CCJBH

Building Bridges to Prevent Incarceration

Council on Criminal Justice and Behavorial Health

Council Members

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Secretary, California Department of Corrections and Rehabilitation

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DRAFT
23rd Annual Legislative Report
March 2025

8260 Longleaf Drive Building C, Elk Grove, CA
www.cdcr.ca.gov/ccjbh

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Overview of the Council on Criminal Justice and Behavioral Health

Established by California Penal Code Section 6044(a), the Council on Criminal Justice and Behavioral Health (CCJBH) is a 12-member council chaired by the Secretary of the California Department of Corrections and Rehabilitation (CDCR) and is comprised of the Directors of the Department of State Hospitals (DSH), the Department of Health Care Services (DHCS), and the remaining members are chosen by the Governor's Office, the State Senate and Assembly, the Attorney General and the California Chief Justice. One member must be a superior court judge, and the remaining members are required to have backgrounds in law enforcement and/or behavioral health. It is encouraged that council members have experience with the justice and health systems either personally or through familial relationships. CCJBH is responsible for identifying and promoting cost-effective strategies statewide to reduce the incarceration of youth and adults with mental illness and substance use disorders focused on prevention, diversion, and reentry strategies. The activities of the council are reported annually to the Governor and the Legislature, which must include recommendations for improving the cost-effectiveness of statewide programs for serving the behavioral health justice-involved population.

The Council on Criminal Justice and Behavioral Health Council Members

Chairperson: Jeff Macomber, *Secretary,* California Department of Corrections and Rehabilitation. The Secretary of CDCR is at times represented by Diana Toche, DDS, *Undersecretary*, California Correctional Health Care Services (CCHCS).

Michelle Baass, *Director,* Department of Health Care Services. The Director of DHCS is represented by Brian Hansen Health, Health Program Specialist II, Health Care Delivery Systems, DHCS.

Stephanie Clendenin, *Director*, Department of State Hospitals. The Director of DSH is represented by Christina Edens, *Chief Deputy Director of Program Services,* DSH.

Diana Becton, J.D., *Contra Costa District Attorney*. Ms. Becton was appointed to CCJBH by the Senate Rules Committee in 2023.

Enrico Castillo, M.D., *Psychiatrist and Associate Vice Chair* for Justice, Equity, Diversion and Inclusion, University of California, Los Angeles**.** Dr. Castillo was appointed to CCJBH by the Senate Rules Committee in 2023.

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

Tony Hobson, Ph.D., *Behavioral Health Director,* Colusa County. Dr. Hobson was appointed to CCJBH by Governor Edmund G. Brown, Jr. 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.

The Council on Criminal Justice and Behavioral Health Council Members

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.

Honorable Scott Svonkin (Ret.), *Director of Intergovernmental Relations*, Los Angeles County Probation. Mr. Svonkin was appointed to CCJBH by Speaker Anthony Rendon in 2022.

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

Council on Criminal Justice and Behavioral Health Staff

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Acronyms

AB	Assembly Bill
AMI	Any Mental Illness
ARCAID	Automated Rehabilitative Catalog and Information Discovery
BH	Behavioral Health
BHAP	Behavioral Health Assistance Program
BH/JI	Behavioral Health/Justice-Involved Population
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHR	Behavioral Health Reintegration
BHRS	Behavioral Health Recovery Services
BHSA	Behavioral Health Services Act
CBH	Commission on Behavioral Health
BJA	Bureau of Justice Assistance
BSCC	Board of State and Community Corrections
CAB	Community Advisory Board
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
CalHOPE	California Hope, Opportunity, Perseverance, and Empowerment
Cal ICH	California Interagency Council on Homelessness
CalMHSA	California Mental Health Services Authority
CALPIA	California Prison Industry Authority
CA-OSG	California Office of the Surgeon General
CAP	Corrective Action Plan
CARE	Community Assistance, Recovery and Empowerment Act
CASOMB	California Sex Offender Management Board
CBO	Community-Based Organization
CBI	Cognitive Behavioral Intervention
CBT	Cognitive Behavioral Therapy
CC	Collaborative Comprehensive
CCCMS	Correctional Clinical Case Management

CCHCS	California Correctional Health Care Services
CCJBH	Council on Criminal Justice and Behavioral Health
CDCR	California Department of Corrections and Rehabilitation
CDCR-OR	California Department of Corrections and Rehabilitation Office of Research
CDE	California Department of Education
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CHW(s)	Community Health Worker(s)
CMC	Community Medical Center
CoC	Continuum of Care
COE	County Office of Education
COMPAS	Correctional Offender Management Profiling for Alternative Sanctions
COVID-19	Coronavirus Disease 2019
CPOC	Chief Probation Officers of California
C-ROB	California Rehabilitation Oversight Board
CSRA	California Static Risk Assessment
CSG	Council of State Governments
CSUS	California State University, Sacramento
CY	Calendar Year
CYBHI	Children and Youth Behavioral Health Initiative
DAPO	Division of Adult Parole Operations
DBT	Dialectical Behavior Therapy
DEI	Diversity, Equity, and Inclusion
DHCS	California Department of Health Care Services
DJJ	CDCR Division of Juvenile Justice
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOJ	California Department of Justice
DRP	Division of Rehabilitative Programs
DSH	California Department of State Hospitals

EBP	Evidence-Based Practices
EEPP	Evidence-Based and Emerging Practices and Programs
ECM	Enhanced Care Management
EOP	Enhanced Outpatient Program
FQHC	Federally Qualified Health Centers
FY(s)	Fiscal Year(s)
GARE	Government Alliance on Race and Equity
HCAI	California Department of Health Care Access and Information
HCD	California Department of Housing and Community Development
HHAP	Homeless Housing, Assistance and Prevention
HHRC	Homeless and Housing Resource Center
IA	Interagency Agreement
IGJJCC	Iris Garrett Juvenile Justice Correctional Complex
IST	Incompetent to Stand Trial
JI	Justice-Involved
JIPSS	Justice-Involved Peer Support Specialist
LACOE	Los Angeles County Office of Education
LEA	Local Education Agency
LEP	Lived Experience Project
MAT	Medicated Assisted Treatment
MCP	Managed Care Plan
MCUP	Medi-Cal Utilization Project
Medi-Cal	California's Medicaid Program
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MTSS	Multi-Tiered System of Support
NAMI	National Alliance on Mental Illness
NIMH	National Institute of Mental Health
OC	Orange County
OHE	Office of Health Equity
OMCP	Occupational Mentor Certification Program

OYCR	Office of Youth and Community Restoration
PH/PS	Public Health Meets Public Safety
PHE	Public Health Emergency
PRCS	Post-Release Community Supervision
PSB	Problem Sexual Behavior
RENEW	Resilience, Empowerment, and Natural Supports for Education and Work
RNR	Risk Needs Responsivity
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SDCOE	San Diego County Office of Education
SMI	Serious Mental Illness
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STRTP	Short Term Residential Therapeutic Program
StimUD(s)	Stimulant Use Disorder(s)
SUD(s)	Substance Use Disorder(s)
TCN	Transitions Clinic Network
TTA	Training and Technical Assistance
UCB	University of California, Berkley
UCSF	University of California, San Francisco
U.S.	United States
VA	Veterans Affairs
W2D	Words to Deeds
WIC	Welfare and Institutions Code

Executive Summary

Amid the dynamic challenges and opportunities at the intersection of behavioral health and criminal justice, the Council on Criminal Justice and Behavioral Health (CCJBH) has remained steadfast in its efforts to drive meaningful change and improve outcomes for California's justice-involved (JI) population. In Calendar Year (CY) 2024, CCJBH advanced its mission to enhance service delivery for California's behavioral health (BH)/JI population by addressing emerging challenges and leveraging innovative approaches. This 23rd annual report highlights progress in building an integrated, equitable system of care that prioritizes rehabilitation, reduces recidivism, and meets the complex needs of the BH/JI population. Efforts this year focused on highlighting evidence-based practices in deflection, diversion, and reentry across the lifespan while continuing to track the CCJBH 2025 systemic policy goals. The Council also amplified the voices of individuals with lived experience (LE), integrating their insights into expanded project initiatives and advisory roles to ensure that policies reflect real-world impact. This report outlines lessons learned, contributions from stakeholders, and ongoing priorities, reaffirming CCJBH's commitment to collaboration, innovation, and actionable progress in meeting the diverse needs of California's BH/JI population.

CCJBH Juvenile Justice Workgroup Recommendations

In CY 2024, CCJBH's Juvenile Justice Workgroup focused on advancing services for BH/JI youth, exploring diverse approaches including restorative justice, gang interventions, and high-needs residential treatment. Additionally, the workgroup examined initiatives from the Children and Youth Behavioral Health Initiative (CYBHI), such as Behavioral Health Virtual Services Platform and Fee Schedule Program, alongside a collaborative school-based effort led by the California Department of Education (CDE) to integrate behavioral health with criminal justice. Using findings from the Juvenile Justice Workgroups and considering the current juvenile justice landscape in California and past CCJBH Annual Legislative Reports, CCJBH developed the below recommendations:

1. State and local agencies that serve these youth are recommended to continue to promote the California Juvenile Justice Toolkit (Toolkit), which provides a compilation of evidence-based and emerging practices and programs (EEPPs). Specific Toolkit implementation considerations are as follows:
    a. The Office of Youth and Community Restoration (OYCR) and county probation departments could promote the use of the Toolkit by presenting it at county-level public meetings.
    b. County probation departments could leverage the Toolkit Training and Technical Assistance (TTA) made available by OYCR and include not only system partners, but also individuals with LE, in the selection of the most effective EEPPs.
    c. County probation departments that utilize the Toolkit could take the lead in formally establishing a multidisciplinary system team (e.g., probation, education, behavioral health) to select and implement EEPP(s). To obtain the intended results, it will be imperative that each system implement the EEPP(s) with fidelity to the model, and

different service modalities would be carefully considered to maximize access, particularly where county resources are scarce (e.g., telehealth, home-based services).

   d. County probation departments that utilize the Toolkit are recommended to consider how selected EEPPs relate to available Medi-Cal services including, but not limited to, the California Advancing and Innovating Medi-Cal (CalAIM) JI Initiative (90-day pre-release services), Medi-Cal non-specialty or specialty mental health services, Drug Medi-Cal services, CYBHI School-Linked Services, and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) to ensure coordination and to maximize federal funding, where appropriate.

   e. OYCR, Department of Health Care Services (DHCS) and the California Department of Public Health's (CDPH) Office of Health Equity (OHE) could consider partnering to leverage the CYBHI Evidence-Based Practices and Community Defined Evidence Practices Grants and California Reducing Disparities Project as it relates to the Toolkit EEPPs to integrate local knowledge and community-defined programs.

2. System partners (e.g., probation, county behavioral health, education, courts) are recommended to collaborate to ensure that BH/JI youth who are placed in Short-Term Residential Therapeutic Programs (STRTPs) have adequate access to high-quality specialized BH and other supportive services, with specific actions as follows:

   a. Prior to discharge, STRTPs would ensure that JI youth and their families are made aware of the Medi-Cal services that will become available to them upon the youth's transition into aftercare.

   b. County probation and behavioral health departments would work collaboratively to ensure sufficient STRTP provider capacity to serve the small number of JI children/youth who have engaged in extremely harmful behaviors, many of whom suffer from serious emotional disability[1]

3. To effectively intervene and deflect youth away from the trajectory to juvenile justice involvement, CDE, DHCS and the Commission for Behavioral Health (CBH; formerly the Behavioral Health Service Oversight & Accountability Commission) could consider providing TTA to relevant system partners on the known risk factors for youth to enter the justice system (e.g., education, primary care, county specialty mental health, courts).

4. The Legislature could allocate funding to University of California and California State University researchers who should consider studying the impact of cognitive behavioral therapy on youth with sexual offending.

5. The Judicial Branch of California could develop, disseminate and promote educational materials to encourage counties to implement youth courts.

[1] Per Assembly Bill 2173, the term "emotional disability" as described above may also be known as "emotional disturbance" under state law.

6. CDE, in partnership with OYCR (as resources are available), are recommended to offer TTA on the California Student Mental Health Implementation Guide to assist Local Education Agencies (LEAs) and county behavioral health departments to partner and create a comprehensive school-based mental health system by:
    a. Implementation of the Resilience, Empowerment, and Natural Supports for Education and Work (RENEW) program.
    b. Establishment of a partnership between LEAs and law enforcement agencies to implement a restorative justice program to facilitate successful mediation between victims and justice-involved youth.
7. To effectively implement the CYBHI to meet the unique needs of, and ensure the access to services for, BH/JI youth, the California Health and Human Services Agency (CalHHS) and associated departments responsible for implementing the workstreams (California Office of the Surgeon General (CA-OSG), California Department of Managed Health Care (DMHC), CDPH, DHCS, and California Department of Health Care Access and Information (HCAI)) are recommended to collaborate with local system partners (e.g., probation, behavioral health, education, courts) to offer TTA, and specifically to:
    a. Optimize the implementation of the Statewide Multi-Payer School-Linked Fee Schedule (Fee Schedule) and encourage more County's Offices of Education (COEs) to opt in, DHCS could support COEs by developing a comprehensive toolkit on how LEAs may integrate it into their current billing structure, including an analysis of the current and new services that could be billed under the Fee Schedule. Implementation considerations could include the following:
        i. Collaboration between DHCS and OYCR on implementation of the Fee Schedule to ensure that the resources are targeting communities with at-promise and JI youth, with targeted efforts to ensure access for gang-involved youth.
        ii. LEAs leveraging the Fee Schedule to fill gaps in their current continuum school-based mental health services.
    b. Expand access to behavioral health support for JI youth, where implementation of the Behavioral Health Virtual Services Platform would be prioritized, with the following considerations:
        i. To effectively bring the services developed in the Behavioral Health Virtual Services Platform to youth in correctional institutions, DHCS could partner with the Chief Probation Officers of California to engage each county's Chief Probation Officer to utilize the Soluna Application, as appropriate. The California Department of Corrections' (CDCR's) Enterprise Information System team could serve as a subject matter expert given their development of the Automated Rehabilitative Catalog and Information Discovery (ARCAID) for adults in correctional facilities.
        ii. LEAs could incorporate the Behavioral Health Virtual Services Platforms into the Multi-Tiered System of Support efforts by promoting the use of the applications to

all students, and their caregivers, to strengthen school and family partnerships and provide youth with 24/7 access to support.

8. The California Health and Human Services Agency (CalHHS) AB 2083 Systems of Care Memorandum of Understanding service delivery approach, designed to address coordination for all local foster care child/youth-serving agencies, could be applied to at-promise and JI youth who are not part of the child welfare system to clearly establish how coordination will occur within each county. This has been recommended in the 2021, 2022 and 2023 CCJBH annual legislative reports, and is reiterated for 2024 given the importance of this approach to prevent and intervene in justice system involvement.

CCJBH Diversion/Reentry Workgroup Recommendations

In 2024, CCJBH's Diversion and Reentry Workgroup advanced discussions on expanding supportive pathways for the BH/JI population. This year's workgroup focused on peer-led support initiatives, including the certification of peer support specialist and substance use disorder (SUD) counselor certifications within both carceral and community settings. Emphasis was also placed on integrating evidence-based practices into correctional and behavioral health systems, ensuring that reentry efforts align with community-based support structures. Using findings from the Diversion and Reentry Workgroups, and considering the current reentry landscape in California and past CCJBH Annual Legislative Reports, CCJBH developed the following recommendations:

1. Relevant state and local policy and program system partners are recommended to ensure a robust specialty system of care to meet the unique needs of individuals with the most complex behavioral health conditions. This involves distinguishing and establishing specialized service planning for the serious mental illness (SMI) population separate from the broader any mental illness (AMI) population, those with mild/moderate SUD from those who suffer from severe SUD, and those with co-occurring SMI/severe SUD.
    a. Currently there is an identified urgent need to expand the workforce across multiple sectors that is specially trained to serve these sub-populations.
    b. It is important to ensure that there is sufficient capacity to provide appropriate treatment and housing.
    c. It is important to acknowledge a plan to prevent/mitigate behavioral issues to avoid escalation that results in placement in restrictive settings.
2. HCAI and DHCS could collaborate to develop a comprehensive strategy to expand the specialty behavioral health clinical workforce that serves the severe SUD and/or SMI populations.
3. DHCS, with input from CDCR, county jails, and individuals with LE, could develop and produce educational videos that inform incarcerated adults and youth about the Enhanced Care Management (ECM) and Community Support services that are now available through the Medi-Cal Managed Care Plans (MCPs) upon release to the community.

4. CDCR and County Sheriff's Departments could expand and implement behavioral health certification programs, respectively, such as the Occupational Mentor Certification Program (OMCP) and the Medi-Cal Behavioral Health Peer Support Specialist Certification training, to increase access to employment after incarceration while simultaneously addressing the behavioral health workforce shortage.
5. State and local systems that serve the BH/JI population could explore opportunities to meaningfully integrate BH/JI LE perspectives and staff into their contracts.
6. DHCS, in consultation with California Mental Health Service Authority (CalMHSA), could reexamine the design and implementation of the JI Peer Support Specialist Certification training offered under the Medi-Cal Peer Support Certification to ensure that the needs of the BH/JI population are adequately addressed.
7. The Legislature could allocate funding to the University of California or California State University to evaluate the impact of encampment sweeps, particularly regarding outcomes such as arrests, as well as health, behavioral health and housing outcomes**.**
8. State and local housing funding and planning entities including, but not limited to, HCD, California Department of Social Services (CDSS), DHCS, Public Housing Authorities, Continuum of Care (CoCs), county social services agencies, and Community-Based Organizations (CBOs) could utilize the CDCR Parole Population Housing Dashboard for local planning efforts. In addition, Cal ICH's "*Putting the Funding Pieces Together*" guide could be used to navigate funding opportunities and increase housing capacity, support transitional housing, and develop permanent supportive solutions tailored to the BH/JI population. In addition, the Homeless and Housing Resource Center's (HHRCs) Expanding Peer Support Roles in Homeless Service Delivery: A Toolkit for Service Providers, could be used to employ forensic peers to connect the BH/JI population to housing and support services.

General Recommendations

The BH/JI population faces significant challenges due to a critical shortage of a specialized workforce and systemic barriers to care. The following recommendations aim to address these gaps:

1. County Administrator's Offices are recommended to lead a comprehensive, cross-system review of the recent investments in health and behavioral health care,[2] housing, etc., to ensure a coordinated, integrated approach across county departments and agencies to serve the BH/JI population rather than implement these initiatives in silos.
2. As appropriate, CDPH and local public health departments could assess all public health education campaigns for opportunities to not only educate, normalize, and destigmatize behavioral health conditions, in general, but also SMI, severe SUD and co-occurring SMI/severe SUD disorders, in particular. This approach could also address the additional stigma faced by individuals who are or are at risk of becoming JI**.**

[2] See the California Health and Human Services' Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts.

3. Given the extensive shortage of the behavioral health workforce specifically trained to serve the BH/JI population, CCJBH recommends that:[3]
    a. All staff at the state and local levels who are responsible for designing, implementing and/or evaluating programs for the BH/JI population be competent in the field of evidence-based corrections.
    b. ECM providers that serve the BH/JI population be trained in evidence-based practices that focus on trauma-informed care**.**
    c. Efforts be made to explore the potential for Federally Qualified Health Centers (FQHCs) to serve as Medi-Cal ECM providers to reach a larger portion of the BH/JI population.

2025 System Policy Goals

In an effort to influence system-level changes, in the 18th Annual CCJBH Legislative Report, CCJBH identified four visionary, measurable goals that CCJBH could track to assess the overarching impact of the investments made in California to meet the unique needs of justice-involved individuals. While CCJBH is not directly responsible for these goals, the Council holds an important role in using data to identify and highlight successes, as well as target areas for improvement. Updates on the measures established to track these goals are as follows:

Goal #1: The prevalence rate of mental illness and SUDs in jails and prisons should be similar, if not equal to, the prevalence rate of mental illness and SUDs in the community.

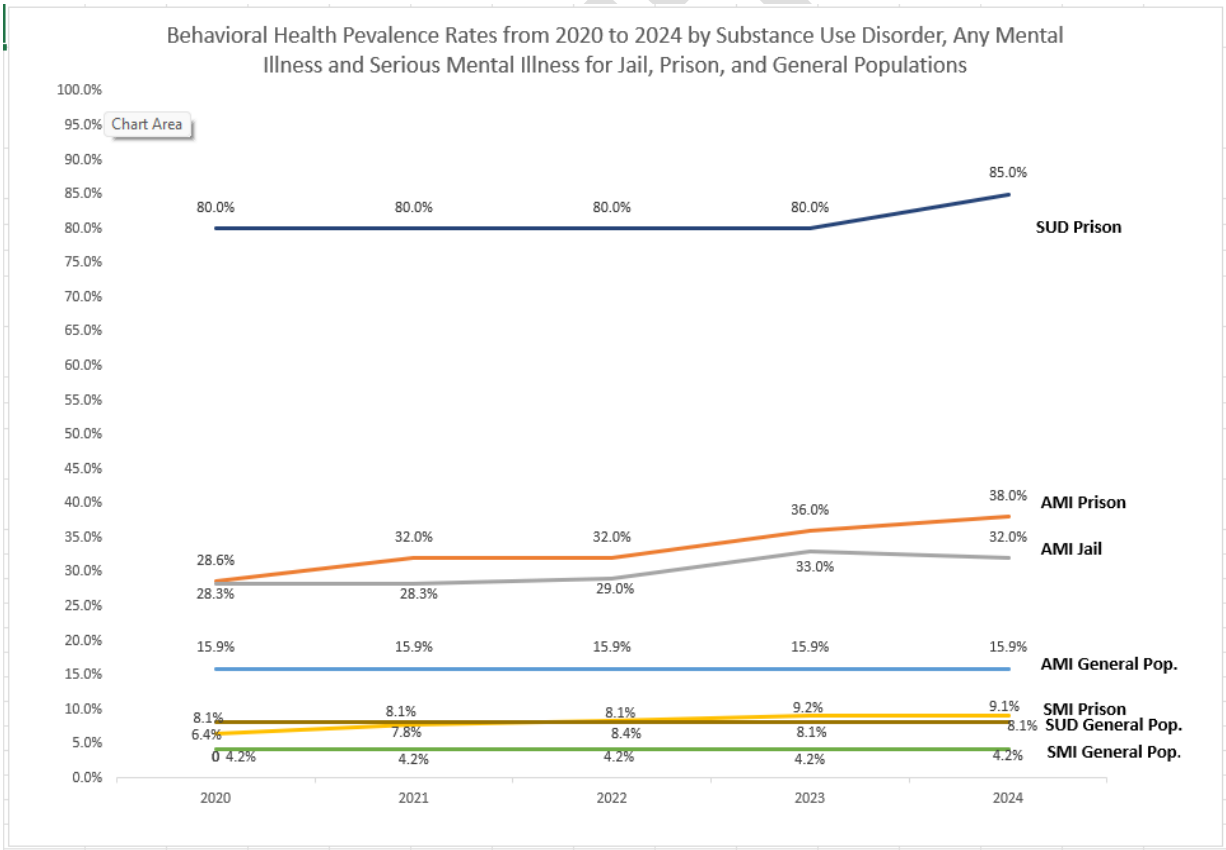
Goal #1 Update:

As shown in Figure 1, there continues to be an overrepresentation of individuals with mental health and/or SUD health conditions in custody settings, with SUD(s) being most overrepresented. Interestingly, while most of these prevalence measures remained stable from Calendar Year (CY) 2023 to 2024, there was a five percentage point increase in the prison SUD rates (i.e., five percentage point increase, a slight increase in the prison AMI rate (i.e., increase of two percentage points), and a slight decrease in jail AMI prevalence (i.e., one percentage

[3] See Building the Future Behavioral Health Workforce: Needs Assessment (February 2023).

point decrease), though both rates remain higher than the rates reported from CY 2020 to CY 2022.[4,5]

Figure 1



[4] Please see the CDCR-Office of Research Data Dashboard for prevalence rates of Any Mental Illness (AMI) and Serious Mental Illness (SMI) in Prison populations. Additionally, a report submitted to the Department of Health Care Services represents the AMI and SMI prevalence rates for Medi-Cal members statewide. The AMI prevalence rates for jail population were obtained from Board of State and Community Corrections' Jail Profile Survey (JPS) data repository.

[5] For the first time, CCHCS' 2024 Annual ISUDT report presents SUD prevalence estimates among CDCR's population, stating that "National SUD prevalence estimates were used as a baseline to develop the ISUDT Program. These estimates show 65% of the U.S. prison population meets the clinical definition for having a SUD, and another 20% did not meet the clinical criteria for a SUD, but were under the influence of drugs or alcohol at the time of their crime…CDCR SUD prevalence estimates for incarcerated individuals show Opioid Use Disorder (OUD) prevalence is high (nearly 30%), with Alcohol Use Disorder (AUD) and stimulant use disorder (StUD) at roughly 25%, respectively, and polysubstance use (OUD and StUD) at nearly 20%. It is important to note CDCR's entire population has not been assessed due to the sheer volume of people who screen positive for possible SUD…and because some people are reluctant to be assessed. Therefore, SUD prevalence estimates among CDCR's population, while consistent with national estimates, are conservative."

Goal #2: Community-based services, particularly residential, are robust enough to meet demand starting with ensuring that those with multiple needs are not left behind due to their numerous and complex challenges.

Goal #2 Update:

For Goal 2, CCJBH continues to monitor four public systems that are critical to meet the unique and complex needs of the BH/JI population: behavioral health, criminal justice, social services, and housing. Overall findings are as follows:

- All MCPs met the network adequacy requirements.[6]
- CCJBH's analyses of the 2023 Evidence-Based Practice Annual Assessment (also known as the Judicial Council's (Senate Bill (SB) 678 data) revealed that most entities engaged in community supervision (i.e., adult felony probation, Mandatory Supervision, and Post-Release Community Supervision) are performing risk and needs assessments for returning community members.
- Most Medi-Cal applications were approved for supervised persons on parole prior to release; however, for Social Security Income (SSI) applications that are submitted for supervised persons prior to release, the majority are pending at the time of release due to the need to verify applicant medical or mental health information. It is anticipated that these numbers will improve as DHCS' CalAIM initiative continues to be implemented.
- Point-in-time data from CDCR indicate that, of the 24,386 individuals who were on parole on June 30, 2024, 85 percent (n=20,634) were housed or residing in a shelter. That said, 15 percent (n=3,752) were unhoused. Furthermore, 72 percent (n=2,720) of the unhoused persons supervised by parole had an identified behavioral health need at the time of their release, indicating the need for supportive housing options available for individuals who are on parole.[7]

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 #3 Update:

CCJBH utilized the 2023 Annual Evidence Based Practice Survey (SB 678) data to track the trends in Probation Officer evidence-based training. The analyses revealed that, of the 57 responding County Probation Departments, nearly all trained their Correctional Workforce

[6] CCJBH is unable to report on MHP and Drug Medi-Cal (DMC) Plan network adequacy at this time as DHCS requested an extension from the Centers for Medicare and Medicaid Services for both county MHPs and DMC Plans because of the impact of DHCS' operationalized enhancements to its network adequacy monitoring processes. These new reporting requirements resulted in a significant increase in county submissions of alternative access standard requests, which resulted in delayed and/or incomplete data reporting.

[7] These data are not available at a statewide aggregate level for individuals on probation.

on at least one specific Evidence Based Practice (EBP) (e.g., criminogenic needs assessment, motivational interviewing, cognitive therapy, positive reinforcement).

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

Goal #4 Update:

CCJBH released an updated Public Health Meets Public Safety (PH/PS) Data Framework and Visualization, which now includes behavioral health prevalence rates, overdose rates, suicide rates, and behavioral health workforce shortage area data that were incorporated through the contract with the UC Berkeley (UCB) Policy Lab. In 2024, CCJBH contracted with the UCB Possibility Lab to continue building the PH/PS Framework and Data Visualization, prioritizing the Crisis Response Domain since the quality of system response to crisis strongly influences the outcomes of individuals with BH needs, including if they enter clinical settings or justice settings. Finally, CCJBH continues to examine Medi-Cal enrollment and behavioral health services utilization for individuals released from CDCR who have identified behavioral health needs through the CDCR/DHCS Medi-Cal Utilization Project (MCUP).

CCJBH Project Updates

Detailed updates on CCJBH's projects are provided in this report. Throughout 2024, CCJBH continued to make progress on the following:

- PH/PS Data Framework and Visualization
- MCUP
- Diversity, Equity, and Inclusion – Government Alliance for Race and Equity
- LEP Contracts
- JI Peer Support Specialist
- CalAIM
- Juvenile Justice Compendium and Toolkit
- Housing/Homelessness
- Words 2 Deeds
- SSI/Social Security Disability Insurance (SSDI) Updates
- Behavioral Health Awareness Activities
- Additional CCJBH Efforts (Weekly Newsletter, California Budget Summaries, Stakeholder Feedback)

In 2024, CCJBH made notable strides in advocating for and supporting the well-being of the BH/JI population. The recommendations in this report, along with those from previous years, should serve as a foundation for informing and shaping policies and programs that prevent and intervene in justice involvement, particularly for individuals with SMI and/or severe SUD.

I. Introduction

The interconnected systems of behavioral health and criminal justice continue to face complex challenges as California works to meet the evolving needs of individuals at the nexus of these fields. Growing demands for effective crisis care, deflection and diversion strategies, and reentry supports highlight the importance of a cohesive and collaborative approach across state and local agencies. These efforts are further driven by the need to address disparities in access to care, workforce shortages, and housing instability, which disproportionately impact the behavioral health/justice-involved (BH/JI) population.

In Calendar Year (CY) 2024, the Council on Criminal Justice and Behavioral Health (CCJBH or Council) remained at the forefront of these efforts, advancing innovative policies and practices to bridge the gaps between justice, health, behavioral health, housing, and social services systems. Building on previous successes, the Council continued to champion evidence-based strategies, data-driven solutions, and the integration of lived experience (LE) into service delivery. By emphasizing investments in behavioral health, workforce expansion, data-sharing improvements, and housing initiatives, CCJBH reinforced its commitment to improving outcomes for individuals at the intersection of behavioral health and justice involvement.

This year's report provides a comprehensive snapshot of the Council's work, showcasing its dedication to collaborative problem-solving and systemic innovation. Through convenings, research, and strategic initiatives, CCJBH has driven progress toward a more integrated and equitable system of care, ensuring California remains a national leader in addressing the diverse needs of the BH/JI population.

II. CCJBH Council Meetings and 2024 Policy Focus

In 2024, CCJBH prioritized strengthening the connections between criminal justice, health, behavioral health, social services, and housing systems to create a more collaborative and responsive framework for addressing the needs of California's BH/JI population. With a continued focus on leveraging recent historic investments in housing and behavioral health care, the Council advanced collaborative strategies to improve outcomes for JI individuals.

A. Council Membership

Throughout 2024, all 12 Council positions remained fully appointed, continuing with a broad representation of perspectives including criminal justice, behavioral health, LE, primary education, and academia.

B. CCJBH Council Meetings

As many organizations resumed in-person meetings following the COVID-19 Public Health Emergency, CCJBH embraced a "hybrid" meeting model, accommodating both teleconference and in-person participation. Effective January 1, 2024, until January 1, 2026, amendments to the Bagley-Keene Open Meeting Act requires a majority of members to be physically present at a public teleconference location, where the public can attend, observe, and participate (Government Code Section 11123.2).

C. CCJBH Calendar Year 2024 Full Council Meeting Policy Focus

CCJBH maintained a comprehensive policy focus for 2024, holding five Full Council Meetings, as follows:

- March 22, 2024 – Explored findings from the California Statewide Study of People Experiencing Homelessness, spearheaded and presented by the University of California, San Francisco (UCSF), Benioff Homelessness and Housing Initiative. UCSF provided insights into the relevant systemic challenges and barriers, alongside proposed strategies to mitigate homelessness, focusing on the Justice Involved population.
- June 28, 2024 – Presentation on the latest innovations in Integrated Substance Use Disorders (SUD's) from the Los Angeles County Department of Public Health, with an emphasis on upcoming related changes to the American Society of Addiction Medicine's guidelines for treatment providers for assessing a patient's needs and determining the most appropriate level of care.
- September 27, 2024 – Highlighted counties at the forefront of implementing the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) 90-Day Pre-Release Services and Behavioral Health Links (BH Links), as per the CalAIM Correctional Facility Readiness Assessment criteria.
- December 6, 2024 – Overview of the Crisis Continuum of Care (COC) and the implementation of Assembly Bill (AB) 988, focusing on how California is transforming its approach to behavioral health crisis response. The presentation covered the strategic planning, partnerships, and resources necessary for the successful rollout of AB 988 to build out a comprehensive, statewide 988-crisis system.

CCJBH registration and attendance tracking for the Full Council and Workgroup meetings, as well as special events and Mental Health Awareness, Suicide Prevention Awareness and SUD Recovery Awareness activities, may be found in Appendix A. Attendance rates for the Full Council and Workgroup meetings ranged from 44 to 73 percent, ranging from 35 to 180 attendees. Overall, attendance in CY 2024 was greater than in CY 2023, with the largest increase occurring for Full Council meetings (36 percentage point increase in the Full Council meeting that had the highest attendance). The top three topics that drew the highest attendance were: 1) the local-level implementation of the CalAIM 90-Day Pre-Release Services and BH Links, 2) a presentation on the multi-system implementation of criminal justice system evidence-based corrections (e.g., the Risk-Needs-Responsivity Model (RNR) and Collaborative Comprehensive (CC) Case Plans) and 3) a presentation on the evaluation and implementation of the Community Assistance, Recovery and Empowerment (CARE) Act.

a. Juvenile Justice Workgroup

Led by Councilmember advisors with subject matter expertise in probation and education, Chief Mack Jenkins (Ret.) and Dr. Danitza Pantoja, respectively, CCJBH held Juvenile Justice Workgroup meetings in February, April, June, August, and October of 2024 (see Appendix B for Juvenile Justice Workgroup participant information). Based on the 2023 Annual Legislative Report recommendations, CCJBH dedicated the CY 2024 Juvenile Justice Workgroup meetings

to exploring programs and services that effectively serve the BH/JI population, including restorative justice, evidence-based resource guides, gang interventions, residential treatment programs for high-needs youth, initiatives related to Children and Youth Behavioral Health Initiative (CYBHI) (i.e., Public Education and Change Campaigns, Universal Fee Schedules and Behavioral Health Virtual Services Platform), and a collaborative school initiative lead by the California Department of Education that connects behavioral health and criminal justice. Using findings from the Juvenile Justice Workgroups (see Appendix C) and considering the current juvenile justice landscape in California and past CCJBH Annual Legislative Reports, CCJBH developed the below recommendations.

Juvenile Justice System Policy Recommendations

1. CCJBH, in collaboration with Office of Youth and Community Restoration (OYCR), under contract with RAND, developed the California Juvenile Justice Toolkit (Toolkit), which provides a compilation of evidence-based and emerging programs and practices (EEPPs) that research has demonstrated are most suited to meet the needs of at-promise and JI youth populations. **State and local agencies that serve these youth are recommended to continue to promote this toolkit to maximize the adoption of these EEPPs.** In particular, it would be utilized by county probation departments, with needed training and technical assistance (TTA) provided by OYCR, to serve high-risk, high-needs youth who would have been traditionally served by Division of Juvenile Justice (DJJ), but per Senate Bill (SB) 823, are now served at the county level. Specific Toolkit implementation considerations are as follows:
    a. **OYCR and county probation departments could promote the use of the Toolkit by presenting it at county-level public meetings**, including the county Board of Supervisors, providing educational materials with specific case study examples to inform them of the TTA and funding available to probation and behavioral health departments to implement optimal services that will effectively meet the needs of at-promise and JI youth.
    b. **County probation departments are recommended to leverage Toolkit TTA made available by the OYCR, and include in the selection of the most effective EEPPs not only system partners, but also individuals within LE.** This approach will help to ensure that program/practice selections are culturally and linguistically competent and meet the needs of the community. The Council on State Governments (CSG) Justice Center's Centering Lived Experience brief could be used as a guide to effectively engage youth and their families/caregivers who have direct experience in the behavioral health and criminal justice systems. Where feasible, members from the Lived Experience Community Advisory Board that informed the development of the Toolkit could also be leveraged to participate in local EEPP planning and implementation efforts.
    c. **County probation departments that utilize the Toolkit could take a lead in formally establishing multidisciplinary system teams** to select and implement EEPP(s) (e.g., probation, education, behavioral health), clearly delineating the role of each system in serving the youth, from custody to community reintegration, understanding that roles

and responsibilities will change throughout the course of the youth's care and treatment. To obtain the intended results, **it will be imperative that each system implement the EEPP(s) with fidelity to the model, and different service modalities should be carefully considered to maximize access (e.g., telehealth, home-based services)**, particularly where county resources are scarce. Collaborative Comprehensive (CC) Case Plans could be used to ensure coordination of a balanced and effective response to all youth needs (e.g., criminogenic, mental health substance use, education/employment, housing).

d. County probation departments that utilize the Toolkit could **consider how selected EEPPs relate to available Medi-Cal services including, but not limited to, CalAIM Justice Initiative (90-day pre-release services), Medi-Cal non-specialty or specialty mental health services, Drug Medi-Cal services, CYBHI Fee Schedule program services, and Behavioral Health Community-Based Organized Networks of Equitable Care (BH-CONNECT) services** to ensure coordination and to maximize federal funding, where appropriate. For example, the probation department could utilize the Toolkit to identify an effective program to address the youth's criminogenic needs, such as Aggression Replacement Therapy, and the county behavioral health department could utilize the Toolkit to identify an effective program to treat the youth's anxiety, depression, and SUD, such as the Adolescent Community Reinforcement Approach. If the youth have had an open child welfare case or an open case in the past 12 months, the Activity Funds, through BH-CONNECT could be leveraged to encourage prosocial interactions.

e. **OYCR, DHCS and the California Department of Public Health's (CDPH's) Office of Health Equity are recommended to consider partnering together to leverage the CYBHI Evidence-Based Practices and Community Defined Evidence Practices Grants and California Reducing Disparities Project as it relates to the Toolkit EEPPs** to integrate local knowledge and community-defined programs. Per community guidance, OYCR should develop a process for discontinuing ineffective or harmful EEPPs.

2. **System partners** (e.g., probation, county behavioral health, education, courts) **could collaborate to ensure that JI youth who are placed in Short-Term Residential Therapeutic Program (STRTPs) have adequate access to high-quality specialized behavioral health and other supportive services**, with specific actions as follows:

   a. Prior to discharge, **STRTPs would ensure that JI youth and their families are made aware of the Medi-Cal services that will become available to them upon the youth's transition into aftercare**. These services are required to be provided for six months discharge in accordance with Welfare and Institutions Code (WIC) 4096.6 and the Family's First Prevention Services Act. As needed, these youth should be referred to outpatient programs to address their behavioral, behavioral health, and criminogenic needs, and provided with assistance to return to their school of record, when it is in the best interest of the student.

b. **County probation and behavioral health departments could work collaboratively to ensure sufficient STRTP provider capacity to serve** the small, but highly impactful, number of JI **children/youth who have engaged in extremely harmful behaviors**, many of whom suffer from serious emotional disability. Examples of the types of effective programs that could be provided in STRTPs for these youth include Multisystemic Therapy (MST) for Youth with Problem Sexual Behavior (PSB), which is an evidence-based program that has a higher frequency and intensity of contacts than traditional MST and also requires videotaping of therapy sessions to be used as a training / supervision tool to ensure program fidelity.

3. To effectively intervene and deflect youth away from the trajectory to juvenile justice involvement, the **California Department of Education (CDE), DHCS and the Commission for Behavioral Health (CBH; formerly the Behavioral Health Service Oversight & Accountability Commission), could consider providing TTA to relevant system partners on the known risk factors for youth to enter the justice system (e.g., education, primary care, county specialty mental health, courts).**[8] Effective intervention can be achieved through a comprehensive assessment that includes behavioral health and familial/caregiver considerations and provides intervention at the appropriate level. Following the assessment, the jurisdiction providing the intervention should look to current state investments to identify and provide funding for the necessary supports (CYBHI, CalAIM, BH-CONNECT).

4. To best serve the at-promise and JI youth populations, **the Legislature could allocate funding for, and University of California and California State University researchers should consider studying, the impact of cognitive behavioral therapy on youth with problematic sexual offending**. Currently, Trauma-Focused Cognitive Behavioral Therapy (CBT) for PSB for children ages 3-12 and PSB-CBT for children ages 7-12 have been validated as an Evidence Based Practice (EBP), but CBT for youth ages 12-25 has not been validated.

5. **The Judicial Branch of California could develop, disseminate and promote educational materials to encourage counties to implement youth courts**, including sharing the Judicial Council's Youth Court Toolkit and the available funding opportunities. This would promote and allow youth courts to successfully engage youth who have become disenfranchised, emotionally disengaged, and unconnected from healthy relationships with adults.

6. **CDE, in partnership with OYCR, are recommended to offer TTA on the California Student Mental Health Implementation Guide to assist Local Education Agencies (LEAs), Managed Care Plans (MCPs) and county behavioral health departments to partner to create a comprehensive school-based mental health system**. The guide provides a library of accessible tools and resources to implement needed programs to support student's behavioral, academic, social, emotional, and mental health, such as:

[8] See Risk and Protective Factors available on youth.gov (formerly FindYouthInfo.gov), which was created by the Interagency Working Group on Youth Programs and is composed of representatives from 13 federal departments and 12 federal agencies that support programs and services focusing on youth.

a. **Implementation of the Resilience, Empowerment, and Natural Supports for Education and Work (RENEW) program**, which serves transition-aged youth (14-26) who are at-risk for school failure because of academic problems and/or being disengaged with school. The program is a wraparound model that increases the high school completion, employment, and post-secondary education participation rates.

b. **Establishment of a partnership between LEAs and law enforcement agencies**, which could be developed using the guidance in the Implementation Guide, to implement a restorative justice program to facilitate successful mediation between victims and justice-involved youth. Police officers in the community should be trained using programs such as the ones offered by the DHCS Behavioral Health Justice Intervention Services grantees (e.g., the Safe Outside the System Program, Healthy Sonoma), to identify and comprehend low-level crimes and refer them accordingly.

7. To effectively implement the CYBHI to meet the unique needs of, and ensure the access to services for, JI youth with behavioral health conditions, **the California Health and Human Services Agency (CalHHS) and associated departments responsible for implementing the workstreams (California Office of the Surgeon General (CA-OSG), California Department of Managed Health Care (DMHC), CDPH, DHCS, and the Department of Health Care Access and Information (HCAI)) could collaborate with system partners (e.g., probation, behavioral health, education, courts) to offer TTA**, with the below specific considerations:

   a. To optimize the implementation of the Statewide Multi-Payer School-Linked Fee Schedule (Fee Schedule) and encourage more County Offices of Education (COEs) to opt in, DHCS could support COEs by developing a comprehensive toolkit on how LEAs may integrate it into their current billing structure, including an analysis of the current and new services that could be billed under the Fee Schedule Program. Implementation considerations should include the following:

      i. DHCS and OYCR could collaborate on implementation of the Fee Schedule Program to ensure that the resources are targeting communities with at-promise and JI youth, with targeted efforts to ensure access for gang-involved youth. The data collected in CalGang database, specifically the 2017 database, could be used as a resource to identify communities that could be prioritized.

      ii. LEAs could leverage the Fee Schedule to fill gaps in their current continuum school-based mental health services, such as paying for teletherapy or referring students to community-based

> *"[CYBHI makes] significant resources available to a youth population that probation officers and probation agencies serve that I personally back in the day when I was a line officer would have welcomed and relished had they been available and…sitting chiefs now will…welcome the addition of these services."*
>
> *– Mack Jenkins, CCJBH Councilmember, Chief Probation Officer (Ret.), San Diego County*

health clinics or health centers throughout the school year and summer to provide year-round services.

b. To expand access to behavioral health support for JI youth, implementation of the Behavioral Health Virtual Services Platform are recommended, with the following considerations:

   i. To effectively bring the services developed in the Behavioral Health Virtual Services Platform (i.e., Soluna App) to youth in correctional institutions, DHCS could partner with the Chief Probation Officers of California (CPOC) to engage each county's Chief Probation Officer and utilize CDCR's Enterprise Information System team as a subject matter expert given their development of the Automated Rehabilitative Catalog and Information Discovery for adults in correctional facilities.

   ii. LEAs could incorporate the Behavioral Health Virtual Services Platform into the Multi-Tiered Systems of Support efforts by promoting the use of the applications to all students, and their caregivers, to strengthen school and family partnerships and provide youth with 24/7 access to support.

8. **The California Health and Human Services Agency (CalHHS) AB 2083 Systems of Care Memorandum of Understanding** service delivery approach, designed to address coordination for all local foster care child/youth-serving agencies, **could be applied to at-promise and justice-involved youth who are not part of the child welfare system to clearly establish how coordination will occur within each county**. This has been recommended in the 2021, 2022 and 2023 CCJBH annual legislative reports, and is reiterated for 2024 given the importance of this approach to prevent and intervene in justice system involvement.

b. Diversion and Reentry Workgroup

CCJBH continues to examine statewide efforts that support the rehabilitation and reentry needs of the BH/JI population, seeking to ensure that they have the opportunity to benefit from available services and supports in their communities. Based on the 2023 Annual Legislative Report and Recommendations, CCJBH's Diversion and Reentry workgroup focused on the implementation of the California Mental Health Services Authority's (CalMHSA's) Peer Support Specialist Certification, programs that utilized peers to provide SUD treatment in carceral and community-based settings, and the application of evidence-based corrections in health and behavioral health care delivery systems. Led by Councilmembers Chief Mack Jenkins (Ret.), Judge Stephen Manley, and Dr. Tony Hobson, CCJBH held the Diversion and Reentry Workgroup meetings in February, April, June, August, and October 2024 (See Appendix D for Diversion and Reentry Workgroup participant information). Using findings from the Diversion/Reentry Workgroup (see Appendix E) and considering the current diversion/reentry landscape, CCJBH developed the recommendations below.

Diversion and Reentry Policy Recommendations

1. **Relevant state and local policy and program system partners are recommended to provide a robust specialty system of care to meet the unique needs of individuals with the most complex behavioral health conditions. This involves distinguishing and establishing specialized service planning for the serious mental illness (SMI) population separate from the broader any mental illness (AMI) population, those with mild/moderate SUD from those who suffer from severe SUD, and those with co-occurring SMI/severe SUD.** This focus is urgently needed because individuals who have these conditions are currently suffering from high rates of crisis, hospitalization, homelessness, and involvement with the criminal justice system, thereby straining local resources and affecting community well-being. Distinguishing and focusing distinctly on these sub-populations is critical to ensure that resources are allocated in a manner that extends beyond episodic care and instead prioritizes long-term, person-centered support to address comprehensive needs, such as supported housing, employment programs and intensive community-based health, behavioral health and social services. **There is also a need to expand the workforce that is specially trained to serve these sub-populations across multiple sectors** (e.g., health, behavioral health, criminal justice, employment / education, housing and social services), **as well to provide sufficient capacity to provide appropriate treatment and housing.** As part of these efforts, **it is important to acknowledge and plan to prevent/mitigate behavioral issues to avoid escalation that results in placement in restrictive settings**. Future work within and across these sectors would directly focus on the needs of these sub-populations to raise awareness of their unique needs and to identify/highlight relevant cost-effective best practices and programs.
2. **HCAI and DHCS could collaborate to develop a comprehensive strategy to expand the specialty behavioral health clinical workforce that serves the SMI and/or severe SUD populations.** As part of this effort, state and local subject matter experts could be convened to discuss and identify strategies to address the shortage of clinicians trained to treat SMI (e.g., psychosis), severe SUD (e.g., Medicated Assisted Treatment (MAT) with psychosocial services), and those who suffer from both SMI/severe SUD, including re-examining the clinical supervision requirements and highlighting/leveraging available financial assistance for students. Important stakeholders who could participate include, but are not limited to, DSH, CDCR, CCJBH, Medi-Cal MCPs, county behavioral health departments, community-based organizations (CBOs) and individuals with LE. Representatives from universities, accrediting bodies[9] and licensing and regulatory boards[10] could also be included to help inform and shape this strategy. Resources that may be used to inform this work are the recommendations outlined in HCAI's Behavioral Health Workforce Strategy and HCAI's

[9] Accrediting bodies can include, but are not limited to, the Council for Accreditation of Counseling and Related Educational Programs, Commission on Accreditation for Marriage and Family Therapy Education and the Council on Social Work Education.

[10] Licensing and Regulatory Boards include the Board of Behavioral Sciences, California Board of Psychology and Medical Board of California (for psychiatrists). DHCS oversees the Certified Alcohol and Drug Counselors and approves SUD counselor certifying organizations such as the California Consortium of Addiction Programs and Professionals and California Association for Alcohol/Drug Educators.

Licensed Mental Health Services Provider Education Program, as well as the resources that have been compiled and made available on DHCS' Behavioral Health Recruitment and Retention webpage and CalHHS' Workforce for a Healthy California webpage.

3. **DHCS, with input from CDCR, county jails, and individuals with LE, is recommended to develop and produce educational videos that inform incarcerated adults and youth about the Enhanced Care Management (ECM) and Community Support (CS) services that are now available through the Medi-Cal MCP's upon release to the community**. These videos would be shown in jails, prisons and youth correctional facilities, offering clear information on how to access these resources and the benefits they provide. Having such targeted education on these resources prior to release will help individuals be better equipped to engage in community-based health and behavioral health care services upon release, thus proactively supporting successful transition into the community.

4. **CDCR and County Sheriff's Departments could expand and implement behavioral health certification programs, such as the Occupational Mentor Certification Program (OMCP) and the Medi-Cal Behavioral Health Peer Support Specialist Certification training to increase access to employment after incarceration while simultaneously addressing the behavioral health workforce shortage.** Expanding these certification programs throughout CDCR's institutions and exploring the possibility of implementing these models in county jail setting can better equip incarcerated persons with the necessary leadership and professional skills to gain employment in the behavioral health sector as Alcohol and Other Drug Counselors and Medi-Cal Behavioral Health Peers upon release into the community. These individuals could also serve as pro-social role models for other incarcerated individuals, encouraging them to seek behavioral health treatment, as well as inspire them towards their own rehabilitation. It would also expand the behavioral health workforce to include staff who are willing and have the expertise to serve the BH/JI population.

> *I spent over 20 years in prison. I had a life sentence and was found suitable, and OMCP had a significant impact and played a significant role in that. It's not just a certification that gets someone educated, [it helps] to address the issues that brought them to prison so that when they take that certification [and go] into the community they can be successful".*
>
> *– Thomas Deschaine*
> *CADC I Journey Counselor*
> *OMCP-DRP*

5. **State and local systems that serve the BH/JI population could explore opportunities to meaningfully integrate BH/JI LE perspectives and staff into their contracts.** Integrating the LE perspective into state and county Requests for Proposals (RFPs) helps to include their preferences and needs into consideration for available funding opportunities. Ideally, it would also result in the inclusion of peers into state and local organizational structures and staffing models. For example, New Jersey's Camden County Department of Corrections

Reentry Committee implemented policies and practices through contracts that require JI peer employment, allowing individuals with JI LE to work in Camden County jails to assist with the development of reentry transition plans, connect individuals to community-based services, and provide support for family reunification. In California, a similar approach could be taken by Medi-Cal MCPs to contract with ECM/90-day pre-release care coordination providers, requiring them to hire individuals with JI LE, as well as coordinating with county jails to ensure these LE staff are authorized to work within the jail environment, as needed. This RFP/contracting strategy could extend beyond criminal justice and health care and be implemented in other sectors that serve the BH/JI population such as housing, social services, etc.

6. **DHCS, in consultation with CalMHSA, is recommended to reexamine the design and implementation of the JI Peer Support Specialist Certification training to ensure that the needs of the BH/JI population are adequately addressed.** Despite being available since July 2023, there are zero peers who have completed the JI Peer Support Specialist certification training.[11] Given that there are several state initiatives that are focused on addressing the complex needs of the BH/JI population, it would be beneficial for DHCS and CalMHSA to engage stakeholders in listening sessions and focus groups to identify barriers and solutions that can increase the number of peers who complete the Justice-Involved Peer Support Specialist Certification training. CCJBH could be a resource to leverage the CCJBH Lived Experience Project (LEP) contractors to assist with stakeholder engagement.
7. The **Legislature could allocate funding to the University of California or California State University to evaluate the impact of encampment sweeps, particularly with regard to outcomes such as arrests, as well as health, behavioral health and housing outcomes.** This research will provide critical insights into the long-term consequences of criminalizing homelessness (e.g., housing stability), helping guide future legislation, policy development and program implementation. Examples of data that could be leveraged for this study include key informant interviews, literature reviews, criminal justice data from the Department of Justice (DOJ) (e.g., Criminal Justice Information System data for arrests and convictions) and health/behavioral health data submitted to DHCS from the Medi-Cal MCPs and county behavioral health plans. In addition to the findings, the final report can identify and make recommendations regarding data collection and reporting gaps, as well as identify best practices to prevent the criminalization of homelessness, particularly for those who suffer from behavioral health conditions (including the jail/prison reentry population).
8. **State and local housing funding and planning entities including, but not limited to, the California Department of Housing and Community Development (HCD), California Interagency Council on Homelessness (Cal ICH), California Department of Social Services (CDSS), DHCS, Public Housing Authorities, CoCs, county social services agencies and CBOs could utilize the CDCR Parole Population Housing Dashboard for local planning efforts.** This dashboard provides valuable data on the number of unhoused individuals on parole in

[11] Data were extracted from CalMHSA's Peer Certification Program Dashboard in October 2024. CalMHSA's dashboard reflects the number of individuals who have completed and submitted a certificate of completion of the Peer Support Specialist certification.

each county, including demographics and mental health and substance use designations at the time of release from prison. By incorporating this information, State and local planning entities can better target resources and support services to meet the specific needs of unhoused supervised persons alongside the broader unhoused population. This targeted approach will help ensure that the unique challenges faced by individuals transitioning from the correctional system are addressed, leading to more effective and inclusive housing solutions. **Cal ICH's "*Putting the Funding Pieces Together*" guide would be used to navigate funding opportunities and increase housing capacity, support transitional housing, and develop permanent supportive solutions tailored to the BH/JI population.** In addition, **the Homeless and Housing Resource Center (HHRC) and their toolkit, Expanding Peer Support Roles in Homeless Service Delivery: A Toolkit for Service Providers, should be used to employ forensic peers** who have LE with mental health issues and the criminal justice system and can play a unique role in connecting the BH/JI population to housing and support services through trust and mentorship during and after their transition from incarceration to the community.

General Recommendations to Improve Outcomes for the BH/JI Population

1. **County Administrator's Offices could lead a comprehensive, cross-system review of the recent investments in health and behavioral health care,[12] social services, housing, etc., to ensure a coordinated, integrated approach across county departments and agencies to serve the BH/JI population rather than implement these initiatives in silos.** Many of these recent significant investments can be leveraged to offer critical support for the BH/JI population (youth and adults); however, historically, implementation of these types of initiatives occurs in isolation, both within county organizations and across systems. A siloed approach risks missing opportunities for collaboration and comprehensive care. By integrating these new investments with existing funding streams across multiple systems – health and behavioral health care, housing, justice and social services – counties can blend resources create a more effective and holistic support structure that improves outcomes for individuals and ensures that the full range of services are accessible. A comprehensive, coordinated approach would maximize the impact of these investments, reduce duplication of efforts, and more efficiently address the complex needs of the BH/JI individuals.
2. **As appropriate, CDPH and local public health departments could assess all public health education campaigns for opportunities to not only educate, normalize, and destigmatize behavioral health conditions, in general, but also SMI, severe SUD and co-occurring SMI/severe SUD disorders, in particular. This approach would also address the additional stigma faced by individuals who are, or are at risk of becoming, justice involved.** This visibility can help promote understanding and foster acceptance of those who have behavioral health conditions, as well as encourage individuals to seek support without fear of judgment. It's an opportunity to inform the public about the complexities and realities of these conditions, highlighting that recovery is possible with appropriate care and support.

[12] See the California Health and Human Services' Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts.

With specific regard to the BH/JI population, these campaigns can be used to educate the public that many JI individuals have untreated SMI and or severe SUD, and that these conditions, when left untreated, can lead to behaviors that come to the attention of law enforcement. This also presents an opportunity to educate on the effectiveness of evidence-based treatments for SUDs, which is not well understood by the general public. This could include raising awareness that approaches such as MAT combined with therapy and social supports have proven to be highly effective in treating conditions such as alcohol use disorder and opioid use disorder. Normalizing behavioral health discussions through such campaigns can foster greater compassion, understanding, and acceptance, emphasizing the importance of early intervention and proper treatment, as well as the need for systemic changes to prevent criminalizing untreated mental health and substance use conditions.

3. Given the extensive shortage of the behavioral health workforce specifically trained to serve the BH/JI population, CCJBH recommends that:[13]

   a. **All staff at the state and local levels who are responsible for designing, implementing and/or evaluating programs for the BH/JI population would be competent in the field of evidence-based corrections**. At a minimum, staff should complete "Evidence Based Practices Courses 1-6" offered by the National Institute of Corrections Learn Center to enhance understanding of how criminal risk and criminogenic needs impact a BH/JI individual's ability to participate in available services, including health and behavioral health services. These concepts apply to JI individuals of all ages and are critical to ensure that interventions are grounded in proven strategies, reduce recidivism, and effectively address their complex needs in order to achieve positive outcomes for both the individuals and the community.

   b. **ECM providers that serve the BH/JI population would be trained in evidence-based practices that focus on trauma-informed care.** ECM providers will manage comprehensive care and coordinate community support for the BH/JI population, who often have complex needs stemming from trauma and social determinants of health. Understanding adverse childhood experiences, the impact of trauma, and how these factors influenced behavioral and medical needs is essential. Resources and training from the Substance Abuse and Mental Health Services Administration (SAMHSA)'s GAINS Center for Behavioral Health and Justice Transformation would greatly benefit these providers.

   c. **Efforts could be made to explore the potential for Federally Qualified Health Centers (FQHCs) to serve as Medi-Cal ECM providers for the JI Population of Focus.** FQHC's have traditionally provided low-to-no cost health care to California safety net, including the BH/JI population. Not only do FQHCs receive referrals from law enforcement, courts, and social services, but they also often serve as the primary health and behavioral health care providers familiar to the BH/JI population as they were the main source for these services prior to California's implementation of the Affordable Care Act. While

[13] See Building the Future Behavioral Health Workforce: Needs Assessment (February 2023).

some FQHCs are seeking or have already become ECM providers, DHCS and Medi-Cal MCPs should seek to engage more FQHCs in order to reach a larger portion of the BH/JI population by increasing the number of available providers. CCJBH could leverage the Medi-Cal Utilization Project (MCUP) to monitor ECM service utilization by Medi-Cal provider type.

III. Update on 2025 Policy Goals

CCJBH continued to monitor the progress of four broad policy goals related to the BH/JI population: 1) behavioral health prevalence rates; 2) the continuum of available behavioral health, criminal justice, and social services (including housing); 3) workforce to support this continuum; and 4) the practice of using data to guide policy and program efforts. While CCJBH is not directly responsible for these goals, nor is any single entity responsible for achieving them, the Council has held an important role in using data to identify and highlighting successes, as well as target areas for improvement. Ideally, in addition to anchoring and guiding CCJBH Full Council and workgroup discussions, this information is used to inform and shape relevant policy and programmatic decisions. Updates on these indicators are as follows:

***Goal #1*:**

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

***2024 Update*:**

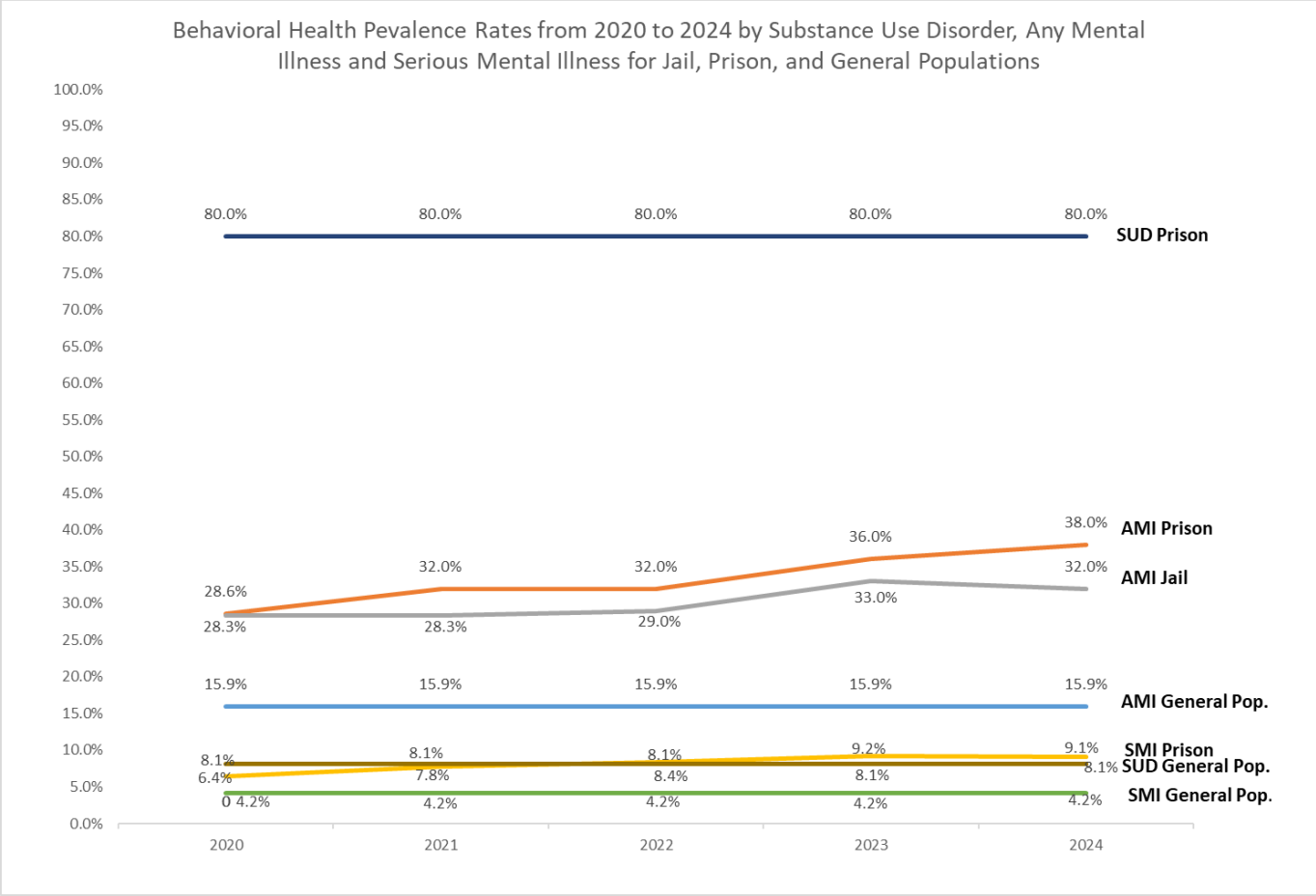
CCJBH continues to report on the prevalence rates of individuals with behavioral health conditions in custody settings compared to those of the general population as a key (if not "the" key) performance measure. As shown in Figure 1, an examination of these data has consistently revealed a pervasive overrepresentation of individuals with behavioral health and/or SUD health conditions in custody settings, with SUD(s) being most overrepresented. Interestingly, while most of these prevalence measures remained stable, there has been a slight increase in the jail and prison rates for "any" mental illness, which CCJBH first documented in the 2020 Annual Legislative Report as it related the COVID-19 Public Health Emergency releases, as well as prison SUD rates (jail SUD rates are not available).

Moreover, the CCHCS 2024 Annual ISUDT report was used to present SUD prevalence estimates among CDCR's population, wherein CCHCS stated that "National SUD prevalence estimates were used as a baseline to develop the ISUDT Program. These estimates show 65% of the U.S. prison population meets the clinical definition for having a SUD, and another 20% did not meet the clinical criteria for a SUD, but were under the influence of drugs or alcohol at the time of their crime…CDCR SUD prevalence estimates for incarcerated individuals show Opioid Use Disorder (OUD) prevalence is high (nearly 30%), with Alcohol Use Disorder (AUD) and stimulant use disorder (StUD) at roughly 25%, respectively, and polysubstance use (OUD and StUD) at nearly 20%. It is important to note CDCR's entire population has not been assessed due to the sheer volume of people who screen positive for possible SUD…and

because some people are reluctant to be assessed. Therefore, SUD prevalence estimates among CDCR's population, while consistent with national estimates, are conservative."

Continuing to report and monitor these data will help to inform ongoing policy and programmatic decisions, particularly given the recent investments in behavioral health care and housing in California, which collectively is expected to result in reducing the BH/JI population's incarceration rates. For a more detailed table regarding Goal #1 prevalence data, see Appendix F.

Figure 1.



***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.

***2024 Update*:**

For Goal 2, CCJBH continues to monitor four public systems that are critical to meet the unique and complex needs of the BH/JI population: behavioral health, criminal justice, social services, and housing. As documented in the 20th Annual CCJBH Legislative Report, the

measures identified for each of these systems is based on relevant, available data that can be monitored at the state-level. While detailed results on the updated data for the Goal #2 measures may be found in Appendix F, overall findings based for each system is as follows:

Public Behavioral Health System

Services to meet behavioral health needs are provided across multiple Medi-Cal delivery systems. To document the degree to which the community behavioral health system adequately meets beneficiary needs, DHCS produces annual Medi-Cal Network Certifications, which certify that each delivery system meets established network adequacy standards, such as time and distance, and timely access to care. The 2022 certification findings regarding the capacity of these systems, as reported in May 2024 (the most recent reporting period for which information for the resulting corrective action plans is available), were as follows:

- All 26 Medi-Cal MCPs met the provider-to-member ratios and time or distance standards.

CCJBH reports the DHCS Network Adequacy certifications for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). The results were published on November 27, 2024, and can be accessed on DHCS website.[14]

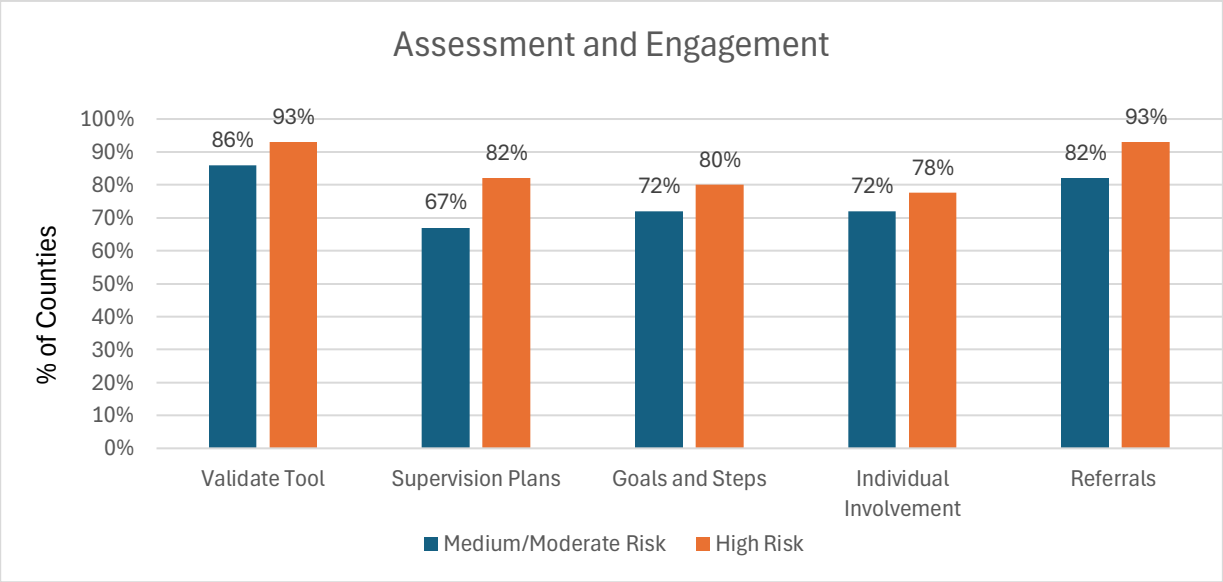
Criminal Justice System

- In FY 2023-24, as stated in the 2024 California Rehabilitation and Oversight Board (C-ROB) Annual Report, the number of supervised persons declined by 6.4 percent. As of June 30, 2024, 94.6 percent of supervised persons received a Reentry Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment, which is a slight decrease since 2023. The department uses the results of the California Static Risk Assessment (CSRA), completed during the start of an individual's incarceration, to assess an incarcerated person's risk to reoffend. Of the released population with a CSRA and COMPAS assessment complete, 88.5 percent had a moderate to high CSRA risk and at least one moderate to high COMPAS reentry need. Additionally, 38.9 percent of supervised people that were designated as moderate to high risk (by CSRA), with at least one need participated in at least one program consistent with their need within their first year of release. The percentage decreased by over 3 percentage points when compared with the prior fiscal year. The total percentage of individuals with both a risk and need who participated in any program within one year decreased slightly from 43 percent to 39.5 percent.
- SB 678 EBP Annual Assessment Survey – In accordance with SB 678, an EBP Annual Assessment Survey is administered for probation departments to meet their statutory obligations under Penal Code Sections 1231 and 1233, and to track progress over time. Based on the CY 2023 survey administration, responding counties (57 total) represent a large portion of California's total

[14] See 2023 Network Adequacy and Access Assurances Report (Managed Care and Behavioral Health).

population and data are self-reported by each probation department.[15] Analyses of data from the 2023 EBPs Annual Assessment Survey indicate that the majority of supervised individuals received a validated risk assessment to identify criminogenic needs (approximately 86 percent of medium/moderate risk and 93 percent of high-risk individuals) and that the majority of supervised individuals were referred to programming, treatment, and/or services based on one or more of their assessed top criminogenic needs (approximately 82 percent of medium/moderate risk and 93 percent of high-risk individuals). Additionally, most probation departments utilized EBPs that were responsive to criminogenic needs assessment (e.g., supervision plan, services, supervision conditions, rewards) for moderate to high-risk individuals. (see Table 1 for an illustration of these findings).

Table 1. Assessment and Engagement of individuals through the implementation of EBP



Social Services System

As reflected in the C-ROB September 2024 Report for FY 2023-24, the status of most Social Security Agency (SSA)/Social Security Insurance (SSI) and Veteran Affairs (VA) applications was pending; however, there was a slight improvement. Although most SSA/SSI and VA applications remain pending (approximately 77 percent), of those applications that were processed, approximately 93 and 48 percent were approved, respectively. As further context, CDCR has stated previously that SSA has historically taken longer to process applications due to the need to verify the applicant's medical or mental health disabilities, and that SSA/SSI regulations dictate pre-release application

[15] Responses are not independently verified after submission. In addition, survey responses likely undercount the implementation of EBPs as probation departments may contract some practices or EBP components out to third parties. Further, the EBP Annual Assessment asks probation departments about their use of evidence-based practices in supervising all felony populations, including individuals on adult felony probation, mandatory supervision and post release community supervision (PRCS).

timelines; therefore, these data will continue to fluctuate. For FY 2023-24, 80.6 percent of applications for Medi-Cal benefits were approved, while 19.2 percent were pending an outcome.[16] These numbers show a slight downward trend, but DHCS' CalAIM Initiative is ongoing and includes prerelease and reentry components including the prerelease Medi-Cal application process. Thus, these rates may increase as the CalAIM reentry initiatives are implemented.

Housing System

- Point-in-time data from CDCR indicate that, of the 24,386 individuals who were on parole on June 30, 2024, 85 percent (n=20,634) were housed.[17] That said, 15 percent (n=3,752) were unhoused.[18] Furthermore, 72 percent (n=2,720) of the unhoused persons supervised by parole had an identified behavioral health need at the time of their release. Specifically, of those who were unhoused:
  - 31 percent (n=1,158) left prison with a SUD *only.*[19]
  - 28 percent (n=1,045), had a co-occurring mental health and SUD and within this group:
    - 76 percent (n=798) had a Correctional Clinical Case Management System (CCCMS) designation.
    - 21 percent (n=219) had an Enhanced Outpatient Program (EOP) designation.
  - 14 percent (n=517), had a mental health designation *only* and within this group:
    - 79 percent (n=408) were CCCMS.
    - 18 percent (n=95) were EOP.
  - 28 percent (n=1,032) had no identified behavioral health need.

[16] The number of individuals releasing from CDCR who are enrolled into Medi-Cal is expected to improve given the recent Medi-Cal expansion to extend full scope Medi-Cal coverage to individuals who are 26 through and including 49 years of age, regardless of their immigration status, as well as the upcoming implementation of CalAIM 90-day in-reach and pre-release services.

[17] Data were provided to CCJBH from the CDCR Office of Research (CDCR-OR).

[18] Note: unhoused supervised persons data can be compared to the 2022 CCJBH Legislative report, but should not be compared to the 2021 CCJBH Legislative report due to a refinement in the CDCR-OR methodology for reporting data regarding housing for this population.

[19] SUD designations are based on results from the COMPAS assessment.

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.

2024 Update:

To shed light on BH/JI workforce capacity and training that is necessary to support the systems specified in Goal #2, given the limited availability of workforce data, CCJBH continues to examine data using the SB 678 EBP Annual Assessment Survey. Updated results are as follows:

SB 678 EBP Annual Assessment Survey

There are measures within the SB 678 EBP Annual Assessment that target correctional workforce training on specific EBPs (e.g., criminogenic needs assessment, motivational interviewing, cognitive therapy, positive reinforcement). Analyses of these data showed that:

- 96 percent of counties trained officers to focus on criminogenic needs when meeting with high-risk, and 95 percent for medium-risk offenders.
- 96 to 98 percent of counties trained officers in intrinsic motivational skills, such as Motivational Interviewing for high-risk and medium-risk offenders, respectively.
- 78 to 81 percent of counties trained officers in the use of CBT techniques for high-risk and medium-risk offenders, respectively.
- 96 to 98 percent of counties trained officers to frequently give verbal positive reinforcement for prosocial behaviors when meeting with high-risk and medium-risk offenders, respectively.

In addition to continuing to report on these data, CCJBH will continue to monitor HCAI's efforts to enhance the training of the behavioral health workforce to serve justice- and system-involved youth (through the CYBHI) and adults, as well as their plans to develop data visualizations on workforce growth and expansion. For more details regarding Goal #3 measures, please see Appendix F.

***Goal #4*:**

Through state leadership to support data-driven practices and policymaking among criminal justice and behavioral health systems, continuity of care and desired public safety and health outcomes improve significantly.

2024 Update:

- *Public Health Meets Public Safety (PH/PS) Data Visualization* – CCJBH launched the PH/PS Framework and Visualization which presents publicly available data on socio-economic factors and criminal justice involvement per county. In the Spring of 2023, CCJBH Councilmembers voted to use unspent Fiscal Year 2023-24 Mental Health Services

Act (MHSA) funds to establish a contract with the UC Berkeley (UCB) Policy Lab during the summer of 2023 to identify additional relevant metrics for the PH/PS Data Visualization, which ended on August 30, 2023. This resulted in the identification of additional data metrics for the PH/PS Data Visualization to include behavioral health prevalence rates, overdose rates, suicide rates, and behavioral health workforce shortage area data. Additionally, in Spring of 2024, CCJBH entered an Interagency Agreement (IA) with UCB Possibility Lab to continue building the PH/PS Framework and Data Visualization. CCJBH requested that UCB prioritize the Crisis Response Domain as they work to expand the PH/PS Data Visualization since the quality of system response to crisis strongly influences the outcomes of individuals with BH needs, including if they enter clinical settings or justice settings.

- *MCUP* – CCJBH continues to examine data regarding individuals released from CDCR facilities in relation to their Medi-Cal enrollment and utilization of Medi-Cal physical and behavioral health care services. CCJBH partnered with the California State University, Sacramento (CSUS), to conduct listening sessions for individuals with behavioral health needs and LE in the justice system. The qualitative data obtained from those listening sessions was compiled and analyzed to inform the findings from the quantitative MCUP analyses. The final reports from both the MCUP data analyses and listening sessions are posted to the CCJBH website.
- The CBH's Data-Driven Recovery Project continues to support criminal justice and behavioral health data linkage at the local level.

IV. CCJBH Project Updates

In addition to supporting the Council, CCJBH staff also work on a variety of projects related to the BH/JI population. Updates on each of these projects, including completed deliverables, are provided below.

A. PH/PS Data Framework and Visualization

In 2023, CCJBH applied for and was granted an embedded Resident Corrections Analyst (RCA) position, funded for one year through the U.S. DOJ, Justice Reinvestment Initiative, to develop protocols for retrieving, cleaning, and standardizing PH/PS Data Visualization data. This effort included documenting the PH/PS data sources, the frequency of and process for updating the data, etc. This information will be utilized by CCJBH and CCJBH contractors to further develop and maintain the PH/PS Data Visualization. The RCA grant ended in August 2024. In addition, during the April 2023 CCJBH Full Council meeting, CCJBH Councilmembers voted to use unspent Fiscal Year 2023-24 Mental Health Services Act Funds to continue developing the PH/PS Framework and Data Visualization. CCJBH entered into an IA with the UCB Possibility Lab. Through this IA, the UCB Possibility Lab will assist CCJBH with the following:

- ✓ Maintaining and updating the data inventory and dashboard.
- ✓ Developing a Data Refresh Schedule.
- ✓ Transitioning the work accomplished in CY 2023 and 204 by the UCB Possibility Lab and RCA.

- ✓ Expanding the PH/PS Framework and Data Visualization.
- ✓ Engaging with additional stakeholders on use cases, including how best to track CCJBH's 2025 System Goals, to inform system efforts (e.g., health, behavioral health, housing, social services, education, employment).

The UCB Possibility Lab over the next two years will work to complete their contract deliverables and provide their expertise to identify and develop metrics that will expand the PH/PS Data Visualization to include crisis response and treatment landscape outcomes that impact the BH/JI population.

B. Medi-Cal Utilization Project (MCUP)

CCJBH is analyzing data for FY 2020-21 and 2021-22 that CDCR releases in order to update the report, Medi-Cal Utilization Project: A Report on the Medi-Cal Enrollment and Behavioral Health Services Utilization for Individuals Released from the California Department of Corrections and Rehabilitation in Fiscal Year 2019-20, which will again examine Medi-Cal enrollment and behavioral health services utilization. Additionally, as part of this updated report, CCJBH anticipates expanding data analyses to examine and establish utilization baselines for the new Medi-Cal ECM and CS services.

C. Diversity, Equity, and Inclusion (DEI) - Government Alliance for Race and Equity (GARE)

As part of CCJBH's commitment to integrate DEI principles into our mission and operations, CCJBH staff actively participate as ambassadors in the CDCR/California Health Care Services (CCHCS) GARE, demonstrating leadership in DEI initiatives across criminal justice and behavioral health sectors. CCJBH's engagement in DEI was prominently featured in communications surrounding World Justice Day and Mental Health Awareness Month, allowing the Council to highlight the historical and ongoing challenges for the BH/JI population. Recalling the influential impacts of Dr. Martin Luther King Jr. and Susan B. Anthony on World Justice Day emphasized the perpetual need for a justice system that embodies fairness and inclusivity. During Mental Health Awareness Month and SUD Awareness Month, CCJBH sought to address historical misconceptions about behavioral health to promote better understanding of mental health and substance use disorders, including the importance of mitigating the generational impact of stigma, especially within communities disproportionately affected by the criminal justice system, particularly for Black/African American and American Indian/Alaska Native populations. By championing collaboration, empathy, and sustained effort, CCJBH seeks to shift paradigms to foster environments where fairness and justice are tangible realities.

D. Lived Experience Projects (LEP)

During the April 2023 CCJBH Full Council meeting, CCJBH Councilmembers voted to fund one State-level and three Local-level LEP contracts for FYs 2023-26. These contracts will sustain and expand the work that was accomplished by the FY 2020-23 LEP contracts and focus on the following areas:

- ✓ Elevating the perspectives and experiences of youth and adults with LE at the state and local levels (e.g., integrate their voices in the planning and decision-making process);
- ✓ Educating and increasing community awareness of the needs of the BH/JI population, including how the success of these individuals is beneficial to community health and safety;
- ✓ Promoting and fostering multi-disciplinary collaborations across the different systems that serve the BH/JI population including, but not limited to health, behavioral health, criminal justice, housing, and social services;
- ✓ Promoting the practice of employing individuals with LE (e.g., peers, community health workers (CHWs), parents, and caregivers) within systems that serve the BH/JI population including, but not limited to, behavioral health, criminal justice, housing, and social services, requesting feedback from consumers and family members, as needed;
- ✓ Gathering stakeholder feedback to help inform the decision-making process on projects and policies that impact the BH/JI population; and
- ✓ Leveraging the utilization of publicly available data, including using the PH/PS Data Visualization, to help inform the decision-making process on projects and policies that impact the BH/JI population.

Through a competitive bidding process, CCJBH selected the following organizations as the LEP Local-level Contractors: Third Sector Capital Partners, Transitions Clinic Network, and Beyond Us and Them. CCJBH also established a contract with Root & Rebound to serve as the State-level LEP Contractor.

E. Justice-Involved Peer Support Specialist

CCJBH continues to track DHCS and CalMHSA's implementation of the SB 803 Medi-Cal Peer Support Certification by participating in the bi-monthly CalMHSA Medi-Cal Peer Certification Advisory Committee meetings. Similarly, CCJBH continues to advocate for the use of peers and CHWs within and across the multiple public sectors that serve the BH/JI population (e.g., primary care, criminal justice, housing, and social services). As part of the 2024 Diversion and Reentry Workgroup meetings, CCJBH featured presentations from Tarzana Treatment Centers College and Self-Help and Recovery Exchange (SHARE!), who are certifying agencies for the CalMHSA's Medi-Cal Justice Involved Peer Support Specialist Certification.

F. CalAIM

CCJBH remains actively committed to support the DHCS' CalAIM initiative, a multi-year effort to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program, and payment reforms. CCJBH has actively supported DHCS' CalAIM efforts since 2021 by participating in a number of workgroups and developing resources to support justice system partners in the implementation of CalAIM. In January 2024, CCJBH updated the Enhanced Care Management (ECM) Referral Flyer for Justice System Partners to include a list of ECM referral processes for each MCP within each county. In November 2024, CCJBH updated the CalAIM Factsheet with relevant information from the recently submitted

BH-CONNECT 1115 Demonstration Waiver and updated implementation dates. Also in August 2024, in response to individuals under parole supervision who were interested in ECM, CCJBH updated the ECM referral process webpage to include a link to each MCP ECM Member Resource Page.

In addition to producing informational materials to educate justice system partners on CalAIM, CCJBH has supported CDCR's criminal justice system partners in efforts to implement referrals for ECM individuals with behavioral health needs who are involved in the justice system. Specifically, CCJBH has facilitated bi-monthly meetings with CDCR Division of Adult Parole Operations (DAPO) Behavioral Health Reintegration (BHR) to identify and address successes and challenges the clinicians have faced in referring individuals on parole to ECM.

G. Juvenile Justice Compendium and Toolkit

To support SB 823 juvenile justice realignment, CCJBH contracted with RAND, a non-profit policy research institute, to develop a compendium, toolkit and training plan to support youth who have been traditionally remanded to the CDCR DJJ, but who, as of July 1, 2021, remain at the county level under the jurisdiction of county probation as a result of SB 823. The contract term with RAND was from April 13, 2022, to April 19, 2024. Over the duration of the contract, RAND developed a California Juvenile Justice Toolkit that compiles current, relevant information regarding the established practices and programs designed to serve the realigned population and other levels of juvenile justice system involvement. The information gathered for the Toolkit was incorporated into a Tableau Dashboard and published as a draft in October 2023. The final version of the Toolkit was completed in April 2024, which expands on information that counties may use to plan for the necessary infrastructure and capacity to implement the programs and practices identified. The completed tool is accompanied by the California Juvenile Justice Toolkit Methods for Development Report that outlines the steps taken to develop the Toolkit. RAND produced the final contract deliverable in April 2024, which was a TTA Plan that counties may use to secure the relevant TTA to assist them in implementing the evidence-based and emerging programs and practices detailed in the Toolkit. OYCR will now lead the next phase of the contract, using the TTA Plan to provide technical assistance and support for counties using this resource to guide their selection and implementation of youth programs and practices.

H. Housing/Homelessness

CCJBH continued its collaboration with DAPO, Division of Rehabilitative Programs (DRP) and the Office of Research as a joint effort to support the Secretary's role as a member of Cal ICH. The group provides quarterly reports on the progress of CDCR's commitments, as outlined in Cal ICH's Action Plan for Preventing and Ending Homelessness. CCJBH also assisted in fostering a partnership between CDCR and HCD for the HOME American Rescue Plan Program Reentry Housing Pilot Project, facilitating cross-departmental collaboration and providing project management support. In addition to these state-level efforts, on June 10, 2024, CCJBH submitted a letter of support and recommendations to the federal U.S. Department of Housing and Urban Development (HUD) in response to their proposed rule, "Reducing Barriers to HUD-Assisted Housing." The letter outlined the necessity of this rule to remove the significant barriers from and broaden access to housing for the BH/JI population.

I. Words 2 Deeds

In July 2023, CCJBH Councilmembers voted to allocate CCJBH's annual MHSA budget to further the efforts of Words to Deeds (W2D). Due to the Council's high level of interest, CCJBH partnered with the CBH through an IA to collaborate on W2D to maximize resources for the Justice Involved population. As part of this partnership, CBH:

- ✓ Planned, coordinated, and facilitated an annual W2D convening in September 2024 (and has another convening planned for Calendar Year 2025);
- ✓ Formed and facilitated a Leadership Group to guide W2D planning; and
- ✓ Developed a report that summarizes the key themes and recommendations that emerged from the convening.

V. Behavioral Health Awareness Activities

In May 2024, CCJBH promoted May is Mental Health Awareness Month by hosting a series of four Lunch and Learns highlighting the voices of youth with lived experience, subject matter experts, programs that benefit the BH/JI population and learning about available local resources, featuring the Rising Scholars Program, Colusa County Safe Haven Wellness and Recovery Center, Social Advocates for Youth San Diego, CARE Act and the SAMHSA's African American Behavioral Health Center of Excellence (AA BH COE). During the final week of the month, CCJBH distributed a weekly blast that recapped the presentations and available resources each organization provides.

In September 2024, CCJBH promoted Suicide Awareness Month and SUD and Recovery Awareness Month by hosting a series of four Lunch and Learn sessions featuring the California Department of Public Health Office of Suicide Prevention, SAMHSA 988 Suicide Prevention & Behavioral Health Crisis Coordinating Office, Kauffman and Associates, Inc. (overview of SUD issues in tribal communities), and HealthRIGHT 360's Contingency Management Program.

VI. Additional CCJBH Efforts

A. Weekly Newsletters

The CCJBH weekly newsletter is an essential resource providing detailed, current information tailored to the needs of stakeholders in behavioral health and criminal justice. Through the Constant Contact platform, CCJBH delivers diverse content, from CCJBH updates to system partner announcements and legislative updates, supporting stakeholders in decision-making, program exploration, and policy development. CCJBH engagement metrics are a testament to its impact, with an average open rate of 50 percent and a click rate of 36 percent, both significantly surpassing industry standards (33 and 2 percent, respectively). CCJBH's stakeholders are not only opening emails, but are also actively engaging with the content, such as registering for webinars or accessing documents. Moreover, CCJBH's bounce rate (the percentage of emails sent that are not accepted by the recipient's email server) is 7 percent, which is below the industry standard of 10 percent, reinforcing the effectiveness of our outreach. These metrics, maintained consistently each week, along with stakeholder

feedback, underscore the CCJBH newsletter's role in promoting an informed community and fostering collaboration.

B. California Budget Summaries

To ensure Councilmembers and stakeholders have efficient access to the California budget information relevant to the BH/JI population, CCJBH continues to produce tailored budget summaries after the release of the Governor's Proposed Budget and the Enacted Budget. Specifically, the relevant categories included in these budget summaries are for Health and Human Services, Housing and Homelessness, Judicial Branch, and Criminal Justice. In FY 2024-25 notable investments include the Behavioral Health Services Act (BHSA), the CYBHI, CalAIM, BH-CONNECT, the Homeless Housing Assisting and Prevention (HHAP) Program and the Encampment Resolutions Funding Program. These initiatives and investments will ensure that vulnerable people have the necessary help to access shelter and mental health services throughout the state of California.

C. Stakeholder Feedback

In 2024, CCJBH provided critical feedback on federal and state initiatives aimed at improving outcomes within the behavioral health and housing sectors. As the only Council in California dedicated to the BH/JI population, CCJBH Councilmembers bring a diverse range of expertise necessary to provide accurate and comprehensive input, shaping policy and program planning to ensure the broad needs of the BH/JI population are met compassionately, equitably, and effectively. Key contributions include leveraging Councilmember and LEP contractor expertise to develop and submit recommendations on the DHCS BH-CONNECT Addendum, DHCS Transitional Rent Concept Paper, DHCS Behavioral Health Transformation Policy Manual Modules 1 and 2, CalHHS 988 Five Year Implementation Plan, and HUD's proposed regulations on Reducing Barriers to HUD-Assisted Housing.

VII. Conclusion

In 2024, CCJBH fulfilled its commitment to advancing the well-being of the BH/JI population by convening local and state stakeholders, alongside individuals with lived experience, to develop impactful legislative recommendations. These efforts focused on maximizing state investments, strengthening treatment and supportive services, addressing housing needs, improving workforce capacity, ensuring data integrity, and increasing community involvement. Recognizing that individuals with SMI and severe SUD are among the most likely to encounter law enforcement, CCJBH emphasized the importance of policy and programmatic strategies that span the entire lifespan—from supporting youth diagnosed with SMI to prevent justice system involvement and foster positive life outcomes to enhancing services for justice-involved adults and older adults to reduce future justice involvement. The recommendations in this report, along with those from previous years, should serve as a foundation for policymakers and stakeholders to continue advancing effective, compassionate approaches that guide individuals toward healthier, more productive lives.

Appendix A
Summary of 2024 Full Council/Workgroup Meetings and Webinars

2024 FULL COUNCIL MEETINGS						
Date	**Format**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Focus**	**Meeting Highlights**
March 22	Microsoft Teams/ In-Person	120	87	73%	Housing	The meeting explored comprehensive findings of the California Statewide Study of People Experiencing Homelessness, spearheaded by the University of California, San Francisco, Benioff Homelessness and Housing Initiative. The presentation highlighted the causes and far-reaching impacts of homelessness across California, with a special emphasis on the experiences of the justice-involved population. It addressed relevant systemic challenges and barriers, alongside proposed strategies to mitigate homelessness.
June 28	Microsoft Teams/ In-Person	106	77	72%	Innovations in SUD Treatment	This meeting explored the latest innovations in treating substance use disorder (SUD). The session provided valuable information for stakeholders at all levels and contributed to our ongoing dialogue on enhancing substance abuse treatment and prevention efforts, particularly in relation to the unique and complex needs of the Justice Involved population.
September 27	Microsoft Teams/ In-Person	290	180	62%	CalAIM 90-Day In Reach and Behavioral Health Links	The meeting highlighted counties at the forefront of implementing the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) 90-Day Pre-Release Services and Behavioral Health Links. The presentation provided valuable insights into the strategic steps counties are taking to meet the CalAIM Correctional Facility Readiness Assessment criteria and prepare for "go-live" implementation. The session showcased best practices, lessons learned, and the collaborative efforts necessary to drive meaningful change within communities.
December 6	Microsoft Teams/ In-Person	182	92	50%	988/Crisis Continuum of Care	This meeting provided an overview of the 988/Crisis Continuum of Care, focusing on how California is transforming its approach to behavioral

2024 FULL COUNCIL MEETINGS						
Date	**Format**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Focus**	**Meeting Highlights**
						health crisis response. The presentation covered the process and partnerships in creating the draft five-year plan for AB 988 implementation, which provides recommendations for a comprehensive 988-crisis system in California. Topics included service coordination, mobile crisis intervention, integration with local resources, and anticipated impact on behavioral health services and law enforcement partnerships across the state.

2024 WORKGROUP MEETINGS							
Workgroup	**Meeting Dates**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Format**	**Focus**	**Highlights**
Juvenile Justice	February 16	80	35	44%	Microsoft Teams/ In-Person	Restorative Justice for Juveniles with Behavioral Health Needs.	The meeting featured best practices in restorative justice for juveniles with behavioral health needs, including presentations from the Marin Youth Court and the Kings Canyon Unified School District Restorative Justice Program. Additionally, the Collaborative Justice Courts Advisory Committee of the Judicial Council of California shared the Youth Court Toolkit and discussed the partnership between the Judicial Council and the California Association of Youth Courts.
Diversion/Reentry	February 16	81	45	56%	Microsoft Teams/ In-Person	Part II: Addressing Hiring and Barriers for Individuals with Lived Experience	This workgroup meeting was the second in a two-part workgroup series that highlighted programs and services from California Department of Corrections and Rehabilitation's (CDCR's) Division of Rehabilitative Programs (DRP) and the Center for Employment Opportunities, which address some of the hiring barriers that individuals who were formerly incarcerated face. In addition, Councilmembers were provided a presentation on how knowledge gained from the California Prison Industry Authority's Healthcare Facilities Maintenance program could be applied to become a business owner after releasing from CDCR, creating employment opportunities not only for himself, but for others in the community.

2024 WORKGROUP MEETINGS							
Workgroup	**Meeting Dates**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Format**	**Focus**	**Highlights**
Juvenile Justice	April 19	101	63	62%	Microsoft Teams/In-Person	RAND Contract Close-out	Council on Criminal Justice and Behavioral Health (CCJBH), Office of Youth and Community Restoration (OYCR), and RAND hosted a launch of the Juvenile Justice Toolkit, which features 234 evidence-based, emerging and exploratory programs and practices, along with information related to implementing the programs and practices. The presentation summarized the collaborative efforts between CCJBH, OYCR, RAND and Community Advisory Boards to develop the Juvenile Justice Toolkit from March 2022 to April 2024, and the proposed next steps to continue the work.
Diversion/Reentry	April 19	88	53	60%	Microsoft Teams/In-Person	Enhancing Support for the Justice-Involved Population, through Peer Support Rehabilitation and Reentry Services	The workgroup showcased programs and services from the Camden County Department of Corrections in New Jersey, particularly strategies being implemented to employ Peer Support Specialty , in carceral settings, focusing on the complex needs of the reentry jail population. In addition, an overview of CDCR's DRP's Occupational Mentor Program facilitated at Valley State Prison was highlighted. Presentations from Tarzana Treatment Centers College and Self-Help and Recovery Exchange, both certifying agencies for the California Mental Health Services Authority's Medi-Cal Justice-Involved Peer Support Specialty (JIPSS) Certification training, provided an overview of services offered by their respective agencies and their implementation of the JIPS Specialty.

2024 WORKGROUP MEETINGS							
Workgroup	**Meeting Dates**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Format**	**Focus**	**Highlights**
Juvenile Justice	June 7	81	50	62%	Microsoft Teams/In-Person	Residential Care for Youth with Serious Mental Illness and SUD	The Councilmember Advisors discussed adopting a definition of restorative justice for CCJBH's work. Presentations were given from the California Alliance of Children and Family Services and two of their members, Trinity Youth Services and Rancho San Antonio, on best practices in residential care and the services offered by the two providers.
Diversion/Reentry	June 7	71	47	66%	Microsoft Teams/In-Person	Utilizing Peers in SUD Treatment	This workgroup meeting highlighted presentations on services and programs that utilize peers to provide substance use disorder treatment in carceral and community-based settings at the state and local levels.
Juvenile Justice	August 16	90	64	71%	Microsoft Teams/In-Person	Children and Youth Behavioral Health Initiative (CYBHI)	The workgroup provided an overview of CYBHI workstreams, specifically the California Department of Public Health's Public Education and Change Campaign, and DHCS' Universal Fee Schedule and Behavioral Health Virtual Services Platform.
Diversion/Reentry	August 23	135	69	51%	Microsoft Teams/ In Person	Evidence-Based Corrections in Relation to CalAIM Implementation	This workgroup highlighted the multi-system implementation of criminal justice system evidence-based practices (e.g., collaborative case planning and the Risk-Responsivity Model) and how this approach can be used to support the implementation of new state initiatives such as CalAIM, the Community Assistance Recovery and Empowerment (CARE) Act, etc.

2024 WORKGROUP MEETINGS							
Workgroup	**Meeting Dates**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Format**	**Focus**	**Highlights**
Juvenile Justice	October 25	90	64	71%	Microsoft Teams/In Person	Behavioral Health and Criminal Justice School Collaborations	This workgroup provided an overview from the California Department of Education on programs that serve justice-involved youth with behavioral health needs, such as school behavioral health programs and transition between alternative and traditional schools. In addition, the San Diego County Office of Education presented effective strategies to support student behavioral health in Juvenile Court and Community Schools.
Diversion/Reentry	October 25	130	67	51%	Microsoft Teams/In Person	CARE Act	This workgroup provided an update from Desert Vista Consulting, who presented on behalf of the California Health and Human Services Agency (CalHHS) on the implementation of the CARE Act and an overview from DHCS on the evaluation and reporting process. In addition, Stanislaus County Behavioral Health and Recovery Services provided an overview of their behavioral health programs, focusing on their successes and opportunities with implementing the CARE Act.

May is Mental Health Awareness Month					
Date	**Format**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Focus**
May 1	Microsoft Teams	42	35	83%	Justice Involved & Transition Age Youth
May 9	Microsoft Teams	37	30	81%	Empowering Mental Health: Holistic Programs to Promote Behavioral Health Wellness for Adults and Older Adults
May 15	Microsoft Teams	54	27	50%	Policy Impact
May 22	Microsoft Teams	55	25	45%	Embedding Equity in Behavioral Health

Suicide Prevention Awareness Month and Substance Use Disorder Recovery Awareness Month					
Date	**Format**	**Number Registered**	**Number Attended**	**Attendance Rate**	**Topic**
September 4	Microsoft Teams	98	65	66%	Understanding and Preventing Suicide Deaths and Attempts in California
September 11	Microsoft Teams	51	29	57%	Leveraging 988 Crisis Hotline to Prevent Justice-Involvement
September 18	Microsoft Teams	35	18	51%	SUD and Justice Involvement in American Indian/Alaska Native Communities
September 25	Microsoft Teams	56	24	42%	Reducing Stimulant Use Disorder's with Contingency Management Programs

Appendix B
Juvenile Justice Workgroup Participants

Councilmember Workgroup Leads:

Mack Jenkins, Chief Probation Officer (Retired), San Diego County Probation, Councilmember, Council on Criminal Justice and Behavioral Health (CCJBH)

Danitza Pantoja, Psy.D, School Psychologist, Antelope Valley Union High School, Councilmember, CCJBH

CCJBH Staff Workgroup Leads:

Emily Mantsch, Associate Governmental Programs Analyst

Participating Organizations/Perspectives:

- Advocates for Human Potential
- Alameda County
- Alameda County Behavioral Health Services
- Authors Inside
- Board of State and Community Corrections
- Butte County
- Calaveras County
- California Alliance of Children and Family Services
- California Behavioral Health Directors Association
- California Behavioral Health Planning Council
- California Department of Corrections and Rehabilitation
- California Department of Education
- California Department of Health Care Access and Information
- California Department of Health Care Services
- California Department of Public Health
- California Department of Social Services
- California Health and Human Services Agency
- California State Senate
- Carelon Behavioral Health
- Catalyst Center
- Chief Probation Officers of California
- Community Driven Strategies
- Community State Association of Counties
- Comprehensive Treatment Centers
- Contra Costa County
- Disability Rights California
- Epic Hope Foundation
- Fresno County
- Gateway Mountain Center

- Glenn County
- Happier Life Project
- Health Center Partners of Southern California
- Hope City
- Hopland Band of Pomo Indians
- Humboldt County
- Inland Empire Health Plan
- Jail Guitar Doors
- Judicial Council of California
- KAI Partners
- La Familia
- Los Angeles County Department of Youth Development
- Merced County
- Monterey County
- Neighborhood Healthcare
- Office of Youth and Community Restoration
- Options Recovery
- Pacific Clinics
- Project Youth Orange County
- Rancho San Antonio
- RAND
- Riverside County Office of Education
- Riverside University Health System
- Root and Rebound
- Sacramento County
- Sacramento County Department of Behavioral Health
- San Benito County
- San Bernardino County Department of Behavioral Health
- San Bernardino County Probation
- San Diego County
- San Diego County Office of Education
- San Diego County Superior Court
- San Francisco Department of Public Health
- San Joaquin County Behavioral Health Services
- San Mateo County
- San Mateo County Health
- Santa Clara County Probation Department
- Santa Clara Family Health Plan
- Santa Cruz County
- SHARE! Recovery Retreat
- Shasta County
- SJA Health Solutions

- Sonoma County Office of Education
- Sutter County
- The Children's Initiative
- Third Sector
- Together Let's Ride
- Trinity Youth Services
- Tulare County Department of Behavioral Health
- Ventura County
- Youth Law Center
- Youth Transforming Justice
- Yuba County
- Yurok Tribe

Appendix C
Summary of Juvenile Justice Workgroup Discussions, Presentations and Workgroup Findings

The findings and recommendations related to the juvenile justice population were based on the Council on Criminal Justice and Behavioral Health (CCJBH) staff research and discussion that occurred at the February, April, June, August, and October 2024 Juvenile Justice Workgroups, all of which are summarized below.

The February 2024 Juvenile Justice Workgroup focused on restorative justice for juveniles with behavioral health needs and featured presentations from the Marin Youth Court and the Kings Canyon Unified School District Restorative Justice Program. The Marin Youth Court implements restorative justice and trauma-informed practices focused on reshaping disciplinary practices to address trauma and promote healing. The Kings Canyon Unified School District and Reedley Police Department partnered to support students who have committed offenses that are violations of the Education Code and/or criminal codes of law through an innovative restorative justice program. The Collaborative Justice Courts Advisory Committee of the Judicial Council of California shared the Youth Court Toolkit, which provides guidance to jurisdictions seeking to start or improve youth and peer courts, and discussed the partnership between the Judicial Council and the California Association of Youth Courts to hold an annual Youth Court Summit. Additionally, Councilmember Advisors discussed adopting a definition of restorative justice that includes the unique needs of justice-involved youth with behavioral health needs. It was decided that the Chief Probation Officers of California's (CPOC) definition of restorative justice would be adopted with additional considerations for the justice-involved youth with behavioral health needs.

In March 2024, CCJBH staff and Councilmember Advisor, Dr. Danitza Pantoja, toured the Iris Garrett Juvenile Justice Correctional Complex (IGJJCC), as requested at Merced County's presentation for CCJBH's Juvenile Justice Workgroup in September 2023, which focused on the implementation of Senate Bill (SB) 823 from the local perspective. IGJJCC is a secure detention and youth treatment facility serving Merced County that has adopted an integrated treatment model to reintegrate justice system-involved youth into their families and communities with the knowledge and skills necessary to live successful, crime-free lives. During the tour, CCJBH learned about the programs offered at IGJJCC, notably the Rise to Higher Grounds Café, which provides youth with employable skills training and leadership development. Youth who participate in this program are enrolled in the Merced County Regional Occupation Program's Culinary Essentials program and receive their food handler's certification card prior to working at the mobile coffee cart, which prepared them for employment in their local labor market transition to the community. Additionally, youth operate a Community Garden, where they are given the autonomy to select the produce that is grown each season and learn valuable lessons in agriculture. In addition to these programs, GEO Reentry Services has operated the Merced County Youth Program since November 2022, providing evidence-based reentry programming for the juveniles that addresses the challenges young participants face in promoting growth and successful reintegration into the community. Through the tour of IGJJCC, it was evident that the staff are fully committed to working together with each other, youth, and their families to

provide the youth with the opportunities they need to transition into the community. CCJBH truly thank Chief Christopher Henn, Deputy Chief Ben Rodriguez, and Division Manager Jennifer Medeiros for educating us on the programs offered at IGJJCC and providing a comprehensive tour of the facility.

The April 2024 Juvenile Justice Workgroup featured the launch of the California Juvenile Justice Toolkit (Toolkit), developed by RAND under contract with CCJBH, in partnership with the Office of Youth and Community Restoration (OYCR). The Toolkit will support California counties in serving youth with high needs who were previously served by the Division of Juvenile Justice, but per SB 823 Juvenile Justice Realignment, are now served by County Probation Departments. The toolkit features 234 evidence-based, emerging and exploratory programs and practices, along with information related to implementing the programs and practices. The development of the Toolkit was informed by two Community Advisory Boards (CABs): one comprised of system partners and the other with individuals with lived experience in the justice system. At the April 2024 workgroup, one representative from each CAB shared their experiences and how their feedback was included throughout the process. OYCR provided an update that they will lead the next phase of the project focused on providing technical assistance and support to counties implementing the interventions found in the toolkit.

The June 2024 Juvenile Justice Workgroup focused on residential treatment for justice-involved youth with serious mental illness and substance use disorder. The workgroup featured a presentation from the California Alliance of Children and Family Services (Alliance), a nonprofit organization that advocates for the state's marginalized and vulnerable children, youth, and families in public human services systems. The Alliance is made up of members who are child and family-serving organizations with programs and services in the areas of child welfare, juvenile justice, education, and children's mental and behavioral health. Two of the Alliance members, Trinity Youth Services (Trinity) and Rancho San Antonio (Rancho), presented a summary of their organization's programs. Trinity provides Short-Term Residential Therapeutic Programs (STRTPs), foster care and adoption services, mental health programs to traumatized, abused, neglected and abandoned children throughout Southern California. Rancho is a multi-service non-profit organization that provides trauma-informed therapeutic services to youth and families. Additionally, Councilmember Advisors continued the conversation on the restorative justice definition from the February Juvenile Justice Workgroup, building off the draft definition of restorative justice, with the caveat of replacing "delinquent behavior" with "law breaking behavior."

The August 2024 Juvenile Justice Workgroup provided information on the Children and Youth Behavioral Health Initiative (CYBHI), specifically the California Department of Public Health's (CDPH) Public Education and Change Campaign and the Department of Health Care Services' (DHCS) Universal Fee Schedule and Behavioral Health Virtual Services Platform. The CDPH Public Education and Change Campaign's goal is to raise behavioral health literacy amongst youth and their caregivers by enhancing awareness of available behavioral health supports and services, reducing the stigma associated with behavioral health, and increasing service utilization. The campaign was co-designed with youth, caregivers, and community members, with a focus on equitable implementation. The DHCS Universal Fee Schedule focuses on

expanding behavioral health workforce in healthcare settings, integrating wellness into classrooms, and expanding school-based services, such as psychoeducation, screening and assessment, treatment, and care coordination. The DHCS Behavioral Health Virtual Services Platform includes the Soluna application, which offers free mental health services and resources for children, youth, and families. The platforms provide coaching through chat and/or video appointments, multimedia educational resources, wellness exercises, and other tools such as goal setting, journaling, and mindful exercises.

The October 2024 Juvenile Justice Workgroup provided an overview of the California Department of Education's (CDE) Whole Child Division. The Educational Options Office and Office of School-Based Health Programs within the Whole Child Division provide technical assistance, support, leadership, and advocacy to ensure all students have quality options of schools in which they attend and receive the support they need to thrive. CDE shared legislation, including SB 224 which mandates that middle and high schools that offer one or more courses in health education include mental health instruction and SB 153 which will develop model referral protocols for addressing pupil behavioral health concerns, as well as requires LEAs to certify that 100% of its certificated and 40% of its classified employees who have direct contact with 7th -12th graders receive youth behavioral health training. The San Diego County Office of Education (SDCOE) provided an overview of the programs they have to support student mental health, including Student and Family Engagement Teams, Social Emotional Learning Classroom Lessons, Wellness Spaces, Mental Health Resource Fairs, Student Clubs, Parent Involvement, and Community Partnerships. Additionally, SDCOE detailed the mental health services available in court schools, including school counseling, alcohol and drug counseling, individual therapy, life skills groups, and Dialectical Behavior Therapy groups. Court schools work together in collaboration with probation, county behavioral health services, and local non-profit agencies through Orientation and Reentry Meetings and Multidisciplinary Meetings to optimize outcomes for students.

Councilmember Advisors continuously emphasized the importance of providing definitions for key terms in order to establish baselines for cross-system partnerships. A focus of the 2024 Juvenile Justice Workgroups has been to establish a definition of restorative justice to enhance clarity and uniformity in CCJBH's work. As such, CCJBH adopted the below definition of restorative justice, which endorses CPOC's definition and emphasizes its application, particularly focusing on youth with behavioral health needs who are involved in the justice system:

> Restorative Justice is a comprehensive philosophy of justice. Various forms of Restorative Justice have been practiced throughout history in cultures around the world. Restorative Justice offers a complete approach to addressing the needs of all affected parties: victims, offenders, and communities. Restorative Justice acknowledges that crime causes harm and injury to victims and their families, offenders and their families, and communities. The purpose of Restorative Justice is to engage all of the parties affected by crime in processes that work to hold the offender accountable, repair the harm done to victims, build offender competencies, and engage communities in finding solutions to the problems associated with the crime.

CCJBH endorses the concept of Restorative Justice as adopted by the CPOC. Recognizing the role of juvenile justice is to concurrently support community safety and the best interest of justice involved youth, CCJBH further recommends the application of Restorative Justice to:

- Emphasize accountability for harmful acts.
- Include active participation of the youth, their families, victims, and the community.
- Support the development of empathy for others.
- Address the impact of trauma on the youth and those harmed, with a focus on healing.
- Address the underlying causes of law-breaking behavior, and behavioral health issues.
- Provide support, interventions, and resources to address the needs of youth, their families, and living environment.
- Build and utilize connections and support networks in the community to promote long term positive outcomes for justice-involved youth with behavioral health needs.

Juvenile Justice Workgroup Findings

1. California Juvenile Justice Toolkit
    a. County-level public meetings (e.g., Board of Supervisor Meetings, townhalls, Countywide Criminal Justice Coordination Committees, Juvenile Justice Coordinating Council) are an effective venue to share information with local-level stakeholders.
    b. The expertise of individuals with lived experience of the criminal justice system could be leveraged to ensure programs and practices that are implemented will meet the needs of the community.
    c. According to an article for the Crime and Justice Institute and the National Institute of Corrections titled "Implementing Evidence-Based Policy and Practice in Community Correction," evidence-based community supervision has the potential to improve reentry outcomes and the cost-effectiveness of the criminal justice system as a whole through targeted interventions in the community that reduces the need for incarceration.
    d. Per SB 823, "For the 2024-25 fiscal year and each year thereafter, two hundred eight million eight hundred thousand dollars ($208,800,000) shall be appropriated from the General Fund to provide appropriate rehabilitative and supervision services for the population specified in subdivision (b) of Section 1990 based on a projected average daily population of 928 wards. The Governor and the Legislature shall work with stakeholders to establish a distribution methodology for the funding in this paragraph by January 10, 2024, and ongoing that improves outcomes for this population."
    e. OYCR will be the lead in providing training and technical assistance for counties using the Toolkit and assist in guiding the selection and implementation of youth programs and practices.

f. Children and youth are vulnerable because of high mobility. Social groups are extremely important for young people and high mobility leads to mental health concerns because the children make friends and then move to a new area, creating a sense of isolation.

2. Residential Care

   a. The Community Transition In-Reach Services offered under DHCS' Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) will provide Medi-Cal reimbursable behavioral health services to youth in STRTPs.

   b. Proper aftercare and warm handoffs for youth transitioning out of a STRTP are best practice to ensure youth successfully transition back into the community.

   c. The Family's First Prevention Services Act requires, per Welfare and Institutions Code (WIC) 4096.6, that each county welfare agency, probation department, and mental health plan will jointly provide, arrange for, or ensure the provision of the six months of aftercare services for youth and nonminor dependents transitions from a STRTP to a family-based setting.[20] Aftercare can provide treatment in home and linkages such as job interview support, providing professional clothing, school enrollment assistance, college campus tours, etc.

   d. The Continuum of Care Reform Dashboard provides insights on STRTP placement that could be helpful in planning for youth's care and ensuring adequate provider capacity.

   e. Treatment programs specifically for youth with problematic/harmful sexual behaviors are not readily available for aftercare services once the youth has left the STRTP.

   f. Jurisdictions providing treatment to children and youth with problematic sexual behaviors should follow the California Sex Offender Management Board's Guidelines for Treating and Supervising Youth Who Have Committed a Sexual Offense regarding evidence-based standards and guidelines for a collaborative model of treatment and supervision of youth, supported by the principles of Risk-Needs-Responsivity.

3. Youth who experience two of the five known risk factors to enter the justice system are on justice-involvement trajectory. It is known that school stability to essential to the success of children who have experienced risk factors to divert them away from the justice system. Restorative justice offers relief for lower-level juvenile offenses, resulting in fewer juveniles interacting with individuals with more serious criminal records who may perpetuate their involvement in the system. By diverting low-level juvenile offenses from the court system, the program not only eases the burden on the courts, but also prevents negative influences on young offenders.

4. SB 1005 *Juveniles* amends WIC section 654 to allow a probation officer, with consent of the minor and the minor's parent or guardian, to refer an offense to a youth, peer, or teen court to implement restorative justice practices in lieu of filing a petition. Such referral offenses may include, but are not limited to, infractions or misdemeanors specified in subdivisions (a) to (v), inclusive, of Section 48900 of the Education Code, or for any other

[20] FFPSA Guidance and Resources (ca.gov)

violation the probation officer may determine appropriate for referral. This provision shall be implemented consistent with subdivision (w) of Section 48900 of the Education Code.

5. School-based mental health
    a. Programs such as Resilience, Empowerment, and Natural Supports for Education and Work (RENEW), a school-to-career transition plan and individualized wraparound process for youth who may be experiencing emotional and behavioral challenges and have a limited social support system, demonstrate it is possible to organize school resources to provide interventions at all three tiers of the Positive Behavioral Interventions and Supports, including an intensive intervention for the most at-risk high school students.
    b. The Placer County Office of Education is implementing RENEW and can be used as a model for implementation in California.
    c. A successful restorative justice program requires a partnership between law enforcement agencies and school districts, as well as dedicated staff to deliver the restorative justice services on the school campus. In the partnership between Reedley Police Department and Kings Canyon Unified School District, two full-time restorative justice coordinators and one case manager were hired to provide evidence-based restorative justice processes for students.
6. Children and Youth Behavioral Health Initiative
    a. The DHCS Statewide Multi-Payer School-Linked Fee Schedule (Fee Schedule) will be a permanent billing option to provide behavioral health services in schools and is a straight fee for service that utilizes Carelon Behavioral Health as a third-party administrator to handle billing and care coordination, auditing, credentials of providers and practitioners, etc.
        i. As of November 2024, 298,[21] of the 2,269 Local Education Agencies in California,[22] have opted in to the Fee Schedule brining the opt-in rate to approximately 13 percent.
        ii. In 2022, the Fair and Accurate Gang Database Act (AB 90) introduced stricter requirements for identifying gang members, leading many law enforcement agencies to stop reporting data to the state. Audits of the reduced data now being reported show it's highly accurate, suggesting that the pre-2022 data was also reliable. While the new regulations were well-intentioned, they created barriers that have cut available data by more than half, complicating state-level informed decision making.
        iii. Virtual teletherapy programs, such as Daybreak Health, can be leveraged to provide student mental health services and combat the high turnover rates of providers.

[21] DHCS Statewide Multi-Payer School-Linked Fee-Schedule
[22] Annual Financial Report of California K-12 School, California State Controller

iv. There is an opportunity to provide the services in the Behavioral Health Virtual Services Platform (BrightLife Kids and Soluna) given the widespread use of tablets in youth correctional facilities, but proper research is needed to ensure the safety of the application and compliance with requirements.

v. BrightLife Kids fits in the care delivery model as prevention and early intervention by building skills to manage separation anxiety, worry, sadness, loneliness, self-confidence, relationship stress and conflict, sleep concerns, tantrums, and communication skills through Parent Management Training and Dyadic Coaching.

vi. Soluna adopted the Multi-Tiered System of Support (MTSS) framework by providing:

    1. Tier 1 supports: Proactive support for the behavioral health of ALL students and youth, including self-help services.
    2. Tier 2 supports: Personalized assistance for the youth, chosen by the youth with individualized content and community.
    3. Tier 3 supports: Compassionate coaches to connect youth to the help they need and want beyond the platform

vii. To promote widespread engagement and ensure a safe space for youth to access the service, the Soluna application will be available in county libraries and other communal areas and can be accessed through telephone.

Appendix D
Diversion and Reentry Workgroup Participants

Councilmember Workgroup Leads:

Mack Jenkins, Chief Probation Officer, Ret. San Diego County

Stephen Manley, Santa Clara County Superior Court Judge

Tony Hobson, PhD, Behavioral Health Director, Colusa County

CCJBH Staff Workgroup Leads:

Jessica Camacho-Hall, Health Program Specialist II

Cameron Byrd, Associate Governmental Programs Analyst

Participating Organizations/Perspectives

- Advocates for Human Potential, Inc.
- Alameda County
- Archway Recovery Services
- Board of State and Community Corrections
- Butte County
- Cal Voices
- California Alliance of Child and Family Services
- California Association of Alcohol and Drug Program Executives Inc.
- California Behavioral Health Planning Council
- California Correctional Health Care Services
- California Courts, Judicial Branch of California
- California Department of Corrections and Rehabilitation
- California Department of Corrections and Rehabilitation, Division of Rehabilitative Programs
- California Department of Health Care Services
- California Health and Human Services Agency
- California Opioid Maintenance Providers
- California Prison Industry Authority
- California State Association of Counties
- Camden County Department of Corrections
- Capstone Solutions Consulting
- Carelon
- Center for Employment Opportunities
- Community Driven Strategies
- Community Medical Centers
- Contra Costa District Attorney's Office
- Contra Costa Health Services
- Corporation for Supportive Housing
- Council of State Governments

- County Behavioral Health Directors Association of California
- County of Humbolt
- County of Merced
- Epiphany Women in Focus
- Fresno County
- HOPE City Redding
- I Am Loves
- Indivior
- Inland Empire Health Plan
- Inyo County
- Judicial Council
- Justice Care and Opportunity, Los Angeles County
- Marin County
- Merced County
- Monterey County
- Options Recovery Services
- Orange County Health Care Agency
- Orange County Probation Department
- Paving the Way Foundation
- Peer Voices of San Diego: Peer Professionals of California
- Project Youth OCBF (Orange County Bar Foundation)
- Quality Touch Cleaning Systems
- Restorative Partners
- Riverside County Office of Education
- Sacramento County
- San Bernardino County Department of Behavioral Health
- San Diego County
- Santa Clara County
- Santa Clara County Sheriff's Office
- Santa Clara Family Health Plan
- Santa Clara Superior Court
- SHARE! Self-Help And Recovery Exchange
- Social Security Administration
- Solano County
- Successful Reentry
- Tarzana Treatment Colleges
- Third Sector Capital Partners, Inc.
- Together We Rise
- Tom Rabin Consulting Services
- University of California, San Francisco
- Ventura County
- Well Point Inc.

- West County Community Services
- Yolo County

Appendix E
Summary of Diversion/Reentry Workgroup Discussions, Presentations and Workgroup Findings

The findings and recommendations related to Diversion and Reentry were based on the Council on Criminal Justice and Behavioral Health (CCJBH) staff research and discussion that occurred at the February, April, June, August, and October 2024 Diversion and Reentry Workgroups, all of which are summarized below.

The February 2024 Workgroup focused on addressing the employment barriers that individuals who are justice-involved often face when seeking employment. This meeting highlighted programs and services from California Department of Corrections and Rehabilitation's (CDCR's) Division of Rehabilitative Programs (DRP), the Center for Employment Opportunities (CEO), and a presentation from Mr. Timothy Jackson. CDCR's DRP is a CDCR division that provides rehabilitative programming and skills to incarcerated individuals to reduce their likelihood of reoffending when they return to their community. DRP's Office of Education provided an overview of the academic, college, and career and technical education programs as well as student support services offered.[23] Mr. Jackson provided a presentation on how he has applied his knowledge from the California Prison Industry Authority's (CALPIA) Healthcare Facilities Maintenance (HFM) program to become a business owner after he was released from CDCR in 2017. Mr. Jackson has created employment opportunities through his successful cleaning company not only for himself, but for others in his community. Similarly, during his presentation he provided some recommendations on how correctional staff and peers can be utilized to engage individuals to participate in certification programs and provide support to individuals who have completed programs and are preparing to transition into their community. CEO is a community-based reentry employment provider that offers individuals who are returning home from prison with the initial and ongoing support necessary to build career capital and financial stability. During their presentation, CEO provided an overview of their program model, economic mobility framework, training pathways,[24] and Emerging Leaders Program, and their HIRE Network reach offered to individuals who are formerly incarcerated.

The April 2024 Workgroup focused on the utilization of Peer Support Specialist in a jail setting and the implementation of the Medi-Cal Peer Support Specialist Certification training program. This meeting showcased presentations from Camden County Department of Corrections in New Jersey, CDCR's DRP Occupational Mentor Program (OMCP), Tarzana Treatment Centers College, and Self-Help and Recovery Exchange (SHARE!). The Camden County Department of Corrections leads the Safety and Justice Challenge; a multi-sector collaborate initiative to address the needs of the jail reentry population. As part of their presentation Camden County provided an

[23] CDCR's Office of Education offers career and technical programs that focus in the following six sectors: building and construction, manufacturing and product development, transportation, business and finance, fashion and interior design, and information and communication technologies.

[24] CEO provides the following training pathways: heavy equipment operator, solar installer, information technology, skilled construction trades, service technician (auto, diesel, and industrial), and service technician fiber optic technician.

overview of the Safety and Justice Challenge, as well as highlighted the services provided by the NuEntry Opportunity Specialist, who serve at every step of helping people return home to the community and prevent recidivism. Tarzana Treatment Centers College (TTCC) is the learning and development division of Tarzana Treatment Centers Inc., a non-profit community-based organization that operates a psychiatric hospital, residential and outpatient alcohol and treatment centers, and family medical clinics. During their presentation, TTTC provided an overview of their services and highlighted their implementation of the Medi-Cal Peer Support Certification training program at Valley State Prison. SHARE! is a peer-run organization that operates two community self-help group centers in Los Angeles where they host over 100 self-help group meetings. In addition, through a private-public partnership, SHARE! provides collaborative housing to disabled people in single-family houses, trainings for peers, and volunteer opportunities. During their presentation, SHARE! provided an overview of their programs, highlighted their Medi-Cal Peer Support Specialist Certification training for the Justice-Involved Peer Support Specialist. OMCP, provides incarcerated people with the training and education needed to become Alcohol and Other Drug (AOD) Counselors. OMCP mentors provide guidance and peer-to-peer support to incarcerated individuals assigned to Cognitive Behavioral Interventions, a component of the Integrated Substance Use Disorder Treatment (ISUDT) program jointly operated by CDCR and the California Correctional Health Care Services (CCHCS), Integrated Substance Use Disorder Treatment (ISUDT). As part of their presentation, OMCP Journey Counselors shared about their experiences with completing the training and education requirements to be certified as an AOD counselor.

The June 2024 Workgroup focused on the services and programs that utilize peers to provide substance use disorder treatment in carceral and community-based settings at the state and local levels. During this meeting, CCJBH featured presentations from CCHC on the ISUDT program, Community Medical Centers (CMC), and a second presentation from DRP on OMCP Program. CMC is a federally qualified health center that provides medical, behavioral health, substance use disorder treatment (SUD), case management, and dental services to individuals living in San Joaquin, Solano, and Yolo Counties. During their presentation, CMC provided an overview of the SUD services provided through their Recovery Center. Similarly, CMC highlighted their Transitions Clinic Model which utilizes Community Health Workers (CHW) with a history of incarceration to engage and provide services to the justice-involved population. CMC's CHWs assist patients with access to documents, primary care, behavioral health, SUD services, community resources, housing, employment, and other services. During the ISUDT presentation, CCHCS provided an overview of the Peer Support Specialist Certification training model that CDCR has implemented as part of their Strategic Plan and the California Model. CDCR has received the designation as an approved training entity by California Mental Health Services Authority (CalMHSA). CDCR's training for the Peer Support Specialist Certification includes a general orientation of CDCR's systems and processes; 17 core competencies, which are required for the state's Medi-Cal Peer Support Specialist Certification training; group facilitation practicum; and on-the-job specialty training. As part of the certification process, OMCP candidates must complete approximately 5 months of Cognitive Behavioral Intervention and SUD programming. Similarly, as part of the certification process, OMCP trainees complete 255 hours of practicum where they apply learned counseling skills, 350 hours of AOD

counseling classroom education, and 80 hours of study prep prior to taking the AOD exam. In order to obtain certification, OMCP graduates who receive a 70 percent or higher are then given the opportunity to complete an internship with ISUDT providers. Lastly, in order to main their certification, OMCP mentors must continue to complete education units.

The August 2024 Workgroup focused on the multi-system implementation of criminal justice system evidence-based practices (e.g., collaborative case (CC) planning and the Risk-Needs-Responsivity Model (RNR)) and how this approach can be used to support the implementation of new state initiatives such as California Advancing and Innovating Medi-Cal (CalAIM), the Community Assistance and Recovery Empowerment (CARE) Act, etc. During this meeting, CCJBH featured presentations from the Council on State Governments (CSG) Justice Center, Boulder County, and the Orange County (OC) Office of Probation. CSG is a nonpartisan community of states committed to connecting, informing, inspiring, and empowering public servants in all three branches of state government to put the best ideas and solutions into practice. During their presentation, CSG provided a brief overview of the RNR Model, CC Case Planning, and Medi-Cal Reentry Coordination. CSG explained the importance of utilizing the RNR model to address the criminogenic and behavioral health needs of an individual. Similarly, CSG shared on how CC Case Planning can be used as a tool to help behavioral health and criminal justice professionals with the integration of the risk/need information gathered from assessments into case plans that engage an individual who is reentering into the community. In the state of Colorado, Boulder County's Community Services Department's Behavioral Health Assistance Program (BHAP) is a jail reentry program that provides intensive, long-term support to people in the justice system who have severe and persistent mental illness, substance use disorders, or co-occurring disorders. During this presentation, Boulder County provided an overview of their reentry services and shared characteristics of their jail population. Similarly, Boulder County shared the steps taken to design and implement CC Case Plans, lessons learned during the implementation process and provided outcomes data on the impact that CC Case plans has had on justice-involved adults receiving BHAP services. Lastly, The OC Probation Department is dedicated to continuous improvement, searching out, and applying "effective and research supported practices" to assist justice involved youth, their families, and adults to successfully navigate and complete probation. During the presentation, the OC Probation Department provided an overview of services and programs that utilize Evidence-Based Corrections practices to address the needs of justice involved youth and adults.

The October 2024 Workgroup meeting focused the CARE Act implementation efforts at the state and local levels. During this meeting, CCJBH featured presentations from CalHHS, DHCS' Evaluation Team, and Stanislaus County. CalHHS is the state agency responsible for administering the CARE Act and has contracted with Desert Vista Consulting to ensure a person-centered and responsive set of services and supports for participants. Desert Vista Consulting during their presentation provided a high-level overview of the legislative intent of CARE, the role and responsibilities of CalHHS in the implementation process, participant eligibility requirements, and pathways for petition. In addition, Desert Vista Consulting shared effective solutions and ongoing challenges that have occurred as part of the implementation process. DHCS contracted with RAND to assist with the evaluation efforts. During the presentation, RAND provided an overview of the independent evaluation that they will be conducting. As part

of the evaluation, RAND will be documenting the theory of change for the CARE Act model, evaluating the program implementation, outcomes, and impact; documenting lessons learned related to the CARE Act model and policies; and will be making recommendations for ongoing implementation. Stanislaus County Behavioral Health and Recovery Services (BHRS) provides integrated mental health services to adults and older adults with a serious mental illness and to children and youth with a serious emotional disability. In addition, BHRS provides outpatient and residential alcohol and drug treatment and prevention services and serves as Stanislaus County's Public Guardian. BHRS is part of Cohort 1 counties that were the first to implement the CARE Act the local level. BHRS during their presentation provided an overview of their behavioral health programs, highlighted their successes with implementing the CARE Act, and provided recommendations that can be utilized by counties that will be part of Cohort 2.

Diversion and Reentry Workgroup Meeting Findings:

Workforce Development

1. According to the National Institute of Mental Health (NIMH), in the United States there are an estimated 59.3 million (23.1 percent) adults with any mental illness (AMI) and approximately 6 percent of adults living with Serious Mental Illness (SMI).[25] Individuals with SMI are often misdiagnosed, underdiagnosed, and have a greater risk of being justice-involved due to unmet social determinants of health (e.g., poverty, unstable housing, adverse childhood experiences, and substance abuse).[26]
2. Programs and services at the state and local levels often combine individuals who have SMI into the broader AMI population. Individuals who have an SMI diagnosis often experience more disparities in health care when compared to those who have a mild-to-moderate mental health diagnosis.[27]
3. Students could benefit from clinical training opportunities working with the SMI and/or SUD population. Some available resources to inform this work include, but are not limited to the RAND Co-Occurring Disorders Toolkit; the Amity Foundation/University of Southern California's Career for a Cause program. Such partnerships can be a potential solution to addressing the rising demand for behavioral health professionals in California.
4. California lacks the number of behavioral health professionals needed to meet the increasing demand for behavioral health services.[28] In addition, there are approximately 80 percent of adults in prison who have an SUD diagnosis and an estimated 8 percent who have an SMI diagnosis.[29] Individuals who are justice-involved and have mental health and/or SUDs are more likely to experience relapse and/or reenter the criminal, have

[25] See National Institute of Mental Health (September 2024).
[26] See the National Alliance on Mental Illness publication, Criminal Justice Involvement of People with Serious Mental Illness (March 2021).
[27] See Inequalities in healthcare provision for people with severe mental illness (2010).
[28] See the California Health Care Foundation publication, Addressing Medi-Cal Behavioral Health Workforce Shortages Through Non-Financial Incentives (May 2024).
[29] Please see the CCJBH 2023 Annual Legislative Report for the prevalence rates of serious mental Illness and SUD in prison populations.

complex diagnosis, and often require more support and wrap around services. Having a behavioral health workforce shortage can further prolong an individual's ability to access treatment and services in a timely manner.

5. The OMCP training is offered in seven[30] CDCR institutions that provide participants with the opportunity to engage in paid mentorship roles to provide guidance and peer-to peer support to individuals assigned to Cognitive Behavioral Interventions (CBI) programs. Programs such as CDCR's OMCP, allow participants to engage in paid mentorship roles within prisons to provide guidance and peer-to peer support to individuals assigned to CBI. Many OMCP graduates once released are hired by non-profit and community-based programs as well as often return to the prisons to facilitate additional programs. Furthermore, having programs such as OMCP can be utilized to address the underlying issues that led to incarceration, enable successful reintegration, and cultivate a culture of accountability and professionalism among peers. Peer Support Specialist can help support health equity initiatives that seek to improve healthcare services and access for individuals who are justice-involved, can serve in many roles, and can work in a community, clinical, or correctional setting where they can provide support to individuals going through recovery, receiving SUD treatment, and/or pre-release.
6. CDCR has been approved by the CalMHSA as a certifying agency for the Medi-Cal Peer Support Specialist Certification training. Utilizing CDCR's Peer Support Specialist Certification training program can enable individuals with lived experience to provide mentorship, linking to reentry services, and assist individuals with understanding the rehabilitative process as they prepare to transition into community and seek employment.
7. Since the January 2023 implementation of the DHCS' Medi-Cal Peer Support Specialist Certification training, CalMHSA has certified 4,238 individuals as general Medi-Cal Peer Support Specialist.
8. Providing training that is focused on trauma-informed care principles and behavioral health fundamentals (e.g., science of addition) will further enhance staff and personnel's ability to adequately address the needs of individuals who are justice-involved and have behavioral health needs. Similarly, having these trainings can help shift perspectives that promote rehabilitation and support to individuals who are justice-involved and have behavioral health conditions. These trainings will become particularly important community-based organizations, managed care plans, jails, and health care providers prepare to implement and provide ECM and 90-day Pre-Release Care Coordination services.
9. It is important that behavioral health and criminal justice system partners at the county level have the knowledge and skills to apply the Eight Principles of Evidence-Based Corrections when developing reentry and case management plans for individuals who are justice involved and have behavioral health conditions. Understanding these principles will allow administrative staff ad personnel developing programs to have a better

[30] The OMCP program is currently offered at the following CDCR Institutions: California Correctional Institution, California Men's Colony, California State Prison- Corcoran, California State Prison-Lancaster, California State Prison- Solano, Central California Women's Facility, and Valley State Prison.

understanding of how criminal risk and behaviors can potentially impact a client and/or patient's ability to comply with treatment.

10. Counties such as Camden, have mandated that the lived experience perspective is integrated into all funding opportunities to ensure that peers are included in the organizational structure and staffing model. This has enabled the county to utilize peers in a jail setting to assist with the development of reentry transition plans, connect individuals to services, and provide support for family reunification. In addition, peers can successfully connect individuals with sober living environments, maintain contact post-discharge, and often facilitate transportation and communication to individuals.
11. There is a need to expand the behavioral health workforce that focuses on providing services to individuals who are justice-involved and have serious mental illness, SUD, and/or co-occurring disorder. When hiring Peers, it is important that employers view substance use disorder as a medical disease. By doing so, it will help them understand that an individual going through recovery may experience relapses.

Infrastructure and Data

12. In January 2025. DHCS implemented a new transitional rent benefit that will provide coverage for temporary assistance to eligible Medi-Cal members. As a result, it will be critical that community-based organizations, including reentry providers, and housing and social services agencies, are aware of this new benefit, the eligibility requirements, and how they can refer the BH/JI population.
13. Self-help support group model programs such as SHARE! have proven to be effective in supporting individuals who are justice involved and have behavioral health conditions who are transitioning into community. As part of their services, SHARE! refers individuals to privately owned homes where residents manage the house like a family. Similarly, SHARE! trains and utilizes Peer Bridgers, who have lived experience provide support services to these houses and help residents resolve conflicts to coexist harmoniously. The program eliminates barriers such as background checks, security deposits, and application fees, which often hinder those returning home from institutional settings. As a result, it would be beneficial to explore housing models that utilize peer support services to address the housing needs of the BH/JI population.
14. Federally Qualified Health Centers (FQHCs) often provide wraparound services that address the needs of the BH/JI population. In addition, they often have multi-disciplinary collaborations with community-based organizations, county courts, DUI and Drug Courts, law enforcement, managed care plans, county behavioral health departments, and healthcare systems. These collaborations enable the referral of individuals to services that address substance use, mental health, and medical needs of individuals who are justice-involved. Similarly, FQHCs who have the infrastructure and services set in place, have the potential to become key players in the implementation of DHCS's CalAIM and Justice-Involved Reentry Initiatives.

15. As of October 22, 2024, CalMHSA has certified 4,238 individuals as Medi-Cal Peer Support Specialist. Similarly, the CalMHSA dashboard has reported that there are zero peers who have completed the Justice-Involved Peer Support Specialist Certification training.

Appendix F

2025 Policy Goals Metrics and Findings

Table F.1. & F.2.

Goal #1: Prevalence of Mental Illness and Substance Use Disorder*

Table F.1. – United States

	2021			2022			2023			2024		
	General	Prison	Jail	General	Prison	Jail	General	Prison	Jail	General	Prison	Jail
Any Mental Illness (AMI)	22.8%	37%	44%	19.9%	41%	44%	22.8%	41%	44%	23.1%	41%	44%
Serious Mental Illness (SMI)	5.5%	14%	26%	4.9%	14%	26%	5.7%	14%	26%	5.9%	14%	26%
Substance Use Disorder (SUD)	7.7%	58%	63%	17%	64%	63%	17%	64%	63%	18%	64%	63%

*2023 Mental Illness (AMI and SMI) and SUD Prevalence data for the general population of the United States was obtained from the National Institute on Mental Health and the Substance Abuse and Mental Health Services Authority-National Survey on Drug Use and Health survey; 2024 prevalence data was obtained from a study conducted by the Mental Health America, an nonprofit dedicated to the promotion of mental health, well-being, and illness prevention.

Table F.2. – California[31]

	2021			2022			2023			2024		
	General	**Prison**	**Jail**	**General**	**Prison**	**Jail**	**General**	**Prison**	**Jail**	**General**	**Prison**	**Jail**
AMI	15.9%	32%	28.3	15.9%	32%	29%	15.9%	36%	33%	15.9%	38%	32%
SMI	4.2%	7.8%	***Data not Available*	4.2%	8.4%	***Data not Available*	4.2%	9.2%	***Data not Available*	4.2%	9.1%	***Data not Available*
SUD	8.1%	80%	***Data not Available*	8.1%	80%	***Data not Available*	8.1%	80%	***Data not Available*	8.1%	80%*	***Data not Available*

* For the first time, CCHCS 2024 Annual ISUDT report presents SUD prevalence estimates among CDCR's population, stating that "National SUD prevalence estimates were used as a baseline to develop the ISUDT Program. These estimates show 65% of the U.S. prison population meets the clinical definition for having a SUD, and another 20% did not meet the clinical criteria for a SUD, but were under the influence of drugs or alcohol at the time of their crime…CDCR SUD prevalence estimates for incarcerated individuals show Opioid Use Disorder (OUD) prevalence at nearly 30%, with Alcohol Use Disorder (AUD) and stimulant use disorder (StUD) at roughly 25%, respectively, and polysubstance use (OUD and StUD) at nearly 20%. It is important to note CDCR's entire population has not been assessed due to the sheer volume of people who screen positive for possible SUD…and because some people are reluctant to be assessed. Therefore, SUD prevalence estimates among CDCR's population, while consistent with national estimates, are conservative."

**No statewide data are available to identify the prevalence of SUDs in California jails.

[31] Please see the CDCR-Office of Research Data Dashboard for prevalence rates of Any Mental Illness (AMI) and Serious Mental Illness (SMI) in Prison populations. Additionally, a report submitted to the Department of Health Care Services represents the AMI and SMI prevalence rates for Medi-Cal members statewide. The AMI prevalence rates for jail population were obtained from Board of State and Community Corrections' Jail Profile Survey (JPS) data repository.

Table F.3.

<u>Goal #2:</u> Multi-Sector System Capacity to Serve the BH/JI Population

#	Sector/System Type Measure (Source)	Description	Findings
2.1	**Health Care** Network Adequacy Department of Health Care Services (DHCS)	DHCS Network Adequacy measure is calculated annually for federal reporting purposes and indicates whether the California's Medicaid Program (Medi-Cal) delivery system meets timeliness, time-and-distance and provider-to-member ratio standards.[32] • For Managed Care Plans (MCPs), outpatient psychiatry is the behavioral health service included in network adequacy requirements.	As of May 2024: • Out of 26 MCPs, all met Network adequacy standards.

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

#	Sector/System Type Measure (Source)	Description	Findings
2.2	**Income Support** Supplemental Security Income (SSI) Applications California Department of Corrections and Rehabilitation (CDCR)	Individuals transitioning from incarceration may qualify for SSI benefits if they meet age and disability criteria and have limited income and other financial resources. Information on benefits applications is reported to the California Rehabilitation Oversight Board (C-ROB). *Note: Data on the receipt of SSI benefits is not available currently. As a result, this metric consists of outcomes for those SSI applications that were submitted prior to release from CDCR.*	As Reflected in the C-ROB's October 2024 Report for Fiscal Year 2023-34: • 3,283 applications (an increase from 2,086 applications submitted FY 22-23) for SSA/SSI were submitted prior to the individual's release from CDCR. • 21.9 percent (718) of applications were approved (a decrease of 3 percentage points from FY 2022-23), while 76.5 percent (2,510) were pending at the time of reporting (an approximately 6 percentage point increase in pending applications from FY 2022-23). • Comparisons to the prior year (FY 2022-23) Benefits Application Outcomes data showed a reduction for application denials (from 4.4 to 1.7 percent).) SSI/SSA application approvals decreased by 3 percent points (from 25 percent to 22 percent in FY 2022-23).

#	Sector/System Type Measure (Source)	Description	Findings
2.3	**Community Corrections** Parole and Probation Support and Implementation of Evidence-Based Practices (EBPs) (CDCR and Judicial Council)[33]	Information about EBPs administered to the parole population is reported to C-ROB. The SB 678 Annual Assessment is administered for probation departments to meet their statutory obligations under Penal Code Sections 1231 and 1233, and to track progress over time.	As Reflected in the C-ROB's October 2024 Report for Fiscal Year 2023-34, CDCR indicated that: • Most individuals (99 percent) on parole with a moderate to high California Static Risk Assessment (CSRA) score received a reentry Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment. • During the reporting period, 38.9 percent of supervised with at least one criminogenic need participated in at least one program consistent with their risk and need within their first year of release. This percentage decreased by over 3 percentage points compared with the prior fiscal year.[59] The total percentage of individuals with a risk and need who participated in any program within one year decreased slightly from 43.0 percent to 39.5 percent.

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

[59] Data cited from the Office of the Inspector General's 2022 California Rehabilitation and Oversight Board Report.

#	Sector/System Type Measure (Source)	Description	Findings
			Responding California probation departments indicated that: • 86 percent of medium-risk individuals and 93 percent of high- risk individuals were assessed with a validated tool to identify their criminogenic needs, which represents a decreased from last year of 4 and 3 percentage points, respectively. • All or nearly all of probation departments supported and monitored the implementation of EBPs to address criminogenic risks/needs, but this was not uniform across different types of practices or individuals on supervision. Further details regarding the above statements are presented in Tables F.4, F.5 and Chart F.1 below.
2.4	**Housing**	Point-in-time data request on transient unhoused persons from the CDCR Office of Research.	• Point-in-time data from CDCR indicate that, of the 24,386 individuals who were on parole on June 30, 2024, 85 percent (n=20,634) were not unhoused or residing in a shelter. That said, 15 percent (n=3,752) were unhoused. Furthermore, 72 percent (n=2,720) of the unhoused

#	Sector/System Type Measure (Source)	Description	Findings

			persons supervised by parole had an identified behavioral health need at the time of their release. Specifically, of those who were unhoused:
			• 31 percent (n=1,158) left prison with a SUD *only*.
			• 28 percent (n=1,045), had a co-occurring mental health and SUD and within that group:
			  • 76 percent (n=798) had a Correctional Clinical Case Management System (CCCMS) designation.
			  • 21 percent (n=219) had an Enhanced Outpatient Program (EOP) designation.
			• 14 percent (n=517), had a mental health designation *only* and within that group:
			  • 79 percent (n=408) were CCCMS.
			  • 18 percent (n=95) were EOP.
			  • 28 percent (n=1,032) had no identified behavioral health need.

Tables F.4 – F.5

<u>Goal #2 (Cont'd):</u> County Probation Department Capacity to Implement EBPs

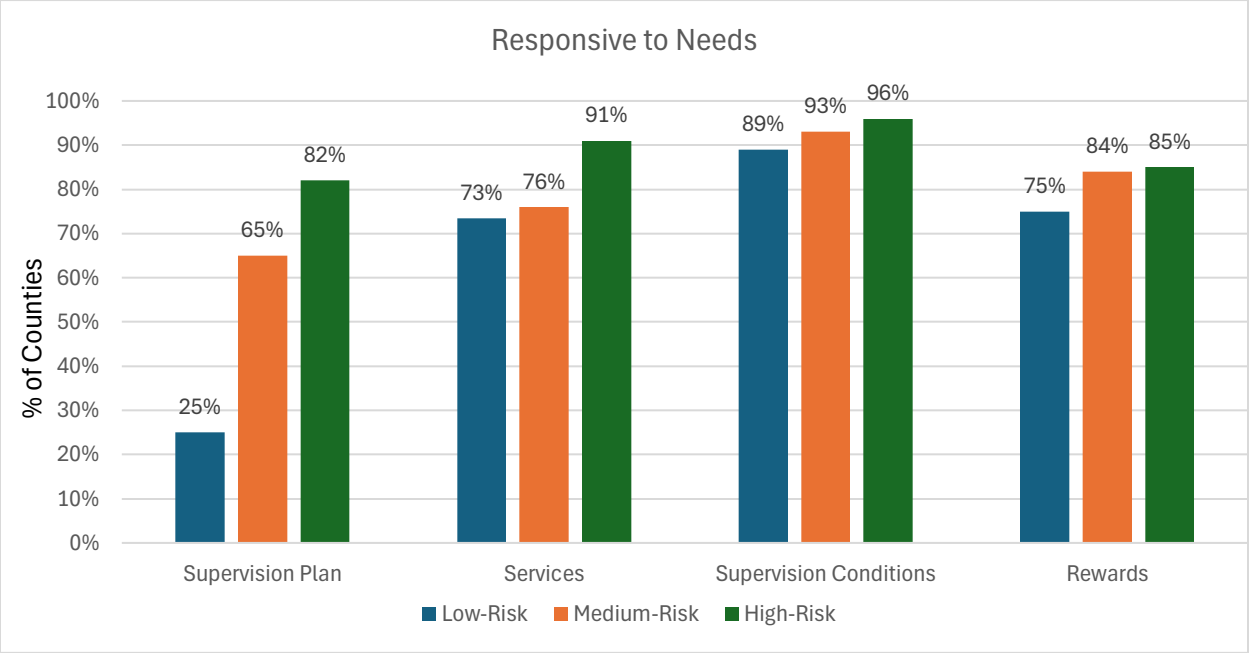
Implementation of Services Based on Identified Risks and Needs

Table F.4 and Chart F.1 display information about the implementation of services based on identified risks and needs for all actively supervised individuals identified as low, medium, and high-risk. The service component with the highest rates of implementation across all risk levels is found for Supervision Conditions, ranging between 89 percent (low-risk) to 96 percent (high-risk) of responding probation departments, whereas the component with the lowest rates of implementation is for Supervision Plans, ranging between 25 percent (low-risk) and 82 percent (high-risk).

Table F.4: Implementation of Services Based on Identified Risks and Needs

	Low-Risk Yes	Low-Risk Total	Low-Risk %	Med-Risk Yes	Med-Risk Total	Med-Risk %	High-Risk Yes	High-Risk Total	High Risk %
Individuals are supervised in accordance with a written supervision plan.	14	55	25%	36	55	65%	45	55	82%
Individuals receive the appropriate level of supervision, monitoring, services, and treatment.	40	55	73%	42	55	76%	50	55	91%
Individuals receive appropriate sanctions and conditions based on the individual's current risk level.	49	55	89%	51	55	93%	53	55	96%
Individuals receive appropriate incentives and rewards based on the individual's current risk level.	41	55	75%	46	55	84%	47	55	85%

Chart F.1: Implementation of Services Based on Identified Risks and Needs



Departmental Support and Monitoring of EBPs

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

- ✓ Follow up basic training with booster training;
- ✓ Observe case-carrying officers using EBPs; and/or
- ✓ Provide feedback to case-carrying officers on the successful use of EBPs.

Table F.5 indicates the percentage of county probation departments that monitored and evaluated the implementation of these EBPs for all adults on probation supervision who were convicted of felony offenses. Nearly all responding probation departments utilized at least one of the methods mentioned above to support and monitor risk/needs assessments, motivational interviewing, and CBT.

Table F.5. Number of Methods Used to Support and Monitor the Use of EBPs

	0 n	0 %	1+ n	1+ %	2+ n	2+ %	All 3 n	All 3 %	Total N	Total %
The department supports and monitors the use of risk/needs assessment.	1	2%	6	11%	20	35%	30	53%	57	100%
The department supports and monitors the development of intrinsic motivation skills such as Motivational Interviewing (MI).	0	0%	11	19%	22	39%	24	42%	57	100%
The department supports and monitors the use of CBT techniques, which could include addressing thinking errors, modeling and reinforcing prosocial behavior, and focusing on problem solving.	6	11%	9	18%	19	33%	22	39%	57	100%

Comparison of Findings between Calendar Year (CY) 2022 and CY 2023

The response rates for the 2022 EBP survey were based on 49 counties, whereas 57 counties responded to the 2023 survey. Thus, a comparison between CY 2022 and CY 2023 responses was performed only for those counties that responded in both calendar years.
For each of the focus areas described above, as reported by probation departments, the comparison is as follows:

- Rates of assessment and engagement of individuals through the implementation of EBP slightly decreased (between 1-4 percentage points).
- The overall implementation of services based on identified risks and needs for medium/moderate and high-risk individuals were similar in both years with a slight difference as follows:
  - 2 percentage point increase in supervision services and treatment based on criminogenic needs for medium-risk individuals
  - 2 percentage point decrease in incentives and rewards based on current risk level for medium -risk individuals
  - 4 percentage point decrease in supervision based on a written supervision plan for high-risk individuals
- Department implementation of 3 or more methods to support and monitor the use of EBPs decreased slightly (between 1 to 5 percentage points).

- Correctional workforce training in cognitive behavioral therapy slightly decreased (3 percentage points) and training on criminogenic needs of medium-risk individuals slightly decreased (4 percentage points).

Table F.6

Goal #3: Workforce and Preliminary Metrics Established to Track Workforce Training

Table F.6 and Chart F.2 present the findings of measures within the SB 678 EBP Annual Assessment targeting Correctional Workforce Training on specific EBP (e.g., criminogenic needs assessment, motivational interviewing, cognitive therapy, positive reinforcement). Nearly all counties provided the workforce training to officers. A summary of the results is as follows:

- 96 percent of counties trained officers to focus on criminogenic needs when meeting with high-risk, and 95 percent for medium-risk offenders.
- 96 to 98 percent of counties trained officers in intrinsic motivational skills, such as Motivational Interviewing for high-risk and medium-risk offenders, respectively.
- 78 to 81 percent of counties trained officers in the use of CBT techniques for high-risk and medium-risk offenders, respectively.
- 96 to 98 percent of counties trained officers to frequently give verbal positive reinforcement for prosocial behaviors when meeting with high-risk and medium-risk offenders, respectively.

Table F.6: SB 678 EBP Annual Assessment Survey- Correctional Workforce Training on specific EBP

Goal 3 Reporting	Medium/Moderate-Risk Individuals			High-Risk Individuals		
	# of Counties that Implemented EBP	# of Counties Responding	%	# of Counties that Implemented EBP	# of Counties Responding	%
Have officers been trained to focus on top criminogenic needs when meeting with individuals?	54	57	95%	53	55	96%
Have officers been trained in intrinsic motivational skills such as Motivational Interviewing?	56	57	98%	53	55	96%
Have officers been trained in the use of CBT techniques?	46	57	81%	43	55	78%
Have officers been trained to frequently give verbal positive reinforcement for prosocial behaviors?	56	57	98%	53	55	96%

Chart F.2.: SB 678 EBP Annual Assessment Survey- Correctional Workforce Training on specific EBP