities	Potential Resource Requirements	
						Requires New Resources	***Being Addressed in a Limited Capacity in Current Efforts***
Section 1: System-Level Barriers							
1.1	System Coordination Within and Between State Departments	There is limited coordination across and within state level agencies that serve the criminal justice population.	• Strengthening communication, collaboration, and information sharing between in-custody supervision and parole. • Promote/strengthen cross-departmental awareness and understanding of existing or new/revised policies/initiatives. • Increase transparency and open communication between departments and with the community.	• Clearly define and operationalize roles and responsibilities of the relevant lead agencies at the state level and the coordination among them. • Memoranda of Understanding between state departments that outline roles / expectations and facilitate data-sharing. • Establish a defined and universally adopted standard of care that includes coordinated health, housing, education, employment,	CDCR CCHCS ISUDT CCHCS Utilization Management CCJBH DHCS HCD Individuals with Lived Experience Veteran Affairs Department of Developmental Services	X	Y

				criminogenic risks/needs, and other wraparound services. • Host quarterly stakeholder meetings to discuss challenges and opportunities as webinars and/or in communities impacted by reentry.			
1.2	System Coordination Between State and Local Level Entities	There is limited coordination across state level and local level agencies that serve the criminal justice population. Processes, regulations, and timelines may be misaligned.	• Strengthening communication and collaboration between in-custody supervision and county departments (e.g., probation, health, behavioral health, social services and housing), including regularly updated contact information at the county level. • Promote/strengthen cross-departmental awareness and understanding of existing or new/revised policies/initiatives. • Strengthened data-sharing infrastructure so that data can be shared	• Clearly define and operationalize roles and responsibilities of the relevant lead agencies at the State and local levels, and the coordination among them. • Strengthening Community Partnerships through the ISUDT Network by developing formal referral workflows with counties, which then coordinate with their contracted providers /	CDCR (DAPO) CDCR (SMHP) CCHCS ISUDT DHCS CDSS DSH HCD Medi-Cal Managed Care Plans (MCPs) County Departments and their Contracted Providers / CBOs Continuums of Care Individuals with Lived Experience Veteran Affairs Regional Centers	X	Y

			from the state to counties, and counties can share data with the state.	community-based organizations (CBOs). • Establish and consistently track shared metrics of success, including leading indicators such as MAT appointments made prior to release and long-term indicators such as reduced costs through reduced incarceration.			
1.3	System Coordination Between Local Level Entities	There is limited coordination across local level entities that serve the criminal justice population, in part because some counties have limited capacity to serve as the coordinating agency for services. Some counties may not work closely with Federally	• Increased communication between local criminal justice, health, behavioral health, housing and social services agencies and their contracted providers / community-based organizations. • Promote/strengthen cross-departmental awareness and understanding of existing or new/revised policies/initiatives.	• Clearly define and operationalize roles and responsibilities of the relevant lead agencies at the Local Level and the coordination among them. • Strengthening Community Corrections Partnerships. • Consistent, high-quality case management using a whole-person approach.	County Departments and their Contracted Providers / CBOs Individuals with Lived Experience Veteran Affairs Regional Centers	X	Unknown

		Qualified Health Centers and other service agencies.		• Select a lead agency for case planning once individuals are in the community. • Collaborative Comprehensive Case Planning, in addition to discharge/release planning processes already in place within CDCR. • Enhanced Care Managers within the Managed Care Plan health care delivery system can help to coordinate services at the local level for those who meet medical necessity criteria. • Leverage the Stepping Up Initiative through the Council on State Governments Justice Center. • Align local-level eligibility requirements and screening / assessment tools with state-level			

				practices, which are already in place and rely on the ASAM criteria.			
1.4	Misaligned or Insufficient Funding Sources	Service providers may not always be aware of available funding sources or the appropriate use of funds. Funds may be insufficient.	• Technical assistance to ensure that responsible staff are familiar with how funds should be used. • Provide additional funding if there are gaps.	• Publish guidance on effectively utilizing multiple funding sources to serve the criminal justice population. • Establish a process to monitor effective use of funds and gaps in funding.	CDCR CCHCS ISUDT DHCS HCD County Departments and their Contracted Providers / CBOs	X	Y
1.5	Data and Information Sharing Challenges Between CDCR and County Departments / Entities	Concerns about liability for potential breaches sometimes prevent county departments / entities such as Medi-Cal Managed Care Plans (MCPs) from establishing data-sharing agreements with State departments, such as CDCR.	• A state level database should contain identified county points of contact so that care can be coordinated across State and county departments / entities. • A statewide collaborative case management platform that all reentry/transition partner agencies can utilize for data sharing, as appropriate. • Requiring local entities to share data with state agencies as a condition of funding.	• CDCR/CCHCS has already developed direction and guidance for counties, which could be widely adopted and implemented. • Counties sign CCHCS ISUDT' MOU to begin data sharing. • Establish guidance for data sharing between agencies and MCPs when CalAIM Enhanced Care Management	CDCR (DAPO) CDCR (SMHP) CCHCS ISUDT County Departments MCPs	X	Y

			• Design and implement data-sharing solutions that protect client / patient confidentiality and minimize the likelihood of unintended negative consequences.	(ECM) benefit is implemented. • Build infrastructure so that entities can comply with regulations. • Implement software solutions that support rather than hinder data sharing. • Consider designing data systems using an open-source data platform, which includes standardized naming and reporting conventions that allow agencies to use and share data more effectively. • All software could be designed with standardized Application Programming Interface (API) functionality allowing counties and the State to utilize data more cost-effectively,			

				oftentimes with the ability to utilize existing internal resources or procure services from a wider range of providers at lower cost. By utilizing an API, other counties can access data in their criminal justice and health systems to gain valuable insight about a justice-involved person's health and services history. • Require that contracted CBOs have the capacity to receive relevant data.			
1.6	Data and Information Sharing Challenges between County Departments and their Contracted Providers / CBOs	Data sharing from county departments to their contracted providers / CBOs can be limited, which prevents or delays the flow of information that providers / CBOs	• Robust and timely transfer of data from counties to their contracted providers/CBOs, so that providers have the information they need, such as the number of individuals returning to their area, data on their	• Development of infrastructure that accommodates concerns about sharing community-based health service utilization data. • County departments will facilitate timely	County Departments and their Contracted Providers / CBOs	X	Unknown

		need to provide services.	health needs, and projected releases.	connection to services for the justice-involved population, including timely communication about changes in county of release with contracted providers/CBOs.			
1.7	Changes to Policies and Programs that are Difficult to Implement, Fail to Address Identified Issues and Fail to Obtain Practical Ideas From a Broad Range of Stakeholders	Often laws are enacted that address very small segments of the reentry population or the reentry population within a certain district, and often are developed without input from reentry stakeholders. Through advocacy organizations, capture practical ideas from currently and formerly incarcerated individuals with	• Collaborative development of policy and programs, including legislation, by involving a broad range of stakeholders. • Through advocacy organizations, capture practical ideas from currently and formerly incarcerated individuals with lived experience in the reentry process and system and incorporate those ideas / experiences into policies.	• Before pursuing laws, legislators should discuss proposals with those agencies and entities who will have to implement them, and with members of population that they intend to serve, to facilitate collaboration on how best to solve the problem.	Legislators Relevant Associations Individuals with Lived Experience Relevant Advocacy Groups	X	Y

		lived experience in the reentry process and system and incorporate those ideas / experiences into policies.					
1.8	Insufficient / Inappropriate Services for Criminal Justice Population	Mental Health Courts and other types of specialized services are not always available, so service needs may go unaddressed or inappropriately addressed.	• Ensure sufficient service capacity so that everyone who requires services can receive those services. • Continue to leverage CDCR's Specialized Treatment for Optimized Programming contractors and other organizations with expertise in corrections and health systems. • Ensure that available services meet needs. • Identify barriers that prevent conservatorship from occurring prior to release.	• Offer light-touch services as well as more intensive services. • Offer services that recognize barriers such as transportation. • Continue to conduct screening and assessment prior to release to ensure that need for services is known. • Regularly update treatment plans to reflect needs. • Include appropriate personnel, such as individuals with lived experience of incarceration. • Review conservatorship barriers to	CDCR CDCR (SMHP) CCHCS ISUDT DHCS HCD County Departments and their Contracted Providers / CBOs Individuals with Lived Experience Veteran Affairs Regional Centers	X	Y

				determine if improvements can be made to this process prior to release for the most acute patients releasing to the community with no support.			
1.9	Limited Service Capacity for the Criminal Justice Population	It can be difficult to find placements that are close to the release county and comply with parole conditions.	• Increase general housing and residential treatment service capacity. • Increase service capacity for people transitioning from incarceration.	• Change placement criteria and practices that can result in discrimination against people transitioning from prison. • Foster co-location of services (e.g., facilitating enrollment into social services benefits at community clinics).	CDCR (DAPO) CDCR (SMHP) CCHCS ISUDT DHCS HCD County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y
1.10	Medi-Cal Provider Enrollment is Too Complex	Medi-Cal certification is difficult and labor-intensive, which can deter providers from participating.	• Streamline the Medi-Cal provider enrollment process.	• Explore opportunities to update the Medi-Cal provider enrollment process and/or expand training opportunities to support providers	DHCS	X	Unknown

				trying to enroll as Medi-Cal providers.			
1.11	Inconsistent Discharge Planning Practices	Not all individuals receive pre-release discharge planning.	• Improve CDCR capacity for discharge planning so that all individuals can receive one-on-one, personalized support. Nurses already conduct assessments during discharge interviews to assess medical needs and gaps. • Mental Health clinicians currently assess individuals receiving mental health services while incarcerated and provide pre-release services to support continuity of care and transition into the community. Improve communication between the State and counties, and between counties and their contracted providers/CBOs. • Continue to refine processes for treatment planning, beginning at intake to include improved information sharing from the	• Engage mental health pre-release coordinators and resource nurses at each institution, and expand these efforts as needed. • Involve and engage the person leaving prison in the discharge planning process. • Include information about individual barriers to reentry in the discharge plan. • Make it a standard practice to arrange pre-release meetings between State and county departments / MCPs, once CalAIM is implemented. These meetings should include Community Health Workers (CHWs) and provide opportunities for CHWs to provide	CDCR CDCR (SMHP) MCPs County Departments and their Contracted Providers / CBOs	X	Y

			direction of community (e.g., county behavioral health and Medi-Cal Managed Care Plans) into CDCR to ensure that an individual's healthcare history (prior to incarceration) is known and can be taken into consideration when providing treatment during incarceration.	input into the release plan. • Establish flexible processes that can accommodate last minute release changes.[1]			
Section 2: Program/Provider-Level Barriers							
2.1	Insufficient Cross-Training of Service Providers	There are inadequate opportunities for service providers across the behavioral health, primary care, criminal justice, and other systems to become familiar with one another's systems. Relevant terminology can vary across systems.	• Support regular cross-training for service providers so that they can become familiar with processes across systems. • Support regular training on best practices for serving the criminal justice population, including trauma-informed care, cultural sensitivity, and addressing criminogenic risks/needs. • Engage with relevant associations as needed.	• Survey providers and agencies regarding available training and potential gaps in knowledge. • Remedy gaps through educational materials. • Provide paid opportunities for people with lived experience to co-facilitate and lead trainings, where feasible / appropriate. • Ensure that relevant providers	CDCR DHCS County Departments MCPs Individuals with Lived Experience and their Contracted Providers / CBOs	X	Y

[1] Processes are in place to minimize the impact of unexpected changes to county of release.

				are included in trainings where needed / appropriate.			
2.2	Low Program Fidelity and Implementation of Ineffective Programming	Some programs have been documented as effective, but they may not be implemented in the way that the curricula dictate. Other programs may not have been evaluated rigorously.	• Invest in required reporting and evaluation, including standards that are enforced and tied to funding. • Implement evidence-based programs that have been documented as best practices. • Ensure that curricula are in-depth and meet individuals' needs.	• Link data across systems for evaluation purposes, and continue to refine processes for access to CDCR data by evaluators as needed. • Increase capacity to implement programs with fidelity. • Increase accountability and transparency for program outcomes. • Create long-term, sustainable funding sources that support evidence-based programs.	CDCR DHCS County Departments and their Contracted Providers / CBOs	X	Y
2.3	Lapsed Benefits After Release	Incarceration in prison can result in suspended benefits, such as Medi-Cal, SSI, VA, SNAP, and housing. People are released	• In-reach, such as the Transitional Case Management Program, enables applications for benefits to be submitted prior to release. • Suspend benefits upon incarceration and	• Although prison in-reach services may not be funded through Medi-Cal, other county funds (e.g., AB 109) may be used to support these services.	CDCR (DAPO) CCHCS ISUDT DHCS County Departments and their Contracted Providers / CBOs	X	Y

		with benefits that are no longer active and struggle with navigating, accessing and reinstating previous benefits.	reactivate benefits upon release.[2] • Change criteria for services when the criteria can exclude people transitioning from incarceration.	• Track and advocate for the federal Medicaid Reentry Act, which would provide thirty days of coverage for Medicaid (Medi-Cal) services prior to release. • Establish processes for service provision across counties where there were last-minute changes to release county. • Provide information about options for service provision while Medi-Cal enrollment is pending.			
2.4	Limited Continuity of Care After Release	All too often, individuals who are receiving services while incarcerated do not continue to receive those services in their community and, if they do, it is not necessarily	• Increase coordination between CDCR and local level entities to ensure continuity of care to ensure service needs that were being addressed in the incarcerated setting continue to be addressed in the community, if needed.	• Once Enhanced Care Management is available through the CalAIM waiver, CDCR Transitional Case Managers can coordinate with MCP Enhanced Care Managers, who will then take lead responsibility for	CDCR CDCR (SMHP) CCHCS ISUDT County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y

[2] Policies and procedures for suspension and re-activation are already in place, per guidance from the federal Center for Medicare and Medicaid Services.

		informed by the treatment they received while incarcerated.	Mental health clinicians already initiate contact with county behavioral health departments for patients presenting with significant mental health concerns in efforts to support and advocate for seamless continuity of care. • Expand capacity for community-based services that are aligned with correctional services so that services are available to all released individuals. • Expand capacity for services in rural areas and small counties.	coordinating health, behavioral health care, as well as coordinate other supportive services, care for returning citizens. • Include individuals with lived experience as service navigators. • Memoranda of Understanding between correctional health care providers and community behavioral health providers would facilitate continuity of care and medical record sharing. • Ensure that individuals on Medication-Assisted Treatment are eligible for appropriate medications and are provided information upon release about medications and			

				incentives provided by AB 1304. • Provide a 30-day supply of medications at release. • Provide a copy of medical records to formerly incarcerated individuals at release.			
2.5	Service Coordination and Program Placement When Medical Needs Increase Post-Release	People are placed into post-release programming based on their needs while incarcerated, and it can be difficult to coordinate services for releases whose health declines after release.	• Greater collaboration between criminal justice providers and local health services providers. • Sufficient service capacity across the continuum of care to meet need. • Create a pathway to services for individuals who require services while in the community, even if they did not receive a mental health diagnosis while incarcerated	• Ensure sufficient service capacity at higher levels of care, including skilled nursing facilities, board and care facilities, and transitional care facilities, to meet needs that increase after release. • Enhanced flexibility in placements to accommodate unexpected changes in need for services.	CDCR CDCR (SMHP) CCHCS ISUDT MCPs County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y
2.6	Limited Outreach and Engagement	Individuals transitioning from incarceration may have	• Share timely and accurate information about services and resources after release,	• Explore/consider opportunities for contracting with community Reentry Resource Centers in	CDCR (DAPO) CDCR (SMHP) County Departments	X	Y

		limited knowledge of recovery-oriented activities that can support reintegration.	relevant to each county because services vary. • Use social media to conduct outreach and raise awareness of services.	communities that lack basic reentry services. Include recovery-oriented recreation (e.g., dances, arts, other healthy outlets) • Provide formerly incarcerated people with resource manuals at release, building on existing efforts.			
Section 3: Individual-Level Barriers							
3.1	Unmet Housing Need and Homelessness	There are significant living restrictions on individuals transitioning from incarceration. Many of these restrictions are placed without regard for rehabilitation or potential to reoffend.	• Additional funding to expand capacity, especially for reentry housing, transitional housing, permanent supportive housing, and sober living so that housing placements fit the needs of people coming home and there are adequate, knowledgeable staff to deliver services. • Partnerships between CDCR and housing providers to facilitate referrals and placements. • Access to Section 8 vouchers and rental	• Examine and implement the recommendations in the report, *Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails*. • Identify how CalAIM ECM and In Lieu of Services can be leveraged to address housing needs / homelessness. • Work with communities to overcome	CDCR CDCR (SMHP) CCHCS ISUDT DHCS HCD Continuums of Care Managed Care Plans County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y

			subsidies, especially for former lifers. • Housing complexes specifically designated for returning citizens, including both single-family and multi-family units. • Investment in public education to address NIMBY issues. • Track progress toward additional system coordination, such as metrics presented in the Homeless Coordinating and Financial Council's Action Plan.	NIMBYism and obtain clearances such as Conditional Use Permits. • Give notice of living restrictions as early as possible before release so that the individual has time to plan their reintegration. • Conduct individual risk evaluations before placing living restrictions on individuals. • Pre-release communication of the placement process and the placements themselves. • Identify low-income housing that does not discriminate against people with histories of incarceration and limited credit history.			
3.2	Medi-Cal Enrollment and Activation	Due to last-minute changes in county of release,	• Develop a process for fast-tracking plan re-enrollment changes for	• Develop and release guidance on this new process.	DHCS	X	Unknown

		individuals may be enrolled in a plan for a different county than they are released to, and it takes at least 30 days to transfer Medi-Cal, leading to delays in care. When individuals are released earlier than anticipated, counties do not activate their Medi-Cal until their original release date. Individuals have to contact their county Medi-Cal office to activate, which can lead to delays in care.	individuals releasing to another county. • Communicate updated release dates with county Medi-Cal offices. • Support successful implementation of pre-release enrollment processes proposed in CalAIM.	• Continuous process improvement to ensure that individuals are enrolled onto Medi-Cal in their release county.			
3.3	Unmet Health Care Needs	Individuals who received health and behavioral health care services while	• Use a client/patient centered approach to determine needs of returning community members.	• Forensic Peer Support Specialists and Community Health Workers who have lived	CDCR CDCR (SMHP) CCHCS ISUDT DHCS MCPs	X	Y

		incarcerated may not opt to continue those services (e.g., medication support) after release.	• Build capacity of county health care systems to effectively care for individuals transitioning from incarceration. • Ensure that health information privacy and confidentiality for people on supervision are maintained. • Ensure connection to Medication Assisted Treatment (MAT) and other necessary treatment for Substance Use Disorder for those who need it. • Eliminate the stigma of mental illness and ensure adequate mental health service capacity, through policy action if necessary. • Develop trust between providers and individuals who require services.	experience in the criminal justice system can be employed to support individuals who need health and behavioral health services to access and engage with treatment services. • Implement evidence-based programs that are identified best practices, such as cognitive-behavioral therapy and motivational interviewing, and establish training requirements to assist with implementation. • Explore the option of providing smartphones to those releasing from incarceration to enable them access to telehealth and other virtual services.	County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers		

				• Build capacity for telemedicine in areas that are rural and have limited transportation options. • Ensure that individuals are not penalized for seeking behavioral health services and that mental health conditions are considered when addressing conduct issues.			
3.4	Trauma and Culture Shock	Many incarcerated individuals have histories of trauma, and incarceration itself can be traumatizing. In addition, returning citizens, especially those who were incarcerated for long periods, can become overwhelmed with the culture	• Apply trauma-informed principles to case planning and delivery of all services, recognizing both histories of trauma and current experiences of trauma. • Utilize comprehensive evidence-based assessment tools that account for length of time incarcerated, trauma, and individual needs, using a holistic approach and motivational interviewing.	• County entities can contract with CBOs that employ mentors and life coaches to provide support after release. Begin building relationships between the reentering individual and peer navigator prior to release, as appropriate. • Provide support for mental and emotional well-	CDCR CDCR (SMHP) CCHCS ISUDT County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y

		shock of reentry / transition.	• Create prison environments to support rehabilitation, including through staff training. • Offer support for life skills, self-efficacy, healing and goal setting prior to release.	being, including support for self-care, maintaining healthy relationships, and navigating grief/loss and mental illness. • Allocate resources to encourage constructive peer support groups, and begin building relationships with peer mentors prior to release. Create continuous, long-term relationships between reentering individuals and peer mentors. Allow prison clearance for peer support specialists, where appropriate. • Minimize trauma through the design of the prison environment to support health (e.g., increase time outside, encourage exercise, bright cheery paint colors).			

3.5	Unaddressed Criminogenic Risks/Needs	Community-based programs do not consistently provide interventions to address criminogenic risks and needs. Specific programs, such as those that address criminal thinking, anger management, negative peer associations, family relationships, etc., may not be widely available.	• Include criminogenic risks and needs within a whole-person, wraparound approach to services for all people who are transitioning from incarceration. • Adequate funding is needed for evidence-based programs that are identified best practices, such as cognitive-behavioral therapy, motivational interviewing, and restorative justice. • Ensure that qualified providers universally administer appropriate screening and assessment tools.	• Implement Collaborative Comprehensive Case Planning for all parolees. This is especially important for the criminal justice population with behavioral health needs, as research shows that addressing both behavioral health and criminogenic needs are addressed are necessary in order to reduce recidivism. • Continue to deliver high-quality behavioral health programming in prison and in the community, and expand efforts as needed. • Ensure a seamless service delivery model by establishing the same programs in	CDCR (DAPO) CDCR (SMHP) CCHCS ISUDT County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y

				prison and in community. • Provide domestic violence, anger management, gang prevention and other classes in prison and in the community. • Provide support for linkages to education and self-growth programs. • Engage individuals with lived experience to lead classes, as appropriate.			
3.6	Challenged Family Relationships	Contact between incarcerated individuals and their families is often limited (for a variety of reasons, including criminal behavior itself), putting stress on family relationships and limiting availability of	• Ensure that incarcerated people are able to stay connected to their families and are reunified with family after release, as appropriate. • Provide wraparound services to help unite parents with their children who are in the child welfare system. • Provide parenting classes while in prison. • Ensure placement close to family, especially	• Make it easier to stay connected to family during incarceration, through placements local to family, longer visiting hours, and reduced-cost phone and video calls. • Provide reliable transportation for family visits, whether a child is in the child welfare system or living	CDCR County Departments and their Contracted Providers / CBOs	X	Y

		family support upon release. Regaining custody of children is a challenge.	young children, upon release.	with family members. • Offer family therapy that meets family court requirements, detailed information about the process. • Establish a plan for regaining child custody prior to release, where possible. • Offer wraparound services that help unite parents with children in the foster care system. • Provide relevant information and support for family members, including spouses and children of incarcerated parents.			
3.7	Limited Human Capital and Poverty	Formerly incarcerated people often have lower levels of education and employment, and face barriers	• Build marketable skills and certificates or credentials for diverse occupations, including knowledge work, while people are in prison through work release programs.	• Expanded access to in-prison educational / vocational programming, apprenticeships, entrepreneurial	CDCR (DAPO) CWDB EDD DOR County Departments	X	Y

		to education and employment post-release, such as legal barriers that preclude licensure and certification.	• Support to accompany employment, such as case management and wraparound services. • Policies that decrease barriers to employment and education, such as restrictions on licensure for certain professions and background checks.	training, and Peer Specialist training. • Explore partnerships with the Department of Rehabilitation (DOR). • Ensure that incarcerated people are receiving education and training for occupations that are currently in-demand and that pay living wages by coordinating with the California Workforce Development Board (CWDB). • Transitional Case Management and wraparound services should accompany employment services. • Consider providing direct cash assistance post-release. • Provide records of in-prison program	and their Contracted Providers / CBOs		

				participation and completion.			
3.8	Fines, Fees, and Restitution	Fines, fees, and restitution imposed by the criminal justice system exacerbate financial difficulties.	• Minimize the impact of criminal justice system fines, fees, and restitution on reentry. • Ensure that individuals transitioning from incarceration are able to apply for unemployment benefits and child custody even if they have outstanding fines, fees, and restitution.	• Limit the use of fines, fees, and restitution as punishment. • Cease the accrual of fines and fees during incarceration. • Create payment plans and sliding scale fines and fees for those individuals with less ability to pay. • Provide a written record of outstanding fines, fees, and restitution at release.	Legislators Judicial Council	X	Unknown
3.9	Lack of Identification	A lack of state-issued identification makes it difficult to apply for benefits upon release from incarceration.	• CDCR has already established a California Identification Card Program through its Division of Rehabilitative Programs. • The California Department of Motor Vehicles has established fee reductions and waivers.	• Ensure that the CDCR ID program is open to everyone and improve processes as necessary. • Exchange Prison ID cards for State ID cards. • Acquire Social Security card and Birth Certificate (for individuals born in	CDCR DMV Social Security Admin.	X	Y

				California) before release and provide California IDs to all returning citizens on the day of release. • Eliminate fees to exchange an ID card or renew driver's licenses for returning citizens. • Ensure that current, updated addresses appear on ID cards.			
3.10	Limited Access to Transportation to Treatment / Intervention Services	A lack of reliable transportation makes it difficult to receive necessary health and criminogenic risks/needs interventions.	• Processes are in place to support transportation at release and when necessary for parole reporting, especially for parolees with mental illness who are unable to take public transportation.	• Ensure that free transportation to county of commitment is available for all returning citizens who need it. • Establish processes to support transportation for job searches, to get to and from work and other necessary appointments and activities, such as parole check-in, obtaining legal documentation, seeking housing.	CDCR County Departments and their Contracted Providers / CBOs	X	Y

				• Provide vouchers for public transit for a minimum of 6 months post-release for returning citizens. • Consider contracting with Lyft/Uber utilizing the voucher system for transportation for returning citizens. • County agencies could set aside funding for private transportation or incorporate local paratransit to incorporate formerly incarcerated individuals into their service. • Ensure that counties and their contracted providers/CBOs know when it is appropriate to bill Medi-Cal, to cover the cost of transportation for			

				medically necessary appointments.			
3.11	Limited Access to Appointments, such as Court Dates	There may be insufficient appointments available, or appointment processes may be difficult to navigate.	• Establish appointments prior to release. • Provide incentives to appear at appointments, where necessary.	• Establish court dates to get driver's license reinstated, family court, and other outstanding court mandated sanctions. • Establish appointments to register as an offender. • Establish appointments for child support. • Enhanced infrastructure for appointment reminders from health care providers.	CDCR County Departments and their Contracted Providers / CBOs	X	Y
3.12	Limited Access to a Bank Account and Limited Financial Literacy	Lack of knowledge about good financial practices can lead to difficulty with establishing a strong financial foundation. Formerly incarcerated	• Support with financial practices that will help to establish credit and savings, including managing paychecks, evaluating financial products, and budgeting.	• Financial education for all incarcerated individuals that begins prior to release, potentially through partnerships between correctional agencies, agencies that regulate financial	CDCR County Departments and their Contracted Providers / CBOs	X	Y

		people may not have bank accounts or credit, and often experience financial instability at release.		institutions, and financial institutions themselves. • Assistance with establishing bank accounts and credit. • Access to debit cards and training as to using them.			
3.13	Limited Familiarity with Opportunities for Support, Healthy Activities, and Rights At Release	Individuals may be released outside of where they used to reside, and they may be unfamiliar with resources in that community.	• Targeted outreach and advertisement of services from credible messengers, such as Community Health Workers. • Culturally appropriate outreach in multiple languages. • Share information about expungement and voting rights at release.	• Create a Reentry Resource Website that serves as a clearinghouse for all critical reentry information. *Note: past attempts for a reentry resource website have been challenging due to it being labor-intensive to keep it updated.* • Provide each individual exiting a prison in California with a Reentry Guidebook that would act as a service directory for people who may lack Internet access. • Leverage Forensic Peer Support Specialists and	CDCR (DAPO) County Departments and their Contracted Providers / CBOs Veteran Affairs Regional Centers	X	Y

				Community Health Workers with lived experience as navigators to provide a sense of belonging, assistance with goal-setting, life skills, and developing positive relationships.			
3.14	Special Considerations for Youth and Older People Transitioning from Incarceration	Both older and younger people transitioning from incarceration require a special level of care. The risk of recidivism among older individuals is lower than among younger individuals.	• Tailored support for older people who may have been incarcerated for extended periods. • Tailored support for individuals who were transferred from juvenile correctional facilities to adult correctional facilities and have never experienced being an adult in the free world. • Tailored support and adequate placements, such as a nursing home setting, for individuals who are elderly or have disabilities and require help with Activities of Daily Living.	• Implement pre-release workshops that are focused on navigating basic responsibilities and social institutions, with emphasis on successful reentry for younger or older people. • Offer classes to increase comfort with technology. • Address special considerations in individualized case plans. • Where necessary, submit applications for exemption for Selective Service Registration.	CDCR CDCR (SMHP) County Departments and their Contracted Providers / CBOs County Public Guardian	X	Y

3.15	Special Considerations for Individuals Convicted of Sex Offenses	Individuals convicted of sex offenses face distinct social stigmas and legal limitations.	• Individuals convicted of sex offenses have extremely limited opportunities for housing because of restrictions around locations such as schools. • Provide specialized programming and support for individuals convicted of sex offenses.	• Repeal legislation that creates barriers to housing for people convicted of sex offenses. • Where barriers are imposed based on sex offenses, differentiate among types of sex offenses.	Legislators	X	Unknown