



Building bridges to prevent incarceration



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Overview of the Council on Criminal Justice and Behavioral Health

Established by [CA Penal Code Section 6044\(a\)](#), the Council on Criminal Justice and Behavioral Health (CCJBH) is a 12-member council chaired by the Secretary of the California Department of Corrections and Rehabilitation (CDCR) and is comprised of the Department of State Hospitals (DSH), the Department of Health Care Services (DHCS), and appointed expert representatives from the criminal justice and behavioral health fields such as probation, court officers, and mental health care professionals. CCJBH serves as a resource to assist and advise the administration and legislature on best practices to reduce the incarceration of youth and adults with mental illness and substance use disorders (SUDs) with a focus on prevention, diversion, and reentry strategies.

The 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*, CCHS

Vice Chair: Will Lightbourne, *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.

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

Tony Hobson, Ph.D., *Behavioral Health Director*, Plumas County. 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.

Acronyms

AB	Assembly Bill
AB 109	California Public Safety Realignment Act of 2011
ACEs	Adverse Childhood Experiences
AI/AN	American Indian/Alaska Natives
AMI	Any Mental Illness
ARC	Anti-Recidivism Coalition
ATI	Alternatives to Incarceration
BH/CJ	Behavioral Health/Criminal Justice Population
BJMHS	Brief Justice Mental Health Screen
BJS	Bureau of Justice Statistics
BSCC	Board of State and Community Corrections
CA	California
CalAIM	California Advancing and Innovating Medi-cal
CARES	Coronavirus Aid, Relief, and Economic Security
CBHDA	County Behavioral Health Directors Association
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCJBH	Council on Criminal Justice and Behavioral Health
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDPH	California Department of Public Health
CESF	Coronavirus Emergency Supplemental Funding
CHHS	California Health and Human Services Agency
CHW(s)	Community Health Worker(s)
CMHS-M	Correctional Mental Health Screening for Men
CMHS-W	Correctional Mental Health Screening for Women
CMS	Centers for Medicare and Medicaid Services
CoCs	Continuums of Care
COVID-19	Coronavirus Disease 2019
CPOC	Chief Probation Officers of California
CRC	California Reentry Commission
CRF	Coronavirus Relief Fund

CRTS	Community Residential Treatment Services
CSA	California State Auditor
CSG	Council of State Governments
CSUS	California State University, Sacramento
CTCs	Community Transition Centers
CWS	California Child Welfare Services
DAPO	CDCR Division of Adult Parole Operations
DHCS	California Department of Health Care Services
DJJ	CDCR Division of Juvenile Justice
DOJ	California Department of Justice
DRP	CDCR Division of Rehabilitative Programs
DSH	California Department of State Hospitals
ECM	Enhanced Care Management
EOP	Enhanced Outpatient Program
FY(s)	Fiscal Year(s)
HCD	California Department of Housing and Community Development
HCFC	Homeless Coordinating and Financing Council
HDIS	Homeless Data Integration System
HHAP	Homeless Housing Assistance Prevention
HUD	U.S. Department of Housing and Urban Development
ILOS	In Lieu of Services
ISMIP	Integrated Services for Mental Ill Parolees
IST	Incompetent to Stand Trial
ISUDT	Integrated Substance Use Disorder Treatment
JSAT	Jail Screening Assessment Tool
LAO	Legislative Analyst's Office
LARRP	Los Angeles Regional Reentry Partnership
LEP	Lived Experience Program
LGBTQ	Lesbian, Gay, Bisexual, Transgendered, and Queer/Questioning
LGBTQ+	All Other LGBTQ Gender Identities and Sexual Orientations
MAP	Fresno County Multi-Agency Access Program
MAT	Medication Assisted Treatment
MCCF	Modified Community Correctional Facility
MCUP	Medi-cal Utilization Project

Medi-Cal	California's Medicaid Program
MHSA	Mental Health Services Act
MHSOAC	Mental Health Service Oversight and Accountability Commission
MOU(s)	Memorandum(s) of Understanding
OYCR	Office of Youth and Community Restoration
PH/PS	Public Health Meets Public Safety
PHE	Public Health Emergency
POC(s)	Parole Outpatient Clinic(s)
PRCS	Post Release Community Supervision
PTSD	Post-Traumatic Stress Disorder
RNR	Risk Need Responsivity
SAVRY	Structured Assessment of Violence Risk in Youth
SB	Senate Bill
SED	Serious Emotional Disturbance
SGF	State General Fund
SMI	Serious Mental Illness
SOR	State Opioid Response
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STOP	Specialized Treatment for Optimized Programming
SUD(s)	Substance Use Disorder(s)
TAR	Treatment Authorization Request
TCN	Transitions Clinic Network
UC	University of California
UCLA	University of California, Los Angeles
U.S.	United States
WPC	Whole Person Care
YASI	Youth Assessment Screening Instrument
YLS/CMI	Youth Level of Service/Case Management Inventory

Executive Summary

The Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE) has had major implications for people in California who experience behavioral health needs and who are involved with the criminal justice system (hereafter referred to as the BH/CJ population). In 2020, the BH/CJ population was propelled to the center of attention since their mental health and/or substance use disorder needs, and high rate of homelessness, made them high-risk for both contracting and spreading COVID-19, requiring both State and local entities to quickly mobilize in order to mitigate or slow the spread of the virus through the reduction of the prison/jail populations, and by addressing the State's homelessness crisis. Despite the myriad of challenges, multiple stakeholders, including the Council on Criminal Justice and Behavioral Health (CCJBH), came together in partnership, passion, and commitment, with the shared goal of not only saving, but also improving, the lives of the BH/CJ population.

In 2020, CCJBH 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, albeit with some modifications to our original work plan. To protect the safety of Council members, as well as meeting presenters and participants, rather than hold meetings in person, CCJBH moved to a virtual platform for both the Full Council and workgroup meetings (Juvenile Justice, Diversion and Reentry). Council meetings were primarily spent on educational efforts that covered the impact of COVID-19 PHE across all areas of behavioral health and the criminal justice systems, housing and homelessness, systemic racism, and CCJBH project updates. CCJBH produced the following written briefs and factsheets for use by BH/CJ policymakers and other administrative leaders:

- [Housing Policy Brief Executive Summary](#)
- [Housing Policy Brief](#)
- [Housing First Factsheet](#)
- [Reduce Preventable Emergency and Inpatient Utilization](#)
- [Juvenile Justice Factsheet](#)
- [Behavioral Health System Transformation Through CalAIM Factsheet](#)

Through the Juvenile Justice, Diversion and Reentry workgroups, CCJBH identified several issues and developed recommendations for systemic changes.

CCJBH Juvenile Justice Workgroup Recommendations

CCJBH's Juvenile Justice Workgroup focused on the existing juvenile population served at the local level as well as the upcoming realignment of CDCR's Division of Juvenile Justice (DJJ). Final Calendar Year 2020 recommendations address the need to:

- Expand/develop local juvenile justice infrastructure through multi-system and stakeholder collaboration.
- Perform behavioral, physical, behavioral health, and criminal justice screenings as well as assessments, and to engage in comprehensive, collaborative case planning.

- Ensure a robust continuum of evidence-based, recovery-oriented services to appropriately meet the needs of youth and their families.
- Identify and implement strategies to address trauma and disparities.
- Use of measures to track outcomes and inform quality improvement processes.
- Leverage existing DJJ policies, practices, and programs to address the needs of the youth subject to the DJJ Realignment.

CCJBH Diversion/Reentry Workgroup Recommendations

The Diversion and Reentry Workgroups, originally held separately, were combined into one workgroup due to the overlap of relevant issues. Final Calendar Year 2020 recommendations address the need for:

- A clear, formal reentry (also known as transition) plan, developed through a collaborative, multi-agency process.
 - To support this effort, a venue is needed for criminal justice stakeholders, including sheriffs, police, probation, and parole, and behavioral health stakeholders, such as county agencies, the Department of State Hospitals, and Department of Health Care Services (DHCS) to develop collaborative strategies in support of their distinct, but related missions. In many cases, these entities currently work together to achieve shared goals at both the state and local levels; however, a consistent platform for convening, communication, and strategic planning will further strengthen/expand these efforts.
 - Formal documents, such as Memorandums of Understanding (MOUs), should be established to clearly specify and delineate roles and responsibilities of all agencies that serve the BH/CJ population.
 - Transition planning must include:
 - Case planning/management, services linkages, and ongoing monitoring, all of which are essential to maximize engagement and service utilization. While processes for case planning are already in place, they are often siloed and, thus, disjointed. Therefore, 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.
 - Early identification of physical health, behavioral health, and criminogenic risks/needs through screening and assessments. *Note: a 30-day supply of medication must be provided upon reentry, as needed.*
 - Assessments to identify the need for support services (e.g., housing; income, such as Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI)).
 - Consideration for timing to maximize identification and engagement of the BH/CJ population. Transition planning must begin prior to release from jail/prison to the community for those who have behavioral health, criminogenic, and other support service needs and all relevant agency partners should be involved. At the

county level, transition planning should begin upon entry to jail given that policy changes due to the COVID-19 PHE have resulted in quicker releases, which do not afford adequate time for the necessary screenings and assessments.

- Consideration of the unique needs of the two county-level BH/CJ populations – those who are pre-trial and those who have been sentenced.
- The employment of peers and community health workers (CHW), implemented in accordance with best practices. Where applicable, prior incarceration should not exclude peers and CHWs from employment since their lived experience is a key skill they bring to the workforce. The new Senate Bill 803 (SB 803) certification should include curriculum on how to address the unique needs of the BH/CJ population.
- The U.S. Department of Housing and Urban Development's (HUD) definition of homelessness should be expanded to include vulnerability for homelessness, not solely chronicity. Incarceration should not be considered as "housing," and should not exclude people from the definition of chronic homelessness. Serious mental illness (SMI) should not be used as criteria to exclude individuals from housing opportunities.
- Examination of the use and expansion of reentry councils, which are an existing community resource available in some counties that could be leveraged to further support transition including adding behavioral health to their portfolio.
- A standard of care to be established for reentry/diversion that is aligned with strategies to reduce disparities, maximize funding for high-quality services, expand data collection, and reporting to support decision-making.

2025 Goals

In the 2019 CCJBH Annual Legislative Report, the Council established four goals to be accomplished by 2025. The 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 2020 Update: The use of different measures at the federal, State, and local levels make the analysis of behavioral health prevalence rates in incarcerated settings challenging. That said, examination of recent, available data continue to show that a disproportionate number of individuals with behavioral health needs are overrepresented in both California jails and prisons, and this sharpens when stratified by race/ethnicity. A data comparison for June 2019 and June 2020 for jails that was done to examine the COVID-19 PHE releases, shows that individuals with mental health needs are being released at almost half the rate of the non-mental health jail population, thereby increasing the overrepresentation of the behavioral health population in local jails. This data shows an exacerbation, rather than improvement, of behavioral health prevalence in California jails. CCJBH will continue to track these data and will engage in discussions to develop strategies to reverse this troubling trend.

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

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 #s 2-4 2020 Update: In 2021, CCJBH will leverage the Medi-Cal Utilization (MCUP) and Public Health Meets Public Safety (PH/PS) Projects to determine how best to establish appropriate, comprehensive metrics for these goals. Note: CCJBH is concerned about the need for adequate community-based treatment bed capacity, particularly given the elimination of the CDCR Integrated Services for Mentally Ill Parolees program.

CCJBH Staff Projects

Updates to other ongoing CCJBH projects are as follows:

- MCUP and PH/PS Projects – CCJBH has continued to build infrastructure for data-driven decision-making, with current efforts focused on expanding reporting. In 2021, activities will include establishing a reporting structure that may be used to monitor prison reentry to the public health and behavioral health systems (i.e., Medi-Cal enrollment and connection to behavioral health services for those with an identified need), as well as developing and performing pilot data analyses to demonstrate the potential for, and limitations of, existing data to inform criminal justice and behavioral health policies.
- Lived Experience Program (LEP) Project Contracts – To help reduce the involvement of youth and adults with behavioral health needs in the criminal justice system, the LEP Project seeks to elevate the perspectives of youth and adults with lived experience through outreach, awareness, and educational activities at the local level. The LEP contractors will also conduct research on organizational hiring policies and best practices related to employing individuals with lived experience in the BH/CJ systems, and will also serve as subject matter experts in CCJBH policy discussions.
- Pre-Trial Diversion – In the past year, CCJBH provided training to counties on topics such as successful pre-trial diversion planning and implementation, sustainability, housing, and case planning. In 2021, CCJBH will establish a contract to establish a final set of pre-trial diversion policy recommendations that will include clear “next steps” for statewide implementation.

CCJBH 2021 Priorities

In 2021, CCJBH will continue leading the Juvenile Justice and Diversion/Reentry Workgroups. The Juvenile Justice Workgroup will focus on supporting the implementation of SB 823 Juvenile Justice Realignment, with CCJBH staff securing a contractor to develop a Juvenile Justice Evidence-Based Practices and Programs Compendium and Toolkit. The Diversion/Reentry Workgroup will focus on supporting the work necessary to comply with the Governor's Veto Message on Senate Bill 369, which directs CDCR and CCJBH to "engage with stakeholders, evaluate the barriers of reentry, and determine what steps need to be taken to overcome those barriers." Through all of these efforts, CCJBH will work with partners and stakeholders to address disparities, and will also assess how best to incorporate the recent work of the California Surgeon General on Adverse Childhood Experiences(ACEs), toxic stress, and health.

I. Introduction

Throughout 2020, the COVID-19 public health emergency (PHE or pandemic) has led to a dramatic loss of human life worldwide and presented an unprecedented challenge to public health and, in particular, the behavioral health and the criminal justice systems. While the economic and social disruption caused by the pandemic has been devastating, it has created opportunities to build new and strengthen existing systems that serve individuals with behavioral health needs who are involved in the criminal justice system (hereafter referred to as the behavioral health / criminal justice (BH/CJ) population). See Appendices A, B, and C for a summary of legislative, budgetary, and programmatic changes for the behavioral health criminal justice, and housing systems respectively.

The Council on Criminal Justice and Behavioral Health (CCJBH or the Council) has remained committed to pooling expertise and experience to support these most vulnerable populations, thinking through crisis response measures, and maximizing efforts to optimize health outcomes and reduce recidivism. Since March 2020, CCJBH has focused on:

- Examining long-term sustainable strategies to address challenges facing the behavioral health and criminal justice sectors, prioritizing attention on addressing underlying system challenges such as the impacts of the budget and public health crisis;
- Understanding and informing the housing needs for the BH/CJ population;
- Facilitating safe and effective pathways for those entering/exiting the criminal justice system; and
- Providing opportunities for diversion and/or safe and successful reentry back into our communities.

II. CCJBH Full Council Meetings and 2020 Policy Focus

With the nation facing the COVID-19 crisis, California encountered unforeseen challenges that had immediate operational impacts on all types of industry across the State, and CCJBH was no exception. Fortunately, the Governor's issuance of [Executive Order N-25-20](#) waived certain provisions of the Bagley-Keene Act, which enabled CCJBH to transition to a virtual platform without delay. This flexibility allowed CCJBH to more frequently convene behavioral health and criminal justice partners, as well as policy advocates representing justice-involved individuals, families, judicial courts, law enforcement, corrections, and behavioral health to learn about solutions being implemented to address emerging issues.

A. CCJBH Full Council Meetings

In Calendar Year 2020, the Council met a total of six times, with the first in-person full Council meeting occurring in February. This first meeting was dedicated to reviewing the 2020 Work Plan and providing a high-level review of the Governor's Budget. Thereafter, given the COVID-19 PHE, the Council began meeting virtually by April, with a shift in focus to address emerging issues related to the pandemic and racial injustice.¹

The vast majority of Council meetings throughout the year were spent on educational efforts, covering the following topics:

- [COVID-19 Response Across all Areas of Behavioral Health and the Criminal Justice Systems](#)
- [Housing and Homelessness](#)
- [Systemic Racism](#)
- [CCJBH Project Updates](#)

In accordance with CCJBH's mission to support proven strategies that promote early intervention, access to effective treatments, and planned reentry and the preservation of public safety, CCJBH produced the following written briefs and factsheets for use by BH/CJ policymakers and administrative leaders:

- [Housing Policy Brief Executive Summary](#)
- [Housing Policy Brief](#)
- [Housing First Factsheet](#)
- [Reduce Preventable Emergency and Inpatient Utilization](#)
- [Juvenile Justice Factsheet](#)
- [Behavioral Health System Transformation Through CalAIM Factsheet](#)

The Council also responded to the public health and State budgetary crisis by establishing [workgroups](#) in the areas most affected by the pandemic – Diversion, Reentry, and Juvenile Justice – to focus discussion in each area, elicit feedback, and develop effective recommendations for this annual report to the Legislature.

Appendix D provides tables that document the dates and topics of discussion for both the Full Council and Workgroup meetings.

¹ At the 4/30 Full Council Meeting, the following modifications were made to the CCJBH 2020 Work Plan: Council meetings were moved to virtual platform, CCJBH meetings would take place more frequently than originally planned, and training contracts were amended to reflect CDC guidance (e.g., all in person trainings moved to virtual training sessions).

B. CCJBH Calendar Year 2020 Policy Focus

During 2020, in addition to reviewing current research, CCJBH informed the annual report policy recommendations by utilizing councilmember advisors and stakeholder participation in a workgroup format. The workgroups were categorized into Juvenile Justice, Prevention and Diversion, and Reentry and Reintegration, all designed to foster an environment of collaborative information sharing among CCJBH stakeholders. As such, this section provides a compilation of current research and workgroup input/recommendations, which culminate in a list of findings and recommendations for criminal justice and behavioral health leaders and includes specific CCJBH commitments to help address these recommendations.

a. Juvenile Justice Workgroup

California's juvenile justice system is a network of county and state agencies and programs. It is intended to ensure the safety and protection of the public and provide care, treatment, and guidance to minors who have committed a violation of the law. Most youth are committed to county level supervision overseen by county probation departments that manage juvenile secured detention centers. Less than 1% of the 225,000 youth who are arrested each year are committed to the CDCR DJJ. The DJJ maintains state-operated, secured facilities, and a conservation camp managed by youth correctional officers.

A 2019 [report](#) by the Legislative Analyst's Office (LAO) indicated that counties are responsible for most youth placed by juvenile courts, who are typically allowed to remain with their families with some level of supervision from county probation departments, while others may be supervised in county-run juvenile halls or camps. The juvenile justice population has declined since 2007 due to reduced arrest rates that some believe is attributed to former legislative reforms and realignments.

In 2007, Governor Arnold Schwarzenegger signed Senate Bill 81 (SB 81), Chapter 175, known as the "Juvenile Justice Realignment" bill. According to a [report](#) by the Center on Criminal and Juvenile Justice, SB 81 is arguably the most impactful juvenile justice legislation in recent decades. This bill ushered in a new era of juvenile justice policy by limiting the types of offenders who could be committed to state youth correctional institutions and by providing funding to county probation systems to improve their capacity to handle higher need youth offenders. The bill resulted in a further decline in State institutional commitments and spurred the development of innovative programs at the county level.

On July 1, 2021, California's juvenile justice system will experience another huge shift. Senate Bill 823 (SB 823) responds to a call for alternatives to youth prison models by suspending the intake of new DJJ commitments, and beginning of closure of DJJ through attrition. As a result, county probation departments will have two populations to address: 1) the current county youth probation population and 2) the population of youth who would have been remanded to DJJ, but will remain at the local level under the jurisdiction of county probation as of July 1, 2021.

In July and September 2020, CCJBH convened the Juvenile Justice Workgroup meetings to determine how to improve outcomes for youth with behavioral health needs who are in the juvenile justice system (see Appendix E for a list of organizations that participated in CCJBH's Juvenile Justice Workgroup). Participants informed the Council on best known practices and strategies to improve outcomes for youth with behavioral health needs who are justice involved. As a result of the workgroup input and research, a compilation of which may be found in Appendix F, CCJBH developed the below recommendations.

Juvenile Justice System Policy Recommendations

1. Given the extensive needs of the youth currently served by the county probation, and the youth population with greater and serious needs that will be realigned to county probation as of July 1, 2021, local probation agencies, and the youth/families they serve, would benefit from (as appropriate):
 - a. Engaging system partners in strategic planning to improve the existing local juvenile justice system and expand to address the unique needs of the transitioning DJJ population. This includes:
 - Local agency partners, such as physical and behavioral health, child welfare, community providers, courts, probation, education, regional centers, Department of Rehabilitation, as well as youth, family members, peers, and other youth advocates.
 - The State DJJ. *Note: if not currently underway, processes should be established to transfer the records of transitioning DJJ youth to local agencies, including probation, health care (Medi-Cal Managed Care Plans), behavioral health, child welfare, and appropriate education agencies.*
 - b. Ensuring that all youth who are involved in the probation system are screened and assessed for behavioral (e.g., anger management), physical health, behavioral health (i.e., mental health and substance use disorders), trauma (e.g., screening for Adverse Childhood Experiences), as well as criminogenic risk and needs.
 - c. Ensuring that comprehensive, individualized treatment plans are developed to address *behavioral, physical health, behavioral health, and criminogenic needs* and that all relevant agencies collaborate with the youth and their families as appropriate on the identification of treatment goals and recovery and coordinate on the provision of treatment as mandated by the Child and Family Team model of care. Criminogenic needs should be addressed using the Risk-Needs-Responsivity (RNR) model.
 - d. Ensuring capacity at all levels of care, including short-term crisis residential treatment options for children/youth requiring intensive treatment, as well as locked treatment facilities.
 - e. Implementing evidence-based practices and programs as available and ensuring that all care provided is trauma-informed and based on recovery-oriented practices and service delivery.

- f. Seeking to identify and develop strategies to address disparities, with a focus on racial justice and race-based trauma. Current efforts, such as the DHCS/California Department of Public Health (CDPH) Community Mental Health Equity Project and Board of State and Community Corrections (BSCC)'s Title II Grant Program: Identifying Effective Interventions and Replicable Strategies for Reducing Racial and Ethnic Disparities, should be leveraged to support this work.
- g. Leverage peers to support connection and engagement in behavioral health services and interventions to address criminogenic needs.
- h. Selecting a manageable number of initial core system-level process and outcome metrics to establish a baseline and track progress in key domains over time. Additional metrics may be added once the core metrics are well-established.
- i. Leveraging model practices established by DJJ, particularly for youth who would have been remanded to DJJ but will realign to county probation departments.
- j. Partnering with existing DJJ treatment providers that have established success with treating the juvenile justice population, particularly for youth who have committed serious and/or violent offenses.

To assist with these efforts, CCJBH shall:

- 2. Seek opportunities and resources to support county justice, behavioral health, education, and regional center partners in the identification and implementation of strategies for best serving youth with greater behavioral health needs being realigned to county probation departments.
- 3. Establish a partnership with the Office of Youth and Community Restoration (OYCR), and serve as a resource and liaison between County Behavioral Health Directors, local probation departments and youth & family networks.
- 4. Work with State and local partners (e.g., Chief Probation Officers of California (CPOC), County Behavioral Health Directors Association of California (CBHDA), the [Department of Health Care Services](#), and the California Health and Human Services Agency (CHHS)'s Office of Youth and Community Restoration) to develop a strategy to ensure that all youth who are involved in the juvenile justice system are screened for trauma by their health care provider (Managed Care Plan or Fee-for-Service provider), and that the results of their trauma screening are addressed in their behavioral health treatment plan.
- 5. Better understand capacity to provide services at higher levels of care and conduct in partnership with key stakeholders and providers an assessment of short-term crisis residential treatment capacity for juveniles as an alternative to juvenile hall. CCJBH can continue to research this area of interest, including current efforts with Continuum of Care reform and the serious mental illness (SMI)/serious emotional disturbance (SED) demonstration that is part of the California Advancing and Innovating Medi-Cal (CalAIM) proposal.

b. Diversion and Reentry Workgroup

The COVID-19 PHE forced both the behavioral health and criminal justice systems to re-think their operational processes. Due to the significant impact of the virus, California took actions to address the health risks associated with the pandemic. In addition to reducing arrests, state and local jurisdictions implemented the following strategies:

- Reduced unnecessary contact, visits, and technical violations for people on probation and parole.
- Reduced jail admissions.
- Released individuals from jails and prisons, as appropriate.

Of note, courts and local governments released individuals who may have otherwise been held in custody before trial, and took [multiple actions](#) to address the PHE. When comparing [June 2019](#) and [June 2020](#), the total CDCR in-state, in-custody population decreased by nearly 10,000, and by December 2020, the reduction more than doubled to approximately 22,000. Through these efforts, California successfully reduced its jail and prison populations, thereby limiting person-to-person interactions, whether with law enforcement, in courts, in jails and prisons, or with community supervision officers and service providers. The expedited number of individuals released from jails and prisons into communities tested discharge and warm hand-off processes in place and new ones were created, including CDCR's [Project Hope](#), which was created to protect people releasing from prison during the COVID-19 pandemic and the California communities to which they are returning by providing free hotel accommodations to people released from state prison who have a need to quarantine or isolate due to COVID-19 exposure or positive status.

With a focus on those who have behavioral health needs, CCJBH sought to understand the impact of the COVID-19 PHE on the thousands of inmates who were released from jail/prison, and how the pandemic has changed the landscape when it comes to diversion and reentry, as related to reintegration across the State of California. Ultimately, the goal is to ensure that these vulnerable individuals are effectively served in their communities. This can be achieved by creating a local community service system that provides housing before and after incarceration, with consistent and continuous treatment provided throughout, to reduce the growing numbers of individuals with serious behavioral health issues in California's jails and prisons, hospitals, and living on the streets. There continues to be significant work to do to link to the public behavioral health systems for expedited releases from jails and prisons during the COVID-19 pandemic and those who continue to exit state correctional or hospital settings.

To inform the development of policy recommendations that are relevant to the needs of the current diversion and reentry populations, CCJBH conducted research and convened two workgroups, one on diversion and one on reentry, that included Councilmember advisors and diverse stakeholder perspectives from across the state (see Appendices G and H for a list of organizations that participated in each workgroup). Multi-system best practices were identified as those that foster successful reintegration strategies to strengthen coordinated services and support for individuals with complex needs who are

vulnerable and at-risk of re-incarceration. The workgroup participants identified three different BH/CJ populations – pre-trial, parolees and people on Post-Release Community Supervision (PRCS), and people released from jails – noting that, although the needs of these three populations will overlap in many cases, there are also distinct differences that must be understood when seeking to implement treatments/interventions. Given the overlap in the diversion and reentry workgroups, the research and workgroup discussion from both were consolidated and may be found in Appendix I. The resulting policy recommendations that could improve system-wide and individual-level outcomes are reflected below.

Diversion and Reentry Policy Recommendations

Case Planning/Management, Service Linkages, and Ongoing Monitoring

1. Case management services should be provided in diversion and reentry programs for at least 365 days post-incarceration based on individual assessment to ensure effective use of the services to ensure stability. The COVID-19 pandemic resulted in the pre-trial release (referred to as zero dollar bail) of a substantial number of individuals arrested and booked into jail, either at the time of bail review on booking or at the time of arraignment (first appearance by a defendant in Court). Law enforcement contact and initial detention (Intercepts 1 and 2 of the [Sequential Intercept Model](#)) are key points at which people can be connected to care. Case management services should reflect the fact that people released from jail receive different types of criminal justice supervision and monitoring while they live in the community. For example, people released after being held in jail pre-trial are not subject to any formal criminal justice supervision.
2. Monitoring individuals in the criminal justice system who have behavioral health needs is as important as case management. Peer navigators and Community Health Workers are an important resource that should be leveraged to provide this type of support to ensure engagement in and adherence to treatment.

Physical and Behavioral Health Care Services

3. A formal process should be established to transition health and behavioral health treatment from jail/prison to the community for all individuals who are in need of medical or behavioral health services upon diversion/reentry. This process should include in-reach services to facilitate planning prior to release so that local health and behavioral health departments may have sufficient time to prepare to receive individuals who are reentering their communities. Since it is often unknown as to how long individuals incarcerated in *jails* will be in custody before being released, an optimal approach is to begin discharge planning upon entry to prepare for transitions to community treatment to ensure continuity of care, including the provision of medications. Counties should examine the feasibility of establishing a secure electronic information exchange system/process to support this transition.

4. To ensure a comprehensive approach, treatment plans should be developed in coordination with the criminal justice system (either CDCR parole or county probation), as well as any other relevant public service agencies with which the individual is involved. Information regarding collaborative case plans is available on the Council of State Governments (CSG) Justice Center's [Collaborative Case Plan website](#). All criminal justice and behavioral health partners should be included.
5. To facilitate behavioral health treatment utilization, those who are most “at-risk” of substance use relapse or mental health issues upon leaving institutions could be provided with mobile phones, which may be used for ongoing communication and reminders (e.g., monitoring, medication, appointments), as well as to access services via telephone or telehealth (if the phone also has internet service). If they are provided with phones at release, and they consent to a provider contacting them directly, then they could immediately initiate treatment. Key emergency numbers could also be loaded into this phone, such as access numbers for behavioral health (main line and crisis) or suicide prevention hotlines.
6. For individuals reentering with a behavioral health need, a 30-day supply of medications and access to behavioral health services should be provided upon release from jail/prison. If the jail does not have a pharmacy, at a minimum, a prescription should be provided that may be filled by a local pharmacy at no cost to the reentering individual. Services should be arranged prior to release, including connection and engagement with the outpatient prescriber. *Note: Since jails do not bill Medi-Cal, there should be a plan for Treatment Authorization Request (TAR) circumstances to prevent delays for clients to receive medication while the county waits for TAR approval.*

Criminogenic Risk and Needs Screening, Assessment and Intervention

7. A criminogenic risk and needs screening and assessment should be completed for each individual being diverted or upon reentry from jail/prison, and treatment plans should be developed using the Risk-Need-Responsivity (RNR) model to address identified criminogenic needs. Screenings should occur as a first step as soon as possible, especially for jails since releases could occur within hours. Assessments should follow shortly thereafter, and criminogenic risk/needs assessments should take place in addition to, not instead of, clinical behavioral health assessments. At the local level, each county should determine when and where the assessments will take place, and by whom it will be completed. There is no standardized risk/needs assessment at this point in time, and it is unknown as to whether there is a need for standardization. To ensure a comprehensive approach, treatment plans should be developed in coordination with behavioral health, in particular, as well as any other relevant public service agencies with which the individual is involved. For example, collaborative comprehensive case plans are an identified best practice that reflects structured and multi-sector partnership. Information regarding collaborative case plans is available on the CSG Justice Center's [Collaborative Case Plan website](#).

8. Optimally, all relevant agencies providing services to individuals in diversion programs or upon reentry for those returning home with behavioral health needs (e.g., health, behavioral health, criminogenic treatment, housing) are communicating and collaborating, and ideally creating comprehensive multi-system treatment plans to address the identified needs, and to establish treatment goals with the ex-offender, and coordinate on the provision of treatment. The recent California Health and Human Services Agency [AB 2083 Systems of Care Memorandum of Understanding guidance](#), designed to address this type of coordination for local child/youth-serving agencies, could be adapted by BH/CJ population-serving agencies to clearly establish how coordination will occur within each county. A standing meeting or other convening platform at the local level can help to facilitate communication and collaboration.

Diversion/Reentry Workforce:

9. Local criminal justice and behavioral health agencies should leverage the Peer and Community Health Worker workforce to support individuals in diversion programs and those reentering from jail/prison in accessing, navigating, and engaging with treatment for their behavioral health and criminogenic needs. Efforts should be made to identify best practices for expanding this workforce. CCJBH encourages the practice of employing as peers those individuals who have a history of incarceration and behavioral health needs and who are in recovery so that they may apply their lived experience to help others. Another recruitment approach is to look to the workforce displaced by COVID-19 (e.g., those in the service industry). Implementation of the recently passed SB 803 Peer Certification bill should be leveraged to ensure proper training for peers that will successfully support those with behavioral health needs who are involved in the criminal justice system.
10. All relevant staff must receive specialized training on the unique needs of the BH/CJ population. Criminal justice staff should know when and how to perform a behavioral health screening, as well as how to refer positive screenings to behavioral health for further assessment. Behavioral health staff should be trained on the unique needs of the BH/CJ population, including the concepts of criminogenic risk and needs, and how it impacts service engagement and the management of behavioral health conditions.
11. To maximize behavioral health service capacity, creative solutions/strategies, particularly the use of peers, should be explored to mitigate the personal and client safety concerns that have been expressed by providers.

Housing and Homelessness

12. Expand the HUD definition(s) of homelessness to ensure that individuals who are exiting institutional settings (prison, jail, hospitals) into homelessness have equal opportunities to federally funded housing services that are based on current vulnerability and not chronicity.
13. Communities should be equipped with the necessary infrastructure to maintain the shelter capabilities, building off of existing efforts such as Project Roomkey/Homekey,

both of which are discussed at length in Appendix C. Hotels and shelters that provide case management and whole person care services have been integral in reducing barriers to successful reintegration. Long-term, permanent housing should be expanded based on these innovative housing programs in order to build capacity and facilitate supporting individuals returning from incarceration.

14. A formal process should be established to ensure housing upon discharge from jail/prison to the community, and should be a key part of the transition (reentry) plan. As with behavioral health, this process should include in-reach services to facilitate planning prior to release so that local housing departments have sufficient time to prepare to receive individuals who are reentering their communities, and discharge planning for those incarcerated in jails should begin upon entry since the length of stay is often unknown. One strategy is to widen access to the Continuum of Care system so that those who are justice-involved may enroll into the system through the criminal justice partners (e.g., parole/probation/community providers). Housing is a critical need at release. Where possible, planning for housing at release should begin with the point of arrest and include county behavioral health.
15. Housing programs should not restrict individuals with serious mental illness (SMI) from participating. In fact, a certain percentage of capacity should be specifically reserved for individuals with SMI, particularly if they are also involved in the criminal justice system, and these dedicated housing programs should include the services and supports necessary to stabilize and retain this population. This would also fill a critical gap needed for diversion programs. In addition, individuals with SMI who have subsidized housing should not lose it because of incarceration as this practice results in subsequent homelessness.
16. Explore new ways to use public/private partnerships to help build local capacity for recovery housing and adult residential facilities, building off of the “Returning Home Well” project, which is discussed in Appendix C.

Income, Vocational and Supportive Services

17. In addition to health and behavioral health services, and criminogenic risk/needs interventions, it is critical to address the social determinants of health, including the provision of income (SSI/SSDI), educational/vocational, employment, and housing supports. This may be accomplished by building upon the successes and lessons learned from existing community-based and State reentry programs and, in particularly, by building out the capacity of local Reentry Councils to assist with establishing / strengthening current transition processes/services. In addition, at the local level, Sheriff's Departments should support the reinstatement of benefits by providing timely access to incarceration records for individuals at the time of their release.

Additional Considerations for Diversion

18. A statewide template for a standard of care for diversion should be developed based on best practices and evidence-based programs, and should include strategies to address disparities, with a focus on racial justice and race-based trauma. This plan could then be used by State and local criminal justice and behavioral health system policy-makers and administrators to develop processes that are tailored to local needs. The goal of this plan is to divert away from the criminal justice system as many offenders who suffer from mental health conditions as possible, at the earliest point in time possible, and instead provide the necessary treatments and supports to assist them in their communities to manage their behavioral health conditions while addressing their criminogenic needs.
19. Given the potential adverse consequences of the COVID-19 PHE, and that the majority of offenders with mental health conditions remain in pre-trial status for multiple months, strategies should be identified (or developed) to divert these individuals at this point in the process to ensure they receive the treatment necessary to stabilize and manage their symptoms.

Additional Considerations for Reentry

20. Similar to diversion, a statewide plan for a standard of care for reentry should be developed based on best practices and evidence-based programs, and should include strategies to address disparities, with a focus on racial justice and race-based trauma. This plan could then be used by State and local criminal justice and behavioral health system policy-makers and administrators to develop processes that are tailored to local needs. The goal of this plan is to develop specific processes that may be employed to support individuals who suffer from mental health conditions that are returning to their community after being incarcerated in jail/prison, providing them with the full array of treatments and supports to assist them in managing their behavioral health conditions while addressing their criminogenic needs.
21. Local/regional Reentry Councils should be considered as key partners to support the development of reentry processes since they currently have an existing infrastructure that engages in advocacy and strategic planning to address the needs of individuals reentering their communities from jail/prison.

Funding

22. Counties should examine funding streams across delivery systems and blend funding to the greatest extent possible. Efforts will need to be made to identify all applicable funding sources, understand the parameters/restrictions for each source, ensure the most restricted funds are allocated appropriately, and that the most flexible funds are used to address system gaps.

Demographic Disparities

23. Counties should identify and develop strategies to address disparities, with a focus on racial justice and race-based trauma. Current efforts, such as the DHCS/CDPH Community Mental Health Equity Project, should be leveraged to support this work. In addition, geographic disparities must also be identified and addressed, particularly since many of CCJBH's recommendations could be difficult to implement in some counties, such as small, rural counties where services may only be available many miles from where there is housing or where the jail is located, or services may not exist at all.

Data Reporting

24. Critical responses in this time of crisis could reveal new ways of operating, including which activities had the greatest impact. As outcome measures are identified, and data are collected across the relevant systems, information should be gleaned as to which strategies employed are most successful, as well as where gaps exist and/or persist. Efforts to evaluate these strategies will provide decision-makers with supporting evidence to determine how to invest critical resources in the coming years (e.g., examination of trends in mental health cases in county jails will help local county agencies and Boards of Supervisors understand the magnitude of behavioral health and criminogenic needs of their incarcerated population so that resources may be allocated accordingly). The CCJBH Public Health Meets Public Safety and Lived Experience Program projects will be leveraged to determine how best to include the perspectives of the BH/CJ population in the development of new strategies and operational processes.

III. Update on 2025 Policy Goals & Prior CCJBH Legislative Report Recommendations

As local systems rapidly changed in response to the needs of the BH/CJ population, the impact of the pandemic, and budgetary constraints, CCJBH continued to work diligently to meet the objectives outlined in CA Penal Code Section 6044(e) and (f). To ensure accountability, monitor progress, and make concrete recommendations, CCJBH is working to establish a methodology to track the 2025 Policy Goals that were established in last year's 18th Annual Legislative Report, and is also tracking the status of the recommendations made in prior year CCJBH Annual Legislative Reports.

A. Updates on 2025 Policy Goals

In last year's Annual Legislative Report, CCJBH recommended four policy goals to be achieved in California by 2025. While the systems responsible for achieving these goals extend beyond the scope of CCJBH's authority, CCJBH is well positioned to operationalize and track them over time in subsequent Annual Legislative Reports, particularly by leveraging CCJBH's Public Health Meets Public Safety project. This will allow CCJBH to evaluate progress (or lack thereof) and inform policy decisions, as well as CCJBH Full Council and workgroup discussions. The 2020 "baseline" 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.

2020 Update: Of all of the metrics being tracked by CCJBH, the State, and counties, the prevalence rate of incarcerated individuals with behavioral health conditions is arguably the most critical indicator of BH/CJ system performance. If the system is performing optimally, then the prevalence rate of the incarcerated BH/CJ population would mirror that of the general population. However, similar to BH/CJ incarceration data in the United States, California's data indicate a pervasive, striking overrepresentation of the BH/CJ population in California's jails and prisons.

Prevalence of Any Mental Illness (AMI) and Serious Mental Illness (SMI) Nationally and in California: General Population vs. Incarcerated Population

As of 2018, the National Institute for Mental Health [reported](#) that 1 in 5 adults in the United States (20 percent) has any mental illness (AMI), which is any mental health diagnosis whether it be mild, moderate or severe; and about 5.2 percent have a serious mental illness (SMI), which is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." A [report](#) submitted to the Department of Health Care Services indicated that 15.9 percent had a mental illness, and about 4.3 percent of Californians had a serious mental illness. Unfortunately, the lack of comparable behavioral health prevalence data makes it extremely difficult to establish an accurate baseline for the BH/CJ population, so this report reflects the data that are available, and notes the gaps that will need to be addressed before this metric may be fully established. For example, some prevalence estimates are derived from surveys of incarcerated people, who self-report their experiences with mental health diagnoses. Other prevalence estimates are based on the level of care that people received while they were incarcerated. While there are concerns about using self-reported data to estimate the prevalence of mental health needs, there is some evidence that self-reported health history aligns with medical records even among the incarcerated population.²

With regard to national measures, a 2017 [report](#) from the Bureau of Justice Statistics (BJS) indicated that "[a]bout 1 in 7 state and federal prisoners (14 percent) and 1 in 4 jail inmates (26 percent) reported experiences that met the threshold for serious psychological distress," and "37 percent of prisoners and 44 percent of jail inmates had been told in the past by a mental health professional that they had a mental disorder." Although these data are not fully comparable, estimates suggest that the national prevalence rate of both AMI and SMI in the criminal justice population is approximately double the prevalence rates in the general population. As shown in Table 1 and Figure 1, rates of behavioral health need are much higher in California prison and jail populations when compared to the general population. As of June 30, 2019, CDCR [reported](#) that 22.2 percent of the in-prison population received mental health care through the Correctional Clinical Case Management System (CCCMS,

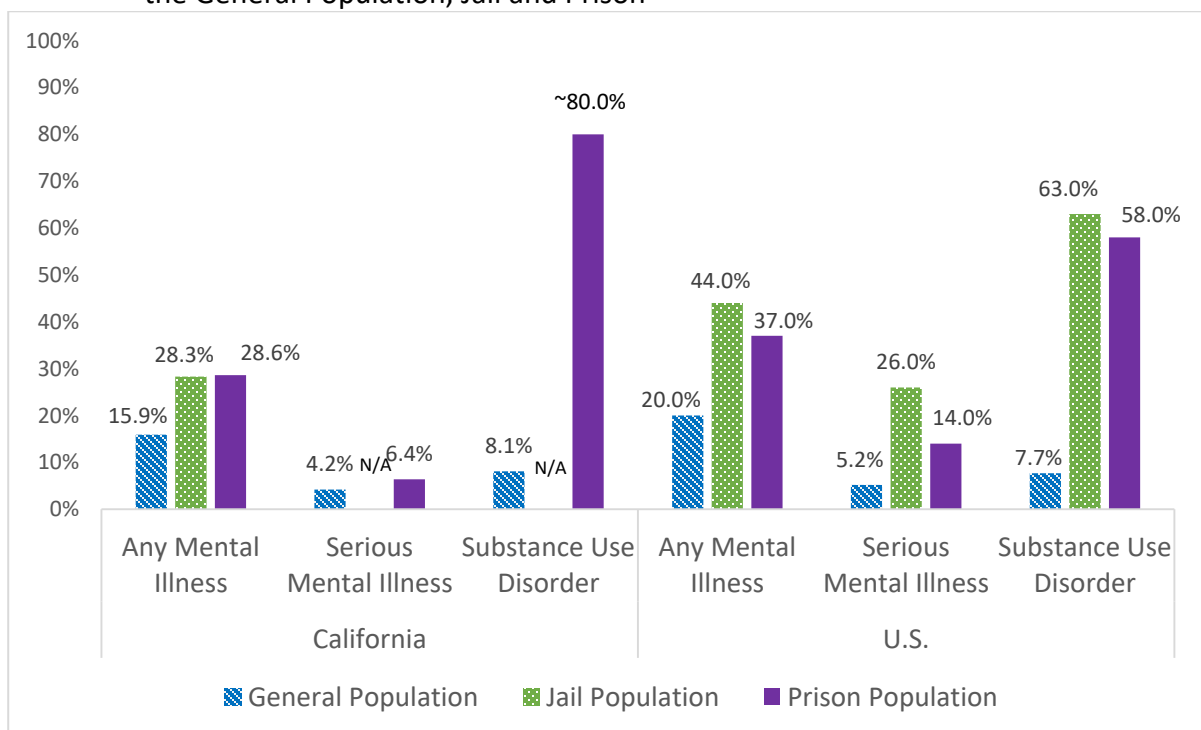
² Schofield, P., Butler, T., Hollis, S., & D'Este, C. (2011). [Are prisoners reliable survey respondents? A validation of self-reported traumatic brain injury \(TBI\) against hospital medical records](#). *Brain injury*, 25(1), 74–82.

comparable to “mild-to-moderate,” outpatient care) and 6.4 percent of the prison population received higher levels of care (comparable to care for SMI), such as the Enhanced Outpatient Program (EOP) and Mental Health Crisis Beds. In total, these data show that nearly 30 percent of the in-custody CDCR prison population has AMI, which is about 10 percentage points greater than the general population. [Data](#) compiled using the BSCC’s Jail Profile Survey shows that, as of June 2020, 27 percent of the jail population was receiving psychotropic medications, which is used as California’s a proxy statewide measure for AMI. No statewide data are available to identify the prevalence of SMI in California jails.

Table 1. Prevalence of Behavioral Health Conditions in the United States and California for the General Population, Jail and Prison

	United States			California		
	General	Prison	Jail	General	Prison	Jail
Any Mental Illness	20%	37%	44%	15.9%	28.6%	28.3%
Serious Mental Illness	5.2%	14%	26%	4.2%	6.4%	Not Available Statewide
Substance Use Disorder	7.7%	58%	63%	8.1%	~80%	Not Available Statewide

Figure 1. Prevalence of Behavioral Health Conditions in the United States and California for the General Population, Jail and Prison



Prevalence of Substance Use Disorders: Nationally and in California, General Population vs. Incarcerated Population

Table 1 and Figure 1 also show that, 7.7 percent of Americans 18 years and older had a SUD based on [results](#) from the 2019 National Survey of Drug Use and Health. According to [estimates](#) from the Substance Abuse and Mental Health Services Administration, approximately 8.1 percent of California adults had a substance use disorder as of 2017-2018. For the incarcerated population, a national estimate from a 2017 BJS [report](#) indicates that “[m]ore than half (58 percent) of state prisoners and two-thirds (63 percent) of sentenced jail inmates met the criteria for drug dependence or abuse.” For California, a 2018 California Correctional Health Care Services [report](#) noted that “[a]lthough currently there are not official validated data regarding the prevalence of SUD...in CDCR, it has been estimated that the prevalence of SUD among the CDCR population is approximately 80 percent or 100,000 patients.” No statewide data are available to identify the prevalence of SUDs in California jails.

COVID-19 PHE Impact on Prison and Jail Releases

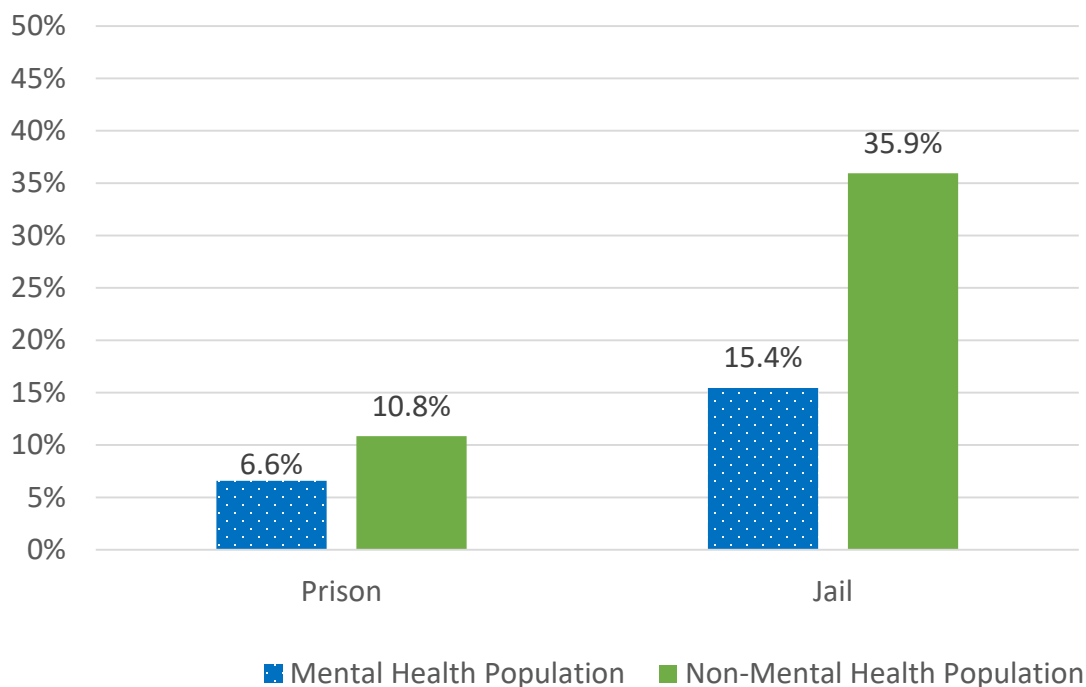
Despite the data limitations, use of the data that are available have shown notable trends with regard to those who have been released from prisons and jails due to the COVID-19 PHE. Overall, both populations declined substantially as a result of emergency measures taken to reduce the spread of COVID-19, with the prison population declining by nearly 10 percent between June 2019 and June 2020 (with an additional 15 percent reduction by [December 2020](#)), and the jail population declining by over 30 percent during the same time period. However, incarcerated people with mental health needs were released at lower rates than those without mental health needs. This was the case across both prisons and jails, although the disparity in releases was strikingly larger among people incarcerated in jails.

As shown in Table 2 and Figure 2, the June 2019 vs. June 2020 prison reduction was 10.8 percent for the non-mental health population and 6.6 percent for the mental health population, a modest difference that was likely due to [standardized release criteria](#) that did not include mental health designation as a factor. In contrast, the reduction in the local jail population was 35.9 percent for the non-mental health population and 15.4 percent (less than half) for the mental health population, likely due to different criteria being applied, particularly risk for public safety given the likelihood of un/undertreated behavioral health conditions. Although the data behind these measures are imperfect (particularly the jail data), it serves as an indicator of the PHE in that the overrepresentation of the BH/CJ population that CCJBH is seeking to mirror the general population is actually going in the opposite direction and, in fact, getting worse.

Table 2. Impact of COVID-19 PHE Prison and Jail Releases: June 2019 vs. June 2020 Percent Decrease

California Populations	June 2019	June 2020	% Change
Prisons			
Mental Health Population	36,039	33,667	-6.6%
Non-Mental Health Population	89,433	79,736	-10.8%
Total Population	125,472	113,403	-9.6%
Jails			
Mental Health Population	17,048	14,415	-15.4%
Non-Mental Health Population	57,024	36,530	-35.9%
Total Population	74,072	50,945	-31.2%

Figure 2. Impact of COVID-19 PHE Prison and Jail Releases (Percent Decrease): June 2019 vs. June 2020



Brief Discussion of the Limitations of Criminal Justice Behavioral Health Data

The limited valid and reliable data available to measure mental health (AMI and SMI) and SUD needs, nationally and in California (in particular) make it difficult, if not impossible, to inform decisions about the BH/CJ population, thereby leaving policy-makers, administrators and oversight entities in a position of having to make decisions based on scant information with the hopes of having some positive impact. California's prison data most closely resembles the national definitions for AMI, SMI, and SUD; however, the level of care (CCCMS, EOP, crisis bed, etc.) is used as a proxy measure rather than actual diagnosis and level of functional impairment. Similarly for jails, the only source for statewide jail data, the Jail Profile Survey, uses even less accurate measures as proxies to identify mental health

need – psychotropic medication prescriptions, open mental health cases, and mental health beds – and it does not capture information that may be used to quantify SMI or SUD at all. Until these data gaps are addressed, CCJBH and others will continue to struggle to understand what, if any, progress is being made to ensure that there is not an overrepresentation of the BH/CJ population in California prisons and jails.

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.

2020 Update: CCJBH remains concerned about the need for adequate community-based treatment capacity, particularly as it relates to psychiatric inpatient and residential treatment, and the elimination of the CDCR Integrated Services for Mentally Ill Parolees program has served to increase such need.³ CCJBH has not yet operationalized this important goal, and thus has not established a measure (or set of measures) to track it. While there are a variety of existing data sources available, the data that are selected for analysis will depend on how this goal is defined. For example, with regard to the service capacity of the Medi-Cal behavioral health system, DHCS annually publishes [network adequacy certifications](#) for Managed Care Plans, Mental Health Plans and Drug Medi-Cal Organized Delivery System Pilots that include network adequacy and timeliness data. These data will only be useful for those using public behavioral health services, which is most likely applicable to adults and older adults involved in the criminal justice system, but may not necessarily apply to juveniles since they may not be on Medi-Cal (e.g., they may be served by commercial plans). There is also hospital inpatient data compiled by the [California Hospital Association](#) and by the Office of Statewide Health Planning and Development. The Council of State Governments Justice Center is currently working on a housing brief that will include a methodology to estimate housing needs among the BH/CJ reentry jail and prison populations, and data will also be needed to assess whether or not interventions are being provided to address criminogenic risk and needs. In addition, the Courts, Chief Justice and Judicial Council, as well as the counties, are implementing Pretrial Diversion pilot projects in a number of Superior Courts that will be tracked to inform CCJBH’s monitoring of system capacity. CCJBH will work with the Council on State Governments Justice Center (CSG or CSG Justice Center) through the Public Health Meets Public Safety project to determine how best to establish appropriate, comprehensive metrics for this goal.

³ In order to meet the needs of justice-involved people, community-based services must be tailored to the individuals being served, and providers must collaborate across systems. However, available data suggest that California’s community-based behavioral health services may leave justice-involved people behind. Findings from the [2019 National Survey of Substance Abuse Treatment Services](#) indicate that only 38.2 percent of substance abuse treatment facilities in California had specially tailored programs for criminal justice clients other than DUI/DWI. Moreover, data from [the 2019 National Mental Health Services Survey](#) suggests that only 19.1 percent of mental health treatment facilities in California accepted state corrections or juvenile justice agency funding, and only 22 percent of mental health treatment facilities offered treatment programs or groups designated or designed exclusively for forensic clients referred from the court or judicial system. The absence of appropriate and timely residential and community services increases the chances that individuals with complex BH/CJ needs will continue to experience poor outcomes, as will their communities.

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.

2020 Update: CCJBH has not yet operationalized this important goal, and thus has not established a measure (or set of measures) to track it. CCJBH will work with CSG through the Public Health Meets Public Safety project to determine how best to establish appropriate, comprehensive metrics for this goal. That said, CCJBH has provided a series of trainings in 2020 to support AB 1810 Implementation (Pre-Trial Mental Health Diversion), and is working to establish another contract in 2021 for Pre-Trial Mental Health Diversion Consultation, Technical Assistance and Policy Recommendations in critical roles that support the adoption of best practices throughout California.

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.

2020 Update: CCJBH is continuing to work on the Medi-Cal Utilization Project, and is also working with CSG through the Public Health Meets Public Safety project to determine how best to establish appropriate, comprehensive metrics for this goal.

B. Updates on Prior CCJBH Legislative Report Recommendations

A compilation of outstanding CCJBH recommendations related to juvenile justice and diversion/reentry from prior annual reports is located in Appendices J and K. In summation, CCJBH has completed 3 of the recommendations from prior year reports (providing pre-trial technical support, directing DHCS to use the opioid federal funds to supply State and local correctional providers with naloxone to offer upon release to those with opioid use disorder, and monitoring progress of the Whole Person Care (WPC) Pilots), 32 are ongoing efforts, 4 were delayed due to COVID-19 and 30 will remain open for further exploration. In Calendar Year 2020, CCJBH worked to address the findings from last year's Annual Legislative Report by:

- ✓ Hosting a focus group in January 2020 that introduced criminal justice partners to the CalAIM reforms.
- ✓ Hosting a CalAIM workshop in February 2020 to help inform criminal justice / behavioral health stakeholders of the pertinent information included in the CalAIM proposal, and to gain input on how the proposals would benefit the justice-involved populations.
- ✓ Co-hosting a Transitions Workgroup with CBHDA, in which CDCR participated that initially met in January 2020 to begin working on reentry planning with the goal to meet quarterly. However, with the COVID-19 PHE and May Revision that eliminated ISMIP, the quarterly meetings for SB 389 implementation were put on hold.

- ✓ Convening the CCJBH Diversion, Reentry, and Juvenile Justice Workgroups three times each in Calendar Year 2020 to formulate recommendations related to reentry for the annual CCJBH Legislative Report.
- ✓ Participating as an appointed member of the Homeless Coordinating and Financing Council to represent the unique and intensive needs of the BH/CJ population.
- ✓ Participating in a teleconference convening with Southern California Continuums of Care to discuss the possibility of collecting information about justice involvement as part of the Point-in-Time Count.
- ✓ Partnering with the CSG Justice Center using funding from the Melville Charitable Trust to develop recommendations for housing individuals with behavioral health needs who are involved in the criminal justice system. A report is expected to be released in early 2021.
- ✓ Establishing a two-year contract with the CSG Justice Center for the Public Health Meets Public Safety project, which involves leveraging linked administrative datasets to help CCJBH meet its mission of improving a broad range of outcomes for justice-involved people.
- ✓ Drafting a survey to gather information from Chief Probation Officers regarding the decline in the youth population to help facilitate the identification of best practices.
Note: The survey was not disseminated due to the COVID-19 PHE, and then DJJ was identified for closure in the State Budget.

IV. CCJBH Project Updates

Despite the impact of the pandemic throughout 2020, CCJBH continued working on existing projects and embarked on new projects, collectively contributing to the fields of behavioral health and criminal justice by providing insight on best practices to improve health outcomes while reducing recidivism. Updates on CCJBH's projects are discussed in this section, along with identified next steps for 2021.

A. Data-Driven Practices and Policymaking

CCJBH has continued to build infrastructure for data-driven decision-making, with current efforts focused on expanding reporting for the Medi-Cal Utilization Project and the new Public Health Meets Public Safety project. Updates for each are discussed below.

a. CDCR-DHCS Medi-Cal Utilization Project

In FY 2016-17, CCJBH was awarded ongoing Mental Health Services Act (MHSA) funds for research staff to link CDCR and DHCS data through the MCUP. The goal of the MCUP is to inform policy development and operational improvements that maximize enrollment onto Medi-Cal for people who are eligible and increase service utilization among people who require health care services. A central goal of the project is to provide information

disaggregated by county to support quality improvement, such as strengthening and monitoring BH and CJ system coordination efforts and targeting outreach to people who would benefit from services.

Currently, CCJBH has access to data on people released from CDCR facilities between January 2012 and March 2017, which is matched to DHCS Medi-Cal service data. Using these data, CCJBH developed a [program brief](#), released in July 2020, which showed utilization of potentially preventable emergency and inpatient behavioral health services. Highlights include:

- ✓ Among people with behavioral health needs who were released from CDCR facilities in 2016, justice-involved people with serious mental illness accessed potentially preventable emergency or inpatient behavioral health services at a much higher rate (nearly 30 percent) as compared to those who did not have identified behavioral health needs (less than 5 percent).
- ✓ People with serious mental illness and/or SUD had the highest rates of emergency/inpatient service utilization (ranging from 27 to 28 percent) even compared to people with mild/moderate mental illness and/or SUD (ranging from 16 to 19 percent).

These analyses serve as baseline information that will among other measures be updated and monitored to assess the impact of past, and inform future policy and program changes.

While there have been challenges renewing the Data Sharing Agreement between CDCR and DHCS, which is needed to secure current data, CCJBH staff are actively working to overcome these challenges so that analyses can be conducted on more recent data. In the interim, CCJBH staff are able to perform longitudinal and cohort analyses that capture longer-term utilization.

In 2021, the MCUP will establish a reporting structure that may be used to monitor prison reentry to the public health and behavioral health systems. For example, findings will assess whether additional outreach is needed so that people coming out of prison enroll onto Medi-Cal in a timely manner and utilize timely services where necessary. Results will be presented by county and region where possible. Results will also be disaggregated by criminal justice supervision type (such as Parole compared to Post-Release Community Supervision) and criminal risks/needs. Throughout, data analyses will evaluate whether there are disparities in behavioral health service utilization and quality of care.

b. Public Health Meets Public Safety

In June 2020, CCJBH awarded a \$485,000 two-year contract to the CSG Justice Center to carry out its Public Health Meets Public Safety project (previously referred to as the Data-Informed State-Level Framework). PH/PS will leverage linked administrative datasets to help CCJBH meet its mission of improving a broad range of outcomes for justice-involved people with behavioral health needs.

Work on the project began in July 2020. CSG is currently developing an inventory of available state-level datasets by conducting key informant interviews, which will also support the development of guiding questions for data analysis. Because many key datasets are not available publicly, CSG will also develop a data governance strategy that details anticipated data access and data sharing issues in order to facilitate long-term data linkage across departments. In 2021, CSG will design and carry out pilot data analyses that demonstrate both the potential and limitations of existing data to inform criminal justice and behavioral health policy. Initial work on the project will focus on improving access to high-quality health care services at reentry through data-informed policy recommendations, research, and operational strategies such as quality improvement and training/technical assistance.

B. Lived Experience Program (LEP) Project Contracts

The 2018-19 enacted state budget provided CCJBH with an ongoing allocation of MHSA funds for one position and \$670,000 in contract funds to administer stakeholder contracts for activities that reduce the involvement of individuals with behavioral health needs in the criminal justice system. Following the MHSA's specific instruction to consider the perspective and experience of those who will be affected and supported by its funding, CCJBH conducted a statewide stakeholder engagement process to inform a funding opportunity to award these contract funds. For this effort, CCJBH executed a contract with the Consensus and Collaboration Program with the College of Continuing Education at California State University, Sacramento (CSUS).

CSUS conducted key informant interviews, population-specific listening sessions and regional forums throughout the state. Based on the input of over 300 stakeholders, CCJBH and the California Correctional Health Care Services (CCHCS) released the Lived Experience Project framework as part of a competitive bid process. Table 3 reflects the identified Project Goals, Project Objectives, Priority Populations and Priority Approaches for the LEP Project.

Table 3. LEP Project Overview

Project Goals	Elevate the perspectives of youth and adults with lived experience to reduce the involvement of youth and adults with behavioral health needs in the criminal justice system.
Project Objectives	<ul style="list-style-type: none"> • Increase advocacy capacity of those with lived experience • Increase education and training opportunities • Increase organizational and community awareness • Improve collaborative efforts and partnerships
Priority Populations	<ul style="list-style-type: none"> • Women • Juveniles/Transition Age Youth • People of color • Youth and adults who have experience with SUD • Family members of justice-involved youth and adults • Youth and adults facing housing insecurity

Table 3. LEP Project Overview (continued)

Priority Approaches	<ul style="list-style-type: none"> • Preventative in nature • Multi-disciplinary team collaboration • Lived experience practitioner utilization • Trauma informed • Culturally responsive • Gender responsive • LGBTQ+ responsive • In-reach combined with post-release continuum of care
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CCJBH successfully awarded five contracts – one for each behavioral health region (see Table 4). These organizations each submitted unique proposals designed to reduce criminal justice involvement in their local communities.

Table 4. LEP Contractors

Region	Organizations	Contract Terms
Bay Area	Transitions Clinic Network (TCN)	8/31/2020 - 8/2/2023
Central	Anti-Recidivism Coalition (ARC)	10/8/2020 - 8/16/2023
Los Angeles	Los Angeles Regional Reentry Partnership (LARRP)	6/30/2020 - 6/29/2023
Southern	Cal Voices	10/13/2020 - 8/14/2023
Superior	Cal Voices	10/13/2020 - 8/14/2023

During 2021, CCJBH will work towards accomplishing the following for the LEP:

- Develop an evaluation methodology and contractor monitoring tools to ensure contract compliance and success in meeting intended objectives.
- Widely promote the LEP and invite the LEP Project contractors to present their proposals, including details on the activities and outcome measures to Councilmembers at a scheduled Council meeting.
- Utilize LEP Project contractors as subject matter experts by inviting them to participate in policy discussions as valuable stakeholders and engaging them in speaking opportunities.
- Incorporate LEP contractors to further expand and promote efforts in other CCJBH projects, including PH/PS.
- Conduct research and disseminate findings on organizational hiring policies and best practices related to employing individuals with lived experience in the BH/CJ systems in order to help further advance efforts to ensure that the workforce is well informed and equipped to utilize the unique skill sets of these individuals.

The LEP Project contractors will conduct outreach, awareness, and education activities at the local level implementing their unique proposals. Additionally, these contractors will all collaborate on a similar set of issues using consistent messaging and materials to combine efforts and make an impact at the state level. CCJBH envisions this to be an opportunity for the contractors to learn best practices from each other to further increase their capacity. This also allows the organizations the ability to be dynamic and relevant during the upcoming years.

C. Supporting the Implementation of Pre-Trial Diversion

In FYs 2018-19 and 2019-20, CCJBH staff supported DSH through a variety of efforts, including developing and scoring county proposals, reviewing scopes of work, and acquiring or delivering technical assistance to the counties. Through a training contract with the CSG Justice Center, and partnership with the Judicial Council and the Courts, CCJBH provided training to counties covering topics such as successful planning and implementation, sustainability, housing, and case planning. Additionally, CCJBH contracted with the Forensic Mental Health Association of California to provide training on best practices to state and county administrators. In furthering CCJBH efforts to identify and promote best practice models, CCJBH contracted with experts to meet the identified need for training on risk assessment, and to provide online training to key stakeholders on how to conduct a program evaluation. These CCJBH training efforts are listed in the Table 5.

Table 5. CCJBH Pre-Trial Diversion Trainings

SCHEDULED TRAINING	COURSE TITLE	TARGET AUDIENCE
November 7, 2019	Words to Deeds XIII –Outcomes Matter: Diversion that Works!	Counties participating in DSH-funded diversion; State policy and decision-makers
January 30, 2020	AB 1810 Diversion Overview Training	Prosecutors, Public Defenders, county supervisors, other criminal justice stakeholders and their designees
July 23, 2020	Making the Case for Diversion: Reentry and Diversion During COVID-19	Criminal court judges, county behavioral health administrators, and treatment providers working in large counties in Southern California
August 20, 2020	Braiding Funding for Diversion Programs	Criminal court judges, county behavioral health administrators, and treatment providers

SCHEDULED TRAINING	COURSE TITLE	TARGET AUDIENCE
September 25, 2020	Case Management for Diversion Participants During COVID-19	Criminal court judges, county behavioral health administrators, and treatment providers
October 15, 2020	Preparing People for Diversion	Criminal court judges, county behavioral health administrators, treatment providers, and policymakers
October 21, 2020	Mental Health Diversion: Making it Work Together – Session 1	Criminal court judges, county behavioral health administrators, treatment providers, and policymakers
November 18, 2020	Mental Health Diversion: Making it Work Together – Session 2	Criminal court judges, county behavioral health administrators, treatment providers, and policymakers

In addition to providing on-going consultation to DSH and direct training and technical assistance to county participants through 2020-21, the remaining funds will support additional information gathering and delivery of technical assistance to local and state leadership to promote the long-term adoption of pre-trial mental health diversion practices. CCJBH uses a state-level steering or advisory committee representing the various partners in diversion to identify policy issues during implementation, find common ground, seek resolutions, and propose recommendations for the Council to consider to strengthen the effectiveness and sustainable impact of AB 1810. Outcomes due by the end of FY 2020-21 will include a final set of policy recommendations and identified next steps to support expanded pre-trial Mental Health Diversion statewide.

D. Additional CCJBH Efforts for 2021

In addition to the above projects, CCJBH will seek to address disparities in all work products. To support this effort, CCJBH will attend the California Department of Public Health (CDPH) Office of Health Equity's Advisory Committee meetings to remain informed about the CDPH California Reducing Disparities Project and joint CDPH/DHCS Community Mental Health Equity Project and will leverage this forum to advocate for the needs of the BH/CJ population. Separate, but closely related, CCJBH will also track the information being released by the California Surgeon General on ACEs, toxic stress, and health using it to inform BJ/CJ policy recommendations.

As recommended by the California State Auditor's (CSA) [report](#) on their audit of the CDCR Integrated Services for Mental Ill Parolees (ISMIP) Program, which stated that CDCR "should review its processes for connecting these individuals to county services by...reporting on its success in meeting its goals to the Council on Criminal Justice and Behavioral Health and the public..." Although the ISMIP program was eliminated in the Fiscal Year 2020-21 budget trailer

bill, CCJBH shall continue to offer the CDCR Division of Adult Parole Operations opportunities to provide ISMIP program transition updates to Councilmembers and public stakeholders at CCJBH's Full Council meetings in order to comply with the corrective action plan submitted to the CSA.

Finally, in 2021, CCJBH will continue leading the Juvenile Justice and Diversion/Reentry Workgroups. The Juvenile Justice Workgroup will focus on supporting the implementation of SB 823 Juvenile Justice Realignment, with CCJBH staff securing a contractor to develop a Juvenile Justice Evidence-Based Practices and Programs Compendium and Toolkit that the workgroup participants will help to inform given their expertise. The Diversion/Reentry Workgroup will focus on supporting the work necessary to comply with the Governor's Veto Message on Senate Bill 369, which directs CDCR and CCJBH to "engage with stakeholders, evaluate the barriers of reentry, and determine what steps need to be taken to overcome those barriers." CCJBH Diversion/Reentry workgroup members, public stakeholders who will participate in the workgroup meetings, and CCJBH staff will coordinate and collaborate with CDCR's Division of Adult Parole Operations, Division of Rehabilitative Programs, Division of Adult Institutions, and any other relevant Department entities, as appropriate, as well as the California Correctional Health Care Services to examine the existing prison/jail to community transition processes in accordance with the SB 369 mandate. Once established, CCJBH will use this information to inform discharge planning for individuals being released from jails. *Note: Parolees who are released from prison and subsequently incarcerated in county jails by order of a Superior Court Judge for violating the terms of their parole will need the same discharge planning as individuals who are in jail and not on parole facing the same barriers as parolees.*

V. Conclusion

Although criminal justice policies have always varied substantially by local jurisdiction, the state-local relationship is changing rapidly to provide even more authority to local communities to design and implement a service delivery system that is equitable and effective. The greatest successes come from state partners working with local communities to help build effective collaborations that impact the community. As local communities evolve to accommodate revised regulations and changing funding streams, critical funding decisions need to be guided by reformed paradigms. Criminal justice reforms that focus solely on narrow changes, such as sentencing guidelines, may not go far enough to meet the needs of justice-involved people. Reform efforts should stride toward providing shelter and services in a robust community-based system that provides a continuum of care that results in safe and healthy communities. Policies need to move away from a fragmented delivery system that disproportionately incarcerates communities of color to a multi-system collaboration that includes individuals with lived experience that work to distribute resources where they are needed most.

The pandemic forced communities to come together and do whatever it takes to uphold public safety by providing shelter and essential services to those who could not provide for themselves. Key to the reformed paradigm needs to be equal access and equitable distribution of resources to fund an effective array of community-based services that can divert people from costly and unnecessary institutional care. The public/private partnership concept has

potential to create solutions to overcome long-standing barriers. Empowering local communities to create similar partnerships has the potential to revolutionize how the service industry operates. Engaging local communities to help provide valuable support in reaching the most vulnerable populations allows them to also advocate for positive changes that will work to address system barriers to reintegration and empower the individuals who made positive changes to become change-makers.

Appendix A

Behavioral Health System Updates

Mental health care is essential to a person's overall health and access to care is needed for someone to recover. With widespread closures and sheltering in place, behavioral health providers and insurers turned to 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. The Department of Healthcare Services posted guidance on their website about [telehealth flexibilities](#) that are available to providers during the COVID-19 public health emergency (PHE). The federal flexibilities will expire at the end of the federally-declared PHE. CCJBH will continue to closely track these efforts. The legislative, budgetary, and programmatic highlights from the past year are discussed below.

New Legislation

This year the California Legislature approved and the Governor signed a package of bills that will improve access to quality mental health and substance use disorder services for all Californians, as well as measures that help homeless Californians suffering from behavioral health challenges access the help they need (see Appendix L for the full list of legislation of interest to CCJBH and justice and behavioral health partners that the Governor and Legislature signed or vetoed in 2020). In the Governor's 2020 State of the State address, he discussed the challenges of homelessness, housing insecurity, and behavioral health.

Of particular interest is SB 803 (Beall), which mandates the establishment of statewide standards for behavioral health Peer Support Specialists and adds these services as an option in Medi-Cal. Statewide standards will ensure consistency and quality of service while offering a level of validity and respect to the position, while satisfying a federal requirement to allow Medi-Cal billing. Peer support is essential to the work CCJBH does working with adults and youth with lived experience. Peer Support Specialists are able to engage, earn trust, and assist with navigating service delivery systems and build bridges with people on the path to recovery.

In addition, Assembly Bill 1976 (Eggman) removes conditions imposed on counties trying to implement Laura's Law by expanding county use of court-ordered outpatient treatment. AB 2265 (Quirk-Silva) clarifies that counties may use MHSA funds "to assess whether a person has co-occurring mental health and substance use disorders and to treat a person who is preliminarily assessed to have co-occurring mental health and substance use disorders, even when the person is later determined not to be eligible for services provided with MHSA funds." Counties will now be able to use MHSA funds to assess and treat individuals with a co-occurring disorder, increasing access to substance use disorder treatment, improving care coordination and leading to a more integrated behavioral health care system.

Other bills related to behavioral health will divert, when appropriate, individuals in crisis at emergency rooms to sobering centers and mental health facilities as well as encourage the creation of a state office to identify and address causes of suicide.

Budget Updates

The [Fiscal Year \(FY\) 2020-2021 State Budget](#) approved strategies to strengthen enforcement of behavioral health parity laws, including focused investigations of commercial health plans, regulated by the Department of Managed Health Care to further evaluate plan compliance with parity and assess whether enrollees have consistent access to medically necessary behavioral health care services.

- [California Advancing and Innovating Medi-Cal](#) – The Governor’s budget sought to allocate \$695 million (\$348 million General Fund) in FY 2021-22, increasing to \$1.4 billion in FYs 2021-22 and 2022-23 for the Department of Health Care Services’ CalAIM initiative (previously called Medi-Cal Healthier California for All). This allocation was delayed in the May Revision due to the COVID-19 PHE since DHCS had to shift operations in response to the pandemic. DHCS anticipates a one-year delay for CalAIM, which would then make future budget allocations effective on January 1, 2022.
- [Realignment Backfill for Counties](#) — To provide support for counties experiencing revenue losses for 1991 Realignment programs due to the pandemic (i.e., behavioral health, social services and public safety), which rely on sales tax and vehicle license fees, the FY 2020-21 budget included \$750 million in one-time funding. An additional \$250 million was also scheduled to be provided to counties pending additional funding from the federal government by October 15, 2020; however, this federal funding was not received by the deadline.
- [Behavioral Health Counselors in Emergency Departments](#) —The enacted budget maintained a one-time \$20 million General Fund allocation to hire behavioral health providers and peer navigators in emergency departments to screen patients and offer intervention and referral to mental health or substance use disorder programs.
- [Medi-Cal Enrollment Navigators](#) — The enacted budget maintained a one-time \$15 million General Fund allocation for the Medi-Cal Health Enrollment Navigators program.

Program Updates

Behavioral health programs were impacted by the PHE of 2020. Many departments were required to put current projects on hold and shift their focus to emerging issues. Below, we have put together an inventory of behavioral health program updates. CCJBH will continue to track these efforts closely.

- Supporting AB 1810 Implementation (Pre-Trial Mental Health Diversion) - The Department of State Hospitals' Felony Mental Health Diversion Program is a collaboration between DSH and county governments to develop or expand diversion programs for individuals with serious mental illness who face felony charges and could be or are determined to be Incompetent to Stand Trial (IST). The DSH Diversion Program provides funding to counties to support community mental health treatment and other wrap-around services for these individuals. 25 counties across the state are participating in the DSH Diversion program and will serve an estimated 841 individuals over the course of the pilot. As of September 2020, eight county programs have been activated and 11 programs are estimated to activate before the end of the 2020 calendar year. The DSH Diversion program has been impacted by the ongoing COVID-19 PHE. Last spring, the closure of courts and mass releases from county jails delayed program activations and created challenges for county programs to identify and flag potential participants before their release from jail. County budgets and hiring have also been impacted by the PHE, creating additional delays and barriers to program activation in counties.
- 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 substance use disorder 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 will include representatives from both the public and private sectors to align efforts to address behavioral health challenges from a public health perspective. CCJBH will continue to participate to represent the BH/CJ perspective.
- California Advancing and Innovating Medi-Cal (CalAIM) – The Department of Health Care Services intended to launch CalAIM, a multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems following the end of the Medicaid waiver period on December 31, 2020. However, the COVID-19 PHE greatly impacted all aspects of California's health care delivery system. As a result, key partners and stakeholders, including managed care plans, providers, and counties, requested a delay in implementing CalAIM since the priority focus was on addressing the pandemic. Given that CalAIM will significantly benefit the BH/CJ population, CCJBH will continue its participation and support of DHCS and the Administration's commitment in advancing the CalAIM proposal in 2021 and beyond.
- Adverse Childhood Experiences (ACEs) – Twenty years ago, a [study](#) measuring the impact of ACEs on an individual's health changed the way trauma is evaluated in relationship to a person's health outcomes. ACEs science is defining the impact of *toxic stress* on health outcomes for ages 0-65. On January 1, 2020, championed by California's first Surgeon General, Nadine Burke Harris, California became the first U.S. State to

screen individuals for ACEs.⁴ With regard to the BH/CJ population, experts assert that there is increasing evidence that the adverse impact of ACEs on health outcomes is heightened for those involved in the criminal justice system. Accordingly, Dr. Burke Harris is confident that screening for ACEs is key to prevention not only for illness, but also for incarceration, [asserting](#) that “Many of the kids who end up in the juvenile justice system, the vast majority of them have been exposed to high doses of adversity.” The potential screening for ACEs has for affecting the juvenile justice system makes ACEs a specific focus for CCJBH in the upcoming year, particularly given that full responsibility for serving juvenile justice system-involved youth will be shifting to county probation in 2021. Therefore, CCJBH will remain attentive to the work done at the local levels to affect and prevent childhood trauma because of the proven effect childhood adversity has on the justice-involved.

- State Opioid Response (SOR) 1 and 2 Grants – Building on the success of California’s [Medication Assisted Treatment \(MAT\) Project](#), the [SOR grants](#) administered by DHCS seek to increase prevention, treatment, and recovery services which are critical resources for the BH/CJ 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 20,000 opioid overdoses reversed, 36,000 individuals have received MAT, and 450,000 naloxone kits have been distributed.
- Children’s System of Care (AB 2083) – The California Health and Human Services Agency 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. 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. While this “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/CJ population). More information may be found on the [Agency Systems of Care website](#).

⁴ In June 2020, to minimize COVID-19 PHE-related budget shortfalls, DHCS and ACEs Aware joined efforts to award 150 grants to 100 organizations across California to community partners working on the statewide initiative to reduce ACEs and toxic stress by half in one generation. The grants, designated to fund Medi-Cal provider education, engagement and communications, can ensure that Medi-Cal beneficiaries have access to trauma-informed care, which is vital to mitigate the damage ACEs causes to children and youth during their developmental stages. For more about the grants, see <https://www.acesaware.org/heal/grants>.

Appendix B

Criminal Justice System Updates

Criminal justice reform remains a key priority in California. There is a moratorium placed on the death penalty, and the Division of Juvenile Justice, one state prison (Deuel Vocational Institute), and two in-state contract prisons (Shafter Modified Community Correctional Facility (MCCF) and Taft Modified Community Correctional Facility), are preparing to close. There have been expanded opportunities for rehabilitation, shortened prison time for incarcerated individuals participating in treatment and education programs, and increased access to higher education for young people who are incarcerated. In the wake of the nationwide outcry against structural racism and systemic injustice, a series of bills were signed into law initiating critical criminal justice, juvenile justice, and policing reforms in California. CCJBH continues to closely track these efforts. The legislative, budgetary, and programmatic highlights from the past year are discussed below.

New Legislation

CCJBH does not sponsor or take positions on legislation. Rather, the role of the Council is to identify legislation that intersects behavioral health and criminal justice, and monitor the potential impacts on the justice-involved population through investigating, identifying, and promoting cost-effective strategies for youth and adults with mental health needs. Listed in Appendix L is the full list of legislation of interest to CCJBH and justice and behavioral health partners that the Governor and Legislature signed or vetoed in 2020.

Through the pandemic and in response to racial injustices that occurred during the summer of 2020, the 2019-2020 legislative session ended with the Governor and the Legislature taking action to address COVID-19, tackling systemic racism, advancing criminal justice and policing reforms, changing the landscape of the juvenile justice system, closing prisons, improving access to behavioral health services, and advancing the cause for California for All, a symbolism for equality.

Relevant to CCJBH's current and future work is SB 369, a bill proposing to establish a California Reentry Commission and a grant program that was vetoed by the Governor, and SB 823, which realigns the CDCR Division of Juvenile Justice to local entities such as county probation as of July 1, 2021. For SB 369, the Governor directed CDCR and CCJBH to work collaboratively to "engage with stakeholders, evaluate the barriers of reentry, and determine what steps need to be taken to overcome those barriers." As such, CCJBH will work with CDCR's Division of Rehabilitative Programs (DRP), Division of Adult Parole Operations (DAPO) and CCHCS ISUDT Team, to comply with this direction. With regard to SB 369, CCJBH will work collaboratively with stakeholders through the full Council meetings, Juvenile Justice Workgroup and any other available means to provide information and resources to justice and behavioral health collaborates because we recognize the challenges of this major shift in services to these justice-involved youth. For SB 823, CCJBH will work within the CCJBH Juvenile Justice Workgroup and Full Council meetings to determine how best to support the State and local agencies in their juvenile justice realignment efforts.

Budget Updates

During these hard times, CCJBH commends the California Legislature and the Governor's efforts to protect and put safety nets in place for the most vulnerable populations. Despite the global economic crisis caused by the COVID-19 pandemic, the Budget closed a \$54.3 billion gap for [FY 2020-21](#), significantly reducing the State's ongoing structural deficit. The FY 2020-21 Budget protects public education, supports Californians facing the greatest hardships, and promotes economic recovery. Although this year's Budget was not able to expand funding for new programs, significant cuts were protected with the anticipation of federal funding, reserves, triggers, revenues, borrowing, transfers, deferrals, and other solutions. The following is a list of significant budgetary changes that impact the BH/CJ population:

- Integrated Services for Mentally Ill Parolee (ISMIP) Program – The budget eliminated the ISMIP program, which provided wraparound services for mentally ill parolees, including some transitional housing, costing roughly \$10,000 per parolee annually, and has shown limited effectiveness at reducing recidivism. CDCR will adjust policies to connect these individuals with community resources, which ultimately provide better continuity of care long-term. Elimination of this program is expected to result in savings of \$8.1 million General Fund in FY 2020-21 and \$16.3 million ongoing General Fund.
- Behavioral Health Reintegration (formerly known as Parole Outpatient Clinics (POCs)) – There is uncertainty in the future of POCs providing behavioral health services that can now be covered with Medi-Cal and/or the Mental Health Services Act (MHSA). The Governor's May Revision proposed eliminating this program, which would result in a savings of \$9.1 million in General Fund in FY 2020-21 and \$17.6 million ongoing; however, this proposal was not enacted in the final FY 2020-21 budget.
- Federal Medicaid Match for Health Care for CDCR Community Reentry Programs — Under federal policy, individuals who are considered prison inmates are ineligible for Medicaid benefits. However, this exclusion does not apply to individuals residing in supervised residential treatment facilities, such as reentry facilities designed to transition individuals from prison to the community. The Centers for Medicare and Medicaid Services (CMS), which sets these policies, recently issued guidance outlining how it distinguishes between prisons and supervised residential treatment facilities. Specifically, CMS has stated that in order to qualify for Medicaid eligibility residents must generally have freedom to seek employment in the community and access resources available to the general public, such as education, libraries, and healthcare facilities. CDCR is implementing operational changes at its reentry facilities to adhere to these guidelines in a manner that ensures public safety, which will thereby allow the State to draw down federal funding for residents' health care, saving \$4.2 million General Fund in FY 2020-21, and \$8.5 million ongoing.
- Prison Closures and the Realignment of the Division of Juvenile Justice to Local Jurisdictions – With earlier releases predicated on inmates participating in rehabilitation programs, the Governor's revised budget specified the closure of one of the state's

34 prisons by mid-2022 and a second a year later, eventually saving \$400 million annually. Furthermore, closing eight fire camps would save a projected \$7.4 million in the FY 2020-21 and doubles annually thereafter. Although the Governor's Budget proposed shifting the Division of Juvenile Justice to the California Health and Human Services Agency, at \$264.3 million, the May Revision instead transferred the responsibility for these youth to local jurisdictions, with \$2.4 million in General Fund in FY 2020-21, increasing to \$9.6 million ongoing, for Board of State and Community Corrections (BSCC) grants for facilities to provide care and supervision for youth with mental health and other needs.

Program Updates

As a result of COVID-19, criminal justice policymakers and administrators found themselves being forced to rethink operational strategies and service delivery systems, quickly mobilizing new or expanded services and supports. The following is a compilation of updates on criminal justice programs followed by CCJBH throughout the year, and those newly phased-in programs that are now supporting the BH/CJ population during these unprecedented times:

- ISMIP Transition – The CDCR Division of Adult Parole Operations is working to transition the current 615 ISMIP program participants to the appropriate community-based services (e.g., county behavioral health). To date, the ISMIP program has operated in eight counties: Fresno, Kern, Los Angeles, Sacramento, San Bernardino, San Diego, San Francisco and Santa Clara. In their [audit](#) of the ISMIP program, the California State Auditor (CSA) provided several recommendations for the program's transition to these counties, one of which pertains to CDCR presenting transition updates to CCJBH. As such, DAPO provided their first update to CCJBH at the October 29, 2020 full Council meeting.
- Integrated Substance Use Disorder Treatment Program - The CDCR ISUDT program implements a methodology to screen, risk stratify, and connect patients to relevant care similar to that available in the community. Doing so assures that the levels of care offered in the prison system will align and dovetail with continuing services available to patients as they are released. The ISUDT program can reduce risk for overdose and recidivism by increasing functions such as maintaining employment, procuring stable housing, and successfully reintegrating into their communities. During the first quarter of 2020, one of the ISUDT program's primary goals was to increase access to appropriate SUD treatment. Focusing on screening and assessing patients to determine the appropriate level of Cognitive Behavioral Intervention treatment and eligibility for MAT has significantly increased the number of people identified with and treated for SUD. Since program implementation the number of patients receiving MAT has expanded quickly, with nearly 6,000 patients receiving MAT, and many more still awaiting evaluation for MAT.

- Prison and MCCF Closures – California was faced with massive budget cuts, which led to the decision to close DVI in 2021.⁵ In addition, as result of COVID-19, lawmakers called for the closure of contracted facilities in the state. In 2020, CDCR ended its contracts with private, for-profit prisons Desert View, Central Valley, and Golden State MCCF, as well as the McFarland Female Community Reentry Facility, and the public-private contract Delano MCCF. Shafter MCCF closed effective October 31, and Taft MCCF is scheduled to be closed no later than May 31, 2021.
- Elimination of DJJ – The call to end youth prison models and close California’s youth correctional facilities operated by the Division of Juvenile Justice, proceeded through the approval of Budget Trailer Bill 823, signed in September 2020. In 2019, Governor Newsom [announced](#) his intentions to end juvenile imprisonment in California, stating that “[j]uvenile justice should be about helping kids imagine and pursue new lives, not jumpstarting the revolving door of the criminal justice system. The system should be about helping kids unpack trauma and adverse experiences many have suffered.” The elimination of DJJ will increase responsibility for county probation departments, child welfare systems, behavioral health departments, and other agencies that make up the juvenile justice system. As early as July 2021, county probation departments will be responsible for supervising youth who have been adjudicated for serious violations and have the most severe behavioral health needs. CCJBH commits to fostering collaboration between justice and behavioral health agencies and serve as a resource to assist with strategies for seamless transitions. CCJBH will seek to work closely with the Office of Youth and Community Restoration on achieving improved youth outcomes.

⁵ The last time California closed a state prison was in 2003, when Northern California Women’s Facility in Stockton was eliminated. Additionally, CDCR has reduced its reliance on out-of-state and contract facilities. In 2019, CDCR exited the last out-of-state facility, La Palma Correctional Center, in Eloy, Arizona.

Appendix C

Housing System Updates

The housing shortage and crisis in California has been of paramount importance throughout 2020 due to the COVID-19 PHE. Prior to the pandemic, 151,278 Californians were identified as experiencing homelessness based on the 2019 Point-in-Time Count, as reported by the U.S. Department of Housing and Urban Development. This is the highest [number](#) since at least 2007 and reflects a nearly 17 percent increase since 2018. While homelessness declined in most states in 2019, California's homeless population [increased](#) by 16 percent (21,306 people), with noteworthy increases among people experiencing unsheltered homelessness (e.g., living on the streets or in cars) and chronic, long-term homelessness. Furthermore, a [study](#) by the California Policy Lab at UC Berkeley found that 75 to 80 percent of people experiencing unsheltered homelessness had a physical health, mental health, or substance use condition with approximately 50 percent experiencing all three concurrently.

Project Roomkey / Homekey

As a result of the pandemic, federal, state, and local resources have been mobilized to immediately address the preexisting homeless crisis in order to alleviate public health concerns. Chapter 2, Statutes of 2020 (SB 89), provided emergency expenditure authority of up to \$1 billion for COVID-19 relief. In March 2020, the Administration issued \$150 million for COVID-19-related emergency assistance, including \$100 million for local governments and Continuums of Care to help protect Californians experiencing homelessness, using the existing Homeless Housing Assistance Prevention (HHAP) allocation formulas administered through the Homeless Coordinating and Financing Council (HCFC) within the Business, Consumer Services and Housing Agency. HCFC has also issued a [Guide to Strategic Uses of Key State and Federal Funds to Reduce Homelessness during the COVID-19 Pandemic in July 2020](#), and also provided two informational letters that during the year on [April 17, 2020](#), and [August 28, 2020](#). Using this funding, local capacity has been expanded in all efforts possible to house California's homeless population to help comply with sequestering, social distancing, and public health directives to curb the spread of COVID-19.

The initial statewide housing effort leveraging this funding to address the pandemic was [Project Roomkey](#), which is a \$50 million California Department of Social Services-led multi-agency housing program that directs funds to use motels and temporary housing to prevent people from being homeless. This housing, which includes criminal justice referrals, provides short-term emergency shelter for homeless individuals to mitigate the spread of COVID-19 among this vulnerable population and were intended to keep hospitals and emergency rooms available for a surge in treating critically ill COVID-19 patients. As part of this effort, CDCR's DAPO and DRP have assisted with the Project Roomkey effort by working to house parolees in need of services both prior to and post release. By early May 2020, the California Health Care Foundation [reported](#) that nearly 90% of California's 58 counties and 300 hotels were participating in the Project Roomkey initiative. An additional \$62 million in one-time funds from the State's Disaster Response Emergency Operations Account for Project Roomkey was [announced](#) in November 2020.

Project Roomkey has now evolved into [Project Homekey](#), which provides additional resources that still include justice referrals, which may be used to secure transitional housing for program participants. Building off the success of Project Roomkey, the Budget included \$550 million of the state's direct allocation of federal Coronavirus Relief Fund (CRF) for Homekey—a statewide effort to acquire hotels, motels, residential care facilities, and other housing that can be converted and rehabilitated to provide permanent housing for persons experiencing homelessness, and who are also at risk of COVID-19. Through the Department of Housing and Community Development, the State will provide grants to local jurisdictions to acquire these facilities, which will be owned and operated at the local level. This funding must be expended by December 30, 2020, per federal requirements.

The Budget also includes an additional \$50 million General Fund for the acquisition of Homekey sites and to provide initial operating subsidies. These funds will provide a critical supplement to allow cities and counties to support interim needs of these facilities and their residents. The state will use future eligible federal stimulus funds and existing state housing/homeless program funds to further encourage local jurisdictions to invest their dollars toward the same goal—acquiring properties to house people experiencing homelessness.

Project Homekey funding also includes a [partnership](#) with Enterprise Community Partners, a nonprofit dedicated to developing affordable housing, to distribute \$45 million in funding – \$20 million from Blue Shield of California and \$25 million from Kaiser Permanente – to support operating subsidies for Homekey projects. [Additional](#) funding for Project Homekey was announced in October 2020, bringing its total budget to \$800 million.

Returning Home Well

“Returning Home Well” is a new public-private partnership that provides essential services like housing, health care, treatment, transportation, direct assistance, and employment support for Californians returning home from prison after July 1, 2020. These are individuals that have either met their natural release date or are being released on an expedited timeline due to COVID-19. The State announced an initial commitment of \$15 million in federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding, which is being matched by philanthropic contributions, for a total investment of \$30 million.

State funds are from the BSCC, which granted \$15 million of its total \$58.5 million federal Coronavirus Emergency Supplemental Funding (CESF) to CDCR. CESF funds are to provide temporary, emergency housing for people released from state prison without other housing options by leveraging existing CDCR [Specialized Treatment for Optimized Programming](#) (STOP) contractors. STOP sites provide housing and comprehensive services through an expansive network of subcontracted nonprofit service providers and community-based organizations. Each STOP contractor provides step-down services ranging from residential treatment and non-medical detoxification to recovery and reentry housing. To date, CDCR’s DAPO and DRP STOP contractors have successfully placed all individuals requesting housing into this program, most straight from the institution as direct placements.

BSCC Reentry Grants

In 2018 and 2019, BSCC awarded nearly \$83 million in funds through its Adult Reentry Grants to provide rental assistance and warm handoff reentry services. In Fiscal Year 2020-21, \$37 million on-going State General Funding was allocated (\$18.5 million for warm handoff services and \$18.5 million for rental assistance). In August 2020, the BSCC awarded \$17.5 million to 8 organizations that had not been previously awarded funds, but were next on the list for rental funding. An additional \$17.5 million in funding for warm handoff programs, referred to as “ARG Warm Hand-Off Reentry Services – Cohort II (7/1/21 – 2/28/25),” will be administered through a competitive bid process. The grantees are providing necessary direct services that became even more critical with the recent expedited releases. CDCR is currently working on establishing partnerships with the BSCC grantees in the community in order to provide services to parolees. More information about the ARG Program may be found on the BSCC [website](#).

Additional Housing Efforts

In addition to the above, the Continuums of Care (CoCs), CDCR, and CSG have begun exploring potentials for partnership. In November 2020, DRP-STOP, DAPO, CSG, and the CoCs engaged in a collaborative webinar to introduce to one another their roles and responsibilities, as well as to educate on the services provided by each entity. Beginning in January 2021, DAPO and DRP-STOP will begin outreach to the CoCs to develop partnerships and establish referral mechanisms, which is an innovative practice that has not yet been implemented anywhere in the country.

Appendix D

Summary of 2020 Full Council and Workgroup Meetings

2020 FULL COUNCIL MEETINGS			
Date	Format	Focus	Meeting Highlights
2/6	In Person	Policy and Budget Priorities for 2020	<ul style="list-style-type: none"> – A high-level overview of key budget goals as they related to the justice-involved population provided to the council – The council reviewed and approved the 2020 Work Plan – Discussed the Annual Legislative report timeline – Approved 2020 Council Meeting Dates
4/30	Virtual	COVID-19 Response	<ul style="list-style-type: none"> – Modifications to previous Work Plan: Council Meetings went virtual, training contracts amended to meet CDC guideline in response to COVID-19 (ie, CSG moved in-person diversion trainings to a virtual format). – Identified critical issues and potential solutions in the immediate response to COVID-19 – Solicited feedback regarding legislative and budget issues that should remain a priority despite significant fiscal constraints
6/26	Virtual	Looking at racial inequalities through a health lens, what are the effects of racism on mental health and behaviors? Can declaring racism as a public health crisis serve as a catalyst to change systemic racism?	<ul style="list-style-type: none"> – Reviewed Public Health and Budget Crisis impact on the criminal justice and behavioral health systems – Discussed the impact on vulnerable populations – Established Workgroups in the areas of Prevention and Diversion, Reentry and Reintegration and Juvenile Justice to help identify creative and innovative strategies in keeping behavioral health and criminal justice programs progressing
8/27	Virtual	Project presentations to council on PH/PS Project and the Housing Policy Project	<ul style="list-style-type: none"> – CSG provided the council with a presentation on the PH/PS. Eliciting feedback from council on possible questions for research data and direction; Project milestones were outlined and deliverables discussed. – Council members had an opportunity to ask questions and provide feedback on the upcoming project

2020 FULL COUNCIL MEETINGS			
			<ul style="list-style-type: none"> – Recap of the effect of COVID-19 on housing in light of budget complications and expedited releases provided to council – CCJBH staff and CSG Housing Policy Project director provided educational presentation and update on the project – Council members had an opportunity to ask questions and provide feedback on the Housing Policy project
10/29	Virtual	Project presentations to council on the ISMIP Transition, Medi-Cal Utilization, Housing Policy Projects, and Annual Legislative Report Recommendations.	<ul style="list-style-type: none"> – DAPO provided an update on the ISMIP transition process and shared CSA recommendations – Council members had an opportunity to ask questions and provide the program feedback – The CCJBH team provided an update on the Medi-Cal Utilization project that included next steps – The CSG Housing Policy Project director, returned to provide presentation on draft findings and recommendations – Council members had an opportunity to ask questions and provide feedback
12/11	Virtual	Adoption of Legislative Report	<ul style="list-style-type: none"> – ISUDT presentation and requested feedback on proposed January Summit – Council members had an opportunity to ask questions and provide program executive feedback – CCJBH presented the council with final findings and recommendations – Council members motioned to adopt recommendations and delegate edits as deemed appropriate

2020 WORKGROUP MEETINGS				
Workgroup	Meeting Dates	Format	Focus	Highlights
Prevention and Diversion	July 31, 2020 September 25, 2020 December 4, 2020	Virtual	Prevention and Diversion in the wake of the public health and budget crisis as a result of COVID-19	<ul style="list-style-type: none"> – Engaged in discussion with partners out in the community to make sure we can keep jail population low – Explored Creative and Innovative Strategies to Keep Diversion Progressing – Recommendations formulated <i>*Workgroup collapsed with Prevention and Diversion**</i>
Reentry and Reintegration	July 24, 2020 September 18, 2020 December 4, 2020	Virtual	Preventing individuals who are released from returning to jail, prison, and state hospitals	<ul style="list-style-type: none"> – Reentry and reintegration crisis predated COVID-19 – Best practices in pre-release and discharge planning – Recommendations formulated <i>*Workgroup collapsed with Prevention and Diversion**</i>
Juvenile Justice	July 24, 2020 September 18, 2020 November 20, 2020	Virtual	How does juvenile justice policy progress with reduced budget and resources?	<ul style="list-style-type: none"> – Addressing the needs of high risk and high need youth – Areas of consensus regarding juvenile justice policy in the wake of a public health and budget crisis – Recommendations formulated

Appendix E

Juvenile Justice Workgroup Participants

On July 31st, September 25th, and November 20th, 2020, CCJBH convened a Juvenile Justice Workgroup to discuss creative and effective strategies in Juvenile Justice as a result of COVID-19. Workgroup participants are listed below.

Councilmember Workgroup Leads:

- Danitza Pantoja, Psy.D., School Psychologist, Antelope Valley Union High School District
- Chief Mack Jenkins, Retired Chief Probation Officer, San Diego County

CCJBH Staff Workgroup Lead:

- Sheron Wright, MPH, Policy Analyst

Participating Organizations/Perspectives:

- Dr. Tony Hobson, Behavioral Health Director, Plumas County, CCJBH Councilmember
- Dr. Heather Bowllds, Director, DJJ
- Chief Tanja Heitman, Santa Barbara County Probation, CPOC
- Rosie McCool, Deputy Director, CPOC
- Deanna Adams, Senior Analyst, Judicial Council
- Dr. Marcus Galeste, Senior Researcher, MHSOAC
- Boys Republic
- California Alliance of Child and Family Services
- Cal Voices
- California Association of Local Behavioral Health Boards
- California Department of Corrections and Rehabilitation
- California Department of Education
- California Department of Finance
- Children Now
- County Behavioral Health Directors Association
- Hathaway-Sycamores Child and Family Services
- Judicial Council of California
- Legislative Analyst's Office
- Public Health Institute
- Self-Awareness Recovery
- SOS Community Counseling
- Starting Over Inc.
- The Children's Partnership
- United Parents
- Youth Solutions

Appendix F

Compilation of Juvenile Justice Research and Workgroup Discussions

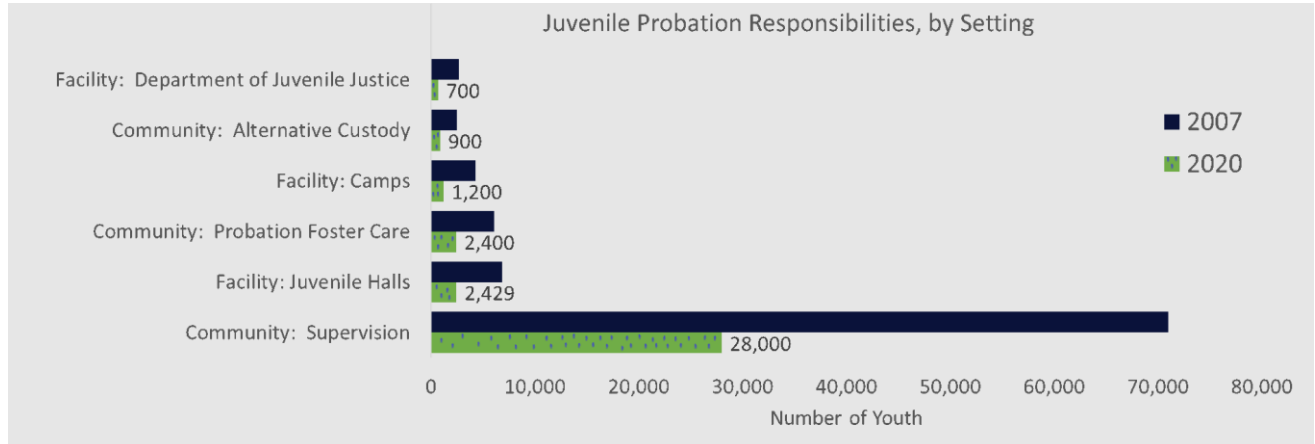
The findings and recommendations related to the justice population were based on CCJBH staff research and discussions that occurred within the CCJBH Prevention Workgroup, all of which are compiled below.

Current County Youth Probation Population

Through realignment and investing in youth, the youth population under supervision by county probation departments has reduced by half. The initial realignment in 2007 contributed to significant investments to build out local infrastructure to better serve juvenile justice youth, and move them closer to family and local support services. As a result, most justice-involved youth are supervised in the community.

Figure 3 shows a snapshot of the distribution of youth currently supervised by California probation departments. Currently there are approximately 35,000 youth under the authority of California probation departments. The number of youth have decreased by half since 2007. In addition, less than 9 percent of the justice-involved youth population are detained in juvenile halls.

Figure 3: Youth Currently Supervised by California Probation Departments



Sources of the data: The Division of Juvenile Justice (DJJ), Board of State and Community Corrections (BSCC), Chief Probation Officers of California (CPOC), Child Welfare Services (CWS).

Youth Previously Served by DJJ Who Will Remain Under the Jurisdiction of County Youth Probation as of July 1, 2021

In 2004, the State entered into a consent decree for the *Farrell v. Allen* lawsuit, which was filed against the State in 2003, alleging that the State had failed to provide adequate care and effective treatment programs to youth placed at DJJ. Through the consent decree, the State

agreed to develop and implement six remedial plans related to safety and welfare, mental health, education, sexual behavior treatment, health care, dental services, and youth with disabilities. The overarching goal of these plans was to move DJJ toward adopting a “rehabilitative model” of care and treatment. This included the implementation of the Integrated Behavioral Treatment Model, which is designed to provide a comprehensive approach to assessing and treating youth while also reducing the likelihood of institutional violence and future criminal behavior.

In 2007 California passed Senate Bill 81 (SB 81) which led to realigning youth except for those with serious violations to county probation departments. DJJ is responsible for youth with higher needs and significant violations (i.e., murder, robbery, and certain sex offenses). These youth are placed within DJJ’s three youth correctional facilities and one fire camp. This reform and steep reductions in youth arrests is reported as contributing to the decline in youth population and better outcomes at DJJ. At its peak in 1996, DJJ housed more than 10,000 youth and young adults ages 12 to 25. According to data obtained from the CDCR Office of Research in June 2020, the population at DJJ was 782 youth (464 Latino youth (59.3%), 227 Black youth (29.0%), 60 white youth (7.7%), and the remaining 31 identifying with another race. Eighty-five point five percent (85.5%) of DJJ’s youth population falls into three offense categories and treatment programs. The majority are committed to DJJ for Assault (37.5%), followed by Robbery (32.7%), and Homicide (15.3%). For those participating in DJJ programs, most are assigned to the Sexual Behavior Treatment Program (11.1%), followed by the Mental Health Residential Treatment Program (8.2%), and Intensive Treatment Program (1.2%).⁶

DJJ provides education and treatment to California’s youthful offenders up to the age of 25 who have criminal backgrounds and most intense treatment needs. Youth are provided with academic and vocational education, medical care, and treatment programs that address violent, criminogenic, and sex offender behavior, as well as substance abuse and mental health needs in a secured environment conducive to learning. Given the extensive reforms that were made by DJJ since 2004, county agencies that will serve the DJJ population beginning on July 1, 2021, should seek to leverage and build off of the foundation that was established through the consent decree.

Demographic Disparities

Youth that are dually involved in the child welfare and juvenile justice systems, known as “Crossover Youth,” are disproportionately youth of color and girls. Compared to white youth, Black youth are 5.1 times more likely to be referred to probation, 7.7 times more likely to have a petition filed in juvenile court, 9.5 times more likely to be declared a ward of the court, and 31.3 times likely to be committed to DJJ (see [Figure 4](#)). This information shows that youth of color bore the brunt of justice system involvement. Over 88 percent (88%) of the DJJ youth population are youth of color who will be the most affected by the realignment to local systems. Furthermore, Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) youth are estimated to only make up 5 to 7% of the nation’s youth population, while they

⁶ Data request, CDCR Office of Research.

represent 13 to 15% of youth in the juvenile justice system, as reported by CCJBH in its [2019 Legislative Report](#).

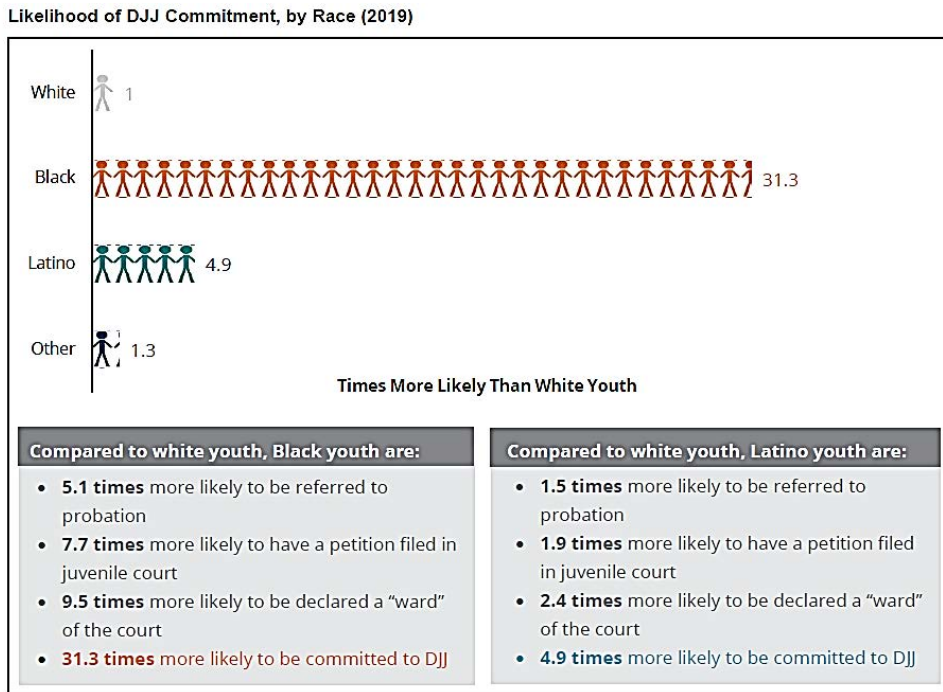
Each of these disparities increases the prevalence of youth with behavioral health needs in the juvenile justice system. Accordingly, the systems must ensure identified needs are addressed and supportive services are provided in a culturally responsive manner, including race, ethnicity, language, sexual orientation, and gender identity / expression perspectives.

Evidence-based practices and programs may need to be adapted to effectively support the actual population of youth that are being served. It is equally as important to collect and continuously analyze data to understand the characteristics of juvenile justice involved youth to identify areas of disparity, identify biases across public systems, and develop community-based alternatives to help reduce the number of youth of color who are detained.

Trauma-Informed Care and Practices

Trauma-informed care considers the nature of trauma, promotes healing, and recovery rather than practices or services that may inadvertently re-traumatize children and youth. Child serving systems and those individuals who deliver services must utilize this approach to ensure services and supports are tailored to each youth to ensure these services are accessible and appropriate to those youth in or at risk of entering the juvenile justice system. Most youth involved with the juvenile justice system have a history of childhood adversity. [Research](#) estimates that 75 to 93 percent of youth entering the justice system each year have experienced some degree of trauma. Justice-involved youth often experience additional mental health problems, beyond trauma exposure and post-traumatic stress disorder, as mentioned within this report either preceding or concurrent with justice involvement. Trauma is a risk factor for nearly all behavioral health (i.e., mental health and substance use disorders). Justice-involved youth are also at risk for academic problems and child welfare involvement. Yet, less is

Figure 4: Likelihood of DJJ Commitment by Race in 2019



Source: DOJ, 2020.

known about the details of their trauma histories, mental health issues, and associated risk factors.⁷

Trauma assessments are encouraged by DHCS as a proven method for obtaining a child or youth's Adverse Childhood Experiences (ACEs) score. These assessments are payable by Medi-Cal to incentivize providers to conduct trauma assessments to connect patients with support, interventions, and resources. Providers who complete the appropriate trauma assessment training are eligible for reimbursement of the cost of the assessments. In doing so, DHCS has initiated a statewide effort to improve the behavioral health care rendered to children/youth and set an example for trauma informed care nationwide.

Behavioral Health Needs for Youth Involved in Juvenile Justice System

Juvenile justice systems across the state are disproportionately filled with youth who have behavioral health needs, with the most substantial overrepresentation among youth assigned to secure confinement after trial.⁸ Numerous comprehensive studies have indicated that there are certain types of mental disorders common among youth offenders, and that some of the symptoms increase the risk that youth will engage in aggressive behaviors.^{9,10} Commonly found mental health diagnoses in youth offenders include affective disorders (major depression, persistent depression, and manic episodes), psychotic disorders, anxiety disorders (panic, separation anxiety, generalized anxiety, obsessive-compulsive disorder, and post-traumatic stress disorder), disruptive behavior disorders (conduct, oppositional defiant disorder, and attention-deficit hyperactivity disorder), and substance use disorders.¹¹ Of youth involved with the juvenile justice system, estimates suggest that approximately 15 to 30 percent have diagnoses of depression or dysthymia (pervasive depressive disorder),¹² 13 to 30 percent have attention-deficit/hyperactivity disorder, 3 to 7 percent have bipolar disorder¹³ and 11 to 32 percent have posttraumatic stress disorder.¹⁴ Researchers estimate that up to 70 percent of youth in juvenile justice detention, correctional, or community-based facilities have a

⁷ Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). [Psychiatric disorders in youth in juvenile detention](#). *Archives of general psychiatry*, 59(12), 1133–1143.

⁸ Underwood, L. A., & Washington, A. (2016). [Mental Illness and Juvenile Offenders](#). *International journal of environmental research and public health*, 13(2), 228.

⁹ Wasserman, G. A., McReynolds, L. S., Lucas, C. P., Fisher, P., & Santos, L. (2002). [The voice DISC-IV with incarcerated male youths: prevalence of disorder](#). *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(3), 314–321.

¹⁰ Underwood, L. A., & Washington, A. (2016). [Mental Illness and Juvenile Offenders](#). *International journal of environmental research and public health*, 13(2), 228.

¹¹ Grisso T. (2008). [Adolescent offenders with mental disorders](#). *The Future of Children*, 18(2), 143–164.

¹² Weiss, B., & Garber, J. (2003). [Developmental differences in the phenomenology of depression](#). *Development and psychopathology*, 15(2), 403–430.

¹³ Goldstein, N.; Olubadewo, O.; Redding, R.; Lexcen, F. 2005. Mental Health Disorders. In *Juvenile Delinquency: Prevention, Assessment, and Intervention*; Heilbrun, K., Goldstein, N., Redding, R., Eds.; Oxford University Press: Oxford, UK.

¹⁴ Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of general psychiatry*, 61(4), 403–410. <https://doi.org/10.1001/archpsyc.61.4.403>

diagnosable mental disorder and a quarter or more have a serious mental disorder that impairs their ability to function.

Criminogenic Risk and Needs Assessments and Intervention

Mental health and substance use disorders are critical factors that impact whether or not youth engage with and respond to programs and services, with SUDs being one of the most common and intractable dynamic risk factors. Risk and needs assessments typically do not assess mental health, and they are not always able to identify youth with significant substance use disorders. Risk and needs assessments are standardized tools that help practitioners collect and synthesize information about a youth to estimate their risk of recidivism and identify other factors that, if treated and changed, can reduce the youth's likelihood of reoffending. Risk and needs assessments are not only designed to inform and guide decisions about estimating a juvenile's risk of recidivating, but they are also helpful when creating plans for appropriate interventions or services. They allow juvenile justice professionals and practitioners to classify offenders and target limited resources to juveniles who may need intensive supervision and services. Risk and needs assessments can be used at various stages in the juvenile justice system, including diversion, adjudication, and disposition. However, the categorization of risk will depend on the stage in the system.

According to one [estimate](#), there are approximately 20 different risk and needs assessment tools used in juvenile justice systems across the United States. Some assessments target the general population of juvenile offenders, whereas others center on estimating risk for specific juvenile populations (such as juvenile sex offenders) or specific delinquent or offending behaviors (such as violent offending). The following are examples of risk and needs assessments that illustrate the variety of formats that assessment tools can take, and are taken from a [literature review](#) prepared for the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention:

- The Youth Assessment and Screening Instrument (YASI) includes a pre-screen section that identifies moderate- or high-risk youth who are then administered the full assessment.
- The Youth Level of Services/Case Management Inventory (YLS/CMI) estimates a youth's risk of recidivating and need for services based on a variety of factors (e.g., education/employment, attitudes/orientation, peer relations, leisure activities, substance abuse treatment, personality/behavior, family circumstances/parenting, personality/behavior, family circumstances/parenting).
- The Structured Assessment of Violence Risk in Youth (SAVRY) estimates the risk of youth committing a specific offending behavior (e.g., violent acts).

When youth are placed at DJJ, they are assessed using the YASI, for which the full assessment consists of 88 items across the following 10 domains: legal history, family, school, community and peers, alcohol and drugs, mental health, aggression/violence, attitudes, skills, and

employment/use of free time.¹⁵ It is based on reviewing the juvenile’s official criminal record, conducting a semi-structured interview with the youth, and looking at any information from additional sources such as family, service agencies, police, and school officials.¹⁶ If an increase in risk is identified, youth are paired with an intervention that is an evidence-based cognitive behavioral health therapy.

Utilization of Peer Partners

Peer support is an evidence-based, cost-effective model of care proven to reduce costly hospitalizations and homelessness, increase participation in treatment, and improve service experience. “603 Support Specialists” are self-identified consumers who use their lived experience along with skills learned in formal training to assist others in their recovery from mental illness. Youth and Parent Partners who provide peer support are a valuable component of effective service delivery. Peer partners provide mentorship and support and can help youth and families connect to needed services in ways that other service providers cannot.

A Continuum of Support and Programs for Juvenile Justice Youth

Although youth advocates and families declare the passing of SB 823 a victory, the justice and behavioral health communities are concerned that DJJ youth are being realigned to counties with limited funds to support their needs. Many of the youth will require highly specialized and trained individuals to provide the appropriate level of behavioral health services to meet their needs. There will need to be ongoing and continued coordination, collaboration, and partnership between the state, county probation, and behavioral health departments to provide the appropriate level of care and supervision for DJJ youth while also ensuring existing youth involved in the juvenile justice system are able to succeed. The OYCR will lead this transition, and CCJBH will lend support to assist with these effort to ensure a successful realignment for county behavioral health and justice partners.

That said, evidence-based services provided in the community have been proven to reduce recidivism by more than 20 percent, and an [estimate](#) by the Justice Policy Institute indicates that an investment of \$1 provides at least \$10 worth of benefits. Therefore, it is important for child serving systems to move upstream and develop effective alternatives to initial or continued formal processing of youth in the juvenile justice system. There are many county behavioral health and probation partnerships that have developed various programs tailored to meet the unique needs of those youth involved in the juvenile justice system and are aimed at promoting resilience through tailored evidence-based programming. Programming must be targeted at both the youth’s clinical needs and their criminogenic needs. Services and supports may include medication support, mental health assessments, individual and family treatment as

¹⁵ Baird, Chris, Theresa Healy, Kristen Johnson, Andrea Bogie, Erin Wicke Dankert, and Chris Scharenbroch. 2013. [A Comparison of Risk Assessment Instruments in Juvenile Justice](#). U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (OJJDP).

¹⁶ Orbis Partners, Inc. 2011. *Validation of the Youth Assessment and Screening Instrument for Use by the Vermont Department for Children and Families*. Ottawa, Ontario.

well as alcohol and drug counseling, and interventions to address criminal thinking, peer associations, and other risks and needs.

Although county-coordinated diversion programs may be an effective alternative, it is critical to ensure those who are currently in detention are also receiving support. Most youth experience at least some degree of emotional distress and anxiety while being arrested or detained. These youth with transitional mental and emotional needs should receive the appropriate level of support and services to meet their behavioral health needs. One particular area of concern that was discussed in the CCJBH Juvenile Justice Workgroup meetings is the lack of residential treatment capacity for youth with serious mental and emotional needs that are justice involved. Now that youth with serious behavioral health issues who would have been remanded to DJJ will be detained at local levels, the need for short-term crisis residential treatment facilities is greater. To address these needs, counties should consider establishing children's crisis residential programs through shared cross-county agency partnerships. Crisis residential programs offer a lower-cost, community-based treatment option in home-like settings to help reduce emergency department visits, divert hospitalization, and incarcerations. These programs often include peer-run programs, such as crisis respite that offer safer, trauma-informed alternatives to psychiatric emergency units, or other locked facilities while producing the same or superior outcomes to those of more costly institutionalized care. That said, there may be situations that necessitate the use of locked facilities, so it is important to ensure capacity across the continuum so that children/youth may be safely, and appropriately, diverted away from the criminal justice system (e.g., juvenile hall).

Transitional programs are also a vital part of the continuum of care for youth involved in the juvenile justice system. Community reintegration programs may be developed to consult with the youth and their family about the youth's history, strengths, and needs as well as the family's special circumstances. Additionally, community reintegration/after care programs which help youth may include individual case planning, home visits and referrals, academic support, vocational skills, job related skills, and legal resources. The continuum of support for youth involved in the juvenile justice system must be developed based on an individualized family-centered, strength-based treatment plan with the goal of rehabilitation.

Juvenile Justice System Findings

1. As of July 1, 2021, County probation departments will be responsible for a population of youth who would have been remanded to DJJ and their existing youth population. Chief Probation Officers have expressed concern with not being financially or structurally prepared for this change. Realigning youth with greater and serious needs to local county detention centers will require planning, funding, and policy development.
2. Youth of color, crossover youth, LGBTQ youth, and youth with behavioral health needs are disproportionately impacted by the juvenile justice system at all points compared to youth who are not in these groups.
3. Research estimates that youth entering the justice system each year have experienced some degree of trauma, yet the details of their trauma histories, mental health issues or risk

factors are not always known. Screening and assessment are essential, as unmet behavioral health needs can be a leading cause of justice involvement and recidivism.

4. There is a high prevalence of youth with behavioral health needs each year who enter the juvenile justice system. Approximately 65 to 70 percent of these youth have at least one mental health disorder. Without effective treatment, high-risk youth remain on a path towards chronic delinquency that puts them at great risk of adult criminality. Behavioral health and criminogenic risk and needs screening, assessment and comprehensive / collaborative case plan development are vital to addressing the behavioral health and criminogenic treatment needs of youth in the juvenile justice system. While there is no current requirement for probation departments to conduct mental health or criminogenic risk/needs screenings/assessments for youth entering the juvenile justices system, many do often perform criminogenic screening/assessments.
5. In accordance with screening and assessment, adequate residential treatment capacity and community-based treatment programs are critical parts of the continuum of care that should be provided for youth.
6. Youth, parents and/or peer partners who provide peer support are valuable components of effective service delivery and provide mentorship and support that can help youth and families connect to needed services in ways that other service providers cannot.
7. The *Ferrell vs Allen* lawsuit required DJJ to implement a “rehabilitative model” of care, which included the implementation of the Integrated Behavior Treatment Model (IBTM), and establishing/expanding treatment that includes physical and behavioral health services. DJJ made significant investments in developing the IBTM and new policies/practices (screening, assessment, etc.), which led to lessons learned and the establishment of best practices.

Appendix G

Prevention and Diversion Workgroup Participants

On July 24th, September 25th, and December 4th, 2020, CCJBH convened a Prevention and Diversion workgroup to discuss creative and effective strategies in Diversion as a result of COVID-19. Workgroup participants are listed below.

Councilmember Workgroup Leads:

- Hon. Stephen Manley, Superior Court Judge, Santa Clara County
- Dr. Tony Hobson, Behavioral Health Director, Plumas County

CCJBH Staff Workgroup Lead:

- Monica Campos, Staff Services Manager III

Participating Organizations/Perspectives:

Alpine County	Department of Behavioral	Mental Health Services Division,
Amity Foundation	Wellness, Santa Barbara	CDCR
Board of State and Community	County	Mental Health Services Oversight
Corrections	Department of Finance, State of	and Accountability Commission
California Behavioral Health	California	Monterey County
Directors Association	Department of Social Services	Our Road Prison Project
California Behavioral Health	Department of State Hospitals	Plumas County Behavioral Health
Planning Council	Disability Rights California	Public Health Institute
California Department of Public	Division of Adult Parole	Riverside County
Health	Operations, CDCR	Riverside County District
California Health Policy Strategies	Division of Rehabilitative	Attorney's Office
California Law Revision	Programs, CDCR	Riverside University HealthSystem
Commission	El Dorado County Probation	Sacramento County
CalVoices	Forensics Mental Health	San Bernardino County
CEO Works	Association	San Diego County District
City of San Francisco	Fresno County	Attorney's Office
City of San Jose	Geo Group	San Joaquin County Behavioral
Community Health Worker, Los	Humboldt County	Health Services
Angeles County	Judicial Council	Self-Awareness Recovery
Community Solutions	Kern County Probation	Senate Staff, State of California
Council of State Governments	Legislative Analyst's Office	Shasta County
Justice Center	Liberty Health Care	Siskiyou County
County of Merced	Los Angeles Regional Reentry	Starting Over Inc.
Del Norte County	Partnership	Successful Reentry
Department of Behavioral Health,	Marin County	Transitions Clinic Network
Santa Barbara County	Mental Health America of San	Tuolumne County
Department of Behavioral Health,	Diego County	
San Luis Obispo		

Appendix H

Reentry and Reintegration Workgroup Participants

On July 24th, September 18th, and December 4th, 2020, CCJBH convened a Reentry and Reintegration Workgroup to discuss creative and effective strategies in reentry as a result of COVID-19. Workgroup participants are listed below.

Councilmember Workgroup Leads:

- Judge Manley, Superior Court Judge, Santa Clara County
- Mack Jenkins, Retired Chief Probation Officer, San Diego County

CCJBH Staff Workgroup Lead:

- Stephanie Welch, Executive Officer
- Catherine Hickinbotham, Health Program Specialist I

Participating Organizations/Perspectives:

Abode Services	East Bay Community Law Center
Amity Foundation	Forensics Mental Health Association
Board of State and Community Corrections	Fred Brown
California Behavioral Health Directors Association	Fresno County
California Behavioral Health Planning Council	Geo Group
California Health Policy Strategies	Judicial Council
CalVoices	Liberty Health Care
CEO Works	Los Angeles Regional Reentry Partnership
City of San Francisco	Mental Health Services Division, CDCR
City of San Jose	MHSOAC
Community Health Worker, LA County	Our Road Prison Project
Conzion	Plumas County Behavioral Health
CSG Justice Center	Riverside County
County of Merced	Riverside County District Attorney's Office
Department of Behavioral Health, Santa Barbara County	Riverside University Health System
Department of Behavioral Wellness, Santa Barbara County	San Diego County District Attorney's Office
Department of Finance, State of California	San Joaquin County Behavioral Health Services
Department of Social Services	Self-Awareness Recovery
Department of State Hospitals	Senate Staff, State of California
Division of Parole Operations, CDCR	Starting Over Inc.
Division of Rehabilitative Programs, CDCR	Successful Reentry
	Transitions Clinic Network

Appendix I

Compilation of Diversion/Reentry Research and Workgroup Discussions

The findings and recommendations related to the justice population were based on CCJBH staff research and discussions that occurred within the CCJBH Diversion/Reentry Workgroups, all of which are compiled below.

Case Planning/Management, Service Linkages and Ongoing Monitoring

The COVID-19 PHE sparked a rapid expansion in the implementation of innovative case planning, management, and service linkage models for those providing diversion/reentry services to the BH/CJ population. Some strategies identified as being used during COVID-19 were telehealth, virtual court hearings, enhanced community outreach, leveraging peer navigation, and the use of concrete participant [incentives](#) (e.g., participation/completion awards, gift certificates, providing alternative to court appearance (i.e., case manager attends court appearance on behalf of client), and providing for basic needs such as grocery deliveries). Another strategy discussed is to make exceptions to allow county-to-county transfers to allow those on parole/PRCS to be closer to family and support systems or treatment programs.

Fortunately, warm handoff, case planning/management, and service linkage models had been successfully established prior to the pandemic through existing efforts such as the [Whole Person Care Pilots](#) and CDCR's Integrated Substance Use Disorder Treatment (ISUDT) Program. These models were foundational to support the rapid mobilization of emergency resources within the behavioral health system and will continue to expand to meet the ongoing needs of the BH/CJ population. [Collaborative comprehensive case plans](#) have also been identified as a best practice. 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." Additional improvements can be made by allowing in-reach activities that have proven successful in ensuring continuity of care, including the implementation of processes that are staffed by community health workers/peers who have lived experience with incarceration. Outpatient treatment with recovery housing would be the ideal transition for most of the individuals to continue their treatment and

Fresno County Multi-Agency Access Program (MAP)

Fresno's MAP has demonstrated the following positive outcomes: a partnership with courts, physical health providers, and homeless advocacy organizations; implementation of a screening tool that is used to help individuals identify their needs, which is used to link them to a variety of resources and services. MAP staff, called Navigators, schedule appointments for clients based on the outcome of the screening tool, and support success by ensuring clients receive the needed services. Transportation is available to clients for MAP-related services and linkages.

ensure successful transition to the community providers for their continued treatment needs.

Once established, additional benefits proposed through the Department of Health Care Services' [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#), which was unfortunately delayed for one year due to the COVID-19 PHE, will assist with successful reentry. In particular, the proposed Enhanced Care Management (ECM) benefit, which is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services, specifically identifies people transitioning from incarceration as one of its target populations. Another provision of CalAIM, known as In Lieu of Services (ILOS), will allow Medi-Cal Managed Care Plans to offer flexible wraparound services, such as housing transition services and sobering centers, when medically appropriate and cost-effective. Expansion of the existing infrastructure for the Mandatory Medi-Cal Application Process upon Release from Jail, will be a critical part of ensuring that the BH/CJ population has access to these enhanced Medi-Cal benefits.

In addition to State efforts, one type of community-based entity that was noted during workgroup discussions are Community Transition Centers (CTCs), which are a public/private multi-agency collaboration that includes an assessment center where individuals returning to the community from prison undergo a number of assessments (criminal risk/needs, clinical, mental health, and substance abuse screens) for the purpose of developing a case plan that would identify need areas and treatment goals. The case plan would then go to the probation officers who would be supervising the individuals in the community. Additionally, the CTCs could provide transitional / recovery housing beds for individuals who had no immediate place to stay upon leaving prison or jail. A residential treatment program could be provided on site for those who are assessed as requiring that level of intervention. The best practice of incorporating transportation in picking up individuals from prison or jail and transporting them to the CTC, taking advantage of this critical point of intervention. A best practice to incorporate would be to include transportation with person with lived experience to help in the transition.

Santa Clara County: Leveraging Cell Phones to Support Reentry

In Santa Clara County, courts are issuing cell phones to facilitate engagement and improve accountability. This approach has proven to be a cost-effective strategy that establishes clear lines of communication, allows courts to be more involved in defendants' treatment, and may be used to track behavior and accomplishments. This innovative use of modern technology departs from the traditional role of the court system.

While case management and linkages are important, Diversion/Reentry Workgroup participants noted that participants must also receive continuous, close monitoring and support due to the significant risk of relapse for their physical and behavioral health conditions. Workgroup participants noted the important role that community health workers have had, not only in case planning during the pandemic, but also in providing linkages to support services and helping to maintain service engagement. They also recommended that monitoring should be provided in diversion/reentry programs upon release from incarceration for at least 365 days, based on individual assessment, to ensure effective use of the services and participant stability, as

was the practice in the [California Communities Transition Project](#), administered through DHCS. As another example of such ongoing monitoring efforts, Santa Clara has implemented a project in which cell phones are issued to BH/CJ program participants, which allows for close communication and monitoring. In 2019, the National Institute of Justice also initiated a grant [program](#) and research-practice partnership to monitor behavior using cell phone technology.

Note: Services should always be based on risk, needs, and responsivity (RNR) model of care.

Prior to the COVID-19 pandemic, people incarcerated in jails were held for comparatively longer periods. As a result, there was more time for transition planning toward the end of a person's jail term. However, because of the COVID-19 PHE, stakeholders earlier in the criminal justice process now have increased responsibility for connecting people with behavioral health needs to services. Specifically, law enforcement contact and initial detention (i.e., Intercepts 1 and 2 of the [Sequential Intercept Model](#)) are key points at which people can be connected to care. Furthermore, the BH/CJ population is under varying levels of local criminal justice supervision, which must also be taken into consideration. In particular, individuals may be convicted of crimes and released from jail to probation supervision or not, or may be released before going to trial (i.e., pre-trial). Different populations have access to different types of support and services. People released after being held in jails pre-trial would not necessarily face restrictions to accessing services based on their criminal history. In addition, people who have been sentenced and released may or may not be on probation supervision, which affects the amount of monitoring and support they receive.

Adapting to the COVID-19 crisis requires collaboration among criminal justice stakeholders, including sheriffs, police, probation, and parole, and behavioral health stakeholders, such as county agencies and DSH. While there are already multiple programs and initiatives in place that connect justice-involved people to services, there is not always coordination among these efforts. Regular and consistent communication, as well as a convening platform, would help stakeholders to carry out strategic planning. This is especially important at the local level.

Physical and Behavioral Health Care Services

Examination of CDCR's population forecasts shows that almost twice as many individuals who will require behavioral health services in the community upon release will be released in 2021 as there were in 2020. CDCR's projects 2,076 releases with a mental health diagnosis in 2020, 4,078 in 2021 and 2,730 in 2022.¹⁷ If the goal is to effectively serve these vulnerable individuals in communities rather than costly incarceration and institutionalization, access to effective community based medical and behavioral health care is a necessity. Maintaining the health and continuing treatment investments that were made while individuals were incarcerated is dependent upon: 1) a system that has the capabilities to address needs and 2) processes and strategies to address barriers and encourage service utilization.

The Affordable Care Act expanded access to health insurance on a tremendous scale. A variety of strategies enhance continuity of care as an individual transitions through different

¹⁷ Data request, CDCR Office of Research.

institutional care settings, including warm handoff activities, supplying cellular phones upon discharge, as appropriate, and providing transportation, transitional housing and supportive services upon reentry. Of particular importance is to ensure that individuals who need medication continue to receive it following release. In particular, it is recommended that a 30-day supply of medications be provided upon release from jail for behavioral health patients either from the jail or through a prescription that may be filled at a community pharmacy. Furthermore, employing individuals with lived experience to provide peer supports has proven to be particularly effective in connecting and engaging individuals into treatment. Such strategies allow for better utilization of health insurance and for systems to better serve individuals in community-based health care.

CalAIM's Behavioral Health, as well as ECM, ILOS, and Mandatory Medi-Cal Application Process upon Release from Jail proposals will benefit the BH/CJ population by providing specific infrastructure and resources to support the medical and behavioral health "warm handoffs" from jail to the community. CCJBH will resume participation in the CalAIM planning efforts in 2021.

Criminogenic Risk and Needs Screening, Assessment and Intervention

Screening and assessment are essential first steps in successful diversion and reentry. Without knowledge of behavioral health needs, it is impossible to determine eligibility for mental health diversion or services at reentry. For example, risk and needs assessments are valuable tools that can help identify individuals at highest risk of recidivating and help guide interventions. These assessments can be administered at any point in the criminal justice process—during the pre-trial period, while on probation, after admission to a correctional facility, prior to release, and during post-release supervision. Criminogenic risk/needs assessments should be conducted in addition to, not instead of, clinical behavioral health assessments.

Criminogenic needs are characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to reoffend. These needs can be categorized as static and dynamic. Static factors cannot be changed or addressed by any sort of program or therapy to reduce recidivism. Examples of static factors include age at the time of first arrest, criminal history, and residing in a single-parent home. The Adverse Childhood Experiences assessment uses static factors. In contrast, dynamic factors can change over time and can be addressed by therapy, training, education, and/or targeted programming to improve recidivism outcomes. Examples of dynamic risk factors are lack of respect for authority, antisocial behavior, lack of literacy or job skills, or other expressed nonconformist behaviors, values, and attitudes that are associated with criminal activity.

Assessing criminogenic risk factors is important to help ensure the correctional interventions provided are effective and decrease likelihood of recidivism. The RNR model is a type of evidence-based practice used in corrections and reentry settings that assigns a risk level to certain individuals to help improve recidivism rates. Each element of the RNR model operates according to a set of principles, which state how offender programming should be set up.

The risk principle states that individuals need to be placed in programs that are commensurate with their risk level; providing more intensive treatment and services to high-risk offenders

while low-risk offenders should receive minimal or even no intervention. The need principle states that effective treatment should also focus on addressing the criminogenic needs that contribute to criminal behavior. The responsivity principle states that rehabilitative programming should be delivered in a culturally competent manner and mode that is consistent with the ability and learning style of the individual.

While there are many available risk assessment tools, counties can maximize available resources by promoting the use of the same risk assessment tool across systems to allow for collaboration, consistency, and a continuum of care from incarcerated settings to community-based services. A formalized assessment and referral system is needed to match people to needed services who are being diverted from or leaving jails/prisons. By treating the criminogenic needs, interventions can help reduce or remove barriers to improve access to available and appropriate housing and treatment for high-risk target populations.

Diversion/Reentry Workforce

Peers and Community Health Workers

As mentioned for the juvenile justice population, investments in peer and community health workers is key to diversion/reentry as it is critical for engaging and maintaining participation in treatment for the BH/CJ population. The passage of SB 803 could not have come at a better time for California to embrace peer support as an innovative and effective model, and a certification program will help to standardize best practices. [Research](#) demonstrates that the utilization of qualified peer support specialists and community health workers has measurable benefits to clients, including reduced hospitalizations, improved functioning, and alleviation of depression and other symptoms. Therefore, the peer certification process that will be established by SB 803 will be critical for providing specialized training that addresses the specific needs of the BH/CJ population.

Furthermore, to maximize the peer and community health worker workforce, those with lived experience who are in recovery must not be hindered by organizational hiring and retention practices such as background checks or lack of career mobility. The behavioral health workforce is full of individuals in recovery who are willing and able to pursue careers using their lived experience to help others. Recognizing the invaluable skill set that these individuals provide in helping people has shown tremendous effects. Organizations should foster a culture that values and respects the individuals with lived experience as a vital member of the team and provide opportunities for career advancement. In addition, organizations should revisit their background clearance procedures not to eliminate candidates because of the experience that most qualifies them for the position.

Specialized Training and Staff Safety

The BH/CJ population requires *both* interventions to address criminogenic needs *and* behavioral health treatment, which necessitates specialized training and innovative approaches to ensure BH/CJ participant engagement. Furthermore, since some of the BH/CJ participants may exhibit behaviors that appear dangerous, or are actually dangerous, providers are hesitant

to serve the BH/CJ population in fear of their own safety and/or the safety of BH/CJ participants. The lack of knowledge and accompanying fear restricts the BH workforce, which is often already stretched thin in treating the non-BH/CJ population. More exploration is needed to fully understand these issues in order to identify strategies to maximize workforce capacity to ensure that behavioral health needs are met.

Housing and Homelessness

Of the individuals returning home from CDCR in 2020, records show that as many 4,500 were released with no known address, or were designated as homeless, and many more were in need of comprehensive health and criminal justice system services to support successful community reintegration.¹⁸ Connecting individuals to these vital resources upon diversion/reentry, including housing assistance, has been a priority of the Newsom Administration, particularly given the COVID-19 public health emergency.

Unprecedented resources have been urgently deployed to house the homeless during the pandemic, which has built local capacity like never before. Efforts are currently underway to address homelessness in California include Project Roomkey and Project Homekey, which accepts criminal justice referrals, and specific to the criminal justice population, the BSCC ARG Program and Returning Home Well. While these efforts to address homelessness in response to the pandemic are beneficial for the criminal justice population, in general, there are additional considerations for those who also have behavioral health needs, particularly at the points of diversion/reentry. For example, data have demonstrated the incidence of drug use within first 30 days, and, as a result, a risk of death in the first two weeks after release increases twelve-fold.¹⁹ These types of adverse outcomes are preventable with the proper services and supports (e.g., housing coupled with physical health care and behavioral health care, and treatment to address criminogenic needs). In addition to the current housing projects, long-term solutions are also needed for the BH/CJ population, such as the expansion of residential programs, board and care facilities, recovery houses, and other congregate living options that house high-risk populations, operate on low margins and have significant staffing and funding challenges. A concrete, State-led effort to stabilize congregate living situations to keep people healthy and housed is critical. To inform local housing efforts as related to the CJ/BH population, CCJBH published in January 2020 a detailed policy brief that includes a detailed analysis with local and state recommendations, entitled ["Improving Housing Outcomes for the Justice-Involved with Behavioral Health Challenges."](#)

In order for California's efforts to be successful in tackling the housing and homelessness crisis, the unique housing needs of individuals experiencing behavioral health challenges and justice involvement must be addressed across multiple systems. Homeless and housing service agencies can connect justice-involved individuals to a robust network of community health providers to promote health, recovery and wellness, and reduce recidivism. Many Continuums

¹⁸ Data request, CDCR Office of Research.

¹⁹ Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). [Release from prison--a high risk of death for former inmates](#). *The New England Journal of Medicine*, 356(2), 157–165.

of Care already include law enforcement and other criminal justice partners on their leadership teams. The development and implementation of policies and procedures that lay the groundwork for ongoing collaboration will increase the likelihood that housing services are available upon release from jail.

Income, Vocational and Supportive Services

CCJBH has documented in past reports that it is committed to addressing needs for income, vocational, and supportive through the issues, strategies, and policy recommendations. As noted in the previous CCJBH Annual Legislative Report, the drivers listed below are significantly and disproportionately experienced by individuals in the intersection of behavioral health and justice systems:

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

Community-based organizations that work in the diversion/reentry arena have historically addressed these drivers to support successful transition between county and state institutions, often utilizing the expertise of individuals with lived experience, or previous justice involvement, to form a trusting bond. These organizations provide a variety of services, including educational/vocational, employment, and housing support, all of which can be a cornerstone to successful reintegration and often go unnoticed, under-recognized, and underfunded.

Oftentimes these small organizations are created by and employ formerly incarcerated individuals who want to make their lived experience, or previous justice involvement, to have purpose by helping others. Shining a spotlight on this work gives value to the thousands of individuals who have personally and successfully mitigated the barriers to successful reintegration and are motivated to help others do the same. These organizations are a “pipeline” to a highly motivated and skilled workforce available to change their community for the better. CCJBH is committed to changing the narrative of what diversion/reentry and reintegration looks like by using these powerful agents to make the positive changes they want to see in their community.

A strong example of this type of effort is Los Angeles County’s Alternatives to Incarceration (ATI) Workgroup, which published a [final report](#) that conveys a new vision centered on health solutions and services provided in the community so that jail is the last option rather than the first and only response. The ATI roadmap includes 114 recommendations for diverting people from jail into care. Similarly, the [Transitions Clinic Network](#) is an in-reach program that utilizes [Community Health Workers](#) to improve health outcomes.

At the State level, through [Innovative Programming Grants](#), CDCR provides funding to community-based organizations, some of which also have a prison in-reach component that provides a variety of traditional and nontraditional therapeutic interventions designed to help promote positive changes. Many have a restorative justice approach that has [potential](#) to have transformative effects on individuals and their communities. Also effective are the trauma-informed, recovery-based curriculums that promote resiliency and equip participants with tools to effectively deal with stress. Participants often continue their program during their transition into the community.

In addition to the Innovative Programming Grants, CDCR also has several effective program models that provide support services to optimize transition into the community ([Female Offender Treatment and Employment Program](#), [Male Community Reentry Program](#), [Long Term Offender Programs](#)), as does the BSCC, which manages the [Adult Reentry Grant Program](#).

Reentry Councils can also play a pivotal role in establishing and strengthening transition processes and services as members participate in local, organized reentry advocacy and strategic planning for their communities. While business models, membership, and services provided through various reentry councils may differ most aim to engage multiple community reentry stakeholders including local government agency leadership, community service providers, individuals previously incarcerated and/or their family members, and other community leaders. For example, [San Francisco's reentry council](#) is established in San Francisco Administrative Code § 5.1-1-6, and has a [specified reporting relationship](#) to the Board of Supervisors, the Community Corrections Partnerships, and other relevant local entities. These efforts help to ensure that local communities are able to address the complex needs of ex-offenders, particularly given the impact of the recent releases that have resulted in response to the COVID-19 public health emergency. While Reentry Councils typically provide support for employment, education, family reunification, and achieving housing goals many do not include behavioral health services, which is foundational to successful community reintegration and supporting people in maintaining their recovery.

Finally, Sheriff's Departments can assist with benefits reinstatement by providing, upon release, timely access to documentation that proves the duration of time an individual was incarcerated.

Funding

Both system- and program-level changes, particularly to facilitate innovative strategies, require adequate funding, which is secured through new and/or existing funding allocations. Funding sources that are currently used to address the needs of the BH/CJ population include, but are not limited to:

- 2011 Public Safety Realignment (AB 109)
- 1991 Realignment (funds social services, probation, and county mental health)
- 2011 Behavioral Health Realignment (funds Specialty Mental Health Services, Drug Medi-Cal, and drug courts)

- Mental Health Services Act (for addressing the needs of individuals with mental health and co-occurring mental health and substance use disorders)
- Supplemental Security Income (SSI) Program
- Social Security Disability Insurance (SSDI) Program
- Proposition 47 BSCC Grant Funding
- Senate Bill 678 Funding
- DSH Diversion Funding (one-time funding)
- County General Funds
- Grants, foundation funding, and other sources

Many counties have blended these funding sources to design creative programs for the BH/CJ population.

Research is needed to determine if these funding sources are being optimized (i.e., local multi-agency shared funding dedicated to serve the BH/CJ population) or if there are inefficiencies (e.g., duplicative efforts, using less restrictive funding before using more restrictive funding). Absent this information, it is difficult to determine if the current funding level is sufficient to support the BH/CJ population, if concentrated efforts are needed to identify inefficiencies so that decisions may be made to maximize existing funding or if additional funding is truly needed to address county-level service gaps. An initial approach to this effort could be to develop a matrix to identify which funding sources may be used at the local level for the different components of diversion/reentry programs, including housing.

Demographic Disparities

Individuals with behavioral health needs are not only overrepresented in the justice system populations, but the rates of incarceration are disproportionately high for racial and ethnic minorities. African Americans and Latinos collectively represent 30 percent of the United States population, but make up more than half the prison population. “At the end of 2016, African Americans made up 26 percent of parolees, but only 6 percent of California’s adult population. Whites also make up 26 percent of the parolee population, but comprise a much larger share (41 percent) of the total adult population. Latinos account for 40 percent of parolees and 35 percent of California adults, while 7 percent of parolees and 18 percent of the adult population are persons of other races,” according to the [Public Policy Institute of California](#). [American Indian/Alaska Natives](#) (AI/AN) were incarcerated at higher rates than the general population in California, with 332 AI/AN people per 100,000 incarcerated in local jails compared to 214 people per 100,000 overall. These statistics signify a lack of effective, culturally competent, community-based services, which has resulted in an overreliance on the justice system to address a myriad of behavioral health issues.

Data Reporting

Systematic data reporting by criminal justice agencies is essential for successful diversion, reentry, and reintegration for justice-involved people, especially in the era of COVID-19. In addition to its routine data reporting, CDCR regularly updates a page related to COVID-19

actions. The BSCC implemented a Supplemental Jail Profile Survey so that stakeholders can track local jail responses to COVID-19. While it does not necessarily reflect the impact of COVID-19, an additional data source that provides information relevant to outcomes for justice-involved people with behavioral health challenges includes the California Department of Justice (CA DOJ) Use of Force Incident Reporting System.

Because successful diversion and reentry requires a multi-system approach, agencies that administer safety-net programs have stratified their existing reporting and collected new data so that stakeholders can readily monitor outcomes for justice-involved people. For example, the Mental Health Services Oversight and Accountability Commission (MHSOAC) Transparency Suite presents results from an analysis of linked administrative datasets from DHCS and CA DOJ. Where data are not readily available, agencies have built the infrastructure for data collection through reporting requirements coupled with training and technical assistance to improve data quality. One example is the Prison to Employment project, which resulted in reporting requirements as well as guidance to ensure that regional and local partners were able to comply. The expansion of data reporting also can include enhanced technical infrastructure, such as the Homeless Data Integration System (HDIS), overseen by the Homeless Coordinating and Financing Council. Continuums of Care (CoCs) assist people experiencing homelessness, and CoCs that include sheriffs as key partners may report information related to justice involvement as part of the HDIS. When utilized across departments, collaboratively developed metrics can help to align incentives, track progress, and direct quality improvement projects. While there are continued efforts toward a Universal Data Sharing Agreement among all agencies under the Governor, the difficulty of establishing Data Sharing Agreements across departments has proven to be a formidable obstacle to data analyses that may be used to produce reports that could support decision-making that leads to improved outcomes for the BH/CJ population. In ongoing work, CCJBH reports on Medi-Cal enrollment and utilization among people returning from state prison and hopes to stratify additional Medi-Cal reporting by justice involvement.

Administrative data only presents a portion of the information necessary to ensure that service delivery consistently meets the needs of justice-involved people. For example, service delivery is more effective when it aligns with consumer needs and preferences. Existing data sources, such as the Consumer Perception Survey (overseen by DHCS) and California Health Interview Survey (fielded by the University of California, Los Angeles (UCLA)), permit inference about satisfaction with services among Californians overall. However, these data sources do not include indicators of justice involvement and cannot be used to assess whether service delivery meets the needs of justice-involved consumers. CCJBH's Lived Experience Contracts and Public Health Meets Public Safety projects, which will be discussed later in this report, will help to address this issue. Through these projects, CCJBH will foreground the perspectives of people with lived experience in recommendations for quality improvement initiatives and policy changes.

Diversion/Reentry Findings

- The COVID-19 pandemic posed unprecedented challenges to the diversion/reentry infrastructure, and ongoing system-wide impacts have major implications for the BH/CJ population. Recent policy changes that have taken place, especially those implemented in response to the pandemic, have shortened probation periods and sentences generally. For many jails, the COVID-19 pandemic has resulted in dramatically shortened time between intake and release. When people cycle in and out of jails so rapidly, opportunities to screen for behavioral health needs are much more limited. Screenings must be made a high priority and conducted as soon as possible after intake.
- The Legislature and Governor have urged an emphasis on diversion rather than a sole focus on reentry so that, whenever possible, people can avoid contact with the criminal justice system. Arrest and initial detention are opportunities for connection to services.
- There is a need to develop distinct processes to meet the needs of the unique needs of the BH/CJ populations in the community. For example, people held in jails pre-trial have not yet been sentenced and, if released, would not be under any supervision. This population is especially vulnerable to re-incarceration because they may not systematically receive support after release. In contrast, people who have been sentenced and have been released to the community may or may not be under probation supervision. In some cases, the sentencing offense may affect opportunities for community-based services.
- Collaborative case management is key to successful diversion, reentry, and reintegration. It requires careful training, planning, and development across multiple stakeholders and service providers. While processes for general case planning are already in place, collaborative case management takes case planning a step further by developing and including specific treatment plans for behavioral health conditions.
- By some estimates, a majority of justice-involved people require mental health or substance abuse disorder treatment. Yet, behavioral health treatment and other support services (e.g., housing, income) is not consistently integrated into reentry services. For example, reentry councils, which exist in some counties, typically provide support for education, employment, and housing but less often include behavioral health services.
- One consequence of a community-based behavioral health system that inadequately meets the needs of the BH/CJ population is an overreliance on the justice system and correctional facilities to provide behavioral health care.
- A formalized assessment and referral process that utilizes screening tools that are consistent across counties and include criminogenic risks/needs, especially dynamic risk factors, are essential not only for criminal justice outcomes but also for behavioral health treatment success. Because there are a wide variety of risk/needs assessment instruments, information collected across jurisdictions may vary. Clinical behavioral health assessments and criminogenic risk/needs assessments are distinct and both essential for successful diversion and reentry. At the local level, timing for completing screenings is critical because some individuals could be released within hours; therefore, it is important to establish a

clear screening and assessment process, with clear roles and responsibilities for all involved systems.

- Workforce development policies that welcome and do not exclude peer providers who can provide support through the lens of their lived experience can help to engage justice-involved people in services. The perspectives of people with lived experience should be foregrounded in quality improvement initiatives and policy changes.
- For the BH/CJ population, successful treatment completion and recovery often requires continued monitoring, follow-up, and a variety of services including health care, behavioral health, criminogenic needs interventions, as well as income (SSI/SSDI), educational / vocational, employment, and housing supports.
- Housing at release is critical to avoiding re-arrest and re-incarceration. Planning for housing at release must include behavioral health partners and must begin as soon as possible after arrest.
- Community-based organizations rely on multiple, braided funding sources as well as inter-agency partnerships to provide services using a Whole Person Care approach.
- African Americans, Latinos, and American Indian/Alaska Native people are overrepresented in the BH/CJ population, which indicates that additional efforts are required to reduce disparities in access to high-quality behavioral health treatment in the community.
- It is important to understand the impact of geographic disparities, and how geography can impact the feasibility of making health, behavioral health, criminogenic and other support services available.
- Successfully meeting behavioral health needs at diversion and reentry is integral to the missions of multiple criminal justice stakeholders, including county behavioral health, the Department of State Hospitals, Department of Health Care Services, sheriffs and police, and probation and parole. Support for an ongoing venue or platform, where both state- and local-level stakeholders can regularly convene and dynamically develop a collaborative strategic plan, is essential for effective diversion and reentry.

Appendix J

CCJBH Juvenile Justice Workgroup: Potential Projects

Below is a list of potential projects that focus on juvenile justice, most of which reflect recommendations made in prior CCJBH Annual Legislative Reports. The exception is the first project, the Juvenile Justice EBP Compendium/Toolkit, which will be a new CCJBH contract. Although all projects listed below are critical for improving California's juvenile justice system, given the limited resource capacity, in 2021, the CCJBH Juvenile Justice Workgroup will focus on the Juvenile Justice Evidence-Based Practices and Programs Compendium and Toolkit project since SB 823, Juvenile Justice Realignment, will implement on July 1, 2021. Other entities may wish to perform work on the remaining projects and/or these projects may be selected by the Juvenile Justice Workgroup in future years.

- Juvenile Justice Evidence-Based Practices and Programs Compendium and Toolkit – Make this contract the focus of the CCJBH Juvenile Justice Workgroup discussions, with participants reviewing and providing feedback on deliverables throughout the year, and ensuring that this information is shared at Full Council meetings. **2021 FOCUS**
- Data-Informed Decision-Making (Juvenile Justice Focus) – Analyze available data and trends to examine the causes and effects of the declining population and remaining concentration of youth with serious behavioral health needs in the Juvenile Detention Centers statewide. If data is not available to review, CCJBH can develop a survey (distributed statewide) to assess what factors local implementers and stakeholders attribute to the decline and concentration of the population. Specifically, CCJBH can explore how youth with behavioral health needs have been impacted and what were the opportunities for diversion.
- Identify Best Practices for Strengthening Families that are Involved in the Criminal Justice System – Study best practice approaches for children and youth visiting parents or family in the California State Prison system and position CDCR as a resource by exploring improved strategies, such as training regarding effective methods to approach and handle youth and children in a correctional setting, proper identification for youth and children for visits and strategies for promoting family visits from youth and children as a therapeutic healing process that may lead to breaking the cycle of generational incarceration.
- Understand and Apply Trauma Principles – Research, study, and seek to support the work of the California Surgeon General and the California Department of Education regarding ACEs and preventative programs to mitigate or divert youth with high ACEs from becoming justice-involved.
- Understand Trauma in the Foster Care and Juvenile Justice Populations – Research if foster youth and probation youth have parallel high ACEs and what services available to foster youth are effective, which can help to determine how both youth populations with similar needs can experience improved outcomes.

- Research/Build Capacity for Court-Appointed Advocates –Research if there are court appointed advocates for youth with behavioral health needs, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.
- Juvenile Justice Forum – CJBH can continue to host forums that feature juvenile justice issues. Objectives could include providing a platform to hear from providers, youth and engaging more system-impacted youth; feature innovative approaches to juvenile justice as a public mental health issue; share information with the legislature on emerging juvenile justice issues; and partner with families, youth, and communities to identify solutions through facilitated forums with state leadership to support consistency across counties that emphasize treatment, community support, and school support over incarceration.
- Identify Residential Treatment Capacity as an Alternative to Juvenile Hall -To better understand high-end service capacity alternatives for youth, CCJBH can conduct, in partnership with key stakeholders and providers an assessment of residential treatment capacity for juveniles as an alternative to juvenile hall.
- Research Existing Law Enforcement Juvenile Arrest Protocols –Explore and research existing law enforcement protocols for arresting youth in California with the intention of identifying their pre-charge diversion, treatment, and crisis support services procedures as alternative options.
- Educate Criminal Justice Partners on Pre-Charge Diversion Options - Bring awareness to our law enforcement, behavioral health, Judicial, and community partners on pre-charge diversion, treatment, and crisis support services for youth known to have or assessed as having behavioral health needs as alternative options.
- Research/Build Capacity for Clinical Coordinators in Juvenile Court Rooms –Research if there are clinical coordinators present in juvenile court rooms, who can provide guidance to judges and probation staff about juvenile mental health evaluation and community-based treatment, and work with the necessary subject matter experts to assess which steps would be needed to create such a process and/or program.

Appendix K

CCJBH Diversion/Reentry Workgroup: Potential Projects

Below is a list of potential Diversion/Reentry projects, most of which reflect recommendations made in prior CCJBH Annual Legislative Reports. Although all projects listed below are critical for improving California's Diversion and Reentry processes, given the limited resource capacity, the CCJBH Diversion/Reentry Workgroup will focus 2021 efforts on supporting the work necessary to comply with the Governor's Veto Message on Senate Bill 369, which directs CDCR and CCJBH to "engage with stakeholders, evaluate the barriers of reentry, and determine what steps need to be taken to overcome those barriers." Other entities may wish to perform work on the remaining projects and/or these projects may be selected by the Diversion and Reentry Workgroup in future years.

Prior Legislative Report Recommendations

- **Collaboratively Develop a Transitions (reentry) Process** – Engage in discussions identify the barriers and inform the development of an effective and efficient transition process from prisons, as well as court diversion to communities. This involves convening stakeholders, reviewing and providing feedback to define an efficient and effective transitions process. **2021 FOCUS**
- **Engage in WPC Pilots** – Actively engage in the current implementation of WPC pilots, of which nine of the twenty-five pilot counties are focusing on the re-entry population. For example, CCJBH can help to identify lessons learned, successes, and challenges, including a need for additional training or support for continued and expanded work with the re-entry population. Counties like Los Angeles and Riverside have been serving individuals returning home from state prison, and CCJBH can learn from those experiences to understand how to improve the warm hand-off and transition to community-based services to inform efforts in this area, including in support of ISUDT and implementation of SB 389 (Hertzberg).
- **Identify/Promote Best Practices for Methamphetamine Treatment** – Promote best practices in treatment for methamphetamine use such as contingency management, which utilizes positive reinforcement and incentives as external motivators to promote adherence to program rules or treatment plans.
- **Overview of Prevention, Diversion and Reentry efforts across the nation; status, progress and impact** – 1. Catalogue existing state and federal efforts in prevention, diversion, and reentry, including the authority and funding provided by different entities; 2. Identify strengths and barriers in existing efforts including opportunities to improve coordination to address gaps in prevention, diversion and reentry efforts; 3. Develop a prioritized plan of legislative, regulatory, financial, educational, training, and technical assistance activities for statewide action; and 4. Create a reasonable structure to measure the progress and impact.

- **Residential Options for BH alternatives to incarceration** – CCJBH can collaborate with other necessary state and local partners to conduct a thorough analysis of the supply and demand for the variety of residential options, including safe and affordable housing needed to support the substantial demand for community based behavioral health alternatives to incarceration.
- **Bail Reform** – CCJBH will analyze and provide recommendations on the implications of Bail Reform for people with serious behavioral health disorders (i.e. identifying strategies to deliver services post-release/pre-trial, risk assessment tools and bias, adequate resources for probation and courts).
- **Expedite Medicaid Eligibility and Enrollment** – CCJBH can research and disseminate other state strategies to expedite Medicaid eligibility and enrollment, such as the use of peer educators to support managed care plan selection prior to release.
- **Broaden Medi-Cal Plan Selection** - CCJBH can explore strategies where Medi-Cal plan selection could be completed simultaneously with eligibility and enrollment processes in small counties that have one plan option. For multi-plan counties, prior to release, individuals can receive information to choose a specific provider within the network of the plan selected upon release. Health navigators can assist with activation and the first appointment post-release.
- **Investigate State General Fund (SGF) Resources** – Investigate if and to what extent State General Fund (SGF) resources that support Parole Outpatient Clinics are paying for Medi-Cal reimbursable services. Assess how State and County resources can be leveraged so that SGF can be used for much needed non-Medi-Cal reimbursable services, such as rental assistance.
- **Adopt the Criminogenic Risk and Behavioral Health Needs Framework** - CCJBH can promote the adoption of the Criminogenic Risk and Behavioral Health Needs Framework to ensure that resources are directed towards those with high behavioral health and criminogenic risk needs.
- **Awareness of Substance Use Disorders (SUD)** – CCJBH will collaborate with other state partners to raise awareness and tackle the stigma associated with substance use disorders (SUD). Support California’s public education campaign efforts regarding opioid safety and treatment.
- **Opioid and Substance Use Disorder (SUD) Screening** – Considering the elevated rates and dangers associated with opioid use, CCJBH further recommends that all incoming detainees be screened with reliable and validated tools that provide clinically useful data in the treatment of opioid use and other SUDs. Moreover, to successfully tackle the crisis, it is critical to understand how many individuals suffering from opioid use disorders are entering jails and prisons.
- **Identify Referral and Care Coordination Pathways** – CCJBH is well-positioned to improve service coordination among state and local partners. CCJBH can identify referral and care coordination pathways for a sample size of counties, identifying strengths and weaknesses,

as well as barriers. Recommendations to address gaps through training, technical assistance or policy change could be provided.

- **Peer Support Specialists Certification** – Create statewide certification with standardized curriculum for Peer Support Specialists who provide quality services allowing this workforce to be considered qualified providers for Medi-Cal reimbursement through Medi-Cal Specialty Mental Health Services.
- **Invest in Collaborative Relationships, Education and Training** – Investigate how peers, Community Health Workers (CHW), and SUD counselors can work to serve people with co-occurring disorders. Strengthen collaborative relationships by cross- training Peer Support Specialists, CHWs, and SUD Counselors. CCJBH will work with policy and community partners to address barriers to employment for Peer Support Specialists, Forensic Peer Specialist, Consumer Peer Specialist, Veteran Health Peer Specialist, and Mental Health Peer Specialist.
- **Support Workforce Education and Training** – Consider a California counterpart for elements of the federal opioid package (H.R. 6) to support workforce, education, and training. For example, expand first responder training regarding opioid safety and develop a student loan repayment program to increase the substance use treatment workforce.
- **Establish a Center of Excellence for Diversion Training** – CCJBH will establish a center of excellence in diversion on the website with webinars and featured tools from experts in the field, but focus more on what individuals are doing in CA. The purpose is not to re-create expertise/tools, but to methodically identify it, and bring it to all 58 counties in a user-friendly, relevant and timely matter.
- **Promote County Screening Tools** – CCJBH can promote easy to use validated screening tools for jails, such as the brief justice mental health screen (BJMHS), correctional mental health screen for men (CMHS-M), correctional mental health screen for women (CMHS-W) and the jail screening assessment tool (JSAT).

Other Issues to Consider

- Identify strategies to keep diversion program participants engaged given that program participation is voluntary during this pandemic (i.e., motivation to change).
- Identify strategies and best practices to prevent individuals being processed in the jail system from “cheating” on mental health screenings/assessments (known as malingering – some individuals have cycled enough times that they’re answering questions in a manner that will result in a mental health diagnosis).
- Identify peer certification training curriculum that has been used to successfully train peers on how to engage and support the behavioral health / criminal justice population.
- Identify strategies to help counties, as a whole, determine if their funding is being spent most efficiently to serve the BH/CJ population, and how to address any identified inefficiencies.
- Develop/publish a statewide funding matrix to reflect how existing funding should be prioritized for reentry, diversion, housing needs (and document any identified gaps).

Appendix L
Legislation of Interest to
CCJBH and Justice and Behavioral Health Partners

Juvenile Justice

AB 901-(Gipson) Juveniles

Chaptered 9/30/2020

This bill will limit school districts' ability to refer students to probation officers and the courts over issues of truancy and insubordination. In California, juveniles can end up in the juvenile court system for "habitual truancy" and for being "habitually insubordinate or disorderly." Existing law authorizes a pupil to be referred to a school attendance review board, or to the probation department for services if the probation department has elected to receive these referrals. This bill would eliminate the authority of the county superintendent of schools to petition the juvenile court on behalf of a pupil, in a county that has not elected to participate in a truancy mediation program.

AB 2425- (Stone) Juvenile police records

Chaptered 9/30/2020

This bill would prohibit a law enforcement agency in any county from releasing a copy of a juvenile police record if the subject of the juvenile police record is (1) a minor who has been diverted by police officers from arrest, citation, detention, or referral to probation or any district attorney and who is currently participating in a diversion program or who has satisfactorily completed a diversion program, (2) a minor who has been counseled and released by police officers without an arrest, citation, detention, or referral to probation or any district attorney, or (3) a minor who does not fall within the jurisdiction of the juvenile delinquency court under current state law, except as specified. The bill would require the law enforcement agency that seals a juvenile police record of a diverted minor to notify the applicable diversion service provider immediately upon sealing of the record, and would require records in the diversion service provider's custody relating to the minor's law enforcement contact or referral and participation in the program to be kept confidential, as specified.

SB 203- (Bradford) Juveniles: custodial interrogation

Chaptered 9/30/2020

This bill extends protections for minors prior to a custodial interrogation by a law enforcement officer and before the waiver of Miranda rights from the age of 15 to the age of 17. Specifically, it requires that, before any custodial interrogation and before the waiver of any Miranda rights, a youth of 17 years or younger must consult with legal counsel in person, by telephone, or by video conference, and prohibits the waiver of such a consultation.

[SB 823](#)- (Committee on Budget) Juvenile Justice Realignment

Chaptered 9/26/2020

This bill codifies language to initiate the closure of the Division of Juvenile Justice and shift the responsibility of managing all youth offenders to county/local jurisdictions. DJJ will no longer accept new commitments after June 30, 2021. DJJ closure is to occur pursuant to population attrition. The new law establishes the Office of Youth and Community Restoration (OYCR) within the California Health and Human Services (CHHS) effective July 1, 2021. This office will report on youth outcomes, make policy recommendations, house the ombudsman, and authorize grant funding in conjunction with the Board of State and Community Corrections (BSCC).

[SB 1290](#)-(Durazo) Juveniles: costs

Chaptered 9/30/20

Existing law, since January 1, 2018, prohibits the imposition of financial liability on the parents or guardians of a minor who has been adjudged a ward of the juvenile court for certain county-assessed or court-ordered costs, such as transportation to a juvenile facility, legal assistance, and home supervision. Existing law, since January 1, 2018, does not require minors who are required to submit to drug and substance abuse testing to pay for the costs associated with testing. Finally, existing law, since January 1, 2018, only requires adults over 21 years of age to pay an administrative fee associated with a home detention program.

This bill would vacate certain county-assessed or court-ordered costs imposed before January 1, 2018, for the parents or guardians of wards in specified circumstances, minors who were ordered to participate in drug and substance abuse testing, and adults who were 21 years of age and under at the time of their home detention.

Probation, Parole, and Diversion

[AB 1196](#)- (Gipson) Peace Officers: Use of Force

Chaptered 9/30/2020

This bill prohibits law enforcement agencies from authorizing the use of carotid restraint holds and choke holds by any peace officer employed by that agency. The law defines a "carotid restraint" as a vascular neck restraint or any similar restraint, hold, or other defensive tactic in which pressure is applied to the sides of a person's neck that involves a substantial risk of restricting blood flow and may render the person unconscious in order to subdue or control the person.

[AB 1304](#)- (Waldron) California MAT Reentry Incentive Program

Chaptered 9/30/2020

This bill establishes the California Medicated Assisted Treatment Reentry Program, contingent upon the appropriation to the California Department of Health Care Services of funds received pursuant to a specified federal grant. The new law provides eligibility for reduction in the period of parole up to 90 days for individuals that successfully participated in a substance abuse treatment program that employs use of approved MAT.

AB 1950 - (Kamlager) Probation: length of terms

Chaptered 9/30/2020

Current law authorizes courts that have jurisdiction in misdemeanor cases to suspend the sentence and make and enforce terms of probation in those cases, for a period not to exceed 3 years, except when the period of the maximum sentence imposed by law exceeds 3 years, in which case the terms of probation may be imposed for a longer period than 3 years. **This bill would instead restrict the period of probation for a misdemeanor to no longer than one year, and two years for a felony except as specified.**

AB 3234 - (Ting) Public Safety

Chaptered 9/30/2020

This bill would authorize a judge in the superior court in which a misdemeanor is being prosecuted to offer misdemeanor diversion to a defendant over the objection of a prosecuting attorney, except as specified. The bill would authorize the judge to continue a diverted case for a period not to exceed 24 months and order the defendant to comply with the terms, conditions, and programs the judge deems appropriate based on the defendant's specific situation. The bill would require the judge, at the end of the diversion period and if the defendant complies with all required terms, conditions, and programs, to dismiss the action against the defendant.

Existing law establishes the Elderly Parole Program for the purpose of reviewing the parole suitability of inmates who are 60 years of age or older and who have served a minimum of 25 years of continuous incarceration on their sentence. This bill would modify the minimum age limitation for that program to 50 years of age and instead require the inmate to have served a minimum of 20 years of continuous incarceration in order to be eligible for the program. The signing message can be found [here](#).

SB 132 - (Wiener) Corrections

Chaptered 9/26/2020

This bill establishes several requirements regarding how CDCR houses and searches individuals who identify as transgender, non-binary, or intersex, and how the department performs intake for all inmates. Also, requires CDCR to house individuals who identify as transgender, non-binary, or intersex in a facility consistent with their gender identity, except if the department has management or security concerns with the person's housing preference.

SB 369 - (Hertzberg) Prisoners: California Reentry Commission

Vetoed 9/30/20. Veto message impacts CCJBH

This bill would have establish the 21 member California Reentry Commission (CRC), within CDCR, to be co-chaired by the CDCR Secretary and a formerly incarcerated individual. This bill would have required the CRC to prepare and develop a new health and safety agenda for those returning home from prison or jail and mandates the development of a grant program, in cooperation with the Board of State and Community Corrections (BSCC), to provide grants to reentry service providers. Additionally, this bill requires the CRC to conduct a review of reentry barriers, review current state criminal justice policies, and report to the Legislature on the impact of COVID-19 on the reentry population, among several other duties.

The veto message provides: This bill would establish CRC and task it with developing a new health and safety agenda for those returning home from custody, reviewing the barriers to reentry, and coordinating with other entities to establish a grant program for reentry service providers.

I share the author's commitment in supporting successful reentry for persons returning to the community from prison. That is why I launched Returning Home Well, a public-private partnership that will provide critical supports including housing, healthcare, treatment, transportation, direct assistance, and employment support for Californians returning home from prison early due to COVID-19. I also agree that there is more to do to ensure that all persons returning home are given the support that they need.

I do not, however, think that creating a new commission with other 20 members and appointees is necessary to achieve this goal. *I am, instead, directing CDCR and the Council on Criminal Justice and Behavioral Health to engage with stakeholders, evaluate the barriers of reentry, and determine what steps need to be taken to overcome those barriers.*

Behavioral Health

AB 1976- (Eggman) Mental health services: assisted outpatient treatment.

Chaptered 9/25/2020

The Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, until January 1, 2022, authorizes each county to elect to offer specified mental health programs either through a resolution adopted by the county board of supervisors or through the county budget process, if the county board of supervisors makes a finding that specified mental health programs will not be reduced as a result of participating. Current law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Mental Health Services Act (MHSA) Funds, when included in a county plan, as specified. This bill, commencing July 1, 2021, would instead require a county or group of counties to offer those mental health programs, unless a county or group of counties opts out by a resolution passed by the governing body stating the reasons for opting out and any facts or circumstances relied on in making that decision.

AB 2265- (Quirk-Silva) Mental Health Services Act: use of funds for substance use disorder treatment.

Chaptered 9/25/2020

The Mental Health Services Act (MHSA), establishes the Mental Health Services Fund, which is continuously appropriated to, and administered by, the State Department of Health Care Services to fund specified county mental health programs. This bill would authorize the services for adults, older adults, and children as well as innovative programs and prevention and early intervention programs that are provided by counties as part of the MHSA to include substance use disorder treatment for children, adults, and older adults with co-occurring mental health and substance use disorders who are eligible to receive mental health services pursuant to those programs.

AB 3242- (Irwin) Mental health: involuntary commitment.

Chaptered 9/25/2020

The Lanterman-Petris-Short Act authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed. Under the act, if a person, as a result of a mental health disorder, is a danger to others, or to themselves, or is gravely disabled, the person may upon probable cause be taken into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment. Current law requires persons providing the evaluation services to be properly qualified professionals and authorizes those professionals to provide telehealth evaluation services. Current law also provides immunity from civil and criminal liability for similar detention by specified licensed general acute care hospitals, licensed acute psychiatric hospitals, licensed professional staff at those hospitals, or any physician and surgeon providing emergency medical services in any department of those hospitals if various conditions are met. This bill would authorize an examination, assessment, or evaluation specified, required, or authorized by the above-mentioned provisions to be conducted using telehealth.

SB 803- (Beall) Mental health services: peer support specialist certification

Chaptered 9/25/2020

This bill would require the Department of Health Care Services, by July 1, 2022, to establish statewide requirements for counties or their representatives to use in developing certification programs for the certification of peer support specialists.

SB 855- (Wiener) Health coverage: mental health or substance abuse disorders

Chaptered 9/25/2020

This bill strengthens the California Mental Health Parity Act to require insurers cover medically necessary treatment for all mental health and substance use disorders, not just in emergency care.