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Deputy District Attorney, Mental Health Liaison, Los Angeles County District Attorney

20th Annual Legislative Report  
December 2021
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Overview of the Council on Criminal Justice and Behavioral Health

Established by California 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 Council on Criminal Justice and Behavioral Health Council Members

**Chairperson:** Kathleen Allison, Secretary, California Department of Corrections and Rehabilitation. The Secretary of CDCR is at times represented by Diana Toche, DDS, Undersecretary, CCHCS.

**Vice Chair:** Michelle Baass, Director, Department of Health Care Services. The Director of DHCS is represented by Jim Kooler, Assistant Deputy Director, Behavioral Health, DHCS.

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

**Anita Fisher,** Consumer/Family Member Representative. Mrs. Fisher was appointed to CCJBH by Governor Gavin Newsom in 2021.

**Tony Hobson,** Ph.D., Behavioral Health Director, Plumas County. Dr. Hobson was appointed to CCJBH by Governor Jerry Brown in 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,** Psy.D., Coordinator of Psychological Services for the Antelope Valley Union High School District. Dr. 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.
Council on Criminal Justice and Behavioral Health Staff

Brenda Grealish, Executive Officer

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Monica Campos, Staff Services Manager III

Liz Vice, Staff Services Manager II

Jessica Camacho, Health Program Specialist II

Catherine Hickinbotham, Health Program Specialist I

Emily Grichuhin, Staff Services Analyst

Paige Hoffman, Staff Services Analyst

Daria Quintero, Graduate Student Assistant
## Acronyms

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<td>OYCR</td>
<td>Office of Youth and Community Restoration</td>
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Executive Summary

Although the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) has brought much uncertainty and fear, it has also created unexpected opportunities to develop innovative approaches to support individuals with behavioral health needs who are involved in the juvenile or adult criminal justice systems (hereafter referred to as the behavioral health / justice involved (BH/JI) population). The unprecedented federal and State investments to improve access to health and behavioral health care, as well as to address the need to increase housing and eliminate homelessness, will be critical to strengthen the delivery system infrastructure to serve this population, but there is still much work to be done in terms of implementation, particularly with regard to multi-system collaboration and client engagement.

Accordingly, throughout 2021, the Council on Criminal Justice and Behavioral Health (CCJBH or the Council) continued to pursue its mission of supporting proven strategies that promote early intervention, access to effective treatments, planned reentry, and the preservation of public safety, taking into consideration the impact of the pandemic, as well as these significant federal and State investments being made in the delivery systems that impact the BH/JI population. Council meetings focused on the behavioral health and the criminal justice systems, housing and homelessness, education, and CCJBH project updates. Through the Juvenile Justice, Diversion and Reentry workgroups, CCJBH identified several issues and developed recommendations for system improvements.

CCJBH Juvenile Justice Workgroup Recommendations

The Juvenile Justice Workgroup focused 2021 efforts on Senate Bill (SB) 823 Juvenile Justice Realignment and the impact of the COVID-19 PHE on children and youth involved in the juvenile justice system, with a particular emphasis on the return to in-person education after one year of home-based schooling that occurred as a result of the shelter-in-place orders. While detailed Workgroup recommendations may be found in the body of this report, highlights are summarized as follows:

- **A distinction must be made between prevention** (targeting at-promise youth who are at-risk of becoming involved in the juvenile justice system) **and intervention** (targeting youth who have had, at a minimum, at least one law enforcement contact).
- **A variety of prevention strategies should be employed**, such as early identification tutoring, truancy intervention, family interventions, mentors and community programs, and all possible efforts must be made to divert youth away from the juvenile justice system if they have infractions to minimize life disruptions.
- **Intervention efforts should be collaborative across all relevant systems and formally established** (e.g., a cross-agency Memorandum of Understanding), which includes evidence based practices in coordinated case planning (e.g., Collaborative Case Planning) and programming (e.g., the Positive Youth Justice Model, Juvenile Wraparound, and the Crossover Youth Practice Model).
• With regard to SB 823, case management and risk assessments should be informed by peers with lived experience, youth across the State should have equal access to all services, there should be a focus on treatment rather than overly punitive approaches to support youth, and educational opportunities should be expanded to align with strategies that have traditionally been provided by California Department of Corrections and Rehabilitation (CDCR) Division of Juvenile Justice, including college or post-high school and workforce development.

• There are a number of school-based efforts that state and local officials may want to consider to mitigate the impact of the pandemic for BH/JI youth and in general, include:
  
  o **Recognizing the difference between behavioral health** (e.g., anxiety / depression) and **behavioral needs**, thereby being prepared to provide a behavioral health-informed response rather than respond punitively. Staff working with children/youth should be trained to respond compassionately, and know what to expect and how to respond accordingly.
  
  o **Services should be preventative**, and educators should be trained to recognize the need for preventative services. Criteria must be developed to avoid missing youth in need of services who may not have or require a behavioral health diagnosis.
  
  o **Intentional Support Plans**, which include student advocates, **should be established** to formally support children/youth in academics, behavioral health, pro-social family environments, within school and justice systems, and any other relevant entities.
  
  o **Treatment for substance use disorders should be provided to students in convenient settings** rather than being a burden/distraction that is disruptive to their overall progress.
  
  o Additional recommendations that address disproportionality; incorporation of youth voices to drive meaningful changes; visiting youth in their homes to gain a better understanding of the community in which they are living; evaluating youth holistically – beyond their test scores, including examining their case history; re-envisioning staffing patterns within a Multi-Tier System of Support framework; establishing as much uniformity as possible and sharing best practices; having counties support the California Department of Education as they are trying to provide statewide leadership for children/youth; and establishing accountability measures to monitor outcomes.

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1 There was a $25 million investment included in the 2021 Budget (AB 130, Sec. 159) to develop and provide training for educators, caregivers, and youth that covers youth mental health topics.
CCJBH Diversion/Reentry Workgroup Recommendations

In 2021, the CCJBH Diversion/Reentry Workgroup focused on innovative strategies to support individuals returning home from prisons/jails in their communities, and to prevent future returns to prison. The COVID-19 PHE added urgency to this ongoing challenge. While detailed recommendations from this Workgroup may be found in the body of this report, highlights are summarized as follows:

- **Ensure sufficient capacity at all levels in California’s behavioral health continuum of care, particularly psychiatric inpatient services.** Counties should leverage the California Department of Health Care Services’ (DHCS’) Behavioral Health Continuum Infrastructure Program (BHCIP) and California Department of Social Services’ Continuum of Care Expansion Project grant opportunities to address gaps identified in the DHCS gap analysis report,2 with proposals developed in a manner that ensures that the complex, unique and multi-system needs of the BH/JI population are met. Accordingly, this planning effort should be comprehensive, and also involve partnering with local Continuums of Care and Public Housing Authorities to establish/expand capacity for permanent supportive housing at the lower end of the continuum for individuals with behavioral health needs, including those involved in the justice system, in order to prevent future justice system involvement. Each Medi-Cal Managed Care Plan should opt to provide all possible Community Supports, or seek additional Community Supports, as appropriate, to maximize service availability and federal funding within the overarching behavioral health continuum.

- **Expand provider capacity to serve the BH/JI population by identifying the “hidden network” of community-based organizations that serve justice-involved individuals, and evaluate the feasibility of transitioning such organizations into California's Medicaid Program (Medi-Cal) and other established provider networks, maximizing full federal reimbursement. Existing providers can also support implementation of a Forensic Peer Support Specialist classification in California.**

- **Ensure coordination between all criminal justice system partners (jails, prisons, probation, parole and courts) and Medi-Cal Managed Care Plans and providers, including Enhanced Care Management providers and other providers** to optimize implementation of DHCS’ California Advancing and Innovating Medi-Cal (CalAIM) initiative by ensuring that treatment is offered and provided to the BH/JI population, as appropriate.

- **Prioritize the BH/JI population for housing/homelessness projects** and establish/pilot housing projects, as well as continue to disseminate recent recommendations and identify key areas of impact and advocate for the BH/JI population.

- **Strengthen system capacity by implementing training and technical assistance,** with a particular eye toward fostering cross-system collaboration, and increased capacity for mental health residential and psychiatric inpatient services. Additional guidance may be

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2 See Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications, which illuminates gaps across the full behavioral health continuum, including residential and psychiatric inpatient services.
required, including directives related to Collaborative Comprehensive Case Planning. Ensure that emergent policy changes do not inadvertently hinder or reverse progress toward the implementation of evidence-based practices.

- **Expand and refine data collection and cross-system data linkage** on the behavioral health needs of the justice-involved population for issues including, but not limited to, expanded and improved data identifying the prevalence of mental health and substance use disorder needs in jails.
- **Consider using a “Pay for Success” model for reimbursement**, which incentivizes desirable outcomes.
- **Provide training and technical assistance about the effective establishment and implementation of Involuntary Medication Orders** with sheriffs and jail personnel to expand options for addressing the immediate needs of individuals who suffer from mental health conditions and are symptomatic (e.g., hallucinating).
- **Explore additional strategies to address the issue of engagement**, including the use of Assisted Outpatient Treatment (Laura’s Law) and Psychiatric Advanced Directives.
- **Inform and engage individuals with lived experience** in the behavioral health and criminal justice systems, as well as their families/caregivers, in all efforts related to the BH/JI population, and ensure that programs and services are designed in a manner that will actually meet their needs.
- **Focus efforts both within and across systems to implement diversion programs.** Community-based agencies should provide services using a whole-person care approach to prevent recidivism and facilitate reintegration into the community.

### 2025 Policy Goals

In the 2019 CCJBH Annual Legislative Report, the Council established four policy goals to be accomplished by 2025. In 2021, CCJBH developed initial operational definitions (i.e., a methodology to define and measure the 2025 Policy Goals) that will continue to be refined through Councilmember and stakeholder input. The 2021 updates for each of these goals are as follows:

**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.

**Goal #1 Update:**

Though some of the data sources were updated since the 2020 CCJBH Legislative Report, results did not change, and there continues to be reliance on jails and prisons to serve individuals with behavioral health conditions.

**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.
Goal #2 Update:

In 2021, CCJBH developed preliminary metrics to track progress toward Goal #2, which seeks to capture adequate system capacity to meet the needs of the BH/JI population. For mental health, as evidenced by the DHCS 2020 Federal Network Certification Requirements, both Medi-Cal Managed Care Plans and Specialty Mental Health Plans overall have sufficient capacity for non-specialty mental health services and specialty mental health services, respectively, including outpatient and psychiatry services. These certifications do not include mental health residential or psychiatric inpatient services as relevant data are not yet available; however, Councilmembers expressed concern about the lack of sufficient residential and psychiatric inpatient services for individuals who suffer from serious mental illness(es). DHCS is making a significant investment to expand access to behavioral health care, including mental health residential and psychiatric inpatient services, through the BHCIP. Through 2022, BHCIP will make available $2.2 billion in state funding for competitive grants for counties, tribal entities, non-profit, and for-profit entities to build new or expand existing capacity in the continuum of behavioral health care facilities, limited to infrastructure (brick and mortar) projects.

For SUDs, mandatory levels of care for the Drug Medi-Cal Organized Delivery System include outpatient substance use disorder services provided by DMC certified outpatient and intensive outpatient facilities; opioid use disorder services provided by DMC certified Narcotic Treatment Program facilities; care coordination services; recovery services; clinician consultation; and residential substance use disorder treatment and withdrawal management services provided by DMC certified, state licensed, and American Society for Addiction Medicine designated residential facilities.

Furthermore, as cited in the 2021 Annual California Rehabilitation and Oversight Board report, and through CCJBH analyses of the Judicial Council’s Senate Bill (SB) 678 data, almost all entities engaged in community supervision, both in parole and across counties for probation, are performing risk and needs assessments for returning community members who are either on parole or Post-Release Community Supervision. Moreover, the majority of applications for Social Security Income (SSI) that are submitted for parolees prior to release are getting approved (data are not available for individuals on probation).

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

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3 Annual Network Certification Components include provider to member requirements, time and distance standards, mandatory provider types and timely access standards.

4 Note that counties that have not opted into the Drug Medi-Cal Organized Delivery System are not subject to the provider capacity requirements or timely access standards, but will be subject to the time and distance standards in future certifications.

5 See the Office of the Inspector General’s 2021 California Rehabilitation and Oversight Board Report.
provide effective integrated correctional and behavioral health services to achieve recovery and reduced recidivism.

Goal #3 Update:

It is well-known that there is a significant workforce shortage and relevant training to address the needs of the BH/JI population. That said, given the limited availability of data and focus on other CCJBH priorities, metrics have yet to be developed for Goal #3. CCJBH will continue to research workforce capacity data and track investments being made to expand workforce in the key sectors that impact the BH/JI population, including behavioral health, criminal justice, housing, and social services.

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.

Goal #4 Update:

CCJBH will work with state and local-level entities to identify existing reporting, as well as facilitate additional data collection to strengthen and expand reporting. Data-informed decision-making across multiple systems is necessary for successful reentry. Ongoing data-related reporting and capacity-building initiatives include work by the Department of State Hospitals to reduce the wait list for Felony Incompetent to Stand Trial referrals, as well as the Mental Health Service Oversight and Accountability Commission’s Data-Driven Recovery Project, which supports criminal justice and behavioral health data linkage at the local level. Also, CCJBH conducts unique data analysis through its CDCR / DHCS Medi-Cal Utilization Project (MCUP). Capacity for expanded CCJBH data reporting is being built through its Public Health Meets Public Safety Project.

CDCR/DHCS Medi-Cal Utilization Project

Leveraging the Statewide Inter-Agency Data Exchange Agreement, data sharing between CDCR and DHCS was re-authorized and reporting for the CDCR/DHCS MCUP was conducted for individuals released in Fiscal Year (FY) 2018-19. Data analyses indicate that, even though the majority of individuals transitioning from CDCR facilities are enrolled onto Medi-Cal within one year of release, Medi-Cal beneficiaries transitioning from incarceration with identified behavioral health needs are not utilizing or engaging in behavioral health services at expected rates across all Medi-Cal behavioral health delivery systems, and especially for SUD services. Because of Medi-Cal claim lag, these findings do not reflect the impact of emergent initiatives, such as the CDCR/California Correctional Health Care Services (CCHCS) Integrated Substance Use Disorder Treatment Program. Nonetheless, it is clear that issues with beneficiary engagement must be addressed in order for CalAIM and other emergent initiatives reflecting substantial State investment to be successful.
Other CCJBH Project Updates

Updates to other ongoing CCJBH projects are as follows:

- **SB 369 Veto Message** – As per the Governor’s veto of SB 369, CCJBH worked with CDCR/CCHCS and stakeholders to “evaluate the barriers of reentry and determine what steps need to be taken to overcome those barriers.” The final report, *Successful Reentry/Transition from the California Department of Corrections and Rehabilitation: Identification of Barriers and Solutions to Address Them*, was published in August 2021.

- **Public Health Meets Public Safety** – This two-year CCJBH project is being conducted in consultation with the Council of State Governments (CSG) Justice Center, aiming to utilize data to track, monitor and ultimately reduce, the prevalence of the BH/JI population in California’s justice system. In 2021, CSG developed for CCJBH’s website an Open Datasets Inventory that serves as a compilation of current publicly available data related to the justice and behavioral health systems. CSG also facilitated two focus groups to capture feedback/input from CCJBH’s Lived Experience Program (LEP) contractors to inform a larger, overarching data reporting framework, anticipated in 2022, that may be used to inform policy- and decision-making.

- **Equity, Diversity and Inclusion** – In 2021, CCJBH staff began the process to review the Mission and Vision Statements of the Council to reflect the need to mitigate disparities for the BH/JI population, which is targeted for completion by the end of 2021. To further these efforts, CCJBH staff have an ambassador on the CDCR/CCHCS Government Alliance for Race and Equity Capitol Cohort team, sponsored by Race Forward and the Health in All Policies, Strategic Growth Council, to assist in communicating to the staff and Council the need to develop policies and practices aimed at diversity, equity, and inclusion.

- **Lived Experience Project (LEP) Contracts** – CCJBH has two LEP Contracts – a Regional LEP, with four regional contractors working to uplift the voices of individuals who have lived experience with the behavioral health and criminal justice systems, and a California State University, Sacramento, LEP Project, to gather input on how to effectively advance the employment of individuals with lived experience in the criminal justice and behavioral health fields. Thus far, Year 1 Regional LEP project highlights include project contractors training and mentoring individuals with lived experience to develop advocacy skills to inform and influence State and local policy conversations, strengthen and expand capacity to more appropriately support and serve the BH/JI population, and to serve on CCJBH’s LEP Advisory Team to provide subject matter expertise. Also, in September 2021, California State University, Sacramento and CCJBH published an initial report on hiring individuals with lived experience in the behavioral health and criminal justice sectors, *Successful Approaches to Employing Individuals with Lived Experience in the Criminal Justice and Behavioral Health Fields*, convening a workshop on solutions in the same month, with a subsequent report expected by the end of 2021.
• **Forensic Peer Support Specialists** – As reflected in the 2020 Legislative Report, CCJBH believes that the use Forensic Peer Support (FPS) Specialists across multiple sectors (e.g., primary care, behavioral health, criminal justice, housing, and social services) can be of significant benefit to individuals who are justice-involved and have a mental health and/or SUD. CCJBH embarked on a project to research publicly available nationwide resources regarding FPS models. Efforts to date have included meeting with experts from the states of Georgia, Pennsylvania, and Connecticut who have experience implementing the FPS model. CCJBH’s findings and recommendations are currently being formulated into a report which, once drafted, will be shared for stakeholder review and input before finalizing.

• **California Advancing and Innovating Medi-Cal (CalAIM)** – CCJBH remains actively committed to supporting DHCS’ CalAIM initiative, a multi-year effort to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms. In August 2021, during the federal public comment period, CCJBH submitted to the Centers for Medicare and Medicaid Services a letter of support for DHCS’ Section 1115 Demonstration waiver, which is an essential component of the CalAIM initiative and which contributes directly to CCJBH priorities. Specifically, DHCS’ CalAIM Section 1115 Demonstration requests federal authority to deliver targeted Medi-Cal services to justice-involved individuals with significant clinical and social needs for 90 days prior to release from state prisons, county jails, and youth correctional facilities into the community. In addition, DHCS’ CalAIM Section 1115 Demonstration requests federal funding to support capacity building among providers, plans, counties, and justice agencies to ensure their readiness to support effective pre-release care for justice-involved populations. CCJBH also prepared for justice system partners a Brief Overview of the Department of Health Care Services (DHCS)’ California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population.

• **Pre-Trial Diversion Training and Technical Assistance** – CCJBH completed the final series of diversion webinar trainings to counties by holding three trainings on criminogenic needs and risk mitigation. CCJBH also entered into a one-year training and technical assistance contract with the CSG Justice Center in June 2021 to provide on-going subject matter expert specialty consultation and technical assistance throughout FY 2021-22 to support county diversion planning and implementation. The knowledge gained from these efforts will culminate into a final report summarizing the effectiveness of existing mental health diversion policies and practices, and providing recommendations on what and how changes must be made in order to advance mental health diversion programs to ensure their success throughout California.

• **Juvenile Justice Compendium and Toolkit Request for Proposal** – As specified in last year’s report, CCJBH is in the process of producing a Juvenile Justice Toolkit and Compendium Request for Proposal that will focus on assisting counties as they implement activities related to SB 823 Juvenile Justice Realignment, providing a compilation of information related to best practices and evidence-based programs that have been shown to be
effective in serving justice-involved youth who have behavioral health needs. CCJBH plans to award this contract in 2022.

- **Housing and Homelessness** – In August 2021, CCJBH and the CSG Justice Center hosted a virtual event to celebrate the public launch of their report, *Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails Recommendations to California's Council on Criminal Justice and Behavioral Health*, providing an overview on key findings and recommendations to increase housing opportunities and to hear from key state leaders and local partners about why the BH/JI population must be prioritized with new housing investments. Accordingly, CCJBH will continue to collaborate with key partners to further efforts to improve housing outcomes for the BH/JI population.

**CCJBH 2022 Priorities**

In 2022, CCJBH will continue leading the Juvenile Justice and Diversion/Reentry Workgroups, and will work to ensure successful completion/continuation of current projects. Given the urgency to address the housing needs of the BH/JI population, CCJBH will work with system partners at federal, State and local levels, as well as stakeholders, to advocate for the prioritization of available affordable housing resources, and to promote cross-system education and collaboration. To support this and other major initiatives, such as CalAIM, given the low penetration and engagement rates of behavioral health services, CCJBH will seek to understand how to better engage and serve the BH/JI population, particularly with regard to the benefits afforded by the Forensic Peer Support Specialist classification/workforce.
I. Introduction

The beginning of 2021 brought with it the continued uncertainty from the Coronavirus Disease 2019 (COVID-19) PHE (pandemic) that had begun in March 2020. In California, nationally, and internationally, it was unknown as to what the impact would be on human life, and it was anticipated by many that a local and global fiscal crisis was inevitable. California took bold precautionary actions to save lives and help provide supplemental financial support to mitigate the unemployment impact from the shelter-in-place orders. These actions have mitigated the impacts of COVID-19, Although California has for years had the highest poverty rate in the nation, federal and State stimulus payments provided throughout 2020 resulted an overall lowering of the California poverty rate than was realized in other states according to the Public Policy Institute of California.6 In addition, the May Revision revealed a budget surplus that resulted from higher-than-expected income taxes, as well as an infusion of federal funding from the Families First Coronavirus Response Act and American Rescue Plan Act of 2021.

Although some outcomes were better than imagined, the pandemic has taken a tremendous toll, with the loss of 710,173 American lives as of October 8, 2021,7 and has resulted in increases in new and exacerbation of existing mental health conditions and substance use disorders, especially among those with disabilities.8,9 Furthermore, although lowering overall, preliminary data on California’s 2020 suicide rate shows increases for children/youth aged 10-18 years old, as well as for individuals who identify as being Asian/Pacific Islander. In particular, suicide rates of certain subgroups of 10-24 year old youth – females and children/youth who are identify as black or Hispanic – increased in 2020.10,11

Given these outcomes for the general population, it is expected that such results will be exacerbated for individuals with behavioral health needs who are involved in the criminal justice system (hereafter referred to as the behavioral health / justice involved (BH/JI) population) due to their extreme vulnerability. Recognizing this heightened need, the Council on Criminal Justice and Behavioral Health (CCJBH or the Council) continued to pursue its mission of supporting proven strategies that promote early intervention, access to effective treatments, and planned reentry and the preservation of public safety, taking into consideration the impact of the pandemic, as well as the significant federal and State investments being made in the delivery systems that impact the BH/JI population (see Appendices A, B, and C for a summary of the latest legislative, budgetary, and programmatic changes occurring within the behavioral health, criminal justice, and housing systems, respectively). Within this framework, CCJBH focused on:

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6 Public Policy Institute of California Blog, Pandemic Aid Helped Lower Poverty in California, September 24, 2021.
7 Johns Hopkins University and Medicine Coronavirus Resource Center New COVID-19 Cases Worldwide.
9 Centers for Disease Control and Prevention, Mental Health and Substance Use Among Adults with Disabilities During the COVID-19 Pandemic — United States, February–March 2021 (August 27, 2021).
10 California Department of Public Health presentation to CCJBH on September 1, 2021.
11 California Department of Public Health data brief (October 26, 2021).
• Efforts that are currently underway by the state and counties in preparation for implementation of Senate Bill (SB) 823 Division of Juvenile Justice (DJJ) Realignment;
• The impact of the pandemic on children/youth who are involved in the juvenile justice system, particularly with regard to collaborative efforts between education and probation, to ensure therapeutic and supportive approaches to prevention and intervention.
• Identifying areas for improvement across multiple delivery systems to optimize successful reentry back into our communities, as well as to promote effective strategies for diversion.
• Promoting and advocating for the prioritization of housing for the BH/JI population;
• Expanding the availability and use of data/information related to the BH/JI population, particularly with regard to examining California's Medicaid Program (Medi-Cal) penetration and engagement rates in preparation for implementation of the Department of Health Care Services’ California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. CCJBH Full Council Meetings and 2021 Policy Focus

A. Council Membership

In late 2020 and throughout 2021, CCJBH experienced Council membership changes. CCJBH Councilmember Jessica Cruz, Chief Executive Officer of the National Alliance on Mental Illness (NAMI), resigned in October 2020, and retired Officer Matthew Garcia resigned in July 2021. At the July 2021 Full Council Meeting, CCJBH staff expressed appreciation to its departing Councilmembers for all their hard work and dedication during their time on the Council.

On May 26, 2021, CCJBH welcomed a new Councilmember. Governor Newsom appointed Anita Fisher to CCJBH to represent the consumer/family member perspective. Ms. Fisher is a member of the National Association for the Advancement of Colored People’s Mental Health and Policing Sub-Committee, the Psychiatric Emergency Response Team Advisory Board, the San Diego County Probation Chief’s Advisory Board, and is an Ambassador for A New PATH (Parents for Addiction Treatment and Healing). Ms. Fisher has been Chief Executive Officer and Consultant at Fisher Mental Health Consulting since 2018. In addition, from 2007-2018, Ms. Fisher was Director of Education at NAMI, San Diego.

Additionally, in September 2021, Michelle Baass was appointed as Director of California Department of Health Care Services (DHCS), filling the position behind now-retired Director Will Lightbourne and serving as Vice-Chair for the Council. As of July, CCJBH has two vacancies, one representing law enforcement and one representing behavioral health, both of which require appointment under the Senate Rules Committee.
**B. CCJBH Full Council Meetings**

As the nation continued to face challenges with the COVID-19 crisis, CCJBH continued meeting with system partners and stakeholders, holding virtual Full Council and Workgroups Meetings, as authorized by the Governor’s Executive Order N-25-20. Most recently, **Assembly Bill (AB) 361** was signed into law by the Governor, which authorizes, until January 31, 2022, a state body to hold public meetings through teleconferencing and to make public meetings accessible telephonically, or otherwise electronically, to all members of the public seeking to observe and to address the state body, subject to specified notice and accessibility requirements. Given this authorization, CCJBH will continue to meet virtually throughout the duration of the public health emergency (PHE).

**C. CCJBH Calendar Year 2021 Policy Focus**

In 2021, CCJBH held five Full Council Meetings, as well as two Special Council Meetings in order to adopt the final report in response to the Governor’s SB 369 Veto Message mandate on addressing barriers to reentry and strategies to overcome them and to adopt the 2021 annual legislative report recommendations. The year’s **first meeting** was dedicated to reviewing the **2021 CCJBH Work Plan Governor’s Budget Summary**. Thereafter, the Council focused on the Governor’s **SB 369 Veto Message Mandate**, new opportunities to address **Housing and Homelessness** for the BH/JI population, **CalAIM** and an overview and update on CCJBH’s Lived Experience Projects. In addition to the Full Council Meetings, CCJBH, in partnership with the Council of State Governments (CSG) Justice Center, also hosted a webinar to formally launch the report, **Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails**, which included introductions from leading State housing experts, perspectives from individuals with lived experience, county implementation experiences, and stakeholder discussion. This event topped CCJBH participation to date, with 626 people registered, of which 496 attended (almost 80 percent).

Overall, CCJBH has seen a rise in registration this year for the Full Council and workgroup meetings, as well as special events and MH and Suicide Prevention and Recovery Awareness activities (see Appendix D). Participation remained fairly stable, with 59 to 65 attendees at Full Council meetings and 25 to 77 attendees at the Juvenile Justice and Diversion/Reentry Workgroups. The exception was DHCS’ CalAIM presentation at the October 29th Full Council meeting, in which 105 individuals participated. The highest participation observed occurred during Awareness activities, peaking at 496 attendees joining the Housing Report Launch event. CCJBH looks forward to continuing efforts to engage stakeholders, county and state leaders, system partners and individuals with valuable lived experience, with the end goal illuminating and inspiring change on issues affecting the BH/JI population.

**a. Juvenile Justice Workgroup**

CCJBH recognizes the importance of the juvenile justice system and the need for the system to offer safety and protection for California citizens while providing care, treatment, and guidance to minors whose behaviors have led them to justice system involvement. To realize the
paradigm shift of California’s changing culture, the juvenile justice system must be recognized as more than juvenile halls and incarceration. It is a network of county and state agencies and programs dedicated to the rehabilitation of youth. Indeed, the Juvenile Justice System, specifically the juvenile court in California, was created for the purpose facilitating the rehabilitation of youth. To support efforts to improve outcomes for youth with behavioral health needs who are in the juvenile justice system, CCJBH continued to convene the Juvenile Justice Workgroup that began in 2020. Led by CCJBH Councilmember subject matter experts, CCJBH held workgroup meetings in March, June, and September of 2021. See Appendix E for a list of organizations that participated in CCJBH’s Juvenile Justice Workgroup meetings.

On July 1, 2021, the juvenile justice system began a historic transition in California with SB 823, Juvenile Justice Realignment, which realigns high risk/high need youth away from the DJJ and transfers the responsibility of care to for this population to the county level. SB 823 calls for alternatives to youth prison models and promotes the development of innovative programs at the county level and the availability of treatment close to home. In March 2021, CCJBH’s Juvenile Justice Workgroup meeting focused on the implementation of SB 823, inviting relevant state and local agencies to provide implementation updates to workgroup participants and share their respective contributions to the successful realignment of high risk/high need youth to county supervision. Workgroup Councilmember Advisors and stakeholders established that it will be imperative for counties to be equipped with the proper tools to increase infrastructure, leverage additional funding, and execute new legislation to both prevent youth from entering the juvenile justice system and provide proper interventions for youth who are involved in the system. To best support the realigned youth, counties should consider to streamlining data sharing, enhancing diversion efforts, and administering risk and needs assessments to determine necessary service levels. CCJBH’s Juvenile Justice Compendium and Toolkit will serve as a key resource for counties as they embark on this transition.

At the June 2021 Juvenile Justice Workgroup, participants discussed the potential for an increase in behavioral health needs as youth transition back to school following the COVID-19 PHE, with a panel seated by members of the Department of Education and other knowledgeable educators. The workgroup discussion brought to light the importance of school-based services for justice involved youth with behavioral health needs. Workgroup Councilmember advisors and stakeholders determined that youth transitioning back to in-person school following the COVID-19 PHE may require unique support. Workgroup participants agreed that the increase in funding in the 2021-22 budget (e.g., the Student Behavioral Health Incentive Program) would be best suited to focus on building the infrastructure capacity of school-based behavioral health services for justice involved youth with behavioral health needs.

CCJBH’s 2021 Juvenile Justice Recommendations were formulated in part by Council input and workgroup presentations, as well as previous legislative report recommendations. As a result of the workgroup input and research CCJBH developed findings to discuss with workgroup participants (see Appendix F compilation of Juvenile Justice Workgroup Findings). CCJBH developed the below recommendations to address these findings.
Juvenile Justice Policy Recommendations

Prevention Recommendations for BH/JI Youth

1. Academic supports should include tutoring, truancy intervention, social and psychological services, and family supports.
2. Family intervention should include family counseling, and parental assistance.
3. Mentors, prosocial community programs and activities should be used to support prosocial leisure time.
4. System stakeholders in collaboration with the community, should utilize research-supported practices to divert youth away from the juvenile justice system when those youth engage in behaviors that might make them subject to a law enforcement contact. The youth should be referred to and engaged with community-based programs to address areas of risk such as family dysfunction, substance use, school problems, etc. For example, a case in which a student who performed well at school and, thus, did not come to the attention of educators, but was hospitalized and placed in a residential setting for being suicidal and aggressive towards the parents, who called law enforcement for assistance – this youth could have been instead diverted from the juvenile justice system.

Intervention Recommendations for BH/JI Youth

5. The California Health and Human Services Agency (CalHHS) AB 2083 Systems of Care Memorandum of Understanding guidance, designed to address coordination for local foster care child/youth-serving agencies, could be adapted to the justice-involved youth population-serving agencies, including courts (and Judicial Council), to clearly establish how coordination will occur within each county. In addition, a standing meeting or other convening platform at the local level can help to further facilitate communication and collaboration.

6. According to the CSG Justice Center, Collaborative Comprehensive Case Plans are developed when “the agencies involved in the participant’s case planning team and in the recovery processes work together with the participant (and the people in his or her support system) throughout the case planning process, and when the case plan includes information from behavioral health, criminogenic risk, and psychosocial assessments in a way that does not value results from one assessment over another.” Collaborative Comprehensive Case Plans, along with a secure electronic information exchange system/process, should be implemented to reduce duplication and increase coordination through ongoing and structured partnerships across relevant agencies and their providers. Transitional housing needs should be addressed for transition aged youth, with caseworkers deployed to help youth navigate available resources.

7. The following models, which have been used with success in California and around the country, should be considered for expanded use with justice-involved youth:
   - The Positive Youth Justice model (PYJ). PYJ is a restorative justice model that captures the therapeutic philosophy of the juvenile court, along with the concept of
accountability. The PYJ approach includes utilizing the youths strengths while at the same time addressing deficits (criminogenic risk factors) while working towards behavior change towards a goal of prosocial community involvement. PYJ involves a community and justice system collaboration.

- **Juvenile Wraparound.** Juvenile Wraparound involves a multidisciplinary approach that focuses on the entire family and not just the youth. It originated in the child welfare system with a primary objective of addressing family issues so that dependent youth could remain in, or more quickly return to their homes. It was then applied to justice-involved youth and found to be effective. Numerous studies show recidivism reductions and reduced risk factors for justice-involved youth who are provided with Wraparound. Wraparound teams typically include, a counselor, a therapist (as necessary), a probation officer, a school representative, a parent partner, and a youth partner.

- **Crossover Youth Practice Model (CYPM).** CYPM is one application of a fairly common theme employed around the country that combines the juvenile justice and child welfare systems. The process starts when the youth who may be a dependent at the time, or has a child welfare history, commits a criminal act. During the referral process, a collaborative assessment is made involving both child welfare and the juvenile justice system. The assessment produces a recommendation for the court as to which system can best serve the youth (and community) needs. The strength of this model is that it combines the resources and expertise of both systems to meet the youth’s needs. It may also involve the practice of “dual status” where a youth can be in both the juvenile justice and child welfare systems simultaneously.

8. Probation practices that employ research-supported principles for working with justice-involved youth, such as enhancing internal motivation, using positive reinforcement, teaching new skills, etc., should continue and become the standard for probation departments in the State. Those practices should include close collaboration with community agencies that serve these youth. A “balanced approach” philosophy of probation services is behaviorally focused with a goal of behavior change for youth. The model requires engagement between the probation officer and the youth from a therapeutic perspective, and should be a component of training for probation officers.

**SB 823:**

9. Case management and risk and needs assessments should be informed by peers with lived experience.

10. Youth across the state should have access to the services they need, regardless of their county of residence.

11. County systems should work collaboratively to share resources and information.

12. Counties should consider expanding the scope of educational services at the county level to offer college or post-high school workforce development, similar to the services that have been traditionally offered by DJJ. The Department of Rehabilitation could be a resource that may be able to offer career opportunity resources for youth who have mental health needs.
Mitigating the Impact of COVID-19 on Justice-Involved Youth Returning to School

13. It is recommended that administrators and teachers be aware of the difference between behavioral health (e.g., anxiety), versus behavioral needs (e.g., physical aggression), and not respond punitively, but rather have a behavioral health-informed response. It is recommended that educators be cautious not to mistake a behavioral health outburst, which could result in law enforcement becoming involved and the youth being placed into custody rather than treatment. It is recommended that staff be trained on increased compassion and what to expect when students act out due to behavioral health and be able to identify the available support services offered by the district and other community-based entities that may assist the student.

14. It is recommended that criteria be established beyond a behavioral health diagnosis that educators may use to mobilize appropriate services and supports to address youth who may have behavioral health needs that do not necessarily equate to a formal behavioral health diagnosis. Services should be preventative, and it is recommended that educators be trained to recognize these needs (e.g., self-harm, anxiety, depression, substance abuse, self-medication, suicidal ideation, decreased ability to self-regulate) and be able to help identified youth access the appropriate resources to address those needs.

General School-based Supports for Justice-Involved Youth

15. It is recommended that school districts increase their bandwidth to provide support and set Intentional Support Plans that include an advocate for students who are justice-involved. These plans should support student in their academics and behavioral health, linking them with a community advocate who can interface with the school, justice system, and other relevant systems (i.e., be a caring adult, which is extremely important), and providing appropriate services and supports to their family while being careful not to overwhelm parents at one time with all of the available resources.

16. It is recommended that disproportionality be addressed by creating transition/reentry plans for students leaving juvenile hall to ensure communication between the court system, county Office of Education, probation, and a liaison for each school district. For example, a youth should not be in juvenile hall for 21 days, get released, and then return to their school with “business as usual” expected. Consider the utilization of interagency Memorandums of Understanding (MOUs).

17. It is recommended that all system partners take time to hear youth voices, asking them what they need, and incorporating their input into policies and practices to drive meaningful changes.

18. It is recommended that Substance Use Disorder (SUD) treatment resources be provided to students in need in convenient settings rather than place them in a position to have to travel to get treatment, and avoid exposing them to drug court altogether, which requires a disruption to their lives, including absence from school. Multidimensional family therapy should be considered.
19. It is recommended that educators serving justice-involved youth be encouraged and supported to perform a home visit to meet their students’ families in order to assess and determine how best to provide the appropriate resources and level of support. This should occur beginning at the elementary level to build consistent connections, and to understand different customs and norms.

20. It is recommended that education staff, particularly school psychologists, focus on the parent and student interviews, observations, and reviewing the student’s record for trends rather than focus solely on assessment scores. For example, a case in which a teacher reported that a student was not engaged/daydreaming, but when the student was interviewed, multiple traumas were revealed that equated to a lack of trust in adults. Students should be evaluated from both a quantitative and qualitative perspective, and trauma should also be assessed.

21. It is recommended that educational staffing patterns be re-envisioned within existing frameworks such as a multi-tier system of support (MTSS). Additionally, it is recommended that school districts consider ways to leverage funding allocations to build sustainable systems based on best practices related to justice-involved youth, including training, system building, youth input and data collection.

22. To inform quality improvement, data can be examined for justice-involved youth, going back to their early childhood to identify system gaps. Target youth in 5th and 6th grades for high-quality early intervention since this is when youth begin entering the juvenile justice system.

23. It is recommended that the California Department of Education (CDE) promote a shift towards social emotional learning and share resources with the county Offices of Education (COE). The 2021-22 Budget included $20 million Proposition 98 General Fund for the selection of a COE to help gather and disseminate social-emotional resources to the field.

24. System partners should strive to establish uniformity/consistency across counties, focusing on best practices in educational systems across counties, so that counties know what resources are available.

25. It is recommended that counties support the CDE in their efforts to learn how best to work with counties in order to integrate education into county systems.

26. It is recommended that accountability measures be established and used to monitor the use and outcomes of available resources. For individuals over the age of 18, adult education should be integrated, approaching learning as a continuum.

27. It is important that system partners engage in and support CDE’s Disproportionality Workgroup, particularly the Task Force CDE plans to implement to focus on the justice-involved population.
b. Diversion and Reentry Workgroup

CCJBH has a focus on those who have behavioral health needs with the goal to ensure that these vulnerable individuals are effectively served in their communities. History has shown us that by creating a local community service system that provides housing before and after incarceration, with consistent and continuous treatment provided throughout, will help reduce the growing numbers of individuals with serious behavioral health issues in California’s jails and prisons, hospitals, and living on the streets.

Throughout the COVID-19 pandemic, thousands of inmates were released from jail/prison, and many more were diverted from jail settings that created changes to the diversion and reentry landscape. New processes were created, expedited services were developed, and many best practices emerged during 2020 and 2021. Diversion and Reentry systems have been empowered to provide dynamic services to best assist individuals involved in the justice system. In 2021, CCJBH continued workgroup meeting in the areas of Diversion and Reentry. Led by CCJBH Councilmember subject matter experts, CCJBH held workgroup meetings in March, June, September and November of 2021. See Appendix G for a list of organizations that participated in CCJBH’s Juvenile Justice Workgroup meetings.

The Diversion and Reentry workgroup meetings focused on ways to prevent individuals released from jail, prison, and state hospitals from returning. The goal was to establish innovative and effective ways to continue diversion and reentry efforts in the wake of the public health and budget crisis as a result of COVID-19 PHE. Workgroup meetings included presentations given by the California Health Facilities Financing Authority with a Community Services Infrastructure Grant Program Update, and an update on the SB 369 Veto Message Report. California Department of State Hospitals (DSH) presented an update on the DSH Diversion Program, including conversations on jail-based Incompetent to Stand Trial (IST) activities. Additionally, the workgroup explored the concept of deflection as a powerful tool to improve community relations and encourage diversion. As a result of the workgroup input and research, a compilation of which may be found in Appendix H, CCJBH developed the below recommendations, which are categorized into themes strengthening system capacity; housing and homelessness; research, evaluation and data; and other considerations.

Diversion and Reentry Policy Recommendations

Strengthening System Capacity

1. There should be sufficient capacity at all levels in California’s behavioral health continuum of care, particularly psychiatric inpatient services. Counties should leverage the DHCS Behavioral Health Continuum Infrastructure Program (BHCIP) and California Department of Social Services Continuum of Care Expansion Project grant opportunities to address gaps identified in the DHCS gap analysis report, with proposals developed in a manner that ensures that the complex, unique and multi-system needs of the BH/JI population are met. Accordingly, this planning effort should be comprehensive, and also involve partnering with local Continuums of Care and Public Housing Authorities to establish/expand capacity for permanent supportive housing at the lower end of the continuum for individuals with
behavioral health needs, including those involved in the justice system, in order to prevent future justice system involvement. Each Managed Care Plan should opt to provide all possible Community Supports, or seek additional Community Supports, as appropriate, to maximize service availability and federal funding within the overarching behavioral health continuum.

2. Efforts should be made to identify the “hidden network” of community-based organizations and evaluate the feasibility of transitioning them into mainstream systems, which would expand capacity to serve the BH/JI population, stabilize their funding, and could also serve to address BH/JI population engagement/service utilization, including addressing disparities. Federal reimbursements across all systems should be maximized to the greatest extent possible.

3. There should be coordination between all criminal justice system partners (jails, prisons, probation, parole and courts) and Medi-Cal Managed Care Plans and providers, including Enhanced Care Management providers and other providers, to optimize implementation of DHCS’ CalAIM initiative by ensuring that treatment is offered and provided to the BH/JI population, as appropriate.

4. CCJBH should explore opportunities to:
   a) Implement trainings and technical assistance to expand expertise of the needs of the BH/JI population and to promote cross-system education, including sharing information about best and promising practices (e.g., engagement and treatment expertise) and facilitating collaboration and cross-training across delivery systems.
   b) Support multi-system collaboration, including exploring the feasibility of developing MOU guidance for counties to use to establish care coordination for their behavioral health population (prevention), including those who have become involved with the justice system (intervention), as well as implementing Collaborative Case Planning as an approach to support multi-system service coordination and treatment/intervention planning. Under DHCS’ CalAIM Justice-Involved initiative and pursuant to California Penal Code Section 4011.11(h)(5), DHCS will collaborate with counties, sheriffs, probation departments, Medi-Cal managed care plans and county behavioral health agencies to develop and implement behavioral health linkages to facilitate behavioral health treatment in the community for county jail and juvenile inmates that were receiving behavioral health services before their release. Note: this is a repeat finding from last year that has yet to be addressed, but is so important, particularly with regard to Medi-Cal Managed Care’s Enhanced Care Management benefit, that it is being mentioned again this year.
   c) Track the Behavioral Health Continuum Infrastructure Program, including but not limited to the forthcoming Needs Analysis and administered grant funds, and identify related opportunities to support the development of additional capacity for mental health residential and psychiatric inpatient treatment.

12 The guidance that was established for foster youth through AB 2083 could be used as a model.
5. All systems that serve the BH/JI population should consider employing Forensic Peer Support Specialists. CCJBH and relevant stakeholders should continue efforts to develop and provide information and guidance related to establishing a Forensic Peer Support Specialist classification in California, including relevant certification(s).

6. CCJBH should work with the Chief Probation Officers of California and the Judicial Council to explore the relationship between, and impact of, AB 1950 on the SB 678 requirements to ensure these new requirements do not adversely impact capacity to maintain the high level of implementation of evidence-based practices that have been established to date.

**Housing/Homelessness**

7. The BH/JI population should be prioritized for housing/homelessness projects that are being developed and implemented using new and continuing federal and state funding.

8. CCJBH and relevant system partners should continue to work to disseminate and address the recommendations in the report produced by the CSG Justice Center.

9. CCJBH should continue learning about the housing system in order to identify key areas of impact and advocate for the BH/JI population.

10. Counties should consider piloting housing projects that target the BH/JI population, leveraging and building upon other successful projects such as the Denver Supportive Housing Social Impact Bond Initiative.13

**Research/Evaluation/Data**

11. State and local entities should consider expanding data collection on the behavioral health needs of the justice-involved population on issues including, but not limited to, expanded and improved data on the prevalence of mental health and SUD needs in jails. It is not clear if individuals booked into jails are universally screened and assessed for behavioral health issues, which negatively affects service delivery and inhibits data collection. As a preliminary step, a statewide survey could be conducted to understand current processes that are in place and current capacity for data collection and reporting on the BH/JI population at the local level. Reporting requirements should be streamlined, where appropriate, and additional data collection and reporting requirements should be considered where necessary, with a high priority placed on establishing a statewide repository of information about the prevalence of behavioral health conditions in jails.

12. Local health care agencies should sign the MOU that the California Correctional Health Care Services (CCHCS) has developed for data sharing, and resources such as Providing Access and Transforming Health funds as part of CalAIM should be efficiently leveraged for capacity-building pursuant to federal approval. Additional guidance should be developed, alongside additional resources provided, for data sharing across local entities.

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13 See [Breaking the Homelessness-Jail Cycle with Housing First: Results from the Denver Supportive Housing Social Impact Bond Initiative](https://example.com/13) and [Housing First Breaks the Homelessness-Jail Cycle](https://example.com/13).
13. CCJBH should explore expanding data linkage efforts beyond Medi-Cal utilization, as feasible (e.g., to address the issue of individuals found IST, better understand the importance of Full Service Partnerships for improved outcomes, and support enhanced understanding of post-release outcomes such as homelessness, education/employment, and overdose/morbidity/mortality). State and local entities should consider expansion of data collection and analysis to facilitate performance monitoring and data-informed policy development, as well as improve data quality and streamline reporting requirements. Shared metrics, tied to funding, should be established across systems to point to areas that require additional investment and inform policy development.

Other Findings/Recommendations

14. System partners who serve the BH/JI population should consider using a “Pay for Success” model for reimbursement, which incentivizes desirable outcomes (e.g., increasing the number of participants in a diversion program). Local Boards of Supervisors should be educated on the benefits of this approach.

15. System partners in criminal justice are struggling on how to best address the immediate needs of individuals who suffer from mental health conditions and are symptomatic (e.g., hallucinating). In particular, many sheriffs and their jail staff are not fully educated on the effective use of Involuntary Medication Orders (IMOs), including best practices, which seem to be leading to misconceptions and, thus, avoiding their use. In some cases, even if an IMO has been established, it is not always implemented. As such, training and technical assistance should be provided to support the proper use of IMOs in local jail settings. CDCR and the DSH could be consulted to learn best practices that have been shown to be effective in institutional settings in California, and Forensic Peer Support Specialists should be considered as an important resource to improve engagement.

16. Additional engagement strategies should be explored to address the issue of engagement, including the use of Assisted Outpatient Treatment (Laura’s Law) and Psychiatric Advanced Directives.

17. Individuals with lived experience in the behavioral health and criminal justice systems, and their families/caregivers, should be informed and engaged in all efforts related to the BH/JI population. CCJBH, and related system partners, should continue leveraging their expertise to ensure that programs and services are designed in a manner that will actually meet their needs, thus maximizing the chance to improve their engagement.

18. There is a clear and persistent overrepresentation of the BH/JI population in jails and prisons, as demonstrated in CCJBH’s 2025 Goal #1, Prevalence in Jails/Prisons. To address this issue, system partners should focus efforts internally and across systems to implement diversion programs. Community-based agencies should provide services using a whole-person approach to prevent recidivism and facilitate reintegration into the community.
III. Update on 2025 Policy Goals

In its 18th Annual Legislative Report, CCJBH established four visionary, but measurable, goals to be achieved by 2025, hereafter referred to as “2025 Policy Goals.” Each of these goals reflects cross-system progress toward desired process and outcome measures for the BH/JI population. In general, this reporting seeks to measure “system health” as it relates to the BH/JI population. Performance monitoring can highlight areas requiring attention, as well as areas of positive progress. The operational definitions and reporting presented here are preliminary and subject to future refinement and expansion as additional data becomes available.

**Goal #1:**

The prevalence rate of mental illness and SUDs in jails and prisons should be similar, if not equal to, the prevalence rate of mental illness and SUDs in the community.

**2021 Update:**

In its 19th Annual Legislative Report, CCJBH compiled and shared detailed information about the prevalence of behavioral health conditions in custody settings, compared to prevalence rates in the community. While these data were limited (i.e., there is no statewide information about the prevalence of SUD in jails), available data nonetheless pointed to a striking and pervasive overrepresentation of individuals with behavioral health conditions in custody settings. Updated data were not consistently available, and where updates were available (e.g., nationwide prevalence of behavioral health needs in the community), estimates were very similar. Thus, previously reported data are reproduced in Appendix I.

**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.

**2021 Update:**

At the April 2021 Full Council meeting, Councilmembers adopted initial Goal 2 metrics with the caveat that the measures only provide a partial picture of the broader systems that serve the BH/JI population, and that reporting would be refined as additional data become available. Members agreed that a multi-system perspective is required for any one system to achieve desired outcomes, and for State investments to produce meaningful results, and that strong measures of system capacity incorporate both information about availability of services and information about the number of individuals who require those services.

Thus far, CCJBH has identified four key systems that it views as critical to meet the unique and complex needs of justice-involved individuals. These systems are behavioral health care, interventions for criminogenic risks and needs, income support services, and housing, each of which are described in detail in Appendix I, and outlined below.
**System Capacity Metric Descriptions**

- **Behavioral Health Needs** – Individuals transitioning from incarceration often have high behavioral health care needs at reentry, and often leverage Medi-Cal to access health care services. Services to meet behavioral health needs are provided across multiple Medi-Cal delivery systems. To document the degree to which the community behavioral health system adequately meets beneficiary needs, DHCS has published its [2020 Medi-Cal Network Certifications](#), which certify that each delivery system meets established network adequacy standards, such as time and distance, and timely access to care.\(^{14}\)

- **Criminogenic Needs** – In recent decades, community corrections agencies have transformed service delivery by increasingly implementing evidence-based practices to address criminogenic risks and needs. To evaluate service capacity to address criminogenic to needs, for County Probation, CCJBH examined SB 678 Annual Assessment survey data reported to the Judicial Council,\(^{15}\) and for parole, CCJBH referenced the [2021 California Rehabilitation Oversight Board’ (C-ROB) Report](#) (this C-ROB report was also used to assess social service and housing needs, mentioned below).

- **Social Service Needs** – Economic hardship, brought on by labor market discrimination and low levels of human capital, is widespread after release. As a result, programs such as Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) and Supplemental Nutrition Assistance Program (in California, CalFresh) can support successful reentry by ensuring that individuals can meet basic needs. CDCR reports outcomes of SSI applications submitted pre-release through the [Transitional Case Management Program](#) (TCMP), which screens releases for SSI/SSDI benefits eligibility.\(^{16}\)

- **Housing Needs** – Individuals transitioning from incarceration are at high risk of homelessness at release. A wide variety of housing programs are available, ranging from temporary placements such as shelters to permanent supportive housing as well as housing vouchers.

See Appendix I for additional information about the current list of Goal 2 Metrics.

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\(^{14}\) Network adequacy standards for Non-Specialty Mental Health Services (Non-SMHS, provided by Medi-Cal Managed Care Plans) and Specialty Mental Health Services (SMHS, provided by county behavioral health) include outpatient and psychiatry (and do not include inpatient), while network adequacy standards for the Drug Medi-Cal Organized Delivery System (DMC-ODS) include outpatient and residential services.

\(^{15}\) The SB 678 Annual Assessment Data are self-reported and are not verified after submission. See Appendix K for additional information about analyses conducted using the SB 678 Annual Assessment.

\(^{16}\) Approved SSI applications reflect outcomes for only a narrow subset of individuals transitioning from incarceration, as the SSI application process is dictated by a Memorandum of Understanding between the Social Security Administration and CDCR, which details criteria for SSI applications. Applications are submitted for all individuals who meet specified criteria.
**System Capacity Findings**

Emergent policy changes, such as updates to statute that directly or indirectly affect access to services, may affect data reporting moving forward. This is especially likely for changes that are applied retroactively. Findings from data analysis should always be interpreted within contexts.

- The capacity of the Medi-Cal behavioral health system as of December 2020 is as follows:
  
  o Out of 26 Medi-Cal Managed Care Plans (MCPs), 22 received a conditional pass for compliance with network adequacy standards subject to a resolution of a corrective action plan, while 4 MCPs fully complied with network adequacy standards. Of 22 MCPs that received a conditional pass, all 22 resolved their corrective action plan by May 2021.
  
  o Out of 56 county Mental Health Plans (MHP)s, 43 received a conditional pass for compliance with network adequacy standards subject to resolution of a corrective action plan, while 13 MHPs fully complied with network adequacy standards. Of the 43 MHPs that received a conditional pass, 41 resolved their corrective action plan by May 2021.
  
  o Out of 30 Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, all received a conditional pass for compliance with network adequacy standards, subject to resolution of a corrective action plan. To date, six DMC-ODS counties remain on a conditional pass and have not resolved their corrective action plan.17

**Note:** Mental health inpatient and psychiatric residential services are not captured in the network adequacy measures. However, the new Behavioral Health Continuum Infrastructure Program will award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources.

- Nearly 100 percent of currently incarcerated individuals as well as individuals on parole have been tested and have California Static Risk Assessment scores. About 40 percent of individuals on parole participated in programming consistent with their identified risks/needs. Analyses of data from the SB 678 Annual Assessment indicates that 94 percent of responding probation departments reported that at least three-fourths of their high-risk caseloads were administered a risk assessment tool. Moreover, the majority of individuals on probation assessed as medium-risk or high-risk received services responsive to their needs, and all or nearly all of responding probation departments engaged in some support and monitoring of evidence-based practices.

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17 Counties that have not opted into the Drug Medi-Cal Organized Delivery System are not subject to the provider ratios or timeliness standards, but will be subject to the time and distance standards in future certifications.
Note: individuals on probation supervision will only receive services that align with their identified risks and needs, which may be impacted by recent changes in the law requiring shorter time frames for probation supervision.

- As reflected in the C-ROB’s September 2021 Report for Fiscal Year (FY) 2020-21 submitted applications, 61 percent of SSA/SSI applications submitted pre-release were in a pending status, with 23 percent of submitted applications in an approved status and 16 percent in a denied status.

- Point-in-time data from CDCR indicate that, of the 45,119 individuals who were on parole on June 30, 2021, approximately 17 percent (n=7,472) were homeless or residing in a shelter. Of these individuals, 36 percent left prison with a mental health designation and about 60 percent had a probable or likely SUD. We note these data may be skewed as a result of COVID-19 Pandemic-related impacts.

Taken together, it appears that system capacity to administer outpatient behavioral health care services and services to address criminogenic risks/needs is robust, although there is room for quality improvement to ensure that clients’ needs are met. For example, those counties that are not fully implementing best practices should consider doing so, seeking the necessary training and technical assistance as appropriate. Data are incomplete for income support and housing support services, and more robust reporting is required.

In 2022, CCJBH will continue to work with system partners to expand reporting on system capacity, as appropriate, with a particular focus on housing and homelessness services.

**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 (i.e., criminogenic needs interventions) and behavioral health services to achieve recovery and reduced recidivism.

**2021 Update:**

CCJBH has not yet established this metric, but will continue to work to identify appropriate methods to track behavioral health / justice system workforce development in 2022.

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18 Moving forward, it is essential to explore the relationship between, and impact of, AB 1950 on the SB 678 requirements to ensure these new requirements do not adversely impact capacity to maintain the high level of implementation of evidence-based practices that have been established to date.

19 Data were provided to CCJBH from the CDCR Office of Research. Estimated releases are based upon the average of actual releases from January 2018 through December 2019, reduced by 10 percent. The estimated number of homeless individuals on parole is based upon the release plan of incarcerated individuals with determinate sentences scheduled to release within 180 days of July 29, 2021.

20 As identified using the Correctional Offender Management Profiling for Alternative Sanctions.
**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.

**2021 Update:**

Work is ongoing across multiple state departments to improve outcomes for the BH/JI population. Examples include efforts by the Department of State Hospitals to leverage data to inform decisions about the Felony Incompetent to Stand Trial (FIST) population, especially the Department’s existing wait list of FIST referrals, as well as the Mental Health Service Oversight and Accountability Commission’s Data-Driven Recovery Project, through which ten counties linked criminal justice and behavioral health data to better understand the mental health needs of people in the criminal justice system.

In collaboration with DHCS and CDCR Office of Research, CCJBH reports on Medi-Cal enrollment and utilization rates after release from prison through its Medi-Cal Utilization Project (MCUP). Findings can be found in Section V of this report. Through the ongoing Public Health Meets Public Safety (PHMPS) project, CCJBH is laying the groundwork for additional data linkage and analysis. In 2021, a dashboard that inventories publicly available data sources was made available on the CCJBH website. Additional information about PHMPS is available in the Project Updates section of this report.

In 2022, CCJBH will work with State and local-level entities to identify existing reporting, as well as facilitate additional data collection to strengthen and expand reporting on these metrics, especially to include stratifications by the behavioral health, justice-involved, and BH/JI populations.

**IV. Reflection on Previous CCJBH Legislative Report Recommendations**

Since 2002, CCJBH has continued to meet its statutory obligation to produce recommendations for the Administration and Legislature related to the BH/JI population. From 2016 through 2020, out of the 160 recommendations made by the Council, 100 (about 63 percent) have been completed or are actively in progress, many of which have been or are being addressed through the DHCS’ CalAIM waiver (e.g., 90-day pre-release jail/prison in-reach services, jail pre-release Medi-Cal enrollment, Enhanced Care Management (ECM) and Community Supports) or through the DSH’s Diversion Program. About 1/3 of the recommendations are not actively being addressed, including establishing system-wide collaborations through MOUs to ensure efficient, coordinated services that include Collaborative Case Planning, all of which are strategies that

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Note that a CCJBH recommendation as being “actively in progress” if any part of the recommendation is being addressed. For example, the 2020 CCJBH Legislative Report recommended that criminogenic needs assessments be performed, particularly in jails because the stays are brief. Because probation and parole perform these assessments, credit is given to this recommendation as being “open/active,” but not all components of the recommendation are being fully addressed (e.g., criminogenic needs screening and assessments are not being consistently administered for the entire jail population).
have not yet been systematically implemented, and that are critical given the multi-system involvement that is necessary to support the needs of the BH/JI population.

V. Medi-Cal Utilization Project

The period immediately after release from prison is critical for establishing connection to health care services and avoiding negative outcomes. Many individuals releasing from CDCR facilities are enrolled onto Medi-Cal and receive Medi-Cal physical and behavioral health care services (hereafter referred to as beneficiaries transitioning from incarceration). As such, connecting individuals leaving prison to Medi-Cal services is an integral part of successful reentry. Both CDCR and DHCS have made investments in pre-release Medi-Cal enrollment infrastructure, facilitated referral and linkage from correctional health care providers to their counterparts in the community, and engagement with needed physical and behavioral health care services. Increased investment in these efforts is forthcoming through the CalAIM initiative.

To examine the impact of previous initiatives and inform the development of emergent efforts, CCJBH partnered with DHCS to carry out the CDCR/DHCS MCUP. In FY 2016-17, CCJBH received ongoing funding to support the MCUP, which analyzes linked administrative datasets from CDCR and DHCS to inform policy and program development, with the goal of improved outcomes for the BH/JI population. CDCR shared data with DHCS in 2017, and a report and factsheet were released based on the initial data-share. Unfortunately, challenges related to sharing certain protected identifiers arose after the initial data were shared, resulting in reporting delays.

The Statewide Inter-Agency Data Exchange Agreement, which streamlines the process of data-sharing across all state departments under the Governor and was signed in December 2020. It has been integral to the continued success of the MCUP, as CCJBH worked closely with CDCR and DHCS to re-establish a Data Sharing Agreement and process for data linkage and analysis, which went into effect in March 2021. With this new agreement in place, CCJBH was able to resume MCUP reporting. As such, this reporting focuses on FY 2018-19 CDCR releases to allow for an adequate follow-up period in FY 2018-19 and FY 2019-20. While detailed source data, as well as methodological documentation for this reporting, is located in Appendix K, a description of the behavioral health needs of the releasing population, along with of their Medi-
Cal utilization (penetration and engagement), stratified by need and by Medi-Cal delivery system types, are summarized below.

**Identified Need for Behavioral Health Services**

Consistent with the high prevalence of mental illness and SUDs in custody settings, the vast majority of beneficiaries transitioning from incarceration have identified need for behavioral health services. Identification of mental health need is based on the CDCR mental health designation upon release, and SUD need is based on the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) intake re-entry assessment (for the parole population) and COMPAS intake assessment (for Post-Release Community Supervision). Findings are as follows:

- Nearly eighty percent of Medi-Cal beneficiaries transitioning from incarceration in FY 2018-19 had identified behavioral health need.
  - Slightly over half of beneficiaries transitioning from incarceration (15,604) had an identified SUD need only.
  - Seven percent of beneficiaries transitioning from incarceration (2,175) had an identified mental health need only.
  - Nearly 1 in 5 (5,619) beneficiaries transitioning from incarceration had co-occurring mental health and SUD needs.

**Enrollment onto Medi-Cal and Medi-Cal Managed Care Plans**

Existing reporting through the Transitional Case Management Program (TCMP) indicates that approximately 82 percent of individuals transitioning from incarceration were enrolled onto Medi-Cal within one year of release, which CCJBH also found when examining Medi-Cal enrollment. In addition, as shown in Appendix K, CCJBH analyses revealed some delay in enrolling onto a MCP post-release, as MCP enrollment rates were 32 percent within one month of release and 55 percent within two months of release for beneficiaries transitioning from incarceration (i.e., among individuals who were enrolled onto Medi-Cal). There is steady improvement in MCP enrollment rates, such that 85 percent were enrolled onto MCPs within one year of release.

**Medi-Cal Behavioral Health Service Utilization by Need – Penetration and Engagement Rates**

In line with DHCS Performance Outcomes System reporting, CCJBH measured “penetration” as having at least one contact, and “engagement” as having five or more contacts, with the Medi-Cal program. Using these criteria, CCJBH examined the Medi-Cal service utilization for individuals transitioning from incarceration during FY 2018-19, following them during FY 2018-19 and FY 2019-20. This section presents utilization of any Medi-Cal behavioral health service, which includes services delivered through the non-specialty and specialty mental health systems as well as Drug Medi-Cal / Drug Medi-Cal Organized Delivery System. Additional discussion of the Medi-Cal behavioral health service delivery systems is below. As shown in Appendix K and the Figure below, penetration and engagement rates by service need are as follows:
• Beneficiaries with mental health needs penetrated in and engaged with at least one of the Medi-Cal behavioral health delivery system at a rate of 55 and 36 percent, respectively.

• Beneficiaries with SUD needs penetrated in and engaged with at least one of the Medi-Cal behavioral health delivery system at a rate of 30 and 16 percent, respectively.

• Beneficiaries with co-occurring mental health and SUD needs penetrated in and engaged with at least one of the Medi-Cal behavioral health delivery system at a rate of 56 and 35 percent, respectively.

• Around 21 percent of beneficiaries transitioning from incarceration without an identified behavioral health need utilized at least one behavioral health service, which is important to note because some individuals may not be identified as requiring services upon release from prison, but may decompensate once in the community and ultimately be in need of services.

Generally, connection to mental health services, specifically the specialty mental health system, was more robust compared to connection to care for SUD services. It would seem that many individuals with identified SUD would utilize SUD services, and individuals with identified mental health needs would utilize mental health services; yet, service utilization rates are quite low overall. Thousands of beneficiaries with identified behavioral health needs are not utilizing even one Medi-Cal behavioral health service.

*Figure: Penetration of (1+ services) and Engagement with (5+ services) Any Medi-Cal Behavioral Health Service Among Beneficiaries Transitioning from Incarceration in FY 2017-18*
There are at least three components that must occur to successfully connect beneficiaries transitioning from incarceration to needed health care services: warm handoff/facilitated referral by correctional health care providers, an intake process by community health care providers, and individuals themselves willingly engaging with services. Though not definitive, CCJBH’s initial findings suggest that quality improvement efforts should be considered across all three components. Facilitated referral and linkage to behavioral health services for individuals transitioning from incarceration, which is included in DHCS’ CalAIM proposal, will likely strengthen the warm hand-off process between delivery systems, but additional efforts are likely needed to support the individuals themselves. For example, opportunities for Forensic Peer Support Specialists, who have lived experience of the behavioral health and criminal justice systems, can be a trusted resource, providing support service navigation, as well as helping to destigmatize the experience of accessing behavioral health services.  

**Medi-Cal Behavioral Health Service Utilization By Medi-Cal Delivery System**

As reflected in Appendix K, Medi-Cal behavioral health services are delivered across multiple systems, as follows (note: medications used in the treatment of MH and SUD are available across all Medi-Cal delivery systems):

- **Managed Care Plans** – MCPs provide Non-Specialty Mental Health Services (Non-SMHS), such as psychotherapy and certain non-specialty mental health outpatient services delivered through Medi-Cal MCPs. For Non-SMHS, the penetration and engagement rates for beneficiaries who only had a mental health need was 26 percent and 5 percent, respectively. For those who had co-occurring needs, the penetration and engagement rates were 26 percent and 6 percent, respectively.

- **Mental Health Plans** – In FY 2018-19, MHPs provided Specialty Mental Health Services (SMHS) to beneficiaries who met criteria as specified in Title 9, California Code of Regulations. For SMHS, the penetration and engagement rates for beneficiaries who only had a mental health need were 39 percent and 27 percent, respectively. For those who had co-occurring needs, the penetration and engagement rates were 33 percent and 20 percent, respectively.

- **County Drug Medi-Cal and Drug Medi-Cal Organized Delivery System** – Substance Use Disorder Services (SUDs) are delivered either through county DMC-ODS program or through counties not participating in DMC-ODS. For SUDs, the penetration and engagement rates for beneficiaries who only had a mental health need were 26 percent and 5 percent, respectively. For those who had co-occurring needs, the penetration and engagement rates were 26 percent and 6 percent, respectively.

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25 In 2022, DHCS will implement a Peer Support Specialist benefit in the Medi-Cal Specialty Mental Health and Drug Medi-Cal Organized Delivery Systems. As part of that implementation, state-approved Medi-Cal Peer Support Certification Programs must implement a Forensic Peer Support Specialist specialization to the certification by January 1, 2023.

26 See [DHCS Boilerplate contract](#).

27 AB 133 (Chapter 143, Statutes of 2021 amended Welfare and Institutions Code Section 14184.402 to update SMHS criteria effective January 1, 2022.

28 Medi-Cal substance use disorder services are provided primarily through the Drug Medi-Cal Organized Delivery System, which covers 96 percent of the Medi-Cal population spanning 37 counties. SUD services provided through the Managed Care and Fee-for-Service systems, including services provided in primary care settings, are included in the results.
engagement rate for beneficiaries with a SUD need only was 23 percent, and 12 percent, respectively. For those with co-occurring needs, the rates were 35 percent and 17 percent, respectively.

In 2022, CCJBH will continue to report on the enrollment and utilization metrics presented above, so that year-over-year comparisons can be made. In addition, CCJBH will work with the Integrated Substance Use Disorder Treatment (ISUDT) program and CDCR Office of Research to incorporate a more refined measure of SUD need into the data analysis.

VI. CCJBH Project Updates

Continuing throughout the pandemic, CCJBH continued its commitment to serving the BH/JI population by working on a variety of projects related to reentry, data, expanding the impact of perspectives from those with lived experience, diversion, and SB 823 implementation. Updates on CCJBH’s projects are discussed in this section, along with identified next steps for 2022.

A. SB 369 Veto Message Project

The Governor’s veto of SB 369 required CDCR and CCJBH to “engage with stakeholders, evaluate the barriers of reentry and determine what steps need to be taken to overcome those barriers.” Throughout the duration of this project, CCJBH worked closely with CDCR’s Division of Adult Parole Operations, Division of Rehabilitative Programs, and Statewide Mental Health Program, as well as the CDCR/CCHCS ISUDT Program. A draft inventory of barriers and potential solutions to address them was developed based on a review of published literature and consultation with internal and external subject matter experts. Between February and April 2021, stakeholders participated in eight SB 369 meetings, including two targeted stakeholder engagement opportunities, three public meetings, and three focus groups, each of which was followed by a two-week public comment period. Overall, there were 32 barriers identified within three categories (individual-, program/provider- and system-levels) confirming that individuals transitioning from incarceration frequently have multiple, complex needs that must be addressed through cross-system collaboration. Recommendations included developing a Barriers Prioritization Survey to identify the top barriers, followed by a Feasibility and Cost Analysis to evaluate the alignment of proposed solutions and strategies with current State and county initiatives. The report, Successful Reentry/Transition from the California Department of Corrections and Rehabilitation: Identification of Barriers and Solutions to Address Them, was finalized in early September 2021.

B. Public Health Meets Public Safety

Public Health Meets Public Safety (PHMPS) is a two-year project being conducted in consultation with the CSG Justice Center. The project aims to utilize data to track, monitor and ultimately reduce, the number of adults and young people with behavioral health needs in California’s justice system by marshaling data to inform policy decisions. Building on existing state and local data integration efforts, CSG is developing resources that support state, local, and community leaders in this shared goal.
In 2021, CSG developed a report for CCJBH that provide recommendations, key considerations, and strategies that may be used to establish data linkage across systems that are in compliance with federal and state privacy laws, and that ensure secure data transfer and storage. The report also provides an initial set of proposed data linkages that CCJBH can utilize as metrics for a data reporting framework (dashboard). In addition, CSG facilitated two focus groups to capture feedback/input from CCJBH’s Lived Experience Program (LEP) contractors to inform the data reporting framework.

As part of the effort to develop a data reporting framework, CSG also developed an Open Datasets Inventory that serves as a compilation of current publicly available data related to the justice and behavioral health systems, categorized in the following domains:

- Community Prevalence & Prevention
- Law Enforcement Contact & Crisis Response Datasets
- Custody Data Sets
- Reentry & Community Supervision Datasets
- Juvenile Justice Data
- Supplemental Data (Demographic & Socio-economic context)

CSG will continue working to populate the data reporting framework for CCJBH, which will include recommendations on how to use the framework to inform policy- and decision-making.

C. Equity, Diversity, and Inclusion

Never before has the issue of Equity, Diversion, and Inclusion been more important to an organization than it has become through the changes brought about by the COVID-19 PHE and the national emphasis on the need to address systemic racism. In the spirit of the cultural change needed, CCJBH is prepared to continue working with partners and stakeholders to address disparities. In 2021, CCJBH began the process to review the Mission and Vision Statements of the council. CCJBH is performing this reassessment to capture the intent and purpose of the Council to reflect that CCJBH recognizes the need for mitigating disparities for the BH/JI population. CDCR and CCHCS have completed their third successful year in the Government Alliance for Race and Equity Capitol Cohort, sponsored by Race Forward and the Health in All Policies, Strategic Growth Council. CCJBH has an ambassador on the team to assist in communicating to the staff and Council the need to develop policies and practices aimed at diversity, equity, and inclusion.

D. Lived Experience Program (LEP) Project

In 2020, CCJBH received Mental Health Services Act funds for stakeholder advocacy contracts, and associated program administration, to support mental health outreach and services for criminal justice-involved populations. Using these funds, CCJBH contracted with the California State University, Sacramento (CSUS), to determine how best to engage statewide public outreach efforts surrounding individuals with lived experience (LE) in the behavioral health and criminal justice systems. This effort resulted in the establishment of the Regional Lived Experience Project Contracts, as well as another separate CSUS Lived Experience Project.
focusing on employing individuals with lived experience in the behavioral health and criminal justice systems.

a. Regional Lived Experience Project (LEP) Contracts

In late FY 2019-20 and early 2020-21, CCJBH entered into contracts with Anti-Recidivism Coalition (ARC), Cal Voices, Los Angeles Regional Reentry Partnership (LARRP) and Transitions Clinic Network (TCN) to increase local and State advocacy capacity of those with lived experience, expand education and training opportunities, promote organizational and community awareness, and improve collaborative efforts and partners at a regional/local level.\(^{29}\) The following are highlights of the work that has been accomplished by the CCJBH LEP contractors as part of Year 1 of the LEP project:

**ARC (Central Region)**

- Connected members to services who live in the Central Region (e.g. in-reach, housing, career development, social support).
- Created opportunities for members, such as mentorship, as a way to use their lived experiences with the behavioral health and criminal justice systems to help others who come from similar backgrounds.
- Provided weekly policy workshops, daily mental health therapy sessions, daily case management/ life coaching sessions, daily reentry services, and weekly Career Readiness workshops to clients daily mental health therapy sessions.
- Participated in stakeholder meetings to actively discuss the housing and employment of individuals who are justice-involved.
- Provided recommendations related to policies, programs, approaches that align with ARC’s priorities.
- Conducted in-services regarding the value of Peer Support roles and employer workshops for their “Fair Chance Hiring” educational campaign.

**Cal Voices (Superior and Southern Regions)**

- Established ACCESS program and implemented an outreach campaign to recruit a total of five Regional ACCESS Ambassadors.
- Trained ACCESS Ambassadors
- Developed a web-based informational clearinghouse for fact sheets, policy summaries, and events as well as a data collection tool for peer provider interviews to support peer support services.
- Stakeholder engagement via social media platforms and quarterly email blasts to share important links to information, events, resources, and program updates to their network.

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\(^{29}\) Additional information about the LEP contractors and their areas of focus is located on the CCJBH [website](#).
LARRP (Los Angeles Region)

- Recruited a total of twelve cohort members to be part of their first Leading-Engaging-Advocating-Demonstrating-Enhancing-Expanding-Reentry-Systems (LEADERS) program. Four cohort members serve in three issue committees were members focus on integrated health, employment, and education.
- Provided trainings four times per month for their members.
- Paired LEADERS with issue working committees were they are able to start discussions regarding policies and resources that are lacking in the criminal justice system for behavioral health needs.

TCN (Bay Area Region)

- Established the California Site Advisory Group that is composed of Community Health Workers (CHWs) and program leads from twelve TCN-affiliated clinics across California.
- Prioritized behavioral health (BH) training topics for CHWs working with TCN-affiliated clinics.
- Continued to work on enhancing and supporting referral partnerships throughout the Bay Area TCN sites as a way to improve linkage and continuity of care for justice-involved individuals returning to the Bay Area (e.g., referrals from social service agencies and CDCR).
- Hosted monthly coordination meetings with program staff from their California sites to discuss coordination and referrals to the services they provide, such as their Reentry Healthcare Hotline.
- Conducted key informant interviews with patients at TCN-affiliated sites that focused on their experience receiving services while incarcerated, how they got referred to community-based programs (such as TCN), and the type of support they received during their incarceration.

In addition, CCJBH established a statewide LEP Advisory Team comprised of representatives from each of the LEP project contractors, which meets quarterly for CCJBH to share project updates for LEP contractor review and feedback. From this LEP Advisory Team process, LEP contractors coordinated with CCJBH to gather broad subject matter expertise from individuals with lived experience to inform the project design for the PHMPS project, as well as the development the SB 369 inventory of re-entry barriers and solutions.

The CCJBH LEP contractors will continue their efforts over the next two years to build capacity, expand outreach, build awareness, and provide education, and shape policy- and decision-making by informing the development and implementation of CCJBH projects.
b. CSUS Lived Experience (LE) Project

In December 2020, CSUS and CCJBH initiated a project to gather input on how to effectively advance the employment of individuals with LE in the criminal justice and behavioral health fields. As summarized in the resulting report, *Successful Approaches to Employing Individuals with Lived Experience in the Criminal Justice and Behavioral Health Fields*, strategies most effectively used to support employees with LE include:

- Stigma Training
- Mentoring
- Educational Opportunities
- Using a Specific Classification for Individuals with Lived Experience
- Career Pathway

In addition, the following barriers to hiring individuals with lived experience were identified:

- Background checks and security clearance (as an issue of technical policy as well as culture)
- Equal Employment Opportunity Laws and disclosure issues
- Lack of funding
- Adequate and fair compensation
- Stigma and lack of recognition of the value of peer support
- Lack of peer support specialist certification
- Degree requirements for advancement within an organization
- Insufficient support and mentorship

In September 2021, CSUS and CCJBH co-hosted a *Solutions to Hiring Individuals with Lived Experience* workshop that focused on identifying paths to overcome these barriers and potential solutions for implementation. Results from the workgroup discussions will be summarized in a report, and CCJBH plans to continue working with CSUS on projects that focus on employing individuals with lived experience across multiple sectors (e.g., behavioral health, criminal justice, social services, and healthcare).

E. Forensic Peer Support Specialists

As reflected in the 2020 Legislative Report, CCJBH believes that the use Forensic Peer Support (FPS) Specialists can be of significant benefit to individuals who are justice-involved and have a mental health and/or SUD. FPS Specialists are individuals who have lived experience with behavioral health conditions and are, or have been, involved with the justice system. Through their lived experience and specialized training, FPS Specialists are able to gain the trust and respect from the individuals they serve, preparing individuals for reentry into their community, assisting with activities of daily living, as well as helping with navigation through, and engagement in, complex State and local public service delivery systems.

In January 2021, CCJBH embarked on a project to research publicly available nationwide resources regarding FPS models. Efforts to date have included meeting with experts from the states of Georgia, Pennsylvania, and Connecticut who have experience implementing the FPS model. As part of the information gathering process, CCJBH developed a short questionnaire to gather input from entities that are operating a certification program for FPS specialists. Questions for this questionnaire focused on training requirements, core competencies, qualifications, and considerations when implementing a certification program for FPS.
specialists. In addition, with regard to the FPS classification within the county behavioral health sector, CCJBH has participated in listening sessions provided by DHCS and is tracking the California Mental Health Services Authority’s progress in providing guidance for counties who are interested in the implementing the peer certification program within the behavioral health sector. CCJBH’s findings and recommendations are currently being formulated into a report which, once drafted, will be shared for stakeholder review and input before finalizing.

F. CalAIM

CCJBH remains actively committed to supporting the DHCS’ CalAIM initiative, a multi-year effort to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms. Key components of the CalAIM proposal applicable to those who are involved with the justice system include limited Medi-Cal services 90 days prior to release from jail/prison, ECM services, Community Supports, as well as mandatory pre-release Medi-Cal enrollment and facilitated linkage to community-based behavioral health services (including SUD) for individuals released from jails, prisons, and youth correctional facilities.

On December 29, 2021, CMS approved the DHCS CalAIM Section 1115 demonstration and Section 1915(b) waiver applications, including the majority of DHCS’ CalAIM proposals.30 However, DHCS and CMS continue to work toward additional approvals for equity-oriented CalAIM initiatives that provide services and supports for justice-involved adults. To be clear, the statutory requirement for county jails and youth correctional facilities to assist individuals eligible for Medi-Cal with submitting an application for and enrolling in Medi-Cal by January 1, 2023, will remain in effect and is not impacted by CMS approval of CalAIM. However, DHCS and CMS continue to work toward an approval in early 2022 for the CalAIM initiative that will cover certain services and supports under Medi-Cal during a 90-day period prior to release.

To ready justice system partners for the CalAIM components that will impact the justice-involved population, including those with behavioral health needs, CCJBH prepared the Brief Overview of the Department of Health Care Services (DHCS)’ California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population. CCJBH also supported DHCS’ CalAIM and other related efforts by continuing to participate as an appointed member of DHCS’ Behavioral Health Stakeholder Advisory Committee, and is participating in DHCS’ CalAIM Justice-Involved Advisory Group.

30 In August 2021, during the federal public comment period, CCJBH submitted to the CMS a letter of support for DHCS’ 1115 Demonstration waiver, which includes several CalAIM components.
G. Pre-Trial Diversion Training and Technical Assistance

To support California’s mental health diversion efforts, beginning in FY 2018-19, CCJBH received three years of funding to provide consultation to the DSH and California counties to develop, implement and operate pre-trial mental health diversion programs. As shown in table below, CCJBH completed the second year of its obligation to DSH by holding three trainings, led by Dr. Sarah Desmarais, Senior Vice President at Policy Research Associates, on criminogenic needs and risk mitigation with regards to pre-trial diversion programs. These trainings were well attended by attorneys, judges, county supervisors and behavioral health administrators and treatment providers. Attendees learned the importance of program evaluations, risk assessment tools and the development of meaningful metrics.

Table: CCJBH Pre-Trial Diversion Trainings

<table>
<thead>
<tr>
<th>TRAINING DATE</th>
<th>COURSE TITLE</th>
<th>TARGET AUDIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 7, 2021</td>
<td>Introduction to Program Evaluation for Behavioral Health Diversion Programs</td>
<td>County supervisors, behavioral health administrators, and behavioral health treatment providers and all other interested stakeholders</td>
</tr>
<tr>
<td>May 5, 2021</td>
<td>Evaluating the Implementation of Behavioral Health Diversion Programs</td>
<td>Behavioral health administrators and behavioral health treatment providers.</td>
</tr>
<tr>
<td>June 2, 2021</td>
<td>Evaluating the Impact of Behavioral Health Diversion Programs</td>
<td>Behavioral health administrators and behavioral health treatment providers.</td>
</tr>
</tbody>
</table>

In order to continue the formative work started with DSH, CCJBH drafted a Request for Proposal (RFP) targeting training and technical assistance and the development of policy recommendations to support the successful implementation and expansion of mental health diversion throughout the state. The project was developed to ensure programs apply an equity lens, understand the differences across rural, urban, and suburban communities in developing and sustaining diversion. The contract was awarded in June 2021 to CSG Justice Center, who provide on-going subject matter expert specialty consultation and technical assistance throughout FY 2021-22 to support county diversion planning and implementation, taking into consideration the impact of the COVID-19 PHE. Activities will include facilitating learning communities for at least 20 California counties, and gathering information from key partners regarding the effectiveness of policies and practices in California’s participating counties. The knowledge gained from these efforts will culminate into a final report summarizing the effectiveness of existing mental health diversion policies and practices, and providing recommendations on what changes must be made (and how) in order to advance mental health diversion programs to ensure their success throughout California.
H. Juvenile Justice Compendium and Toolkit Request for Proposal

CCJBH developed a Juvenile Justice Compendium and Toolkit RFP with the purpose of providing a compilation of information related to best practices and evidence-based programs that have been shown to be effective in serving justice-involved youth who have serious behavioral health needs. The work done through the compendium and toolkit may be used to assist counties as they implement activities related to SB 823, Juvenile Justice Realignment, and it will complement the efforts of the Office of Youth and Community Restoration (OYCR). It will also serve as a key resource for county probation, child welfare, and behavioral health departments and help to strengthen and sustain cross-system partnerships, utilize a MTSS, identify funding streams, and leverage existing data to track progress, treatment, and program outcomes. Once executed, the contract will operate over a period of two years and will include deliverables on completion of the compendium and toolkit, as well as development of a county training and technical assistance plan.

I. Housing/Homelessness

In January 2020, CCJBH released a policy brief providing several strategies on Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges. As a result of this policy brief, and in response to Governor Newsom’s call to action on homelessness over a year ago, CCJBH partnered with the CSG Justice Center, supported with funding from the Melville Charitable Trust, to identify strategies to improve housing outcomes for people with behavioral health needs who are exiting the criminal justice system. Released in March 2021, the CSG Justice Center’s final report, Reducing Homelessness for People with Behavioral Health Needs Leaving Prison and Jails, identifies 5 key challenges that lead to unmet housing and behavioral health needs and 10 specific recommendations to address these challenges, particularly with the goal of providing permanent supportive housing and rapid re-housing since research has shown that these are the most effective evidence-based models that have been established to date. CSG asserts that, unless actions such as these are taken, “people will continue to cycle between incarceration and homelessness with unmet behavioral health needs.”

Therefore, CCJBH is committed to continue building momentum to ensure access to affordable housing with the appropriate supports for the justice-involved population with behavioral health needs by actively pursuing efforts to address the CSG Justice Center’s report recommendations. Thus far, the Homeless Coordinating and Financing Council has cited the CSG report recommendations in its Action Plan under “Activities Prioritized for Implementation,” and is committing to assessing the recommendations to identify priorities for actions to be taken in FYs 2021-22 and 2022-23. Accordingly, CCJBH will continue to collaborate with key partners to further efforts to study strategies to improve housing outcomes for the BH/JI population, particularly given the significant federal and state investments to expand housing and address homelessness, as well as to help prepare for the new CalAIM Community Supports benefit that DHCS will be implementing, which include services such as housing transition navigation, housing deposits, housing tenancy and sustaining services, etc.
VII. Mental Health, Suicide and Recovery Awareness Activities

This year, CCJBH recognized May is Mental Health Awareness Month and September’s Suicide Prevention Awareness and Recovery Awareness Month. Learn-and-lunch webinars were offered weekly from noon to 1 PM throughout May and September, along with resources disseminated weekly via the CCJBH listserv. Registration for the May webinars ranged from 52 to 171 registrants, with attendance averaging about 50 percent. Registration for September activities ranged from 83 to 170 registrants, with attendance averaging about 70 percent (see Appendix D).

VIII. Additional CCJBH Efforts

In addition to advancing efforts on major projects, CCJBH also worked on a variety of additional projects, including disseminating information through a bi-monthly CCJBH Newsletter, tracking the Governor’s Budget, May Revision and final budget as it relates to the BH/JI population, and also by serving as an appointed member on behalf of CDCR for the Incompetent to Stand Trial (IST) Solutions Workgroup that was authorized in WIC 4147 and established in August 2021.

A. Bi-Monthly Newsletters

The CCJBH’s Bi-Monthly Newsletters focused on disseminating project updates, announcements, Full Council and Workgroup Meeting dates, legislative updates, and upcoming events related to the BH/JI population via a listserv that includes approximately 1,000 stakeholders representing diverse populations across California (e.g., behavioral health and criminal justice system partners, advocates, other individuals interested in CCJBH’s efforts). May’s newsletter highlighted the events hosted by CCJBH for Mental Health Awareness Month. July’s newsletter honored the importance of Bebe Moore Campbell National Minority Mental Health Awareness Month, also referred to as Black, Indigenous, and People of Color Mental Health Awareness Month. September’s newsletter focused on the webinars hosted by CCJBH for Suicide Prevention Awareness and Recovery Awareness Month and shared helpful resources. Moving forward, CCJBH will continue to continuously provide current updates on the CCJBH News and Events website.

B. California Budget Summaries

CCJBH also produced budget summaries for Councilmembers for the Governor’s Proposed Budget, the May Revision, and the Enacted Budget. The Budget Summaries highlight areas of interest in the intersection of criminal justice and behavioral health systems and provide a breakdown to the funding allocated to each department. The relevant categories included in the Budget Summaries are Health and Human Services, Housing and Homelessness, Judicial Branch, and Criminal Justice.
C. Incompetent to Stand Trial (IST) Solutions Workgroup Member

Beginning in August 2021, CalHHS and DSH convened an IST Solutions Workgroup as authorized in WIC 4147, with three sub-workgroups, to identify actionable solutions that will address the increasing number of individuals with Serious Mental Illness who become justice-involved and deemed IST on felony charges. As members appointed to the workgroup, CCJBH staff and Councilmembers worked to support the Workgroup’s efforts to develop recommendations for short-, medium- and long-term IST solutions, which were presented into a final report to the CalHHS Secretary and Department of Finance by November 30, 2021. The efforts of the IST Solutions Workgroup resulted in a compendium of recommended strategies and solutions summarized in the statutorily required IST Solutions Workgroup report released on November 30, 2021. To learn more, visit the IST Solutions Workgroup website.

IX. Conclusion

The COVID-19 PHE created continued challenges for service delivery to the BH/JI population. Yet, the combination of emergency, short-term measures and ongoing, longer-term initiatives, present a new opportunity to ensure that the BH/JI population receives the full complement of required services. Substantial state investment has made the expansion of service possibilities known, but additional attention must be paid to the implementation of policy initiatives so as to engage this difficult-to-reach population. For example, expanded, comprehensive data reporting can shed light on service utilization across systems and the effectiveness of received services on reducing poor and costly outcomes, such as emergency/inpatient services, overdose/mortality, and criminal justice recidivism. In addition, state and local entities are in need of training and technical assistance that is tailored to the BH/JI population, including understanding how to best address their unique and complex multi-system needs. Core systems that serve the BH/JI population include, but are not limited to, primary care, behavioral health, housing, criminal justice, and social services, such as income support and workforce training.
Appendix A
Behavioral Health System Updates

Access to care can be complex for individuals involved in the justice system who have behavioral health needs, but access to quality primary and behavioral health care is necessary for someone to maintain health and recovery. With the pandemic continuing and social distancing an ongoing reality, providers and insurers are using technology, including telehealth, to provide behavioral health services. Early in the pandemic, the federal and California state governments temporarily relaxed rules for reimbursing health care providers for services delivered over the phone or by video, and these modifications are prompting permanent changes in creating a system that delivers effective and efficient services with a whole person care philosophy.

Formalizing this philosophy, the “California Comeback Plan” envisions a 21st century public health system that advances and innovates the California’s Medicaid Program (Medi-Cal) system, supports vulnerable and homeless families by providing care for the most marginalized populations, builds an age-friendly state for older individuals, and transforms the behavioral health system for children and youth. Many of the programs involved in the California Comeback Plan will positively impact the justice-involved populations through community based interventions and the provision of prevention services.

Highlights related to the public behavioral health system are discussed below.

- **California Advancing and Innovating Medi-Cal (CalAIM)** – CalAIM is a multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems. On June 30, 2021, California Department of Health Care Services (DHCS) submitted the [CalAIM Section 1115 Demonstration](#) and [CalAIM Section 1915(b) waivers](#) to Centers for Medicare and Medicaid Services (CMS) for review and approval. Key components of the CalAIM proposal applicable to those who are involved with the justice system include Enhanced Care Management services, limited Medi-Cal services 90 days prior to release from jail/prison, Community Supports, as well as mandatory pre-release Medi-Cal enrollment and facilitated referral to community-based behavioral health services for individuals released from jails, prisons, and youth correctional facilities. To begin preparing justice system partners for the CalAIM components that will impact the justice-involved population, including those with behavioral health needs, Council on Criminal Justice and Behavioral Health (CCJBH) prepared a [Brief Overview of the Department of Health Care Services (DHCS)’ California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population](#). On December 29, 2021, CMS approved the DHCS CalAIM Section 1115 demonstration and Section 1915(b) waiver applications, including the majority of DHCS’ CalAIM proposals. However, DHCS and CMS continue to work toward additional approvals for equity-oriented CalAIM initiatives that provide services and supports for justice-involved adults. To be clear, the statutory requirement for county jails and youth correctional facilities to assist individuals eligible for Medi-Cal with submitting an application for and enrolling in
Medi-Cal by January 1, 2023, will remain in effect and is not impacted by CMS approval of CalAIM. However, DHCS and CMS continue to work toward an approval in early 2022 for the CalAIM initiative that will cover certain services and supports under Medi-Cal during a 90-day period prior to release.

- **Home and Community-Based Services (HCBS) Spending Plan** – The American Rescue Plan Act provides states with a temporary increase in federal funds for certain HCBS Medicaid expenditures from April 1, 2021, through March 31, 2022. On July 12, 2021, DHCS submitted to CMS an initial HCBS Spending Plan and, after receiving CMS’ response, DHCS re-submitted an updated HCBS Spending Plan to CMS on September 17, 2021. Of the 30 initiatives included in the HCBS Spending Plan, 12 directly relate to the behavioral health and/or justice involved population to address retaining and building a network of home and community based direct care workers, provide navigation services, and help develop an infrastructure of home and community based services for the behavioral health / justice involved (BH/JI), aging and disabled populations, totally in $2.65 billion in funding. As of September 2021, seven of the twelve initiatives had been approved by CMS and five were currently under review.

- **Children and Youth Behavioral Health Initiative** – This $4.4 billion multidepartment allocation spread over five years will transform California’s behavioral health system for children and youth into an innovative and prevention-focused system where all children and youth are routinely screened, supported, and served for emerging and existing behavioral health needs regardless of payer. Many of the components included in this initiative will make an impact on the BH/JI populations by supporting prevention efforts and a broader service delivery system including an expanded workforce. The California Health and Human Services Agency Children and Youth Behavioral Health Initiative May Revision 2021-22 and the Children and Youth Behavioral Health Initiative brief (posted to the new Children and Youth Behavioral Health Initiative website) documents include detailed descriptions of the proposal. Below is a summary of the main components:
  - DHCS will:
    - Establish a virtual platform that would facilitate the provision of behavioral health services to children and youth age 25 and younger.
    - Continue the CalHOPE Student Support Program, which provides free crisis counseling and support services through a centralized resource website. This funding is intended to sustain the program until the Behavioral Health Service Virtual Platform is implemented.
    - Establish a new benefit in the Medi-Cal program for dyadic care—a model of care which provides integrated physical and behavioral health screening and services to children and youth and their families.
Coordinate pediatric, primary care, and other health care provider training in Fiscal Year (FY) 2022-23, with provisions requiring both commercial and Medi-Cal Managed Care Plans to cover behavioral health services provided by schools for children and youth age 25 and younger.

Provide grant funding to:

- build infrastructure for establishing partnerships to provide behavioral health services in schools (eligible entities include, but are not limited to, schools, community colleges, universities, commercial health insurance plans, Medi-Cal Managed Care Plans, community-based organizations, behavioral health providers, tribal entities, and counties).

- support the implementation of evidence-based behavioral health treatment services for children and youth (eligible entities include, but are not limited to, counties, tribal entities, commercial health insurance plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers).

- support implementation of youth behavioral health infrastructure by adding child/adolescent beds/units/slots to existing facilities, or to set up new facilities or new crisis mobile service (eligible entities include, but are not limited to, counties, tribal entities, non-profit entities, for-profit entities). This is a component of the Behavioral Health Continuum Infrastructure Program (discussed below).

- The Department of Health Care Access and Information (formerly the Office of Statewide Health Planning and Development) will support their existing, and establish new, workforce programs to:
  - increase the behavioral health workforce and
  - provide training for existing behavioral health professionals.

- California Department of Public Health (CDPH) will implement a behavioral health literacy awareness campaign.

- The Office of the Surgeon General will implement an Adverse Childhood Experiences (ACEs) and toxic stress awareness campaign.

- The CalHHS will coordinate activities under the initiative across departments, acquire subject matter expertise, engage stakeholders, and lead the overall evaluation of the initiative.
• **Behavioral Health Continuum Infrastructure Program (BHCIP)** – The BHCIP includes $2.2B for DHCS to award competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. DHCS hosted a listening session on this project in October 2021, and released a gap analysis report, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications*, in January 2022 that provides results from a needs assessment of the current statewide behavioral health continuum. The project has a six-phase funding timeline:
  
  - Round 1: Crisis Care Mobile - Request for Applications (RFA) released in July 2021 (discussed below).
  - Round 3: Ready Grants - RFA anticipated to be released in January 2022.
  - Round 4: Children and Youth Grants - RFA anticipated to be released in August 2022.
  - Round 5: Addressing Gaps #1 - anticipated to be released in October 2022.
  - Round 6: Addressing Gaps #2 - anticipated to be released in December 2022.

• **Crisis Care Mobile Units (CCMU) Funding** – The CCMU project is funded by $55 million for direct services from the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant appropriated from the Coronavirus Response and Relief Supplemental Appropriations Act, and $150 million in infrastructure included in FY 2021-22 DHCS BHCIP. This funding provides an opportunity to help California counties, city behavioral health agencies, or joint groups of counties and/or city behavioral health agencies, to provide behavioral health crisis and non-crisis services from September 15, 2021, through June 30, 2025. Applications for the RFA were due on August 23, 2021. DHCS offered two separate tracks of funding; applicants could have applied for either Track 1 or Track 2 funding, but not both. The two funding tracks are:
  
  - Planning grants up to $200,000 to assess the need of mobile crisis and non-crisis programs and to develop an action plan to address the need.
  - Implementation grants up to $1 million per CCMU team to implement a new, or expand an existing, CCMU program.

All CCMU grantees are required to prioritize efforts to support mobile behavioral health crisis services to individuals age 25 and younger while also serving the broader population, and will be encouraged to support justice-intervention services.
• **“988” Crisis Number** – DHCS is investing $20 million in the state’s network of emergency call centers to support the launch of a new 988 hotline, an alternative to 911 for people seeking help during a mental health crisis. Beginning in July 2022, calls to the new 988 mental health crisis number will be received by the 13 public and private call centers in California that currently take calls that are routed to them from the National Suicide Prevention Lifeline. These counselors, which include volunteers who are not registered/certified professional behavioral health counselors, are highly trained to assist people in emotional distress or suicidal crisis.

• **Medi-Cal Telehealth** – DHCS will seek to temporarily continue the telehealth flexibilities established to address the Coronavirus Disease 2019 (COVID-19) public health emergency through December 31, 2022, subject to approval from the federal CMS. DHCS has convened an advisory group, consisting of consultants, subject matter experts, and other affected stakeholders, to provide recommendations to DHCS in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program.

• **DHCS Telehealth Expansion** – Another part of the Behavioral Health Response and Rescue Project is DHCS’ support for organizations to develop, enhance and/or expand their facility’s telehealth infrastructure to address the needs of individuals with Substance Use Disorders (SUDs) and/or mental health disorders. The Center at Sierra Health Foundation will assist DHCS with the administration of the funds. DHCS will fund organizations that provide direct treatment and recovery support services and who only use funds for provider telehealth development, enhancement and/or expansion.

• **State Opioid Response (SOR) 1 and 2 Grants** – A part of California’s Medication-Assisted Treatment (MAT) Project, DHCS continues to administer SOR grants to increase prevention, treatment, and recovery services which are critical resources for the BH/JI population given the high prevalence of addiction to and overdose from opioids. There are currently over 30 projects supported with SOR funding, including Expanding MAT in Criminal Justice Settings, the Naloxone Distribution Project, and the California Hub and Spoke System to name a few. Statewide to date, there have been almost 40,000 opioid overdoses reversed, 67,000 individuals have received MAT, and 750,000 naloxone kits have been distributed. Programs are expanding to promote best practices in prevention and treatment for stimulant use disorders.

• **Peer Support Certification and Workforce Investments** – Senate Bill (SB) 803 (Beall, Chapter 150, Statutes of 2020) requires DHCS to seek federal approval to establish Peer Support Specialist as a Medi-Cal provider type and to create Medi-Cal certification standards and a certification process for Peer Support Specialists. In December 2021, CMS approved DHCS’ State Plan Amendments to cover Peer Support Specialist services under Medi-Cal in the SMHS program, the DMC-ODS program, and in DMC counties effective July 1, 2022. In conjunction with the CalAIM
 waivers approved by CMS, these SPAs will allow counties to cover Peer Support Specialist services on a voluntary, opt-in basis on a rolling basis beginning July 1, 2022. Please visit the DHCS Peer Support Services website for more information on Peer Specialist certification. To prepare for the increase of use of peers, DHCS has contracted with the Advocates for Human Potential, Inc. to implement two funding opportunities, Expanding Peer Organization Capacity and Peer Workforce Investment which is part of DHCS’ Behavioral Health Workforce Development Project.

- **Felony Incompetent to Stand Trial Projects** – The 2021 Budget includes $75 million in one-time funding for the purposes of implementing solutions identified by the Incompetent to Stand Trial (IST) Solutions Workgroup to address the IST patient waitlist. In addition, increased funding was included in the budget to:
  - expand jail-based competency restoration services for felony IST patients residing in county jail;
  - reevaluate individuals deemed IST on a felony charge waiting in jail 60 days or more pending placement to a California Department of State Hospitals (DSH) treatment program;
  - expand the current IST/Pre-Trial Felony Mental Health Diversion program (community based treatment in lieu of criminal justice proceedings) to current and new counties;
  - provide competency restoration service for IST patients in community mental health treatment settings, and
  - expand Institute for Mental Disease (IMD) and sub-acute treatment capacity for ISTs. In addition, funds could be used to support an increase in community-based facilities to treat other DSH patient commitments who could be stepped down from the State Hospitals, thereby allowing hospital beds to be backfilled with IST patients.

As of September 30, 2021, DSH has executed contracts with 24 counties and all 24 have activated their Diversion programs. These programs aim to divert a total of 820 felony ISTs over the course of their program. As of June 30, 2021, 458 eligible individuals have been diverted to a county-run program. CCJBH is working collaboratively with DSH to help expand the use of Mental Health Diversion programs across the State. As part of this effort, the Council of State Governments (CSG) Justice Center will be providing training, technical assistance, and consultation to a variety of counties to enhance, sustain, and/or expand local capacity to successfully implement mental health diversion. CSG Justice Center will develop curriculum for fall learning community sessions, which will include presentations by relevant subject matter experts and breakout discussion groups. These fall learning sessions will complement the training efforts used during the DSH Diversion Academy, which will help expand the Pre-Trial Felony Mental Health Diversion
Program to new counties. For more information, please visit the DSH Diversion Programs website.

- **Office of Suicide Prevention, California Department of Public Health (CDPH)**
  Assembly Bill (AB) 2112 (Chapter 142, Statutes of 2020) signed into law by Governor Newsom, authorizes the establishment of an Office of Suicide Prevention (OSP) within CDPH, which aligns with the Mental Health Service Oversight and Accountability Commission (MHSAOC’s) recommendations from *Striving for Zero: Strategic Plan for Suicide Prevention 2020-2025*. The OSP is intended to be an overarching convener and coordinator of suicide prevention efforts that are being planned and implemented across the state. As of September 2021, the Office is recruiting staff and will build upon other suicide prevention efforts being implemented with CDPH’s Injury and Violence Prevention Branch to start OSP activities.

- **Office of Youth and Community Restoration (OYCR)** – The OYCR was established to promote a youth continuum of services that are trauma-responsive and culturally-informed, using public health approaches that support positive youth development, build the capacity of community-based approaches, and reduce the justice involvement of youth. Initial efforts will focus on assisting counties probation departments with the realignment of the SB 823 California Department of Corrections and Rehabilitation Division of Juvenile Justice population, providing technical assistance and disseminating best practices to transform the juvenile justice system in order to improve outcomes for justice-involved youth. The FY 2021-22 budget includes OYCR-related resources.

- **Student Mental Health Efforts** – In FY 2019-20, the state funded $50 million ($40 million one-time and $10 million ongoing) to the MHSOAC for the Mental Health Student Services Act to distribute funds to support partnerships between schools and mental health agencies and providers. The state’s FY 2021-22 budget includes an augmentation of $205 million to support the grant program. It also included $45 million in one-time federal funds provided to expand existing community schools, and $3 billion Proposition 98 General Fund, available over several years, to expand and strengthen the implementation and use of the community school model to all schools in communities with high levels of poverty. Community schools partner with education, county, and nonprofit entities to provide integrated health, mental health, and social services alongside high-quality, supportive instruction. Over $140 million of the nearly $3 billion will support the establishment of regional technical assistance centers across the state to assist local educational agencies in establishing and maintaining community schools using multiple funding sources to meet students' needs.
- **Children’s System of Care (AB 2083)** – CalHHS convened all child-serving departments within the agency to strengthen California’s children’s system of care, which was accelerated with the passage of AB 2083 (2018). The result of these efforts is guidance for the development of local Memorandums of Understanding (MOUs), including a template, as well as the establishment of a dispute resolution process for any issues that are unable to be resolved at the local level. As of September 2021, 43 counties have completed their MOUs. While AB 2083 (2018) “interagency” MOU guidance was developed and is mandated for all local child welfare-serving entities, it could also be used as a model for other efforts wherein multiple entities share a common population (e.g., local entities that share responsibilities for the adult/older adult BH/JI population). More information may be found on the [Agency Systems of Care website](https://www.consume.org/about-us/systems-of-care).

- **Adverse Childhood Experiences (ACEs)** – ACEs can include childhood physical violence, sexual abuse, emotional neglect, poverty or having a family member in prison. Screenings are conducted based on 10 questions that reveal a score; with higher ACE scores being considered a predictor of future justice involvement and negative health outcomes. ACEs science is defining the impact of toxic stress on health outcomes for ages 0-65 and promotes trauma informed care to help resolve the core issue. California became the first United States (U.S.) State to screen individuals for ACEs and the program continues to expand. The 2019-20 State budget included a funding allocation to the California Initiative to Advance Precision Medicine under the Governor’s Office for seven demonstration projects focused on ACEs. The [projects](https://www.consume.org/about-us/systems-of-care), which began implementation in summer 2021, support collaborative research and partnerships to advance a holistic perspective of physical and mental wellbeing.

- **California Health and Human Services Agency Behavioral Health Task Force** – In January 2020, the Governor formed a Behavioral Health Task Force to address the urgent mental health and SUD needs across California. The mission of the task force is to develop recommendations for the Governor about how California can best provide timely access to high-quality behavioral health care for all of its residents. The task force includes representatives from both the public and private sectors to align efforts to address behavioral health challenges from a public health perspective. The task force met regularly throughout 2021 to share their experiences and insights regarding how COVID-19 and society’s awareness of the impact of systemic racism have impacted the behavioral health of Californians, how that impact can be mitigated and how lessons learned should be applied going forward. These workgroup meeting have contributed to advances made by this Administration with respects to improving the behavioral health systems.
Appendix B
Criminal Justice System Updates

Criminal justice reform remains a top priority for the State of California. The impact of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) affected the daily prison and jail operations; however, the California Department of Corrections and Rehabilitation (CDCR), in conjunction with the state health officials took swift action to mitigate the spread of the virus. As CDCR operations resume, the population projections are estimated to continue to increase through 2022-23. Expansion opportunities for rehabilitation programs and quality improvement of existing services from the previous year continue. Highlights related to the criminal justice system are discussed below.

- **CDCR Prison Closures** – The Deuel Vocational Institution, located in the city of Tracy, was deactivated on September 30, 2021, and the Administration announced closure of the California Correctional Center in April 2021.

- **DJJ Transition** – Effective July 1, 2021, Senate Bill (SB) 823 established the Office of Youth and Community Restoration (OYCR) within the California Health and Human Services Agency and, consistent with WIC 2201(a), until July 1, 2023, a subcommittee of the Child Welfare Council will advise on policies, programs and approaches to improve youth outcomes, reduce youth detention, reduce recidivism, and provide recommendations to the OYCR. Similarly, the SB 823 Juvenile Justice Realignment Block Grant allocated approximately $40 million in Fiscal Year (FY) 2021-22, with increasing allocations for FY 2022-23 and 2023-24 and an ongoing set amount after FY 2024-25, to counties to provide custody, care, and supervision of youth who are realigned from DJJ. Board of State and Community Corrections (BSCC) also issued a $9.6 million one-time Youth Programs and Facilities Grant to fund regional hub programs focused on specialized youth populations, including females, sex offenders, and youth with Serious Mental Illness. Additional funds were divided between small, medium, and large counties to support infrastructure and improvement needs to serve the realigned youth. SB 823 requires counties to prepare for the increase in high risk/high needs youth by developing an SB 823 Realignment Plan describing the facilities, programs, placements, services, supervision and reentry strategies that are needed to provide appropriate rehabilitation and supervision services for this population. The plan must be formulated with input from a county specific Juvenile Justice Coordinating Council made up of key leaders, and no less than three community members with expertise and knowledge in the juvenile justice system, which must be submitted to OYCR by January 1, 2022.
- **CDCR Rehabilitative Programs** – CDCR received funding to improve facility infrastructure and equipment (e.g., laptops, expansion of internet bandwidth, development of online academic portals); an expansion resources and rehabilitative programming; investments in workforce development and improvement of services (e.g., hiring and training of staff to increase service capacity); expansion of health services for incarcerated individuals (e.g., telepsychiatry, hiring of personnel to evaluate risks); and the implementation of a one-year pilot program that will require state-appointed attorneys to provide additional counsel to incarcerated persons before they are interviewed for their comprehensive risk assessments.

- **Integrated Substance Use Disorder Treatment (ISUDT) Program** – Launched in January 2020, the ISUDT program is a comprehensive approach to providing timely and evidence-based treatment for individuals with Substance Use Disorders (SUDs) who are incarcerated. The ISUDT program continues to provide evidence-based screening and assessments, access to Medication-Assisted Treatment (MAT), evidence-based cognitive behavioral interventions, supporting housing, and trauma informed care. Since the implementation of the ISUDT program, over 13,000 people currently incarcerated are actively receiving MAT statewide. To learn more about the ISUDT program outcomes you can visit the ISUDT Dashboard.

- **Returning Home Well** – Through a public-private partnership, $30 million was allocated at the beginning of the pandemic to provide transitional housing services and supports to individuals released from CDCR who met their release date or were released on an expedited timeframe due to the COVID-19 PHE that were at risk of being unhoused at the time of their release.

- **Adult Reentry Grants** – A one-time $30 million General Fund allocation to provide additional resources for Adult Reentry Grants was provided to BSCC. These funds will supplement the ongoing baseline $37 million General Fund. Funding will be used to continue the support of the Rental Assistance and Warm Handoff Programs. For FY 2020-21, the Rental Assistance funding was awarded to 23 community-based organizations (CBOs), 53 CBOs were awarded funding for the Warm Handoff program, and 1 CBO was awarded funding for the Rehabilitation of Existing Property program. In addition, the Request for Proposals for the Warm Handoff Grant Cohort II was finalized on February 5, 2021, with implementation occurring from July 1, 2021 to February 28, 2025.
Appendix C
Housing System Updates

Governor Newsom signed the California Comeback Plan in May 2021, part of which invested approximately $12 billion over two years to confront the homelessness crisis. The investments include expanding the Homekey program to add over 40,000 new housing units, special considerations for housing people with mental health needs, expanding clinically enhanced behavioral health housing, and targeted programs and grants for local governments to move people out of unsafe, unhealthy encampments, and into safer, more stable housing. The California Comeback Plan also includes a $10.3 billion Affordable Housing Package, which includes investments to incentivize repurposing unused real estate for new developments, preserve the state’s affordable housing stock, promote affordable homeownership, create more accessory dwelling units, build more housing on state-owned excess land, and invest in farmworker housing. In addition to California’s monumental investments, the United States (U.S.) Department of Housing and Urban Development and the U.S. Interagency Council on Homelessness invested in House America: An All-Hands-on-Deck Effort to Address the Nation’s Homelessness Crisis. House America to address the crisis of homelessness through a Housing First approach, utilizing funding from the American Rescue Plan, which includes 70,000 emergency housing vouchers and $5 billion in HOME Investment Partnership grants.

The 2021-22 Enacted Budget invests more than $10 billion in housing resources and $12 billion over two years in homeless resources ($7.3 billion in 2021-22 and $4.7 billion in 2022-23) to keep expanding stable and affordable housing to individuals and families struggling to stay housed, experiencing homelessness, or at risk of homelessness. Funding from the Budget allowed for multiple state agencies to expanded housing programs that will continue to support the vulnerable populations experiencing homelessness in California. Highlights related to the housing system are discussed below.

- **Project Roomkey / Homekey** – Project Roomkey was established in March 2020 and mobilized federal, state, and local resources to address the homeless crisis and alleviate public health concerns. Over the past year and a half as the nation has been navigating the Coronavirus Disease 2019 (COVID-19) pandemic, Project Roomkey has been instrumental and proven to be a critical intervention to help people experiencing homelessness stabilize, access services, and move into permanent housing. Individuals with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) are more susceptible to underlying health conditions, therefore making them a high risk population for contracting COVID-19. As of July 27, 2021, 33,141 individuals exited project Roomkey and 6,710 entered permanent housing, proving the services provided have been successful in engaging individuals in housing services. The 2021-22 Enacted Budget included the expansion of the Homekey program, which creates additional opportunities for local agencies to purchase and rehabilitate hotels, motels, vacant apartments, and other buildings to provide long-term homes for people experiencing or at risk of homelessness. Nearly 6,000 units have been created by Homekey.
• **Housing is Key** – The federal Consolidated Appropriations Act of 2021 provides tenant protection laws and funding to support the California COVID-19 Rent Relief Program, which was signed by Governor Newsom in January 2021. The Housing is Key program provides assistance with unpaid rent, upcoming rent, and utility assistance for income-eligible Californians who were impacted by COVID-19. Landlords are also eligible to participate in the program if they have renters who are behind on rent and need financial assistance to support income lost. Landlords who participate in the program can be reimbursed for 80 percent of an eligible renter’s unpaid rent, contingent on an agreement to waive the remaining 20 percent. As of September 27, 2021, over 300,000 applications had been received and approximately $650 million of assistance has been disbursed.

• **Homeless Coordinating and Financing Council Action Plan** – The Homeless Coordinating and Financing Council (HCFC) adopted an action plan in March 2021 for addressing homelessness in California. HCFC’s mission is to develop policies and to identify and coordinate resources, benefits, and services to prevent homelessness. The development and adoption of the *Action Plan for Preventing and Ending Homelessness in California* is a significant step forward for the HCFC and for the state of California. This Plan represents a commitment to action-oriented coordination across State agencies and programs and deeper collaboration with public and private partners in communities, in pursuit of a future in which homelessness in California is a rare experience, prevented whenever possible, and is a brief and one-time experience when it cannot be prevented.

• **Homeless Data Integration System (HDIS)** – Through the state’s partnership with 44 regional Continuums of Care (CoC), HDIS provides insight on California’s response to the growing homelessness crisis through a statewide data warehouse. HDIS is California’s first statewide repository of common homelessness data variables, which helps to streamline analyses by combining information from each of the CoCs into one single point of access and to improve the state’s data-informed response towards preventing, reducing, and ultimately ending homelessness. The HDIS site launched on April 7, 2021, and provides point-in-time estimates of the number of people in California who have experienced homelessness and received services.\(^{31}\)

• **Home and Community Based Services (HCBS) Spending Plan** – The American Rescue Plan Act provides states with a temporary increase in federal funds for certain HCBS Medicaid expenditures from April 1, 2021, through March 31, 2022. On July 12, 2021, California Department of Health Care Services (DHCS) submitted to the Centers for Medicare and Medicaid Services (CMS) an initial HCBS Spending Plan and, after receiving CMS’ response, DHCS re-submitted an updated HCBS Spending Plan to CMS on

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\(^{31}\) According to the [U.S. Department of Housing and Urban Development](https://www.hud.gov), the successful implementation of data sharing across systems informs policymakers and advocates on demographics, trends, and the availability and usage of services among the homeless population. Programs that support homeless individuals with SMI, such as Projects for Assistance in Transition from Homelessness (PATH), are able to use data to determine the number of individuals experiencing homelessness or at risk of experiencing homelessness and what services are needed to assist this population.
September 17, 2021. Of the 30 initiatives included in the HCBS Spending Plan, 12 directly relate to the behavioral health / justice involved (BH/JI) populations to address retaining and building a network of home and community-based direct care workers, provide navigation services, and help develop an infrastructure of home and community-based services for the BH/JI population, as well as aging and disabled populations, totally in $2.65 billion in funding. Seven of the twelve initiatives have been approved by CMS and five are currently under review. Of the twelve initiatives that relate to the BH/JI population, five directly relate to supporting the housing needs of the BH/JI population, as described below:

- **In Home Support Services Career Pathways**: Transforms behavioral health system and addresses housing needs.
- **Providing Access and Transforming Health funds for Homeless and HCBS Direct Care Providers**: Builds capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and California’s Medicaid Program (Medi-Cal) coverage of services 30 days prior to release.
- **Traumatic Brain Injury (TBI) Program**: Provides five core services designed to increase independent living skills. These core services are also preventative as many TBI survivors who do not have access to a network of services and supports are at a higher risk of chronic homelessness, institutionalization, imprisonment, and placement in skilled nursing facilities due to an inability to perform activities of daily living and impaired emotional regulation.
- **Community Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations activity**: For the Prison, Jail, and Juvenile Justice Re-entry and Diversion Populations, this proposal will establish interim housing or board and care settings where medical, behavioral and social services are available on-site, as re-entry hubs for this population. This initiative is currently pending.
- **Housing and Homelessness Incentive Program**: As a means of addressing social determinants of health and health disparities, Medi-Cal managed care plans would be able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. This initiative is currently pending.

- **Homeless Housing, Assistance, and Prevention Program** – HCFC within the California Business, Consumer Services and Housing Agency received a third round of funding to administer homeless assistance to local governments through the Homeless Housing, Assistance, and Prevention Program (HHAP), as well as funding to conduct a landscape assessment of state-funded homelessness programs that provide unsheltered outreach services, emergency shelter, housing or housing-based services to people experiencing homelessness or at risk of homelessness. The funding was established through Assembly Bill (AB) 140 (2021), which states grantees must plan to increase partnerships with behavioral health and justice entities, as well as individuals with lived experience of homelessness. The HHAP Standard Agreement to Apply was available from
September 15, 2021, through October 15, 2021, and allowed eligible applicants to receive an initial funding disbursement upon receipt of the form. The HHAP-3 application will be made available by February 2022 and due by June 30, 2022, and applicants will receive the remaining funds at this time. The grant period will run through June 30, 2026, with opportunities to earn bonus funds of up to 18 percent for grantees who meet the program’s performance goals.

**Department of Social Services Programs** – The Department of Social Services received significant funding allocations in the FY 2021-22 Budget to expand existing housing services, including the CalWORKs Housing Support Program, the Bringing Families Home Program, the Housing and Disability Advocacy Program, and the Home Safe Program. The programs offer financial assistance and housing-related wraparound services, including rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, hotel and motel vouchers, legal services, and credit repairs. CalWORKs offers local outpatient services for individuals experiencing behavioral health issues and/or SUD to help remove barriers that may be preventing participants from obtaining and maintaining a job.

**Homeless Youth Emergency Services and Housing Program.** The Governor’s Office of Emergency Services has provided $38 million of grant funding for the Homeless Youth Emergency Services and Housing Program to select 12 non-government organization grantees in counties throughout California to establish or expand access to housing options and provide crisis intervention and stabilization services to homeless youth. Grant applications were due October 18, 2021, and award letters were released on December 23, 2021. The grant period will run from January 1, 2022, through December 31, 2026.

**Returning Home Well** – See Appendix B.

**Adult Reentry Grant** – See Appendix B.

**The Council of State Governments (CSG) Justice Center: Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails** – In February 2021, the CSG Justice Center published a report highlighting policy recommendations to Council on Criminal Justice and Behavioral Health (CCJBH) that address challenges to accessing housing for individuals with behavioral health needs leaving California prisons and jails. The recommendations, and corresponding action items, were derived from interviews with key leaders across California in government, criminal justice, housing, research, and other sections, as well as people who have firsthand experience trying to access housing after incarceration. CCJBH will use the information in the report to support and inform efforts to expand housing and address homelessness, advocating to ensure resources are dedicated to those with behavioral health needs, including those involved with the justice system.
# Appendix D
## Summary of 2021 Full Council/Workgroup Meetings and Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Format</th>
<th>Number Registered</th>
<th>Number Attended</th>
<th>Focus</th>
<th>Meeting Highlights</th>
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<tbody>
<tr>
<td>1/29</td>
<td>Virtual</td>
<td>76</td>
<td>65 (86%)</td>
<td>Policy and Budget Priorities for 2021</td>
<td>• A high-level overview of key budget goals as they related to the justice-involved population provided to the Council.</td>
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<td>• The Council reviewed and approved the 2021 Work Plan.</td>
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<td>• Approved 2021 Council Meeting Dates.</td>
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<tr>
<td>4/30</td>
<td>Virtual</td>
<td>85</td>
<td>59 (69%)</td>
<td>Senate Bill (SB) 369 Veto Message Mandate</td>
<td>• Integrated Services for Mental Ill Parolees program transition updates to Councilmembers and public stakeholders.</td>
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<td>• Council on Criminal Justice and Behavioral Health (CCJBH) Staff provided an update to the Council on Workgroups / project status.</td>
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<td>• California Department of Corrections and Rehabilitation (CDCR)/ California Correctional Health Care Services (CCHCS)/CCJBH facilitated a final Councilmember and stakeholder review of the compilation of identified reentry/transition barriers and strategies to address them in order to address the Governor’s SB 369 Veto Message Mandate, along with a high-level report outline on which the Council voted.</td>
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<tr>
<td>7/30</td>
<td>Virtual</td>
<td>97</td>
<td>63 (65%)</td>
<td>Panel Discussion: Housing and Homelessness</td>
<td>• Appointed Council Member Anita Fisher was introduced.</td>
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<td>• The California Department of Social Services, Homeless Coordinating and Financing Council, Housing and Community Development, California Department of Health Care Services (DHCS) and CDCR, CDCR Division of Adult Parole Operations and CDCR Division of Rehabilitative Programs (DRP), discussed the impact the pandemic has had on the housing and homelessness crisis.</td>
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<td>• Explored the funding opportunities available and ways to leverage such funds to meet the behavioral health needs of those who are justice system-involved to ensure equity.</td>
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<td>• CJBH Staff provided an update to the Council on Workgroups and the status of CCJBH projects.</td>
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### 2021 WORKGROUP MEETINGS

<table>
<thead>
<tr>
<th>Workgroup</th>
<th>Meeting Dates</th>
<th>Number Registered</th>
<th>Number Attended</th>
<th>Format</th>
<th>Focus</th>
<th>Highlights</th>
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</table>
| Diversion and Reentry      | March 19, 2021                | 110               | 77 (70%)        | Virtual| This workgroup focuses on strategies to increase success for individuals released from jail, prison and State Hospitals, particularly through innovative and effective ways to continue diversion and reentry efforts in the | - Presentation from the California Health Facilities Financing Authority with a Community Services Infrastructure Grant.  
- Presentation on barriers/solutions for SB 369 Veto Message Report.  
- California Department of State Hospitals (DSH) update |

### 2021 FULL COUNCIL MEETINGS (continued)

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| 10/29  | Virtual| 186               | 105             | California Advancing and Innovating Medi-Cal (CalAIM)               | • DHCS provided an overview of the CalAIM initiative.  
• DHCS also discussed current investments and commitment to efforts involving the behavioral health / justice involved (BH/JI) involved population.  
• CCJBH Staff provided an update to the Council on Workgroups and the status of CCJBH projects.  
• CCJBH presented the Council with final legislative report findings and recommendations.  
• Vote taken to approve the 2021 Legislative Report. |
| 12/10  | Virtual| 69                | 66              | Updates on the Lived Experience Projects                           | • Voted on meeting dates for 2022.  
• Discussed 2022 planned projects.  
• Lived Experience contractors provided project updates  
• CCJBH Staff provided an update to the Council on Workgroups and the status of CCJBH projects. |
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<thead>
<tr>
<th>Workgroup</th>
<th>Meeting Dates</th>
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<th>Highlights</th>
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| Juvenile Justice    | March 12, 2021<br>June 25, 2021<br>September 10, 2021 | 77<br>44<br>71   | 47 (61%)<br>25 (57%)<br>29 (41%) | Virtual | This workgroup focused on how to best support the realignment of CDCR Division of Juvenile Justice (DJJ) youth to county supervision per SB 823                                                                                                                                       | • Overview of the formation of the Office of Youth and Community Restoration, current DJJ demographics, money available for infrastructure needs, and preliminary county plan.  
• Impacts of COVID-19 on the BH/JI population from a school system perspective.  
• Discussion of the funding for education in the Governor’s Budget and what programs could be funded to best support this population.  
• Recommendations formulated and discussed with Councilmember advisors.                                                                                                         |
### Report Launch

**Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails: Recommendations to California’s Council on Criminal Justice and Behavioral Health**

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<tr>
<td>8/18/21</td>
<td>Virtual</td>
<td>626</td>
<td>496 (79%)</td>
<td>Public launch of the report, <em>Reducing Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons</em>. Council of State Governments (CSG) Justice Center presented findings and recommendations to increase housing opportunities, guest speakers shared personal stories about the life-changing value of housing, and attendees heard from key State leaders and local partners about why we must prioritize housing for this population using new housing investment opportunities. The purpose of this event was to set the stage for future collaborative efforts around this critical issue.</td>
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### May is Mental Health Awareness

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<tr>
<td>5/4/21</td>
<td>Virtual</td>
<td>81</td>
<td>41 (51%)</td>
<td><strong>CalHope</strong>: The Department of Health Care Services, California Mental Health Services Authority (CalMHSA) and the Multi-Ethnic Collaborative of Community Agencies presented on safe, secure, and culturally sensitive emotional support provided through CalHope for all Californians needing support related to the impacts of COVID-19.</td>
</tr>
<tr>
<td>5/12/21</td>
<td>Virtual</td>
<td>93</td>
<td>45 (48%)</td>
<td><strong>A Spotlight on Housing</strong>: The CSG Justice Center presented their housing report, <em>Reducing Homelessness for People with Behavioral Health Needs Leaving Prison and Jails</em> and the Department of Housing and Community Development presented on their COVID-19 Rental Assistance program.</td>
</tr>
<tr>
<td>5/19/21</td>
<td>Virtual</td>
<td>171</td>
<td>90 (53%)</td>
<td><strong>CCJBH Lived Experience Project</strong>: CCJBH contractors, Cal Voices and Transitions Clinic Network (TCN), presented on their CCJBH Lived Experience Project, as well as the anticipated deliverables, all within a framework of success and recovery.</td>
</tr>
<tr>
<td>5/26/21</td>
<td>Virtual</td>
<td>52</td>
<td>25 (48%)</td>
<td><strong>Innovative Behavioral Health County Programs</strong>: Nevada County Behavioral Health presented on their Proposition 47 program and Santa Barbara Behavioral Health on their Crisis, Recovery, Engagement, Diversion, and Outreach (CREDO 47) crisis intervention program.</td>
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### September: Suicide Prevention and Recovery Awareness Week

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<tr>
<td>9/8/21</td>
<td>Virtual</td>
<td>83</td>
<td>61 (73%)</td>
<td>California Department of Public Health (CDPH) highlighted state suicide and self-harm data, providing a detailed examination to show how suicide and self-harm have been experienced differently by age, race/ethnicity and/or sex, particularly during the COVID-19 PHE. Information was also provided on the new CDPH Center for Healthy Communities, Injury and Violence Prevention Branch, Office of Suicide Prevention, as well as evidence-based suicide prevention strategies. CalMHSA was also present and provided an overview of resources available to the community.</td>
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### Recovery Awareness Month

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<tr>
<td>9/15/21</td>
<td>Virtual</td>
<td>170</td>
<td>119 (70%)</td>
<td>The Department of Health Care Services discussed youth recovery programs, including youth served under the Drug Medi-Cal Organized Delivery System. In addition, perspectives from former justice-system involved individuals was shared by members of the Anti-Recidivism Coalition to highlight successes and challenges for serving this vulnerable population.</td>
</tr>
<tr>
<td>9/22/21</td>
<td>Virtual</td>
<td>124</td>
<td>96 (77%)</td>
<td>CCHCS provided an overview and update on the Integrated Substance Use Disorder Treatment Program. Additionally, the Transitions Clinic Network shared how their Community Health Workers, individuals with lived experience in the behavioral health and criminal justice systems, have worked in collaboration with CCHCS to successfully support individuals who are in need of Substance Use Disorder (SUD) (and other) services as they transition from incarceration to their communities.</td>
</tr>
<tr>
<td>9/29/21</td>
<td>Virtual</td>
<td>100</td>
<td>56 (56%)</td>
<td>As a provider contracted with the DRP’s Specialized Treatment for Optimized Programming, the Amity Foundation provides a myriad of reentry services including, but not limited to, case management, linkage and support to access mental health, linkage and support to employment services and SUD services, housing and social supports. Amity Foundation provided an overview of their program and services, including perspectives from individuals with lived experienced who have benefitted from this comprehensive approach to reentry services that are designed to support individuals transitioning from incarceration to their communities. DRP was also in attendance to welcome the speakers.</td>
</tr>
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Appendix E
Juvenile Justice Workgroup Participants

On March 12th, June 25th, and September 10th, 2021, the Council on Criminal Justice and Behavioral Health (CCJBH) convened a Juvenile Justice Workgroup to discuss creative and effective strategies in Juvenile Justice Realignment. Workgroup participants are listed below.

Councilmember Workgroup Leads:

Mack Jenkins, Chief Probation Officer (Retired), San Diego County Probation, Council member, CCJBH
Danitza Pantoja, Psy.D, School Psychologist, Antelope Valley Union High School, Council member, CCJBH

CCJBH Staff Workgroup Leads:

Brenda Grealish, Executive Officer
Monica Campos, Staff Services Manager III
Emily Grichuhin, Staff Services Analyst

Participating Organizations/Perspectives:

- Board of State and Community Corrections
- Cal Voices
- California Department of Corrections and Rehabilitation (CDCR)
- California Department of Education
- California Department of Finance
- California Health and Human Services Agency
- California Department of Health Care Services
- California District Attorneys Association
- Californians for Safety and Justice
- California State Association of Counties
- Center for Children
- Central Coast Counseling Services
- Central Valley Youth for Christ
- Chief Probation Officers of California
- Community Medical Centers
- Community Research Foundation
- County Behavioral Health Directors Association
- Division of Juvenile Justice, CDCR
- Fields Comprehensive Youth Services
- Fresno County
- Glenn County
• Hathaway-Sycamores Child and Family Services
• Judicial Council of California
• Merced County
• Monterey County
• Monterey Peninsula Unified School District
• National Alliance on Mental Illness (Urban Los Angeles)
• Operation New Hope Youth Opportunity Centers
• Rancho San Antonio Boys Home
• Riverside University Health System
• Root & Rebound
• Sacramento City
• San Bernardino County Department of Behavioral Health
• San Joaquin Behavioral Health Services
• Second Change Program
• Solano County Office of Education
• Stanislaus County Behavioral Health and Recovery Services
• Timelist Group
• University of California, Davis
• Valley Teen Ranch
• Youth Solutions
Appendix F
Summary of Juvenile Justice Workgroup
Discussions, Presentations and Workgroup Findings

The findings and recommendations related to the justice population were based on the Council on Criminal Justice and Behavioral Health (CCJBH) staff research and discussions that occurred within the March and June 2021 CCJBH Juvenile Justice Workgroup, all of which are compiled below.

The March 2021 Juvenile Justice Workgroup focused on the implementation of Senate Bill (SB) 823, Juvenile Justice Realignment, and how to best support the realigned youth at the county level. The workgroup featured presentations from a number of key state agencies who will influence the successful implementation, including California Health and Human Services Agency (CalHHS), California Department of Corrections and Rehabilitation Division of Juvenile Justice (DJJ), Board of State and Community Corrections (BSCC), and Chief Probation Officers of California (CPOC). CalHHS gave an overview of the Office of Youth and Community Restoration (OYCR), which included background on the statute and outlined the key responsibilities of the OYCR. DJJ gave an update on the total population in the facility at that time and their plans to downsize operations and work with county partners and the Judicial Council to determine realignment plans for those youth whose indeterminate sentencing date is after the June 30, 2023, the date in which all DJJ facilities will be permanently closed. The BSCC shared information on their Request for Application for the Youth Programs and Facilities Grant, which allocated $9.6 million to youth realignment resulting from SB 823. The grant awarded counties one-time funding for infrastructure related needs and improvements to assist in the development of a local continuum of care. CPOC summarized their efforts to prepare for the influx of high risk/high need youth as a result of SB 823, namely their plan to categorize counties based on the level of service they will be able to provide. Counties will be categorized as:

1) Independent Counties – counties who have the services necessary to serve the youth in their county.
2) Host Counties – counties who have services to support both their population and youth from other counties as needed.
3) Partner Counties – counties who will need to contract with other counties for all their services.
4) Hybrid Counties – counties who will need to contract with other counties for specialized services, but have the necessary services to meet the needs of the majority of their population.

The June 2021 Juvenile Justice Workgroup focused on the impacts of the Coronavirus Disease 2019 (COVID-19) public health emergency on youth who are justice involved. The workgroup featured a panel with the Department of Education, and other knowledgeable education partners from the Monterey Peninsula School District and the Antelope Union Valley High School District. The panel discussed the unique needs of justice-involved youth with behavioral health needs as they return to in-person school and the possible increase in behavioral health
issues due to trauma faced during the pandemic. The panel also discussed new funding opportunities available to this population and the new investments in mental health and community schools. Panelists emphasized the importance of expanding resources and positioning schools to become centers of wellness that are able to offer services for this population. Additionally, the panel suggested general recommendations that would serve youth with behavioral health needs in the justice system, such as uniformity and consistency between county agencies and across all counties and the development of transition plans for youth who leave juvenile facilities and return to the school system.

The September 2021 Juvenile Justice Workgroup focused on formulating recommendations that build off Council input, workgroup presentation information, and previous year legislative report recommendations. The findings and recommendations gathered through the March and June Juvenile Justice Workgroups have been categorized into prevention and intervention, SB 823, and COVID-19 impacts for justice involved youth, as well as general findings and recommendations for school based supports for justice involved youth. As Councilmember advisors discussed the findings and recommendations, they emphasized the importance of providing definitions for key terms in order to establish baselines for cross-system partnerships. The following key terms are defined to give context to the report and serve as a starting point of conversation.

Definitions:

Juvenile Justice System

The “juvenile justice system” encompasses more than juvenile halls, juvenile institutions and/or incarceration, in general, which is a point that is frequently lost in discussions about justice-involved youth even though the data are clear that the percentage of youth in the juvenile justice system is five times greater than those incarcerated, and many youth who come into contact with the juvenile justice system do not experience incarceration at all. This report, including relevant recommendations, focuses on all justice-involved youth, not just those who experience a period of incarceration.

At-Promise Youth

There are youth who may be at-risk of juvenile justice system involvement as a result of many factors, such as home environment, abuse, academic failure, negative peer influence, early substance use problems, mental health issues, etc., but have not yet experienced a police contact, so they cannot accurately be described as “justice involved.” However it is important to address these youth in this report to understand and advocate for an appropriate response. Given the movement away from the term “at-risk” when referring to youth as per Assembly Bill (AB) 413, these youth will be referred to as “at-promise” youth.
Justice-involved Youth

For this report, the term “justice-involved” refers to youth who have had, at a minimum, at least one police contact. That contact may or may not have resulted in a formal entry into the juvenile justice system (e.g., having a petition filed), but it presents the possibility that the youth could ultimately fall under the jurisdiction of the juvenile court.

Juvenile Justice Workgroup Findings

Prevention

1. There are multiple entities that can identify “at-promise” youth and refer them to community-based services designed to address the factors or issues that place them at risk of future justice system involvement. These entities include schools, counseling programs, community centers, etc. Research on chronic involvement in the juvenile justice system (i.e., youth who penetrate deeply and repeatedly in the juvenile justice system) is clear on the factors that may be used for such identification, including:
   - First arrest before age 13
   - Some form of family dysfunction
   - Academic failure
   - Justice-involved peers
   - Substance use beyond experimentation

2. The presence of a single factor is not predictive, but youth presenting with two or more of those factors are at greater risk of not only entering the system, but remaining in the system until the age of majority.

3. Furthermore, most youth who do have a police contact, or who actually enter the juvenile justice system, do not penetrate deeply or repeatedly, but would benefit from referrals to appropriate community-based services. In fact, 54 percent of males and 73 percent of females who have one contact never return before they become adults. Thus, the point of intervening early and at the appropriate level with “at-promise” youth to prevent formal and deep penetration into the system is made.

4. In the juvenile justice case processing continuum, probation (by statute) plays a screening role for youth who have a law enforcement contact and face the possibility of formally entering the system (having petition filed and subsequently sustained). California law requires probation to evaluate the youth, including the circumstances of the referral, to determine whether the youth needs to formally enter the system or can be redirected (diverted) to an alternative course of action, which can include counseling

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and other community-based programs. Of the 71,000 juveniles referred to probation in 2018, only about 7,000 were placed in detention facilities.\footnote{California’s Historic Juvenile Justice Evolution: Led by Chief Probation Officers, California has seen a historic shift in how we serve youth referred to our justice system.}

**Intervention**

5. Based on data that is available from probation departments around the state, youth who do enter the system have been assessed as having a high risk to recidivate, and also generally have behavioral health needs. Research has demonstrated that there should be minimal supervision/interventions for low-risk youth. Conversely, youth who are high-risk and have behavioral health issues should receive higher levels of dedicated resources (supervision and interventions).

**SB 823**

6. A key goal is a reduction in the use of adult court for justice-involved youth.

7. It is critical to ensure that there is consistency across counties such that justice-involved youth have access to needed services no matter where they reside.

8. An important consideration is the transition from the juvenile justice system to career or vocational training. DJJ currently provides this type of training to help reduce recidivism, which help youth to have purpose and career opportunities.

**Mitigating the Impact of COVID-19 on Justice-Involved Youth Returning to School**

9. The pandemic highlighted the disproportionalities that exist in the education system for students with behavioral health needs, especially substance use disorders.

10. Youth involved in the juvenile justice system have always had many additional barriers from homes, neighborhoods, probation conditions, schools, etc., and need additional supports (before and increasingly now due to the pandemic).

11. Many of these students were disengaged before the pandemic; therefore, even more concerted efforts/strategies are needed to engage them during and after the pandemic.

12. Many youth who are justice-involved have experienced some type of abuse, and, schools are a usual place for reporting child abuse. Given the shelter in place orders due to the pandemic, many educators are worried that youth have been getting abused without notice.

13. The pandemic has been a traumatic event. Students have experienced grief and losses.

14. Multi-tier System of Support Tier 1 is for all students to feel safe and secure; therefore, having the reconnection to school is crucial.
General School-based Supports for Justice-Involved Youth

15. Schools should be leveraged as a resource. Funding is not currently an issue. Instead, the issue is accountability and, although the state has strengthened its accountability standards following the veto of AB 1835, there should be coherence across systems and funding streams, with a focus on equity. There is a need for improved coherence across justice and education systems that hasn’t been achieved yet, even with improvements to Local Control and Accountability Plan process.

16. Inclusion takes time and it takes intention. All stakeholders, including parents/families and youth, must be educated on the various systems so that they may be effective partners. Currently, the California Department of Education is approaching this engagement from a multi-systems perspective, seeking to leverage the expertise of trusted messengers (individuals who can help to educate/engage) and inviting interested stakeholders to collaborate with local educational agencies in the development of Significant Disproportionality Comprehensive Coordinated Early Intervening Services Plans.

17. Data currently show an increase in drug use and overdose during pandemic; therefore, it is important to recognize Substance Use Disorder (SUD) in addition to mental health, and youth in the juvenile justice system should have access to the same quality level of treatment as more affluent youth. Punitive responses should be avoided, and instead SUD should be approached through a health care lens. Youth with SUD are likely to relapse more than once, which is part of the process of recovery. If the goal is to decriminalize these youth, placing them in the criminal justice system is not a best practice for recovery. In fact, research shows that incarceration is counterproductive to recovery.

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35 Overdose Deaths Accelerating During COVID-19 | CDC Online Newsroom | CDC
Appendix G
Diversion and Reentry Workgroup Participants

On March 19th, June 18th, September 17th and November 19th, 2021, the Council on Criminal Justice and Behavioral Health (CCJBH) convened Diversion and Reentry Workgroups to discuss innovative ways to prevent individuals released from jail, prison, and state hospitals from returning. Workgroup participants are listed below.

Councilmember Workgroup Leads:

- Mack Jenkins, Chief Probation Officer, Ret. San Diego County
- Stephen Manley, Santa Clara County Superior Court Judge
- Tony Hobson, PhD, Behavioral Health Director, Plumas County

CCJBH Staff Workgroup Members:

- Brenda Grealish, Executive Officer
- Monica Campos, Staff Services Manager III
- Elizabeth Vice, Staff Services Manager II
- Angela Kranz, Research Scientist III
- Jessica Camacho Duran, Health Program Specialist II
- Emily Grichuhin, Staff Services Analyst
- Paige Hoffman, Staff Services Analyst
- Daria Quintero, Graduate Student Assistant

Participating Organizations/Perspectives

- Amity Foundation
- Behavioral Health Concepts, California’s External Quality Review Organization
- Behavioral Health Department, Stanislaus County
- BHAB Rehab (Reforming California’s Mental and Behavioral Health Advisory Boards)
- Cal Voices
- California Behavioral Health Planning Council, Department of Health Care Services
- California Department of Corrections and Rehabilitation (CDCR)
- CDCR, Division of Adult Parole Operations
- CDCR, Division of Rehabilitative Program
- CDCR, Integrated Substance Use Disorder Treatment
- California Department of State Hospitals
- California Health Facilities Financing Authority
- California for Safety and Justice
- California Mental Health Services Oversight and Accountability Commission
- California Association of Alcohol and Drug Program Executives
- Center for Employment Opportunities
• Central Valley Youth for Christ
• Community Research Foundation
• County Behavioral Health Directors Association of California
• Fresno County
• Healing Dialogue and Action
• Heluna Health
• Homeboy Industries
• Imperial County
• Interim, Inc.
• Judicial Council of California
• Los Angeles Regional Reentry Partnership
• Momentum for Health
• NAMI Urban Los Angeles
• Neighborhood House Association
• Public Policy Institute of California
• Pure 1 Organization
• Riverside University Health System
• San Diego County Case Manager
• San Francisco Department of Public Health
• San Luis Obispo County
• Self Awareness & Recovery
• Successful Reentry
• Sutter County
• Telecare Corporation
• The GEO Group, Inc.
• Transitions Clinic Networks
• Tuolumne County
• Youth Solution
Appendix H
Summary of Diversion/Reentry Workgroup Discussions, Presentations and Workgroup Findings

Realizing that the array of services provided through diversion programs is similar to those needed upon reentry, in Calendar Year 2021, the Council on Criminal Justice and Behavioral Health (CCJBH) continued to combine efforts to inform the development of policy recommendations that are relevant to the needs of both the current diversion and reentry populations, which may overlap in many cases, but there are also distinct differences that must be understood when implementing treatments and intervention. Accordingly, CCJBH conducted research and convened Diversion and Reentry Workgroup Meetings to include Councilmember Advisors and diverse stakeholder perspectives from across the state (see Appendix G for a list of organizations that participated in the workgroup).

The March 2021 Diversion and Reentry Workgroup included presentations from the California Health Facilities Financing Authority (CHFFA), with an update on the Community Services Infrastructure Grant Program that funds community alternatives to jail and prison for justice involved individuals with mental health illness, Substance Use Disorder (SUD) or trauma. CHFFA is working closely with the counties to ensure timely completion of all projects and that funds are disbursed before the grant expiration date of June 30, 2022. Counties will submit status reports while the project is underway, upon completion, and annually for the subsequent five years, reflecting client demographics, treatments and services provided, and program outcomes once the program is implemented.

Additionally, the March 2021 Workgroup focused on Senate Bill (SB) 369, which proposed the establishment of a California Reentry Commission to develop a new health and safety agenda for those returning home from custody. In his veto of the bill, the Governor placed the responsibility on the California Department of Corrections and Rehabilitation (CDCR) and CCJBH to engage with stakeholders to evaluate the barriers to reentry and determine the necessary next steps to overcome them. CDCR, California Correctional Health Care Services and CCJBH compiled information from research/technical reports, reentry experts and individuals with lived experience in the behavioral health and criminal justice systems to create a comprehensive inventory of reentry/transition barriers and strategies and solutions that may be implemented to address them. This inventory, referred to as the SB 369 Veto Message Barriers Table, was presented at the March 2021 meeting, with opportunity for stakeholder input at the meeting and for two weeks thereafter.

The June 2021 Diversion and Reentry Workgroup included staff from the California Department of State Hospitals (DSH) who presented an update on the DSH Diversion Program, including the successes and challenges faced during the first half of the three-year pilot program and plans to expand the program. DSH also gave an overview of the DSH Incompetent to Stand Trial (IST) Reevaluation Service that arose out of the COVID-19 pandemic as an emergent need and a way to support the long IST waitlist of people trying to get reevaluated. Individuals waiting in jail on the IST waitlist for more than 60 days since commitment are reevaluated to see if they have
become competent to stand trial. The meeting also included conversations around Involuntary Medication Orders and strategies jails can implement to advance IST efforts.

The September 2021 Diversion and Reentry Workgroup included a presentation on the draft findings and recommendations included in this report. The findings and recommendations gathered through the March and June Workgroup Meetings were categorized into strengthening system capacity; housing and homelessness; research, evaluations and data; and other considerations important to the goal of diverting individuals with behavioral health needs away from the justice system, and ensuring that justice involved individuals with behavioral health care needs reentering communities across the state have access the services necessary to ensure successful reentry following release.

The November 2021 Diversion and Reentry Workgroup explored the concept of deflection, also known as Pre-Arrest Diversion, as a powerful tool to improve community relations and encourage diversion. Deflection is a collaborative intervention connecting public safety and public health systems to create community-based pathways to treatment for people who have mental health and/or SUDs and prevent them from entering into the justice systems creating a pathway to facilitate connections to recovery, housing and social services via case management. Deflection is considered an alternative option to traditional arrest when officers encounter individuals with behavioral health conditions that maybe contributing to their contact with law enforcement.

The following findings were gleaned from the presentations and conversations by Councilmember leads and participating stakeholders:

**Diversion/Reentry Workgroup Findings**

**Strengthening System Capacity**

1. Many individuals with behavioral health (BH) needs who have justice system involvement (JI) are in need of a variety of services across multiple sectors (systems) including, but not limited to behavioral health, criminal justice, housing, and social services, in order to optimize their chances for positive outcomes. Access to these services is critical, yet system partners across these sectors often report that it is difficult to engage this population, and that they are unaware of strategies on how best to address this issue.

2. There is often a lack of formal coordination between these systems (e.g., Memorandums of Understanding) to serve this shared population, and many of these system partners lack the necessary knowledge about one another that is needed to effectively and efficiently engage coordination efforts.

3. The limited formal multi-sector (system) coordination may be resulting in system inefficiencies such as duplication of efforts, missed prevention opportunities, incomplete infrastructure to implement comprehensive programs, and poor user (behavioral health / justice involved (BH/JI) population) experiences that result in frustration/disengagement.
4. A strong, robust system of providers who specialize in addressing the complex needs of the BH/JI population is needed within each of these systems to assist with reentry and to provide community-based services, as needed and appropriate. However, as has been discussed at CCJBH meetings and other related forums, there is an insufficient number of providers within these systems who have this knowledge and expertise, which could be one important reason why engagement of this population into needed services is insufficient (e.g., low utilization of behavioral health services, limited access to and maintenance of housing). There is an unknown number of community-based organizations, or “hidden network,” that have the expertise to provide services to the BH/JI population outside of the larger community systems that are considered to be credible resources for the BH/JI population that could be leveraged to fill current system gaps. Forensic Peer Support Specialists have demonstrated success in addressing and supporting the various needs of the BH/JI population.

5. Addressing these issues of engagement, cross-system knowledge/collaboration and provider capacity/expertise are critical to the success of current initiatives, such as the Department of Health Care Services’ California Advancing and Innovating Medi-Cal (CalAIM) justice-involved proposals; BH/JI diversion, including the DSH’ Diversion Program; and the statewide expansion of housing availability.

6. Examination of the metrics established for CCJBH’s 2025 Goal #2, System Capacity, overall show sufficient capacity in terms of primary care, outpatient mental health, and substance use disorder services, as well as parole and probation criminogenic risks and needs assessment/interventions. Data reporting on mental health residential and psychiatric inpatient treatment are not available at this time, and capacity limitations for residential and inpatient services have been anecdotally reported at the local level. With regard to probation, Assembly Bill 1950 could have an impact that may require more intense programming in shorter periods of time.

Housing/Homelessness

7. The BH/JI population is all-too-often excluded from available housing opportunities for a variety of reasons (e.g., eligibility criteria, stigma), but is extremely vulnerable and critically in need of housing in order to live healthy and productive lives within their community. A lack of housing, a basic human need, further disadvantages their chance for successful outcomes and, in fact, increases the likelihood for preventable negative outcomes that place pressure on health and behavioral health care systems (e.g., emergency service utilization, hospitalization) and criminal justice systems (jails, prisons, probation and parole).

37 These community-based organizations are often funded by grants and other sources, which are not always sustainable.
8. A significant infusion of federal and state funding has been made available to address homelessness in California, which includes an expansion of housing capacity.38

9. Council of State Governments (CSG) Justice Center, supported with funding provided by the Melville Charitable Trust, produced a report for CCJBH, entitled *Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails Recommendations to California’s Council on Criminal Justice and Behavioral Health*, which outlines 10 recommendations in 5 key areas to build infrastructure and system capacity to address the housing needs of the BH/JI population.

10. There are existing/emerging models for housing programs, such as the Denver Supportive Housing Social Impact Bond Initiative, that have demonstrated positive outcomes for individuals experiencing chronic homelessness who frequently use the criminal justice and emergency health systems.

**Research/Evaluation/Data**

11. Data on key issues are not available. For example, as reported in CCJBH’s 19th Annual Legislative Report, information about the prevalence of behavioral health conditions in jails continues to be extremely limited, in part because current data collection is inadequate. Available data on the prevalence of mental health conditions is a proxy measure that is not based on an actual definition of mental illness, and it does not delineate between Any Mental Illness and Serious Mental Illness. There is no available data on the prevalence of SUD in jails.

12. Because of current data limitations, it is unclear whether jails have adequate resources to meet the needs of their populations. Moreover, emergent investments as part of CalAIM, including facilitated referral and linkage to behavioral health services and certain components of pre-release Enhanced Care Management, are conditional on identified behavioral health need. Lack of information about behavioral health needs means that individuals who may be eligible for services may not receive those services.

13. While there has been progress made through the Inter-Agency Data Exchange Agreement (IDEA), IDEA only applies to State agencies, and data sharing between state and local agencies and between local entities is inconsistent. Different state and local systems collect data, but because the data are not consistently linked, service providers are not always able to identify justice-involved individuals who utilize services across multiple systems, which can result in less effective treatment, unmet needs and fragmented, frustrating beneficiary experiences. Absent regular, robust, comprehensive reporting on all services, the BH/JI population could be overlooked in some policymaking decisions, which may not lead to improved outcomes.

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38 See the Homeless Coordinating and Financing Council's *Putting the Funding Pieces Together: Guide to Strategic Uses of New and Recent State and Federal Funds to Prevent and End Homelessness* and the Department of Health Care Services’ *Home and Community Based Services Spending Plan*.
Appendix I
2025 Policy Goals Metrics and Findings

Table I.1.
Goal #1: Prevalence of Behavioral Health Conditions in the United States and California for the General Population Jail and Prison

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<td><strong>Table I.1.</strong></td>
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<td><strong>Any Mental Illness</strong></td>
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<td>United States</td>
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<tr>
<td>General</td>
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<tr>
<td>Any Mental Illness</td>
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<td>Serious Mental Illness</td>
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<td>Substance Use Disorder</td>
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As of May 2021:
- Out of 26 Medi-Cal Managed Care Plans (MCPs), 22 received a conditional pass for compliance with network adequacy standards subject to a resolution of a
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<th>Sector/System Type Measure (Source)</th>
<th>Description</th>
<th>Findings</th>
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|   | distance and provider-to-member ratio standards.\(^{39}\)  
  - For Managed Care Plans (MCPs), outpatient psychiatry is the behavioral health service included in network adequacy requirements.  
  - For Mental Health Plans (MHPs), outpatient psychiatry and outpatient specialty mental health services are included in network adequacy requirements.\(^{40}\)  
  - For Drug Medi-Cal Organized Delivery System (DMC-ODS), both outpatient (including intensive outpatient) treatment and residential treatment, as well as narcotic treatment programs, are included in the network adequacy measure. | corrective action plan, while 4 MCPs fully complied with network adequacy standards. Of 22 MCPs that received a conditional pass, all 22 resolved their corrective action plan by May 2021.  
• Out of 56 county Mental Health Plans (MHP)s, 43 received a conditional pass for compliance with network adequacy standards subject to resolution of a corrective action plan, while 13 MHPs fully complied with network adequacy standards. Of the 43 MHPs that received a conditional pass, 41 resolved their corrective action plan by May 2021.  
• Out of 30 Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, all received a conditional pass for compliance with network adequacy standards, subject to resolution of a corrective action plan. To date, six DMC-ODS counties remain on a corrective action plan. |  

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\(^{39}\) These data only reflect service capacity of the public behavioral health system. As such, these data likely accurately describe health care service capacity for justice-involved adults, but may be less accurate for justice-involved youth since youth may be served by commercial plans rather than Medi-Cal.

\(^{40}\) Mental health inpatient and psychiatric residential services are not captured in the network adequacy measures. However, the new Behavioral Health Continuum Infrastructure Program will award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources.
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<tr>
<th>#</th>
<th>Sector/System Type Measure (Source)</th>
<th>Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>conditional pass and have not resolved their corrective action plan.</td>
</tr>
</tbody>
</table>
| 2.2 | **Income Support** SSI Applications (CDCR) | Individuals transitioning from incarceration may qualify for Supplemental Security Income (SSI) benefits if they meet age and disability criteria and have limited income and other financial resources. *Note: Data on the receipt of SSI benefits is not available at this time. As a result, this metric consists of outcomes for those SSI applications that were submitted prior to release from CDCR.* | As of Fiscal Year 2020-21:  
- 2,389 applications were submitted prior to the individual’s release from California Department of Corrections and Rehabilitation (CDCR).  
- 23% (547) of applications were approved, while 61% (1,452) were pending at the time of reporting. |
| 2.3 | **Community Corrections** Parole and Probation Support and Implementation of Evidence-Based Practices (CDCR and Judicial Council)\(^{41}\) | Information about evidence-based practices administered to the parole population is reported to the California Rehabilitation Oversight Board.  
The Senate Bill (SB) 678 Annual Assessment is administered for probation departments to meet their statutory obligations under Penal Code Sections 1231 and 1233, and to track progress over time. | CDCR indicated that:  
- Nearly 100 percent of currently incarcerated individuals as well as individuals on parole have been tested and have CSRA scores.  
- About 40 percent of individuals on parole participated in programming consistent with their identified risks/needs.\(^{42}\) |

---

\(^{41}\) The Judicial Council already does ongoing reporting on the implementation of EBPs based on the SB 678 Annual Assessment, which provides information about probation departments’ implementation of evidence-based practices, and this reporting indicates substantial progress over time in the last two decades. Data are self-reported by each probation department, and responses are not independently verified after submission. Survey responses likely undercount the implementation of EBPs as probation departments may contract some practices or EBP components out to third parties.

<table>
<thead>
<tr>
<th>#</th>
<th>Sector/System Type Measure (Source)</th>
<th>Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Responding California probation departments indicated that:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 77 percent of medium-risk individuals and 94 percent of high-risk individuals were assessed with a validated tool to identify their criminogenic needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All or nearly all of probation departments supported and monitored the implementation of evidence-based practices to address criminogenic risks/needs, but this was not uniform across different types of practices or individuals on supervision.</td>
</tr>
</tbody>
</table>
Appendix J

County Probation Department Capacity to Implement Evidence-Based Practices

Probation departments vary in their capacity to implement EBPs. With this in mind, the Judicial Council of California annually administers the Senate Bill (SB) 678 Annual Assessment to assess the implementation and outcomes of EBPs across California. The primary aims of the survey tool are for probation departments to meet their statutory obligations under Penal Code Sections 1231 and 1233, and to track progress over time. Progress looks different in every county, and as a result, at this time there are no established statewide benchmarks based on the SB 678 Annual Assessment. The data analyses presented here are based on the Calendar Year 2020 survey administration. Responding counties (57 total) represent nearly all of California’s total population.

Data are self-reported by each probation department, and responses are not independently verified after submission. In addition, survey responses likely undercount the implementation of EBPs as probation departments may contract some practices or EBP components out to third parties.

Emergent policy changes, such as updates to statute that affect probation terms, may affect data reporting moving forward. This is especially likely for changes that are applied retroactively. Findings from data analysis should always be interpreted within contexts. Moving forward, it is essential to explore the relationship between, and impact of, Assembly Bill 1950 on the SB 678 requirements to ensure these new requirements do not adversely impact capacity to maintain the high level of implementation of evidence-based practices that have been established to date.

Implementation of Services Based on Identified Risks and Needs

The SB 678 Annual Assessment indicates that 77 percent of California probation departments assessed individuals identified as medium-risk with a validated tool to identify their criminogenic needs and 94 percent of departments did so for individuals identified as high-risk. All but three California probation departments indicated that at least 75 percent of the sentenced adult felony offenders under their supervision were assessed for risk level with a validated risk assessment tool.

The SB 678 Annual Assessment includes a question about the implementation of services based on identified risks and needs. Individuals on supervision may or may not have written supervision plans (i.e., written plans that identify the issues that individuals on supervision face and provide a guide to addressing those issues), services (e.g., treatment programs or interventions), supervision conditions (i.e., conditions set by the court that must be met by the probationer to reduce risk of reoffending and/or further sanction or revocation), and incentives/rewards (e.g., fewer program requirements or contacts) that are based on their identified risks and needs.
Table 1 displays information about the implementation of services based on identified risks and needs for all actively supervised individuals identified as low, medium, and high-risk. The service component with the highest rates of implementation across all risk levels is found for Supervision Conditions, ranging between 88 (low-risk) to 93 (high-risk) percent of responding probation departments, whereas the service component with the lowest rates of implementation is for Rewards, ranging between 71 (low-risk) and 80 (high-risk) percent. The greatest variation in the implementation between risk levels is found for the Services and Supervision Plan service components. For Services, the implementation rate for probation departments is 68 percent for low-risk, 71 percent for medium-risk and 88 percent for high-risk. The variation is even greater for the Supervision Plan component, with 29 percent of county probation departments implementing the practice for low-risk, 59 percent for medium-risk, and 77 percent for high-risk.

Table K.1: Implementation of Services Based on Identified Risks and Needs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals are supervised in accordance with a written supervision plan.</td>
<td>16</td>
<td>55</td>
<td>29%</td>
<td>33</td>
<td>56</td>
<td>59%</td>
<td>44</td>
<td>57</td>
<td>77%</td>
</tr>
<tr>
<td>Individuals receive the appropriate level of supervision, monitoring, services,</td>
<td>39</td>
<td>57</td>
<td>68%</td>
<td>40</td>
<td>56</td>
<td>71%</td>
<td>50</td>
<td>57</td>
<td>88%</td>
</tr>
<tr>
<td>and treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals receive appropriate sanctions and conditions based on the individual's</td>
<td>50</td>
<td>57</td>
<td>88%</td>
<td>50</td>
<td>56</td>
<td>89%</td>
<td>53</td>
<td>57</td>
<td>93%</td>
</tr>
<tr>
<td>current risk level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals receive appropriate incentives and rewards based on the individual's</td>
<td>40</td>
<td>56</td>
<td>71%</td>
<td>42</td>
<td>55</td>
<td>76%</td>
<td>45</td>
<td>56</td>
<td>80%</td>
</tr>
<tr>
<td>current risk level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Departmental Support and Monitoring of EBPs*

The SB 678 Annual Assessment asks county probation departments if they support and monitor the use of risk and needs assessment, motivational interviewing (i.e., a collaborative, goal-oriented style of communication with particular attention to the language of change) and cognitive behavioral therapy (CBT) (i.e., techniques to identify unhelpful ways of thinking and associated behaviors) using the following methods:

- Follow up basic training with booster training;
- Observe case-carrying officers using EBPs; and/or
- Provide feedback to case-carrying officers on the successful use of EBPs.
Table 2 indicate the percentage of county probation departments that monitored and evaluated the implementation of these EBPs for all adults on probation supervision who were convicted of felony offenses. Nearly all of responding probation departments utilized at least one of the methods mentioned above to support and monitor risk/needs assessments, motivational interviewing, and CBT. At least two-thirds of responding departments utilized at least two of the methods mentioned above to support and monitor each of the aforementioned EBPs, but there was variation by EBP. While 86 percent of responding departments implemented two or more methods to support and monitor the use of risk/needs assessments and 75 percent of responding counties implemented two or more methods to support and monitor the use of motivational interviewing, only 72 percent of responding departments reported that they implemented two or more methods to support and monitor CBT. Comparatively fewer of responding departments reported that they use all three of the methods mentioned above to support and monitor EBPs. The percentage of responding departments using all three methods to support and monitor EBPs hovered between 35 and 53 percent for all of the EBPs identified above.

**Table K.2. Number of Methods Used to Support and Monitor the Use of EBPs**

<table>
<thead>
<tr>
<th>EBPs</th>
<th>1+ n</th>
<th>1+ %</th>
<th>2+ n</th>
<th>2+ %</th>
<th>All 3 n</th>
<th>All 3 %</th>
<th>Total n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>The department supports and monitors the use of risk/needs assessment.</td>
<td>57</td>
<td>100%</td>
<td>49</td>
<td>86%</td>
<td>30</td>
<td>53%</td>
<td>57</td>
<td>100%</td>
</tr>
<tr>
<td>The department supports and monitors the development of intrinsic motivation skills such as Motivational Interviewing.</td>
<td>57</td>
<td>100%</td>
<td>43</td>
<td>75%</td>
<td>28</td>
<td>49%</td>
<td>57</td>
<td>100%</td>
</tr>
<tr>
<td>The department supports and monitors the use of cognitive behavioral therapy techniques, which could include addressing thinking errors, modeling and reinforcing prosocial behavior, and focusing on problem solving.</td>
<td>54</td>
<td>95%</td>
<td>41</td>
<td>72%</td>
<td>20</td>
<td>35%</td>
<td>57</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix K

Medi-Cal Utilization Project: Data and Methods

The analytic sample for the results presented below is all individuals who were released from the California Department of Corrections and Rehabilitation (CDCR) facilities in Fiscal Year (FY) 2018-19 and have at least one month of certified California's Medicaid Program (Medi-Cal) enrollment within the specified time periods post-release (referred to as beneficiaries transitioning from incarceration). CDCR data are from the Strategic Offender Management System. California Department of Health Care Services (DHCS) data are from the Management Information System/Decision Support System.

Claims data are not populated in the DHCS database in real time because of lags in claim submission and processing. For example, there may be a lag of six or more months for specialty mental health claims processed through the Short-Doyle system. Data analyses presented here were conducted in July 2021. As such, data on FY 2018-19 releases are presented because these data permit a complete one-year follow-up period, at minimum, for health care service utilization. Some beneficiaries have a longer follow-up period depending on their release date. The follow-up period is at least one year for all beneficiaries, but is longer for some beneficiaries compared to others. For example, individuals released during the earlier part of FY 2018-19 were in the community for a longer period compared to individuals released later in FY 2018-19. As a result, individuals released earlier in FY 2018-19 had greater opportunity than individuals released later to utilize behavioral health services in the community.

Data on individuals released from CDCR facilities who were not enrolled onto Medi-Cal were not included in these analyses, as the focus of this report is on Medi-Cal utilization. Data on individuals transitioning from jail incarceration are not available at this time, as there is no centralized, statewide database that captures this information.

Overview of CDCR-Identified Behavioral Health Need Measure

The measure of identified behavioral health need is based on the following CDCR data:

- Mental Health Designations, which reflect levels of mental health care received while incarcerated. Examples of mental health designations include Mental Health Crisis Bed and Enhanced Outpatient Program services provided to individuals with serious mental illness, and Correctional Clinical Case Management System services provided to individuals requiring lower levels of care. When individuals had multiple mental health designations, the most recent designation is used. For purposes of this data analysis, all mental health designations are taken as indicators of mental health need.
Substance Use Disorder (SUD) Need, which is taken from the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk/needs assessment. COMPAS is a tool that supports rehabilitation by assessing incarcerated individuals’ needs and targeting those needs through appropriate programming. Custody staff administer the COMPAS to all incarcerated individuals when they are admitted to prison, and administer the COMPAS to parolees upon reentry. The most recent COMPAS information is used for this analysis. Since the reentry COMPAS is only administered to individuals releasing to parole, it was used to identify SUD needs for parolees whereas the intake COMPAS was used to identify SUD needs for individuals released to Post-Release Community Supervision or who were directly discharged. The original question on the assessment categorizes offenders as having no need, a probable need, or a highly probable need for services, including but not limited to substance use disorder treatment. Individuals with both probable and highly probable need for substance use disorder treatment are included in the SUD need category.

Information about Data Match

Nearly 80 percent (30,257 enrolled of 39,149 total releases) of individuals transitioning from CDCR facilities in FY 2018-19 were enrolled onto Medi-Cal within one year of release from prison, as indicated by the rate of matches between the CDCR file (all CDCR releases) and DHCS file (all Medi-Cal beneficiaries). This estimate is consistent with existing reporting regarding the Transitional Case Management Program that CDCR submits to the California Rehabilitation Oversight Board.

DHCS shared a file with CDCR in April 2021, which contained information about all Medi-Cal beneficiaries between July 1, 2012, and December 31, 2020. The DHCS source file contained 19,510,961 records and contained identifying information from the Management Information System/Decision Support System, including First/Last Name, Middle Initial, Social Security Number, and Birth Date. CDCR used a matching strategy detailed in Table K.1, below, which is already employed by CDCR’s Enterprise Information Systems Division for use with CDCR and DHCS data, to identify Medi-Cal beneficiaries transitioning from incarceration. In the initial stage, records were matched on multiple rounds. Subsequently, matched records were de-duplicated and the matched record with the strongest match was retained (A: strongest; E3: weakest). In total, 585,213 records were retained.
Table K.1: Cases Matched and Retained in CDCR-DHCS Data Match

<table>
<thead>
<tr>
<th>Round</th>
<th>Required Elements</th>
<th># Matched</th>
<th># Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>First name, last name, middle initial, DOB</td>
<td>397,181</td>
<td>388,254</td>
</tr>
<tr>
<td>B</td>
<td>First name, last name, DOB</td>
<td>645,617</td>
<td>127,069</td>
</tr>
<tr>
<td>C</td>
<td>Using CDCR’s alias file: first name, last name, DOB</td>
<td>559,588</td>
<td>30,226</td>
</tr>
<tr>
<td>D</td>
<td>Using CDCR’s alias file: first name, last name, DOB</td>
<td>1,057,306</td>
<td>7,597</td>
</tr>
<tr>
<td>E1</td>
<td>SSN, DOB, last name</td>
<td>538,053</td>
<td>10,359</td>
</tr>
<tr>
<td>E2</td>
<td>SSN, DOB, first name</td>
<td>51,078</td>
<td>18,333</td>
</tr>
<tr>
<td>E3</td>
<td>SSN and DOB</td>
<td>15,507</td>
<td>3,375</td>
</tr>
</tbody>
</table>

Source Data for Presented Findings

Table K.2: Managed Care Plan Enrollment among Beneficiaries Transitioning from Incarceration in FY 2018-19 in FY 2018-19 and FY 2019-20, by Specified Time Periods Post-Release

This table presents counts and rates of Managed Care Plan (MCP) enrollment within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.

<table>
<thead>
<tr>
<th>CDCR Identified BH Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>MCP Enrolled</td>
<td>9,117</td>
<td>32%</td>
<td>15,968</td>
<td>55%</td>
<td>20,662</td>
<td>71%</td>
<td>23,780</td>
<td>80%</td>
<td>25,651</td>
<td>85%</td>
<td>27,600</td>
<td>89%</td>
</tr>
<tr>
<td>Total</td>
<td>28,756</td>
<td>100%</td>
<td>29,093</td>
<td>100%</td>
<td>29,302</td>
<td>100%</td>
<td>29,749</td>
<td>100%</td>
<td>30,257</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
</tr>
<tr>
<td>Co-Ocurring</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>MCP Enrolled</td>
<td>1,673</td>
<td>31%</td>
<td>2,969</td>
<td>55%</td>
<td>3,810</td>
<td>70%</td>
<td>4,393</td>
<td>79%</td>
<td>4,802</td>
<td>85%</td>
<td>5,179</td>
<td>89%</td>
</tr>
<tr>
<td>Total</td>
<td>5,376</td>
<td>100%</td>
<td>5,432</td>
<td>100%</td>
<td>5,466</td>
<td>100%</td>
<td>5,545</td>
<td>100%</td>
<td>5,619</td>
<td>100%</td>
<td>5,726</td>
<td>100%</td>
</tr>
<tr>
<td>MH Only</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>MCP Enrolled</td>
<td>674</td>
<td>33%</td>
<td>1,122</td>
<td>55%</td>
<td>1,397</td>
<td>67%</td>
<td>1,624</td>
<td>76%</td>
<td>1,769</td>
<td>81%</td>
<td>1,932</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>2,037</td>
<td>100%</td>
<td>2,057</td>
<td>100%</td>
<td>2,072</td>
<td>100%</td>
<td>2,123</td>
<td>100%</td>
<td>2,175</td>
<td>100%</td>
<td>2,223</td>
<td>100%</td>
</tr>
<tr>
<td>CDCR Identified BH Need at Release</td>
<td>1M</td>
<td>1M</td>
<td>2M</td>
<td>2M</td>
<td>3M</td>
<td>3M</td>
<td>6M</td>
<td>6M</td>
<td>1Y</td>
<td>1Y</td>
<td>1Y+</td>
<td>1Y+</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
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<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>MCP Enrolled</td>
<td>4,602</td>
<td>31%</td>
<td>8,219</td>
<td>55%</td>
<td>10,792</td>
<td>71%</td>
<td>12,435</td>
<td>81%</td>
<td>13,340</td>
<td>85%</td>
<td>14,292</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>14,875</td>
<td>100%</td>
<td>15,053</td>
<td>100%</td>
<td>15,152</td>
<td>100%</td>
<td>15,354</td>
<td>100%</td>
<td>15,604</td>
<td>100%</td>
<td>15,912</td>
<td>100%</td>
</tr>
<tr>
<td>No Identified</td>
<td>1,978</td>
<td>32%</td>
<td>3,422</td>
<td>55%</td>
<td>4,383</td>
<td>70%</td>
<td>5,018</td>
<td>79%</td>
<td>5,398</td>
<td>83%</td>
<td>5,825</td>
<td>88%</td>
</tr>
<tr>
<td>MCP Enrolled</td>
<td>6,109</td>
<td>100%</td>
<td>6,190</td>
<td>100%</td>
<td>6,243</td>
<td>100%</td>
<td>6,348</td>
<td>100%</td>
<td>6,470</td>
<td>100%</td>
<td>6,624</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>100%</td>
<td>361</td>
<td>100%</td>
<td>369</td>
<td>100%</td>
<td>379</td>
<td>100%</td>
<td>389</td>
<td>100%</td>
<td>404</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table K.3: Behavioral Health Penetration and Engagement Rates for Beneficiaries Transitioning from Incarceration in FY 2018-19 in FY 2018-19 and FY 2019-20, by Specified Time Periods Post-Release**

This table presents counts and rates of behavioral health (BH) service utilization stratified by identified behavioral health need at release. It reflects up to a two-year follow-up period for service utilization, which varies depending on release date (i.e., individuals released earlier in FY 2018-19 have a longer period to utilize services). The measure of behavioral health need is taken from the CDCR data. Penetration rates, indicating utilization of one or more (1+) services, and engagement rates, indicating utilization of five or more (5+) services, are presented.
<table>
<thead>
<tr>
<th>CDCR Identified BH Need at Release</th>
<th>#</th>
<th>Any BH</th>
<th>Any BH</th>
<th>Non-SMH</th>
<th>Non-SMH</th>
<th>SMH</th>
<th>SMH</th>
<th>SUD</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Overall</td>
<td>1+</td>
<td>10,832</td>
<td>35%</td>
<td>4,045</td>
<td>13%</td>
<td>4,527</td>
<td>15%</td>
<td>7,359</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>5+</td>
<td>6,112</td>
<td>20%</td>
<td>832</td>
<td>3%</td>
<td>2,607</td>
<td>8%</td>
<td>3,653</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>30,889</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
</tr>
<tr>
<td>Co-Occurring</td>
<td>1+</td>
<td>3,233</td>
<td>56%</td>
<td>1,483</td>
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<td>1,885</td>
<td>33%</td>
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<td>5,726</td>
<td>100%</td>
</tr>
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<td>6,624</td>
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<td>100%</td>
<td>404</td>
<td>100%</td>
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</table>

**Table K.4: Any Behavioral Health Delivery System Utilization among Beneficiaries Transitioning from Incarceration in FY 2018-19 in FY 2018-19 and FY 2019-20, by Specified Time Periods Post-Release**

This table presents counts and rates of any behavioral health (BH) service utilization within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health need at release. The measure of behavioral health need is taken from the CDCR data. Utilization of services in the non-specialty and specialty mental health systems, as well as substance use disorder services, is presented.
<table>
<thead>
<tr>
<th>CDCR Identified BH Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
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<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
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<td>5,071</td>
<td>17%</td>
<td>7,118</td>
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<td>9,550</td>
<td>32%</td>
<td>10,832</td>
<td>35%</td>
</tr>
<tr>
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<td>100%</td>
<td>29,093</td>
<td>100%</td>
<td>29,302</td>
<td>100%</td>
<td>29,749</td>
<td>100%</td>
<td>30,257</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
</tr>
<tr>
<td>Co-Occurring</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ BH</td>
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<td>1,528</td>
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<td>1,774</td>
<td>32%</td>
<td>2,307</td>
<td>42%</td>
<td>2,925</td>
<td>52%</td>
<td>3,233</td>
<td>56%</td>
</tr>
<tr>
<td>Total</td>
<td>5,376</td>
<td>100%</td>
<td>5,432</td>
<td>100%</td>
<td>5,466</td>
<td>100%</td>
<td>5,545</td>
<td>100%</td>
<td>5,619</td>
<td>100%</td>
<td>5,726</td>
<td>100%</td>
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<tr>
<td>MH Only</td>
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</tr>
<tr>
<td>Utilized 1+ BH</td>
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<td>658</td>
<td>32%</td>
<td>741</td>
<td>36%</td>
<td>914</td>
<td>43%</td>
<td>1,102</td>
<td>51%</td>
<td>1,213</td>
<td>55%</td>
</tr>
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<td>100%</td>
<td>2,057</td>
<td>100%</td>
<td>2,072</td>
<td>100%</td>
<td>2,123</td>
<td>100%</td>
<td>2,175</td>
<td>100%</td>
<td>2,223</td>
<td>100%</td>
</tr>
<tr>
<td>SUD Only</td>
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</tr>
<tr>
<td>Utilized 1+ BH</td>
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<td>1,529</td>
<td>10%</td>
<td>1,932</td>
<td>13%</td>
<td>2,936</td>
<td>19%</td>
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<td>27%</td>
<td>4,800</td>
<td>30%</td>
</tr>
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<td>100%</td>
<td>15,053</td>
<td>100%</td>
<td>15,152</td>
<td>100%</td>
<td>15,354</td>
<td>100%</td>
<td>15,604</td>
<td>100%</td>
<td>15,912</td>
<td>100%</td>
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</tr>
<tr>
<td>Utilized 1+ BH</td>
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<td>414</td>
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<td>523</td>
<td>8%</td>
<td>830</td>
<td>13%</td>
<td>1,176</td>
<td>18%</td>
<td>1,409</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>6,109</td>
<td>100%</td>
<td>6,190</td>
<td>100%</td>
<td>6,243</td>
<td>100%</td>
<td>6,348</td>
<td>100%</td>
<td>6,470</td>
<td>100%</td>
<td>6,624</td>
<td>100%</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Utilized 1+ BH</td>
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<td>101</td>
<td>27%</td>
<td>131</td>
<td>35%</td>
<td>165</td>
<td>42%</td>
<td>177</td>
<td>44%</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>100%</td>
<td>361</td>
<td>100%</td>
<td>369</td>
<td>100%</td>
<td>379</td>
<td>100%</td>
<td>389</td>
<td>100%</td>
<td>404</td>
<td>100%</td>
</tr>
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</table>

**Table K.5: Managed Care Plan (Non-Specialty Mental Health Service) Utilization among Beneficiaries Transitioning from Incarceration in FY 2018-19 in FY 2018-19 and FY 2019-20, by Specified Time Periods After Release**

This table presents counts and rates of Managed Care Plans non-specialty mental health service utilization within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.
<table>
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<tr>
<th>CDCR Identified BH Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Utilized 1+ NSMHS</td>
<td>497</td>
<td>2%</td>
<td>855</td>
<td>3%</td>
<td>1,188</td>
<td>4%</td>
<td>2,055</td>
<td>7%</td>
<td>3,260</td>
<td>11%</td>
<td>4,045</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
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<td>100%</td>
<td>29,093</td>
<td>100%</td>
<td>29,302</td>
<td>100%</td>
<td>29,749</td>
<td>100%</td>
<td>30,257</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
</tr>
<tr>
<td>Co-Occurring</td>
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</tr>
<tr>
<td>Utilized 1+ NSMHS</td>
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<td>345</td>
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<td>474</td>
<td>9%</td>
<td>778</td>
<td>14%</td>
<td>1,216</td>
<td>22%</td>
<td>1,483</td>
<td>26%</td>
</tr>
<tr>
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<td>100%</td>
<td>5,432</td>
<td>100%</td>
<td>5,466</td>
<td>100%</td>
<td>5,545</td>
<td>100%</td>
<td>5,619</td>
<td>100%</td>
<td>5,726</td>
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</tr>
<tr>
<td>Utilized 1+ NSMHS</td>
<td>94</td>
<td>5%</td>
<td>159</td>
<td>8%</td>
<td>201</td>
<td>10%</td>
<td>309</td>
<td>15%</td>
<td>478</td>
<td>22%</td>
<td>585</td>
<td>26%</td>
</tr>
<tr>
<td>Total</td>
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<td>2,057</td>
<td>100%</td>
<td>2,072</td>
<td>100%</td>
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<td>100%</td>
<td>2,175</td>
<td>100%</td>
<td>2,223</td>
<td>100%</td>
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<tr>
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</tr>
<tr>
<td>Utilized 1+ NSMHS</td>
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<td>378</td>
<td>2%</td>
<td>714</td>
<td>5%</td>
<td>1,156</td>
<td>7%</td>
<td>1,456</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>14,875</td>
<td>100%</td>
<td>15,053</td>
<td>100%</td>
<td>15,152</td>
<td>100%</td>
<td>15,354</td>
<td>100%</td>
<td>15,604</td>
<td>100%</td>
<td>15,912</td>
<td>100%</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Utilized 1+ NSMHS</td>
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<td>83</td>
<td>1%</td>
<td>111</td>
<td>2%</td>
<td>222</td>
<td>3%</td>
<td>359</td>
<td>6%</td>
<td>462</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>6,109</td>
<td>100%</td>
<td>6,190</td>
<td>100%</td>
<td>6,243</td>
<td>100%</td>
<td>6,348</td>
<td>100%</td>
<td>6,470</td>
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<td>6,624</td>
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<td></td>
</tr>
<tr>
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<td>20</td>
<td>6%</td>
<td>24</td>
<td>7%</td>
<td>32</td>
<td>8%</td>
<td>51</td>
<td>13%</td>
<td>59</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>100%</td>
<td>361</td>
<td>100%</td>
<td>369</td>
<td>100%</td>
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<td>100%</td>
<td>389</td>
<td>100%</td>
<td>404</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table K.6: Mental Health Plan (Specialty Mental Health Service) Utilization among Beneficiaries Transitioning from Incarceration in FY 2018-19 in FY 2018-19 and FY 2019-20, by Specified Time Periods Post-Release

This table presents counts and rates of Mental Health Plan specialty mental health service utilization within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.

<table>
<thead>
<tr>
<th>CDCR Identified Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
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<td>2,167</td>
<td>7%</td>
<td>2,486</td>
<td>8%</td>
<td>3,152</td>
<td>11%</td>
<td>3,985</td>
<td>13%</td>
<td>4,527</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
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<td>100%</td>
<td>29,093</td>
<td>100%</td>
<td>29,302</td>
<td>100%</td>
<td>29,749</td>
<td>100%</td>
<td>30,257</td>
<td>100%</td>
<td>30,889</td>
<td>100%</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
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<td>954</td>
<td>18%</td>
<td>1,082</td>
<td>20%</td>
<td>1,352</td>
<td>24%</td>
<td>1,660</td>
<td>30%</td>
<td>1,885</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>5,376</td>
<td>100%</td>
<td>5,432</td>
<td>100%</td>
<td>5,466</td>
<td>100%</td>
<td>5,545</td>
<td>100%</td>
<td>5,619</td>
<td>100%</td>
<td>5,726</td>
<td>100%</td>
</tr>
<tr>
<td>MH Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
<td>454</td>
<td>22%</td>
<td>516</td>
<td>25%</td>
<td>570</td>
<td>28%</td>
<td>678</td>
<td>32%</td>
<td>792</td>
<td>36%</td>
<td>858</td>
<td>39%</td>
</tr>
<tr>
<td>Total</td>
<td>2,037</td>
<td>100%</td>
<td>2,057</td>
<td>100%</td>
<td>2,072</td>
<td>100%</td>
<td>2,123</td>
<td>100%</td>
<td>2,175</td>
<td>100%</td>
<td>2,223</td>
<td>100%</td>
</tr>
<tr>
<td>SUD Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
<td>367</td>
<td>2%</td>
<td>478</td>
<td>3%</td>
<td>573</td>
<td>4%</td>
<td>772</td>
<td>5%</td>
<td>1,077</td>
<td>7%</td>
<td>1,275</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>14,875</td>
<td>100%</td>
<td>15,053</td>
<td>100%</td>
<td>15,152</td>
<td>100%</td>
<td>15,354</td>
<td>100%</td>
<td>15,604</td>
<td>100%</td>
<td>15,912</td>
<td>100%</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
<td>137</td>
<td>2%</td>
<td>162</td>
<td>3%</td>
<td>196</td>
<td>3%</td>
<td>270</td>
<td>4%</td>
<td>366</td>
<td>6%</td>
<td>415</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>6,109</td>
<td>100%</td>
<td>6,190</td>
<td>100%</td>
<td>6,243</td>
<td>100%</td>
<td>6,348</td>
<td>100%</td>
<td>6,470</td>
<td>100%</td>
<td>6,624</td>
<td>100%</td>
</tr>
<tr>
<td>Unknown</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Table K.7: Drug Medi-Cal (Substance Use Disorder Service) Utilization in FY 2018-19 and FY 2019-20 among Beneficiaries Transitioning from Incarceration in FY 2018-19, by Specified Time Periods Post-Release

This table presents counts and rates of Drug Medi-Cal substance use disorder service utilization, which includes County Drug Medi-Cal and Drug Medi-Cal Organized Delivery System counties, within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.

<table>
<thead>
<tr>
<th>CDCR Identified Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Utilized 1+ SMHS</td>
<td>49</td>
<td>14%</td>
<td>57</td>
<td>16%</td>
<td>65</td>
<td>18%</td>
<td>80</td>
<td>21%</td>
<td>90</td>
<td>23%</td>
<td>94</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>100%</td>
<td>361</td>
<td>100%</td>
<td>369</td>
<td>100%</td>
<td>379</td>
<td>100%</td>
<td>389</td>
<td>100%</td>
<td>404</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table K.7: Drug Medi-Cal (Substance Use Disorder Service) Utilization in FY 2018-19 and FY 2019-20 among Beneficiaries Transitioning from Incarceration in FY 2018-19, by Specified Time Periods Post-Release**

This table presents counts and rates of Drug Medi-Cal substance use disorder service utilization, which includes County Drug Medi-Cal and Drug Medi-Cal Organized Delivery System counties, within one month (1M), two month (2M), three month (3M), six month (6M), one year (1Y), and over one year (1Y+) time periods, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.
Table K.8: Demographic Attributes of Medi-Cal Beneficiaries Transitioning from Incarceration in FY 2018-19 and Enrolled Onto Medi-Cal Within One Year

This table presents demographic attributes of the analytic sample, stratified by identified behavioral health (BH) need at release. The measure of behavioral health need is taken from the CDCR data.

<table>
<thead>
<tr>
<th>CDCR Identified Need at Release</th>
<th>1M</th>
<th>1M</th>
<th>2M</th>
<th>2M</th>
<th>3M</th>
<th>3M</th>
<th>6M</th>
<th>6M</th>
<th>1Y</th>
<th>1Y</th>
<th>1Y+</th>
<th>1Y+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Utilized 1+ DMC</td>
<td>141</td>
<td>2%</td>
<td>215</td>
<td>3%</td>
<td>293</td>
<td>5%</td>
<td>497</td>
<td>8%</td>
<td>772</td>
<td>12%</td>
<td>954</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>6,109</td>
<td>100%</td>
<td>6,190</td>
<td>100%</td>
<td>6,243</td>
<td>100%</td>
<td>6,348</td>
<td>100%</td>
<td>6,470</td>
<td>100%</td>
<td>6,624</td>
<td>100%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilized 1+ DMC</td>
<td>38</td>
<td>11%</td>
<td>47</td>
<td>13%</td>
<td>56</td>
<td>15%</td>
<td>76</td>
<td>20%</td>
<td>111</td>
<td>29%</td>
<td>121</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>100%</td>
<td>361</td>
<td>100%</td>
<td>369</td>
<td>100%</td>
<td>379</td>
<td>100%</td>
<td>389</td>
<td>100%</td>
<td>404</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30,257</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identified Behavioral Health Need</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Occurring Mental Health Designation and SUD</td>
<td>5,619</td>
<td>19%</td>
</tr>
<tr>
<td>Mental Health Designation without SUD</td>
<td>2,175</td>
<td>7%</td>
</tr>
<tr>
<td>SUD with No/Unknown Mental Health Designation</td>
<td>15,604</td>
<td>52%</td>
</tr>
<tr>
<td>No Identified Behavioral Health Need</td>
<td>6,470</td>
<td>21%</td>
</tr>
<tr>
<td>Unknown Behavioral Health Need</td>
<td>389</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>290</td>
<td>1%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>655</td>
<td>2%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>6,077</td>
<td>20%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10,962</td>
<td>36%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5,161</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>White</td>
<td>7,112</td>
<td>24%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,400</td>
<td>8%</td>
</tr>
<tr>
<td>Male</td>
<td>27,857</td>
<td>92%</td>
</tr>
</tbody>
</table>