



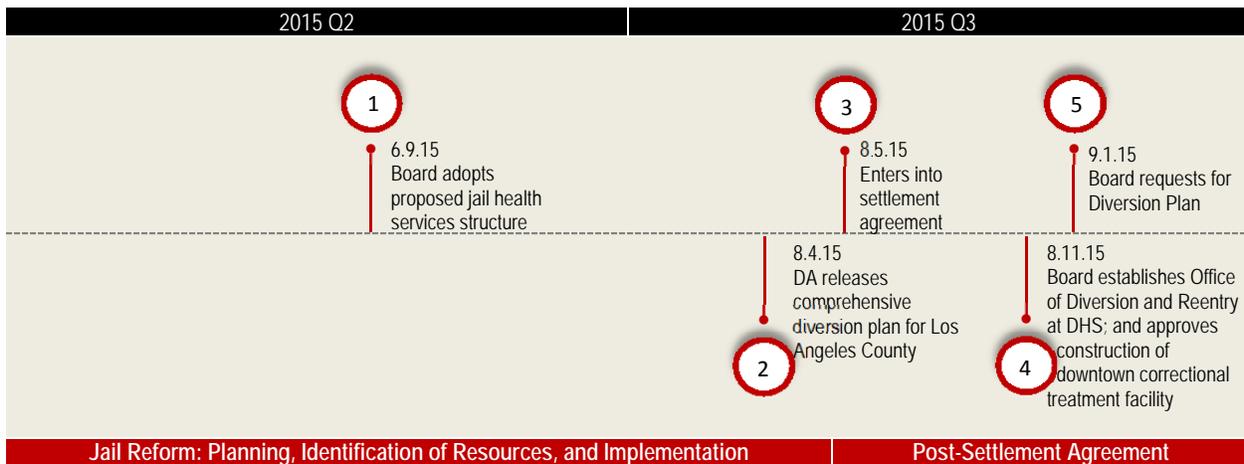
County of Los Angeles  
**AD HOC INITIATIVES**

**SHERIFF'S DEPARTMENT INITIATIVE (DIVERSION, RE-ENTRY, AND MENTAL HEALTH)**

Topic	Document	Date
<b>Jail Health Services</b>	1. <b>Board Letter</b> - Approval of Proposed Jail Health Services Structure - Adopted	6/9/15
<b>Correctional Treatment</b>	2. <b>Board Correspondence</b> - Providing Treatment, Promoting Rehabilitation, and Reducing Recidivism: An Initiative to Develop a Comprehensive Diversion Plan for Los Angeles County. District Attorney, Mental Health Advisory Board Report: A Blueprint for Change	8/4/15
<b>Settlement Agreement</b>	3. <b>Settlement Agreement</b> - County enters into settlement agreement with federal government and identifies resources and strategies to better address needs of offenders with mental health conditions	8/5/15
<b>Office of Diversion &amp; Re-entry</b>	4. <b>Board Motion</b> - Expanding Effective Diversion Efforts in Los Angeles County	8/11/15
	5. <b>Board Motion</b> - Report Back on Diversion Plan within 90 days of Hiring the Director of the Office of Diversion	9/1/15
	6. <b>Board Correspondence</b> - Office of Diversion and Re-Entry Status Report	3/14/16

- Information Available on County Sheriff's Initiative Website at: <http://priorities.lacounty.gov/sheriff/>
- Board Correspondence may be searched by title and date at: <http://portal.lacounty.gov/wps/portal/bc>

**SHERIFF'S DEPARTMENT INITIATIVE (DIVERSION & RE-ENTRY) TIMELINE**





County of Los Angeles  
**CHIEF EXECUTIVE OFFICE**

Kenneth Hahn Hall of Administration  
500 West Temple Street, Room 713, Los Angeles, California 90012  
(213) 974-1101  
<http://ceo.lacounty.gov>

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SACHI A. HAMAI  
Interim Chief Executive Officer

*"To Enrich Lives Through Effective And Caring Service"*

June 09, 2015

**ADOPTED**

BOARD OF SUPERVISORS  
COUNTY OF LOS ANGELES

15 June 9, 2015

  
PATRICK OGAWA  
ACTING EXECUTIVE OFFICER

The Honorable Board of Supervisors  
County of Los Angeles  
383 Kenneth Hahn Hall of Administration  
500 West Temple Street  
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF PROPOSED JAIL HEALTH SERVICES STRUCTURE  
(ALL DISTRICTS)  
(3 VOTES)**

**SUBJECT**

Approval of the proposed integrated jail health services organizational structure and the transition of jail health staff from the Department of Mental Health and Sheriff's Department Medical Services Bureau to the Department of Health Services.

**IT IS RECOMMENDED THAT THE BOARD:**

1. Approve the proposed organizational structure to create a single, integrated jail health services unit that consolidates the currently separate jail health services functions under a single Correctional Health Director within the Department of Health Services and instruct the Interim Chief Executive Officer to work with County Counsel, Sheriff's Department, Departments of Health Services, Mental Health, Public Health, and Human Resources to complete Phase Zero planning activities related to the implementation of this structure.
2. Instruct the Interim Chief Executive Officer to work with the affected departments noted above to implement Phase One of the transition to the new jail health services organizational model, including the transfer of Sheriff's Department Medical Services Bureau and Department of Mental Health staff and services, as described herein, to the Department of Health Services, pending labor consultations and completion of necessary Phase Zero planning activities.
3. Instruct the Interim Chief Executive Officer to work with the affected departments noted above to implement Phase Two of the transition, including the transfer of the remaining Sheriff's Department

Medical Services Bureau staff and services, as described herein, to the Department of Health Services within approximately 12-18 months of the initiation of Phase One, assuming the transition process is successful and the Board does not determine that any problems or concerns warrant reconsideration of the timing or scope of Phase Two.

4. Approve interim ordinance authority, pursuant to County Code Section 6.06.020, for the Department of Health Services to recruit and hire three (3.0) new jail leadership positions, subject to allocation by the Interim Chief Executive Officer, and instruct the Department of Health Services and the Interim Chief Executive Officer to take necessary steps to commence a classification study of the current Medical Services Director position in the Medical Services Bureau.

5. Direct County Counsel to prepare the required ordinance changes to facilitate the transition of jail health and mental health services currently performed by the Medical Services Bureau and the Department of Mental Health.

6. Instruct the Interim Chief Executive Officer, the Departments of Mental Health and Health Services, and the Sheriff's Department to examine staffing for jail mental health services and propose any changes required to achieve an enhanced level of mental health services within the County jails beyond the requirements of the Department of Justice settlement agreement, if necessary.

7. Instruct the Interim Chief Executive Officer, the Departments of Public Health and Health Services, and the Sheriff's Department to begin an assessment of the programmatic components, associated costs, and possible funding streams of a comprehensive substance abuse treatment program in the jails that is linked to community-based treatment services with an initial report back to the Board within 90 days.

8. Instruct the Sheriff and the Director of the Department of Health Services to report on a quarterly basis the progress of the phased implementation of the integrated jail health services organizational model.

#### **PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION**

On March 3, 2015 (Item No. 2, Agenda of March 3, 2015), the Board directed the Interim Chief Executive Officer (CEO), in conjunction with County Counsel and the Directors of the Department of Human Resources (DHR), Health Services (DHS), Mental Health (DMH), Public Health (DPH), and the Sheriff's Department (LASD), to report back to the Board in writing summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report is also to outline a set of proposed approaches and strategies to address the highlighted issues and improve the overall quality and delivery of the care provided in the County jails.

A multi-departmental workgroup was immediately formed to discuss issues pertaining to provision of health, mental health and public health services within the jails. They developed a proposal for a new integrated jail health care services organizational structure intended to address the challenges of the current County jail health care system. This working group built upon preexisting and ongoing efforts by the LASD to assess and improve the quality of health and mental health services for those in its custody. The Attachment provides detailed information on the status and challenges of the current County jail health care system resulting from the ongoing focus on this issue by LASD and other County leaders; the report presents the proposed alternative integrated structure, and a multi-

phased implementation plan. The integrated structure was developed by consensus of the workgroup and will be formed by transferring existing staff from LASD's Medical Services Bureau (MSB) and DMH to DHS and by adding new functions (e.g., reentry services and a substance abuse director), as needed, to create a single integrated organizational model. Special consideration was given to the structure to ensure that the Sheriff could carry out his legal obligations to oversee the operation of the jails and attend to the needs of those in his custody and enhance the nature and continuity of health services for individuals who move in and out of the jails.

One of the primary goals of the proposed structure is to add a new Correctional Health Director (CHD) to be the overall single point of leadership for jail health services. The CHD will work with an expanded clinical leadership team to lead the provision of health services pursuant to a memorandum of understanding (MOU) with the Sheriff and in collaboration with custody personnel who will ensure proper access to care. In addition to the CHD, the leadership team will include the addition of two new positions: a Care Transitions Director who will ensure that a care model is in place to effectively link inmates to reentry services upon their release, and a Substance Use Treatments Director who will build and lead a substance abuse treatment program within the jails. These three new leadership positions are in addition to existing leadership positions (Jail Medical Director, Jail Mental Health Director, and Jail Nursing Director) that already exist within LASD and DMH. While DHS will be the appointing authority for the position, both DHS and LASD will actively participate in the selection of the Correctional Health Director. Further, the Departments will communicate and collaborate on the review of the performance, or process to terminate employment, of such individual.

The workgroup also developed a multi-phased implementation plan that will begin with a Phase Zero focused on operational planning. Approval of the first recommendation will allow for the creation of the proposed organizational structure and continued progress on Phase Zero planning activities, including, but not limited to, the development of MOUs to govern the roles and relationships under the proposed structure; County ordinance changes to reflect staffing changes; development of a jail health services budget funded by movement of necessary funding from DMH and LASD to DHS; classification and compensation studies to allocate the new leadership and other existing positions; communication with stakeholders (employees, labor partners, and the community) to ensure the success of the proposed jail health services redesign; and planning/development of a substance abuse services program with linkage to community-based treatments. The latter element is critical in that adequately resourced substance use services in the jails are needed to ensure successful community reentry and reduced recidivism. Phase Zero is estimated to take approximately six months.

Approval of the second recommendation will also allow for implementation of Phase One, which will involve the transfer of LASD MSB provider staff (i.e., physicians, nurse practitioners and physician assistants) and all DMH jail health staff (e.g., provider, social work, nursing, clerical, administrative positions) to DHS over the course of 12-18 months. During this transition period, the Departments will collaboratively assess opportunities and identify major gaps and funding needs in order to enhance efficiencies, reduce duplication of efforts, and develop new clinical programs and care models, etc. It is anticipated that these milestones will be accomplished after the County concludes labor consultations.

Approval of the third recommendation will allow for implementation of Phase Two, which will involve the transfer of all remaining MSB clinical and non-clinical staff (nursing, pharmacy, radiology, laboratory, other ancillary areas, health information management, clerical, etc.), absent any unforeseen issues or concerns. Phase Two is projected to start after the completion of Phase One, but the precise timing will be dependent on the involved Departments' assessment of progress and

achievements in Phase One, readiness for additional staff movements, the status of overall health services in the jails, and the identification of any issues or concerns that may warrant further consideration in regard to the propriety and/or timing of this phase. With Phase Two staff movements, responsibility of the associated functions will move to DHS. For example, when the MSB pharmacy staff moves to DHS, the responsibility for medication procurement, pharmacy equipment, and formulary management will also move to DHS.

Approval of the fourth recommendation will provide ordinance authority to allow DHS to start the recruitment process to hire 3.0 new positions responsible for leading the proposed organizational structure once CEO Classification and Compensation determines the appropriate level and classification of each position. Once funding for these positions is determined, the Interim CEO will make recommendations to the Board for approval of any necessary budget actions.

Approval of the fifth recommendation will direct County Counsel to prepare the required County ordinance amendments to reflect staffing changes, including the creation of the 3.0 new positions, for introduction and adoption by the Board.

Approval of the sixth recommendation will allow for a comprehensive review of existing jail mental health programs and resources to determine specific areas that may require changes in order to keep pace with existing and growing demand for mental health services in the jails.

Approval of the seventh recommendation will allow for programmatic and financial assessments to begin with respect to developing a comprehensive substance abuse treatment program in the County jails.

Approval of the last recommendation will require that the Board be provided with quarterly progress reports.

### **Implementation of Strategic Plan Goals**

The recommended actions support Goal 3 Integrated Services Delivery intended to maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

### **FISCAL IMPACT/FINANCING**

The CEO is reviewing the potential revenue sources to fund DHS' provision of integrated healthcare services in the jails. Once that review is complete, LASD, DHS and DMH will submit requests for budget adjustments to your Board as the phased implementation progresses. Such requests may be made either in the mid-year or in the next fiscal year budget process. There will also be continued focus on identifying revenue sources to support these costs to the extent possible, such as Mental Health Service Act or Assembly Bill 109 funding.

The CEO will also work with DHS to create a budgetary structure to ensure positions and funding transitioned to DHS for integrated jail health services remain dedicated for that purpose.

### **FACTS AND PROVISIONS/LEGAL REQUIREMENTS**

As a part of Phase Zero, County Counsel will work with the Departments to determine amendments that are necessary to the County Code in order to implement the new proposed structure and to reflect the staffing changes. The amendments will be presented to the Board for adoption before

staffing changes occur.

Appropriate consultations will be conducted with the impacted employee organizations regarding the proposed structure and staff changes. Every effort will be made to implement changes in a manner that both acknowledges the positive relationship the LASD has enjoyed for years with its medical and nursing staff and that provides staff with enhanced opportunities for professional growth and development as part of the implementation of an integrated health services model.

**IMPACT ON CURRENT SERVICES (OR PROJECTS)**

The integration of jail health, mental health and public health services under the supervision of a single Correctional Health Director working in collaboration with DHS and LASD custody personnel will implement a number of enhancements, such as coordinated primary care and preventative care; improved workflows and clinical processes, access to care and discharge/reentry planning; enhanced jail mental health services; emphasis on substance use services; and improved opportunities for recruitment, retention and training of jail health staff.

Respectfully submitted,



SACHI A. HAMAI

Interim Chief Executive Officer

SAH:CRG

MM:bjs

Enclosures

- c: Executive Office, Board of Supervisors
- County Counsel
- Sheriff
- Auditor-Controller
- Health Services
- Human Resources
- Mental Health
- Public Health

**REPORT ON ENSURING QUALITY HEALTH CARE SERVICES  
IN LOS ANGELES COUNTY JAILS  
(ITEM NO. 2, AGENDA OF MARCH 3, 2015)**

On March 3, 2015, the Board directed the Interim Chief Executive Officer, in conjunction with County Counsel and the Directors of the Department of Human Resources, Health Services, Mental Health, Public Health, and the Sheriff's Department, to report back to the Board in writing in 30 days summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report is to also outline a proposed approach and strategy to address these issues and improve the overall quality and delivery of the care provided. On April 1, 2015, the Board granted an extension for the submission of this report.

## **BACKGROUND**

The Medical Services Bureau (MSB) of the Los Angeles Sheriff's Department (LASD) is under the direction of the Assistant Sheriff of Custody Operations and coordinates access to medical services for approximately 17,500 sentenced and pre-trial inmates currently housed within the County jail. With over 1,700 budgeted employees and an annual budget of \$238 million, MSB is comprised of physicians, nurses, and other clinical/non-clinical staff who provide or support provision of medical care to inmates. This includes a vast array of on-site primary and specialty care services such as dental and oral surgery, eye care, pharmacy, radiology, laboratory, orthopedics, obstetrics and gynecology, general surgery, urology, HIV, and neurology. MSB also operates a 160-bed state-licensed Correctional Treatment Center where skilled nursing facility level care is provided.

In addition to the services provided by MSB, the Department of Mental Health (DMH), the Department of Public Health (DPH) and the Department of Health Services (DHS) also provide services to County inmates. DMH employs around 300 staff including psychiatrists, psychologists, social workers, and mental health nurses who provide direct mental health evaluation and treatment to any inmate determined to need these services. In addition to providing mental health treatment for those in the general inmate population, DMH operates 40 mental health inpatient beds, approximately 550 high observation housing beds and another 1,500 moderate observation or step-down beds. DPH provides limited in-custody substance use treatment services, tuberculosis (TB) screening and evaluation, and screening and treatment for HIV and sexually transmitted infections. DHS is the primary referral department for MSB providers when inmate-patients are in need of specialty medical care, acute care, surgery, or advanced diagnostic or therapeutic services not provided at the jails. Inmate-patients are transported to a DHS facility, mainly LAC+USC Medical Center, for care. In the past two years, in partnership with LASD, DHS has also begun to provide on-site services at Twin Towers Correctional Facility, including urgent care services provided by Board-Certified emergency room physicians and specific on-site specialty services (e.g., cardiology and orthopedics). Attachment A is the organizational chart that depicts the current structure and programmatic areas of responsibility of each department as it relates to jail health services. A full description of the jail health services provided by each department is provided in Attachment B.

The table below summarizes the approximate investment by each County department for services provided to County inmates. Because federal legislation stipulates that all entitlements, such as Medicaid, are lost or suspended when a person is sentenced, jail health

services are funded primarily by net County cost and Assembly Bill 109 (AB109) funds or, in the case of DMH programs, by Sales Tax Realignment funding.

Department / Program <sup>1</sup>	2013-14 Actuals	2014-15 Final Budget	2014-15 Budgeted Positions
LASD MSB	\$221,791,637	\$238,215,000	1,719.0
DHS <sup>2</sup>	48,429,211	48,911,000	46.0
DMH	33,300,000	40,119,000	293.0
DPH - Division of HIV and STD Programs	1,934,404	2,667,000	12.0
DPH - Tuberculosis	131,131	131,000	1.0
DPH - Substance Abuse Treatment and Prevention	90,000	90,000	0.0
<b>Total</b>	<b>\$305,676,383</b>	<b>\$330,133,000</b>	<b>2,071.0</b>

**CURRENT SYSTEM ISSUES**

While staff within LASD, MSB, DMH and DPH work hard and are deeply committed to providing appropriate care, the current system that provides health care for LASD inmate-patients faces a variety of challenges related to 1) the organizational structure in which jail health services are provided, 2) the care models currently in use, and 3) care coordination and integration.

Organizational Structure and Leadership

The existing health care system in the County jails lacks unified organizational leadership. In other California Counties that do not contract out jail health services to a private entity, jail health clinical programs are created and supervised by county clinical professionals in an integrated approach model. In Los Angeles County, MSB is overseen by a custody-led structure, while DMH and DPH have separate reporting lines of authority without a single unifying leader overseeing all aspects of the provision of care and without a seamless provision and transition of services both during and after incarceration. The majority of medical care staff report to LASD. However, specialty medical care which largely occurs outside of the jail facilities reports to DHS and mental health reports to DMH. DPH’s various areas of involvement in the jail are themselves separate from one another as well as from the services provided by LASD, DHS, and DMH. Further, the connection of services from the time an inmate is in custody until they are released into the community is not always seamless. The result is a complicated web of relationships that makes it challenging to coordinate and integrate services and ensure accountability for providing care in a timely and high quality manner.

The proposed change in organizational structure and leadership will enhance the clinical rigor of existing clinical programs, provide direct oversight by knowledgeable, experienced health care

<sup>1</sup> DPH programs include the Division of HIV and STD Programs (DHSP), Tuberculosis (TB) Program, and Substance Abuse Prevention and Control (SAPC).

<sup>2</sup> DHS budgeted positions reflect only those 46.0 positions specifically used in to the LAC+USC jail clinic, emergency department and inpatient areas. It does not include the effort of staff from other areas of the hospital that also provide services to County inmates.

leaders with a broad perspective on health care, and better ensure the uninterrupted provision of care for individuals who cycle in and out of county custody. This proposed leadership change will allow the hard working, committed, and dedicated staff, such as the many physicians, psychiatrists, nurses, pharmacists and technicians, already working in the jails to provide care to inmates in an integrated system designed by and under the direct authority of health care professionals. This will afford greater accountability and collaboration for the various health care disciplines, mirror nationally recognized approaches for a unified correctional health care system, and provide enhanced opportunities for professional growth for nurses and nurse practitioners.

#### Care Model

Today, jail physical health care services are primarily focused on addressing an inmate's immediate and acute issues (i.e., broken arm, active seizure, head trauma) as jails historically were short term correctional systems. That has changed with Public Safety Realignment and the jail health care system must adapt to the changing inmate demographics. There is potential for growth toward a model that emphasizes both acute and chronic issues while providing primary care and preventative services. In jail mental health, available staff and resources must focus on the needs of the most acutely-ill inmates. Although this is the right priority, the growth in demand for such services over recent years has led to significant stress on existing staff and clinical space where the services are provided. In the area of substance abuse services, while LASD estimates that about 60% of inmates (nearly 11,000 individuals at any one time) have active substance abuse problems without a concurrent mental health issue, only a small amount of funding targets the treatment of these problems. The absence of a more robust substance abuse services program within the jail with linkage to community-based treatment upon an inmate's release is a weakness of today's jail health care model. Moreover, the lack of adequate treatment facilities to address the health and mental health needs of those in the County's custody in the best possible environment presents an added challenge.

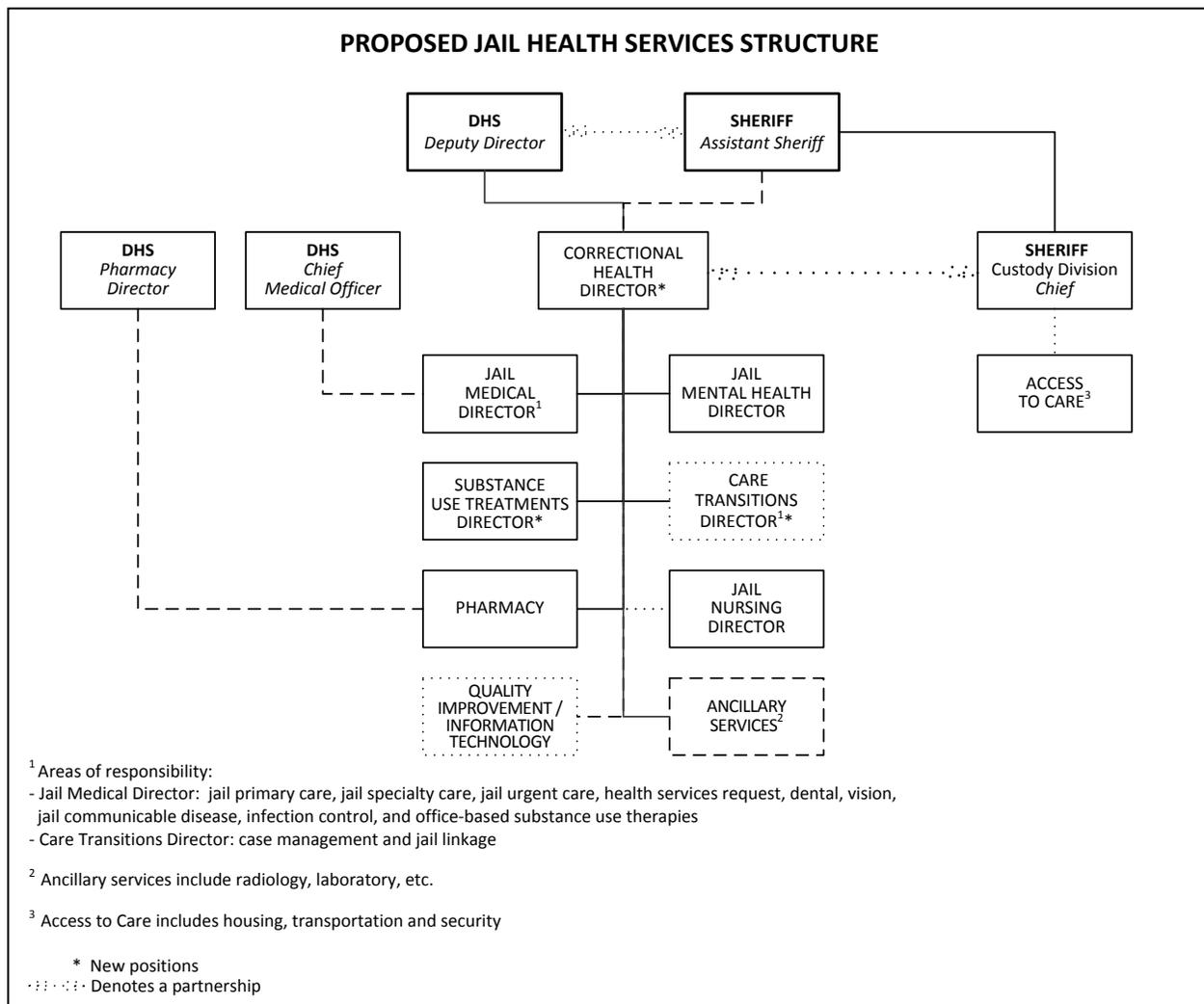
#### Care Coordination

Under the current structure, the County is not maximizing the opportunity to (a) coordinate health care services between the different departments providing care to those in custody, and (b) coordinate reentry services at the time of an inmate's release. Within custody, care coordination challenges are driven by the existing organizational structure where departments and service lines are functioning in both organizational and physical plant silos (i.e., mental health housing is not close to medical services). In regards to reentry care coordination, the opportunity to improve in this area is heightened with the opportunity inherent in the Affordable Care Act. Less than 5 years ago, most inmates were not eligible for coverage either through the Health Insurance Exchange or Medicaid expansion. Today, most are eligible for coverage. In order to capitalize on this coverage and the opportunity to draw inmates with ongoing health care needs into care upon community reentry, the existing efforts and strategies to link to such services in the community must become more robust. Building up the reentry linkage systems and resources within the jails must also be complemented by an increased focus on organizing and augmenting community-based services able to care for the needs of the reentry population.

### **THE PATH FORWARD: JAIL HEALTH SERVICES ORGANIZATIONAL MODEL**

The Sheriff and other County leaders recognize these challenges and the need to develop new strategies and approaches. Special consideration was given to the structure to ensure that the Sheriff could carry out his legal obligations to oversee the operation of the jails and attend to the needs of those in his custody and enhance the nature and continuity of health services for individuals who move in and out of the jails. All parties agree that in order to optimize jail health

services and community reentry, a more cohesive organizational structure should be considered. This structure will allow the County to better meet the health care needs of the current jail population and better seize the opportunities under the Affordable Care Act to support inmates when they reenter our communities. The proposed organizational structure will create a stronger, more visible health leadership team with authority to set the ultimate vision for health care services within the jails and will operationalize full integration of health services currently delivered by multiple different County departments. The proposed jail health services organizational structure is laid out below.



The goals of the proposed structure are to:

1. Establish a single point of leadership for jail health services – as provided by health professionals working in partnership with those responsible for custody-related duties – by enhancing clinical programs and models of care to better meet the ongoing comprehensive health needs of the inmate population in an efficient, integrated, and coordinated manner, and

2. Effectively link inmates to reentry services upon their release from jail.

The key characteristics of the organizational structure include:

- Overall jail health services leadership will be provided by a new Correctional Health Director (CHD), who is a medical professional, selected by LASD and DHS, reporting to a Deputy Director of DHS with a dotted line reporting relationship to the Assistant Sheriff. Recognizing the importance of this role to both DHS and LASD, the appointment will be the result of a collaborative selection process and the CHD will be expected to work in conjunction with LASD on a day-to-day basis. While DHS will be the appointing authority for the position, the Departments will communicate and collaborate on the review of the performance of, or process to terminate employment, of such individual.
- Five major aspects of jail health services will report to the CHD:
  - A Jail Medical Director, responsible for physical health components of jail health services and directly responsible for all medical provider staffing, including physicians, physician's assistants, nurse practitioners and dentists. This individual will be selected by and directly report to the CHD.
  - A Jail Mental Health Director, directly responsible for leading and supervising all mental health staff working in the County jail. This individual will be selected by and directly report to the CHD
  - A Jail Nursing Director, responsible for supervising nursing and ancillary staff, selected by and directly reporting to the CHD.
  - A Care Transitions Director, designed to create and direct the systems to support care coordination and linkage to out of jail services to optimally support inmates when they reenter communities upon their release, will be selected by and directly report to the CHD. This represents a new position in the County.
  - A Substance Use Treatments Director, who elevates the importance of substance use treatment services in the jails and can focus on the creation of substance use treatment programs within the jail and linkage to programs upon reentry, will be selected by the CHD in partnership with DPH-SAPC, and directly reports to the CHD. This also represents a new position in the County.
- Two ancillary areas, including pharmacy and quality improvement/information technology, will serve as support functions to the jail health services structure and will report directly to the CHD.

Explicit within the proposed structure is a strong partnership relationship between DHS and LASD. The importance of this partnership cannot be overemphasized. Although DHS ultimately supervises the CHD and drives the clinical program, LASD and DHS, together, help to provide oversight of his/her day-to-day activities. Similarly, although LASD controls the access to care for inmate-patients, the plans and protocols to ensure access will be developed by both departments. It is because of this strong partnership that a phased implementation approach is possible, as is discussed in detail later in this report.

## **OPPORTUNITIES OF THE PROPOSED STRUCTURE**

This proposed organizational structure ensures that leadership over health care activities in the jails will be directed by experienced health care professionals and all existing and new health activities provided by various County departments will come together under a single umbrella with a single vision toward integration and coordination. Reducing the level of separation

between clinical disciplines and establishing a clinically-experienced leadership team will set a new, consistent and whole-person focus that will manifest in the form and function of the resulting health care delivery system.

More specifically, the proposed organizational structure will allow for: (a) enhancement of the existing care model to emphasize primary care and preventative care; (b) creation of a robust substance abuse services program; (c) augmentation of the existing mental health services structure to better meet the high acuity needs of seriously mentally ill inmates while integrating more basic mental health services in the primary care program; (d) improvements in the overall operational effectiveness through maximizing staff capabilities, providing opportunities for professional development and establishing workflows and clinical processes; (e) better recruitment and retention of staff with a focus on physicians and other providers; (f) improvements in the adequacy of clinical space with ongoing consideration of longer term strategies to develop a needed correctional treatment facility; (g) the coordination with custody staff to ensure access to care; (h) improvements to the existing clinical quality program; (i) improvements in procurement; and (j) improvements in discharge/reentry planning for inmate-patients with chronic medical, mental health and substance treatment needs, and disease control efforts.

#### Emphasis on Primary Care and Preventative Service

Under the proposed structure, physical health services within the jail will be modeled around widely accepted primary care principles. This begins by hiring primary care providers who are board certified and organizing them into teams to provide care in specific areas of the jail. Next is to establish a focus on health screening, preventative services and the identification of chronic disease with subsequent evidence-based management and regular follow-up. Furthermore, the primary care model will integrate basic mental health and substance use screening and interventions to allow inmates who manifest or present with issues in these areas but who were not identified and served at the time of booking, to receive indicated care. As with any strong primary care model, the use of referral to specialty services will be actively managed so that inmate-patients who have specialty care needs are gaining access to these specialty services in an efficient and timely manner and, most importantly, that the specialist recommendations are implemented while the inmate is under LASD custody. The placement of correctional health care services under the leadership of DHS will more likely assure that the primary care-specialty care connection is tightly coordinated and appropriately used. By broadly implementing eConsult, the DHS specialty referral system, primary care providers in the jails will enjoy the full benefit of immediate specialist input and more reliable follow-up to their referrals.

Another area of opportunity under the proposed organizational structure is to deepen the partnership with DPH in the areas of TB, HIV and sexually transmitted disease (STD) services and infection control. Although the DPH resources focused in these areas will remain under DPH, the new organizational structure and specifically the broader role of the Jail Medical Director, will allow for a deeper partnership between the classic DPH responsibilities in the jail and the medical care. For example, when health care screening is completed in the Inmate Reception Center, there are opportunities to complete additional screenings without significant increases in workload if these are done collaboratively with the jail health leadership team. Having a strong partnership between DPH's HIV section and the Jail Medical Director will more likely ensure HIV positive inmates are identified early in their incarceration, started or re-started on medications and provided appropriate care services.

### Build Substance Use Treatment Services

The need to enhance substance use treatment services in the jails is critical. Substance abuse services have not previously been a central aspect of care for jail health services. The addition of in-custody substance abuse treatment services will require a dedicated funding stream to yield downstream savings related to reducing recidivism associated with chronic substance use. Currently, very few inmates with known substance abuse issues receive services. Having an accountable leader, the Substance Use Treatments Director, reporting directly to the CHD, will allow a program to develop over time that seeks to provide services in a targeted way within a variety of clinical settings - including primary care and the mental health areas. Developing such a program will help ensure that inmates who suffer from addictions might withdraw safely, begin indicated treatment in-custody and be linked to ongoing services upon their release. With such a model, not only will patient safety improve but recidivism rates are expected to decline, as inmates are more likely to continue treatment within the community and avoid future drug-related arrests. This said, as a jail-based substance abuse treatment program grows, the need for improved access to services at reentry is imperative. DPH-SAPC leadership will support the Substance Use Treatments Director to build programs in the jail and work with contractors to build community-based reentry treatment programs for inmates. The goal is to provide a well-coordinated and thoughtful model to serve people both in and out of custody.

### Enhance Jail Mental Health

Mental health services in the jails will continue to move toward more aggressive identification and triage of mental health issues at the time of booking as well as other elements called for and being put into place through the United States Department of Justice (DOJ) settlement agreement. The current high acuity mental health areas beginning to mirror the programming and staffing found in "institutionalized" settings such as acute hospitals and specialized mental health facilities. Specifically, more 24/7 services are in the process of being provided so that acute issues arising during late night hours and weekends outside of the inpatient unit can be immediately addressed. With the proposed transition of jail mental health from DMH to DHS, the current experience within DHS operating the acute psychiatric services in hospitals will inform the program design within the jails. An initial, comprehensive review of the mental health programs in the jails and existing resources to deliver these programs is required. Having this done under the leadership of the CHD supplemented by experienced correctional mental health experts will develop a set of priorities and opportunities to continue to enhance services to meet the greater acuity needs of what has been a rapidly growing mental health population within our jails and evaluate the need for additional mental health treatment resources.

### Operational Effectiveness

Under the proposed organizational structure, the CHD sets the clinical direction and operational priorities for jail health services. This person functions similar to a hospital chief executive officer. They have ultimate responsibility for staffing, clinical practice, and budgets, and with his or her leadership team, will make decisions as to how care is delivered. In contrast to the current model where care is designed and implemented in silos, the proposed structure will allow programs to be designed and implemented in a collaborative environment wherein each area is informing the final form. For example, with a greater focus on primary care and integrating behavioral health into primary care, mental health services which may not be easily available today to the population of inmates with significant chronic disease issues will become more readily available. With a greater number of nurses receiving additional mental health training, the opportunity for nurses to recognize deterioration in functional status is more likely to trigger a referral when an inmate's mental health condition worsens. The entire correctional health care team will be built to work more as a team rather than independently and will be better able to treat the whole person as opposed to isolated conditions.

Currently, MSB provides a limited number of ancillary services in the confines of the jails. DHS will work to enhance the type and quantity of ancillary services available on-site at MSB, reducing the time, security risks and costs of transporting inmates out of the jail for treatment services. These will include, but are not limited to, the greater availability of point-of-care testing, a wider array of radiology examinations such as ultrasound and CT, and on-site physical and occupational therapy. A priority will also be placed on developing a dialysis unit at MSB so that this service can be provided in a more-timely, clinically appropriate, and cost-effective manner. Additionally, decisions about such things like which equipment to buy, where to provide certain ancillary services, which tests to provide during intake and how to build a cost-effective yet comprehensive pharmacy and supply formulary will be done more efficiently and effectively when these decisions are driven from a single vision.

#### Recruitment, Retention and Training of Staff

Under the proposed structure, the physical health and mental health physicians, physician's assistants, nurse practitioners as well as the dentists and eye care providers will ultimately become DHS employees through a deliberate and well managed process of transition. In the physical health areas, this creates an immediate opportunity to recruit higher quality, board-certified, primary care providers from a larger DHS applicant pool when vacancies within the jail exist. Some providers may be attracted to a split role, part-time practice in the community, part-time in the jail – flexibility not available when hired by LASD. In the area of mental health, DHS will continue to establish an environment and expectations among providers that more closely mirror an institutional setting where services are available around the clock. DHS will work with DMH during the transition period to retain existing clinical staff and further efforts to recruit and fill vacancies with high quality clinicians. Additionally, DHS can support all existing correctional health care providers, including nurses, by implementing more training and professional development activities as well as by consistently evaluating and improving clinical processes and procedures. These efforts will create a consistent and reliable clinical care environment in which to practice and in turn provide the structure and milieu many providers and other health care professionals rely on to do their job well. DHS will also bring to the jails some of the successes the Department has had in supporting the training of nurses from within the system to become mid-level providers who remain in the jail during their nurse practitioner training and assume jail clinician duties upon their completion. This strategy will be a valuable way to provide nurses with a promotional job-ladder while allowing those who are passionate about serving inmate-patients to continue fulfilling this mission.

#### Access to Care

A hallmark of the proposed organizational structure is the deliberate and direct link between jail health leadership and the LASD Chief of Custody Operations responsible for ensuring inmate access to care. This Chief and his or her team must work to ensure inmates can access the care they need, when they need it. This coordination must be constantly emphasized because without such coordination, inmates will not be able to access fully the benefits of improved clinical services. Custody and jail health leadership must design new systems and accountability metrics to better ensure patients are scheduled for care in a way that is appropriate given the custody responsibility for keeping a safe and controlled environment within the jails. These systems must ensure general clinical care is a priority but also that emergency or urgent care can be accessed immediately when clinically necessary.

#### Clinical Space

Many existing areas for the delivery of clinical care in the LASD facilities are not as conducive as they should be to obtaining a comprehensive clinical history and physical exam or for

maintaining patient/client confidentiality. The new jail health leadership team can work with LASD and DHS clinical space design experts to determine opportunities to utilize existing space for a variety of direct clinical and non-clinical (e.g., case management, referral/linkage) activities. Renovations may be required in order to create an environment that fosters the provision of high quality care and is attractive to staff considering roles in jail-based settings. Without improvements in these areas, certain clinical workflows are more challenging to implement and potential shortcomings in the care model may persist. Under the CHD, these space improvements can be prioritized so to create the optimal conditions given space size, locations and configuration. Moreover, the jail health leadership team can participate in ongoing efforts to assess and promote the development of a new and improved correctional treatment facility.

#### Quality Improvement

DHS will immediately begin to work with current LASD clinicians, who will become employees of DHS under the proposed structure, to establish a more robust quality improvement program. This begins by establishing more detailed and prescriptive quality policies and procedures. It will also require enhancing capacity to gather and analyze data from the jail electronic health record, a Cerner system called Jail Health Information System (JHIS). The robust quality improvement program will support ongoing improvement in clinical staffing and help prioritize the future planning of the jail health system. An important benefit of creating a robust quality improvement program is to mitigate risk and liability. As with every system, errors occur in the day-to-day delivery of care. The quality program will allow the jail health services team to identify these errors, perform investigations into root causes, and act swiftly to put in place the systems, policies, procedures, and trainings needed to prevent such errors in the future, as well as individual staff corrective measures when appropriate, needed to prevent such errors in the future.

#### Procurement

As the largest entity purchasing health care related equipment and supplies in Los Angeles County, DHS can support LASD in acquiring items needed for care delivery in a more efficient and clinically appropriate manner. DHS has the expertise on how medical equipment and supplies in different clinical areas are evolving and on value-based purchasing analyses and can apply this knowledge to purchases required in jail settings.

#### Discharge and Reentry Planning

Stakeholders and department leaders agree that one of the strengths of the proposed organizational structure for jail health services is its strong focus on discharge planning and linkage to care efforts and the prominent role of the newly-proposed Care Transitions Director responsible for managing and leading these activities. Given Medicaid expansion and the near universal coverage of inmates under the Affordable Care Act, few inmates should leave jail without having started a process to newly gain or regain health coverage. For those released with a chronic illness or a persistent substance use disorder requiring additional follow-up, this coverage is imperative to connecting the inmate-patient with a medical/behavioral health home as a means to receiving ongoing care and support. Furthermore, because LASD and DHS use the same electronic health record vendor, Cerner, the information collected and documented in the jail can be shared with a DHS provider who can serve the patient once they are released. The development of the Cerner Hub, set to launch in the next 12-18 months, creates an opportunity to allow the services provided in the jail to more seamlessly inform care in the community, and vice versa. For those patients seeking care outside of directly-operated County settings, additional steps will need to be taken to be sure that medical information is appropriately transmitted to the community-based responsible provider(s), while maintaining compliance with all relevant privacy and information security regulations. This connection to

community-based care can be enhanced through establishment of local reentry networks, involving both public and private providers, throughout the various communities of Los Angeles County who can be specifically trained and engaged to provide care to this unique population in a reliable and coordinated way. With the addition of a partnership with the local health plans, LA Care and Health Net, the coordination and continuity of care for the Los Angeles County reentry population can be optimized and potentially serve as a national model.

### **PROPOSED HEALTH AGENCY MODEL**

In January 2015, the Board approved in concept the creation of a health agency, uniting DHS, DMH, and DPH under a single umbrella structure. A report to the Board on the opportunities, drawbacks, proposed structure, implementation steps, and timeline is due to the Board by June 30, 2015. The departments agree that the proposed structure for jail health services as proposed in this report would adapt very well under an agency model.

However, it should be stressed that the restructuring of jail health services to have a single point of leadership able to integrate services across the full spectrum of clinical needs is a positive step, independent of whether a health agency is formed. The opportunities previously discussed will allow the County to address the interconnected health issues and improve the overall quality and delivery of health care services provided within the jail system while maximizing health outcomes of the County's incarcerated and post-incarcerated population.

### **LABOR AND WORK FORCE POINTS FOR CONSIDERATION**

To facilitate the transition of services and ease Labor concerns, it will necessary to maintain an open channel of communication with the various labor representatives throughout each phase of employee movement. Labor's early involvement in the transition process, such as allowing labor input on operational effectiveness, staff movement, recruitment, retention and training will aid in relieving employee apprehension related to these operational changes. It will also be important to develop a more formal approach to support staff transitions and change management. This could involve use of County (e.g., DHR) or non-County resources on an as-needed basis.

It will also be advantageous to promptly address with Labor the level of competency expected by DHS that may not have been as strongly emphasized in LASD.

These efforts may require a re-evaluation of applicable memoranda of understanding (MOU) provisions. Purposely, this would ensure that the parties have a clear understanding of how specific DHS related MOU provisions will translate to the LASD staff who are transferred to DHS and/or if specific MOU provisions that are pertinent only to LASD should continue to be applicable to the staff following their transfer to DHS.

### **IMPLEMENTATION PLAN**

The transition of jail health services to DHS would be implemented in three phases. It must be stressed, that the work to implement the expected DOJ and known Rosas settlement terms are currently underway and therefore, it is critical that LASD be able to meet considerable milestones in response to those terms before it can successfully implement the transition of jail health services. As a result, this plan would not begin implementation until all involved departments can be focused on the work, which is estimated to be completed this coming fall. The work required for this transition will involve many resources already deployed for DOJ and

Rosas implementation. So that the success of that work and the transition contemplated in this report back are not compromised, a fall timeframe for the transition to begin is the most realistic.

Because of the enormity of the work involved in the proposed reorganization and restructuring and because of the need to stage and sequence the transition, a phased transition is recommended. Furthermore, as LASD prepares for a new clinical environment within the jails, moving areas in phases will allow for a more cautious and measured approach to unfold, protecting against potential disruptions in staffing or erosion of the quality of existing clinical programs.

The proposed organizational structure would be assessed and, where appropriate, implemented in three phases. At a high level, this will start with a Phase Zero planning phase, a Phase One in which LASD provider staff and all DMH staff would transition to DHS, and Phase Two in which remaining LASD MSB staff and functions (e.g., nursing staff, technicians, pharmacy, etc.) would move, absent any issues or concerns that provide a basis for revisiting the timing or nature of this phase. These phases are described in detail below.

#### Phase Zero

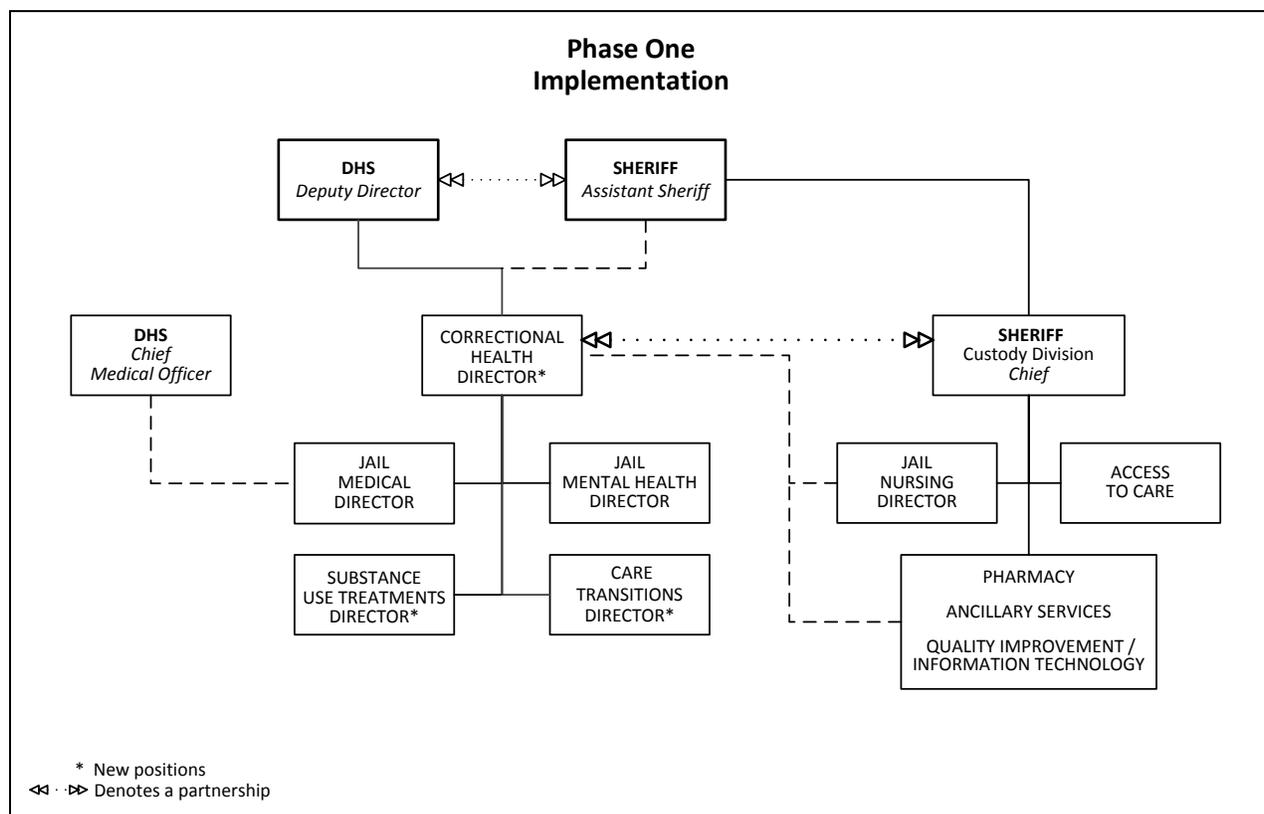
The following immediate steps, to occur over 6 months, are recommended in order to begin operational planning for Phases One and Two described below.

- Evaluate need for changes to County ordinances: County Counsel will review relevant County ordinances to determine what amendments are necessary in order to implement the new proposed structure. This is particularly true of staffing additions and changes that are being contemplated. County Counsel will work with all departments to ensure that the appropriate ordinances are amended and proposed to the Board for adoption before staffing changes occur.
- Develop jail health services budget: Existing budgets and item controls for each of the entities (DMH, DHS and LASD MSB) being considered for movement under the proposed organizational restructuring must be fully vetted to ensure they are accurate and that sufficient funding is available for jail health services. Without a meticulous examination of current item controls, budgets and expenditures and a clear understanding of the adequacy of current funding levels, the proposed transition will be difficult. This analysis will also include discussions with the CEO as to how future cost-of-living adjustments will be managed and funded.
- Plan for addition of new leadership roles: The creation of and securing funding for the three new leadership positions (i.e., CHD, Care Transitions Director, and Substance Use Treatments Director) are critical components of the proposed model. In this initial planning period, duty statements will be written so that classification/compensation can allocate the appropriate positions. New funding for these positions is required. Additionally, the medical director position currently allocated to MSB will require a re-classification study given the larger scope of responsibility assigned to this position in the proposed organizational structure.
- Establish initial stakeholder communication strategy: Communication with internal and external stakeholders with an emphasis on County personnel and labor partners will play a crucial role in the success of this proposed jail health services redesign. As such, a clear, continuous and inclusive communication strategy with all the stakeholders is paramount and will begin immediately.

- For county labor partners, this process would involve an initial written invitation to impacted union locals to meet for a review of the redesign. Those labor organizations that respond to this written invitation will be identified as ongoing participants in the development and implementation of the organizational changes, particularly in the area of employee impact.
- Establish MOU: Clear and comprehensive agreements must be developed to govern the roles and relationships between LASD and DHS under this proposed organizational model. In assessing the MOU, special consideration will need to be given to the fact that the Sheriff maintains statutory responsibility for all aspects of jail management and that all parties remain equally committed to providing constitutionally mandated health care and access to those services in the jails during and after the transition. Clarity in the MOU is particularly important given that Phase One involves having most MSB clinical personnel remaining under the supervision of LASD (i.e., nursing, pharmacy, laboratory, and radiology staff). Given this, a clear delineation is needed for how the DHS-supervised clinical leadership will provide these personnel their clinical and operational direction while maintaining a direct reporting relationship to LASD. The MOU will also help govern the budgetary and fiscal considerations that will become clearer during Phase Zero. Similar to the MOU established between DHS and the Probation Department for the provision of medical services within the Juvenile Probation system, the MOU between LASD and DHS will focus on roles and responsibilities for each department needed to build strong clinical programs and ensure timely access to care. The MOU will clearly outline roles and responsibilities of LASD and DHS. Example of topics to be addressed in the MOU include:
  - Establishing that the CHD sets the clinical priorities, including where staffing must be augmented or reduced, which screening questions will be administered, and which medications and supplies will be ordered and which will not.
  - Establishing who sets the jail health budget and how budgetary issues are handled between DHS and LASD or DHS and other involved departments.
  - Describing the relationship between DHS staff and LASD staff during Phase Zero and Phase One, before staff move to DHS.
  - Establishing regular meeting schedules between involved departments and including how progress will be assessed toward implementation of this jail health transition plan.As the content of the MOU is developed, it will be shared in the quarterly reports to the BOS, if the proposed concept is approved.
- Assess and address labor and work force related activities: Labor representatives will be afforded the opportunity to provide input on the transfer of employees to DHS. CEO Employee Relations will facilitate meetings with the various labor unions to address and resolve, when appropriate, employee concerns related to salaries, supervisory reporting structures, and possible layoffs/reductions; enhance the employee transfer process; and clarify/implement applicable MOU related provisions. This strategy of open communication and transparency would continue through Phase Zero and Phase Two of the transition process.
  - As the County is currently negotiating with the labor organizations on successor MOUs, CEO Employee Relations will identify and propose MOU language revisions to ensure that MOU provisions are applied appropriately to all affected employees (e.g., eliminate/reduce departmental specific MOU provisions).

Phase One

If the proposed organizational structure is approved in concept by the Board and the Sheriff, Phase One, to occur over the course of 12 to 18 months, would involve the transfer of MSB providers (physicians, nurse practitioners, physician assistants and dentists) and all DMH clinicians (physicians, nurse practitioners, physicians assistants, and psychiatric social workers) and staff to DHS as shown in the organizational chart below. DHS and LASD will work together to assess opportunities to enhance efficiencies in clinical and administrative functions in order to generate cost savings. This may include opportunities to reduce redundancy in roles currently split among departments, to reclassify certain positions, etc. The departments will also assess major gaps in services, including the need for additional specialty or diagnostic services<sup>3</sup>, the need for a comprehensive substance use treatment program, and physical space for clinical and non-clinical activities, seeking additional funding as needed if costs are not able to be covered within the existing jail health services budget. Attachment C outlines the work involved to accomplish Phase One.



Phase Two

In Phase Two, all remaining MSB staff, including nursing staff, pharmacy staff, and any other remaining clinical and clinical support staff will be transferred to DHS. The timing of Phase Two changes will be dependent on successfully completing the Phase One transition, estimated to take 12-18 months from the beginning of Phase One in the absence of any unforeseen issues or concerns.

<sup>3</sup> The implementation of a more robust clinical care model will likely result in an increased level of referrals for specialty and other health services and ultimately, the need for additional staff and financial investment.

DHS, DMH and LASD will continually assess and evaluate progress, opportunities, and challenges to determine if additional structural changes, leadership/supervisory positions, and work process changes may be necessary. A progress update will be provided to the Board and the Sheriff on a quarterly basis with a focus on progress toward implementation of the distinct phases as well as ways the Board and the Sheriff can support the swiftest path toward an integrated clinical care program that ensures appropriate health care to inmates, focuses acutely on reentry efforts, and ensures a commitment to increasing substance abuse services to criminally involved individuals in Los Angeles County.

## CURRENT DELIVERY OF JAIL HEALTH, MENTAL HEALTH, AND PUBLIC HEALTH SERVICES

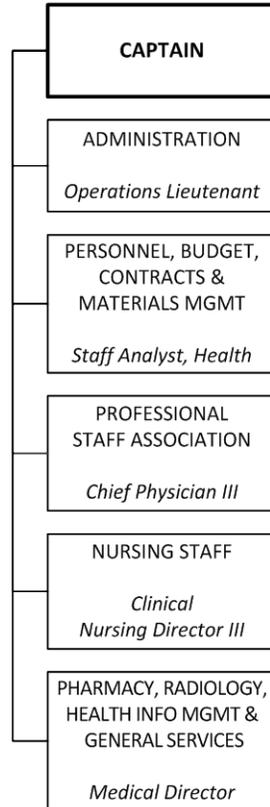
DEPARTMENT OF HEALTH SERVICES  
LAC+USC Medical Center

PRIMARY REFERRAL DEPARTMENT FOR MSB PROVIDERS

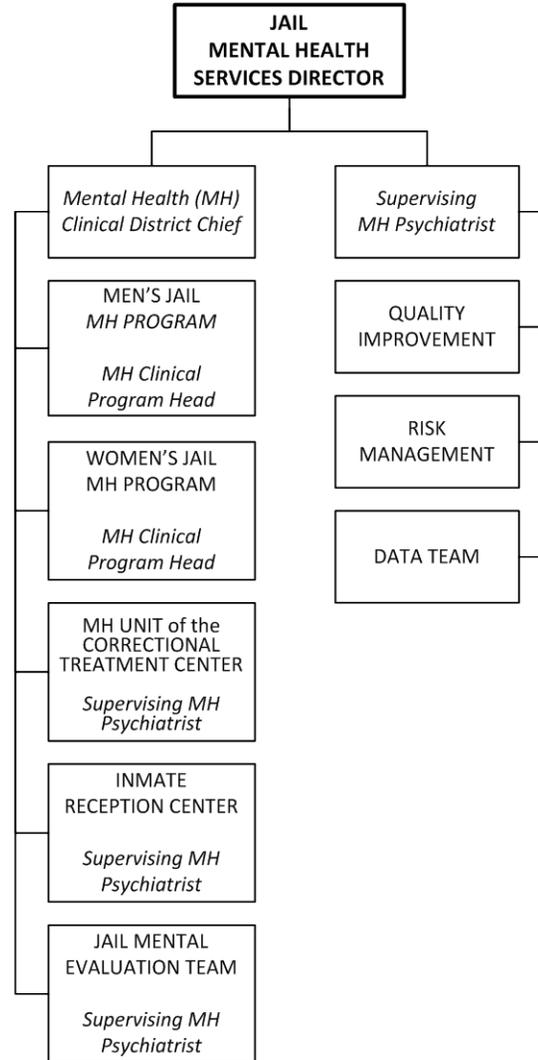
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SPECIALTY MEDICAL CARE, ACUTE CARE, SURGERY, DIAGNOSTIC, OR THERAPEUTIC SERVICES

SHERIFF'S DEPARTMENT  
Medical Services Bureau (MSB)



DEPARTMENT OF MENTAL HEALTH  
Jail Mental Health Services



DEPARTMENT OF PUBLIC HEALTH  
Jail Public Health Services

COMMUNICABLE DISEASE CONTROL & PREVENTION

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TUBERCULOSIS SCREENING & EVALUATION

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HIV & STD SCREENING & TREATMENT

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SUBSTANCE USE TREATMENT SERVICES

## COUNTY JAIL HEALTH SERVICES

### DEPARTMENT OF HEALTH SERVICES

Historically, the DHS has had a Memorandum of Understanding (MOU) with LASD, last updated in October 1997, which effectively obligates DHS to provide specialty care, diagnostic care, therapeutic care, inpatient hospitalization, and surgical care to inmates when LASD MSB is unable to provide these services themselves. To this end, DHS has always maintained a specialized jail clinical area at LAC+USC Medical Center. This specialized area includes a 15 bay emergency room staffed by the LAC+USC Emergency Department, a 5 exam room specialty clinical area where LAC+USC providers deliver specialty care services to inmate-patients transported to LAC+USC 5 days per week. There is also a 24 bed inpatient medical-surgical unit where inmate-patients in need of acute medical care can be admitted and cared for by LAC+USC inpatient staff.

In addition to this work by DHS, approximately two years ago, at the request of the Board, DHS executed an inmate specialty care agreement and MOU with LASD to augment medical services available on-site at MSB. As a result, DHS engaged USC Medical School to help provide some of these services. Specifically, since the spring of 2013, DHS provides the following services at MSB sites:

- 16 hours per day, 365 days per year, urgent care services provided by board certified emergency room physicians and physician assistants working each shift, and
- 12 hours per week Obstetrics and Gynecology specialty services with a focus on the care of the highest risk pregnant women under LASD's custody.
- 2 full time nurses designated as care coordination nurses who support the care of inmates whose conditions rely heavily on care provided beyond the four walls of the jails. Examples include inmates with cancer care, major orthopedic injuries, cardiac issues and multiple, complex medical conditions.
- Access for MSB providers to eConsult to consult with DHS for specialty care and facilitate referrals patients from the jails to LAC+USC for specialty care services. This has allowed patients to come to LAC+USC with the right level of work-up done before their visit and ensures those who need more immediate specialty care are appropriately triaged.
- A growing group of specialty care trained nurse practitioners (NP) working at the jail under the supervision of DHS specialty providers at LAC+USC. This NP specialty model has allowed many patients to receive more timely specialty care in the jails as opposed to waiting for a visit slot at LAC+USC.
- Installation of a mobile computed tomography (CT) scanner in MSB to help with the evaluation of closed head injuries, a frequent issue at LASD.
- Point-of-care testing to support the clinical decision making of providers working at MSB so more immediate diagnostic information is available and more appropriate and timely care can be provided.

The objectives of the recent collaboration between DHS and LASD MSB have focused on (a) improving the accessibility of care for inmates; (b) improving quality and coordination of care; (c) reducing inmate transportation required for care.

## DEPARTMENT OF MENTAL HEALTH

Jail Mental Health Services (JMHS) programs are administered by DMH and provide care to men and women identified as having mental health needs while incarcerated in the Los Angeles County jails. Services are provided at four locations: the Twin Towers Correctional Facility (TTCF), Men's Central Jail (MCJ), Century Regional Detention Facility (CRDF), and North County Correctional Facilities (NCCF).

Approximately 3,500 individuals, or 20% of the current average jail census of nearly 17,500, receive mental health services on any given day. The JMHS client census is comprised of approximately 2,950 men and 550 women. Over two-thirds of these clients are housed in mental health areas of TTCF and CRDF, with the remainder housed in the general population areas of TTCF, CRDF and MCJ. Included in the client census are on average 450 inmates that are incarcerated under the provisions of Assembly Bill (AB) 109, the Public Safety Realignment Act.

JMHS has a jail-based staff of 302 individuals, including psychiatrists, psychologists, social workers, psychiatric nurses and technicians, service coordinators, and case workers that function as group leaders and release planners, substance abuse counselors, recreation therapists, and support and administrative staff. The collaboration between DMH and LASD extends from an individual's entrance to jail to his/her exit. Services are organized by programs that work in concert with each other to provide a continuum of mental health care.

- Inmate Reception Center (IRC) - Located at TTCF, IRC is the entry point for male offenders into the jail system. All are screened by LASD custody staff for medical and mental health issues, with over 3,600 referred monthly for mental health assessment. Women are similarly processed through a Reception Center at CRDF, with over 800 referred monthly.
- Mental Health Unit of the Correctional Treatment Center - Also known as the Forensic Inpatient Program, it is a 46-bed licensed unit located in TTCF to provide acute psychiatric inpatient care and is Lanterman-Petris-Short (LPS) designated to provide involuntary treatment for individuals most in need due to their immediate danger to self or others and/or grave disability that severely interferes with their ability to function.
- High Observation and Moderate Observation Housing - The Men's Program, located in TTCF, and the Women's Program at CRDF provide two levels of care: High Observation Housing (HOH) for clients at risk of dangerous behavior or self-harm who require intensive observation and care including risk precautions, but do not require hospitalization. Moderate Observation Housing (MOH) is the dormitory level of care that is for more stable clients whose mental health needs can be cared for in a less intensive and more open setting, but preclude their tolerating general population housing. Approximately 85-90% of these inmates have co-occurring substance use disorders.
- Jail Mental Evaluation Teams - Comprised of mental health clinicians and specially trained deputies, as well as psychiatrists, other clinicians, and release planners, the teams identify inmates in the general and special population housing areas of TTCF and MCJ who were not previously recognized as having mental health care needs. Two additional JMETS teams serve the NCCF for screening of inmates that may require mental health care. In the general population areas of CRDF, the Women's Program provides medication management and follow-up care.

- Jail Linkage Program - This program is critical as increasing emphasis has been placed on re-entry planning and linkage to community services and supports for mental health clients at all levels of care. The team works throughout the system with clients who require comprehensive release planning such as conservatorship and placement in Institutions for Mental Disease (IMD) or IMD Step-down facilities, as well as with clients who require less intensive assistance related to housing, benefits establishment and linkage to outpatient mental health treatment in the community. Release planning is done collaboratively between JMHS and DMH Countywide Resource Management (CRM) for AB 109 clients.
- CRM Vivitrol Administration - This project is for AB 109 clients with co-occurring mental illness and opiate dependence. Through this project, clients who have been appropriately screened can receive one administration of Vivitrol approximately one week before their scheduled release date and can then be linked with an AB 109-funded community clinic that can continue the Vivitrol protocol upon the clients' release.
- Misdemeanor Incompetent to Stand Trial (MIST) - This program is for misdemeanor offenders who have been adjudicated Incompetent to Stand Trial (IST), including those who refuse psychiatric medication. JMHS provides competency restoration services for these clients through the MIST program, including administration of court-authorized medications. JMHS is currently exploring legal avenues to also administer medication pursuant to a court order for felony offenders ISTs who are pending transfer to a State hospital for competency restoration services.
- Tele-psychiatry - This program was recently initiated at NCCF and currently serves a limited number of inmates to assist with overcrowding of inmates on psychiatric medications at TTCF and MCJ. The program identifies relatively stable inmates on psychotropic medications to be moved to NCCF, which has more available beds than in TTCF and a less restrictive, more modern facility than MCJ. Clients are selected based on diagnosis, class of psychotropic medications, review of their IS records, and review of their electronic medical records (EMR). Qualifying clients have remained stable on their current medications for a period of at least a month, do not have a psychotic diagnosis, are not taking antipsychotics, and do not have evidence of problematic behaviors or suicide attempts documented in their IS records or their EMR. The clients go to NCCF with a 90 day supply of medications as ordered in their EMR. The JMHS psychiatrist trained in using Telepsychiatry sees the clients every 90 days via Telepsychiatry to assess their stability and renew their medications. Any urgent or emergent situations are dealt with by transferring the client back to the IRC clinic for assessment. The appropriateness of their returning to NCCF is also discussed. The program goal is to maintain an average census of about 40 clients with the plan to assess the feasibility of expanding the services.

The focus of care throughout the DMH JMHS programs is on stabilizing clients' mental illness; engaging them in treatment for mental health and co-occurring substance use disorders; and immediately beginning to develop and/or solidify release plans for housing; mental health care (including but not limited to institutional care, Full Service Partnerships, integrated services/supportive housing projects, and outpatient clinics); access to benefits, employment or education; and connecting or reconnecting with families and other community supports. Community partners are encouraged to provide in-reach while referred clients are still incarcerated.

## **DEPARTMENT OF PUBLIC HEALTH**

Three programs within DPH have strong involvement and experience working with LASD: the Division of HIV and Sexually Transmitted Diseases (STD) Programs, the Tuberculosis (TB) Control Program, and the Substance Abuse Prevention and Control Program.

### Division of HIV and STD Programs (DHSP)

LASD plays a critical component in DHSP's overall HIV and STD control strategy as many persons at risk for or diagnosed with HIV or STDs interact with the criminal justice system in the following areas: locating DHSP staff to work in the jail, 2) contracting with community based organizations (CBO) to provide services in the jail, and 3) funding positions in LASD through a cross-departmental MOU. In addition, DHSP works closely with LASD's Medical Services Bureau and Community Transition Unit.

Currently, five DHSP staff at the jails full time to perform HIV and STD screening in Men Central Jail's "K6G" dorm, which houses gay/bisexual men and transgender women, and the women's inmate reception center at Century Regional Detention Facility (CRDF). At least twice a week, staff members distribute condoms in the K6G dorm, where prevalence of HIV exceeds 20%. Two DHSP public health investigators (PHIs) perform partner elicitation and notification services for inmates with high priority STDs, and follow-up of syphilis and HIV cases released prior to receiving their results to ensure linkage to care and treatment of partners.

DHSP-funded CBOs fall into two categories: five organizations that provide HIV transitional case management (TCM) and pre-release planning services for HIV positive inmates and one organization that provides sexual health education with inmates at high risk of HIV and STDs. Historically, the yield from the TCM program has been less than optimal due to several factors, many of which relate to the lack of true LASD institutional support or appreciation for the role such programs play in improving individual and even public health outcomes after individuals transition back to their communities. Recently, based on a pilot program, DHSP decided to invest up to six additional DHSP staff to serve as health navigators to meet with HIV positive inmates once before release and work with them for 6-12 months after release from jail to ensure their continuity of medical care and link them to appropriate social services in the community.

DHSP currently funds one public health nurse (PHN) who serves as an HIV nurse case manager, ensuring that all incoming and exiting HIV positive inmates are started and released with their medications. The PHN also communicates with patients' HIV providers in the community to get recent medication lists and laboratories to reduce errors and unnecessary repeat testing. DHSP and LASD recently renewed and modified the MOU to include an additional PHN position to assist with the high HIV positive inmate caseload, which is usually around 300-350 inmates at a given time. DHSP has also historically loaned one of its Program Manager I items to LASD to hire a staff member to serve as a Jails HIV Services Coordinator and function as a liaison between LASD and DHSP to coordinate HIV and STD public health activities with LASD custody staff. This position is currently vacant due to staff retirement.

DHSP has worked closely with MSB's Infection Control Unit (ICU). The ICU staff includes a medical epidemiologist (currently vacant), and epidemiologist, and a team of committed public health nurses who ensure appropriate patient management for a variety of communicable diseases, including non-HIV STDs, TB, hepatitis, influenza, and help address any outbreak situations (examples include MRSA, norovirus). The ICU team has been a critical asset to many members of the DPH to help to implement new public health programs, such as offering accelerated schedule hepatitis A/B vaccination in the K6G dorm, as well as providing influenza vaccination in the dorms for inmates with chronic diseases. These examples highlight the potential for implementing evidence and guideline best practices to improve the health of this vulnerable population.

Lastly, over the past two years, DHSP has worked with the Community Transition Unit to coordinate release times for HIV positive inmates who are being released into residential programs or are working closely with one of our health navigation pilot programs. This program has been very successful in allowing DHSP to ensure that the clients receiving case management services are linked to services but it remains very limited in scope and would benefit from significant investment to scale it up and apply it to a much broader cross section of inmates.

#### TB Control Program

The DPH's TB Control Program currently funds 1.5 FTE staff to conduct case management and pre-release planning for inmates infected with tuberculosis to ensure appropriate treatment and follow-up inside and outside of custody. Also, staff monitors medication adherence and oversees discharge planning to ensure continued treatment. Over the past four years, 59 TB cases were diagnosed at the time of incarceration (approximately 10-15 infectious cases/year are identified of inmates entering the jail). Approximately 250 inmates per year are worked up as potential TB cases.

#### Substance Abuse Prevention and Control Program (SAPC)

Current SAPC programming that relates to the LASD includes the following:

- The Sentenced Offender Drug Court (SODC) program was established in 1998 at the request of the Los Angeles County Superior Court. SODC is an intensive substance use disorder (SUD) treatment approach for convicted, non-violent felony offenders facing lengthy state prison terms for drug-related offenses. SAPC currently contracts with Principles, Inc., (dba IMPACT) for the provision of in-custody SUD treatment services. With an in-custody 60-bed capacity for male clients at Pitchess Detention Center and 24 beds for female clients at the Century Regional Detention Facility, the in-custody treatment services are court-ordered for up to 90 days. Upon release from in-custody treatment, clients continue residential or outpatient SUD treatment services, depending on the severity needs of the client. The client remains under the supervision of the dedicated drug court bench officer and probation for the duration of their community-based treatment services.
- SAPC currently contracts with Homeless Health Care Los Angeles (HHCLA) to operate a Community in the LASD Community Resource and Re-entry Center (CRRRC). The HHCLA staff provide on-site SUD screening and assessment, and are able to make and coordinate SUD treatment referrals for recently released persons.
- SAPC is currently developing the Substance Treatment and Re-Entry Transition program (START), which will incorporate in-custody and community-based SUD treatment services. The in-custody program, pending Board approval, will implement In-Custody Education Treatment (ICET) services in accordance with the LASD's Education Based Incarceration Maximizing Education Reaching Program. The community-based treatment component entails LASD conducting a risk/needs assessment to identify female inmates for an initial 90-day episode of SUD residential care in a supervised non-custodial setting, as an alternative to incarceration.

## **IMPLEMENTATION PLAN STEPS PHASE ONE**

These are the priority activities that need to be accomplished in the first 12 months following approval of the proposed organizational structure:

- Hire/appoint an interim Correctional Health Director, interim Jail Medical Director, interim Jail Mental Health Director, Substance Use Treatments Director, and interim Care Transitions Director.
- Appoint an interim Jail Nursing Director.
- Have the DHS Director of Quality Improvement work with jail health services leadership to establish an executive peer review process and improve physician credentialing.
- Establish the appropriate MOU(s) that governs the transition of existing MSB providers (physicians, nurse practitioners, and physician assistants) to DHS.
- Establish the transition plan to govern the transition of existing DMH providers to DHS.
- Work with DHR, CEO, and DHS/DMH/LASD Human Resources to transition personnel from LASD and DMH to DHS.
- Hire primary care providers to fill existing LASD MSB vacancies.
- Restructure the existing clinical nursing infrastructure to improve leadership, improve front line nurse workflows, and enhance nursing decision support to ensure safe, timely, and appropriate care.
- Improve chronic care management programs for inmates, including redesigning the intake and sick call systems (ensuring mental health issues are addressed in both of these areas) and enhancing access to urgent care.
- Redesign clinical space to enhance inmate-patient care and staff working conditions.
- Restructure pharmacy and medication administration systems, processes, purchasing, staffing, and space allocation.
- Streamline supply procurement and material management systems in all LASD facilities.
- Implement a robust quality and risk program founded on peer review and continuously reevaluate system-level data.
- Develop and implement a robust access to care tracking mechanism to improve access to services and accountability for missed services.
- Enhance jail system public health practice and expertise and consider refilling the vacant Infection Control Physician position to maximize infection and disease control efforts, including compliance with Title 15 requirements.
- Work with custody to optimize housing decisions for persons with medical, mental health and substance use conditions in order to improve population management strategies and resources for inmates in need of medical and mental health/ADA housing.
- Enhance in-custody residential substance abuse treatment programs.

1 LORETTA E. LYNCH

Attorney General

2 MARK J. KAPPELHOFF

Deputy Assistant Attorney General

3 Civil Rights Division

JUDITH C. PRESTON

4 Acting Chief, Special Litigation Section

LAURA L. COON, Special Counsel, Special Litigation Section

5 LUIS E. SAUCEDO, Counselor to the Chief, Special Litigation Section

CATHLEEN S. TRAINOR

6 Trial Attorneys

U.S. Department of Justice

7 Civil Rights Division, Special Litigation Section

8 950 Pennsylvania Avenue, N.W., PHB 5026

Washington, D.C. 20530

9 Telephone: (202) 514-6255

Email: laura.coon@usdoj.gov; cathleen.trainor@usdoj.gov

10 EILEEN M. DECKER

11 United States Attorney

LEON W. WEIDMAN

12 Assistant United States Attorney

Chief, Civil Division

13 ROBYN-MARIE LYON MONTELEONE (State Bar No. 130005)

Assistant United States Attorney

14 Assistant Division Chief, Civil Rights Unit Chief, Civil Division

JOANNA HULL (State Bar No. 227153)

15 Assistant United States Attorney

16 300 North Los Angeles Street, Suite 7516

Los Angeles, California 90012

17 Telephone: (213) 894-2458/6585; Facsimile: (213) 894-7819

E-mail: Robby.Monteleone@usdoj.gov; Joanna.Hull@usdoj.gov

18 Attorneys for Plaintiff

19 UNITED STATES OF AMERICA

20  
21 MARY C. WICKHAM

Interim County Counsel

22 RODRIGO A. CASTRO-SILVA (SBN 185251)

Senior Assistant County Counsel

23 BRANDON NICHOLS (SBN 187188)

Assistant County Counsel

24 KAREN JOYNT (SBN 206332)

Deputy County Counsel

25 648 Kenneth Hahn Hall of Administration

500 West Temple Street

26 Los Angeles, California 90012

Tel: (213) 974-1811 Fax: (213) 626-7446

27 Email: rcastro-silva@counsel.lacounty.gov

bnichols@counsel.lacounty.gov

28 kjoynt@counsel.lacounty.gov

1 Attorneys for Defendants  
2 COUNTY OF LOS ANGELES and LOS ANGELES  
3 COUNTY SHERIFF JIM MCDONNELL, in his  
4 Official Capacity

5 UNITED STATES DISTRICT COURT  
6 FOR THE CENTRAL DISTRICT OF CALIFORNIA  
7 WESTERN DIVISION

8  
9 UNITED STATES OF AMERICA,

10 Plaintiff,

11 v.

12 COUNTY OF LOS ANGELES AND  
13 LOS ANGELES COUNTY SHERIFF  
14 JIM MCDONNELL, in his Official  
15 Capacity,

16 Defendants.

CV No. 15- 5903

**JOINT SETTLEMENT  
AGREEMENT REGARDING THE  
LOS ANGELES COUNTY JAILS;  
AND STIPULATED [PROPOSED]  
ORDER OF RESOLUTION**

17 **I. INTRODUCTION**

18 1. The United States of America, acting through the United States  
19 Department of Justice (“United States”), the County of Los Angeles (“County”)  
20 and Sheriff Jim McDonnell, in his official capacity (“Sheriff”), (collectively, the  
21 “Parties”) share a mutual interest in treating all members of the community with  
22 respect, promoting safe and effective custodial care, protecting public safety, and  
23 upholding the constitutional rights of prisoners.<sup>1</sup>

24 2. The Los Angeles County Jails (“Jails”) are an integral part of the  
25 public safety system in Los Angeles County, California. Together, the Jails form

26  
27 <sup>1</sup> “Prisoners” is a defined term in Section III of this Agreement and includes  
28 pre-trial detainees and individuals convicted of a criminal offense.

1 the largest jail system in the nation and house among the highest populations of  
2 prisoners with mental illness. Maintaining these facilities is an immensely  
3 complex enterprise -- approximately 15,500 to 19,500 prisoners are held in custody  
4 daily, spread across multiple custody facilities, numerous patrol stations, and over  
5 29 courthouses. These facilities' primary function is to incarcerate individuals  
6 accused or convicted of committing a crime. In doing so, these facilities provide  
7 food, shelter, and clothing, but must also address the serious medical and mental  
8 health needs of the prisoners and ensure their reasonable safety.

9 3. The United States acknowledges that the County and the Sheriff have  
10 demonstrated a renewed commitment to reforming the Jails and have begun to  
11 implement improved policies and practices designed to enhance the treatment and  
12 care of prisoners with mental illness. The County and the Sheriff are also  
13 exploring strategies to safely divert individuals with mental illness from the  
14 criminal justice system, whenever possible. The United States further  
15 acknowledges that the number of suicides at the Jails decreased in 2014 from the  
16 previous year. In addition, the County and the Sheriff have made significant  
17 commitments to protect prisoners from abuse and excessive force by staff that  
18 further the Parties' mutual interest. Finally, the United States acknowledges that  
19 some of the needed changes the County and the Sheriff seek to implement through  
20 this Agreement will require the allocation of additional resources to the Sheriff's  
21 Department and the Los Angeles County Department of Mental Health ("DMH").

22 4. Accordingly, this Joint Settlement Agreement Regarding the Los  
23 Angeles County Jails ("Agreement") is intended to build upon measures that are  
24 underway and to sustain systemic improvements that are designed to protect  
25 prisoners from conditions in custody that place them at unreasonable risk of harm  
26 from suicide, self-injurious behavior, or unlawful injury by others, in accordance  
27 with their constitutional rights. This Agreement also is expected to have collateral  
28 benefits that promote public safety, improve confidence in the County's criminal

1 justice system, and support the County's and the Sheriff's collaborative efforts to  
2 expand comprehensive and effective mental health diversion and re-entry programs  
3 that are designed to lead to more positive outcomes in the care and custody of  
4 individuals with serious mental illness who are also participants in the criminal  
5 justice system.

## 6 **II. BACKGROUND**

7 5. The County owns and funds the operations of the Jails. The Sheriff's  
8 Department is responsible for providing care, custody, and control of prisoners at  
9 the Jails. The Sheriff's Department Medical Services Bureau provides medical  
10 care within the Jails. DMH is responsible for providing mental health care in the  
11 Jails through its Jail Mental Health Services program.

12 6. The Sheriff is an elected official who is responsible for operating and  
13 exercising authority over the Jails.

14 7. In June 1996, the Department of Justice notified the County and  
15 Sheriff that it was opening an investigation under the Civil Rights of  
16 Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, to determine whether  
17 the conditions in the Jails violate the constitutional rights of its prisoners.

18 8. In September 1997, the Department of Justice issued a findings letter  
19 alleging that mental health care at the Jails violated prisoners' constitutional rights.  
20 The letter further alleged that systemic deficiencies contributed to the violations,  
21 including inadequate: (1) intake screening and evaluation; (2) diagnosis; (3)  
22 referral to mental health professionals; (4) treatment plans; (5) administration of  
23 medications; (6) suicide prevention; (7) tracking and medical record keeping;  
24 (8) staffing; (9) communication; and (10) quality assurance.

25 9. In December 2002, following extensive negotiations and additional  
26 site visits, the Parties entered into a Memorandum of Agreement (MOA) that  
27 outlined a series of reforms to ensure that adequate and reasonable mental health  
28

1 care services are provided at the Jails. The MOA also included measures to protect  
2 prisoners with mental illness from abuse and mistreatment.

3 10. Under the MOA, the County and the Sheriff have made significant  
4 improvements to the delivery of mental health care at the Jails, including  
5 implementing electronic medical records, increasing mental health staffing, and  
6 developing roving evaluation teams composed of mental health professionals and  
7 specially-trained custody staff. Despite considerable progress, the United States  
8 alleges that systemic deficiencies remain related to suicide prevention and mental  
9 health care that violate prisoners' constitutional rights. The Department of Justice  
10 notified the County and the Sheriff of these allegations in a letter dated June 4,  
11 2014, following on-site evaluations with expert consultants.

12 11. In September 2013, the Department of Justice opened a separate  
13 investigation of the Jails under CRIPA and 42 U.S.C. § 14141 ("Section 14141")  
14 to address allegations of use of excessive force against all prisoners at the Jails, not  
15 just prisoners with mental illness. During the course of the investigation, the  
16 County and the Sheriff entered into a comprehensive settlement agreement to  
17 resolve *Rosas v. McDonnell*, Case No. CV 12-0428-DDP (C.D. Ca. filed on Jan.  
18 18, 2012) (hereinafter "*Rosas*"), a class action lawsuit alleging abuse and excessive  
19 force by staff at certain Jails located in downtown Los Angeles. As part of the  
20 *Rosas* settlement agreement, the County and the Sheriff have agreed to implement  
21 significant measures to protect prisoners from excessive force by staff, including  
22 improvements in policies, training, incident tracking and reporting, investigations,  
23 resolution of prisoner grievances, prisoner and staff supervision, and  
24 accountability.

25 12. This Agreement addresses remaining allegations concerning suicide  
26 prevention and mental health care at the Jails resulting from the partial  
27 implementation of the 2002 MOA and current conditions within the Jails. This  
28 Agreement also extends the remedial measures in the Implementation Plan of the

1 Rosas settlement agreement to fully resolve the Department of Justice's CRIPA  
2 findings regarding alleged mistreatment of prisoners with mental illness and claims  
3 under Section 14141 regarding alleged excessive force against prisoners at all of  
4 the Jails.

5 13. As indicated in Section VII of this Agreement, the Parties consent to a  
6 finding that this Agreement complies in all respects with the provisions of the  
7 Prison Litigation Reform Act, 18 U.S.C. § 3626(a).

8 14. Except to enforce, modify, or terminate this Agreement, this  
9 Agreement, and any findings made to effectuate this Agreement, will not be  
10 admissible against either the County or the Sheriff in any court for any purpose.  
11 Moreover, this Agreement is not an admission of any liability on the part of the  
12 County or the Sheriff, and/or either of its employees, agents, and former employees  
13 and agents, or any other persons, and will not constitute evidence of any pattern or  
14 practice of wrongdoing.

15 **III. DEFINITIONS**

16 15. The following definitions will apply to terms in this Agreement:

- 17 (a) "Sheriff's Department" refers to the Los Angeles County Sheriff's  
18 Department, which is responsible for all custody, corrections, and  
19 security functions within the Los Angeles County Jails system,  
20 including the provision of medical care to prisoners through the  
21 Sheriff's Department Medical Services Bureau.
- 22 (b) "Jails" refers to the Los Angeles County Jails system, and shall  
23 include Men's Central Jail ("MCJ"), Twin Towers Correctional  
24 Facility ("TTCF"), Inmate Reception Center ("IRC"), Century  
25 Regional Detention Facility ("CRDF"), North County Correctional  
26 Facility ("NCCF"), Pitchess Detention Center ("PDC"), and other  
27 facilities in which prisoners are detained or held in custody by the  
28 County and the Sheriff, including lockup facilities and courthouse

1 holding areas as well as any visiting area in the facility, and any  
2 facility that is built, leased, or otherwise used, to replace or  
3 supplement the current Jails or any part of the Jails.

4 (c) "United States" or "DOJ" refers to the United States Department of  
5 Justice, specifically the Special Litigation Section of the Civil Rights  
6 Division and the United States Attorney's Office for the Central  
7 District of California, which represent the United States in this matter.

8 (d) "The County" refers to the County of Los Angeles, the Los Angeles  
9 County Sheriff's Department, the Los Angeles County Department of  
10 Mental Health, and the agents and employees of the Sheriff's  
11 Department and the Department of Mental Health. The Department  
12 of Mental Health ("DMH") includes any successor County department  
13 that assumes the duties and responsibilities of DMH.

14 (e) "Sheriff" refers to the Los Angeles County Sheriff, currently Jim  
15 McDonnell, an independently-elected constitutional officer, in his  
16 official capacity, and any predecessors or successors in office,  
17 including any designated acting or interim Sheriff.

18 (f) "Custody staff" means sworn deputy sheriffs and custody assistants.

19 (g) "Days" are measured in calendar days; weekend days and County  
20 holidays are included.

21 (h) "Normal business work days" means all days except for weekend days  
22 and County holidays.

23 (i) "Describe" means provide a clear and detailed description of  
24 something done, experienced, seen, or heard.

25 (j) "Document" when used in this Agreement as a verb means  
26 completing a record of information either in hard copy or in electronic  
27 format.  
28

- 1 (k) "Effective Date" means the date the Court enters the signed  
2 Agreement as an order of the Court, or July 1, 2015, whichever is  
3 earlier.
- 4 (l) "Emergency maintenance needs" means a need that if left unattended  
5 could result in imminent danger to the life, safety, or health of  
6 prisoners.
- 7 (m) An "emergent" or "urgent" mental health need, as used in this  
8 Agreement, is one which the Arrestee Medical Screening Form (SH-  
9 R-422) or its equivalent and/or the Medical/Mental Health Screening  
10 Questionnaire indicate that immediate action is required to preserve  
11 life, prevent serious bodily harm, or relieve significant suffering.
- 12 (n) "Good cause" means fair and honest reasons, regulated by good faith  
13 on the part of either party, that are not arbitrary, capricious, trivial, or  
14 pretextual.
- 15 (o) "Implement" or "implementation" means putting a remedial measure  
16 into effect, including informing, instructing, or training impacted  
17 personnel as required by this Agreement, and ensuring that policies or  
18 procedures are in fact followed.
- 19 (p) "Include," "includes," or "including" means "include, but not be  
20 limited to" or "including, but not limited to."
- 21 (q) "Jail Reception Centers" mean all Sheriff's Department processing  
22 facilities that handle incoming bookings and arrests and that are  
23 responsible for medical and mental health screenings and  
24 classification, including the Inmate Reception Center and the Century  
25 Regional Detention Facility. This does not include Sheriff's  
26 Department station jails.
- 27  
28

- 1 (r) "Mental Health Housing" refers to prisoner housing areas in the Jails  
2 that include only the Forensic In-Patient (FIP), High Observation  
3 Housing (HOH), and Moderate Observation Housing (MOH) areas.
- 4 (i) "Correctional Treatment Center" or "CTC" refers to the  
5 licensed health facility with a specified number of beds within  
6 the Jails designated to provide health care to that portion of the  
7 prisoner population that does not require a general acute care  
8 level of services, but which is in need of professionally  
9 supervised health care beyond that normally provided in the  
10 community on an outpatient basis.
- 11 (ii) "Forensic In-Patient" or "FIP" can be used interchangeably  
12 with Mental Health Unit of the Correctional Treatment Center  
13 (MHU CTC). The FIP is located in the CTC and houses  
14 prisoners who present an acute danger to self or others or are  
15 gravely disabled due to a mental illness and require inpatient  
16 care.
- 17 (iii) "High Observation Housing" or "HOH" refers to designated  
18 areas for prisoners with mental illness who require an intensive  
19 level of observation and care and/or safety precautions.
- 20 (iv) "Moderate Observation Housing" or "MOH" refers to  
21 designated areas for prisoners with a broad range of mental  
22 health diagnoses and functioning whose mental health needs  
23 can be cared for in a less intensive and more open setting than  
24 the HOH areas, but preclude general population housing.
- 25 (s) "Monitor" or "Independent Monitor" means the individual selected by  
26 the Parties whose duties, responsibilities, and authority are set forth in  
27 Section VI of this Agreement.  
28

- 1 (t) "Subject Matter Experts" or "SMEs" means the individuals selected  
2 by the Parties whose duties, responsibilities, and authority are set forth  
3 in Section VI of this Agreement.
- 4 (u) "Prisoners" or "Prisoner" is construed broadly to refer to one or more  
5 individuals detained at, or otherwise housed, held, in the custody of,  
6 or confined at the Jails based on arrests, detainers, criminal charges,  
7 civil contempt charges, or convictions.
- 8 (v) "Psychotropic medication" means any substance used to treat mental  
9 health problems or mental illness and is capable of modifying mental  
10 activity or behavior.
- 11 (w) "Qualified Medical Staff" refers to physicians, physician assistants,  
12 nurse practitioners, registered nurses, certified nursing assistants, and  
13 licensed vocational nurses, each of whom is permitted by law to  
14 evaluate and care for the medical needs of patients.
- 15 (x) "Qualified Mental Health Professional" or "QMHP" refers to  
16 psychiatrists, psychologists, psychiatric social workers, psychiatric  
17 nurses, and others who by virtue of their education, credentials, and  
18 experience are permitted by law to evaluate and care for the mental  
19 health needs of patients.
- 20 (y) "Clinical Restraints" is any device that limits a person's ability to  
21 move freely and has been ordered or approved by a licensed  
22 psychiatrist for the purpose of managing behavior that appears to be  
23 symptomatic of a mental illness.
- 24 (z) "Security Restraints" is any device that limits a person's ability to  
25 move freely and has not been ordered by a licensed psychiatrist or  
26 Qualified Medical Staff.
- 27 (aa) "Serious mental illness" includes psychotic disorders, major mood  
28 disorders (including major depression and bipolar disorders), and any

1 other condition (excluding personality disorders, substance abuse and  
2 dependence disorders, dementia, and developmental disability) that is  
3 associated with serious or recurrent significant self-harm, suicidal  
4 ideation, imminent danger to others, current grave disability, or  
5 substantially impaired ability to understand routine instructions, or  
6 that prevents access to available programs. Although personality  
7 disorders alone generally do not qualify as serious mental illness,  
8 personality disorders associated with serious or recurrent significant  
9 self-harm do qualify as serious mental illnesses.

10 (bb) "Suicide attempt" means any serious effort to commit an act of self-  
11 harm that can result in death and involving definite risk.

12 (cc) "Serious suicide attempt" means a suicide attempt that resulted in or  
13 could have resulted in significant and life-threatening injury.

14 (dd) "Suicide Precautions" means any level of watch, observation, or  
15 measures specifically intended to prevent suicide or self-harm and  
16 includes both Suicide Watch and Risk Precautions as defined in this  
17 Agreement.

18 (ee) "Suicide Watch" means the level of watch, observation, or measures  
19 intended to identify and safely maintain prisoners who are imminently  
20 suicidal and require admission to the Mental Health Unit of the  
21 Correctional Treatment Center (MHU CTC or FIP) on a 72-hour hold,  
22 in accordance with California Welfare and Institutions Code Section  
23 5150.

24 (ff) "Risk Precautions" means a level of watch, observation, or measures  
25 used to identify and safely maintain those prisoners who require  
26 heightened observation and daily re-evaluation, and require admission  
27 to HOH but are not considered to pose an imminent risk of suicide.  
28

- 1 (gg) "Suicide resistant location" means a housing assignment in which  
2 known or apparent suicide hazards do not exist or have been removed.
- 3 (hh) "Self-injurious behavior" means any behavior that is self-directed and  
4 deliberately results in injury or the potential for injury to oneself and  
5 there is no evidence of suicidal intent.
- 6 (ii) "Serious self-injurious behavior" means self-injurious behavior where  
7 the injury is significant enough that it could lead to loss of life or limb  
8 or have serious medical complications.
- 9 (jj) "Direct constant observation" means continuous uninterrupted  
10 observation of a prisoner within a proximity that ensures the observer  
11 can both see and hear the prisoner to assure the prisoner's well-being,  
12 absent extraordinary circumstances.
- 13 (kk) "Unobstructed visual observation" means continuous but not  
14 necessarily uninterrupted observation within a reasonable physical  
15 distance of the prisoner(s).
- 16 (ll) "Train" means to instruct in skills to a level that the trainee has the  
17 demonstrated proficiency, through an assessment or evaluation, to  
18 implement those skills as and when called for. "Trained" means  
19 proficient in the skills.
- 20 (mm) Throughout this Agreement, the following terms are used when  
21 discussing compliance: substantial compliance, partial compliance,  
22 and non-compliance. "Substantial Compliance" means that the  
23 County and the Sheriff have achieved compliance with the material  
24 components of the relevant provision of this Agreement in accordance  
25 with the Monitor and SMEs' monitoring plan and compliance  
26 measures. "Partial Compliance" means that the County and the  
27 Sheriff have achieved compliance on some, but not all, of the material  
28 components of the relevant provision of this Agreement. "Non-

1 compliance” means that the County and the Sheriff have not met most  
2 or all of the material components of the relevant provision of this  
3 Agreement. Non-compliance with mere technicalities, or temporary  
4 failure to comply coupled with prompt and appropriate corrective  
5 action during a period of otherwise sustained compliance, will not  
6 constitute failure to maintain Substantial Compliance. At the same  
7 time, temporary compliance during a period of otherwise sustained  
8 Non-compliance will not constitute Substantial Compliance.

9 (nn) “Policy” or “Policies” mean regulations, directives, or manuals,  
10 regardless of name, that have been approved by a senior executive  
11 within the Sheriff's Department (“LASD”) or DMH and that describe  
12 the duties, functions, or obligations of LASD or DMH staff and  
13 provide specific direction in how to fulfill those duties, functions, or  
14 obligations. References to “existing” policies mean those policies in  
15 effect on the Effective Date of this Agreement, and include any  
16 subsequent revisions or changes made to those policies after the  
17 Effective Date of this Agreement.

#### 18 **IV. OVERALL OBJECTIVES AND GOALS**

19 16. Consistent with constitutional standards, the County and the Sheriff  
20 will provide prisoners at the Jails with safe and secure conditions and ensure their  
21 reasonable safety from harm, including serious risk from self-harm and excessive  
22 force, and ensure adequate treatment for their serious mental health needs. In order  
23 to achieve and maintain these objectives, the County and the Sheriff agree to  
24 continue, and where appropriate enhance, their current policies and practices, and  
25 to implement the additional measures set forth in this Agreement.

26 17. The Parties recognize that the County and the Sheriff have made  
27 considerable progress to improve conditions and the delivery of mental health care  
28 at the Jails, but that additional measures are necessary to provide prisoners at the

1 Jails with safe and secure conditions, ensure their reasonable safety from harm,  
2 including serious risk from self-harm and excessive force, and meet the serious  
3 mental health needs of prisoners, in accordance with prisoners' constitutional  
4 rights. The measures set forth in this Agreement address the following areas: (1)  
5 training; (2) suicide hazard inspections; (3) intake; (4) medical records; (5) mental  
6 health referrals; (6) mental health follow-up; (7) suicide risk procedures; (8)  
7 staffing; (9) environmental conditions; (10) allowable property privileges; (11)  
8 communication related to mental health; (12) safety checks; (13) quality  
9 improvement plan; (14) mental health housing; (15) medication; (16) restraints;  
10 (17) suicide death reviews and critical incident reviews; (18) mental health  
11 treatment; and (19) use of force. The County and the Sheriff agree to maintain an  
12 adequate system of mental health screening, assessment, treatment planning, and  
13 record-keeping as specifically set forth in this Agreement.

14 **V. SUBSTANTIVE PROVISIONS**

15 **A. Training**

16 18. Within three months of the Effective Date, the County and the Sheriff  
17 will develop, and within six months of the Effective Date will commence  
18 providing: (1) a four-hour custody-specific, scenario-based, skill development  
19 training on suicide prevention, which can be part of the eight-hour training  
20 described in paragraph 4.8 of the Implementation Plan in *Rosas* to all new  
21 Deputies as part of the Jail Operations Continuum and to all new Custody  
22 Assistants at the Custody Assistants academy; and (2) a two-hour custody-specific,  
23 scenario-based, skill development training on suicide prevention to all existing  
24 Deputies and Custody Assistants at their respective facilities, which can be part of  
25 the eight-hour training described in paragraph 4.7 of the Implementation Plan in  
26 *Rosas*, through in-service Intensified Formatted Training, which training will be  
27 completed by December 31, 2016.

28 These trainings will include the following topics:

- 1 (a) suicide prevention policies and procedures, including observation and
- 2 supervision of prisoners at risk for suicide or self-injurious behavior;
- 3 (b) discussion of facility environments and staff interactions and why
- 4 they may contribute to suicidal behavior;
- 5 (c) potential predisposing factors to suicide;
- 6 (d) high-risk suicide periods and settings;
- 7 (e) warning signs and symptoms of suicidal behavior;
- 8 (f) case studies of recent suicides and serious suicide attempts;
- 9 (g) emergency notification procedures;
- 10 (h) mock demonstrations regarding the proper response to a suicide
- 11 attempt, including a hands-on simulation experience that incorporates
- 12 the challenges that often accompany a jail suicide, such as cell doors
- 13 being blocked by a hanging body and delays in securing back-up
- 14 assistance;
- 15 (i) differentiating between suicidal and self-injurious behavior; and
- 16 (j) the proper use of emergency equipment.

17 19. Commencing July 1, 2015, the County and the Sheriff will provide:

- 18 (a) Custody-specific, scenario-based, skill development training to new
- 19 Deputies during their Jail Operations training, and to existing
- 20 Deputies assigned to Twin Towers Correctional Facility, Inmate
- 21 Reception Center, Men's Central Jail, the Mental Health Housing
- 22 Units at Century Regional Detention Facility, and the Jail Mental
- 23 Evaluation Teams ("JMET") at North County Correctional Facility as
- 24 follows:
  - 25 (i) 32 hours of Crisis Intervention and Conflict Resolution as
  - 26 described in paragraphs 4.6 and 4.9 of the Implementation Plan
  - 27 in *Rosas* to be completed within the time frames established in
  - 28 that case (currently December 31, 2016). Deputies at these

1 facilities will receive an eight hour refresher course consistent  
2 with paragraph 4.6 of the Implementation Plan in *Rosas* every  
3 other year until termination of court jurisdiction in that case and  
4 then a four hour refresher course every other year thereafter.

5 (ii) Eight hours identifying and working with mentally ill prisoners  
6 as described in paragraph 4.7 of the Implementation Plan in  
7 *Rosas* to be completed by December 31, 2016. This training  
8 requirement may be a part of the 32-hour training described in  
9 the previous subsection. Deputies at these facilities will receive  
10 a four hour refresher course consistent with paragraph 4.7 of the  
11 Implementation Plan in *Rosas* every other year thereafter.

12 (b) Commencing July 1, 2015, the County and the Sheriff will ensure that  
13 new Custody Assistants receive eight hours of training in the Custody  
14 Assistant academy, and that all existing Custody Assistants receive  
15 eight hours of training, related to identifying and working with  
16 mentally ill prisoners as described in paragraph 4.7 of the  
17 Implementation Plan in *Rosas*. This training will be completed by  
18 December 31, 2016. Custody Assistants will receive a four hour  
19 refresher course consistent with paragraph 4.7 of the Implementation  
20 Plan in *Rosas* every other year thereafter.

21 20. Commencing no later than July 1, 2017, the County and the Sheriff  
22 will provide:

23 (a) Custody-specific, scenario-based, skill development training to  
24 existing Deputies assigned to North County Correctional Facility,  
25 Pitchess Detention Center, and the non-Mental Health Housing Units  
26 in Century Regional Detention Facility as follows:

27 (i) 32 hours of Crisis Intervention and Conflict Resolution as  
28 described in paragraphs 4.6 and 4.9 of the Implementation Plan

1 in *Rosas* to be completed by December 31, 2019. Deputies at  
2 these facilities will receive an eight hour refresher course  
3 consistent with paragraph 4.6 of the Implementation Plan in  
4 *Rosas* every other year until termination of court jurisdiction in  
5 that case and then a four hour refresher course every other year  
6 thereafter.

7 (ii) Eight hours identifying and working with mentally ill prisoners  
8 as described in paragraph 4.7 of the Implementation Plan in  
9 *Rosas* to be completed by December 31, 2019. This training  
10 requirement may be a part of the 32-hour training described in  
11 the previous subsection. Deputies at these facilities will receive  
12 a four hour refresher course consistent with paragraph 4.7 of the  
13 Implementation Plan in *Rosas* every other year thereafter.

14 21. Consistent with existing Sheriff's Department policies regarding  
15 training requirements for sworn personnel, the County and the Sheriff will ensure  
16 that existing custody staff that have contact with prisoners maintain active  
17 certification in cardiopulmonary resuscitation and first aid.

18 22. Within six months of the Effective Date and at least annually  
19 thereafter, the County and the Sheriff will provide instructional material, to all  
20 Sheriff station personnel, Sheriff court personnel, custody booking personnel, and  
21 outside law enforcement agencies on the use of arresting and booking documents,  
22 including the Arrestee Medical Screening Form, to ensure the sharing of known  
23 relevant and available information on prisoners' mental health status and suicide  
24 risk. Such instructional material will be in addition to the training provided to all  
25 custody booking personnel regarding intake.

26 **B. Suicide Hazard Inspections**

27 23. Within three months of the Effective Date, the County and the Sheriff  
28 will commence a systematic review of all prisoner housing, beginning with the

1 Mental Health Unit of the Correctional Treatment Center, all High Observation  
2 Housing areas, all Moderate Observation Housing areas, single-person discipline,  
3 and areas in which safety precautions are implemented, to reduce the risk of self-  
4 harm and to identify and address suicide hazards. The County and the Sheriff will  
5 utilize a nationally-recognized audit tool for the review. From this tool, the County  
6 and the Sheriff will:

- 7 (a) develop short and long term plans to reasonably mitigate suicide  
8 hazards identified by this review; and  
9 (b) prioritize planning and mitigation in areas where suicide precautions  
10 are implemented and seek reasonable mitigation efforts in those areas.

11 24. The County and the Sheriff will review and inspect housing areas on  
12 at least an annual basis to identify suicide hazards.

13 **C. Intake**

14 25. The County and the Sheriff will ensure that any prisoner in a Sheriff's  
15 Department station jail who verbalizes or who exhibits a clear and obvious  
16 indication of current suicidal intent will be transported to IRC, CRDF, or a medical  
17 facility as soon as practicable. Pending transport, such prisoners will be under  
18 unobstructed visual observation, or in a suicide resistant location with safety  
19 checks every 15 minutes.

20 26. Consistent with existing Sheriff's Department policies, the County  
21 and the Sheriff will follow established screening procedures to identify prisoners  
22 with emergent or urgent mental health needs based upon information contained in  
23 the Arrestee Medical Screening Form (SH-R-422) or its equivalent and the  
24 Medical/Mental Health Screening Questionnaire and to expedite such prisoners for  
25 mental health evaluation upon arrival at the Jail Reception Centers and prior to  
26 routine screening. Prisoners who are identified as having emergent or urgent  
27 mental health needs, including the need for emergent psychotropic medication, will  
28

1 be evaluated by a QMHP as soon as possible but no later than four hours from the  
2 time of identification.

3 27. Consistent with existing Sheriff's Department policies, the County  
4 and the Sheriff will ensure that all prisoners are individually and privately screened  
5 by Qualified Medical Staff or trained custody personnel as soon as possible upon  
6 arrival to the Jails, but no later than 12 hours, barring an extraordinary  
7 circumstance, to identify a prisoner's need for mental health care and risk for  
8 suicide or self-injurious behavior. The County and the Sheriff will ensure that the  
9 Medical/Mental Health Screening Questionnaire, the Arrestee Medical Screening  
10 Form (SH-R-422) or its equivalent, and/or the Confidential Medical Mental Health  
11 Transfer Form are in the prisoner's electronic medical record or otherwise  
12 available at the time the prisoner is initially assessed by a QMHP.

13 28. The County and the Sheriff will ensure that any prisoner who has been  
14 identified during the intake process as having emergent or urgent mental health  
15 needs as described in Paragraph 26 of this Agreement will be expedited through  
16 the booking process. While the prisoner awaits evaluation, the County and the  
17 Sheriff will maintain unobstructed visual observation of the prisoner when  
18 necessary to protect his or her safety, and will conduct 15-minute safety checks if  
19 the prisoner is in a cell.

20 29. The County and the Sheriff will ensure that a QMHP conducts a  
21 mental health assessment of prisoners who have non-emergent mental health needs  
22 within 24 hours (or within 72 hours on weekends and legal holidays) of a  
23 registered nurse conducting an intake nursing assessment at IRC or CRDF.

24 30. Consistent with existing DMH policies, the initial mental health  
25 assessment will include a brief initial treatment plan. The initial treatment plan  
26 will address housing recommendations and preliminary discharge information.  
27 During the initial assessment, a referral will be made for a more comprehensive  
28 mental health assessment if clinically indicated. The initial assessment will

1 identify any immediate issues and determine whether a more comprehensive  
2 mental health evaluation is indicated. The Monitor and SMEs will monitor  
3 whether the housing recommendations in the initial treatment plan have been  
4 followed.

5 **D. Medical Records**

6 31. Consistent with existing DMH and Sheriff's Department policies, the  
7 County and the Sheriff will maintain electronic mental health alerts in prisoners'  
8 electronic medical records that notify medical and mental health staff of a  
9 prisoner's risk for suicide or self-injurious behavior. The alerts will be for the  
10 following risk factors:

- 11 (a) current suicide risk;
- 12 (b) hoarding medications; and
- 13 (c) prior suicide attempts.

14 32. Information regarding a serious suicide attempt will be entered in the  
15 prisoner's electronic medical record in a timely manner.

16 33. The County will require mental health supervisors in the Jails to  
17 review electronic medical records on a quarterly basis to assess their accuracy as  
18 follows:

- 19 (a) Supervisors will randomly select two prisoners from each clinician's  
20 caseload in the prior quarter;
- 21 (b) Supervisors will compare records for those prisoners to corroborate  
22 clinician attendance, units of service, and any unusual trends,  
23 including appropriate time spent with prisoners, recording more units  
24 of service than hours worked, and to determine whether contacts with  
25 those prisoners are inconsistent with their clinical needs;
- 26 (c) Where supervisors identify discrepancies through these reviews, they  
27 will conduct a more thorough review using a DMH-developed  
28

1 standardized tool and will consider detailed information contained in  
2 the electronic medical record and progress notes;

- 3 (d) Serious concerns remaining after the secondary review will be  
4 elevated for administrative action in consultation with DMH's  
5 centralized Human Resources.

6 34. The County and the Sheriff will conduct discharge planning and  
7 linkage to community mental health providers and aftercare services for all  
8 prisoners with serious mental illness as follows:

9 (a) For prisoners who are in Jail seven days or less, a preliminary  
10 treatment plan, including discharge information, will be developed.

11 (b) For prisoners who are in Jail more than seven days, a QMHP will also  
12 make available:

13 (i) for prisoners who are receiving psychotropic medications, a 30-  
14 day prescription for those medications will be offered either  
15 through the release planning process, through referral to a re-  
16 entry resource center, or through referral to an appropriate  
17 community provider, unless clinically contraindicated;

18 (ii) in-person consultation to address housing, mental  
19 health/medical/substance abuse treatment, income/benefits  
20 establishment, and family/community/social supports. This  
21 consultation will also identify specific actions to be taken and  
22 identify individuals responsible for each action;

23 (iii) if the prisoner has an intense need for assistance, as described in  
24 DMH policies, the prisoner will further be provided direct  
25 linkage to an Institution for Mental Disease ("IMD"), IMD-  
26 Step-down facility, or appropriately licensed hospital;

27 (iv) if the prisoner has a moderate need for assistance, as described  
28 in DMH policies, and as clinically appropriate to the needs of

1 the prisoner, the prisoner will be offered enrollment in Full  
2 Service Partnership or similar program, placement in an Adult  
3 Residential Facility (“Board and Care”) or other residential  
4 treatment facility, and direct assistance accessing community  
5 resources; and

6 (v) if the prisoner has minimal needs for assistance, as described in  
7 DMH policies, the prisoner will be offered referrals to routine  
8 services as appropriate, such as General Relief, Social Security,  
9 community mental health clinics, substance abuse programs,  
10 and/or outpatient care/support groups.

11 (c) The County will provide a re-entry resource center with QMHPs  
12 available to all prisoners where they may obtain information about  
13 available mental health services and other community resources.

14 **E. Mental Health Referrals**

15 35. Consistent with existing DMH and Sheriff’s Department policies, the  
16 County and the Sheriff will ensure that custody staff, before the end of shift, refer  
17 prisoners in general or special populations who are demonstrating a potential need  
18 for routine mental health care to a QMHP or a Jail Mental Evaluation Team  
19 (“JMET”) member for evaluation, and document such referrals. Custody staff will  
20 utilize the Behavior Observation and Referral Form.

21 36. Consistent with existing DMH policies, the County and the Sheriff  
22 will ensure that a QMHP performs a mental health assessment after any adverse  
23 triggering event, such as a suicide attempt, suicide threat, self-injurious behavior,  
24 or any clear decompensation of mental health status. For those prisoners who  
25 repeatedly engage in self-injurious behavior, the County will perform such a  
26 mental health assessment only when clinically indicated, and will, when clinically  
27 indicated, develop an individualized treatment plan to reduce, and minimize  
28 reinforcement of, such behavior. The County and the Sheriff will maintain an on-

1 call system to ensure that mental health assessments are conducted within four  
2 hours following the notification of the adverse triggering event or upon notification  
3 that the prisoner has returned from a medical assessment related to the adverse  
4 triggering event. The prisoner will remain under unobstructed visual observation  
5 by custody staff until a QMHP has completed his or her evaluation.

6 37. Sheriff's Court Services Division staff will complete a Behavioral  
7 Observation and Mental Health Referral Form and forward it to the Jail's mental  
8 health and/or medical staff when the Court Services Division staff obtains  
9 information that indicates a prisoner has displayed obvious suicidal ideation or  
10 when the prisoner exhibits unusual behavior that clearly manifests self-injurious  
11 behavior, or other clear indication of mental health crisis. Pending transport, such  
12 prisoner will be under unobstructed visual observation or subject to 15-minute  
13 safety checks.

14 38. Consistent with existing DMH policies and National Commission on  
15 Correctional Health Care standards for jails, the County and the Sheriff will ensure  
16 that mental health staff or JMET teams make weekly cell-by-cell rounds in  
17 restricted non-mental health housing modules (e.g., administrative segregation,  
18 disciplinary segregation) at the Jails to identify prisoners with mental illness who  
19 may have been missed during screening or who have decompensated while in the  
20 Jails. In conducting the rounds, either the clinician, the JMET deputy, or the  
21 prisoner may request an out-of-cell interview. This request will be granted unless  
22 there is a clear and documented security concern that would prohibit such an  
23 interview or the prisoner has a documented history of repeated, unjustified requests  
24 for such out-of-cell interviews.

25 39. The County and the Sheriff will continue to use a confidential self-  
26 referral system by which all prisoners can request mental health care without  
27 revealing the substance of their request to custody staff or other prisoners.

28

1           40. The County and the Sheriff will ensure a QMHP will be available on-  
2 site, by transportation of the prisoner, or through tele-psych 24 hours per day,  
3 seven days per week (24/7) to provide clinically appropriate mental health crisis  
4 intervention services.

5           **F. Mental Health Follow Up**

6           41. Consistent with existing DMH policies, the County and the Sheriff  
7 will implement step-down protocols that provide clinically appropriate transition  
8 when prisoners are discharged from FIP after being the subject of suicide watch.  
9 The protocols will provide:

- 10           (a) intermediate steps between highly restrictive suicide measures (e.g.,  
11           clinical restraints and direct constant observation) and the  
12           discontinuation of suicide watch;  
13           (b) an evaluation by a QMHP before a prisoner is removed from suicide  
14           watch;  
15           (c) every prisoner discharged from FIP following a period of suicide  
16           watch will be housed upon release in the least restrictive setting  
17           deemed clinically appropriate unless exceptional circumstances  
18           affecting the facility exist; and  
19           (d) all FIP discharges following a period of suicide watch will be seen by  
20           a QMHP within 72 hours of FIP release, or sooner if indicated, unless  
21           exceptional circumstances affecting the facility exist.

22           42. Consistent with existing DMH policies, the County and the Sheriff  
23 will implement step-down protocols to ensure that prisoners admitted to HOH and  
24 placed on risk precautions are assessed by a QMHP. As part of the assessment, the  
25 QMHP will determine on an individualized basis whether to implement “step-  
26 down” procedures for that prisoner as follows:  
27  
28

- 1 (a) the prisoner will be assessed by a QMHP within three Normal  
2 business work days, but not to exceed four Days, following  
3 discontinuance of risk precautions;
- 4 (b) the prisoner is counseled to ameliorate the negative psychological  
5 impact that any restrictions may have had and in ways of dealing with  
6 this impact;
- 7 (c) the prisoner will remain in HOH or be transferred to MOH, as  
8 determined on a case by case basis, until such assessment and  
9 counseling is completed, unless exceptional circumstances affecting  
10 the facility exist; and
- 11 (d) the prisoner is subsequently placed in a level of care/housing as  
12 determined by a QMHP.

13 43. Within six months of the Effective Date, the County and the Sheriff  
14 will develop and implement written policies for formal discipline of prisoners with  
15 serious mental illness incorporating the following:

- 16 (a) Prior to transfer, custody staff will consult with a QMHP to determine  
17 whether assignment of a prisoner in mental health housing to  
18 disciplinary housing is clinically contraindicated and whether  
19 placement in a higher level of mental health housing is clinically  
20 indicated, and will thereafter follow the QMHP's recommendation;
- 21 (b) If a prisoner is receiving psychotropic medication and is placed in  
22 disciplinary housing from an area other than mental health housing, a  
23 QMHP will meet with that prisoner within 24 hours of such placement  
24 to determine whether maintenance of the prisoner in such placement is  
25 clinically contraindicated and whether transfer of the prisoner to  
26 mental health housing is clinically appropriate, and custody staff will  
27 thereafter follow the QMHP's recommendation;
- 28

1 (c) A QMHP will participate in weekly walks, as specified in Paragraph  
2 38, in disciplinary housing areas to observe prisoners in those areas  
3 and to identify those prisoners with mental health needs;

4 (d) Prior to a prisoner in mental health housing losing behavioral credits  
5 for disciplinary reasons, the disciplinary decision-maker will receive  
6 and take into consideration information from a QMHP regarding the  
7 prisoner's underlying mental illness, the potential effects of the  
8 discipline being considered, and whether transfer of the prisoner to a  
9 higher level of mental health housing is clinically indicated.

10 **G. Suicide Risk Procedures**

11 44. Within six months of the Effective Date, the County and the Sheriff  
12 will install protective barriers that do not prevent line-of-sight supervision on the  
13 second floor tier of all High Observation Housing areas to prevent prisoners from  
14 jumping off of the second floor tier. Within six months of the Effective Date, the  
15 County and the Sheriff will also develop a plan that identifies any other areas in  
16 mental health housing where such protective barriers should be installed.

17 45. Consistent with existing Sheriff's Department policies, the County  
18 and the Sheriff will provide both a Suicide Intervention Kit that contains an  
19 emergency cut-down tool and a first-aid kit in the control booth or officer's station  
20 of each housing unit. All custody staff who have contact with prisoners will know  
21 the location of the Suicide Intervention Kit and first-aid kit and be trained to use  
22 their contents.

23 46. The County and the Sheriff will immediately interrupt, and if  
24 necessary, provide appropriate aid to, any prisoner who threatens or exhibits self-  
25 injurious behavior.

26 **H. Staffing**

27 47. The County and the Sheriff will ensure there are sufficient custodial,  
28 medical, and mental health staff at the Jails to fulfill the terms of this Agreement.

1 Within six months of the Effective Date, and on a semi-annual basis thereafter, the  
2 County and the Sheriff will, in conjunction with the requirements of Paragraph 92  
3 of this Agreement, provide to the Monitor and DOJ a report identifying the steps  
4 taken by the County and the Sheriff during the review period to implement the  
5 terms of this Agreement and any barriers to implementation, such as insufficient  
6 staffing levels at the Jails, if any. The County and the Sheriff will retain staffing  
7 records for two years to ensure that for any critical incident or non-compliance  
8 with this Agreement, the Monitor and DOJ can obtain those records to determine  
9 whether staffing levels were a factor in that critical incident and/or non-  
10 compliance.

11 **I. Environmental Conditions**

12 48. Within three months of the Effective Date, the County and the Sheriff  
13 will have written housekeeping, sanitation, and inspection plans to ensure the  
14 proper cleaning of, and trash collection and removal in, housing, shower, and  
15 medical areas, in accordance with California Code of Regulations (“CCR”) Title  
16 15 § 1280: Facility Sanitation, Safety, and Maintenance.

17 49. Within three months of the Effective Date, the County and the Sheriff  
18 will have a maintenance plan to respond to routine and emergency maintenance  
19 needs, including ensuring that shower, toilet, sink, and lighting units, and heating,  
20 ventilation, and cooling systems are adequately maintained and installed. The plan  
21 will also include steps to treat large mold infestations.

22 50. Consistent with existing Sheriff’s Department policies regarding  
23 control of vermin, the County and the Sheriff will provide pest control throughout  
24 the housing units, medical units, kitchen, and food storage areas.

25 51. Consistent with existing Sheriff’s Department policies regarding  
26 personal care items and supplies for inmates, the County and the Sheriff will  
27 ensure that all prisoners have access to basic hygiene supplies, in accordance with  
28 CCR Title 15 § 1265: Issue of Personal Care Items.

1       **J.     Allowable Property Privileges**

2           52.    The County and the Sheriff will implement policies governing  
3 property restrictions in High Observation Housing that provide:

4           (a)    Except when transferred directly from FIP, upon initial placement in  
5                HOH:

6                (i)    Suicide-resistant blankets, gowns, and mattresses will be  
7                    provided until the assessment set forth in section (a)(ii) below is  
8                    conducted, unless clinically contraindicated as determined and  
9                    documented by a QMHP.

10              (ii)   Within 24 hours, a QMHP will make recommendations  
11                  regarding allowable property based upon an individual clinical  
12                  assessment.

13           (b)    Property restrictions in HOH beyond 24 hours will be based on  
14                  clinical judgment and assessment by a QMHP as necessary to ensure  
15                  the safety and well-being of the prisoner and documented in the  
16                  Electronic Medical Record.

17           53.    If otherwise eligible for an education, work, or similar program, a  
18 prisoner's mental health diagnosis or prescription for medication alone will not  
19 preclude that prisoner from participating in said programming.

20           54.    Prisoners who are not in Mental Health Housing will not be denied  
21 privileges and programming based solely on their mental health status or  
22 prescription for psychotropic medication.

23       **K.     Communication Related to Mental Health**

24           55.    Relevant custody, medical, and mental health staff in all High  
25 Observation Housing units will meet on Normal business work days and such staff  
26 in all Moderate Observation Housing units will meet at least weekly to ensure  
27 coordination and communication regarding the needs of prisoners in mental health  
28 housing units as outlined in Custody Services Division Directive(s) regarding

1 coordination of mental health treatment and housing. When a custody staff  
2 member is serving as a member of a treatment team, he or she is subject to the  
3 same confidentiality rules and regulations as any other member of the treatment  
4 team, and will be trained in those rules and regulations.

5 56. Consistent with existing DMH and Sheriff's Department policies, the  
6 County and the Sheriff will ensure that custody, medical, and mental health staff  
7 communicate regarding any change in a prisoner's housing assignment following a  
8 suicide threat, gesture, or attempt, or other indication of an obvious and serious  
9 change in mental health condition.

10 **L. Safety Checks**

11 57. Within three months of the Effective Date, the County and the Sheriff  
12 will revise and implement their policies on safety checks to ensure a range of  
13 supervision for prisoners housed in Mental Health Housing. The County and the  
14 Sheriff will ensure that safety checks in Mental Health Housing are completed and  
15 documented in accordance with policy and regulatory requirements as set forth  
16 below:

- 17 (a) Custody staff will conduct safety checks in a manner that allows staff  
18 to view the prisoner to assure his or her well-being and security.  
19 Safety checks involve visual observation and, if necessary to  
20 determine the prisoner's well-being, verbal interaction with the  
21 prisoner;
- 22 (b) Custody staff will document their checks in a format that does not  
23 have pre-printed times;
- 24 (c) Custody staff will stagger checks to minimize prisoners' ability to  
25 plan around anticipated checks;
- 26 (d) Video surveillance may not be used to replace rounds and supervision  
27 by custodial staff unless new construction is built specifically with  
28 constant video surveillance enhancements and could only be used to

1 replace 15 minute checks in non-FIP housing, subject to approval by  
2 the Monitor;

3 (e) A QMHP, in coordination with custody (and medical staff if  
4 necessary), will determine mental health housing assignments.

5 (f) Supervision of prisoners in mental health housing will be conducted at  
6 the following intervals:

7 (i) FIP: Custody staff will perform safety checks every 15  
8 minutes. DMH staff will perform direct constant observation or  
9 one-to-one observation when determined to be clinically  
10 appropriate;

11 (ii) High Observation Housing: Every 15 minutes;

12 (iii) Moderate Observation Housing: Every 30 minutes.

13 58. Within three months of the Effective Date, the County and the Sheriff  
14 will revise and implement their policies on safety checks. The County and the  
15 Sheriff will ensure that safety checks in non-mental health housing units are  
16 completed and documented in accordance with policy and regulatory requirements  
17 as set forth below:

18 (a) At least every 30 minutes in housing areas with cells;

19 (b) At least every 30 minutes in dormitory-style housing units where the  
20 unit does not provide for unobstructed direct supervision of prisoners  
21 from a security control room.

22 (c) Where a dormitory-style housing unit does provide for unobstructed  
23 direct supervision of prisoners, safety checks must be completed  
24 inside the unit at least every 60 minutes;

25 (d) At least every 60 minutes in designated minimum security dormitory  
26 housing at PDC South, or other similar campus-style unlocked  
27 dormitory housing;

28

- 1 (e) Custody staff will conduct safety checks in a manner that allows staff  
2 to view the prisoner to assure his or her well-being and security.  
3 Safety checks involve visual observation and, if necessary to  
4 determine the prisoner's well-being, verbal interaction with the  
5 prisoner;
- 6 (f) Custody staff will document their checks in a format that does not  
7 have pre-printed times;
- 8 (g) Custody staff will stagger checks to minimize prisoners' ability to  
9 plan around anticipated checks; and
- 10 (h) Video surveillance may not be used to replace rounds and supervision  
11 by custodial staff.

12 59. Consistent with existing Sheriff's Department policies regarding  
13 uniform daily activity logs, the County and the Sheriff will ensure that a custodial  
14 supervisor conducts unannounced daily rounds on each shift in the prisoner  
15 housing units to ensure custodial staff conduct necessary safety checks and  
16 document their rounds.

17 **M. Quality Improvement Plan**

18 60. Within six months of the Effective Date, the Department of Mental  
19 Health, in cooperation with the Sheriff's Unit described in Paragraph 77 of this  
20 Agreement, will implement a quality improvement program to identify and address  
21 clinical issues that place prisoners at significant risk of suicide or self-injurious  
22 behavior.

23 61. The quality improvement program will review, collect, and aggregate  
24 data in the following areas and recommend corrective actions and systemic  
25 improvements:

- 26 (a) Suicides and serious suicide attempts:
- 27 (i) Prior suicide attempts or other serious self-injurious behavior
- 28 (ii) Locations

- 1 (iii) Method
- 2 (iv) Lethality
- 3 (v) Demographic information
- 4 (vi) Proximity to court date;
- 5 (b) Use of clinical restraints;
- 6 (c) Psychotropic medications;
- 7 (d) Access to care, timeliness of service, and utilization of the Forensic
- 8 In-patient Unit; and
- 9 (e) Elements of documentation and use of medical records.

10 62. The County and the Sheriff's Unit described in Paragraph 77 of this  
11 Agreement will develop, implement, and track corrective action plans addressing  
12 recommendations of the quality improvement program.

13 **N. Mental Health Housing**

14 63. The County and the Sheriff will maintain adequate High Observation  
15 Housing and Moderate Observation Housing sufficient to meet the needs of the jail  
16 population with mental illness, as assessed by the County and the Sheriff on an  
17 ongoing basis. The County will continue its practice of placing prisoners with  
18 mental illness in the least restrictive setting consistent with their clinical needs.

19 64. Within six months of the Effective Date, the County and the Sheriff  
20 will develop a short-term plan addressing the following 12-month period, and  
21 within 12 months of the Effective Date, the County and the Sheriff will develop a  
22 long-term plan addressing the following five-year period, to reasonably ensure the  
23 availability of licensed inpatient mental health care for prisoners in the Jails. The  
24 County and the Sheriff will begin implementation of each plan within 90 days of  
25 plan completion. These plans will describe the projected capacity required,  
26 strategies that will be used to obtain additional capacity if it is needed, and identify  
27 the resources necessary for implementation. Thereafter, the County and the Sheriff  
28 will review, and if necessary revise, these plans every 12 months.

1       **O.    Medication**

2           65.    Consistent with existing Sheriff's Department policies, the County  
3 and the Sheriff will ensure that psychotropic medications are administered in a  
4 clinically appropriate manner to prevent misuse, hoarding, and overdose.

5           66.    Consistent with existing DMH policies, prisoners in High Observation  
6 Housing and Moderate Observation Housing, and those with a serious mental  
7 illness who reside in other housing areas of the Jails, will remain on an active  
8 mental health caseload and receive clinically appropriate mental health treatment,  
9 regardless of whether they refuse medications.

10          67.    Within three months of the Effective Date, the County and the Sheriff  
11 will implement policies for prisoners housed in High Observation Housing and  
12 Moderate Observation Housing that require:

- 13           (a)    documentation of a prisoner's refusal of psychotropic medication in  
14                the prisoner's electronic medical record;
- 15           (b)    discussion of a prisoner's refusal in treatment team meetings;
- 16           (c)    the use of clinically appropriate interventions with such prisoners to  
17                encourage medication compliance;
- 18           (d)    consideration of the need to transfer non-compliant prisoners to higher  
19                levels of mental health housing; and
- 20           (e)    individualized consideration of the appropriateness of seeking court  
21                orders for involuntary medication pursuant to the provisions of  
22                California Welfare and Institutions Code sections 5332-5336 and/or  
23                California Penal Code section 2603(a).

24          68.    Within six months of the Effective Date, the County and the Sheriff  
25 will develop and implement a procedure for contraband searches on a regular, but  
26 staggered basis in all housing units. High Observation Housing cells will be  
27 visually inspected prior to initial housing of inmates with mental health issues.

28

1 **P. Restraints**

2 69. Consistent with existing DMH policies regarding use of clinical  
3 restraints, the County and the Sheriff will use clinical restraints only in the  
4 Correctional Treatment Center and only with the approval of a licensed psychiatrist  
5 who has performed an individualized assessment and an appropriate Forensic  
6 Inpatient order. Use of clinical restraints in CTC will be documented in the  
7 prisoner's electronic medical record. The documentation will include the basis for  
8 and duration of the use of clinical restraints and the performance and results of the  
9 medical welfare checks on restrained prisoners. When applying clinical restraints,  
10 custody staff will ensure a QMHP is present to document and monitor the  
11 condition of the prisoner being placed in clinical restraints.

12 70. Within three months of the Effective Date, the County and the Sheriff  
13 will have policies and procedures regarding the use of Security Restraints in HOH  
14 and MOH. Such policies will provide that:

- 15 (a) Security Restraints in these areas will not be used as an alternative to  
16 mental health treatment and will be used only when necessary to  
17 insure safety;
- 18 (b) Security Restraints will not be used to punish prisoners, but will be  
19 used only when there is a threat or potential threat of physical harm,  
20 destruction of property, or escape;
- 21 (c) Custody staff in HOH and MOH will consider a range of security  
22 restraint devices and utilize the least restrictive option, for the least  
23 amount of time, necessary to provide safety in these areas;
- 24 (d) Whenever a prisoner is recalcitrant, as defined by Sheriff's  
25 Department policy, and appears to be in a mental health crisis,  
26 Custody staff will request a sergeant and immediately refer the  
27 prisoner to a QMHP.  
28

1           71. The County and the Sheriff will ensure that any prisoner subjected to  
2 clinical restraints in response to a mental health crisis receives therapeutic services  
3 to remediate any effects from the episode(s) of restraint.

4           **Q. Suicide Death Reviews and Critical Incident Reviews**

5           72. The County and the Sheriff will develop and implement policies and  
6 procedures that ensure that incidents involving suicide and serious self-injurious  
7 behavior are reported and reviewed to determine: (a) whether staff engaged in any  
8 violations of policies, rules, or laws; and (b) whether any improvements to policy,  
9 training, operations, treatment programs, or facilities are warranted. These policies  
10 and procedures will define terms clearly and consistently to ensure that incidents  
11 are reported and tracked accurately by DMH and the Sheriff's Department.

12           73. Depending on the level of severity of an incident involving a prisoner  
13 who threatens or exhibits self-injurious behavior, a custody staff member will  
14 prepare a detailed report (Behavioral Observation and Mental Health Referral  
15 Form, Inmate Injury Report, and/or Incident Report) that includes information  
16 from individuals who were involved in or witnessed the incident as soon as  
17 practicable, but no later than the end of shift. The report will include a description  
18 of the events surrounding the incident and the steps taken in response to the  
19 incident. The report will also include the date and time that the report was  
20 completed and the names of any witnesses. The Sheriff's Department will  
21 immediately notify the County Office of Inspector General of all apparent or  
22 suspected suicides occurring at the Jails.

23           74. The Sheriff's Department will ensure that there is a timely, thorough,  
24 and objective law enforcement investigation of any suicide that occurs in the Jails.  
25 Investigations shall include recorded interviews of persons involved in, or who  
26 witnessed, the incident, including other prisoners. Sheriff's Department personnel  
27 who are investigating a prisoner suicide or suspected suicide at the Jails will ensure  
28

1 the preservation of all evidence, including physical evidence, relevant witness  
2 statements, reports, videos, and photographs.

3 75. Within three months of the Effective Date, the County and the Sheriff  
4 will review every suicide attempt that occurs in the Jails as follows:

5 (a) Within two working days, DMH staff will review the incident, the  
6 prisoner's mental health status known at the time of the incident, the  
7 need for immediate corrective action if any, and determine the level of  
8 suicide attempt pursuant to the Centers for Disease Control and  
9 Prevention's Risk Rating Scale;

10 (b) Within 30 working days, and only for those incidents determined to be  
11 a serious suicide attempt by DMH staff after the review described in  
12 subsection (a) above, management and command-level personnel  
13 from DMH and the Sheriff's Department (including Custody Division  
14 and Medical Services Bureau) will meet to review relevant  
15 information known at that time, including the events preceding and  
16 following the incident, the prisoner's incarceration, mental health, and  
17 health history, the status of any corrective actions taken, and the need  
18 for additional corrective action if necessary;

19 (c) The County and the Sheriff will document the findings that result  
20 from the review of serious suicide attempts described in subsection (b)  
21 above; and

22 (d) The County and the Sheriff will ensure that information for all suicide  
23 attempts is input into a database for tracking and statistical analysis.

24 76. The County and the Sheriff will review every apparent or suspected  
25 suicide that occurs in the Jails as follows:

26 (a) Within no more than two working days, management and command-  
27 level personnel from DMH and the Sheriff's Department (including  
28 Custody Division and Medical Services Bureau) will meet to review

1 and discuss the suicide, the prisoner's mental health status known at  
2 the time of the suicide, and the need for immediate corrective or  
3 preventive action if any;

4 (b) Within seven working days, and again within 30 working days,  
5 management and command-level personnel from DMH and the  
6 Sheriff's Department (including Custody Division and Medical  
7 Services Bureau) will meet to review relevant information known at  
8 that time, including the events preceding and following the suicide,  
9 the prisoner's incarceration, mental health, and health history, the  
10 status of any corrective or preventive actions taken, and the need for  
11 additional corrective or preventive action if necessary;

12 (c) Within six months of the suicide, the County and the Sheriff will  
13 prepare a final written report regarding the suicide. The report will  
14 include:

- 15 (i) time and dated incident reports and any supplemental reports  
16 with the same Uniform Reference Number (URN) from custody  
17 staff who were directly involved in and/or witnessed the  
18 incident;
- 19 (ii) a timeline regarding the discovery of the prisoner and any  
20 responsive actions or medical interventions;
- 21 (iii) copies of a representative sample of material video recordings  
22 or photographs, to the extent that inclusion of such items does  
23 not interfere with any criminal investigation;
- 24 (iv) a reference to, or reports if available, from the Sheriff's  
25 Department Homicide Bureau;
- 26 (v) reference to the Internal Affairs Bureau or other personnel  
27 investigations, if any, and findings, if any;
- 28

- 1 (vi) a Coroner's report, if it is available at the time of the final
- 2 report, and if it is not available, a summary of efforts made to
- 3 obtain the report;
- 4 (vii) a summary of relevant information discussed at the prior review
- 5 meetings, or otherwise known at the time of the final report,
- 6 including analysis of housing or classification issues if relevant;
- 7 (viii) a clinical mortality review;
- 8 (ix) a Psychological Autopsy utilizing the National Commission on
- 9 Correctional Health Care's standards; and
- 10 (x) a summary of corrective actions taken and recommendations
- 11 regarding additional corrective actions if any are needed.

12 77. The County and the Sheriff will create a specialized unit to oversee,  
13 monitor, and audit the County's jail suicide prevention program in coordination  
14 with the Department of Mental Health. The Unit will be headed by a Captain, or  
15 another Sheriff's Department official of appropriate rank, who reports to the  
16 Assistant Sheriff for Custody Operations through the chain of command. The Unit  
17 will be responsible for:

- 18 (a) Ensuring the timely and thorough administrative review of suicides
- 19 and serious suicide attempts in the Jails as described in this
- 20 Agreement;
- 21 (b) Identifying patterns and trends of suicides and serious suicide
- 22 attempts in the Jails, keeping centralized records and inputting data
- 23 into a unit database for statistical analysis, trends, and corrective
- 24 action, if necessary;
- 25 (c) Ensuring that corrective actions are taken to mitigate suicide risks at
- 26 both the location of occurrence and throughout the concerned system
- 27 by providing, or obtaining where appropriate, technical assistance to
- 28

1 other administrative units within the Custody Division when such  
2 assistance is needed to address suicide-risk issues;

3 (d) Analyzing staffing, personnel/disciplinary, prisoner classification, and  
4 mental health service delivery issues as they relate to suicides and  
5 serious suicide attempts to identify the need for corrective action  
6 where appropriate; and recommend remedial measures, including  
7 policy revisions, re-training, or staff discipline, to address the  
8 deficiencies and ensure implementation; and

9 (e) Participating in meetings with DMH to develop, implement, and track  
10 corrective action plans addressing recommendations of the quality  
11 improvement program.

12 78. The County and the Sheriff will maintain a county-level Suicide  
13 Prevention Advisory Committee that will be open to representatives from the  
14 Sheriff's Department Custody Division, Court Services, Custody Support Services,  
15 and Medical Services Bureau; the Department of Mental Health; the Public  
16 Defender's Office; County Counsel's Office; the Office of the Inspector General;  
17 and the Department of Mental Health Patients' Rights Office. The Suicide  
18 Prevention Advisory Committee will meet twice per year and will serve as an  
19 advisory body to address system issues and recommend coordinated approaches to  
20 suicide prevention in the Jails.

21 **R. Mental Health Treatment**

22 79. (a) Unless clinically contraindicated, the County and the Sheriff will  
23 offer prisoners in mental health housing:

- 24 (i) therapeutically appropriate individual visits with a QMHP;  
25 (ii) therapeutically appropriate group programming conducted by a  
26 QMHP or other appropriate provider that does not exceed 90  
27 minutes per session;

1 (b) The County and the Sheriff will provide prisoners outside of mental  
2 health housing with medication support services when those prisoners are  
3 receiving psychotropic medications and therapeutically appropriate individual  
4 monthly visits with a QMHP when those prisoners are designated as Seriously  
5 Mentally Ill.

6 (c) The date, location, topic, attendees, and provider of programming or  
7 therapy sessions will be documented. A clinical supervisor will review  
8 documentation of group sessions on a monthly basis.

9 80. (a) The County and the Sheriff will continue to make best efforts to  
10 provide appropriate out-of-cell time to all prisoners with serious mental illness,  
11 absent exceptional circumstances, and unless individually clinically  
12 contraindicated and documented in the prisoner's electronic medical record. To  
13 implement this requirement, the County and the Sheriff will follow the schedule  
14 below:

15 (i) By no later than six months after the Effective Date, will offer  
16 25% of the prisoners in HOH ten hours of unstructured out-of-  
17 cell recreational time and ten hours of structured therapeutic or  
18 programmatic time per week;

19 (ii) By no later than 12 months after the Effective Date, will offer  
20 50% of the prisoners in HOH ten hours of unstructured out-of-  
21 cell recreational time and ten hours of structured therapeutic or  
22 programmatic time per week;

23 (iii) By no later than 18 months after the Effective Date, will offer  
24 100% of the prisoners in HOH ten hours of unstructured out-of-  
25 cell recreational time and ten hours of structured therapeutic or  
26 programmatic time per week.

27 (b) No later than six months after the Effective Date, the County and the  
28 Sheriff will record at the end of each day which prisoners in HOH, if any, refused

1 to leave their cells that day. That data will be presented and discussed with DMH  
2 staff at the daily meeting on the following Normal business work day. The data  
3 will also be provided to the specialized unit described in Paragraph 77 and to  
4 DMH's quality improvement program to analyze the data for any trends and to  
5 implement any corrective action(s) deemed necessary to maximize out-of-cell time  
6 opportunities and avoid unnecessary isolation.

7 **S. Use of Force**

8 81. Except as specifically set forth in Paragraphs 18-20 of this  
9 Agreement, and except as specifically identified below, the County and the Sheriff  
10 will implement the following paragraphs of the Implementation Plan in *Rosas* at all  
11 Jails facilities, including the Pitchess Detention Center and the Century Regional  
12 Detention Facility, by no later than the dates set forth in the Implementation Plan  
13 or as revised by the *Rosas* Monitoring Panel: Paragraphs 2.2-2.13 (use of force  
14 policies and practices); 3.1-3.6 (training and professional development); 4.1-4.10  
15 (use of force on mentally ill prisoners); 5.1-5.3 (data tracking and reporting of  
16 force); 6.1-6.20 (prisoner grievances and complaints); 7.1-7.3 (prisoner  
17 supervision); 8.1-8.3 (anti-retaliation provisions); 9.1-9.3 (security practices); 10.1-  
18 10.2 (management presence in housing units); 11.1 (management review of force);  
19 12.1-12.5 (force investigations, with the training requirement of paragraph 12.1 to  
20 be completed by December 31, 2016); 13.1-13.2 (use of force reviews and staff  
21 discipline); 14.1-14.2 (criminal referrals and external review); 15.1-15.7  
22 (documentation and recording of force); 16.1-16.3 (health care assessments); 17.1-  
23 17.10 (use of restraints); 18.1-18.2 (adequate staffing); 19.1-19.3 (early warning  
24 system); 20.1-20.3 (planned uses of force); and 21.1 (organizational culture).

25 82. With respect to paragraph 6.16 of the *Rosas* Implementation Plan, the  
26 County and the Sheriff will ensure that Sheriff's Department personnel responsible  
27 for collecting prisoners' grievances as set forth in that paragraph are also co-  
28 located in the Century Regional Detention Facility.

1           83. The County and the Sheriff will install closed circuit security cameras  
2 throughout all Jails facilities' common areas where prisoners engage in  
3 programming, treatment, recreation, visitation, and intra-facility movement  
4 ("Common Areas"), including in the Common Areas at the Pitchess Detention  
5 Center and the Century Regional Detention Facility. The County and the Sheriff  
6 will install a sufficient number of cameras in Jails facilities that do not currently  
7 have cameras to ensure that all Common Areas of these facilities have security-  
8 camera coverage. The installation of these cameras will be completed no later than  
9 June 30, 2018; with TTCF, MCJ, and IRC completed by the Effective Date; CRDF  
10 completed by March 1, 2016; and the remaining facilities completed by June 30,  
11 2018. The County and the Sheriff will also ensure that all video recordings of  
12 force incidents are adequately stored and retained for a period of at least one year  
13 after the force incident occurs or until all investigations and proceedings related to  
14 the use of force are concluded.

15           84. The Sheriff will continue to maintain and implement policies for the  
16 timely and thorough investigation of alleged staff misconduct related to use of  
17 force and for timely disciplinary action arising from such investigations.

18 Specifically:

- 19           (a) Sworn custody staff subject to the provisions of California  
20 Government Code section 3304 will be notified of the completion of  
21 the investigation and the proposed discipline arising from force  
22 incidents in accordance with the requirements of that Code section;  
23 and  
24           (b) All non-sworn Sheriff's Department staff will be notified of the  
25 proposed discipline arising from force incidents in time to allow for  
26 the imposition of that discipline.

1           85. The County and the Sheriff will ensure that Internal Affairs Bureau  
2 management and staff receive adequate specialized training in conducting  
3 investigations of misconduct.

4           86. Within three months of the Effective Date, the County and the Sheriff  
5 will develop and implement policies and procedures for the effective and accurate  
6 maintenance, inventory, and assignment of chemical agents and other security  
7 equipment. The County and the Sheriff will develop and maintain an adequate  
8 inventory control system for all weapons, including OC spray.

9                   **VI. IMPLEMENTATION, COMPLIANCE ASSESSMENT,**  
10                   **ENFORCEMENT, AND TERMINATION**

11           **A. Review and Implementation of Policies, Procedures, and Programs**

12           87. The County and the Sheriff are committed to continuous quality  
13 improvement and have taken significant steps to review and update policies and  
14 procedures to protect the constitutional and federal rights of prisoners at the Jails.  
15 Where necessary, the County and the Sheriff will maintain existing policies,  
16 procedures, and practices to support the substantive provisions in this Agreement.

17           88. The County and the Sheriff will review all relevant policies,  
18 procedures, and other written executive-approved directives within four months of  
19 the Effective Date to ensure that they are consistent with the terms of this  
20 Agreement, unless they were reviewed and revised for such purposes within six  
21 months preceding the Effective Date.

22           89. (a) If the County or the Sheriff create or materially revise a policy  
23 related to this Agreement after the Effective Date, the following process will be  
24 followed before implementation:

- 25           (1) the County and Sheriff will provide a copy of the proposed policy to  
26 the Monitor and DOJ prior to its implementation;
- 27           (2) the Monitor and DOJ will have 30 days to review the policy and  
28 submit comments, if any, to the County and the Sheriff;

- 1 (3) if the Monitor and DOJ do not submit any comments within the 30-
- 2 day period, the County and the Sheriff will begin implementation of
- 3 the policy no later than 180 days after the expiration of the 30 day-
- 4 review period or notice that no comments will be forthcoming;
- 5 (4) if the Monitor or DOJ objects to the proposed policy, the Monitor or
- 6 DOJ will note the objection in writing to all Parties within the
- 7 respective review period;
- 8 (5) if there is any objection to the proposed policy, the County and the
- 9 Sheriff will have 30 days to address the objection(s);
- 10 (6) if the Monitor and the Parties cannot resolve the objection(s), either
- 11 Party may ask the Court to resolve the matter;
- 12 (7) the Monitor may extend any time frame within this paragraph by up to
- 13 15 additional days. Further extensions may be granted by the Monitor
- 14 with the agreement of both Parties when necessary to permit amicable
- 15 resolution of objections.

16 (b) If after the Effective Date, the County or the Sheriff is confronted with a  
17 critical circumstance requiring immediate action, the County or the Sheriff may  
18 create or substantially revise, and then implement, a policy related to this  
19 Agreement without the prior review of the Monitor and DOJ, so long as the  
20 review, comment, and objection procedures set forth above in subparagraph (a) are  
21 followed immediately upon implementation.

22 90. The County and the Sheriff will provide relevant staff with any policy  
23 that is created or materially revised after the Effective Date if it relates to the  
24 provisions of this Agreement. The County and the Sheriff will further document  
25 that any such policy has been received by that staff and that such staff has been  
26 trained, instructed, or briefed, as appropriate, on that policy.

1       **B. Compliance Coordination Unit**

2           91. The County and the Sheriff will establish and maintain a compliance  
3 coordination unit for the duration of this Agreement. The unit will:

- 4           (a) serve as a liaison between the Parties and the Monitor and assume  
5 primary responsibility for collecting information the Monitor requires  
6 to carry out the duties assigned to the Monitor;
- 7           (b) maintain sufficient records to document that the requirements of this  
8 Agreement are being properly implemented (e.g., census summaries,  
9 policies, procedures, protocols, training materials, investigations,  
10 incident reports, tier logs, use-of-force reports);
- 11           (c) provide written answers by electronic mail or other format when  
12 necessary and any documents requested by the Monitor or DOJ  
13 concerning implementation of this Agreement in a timely manner;
- 14           (d) coordinate and monitor compliance and implementation activities,  
15 including coordination between Custody and DMH staff, and assist  
16 managers in assigning compliance tasks to County or Sheriff  
17 personnel; and
- 18           (e) ensure that the County and the Sheriff notify DOJ and the Monitor of  
19 any suspected or apparent suicide within 24 hours and make related  
20 reports available to the Monitor and DOJ for inspection.

21       **C. Self-Assessments and Reports**

22           92. (a) Fifteen days before the end of the reporting period described in  
23 Paragraph 109 of this Agreement, the County and the Sheriff will provide the  
24 Monitor and DOJ a Self-Assessment Status Report that includes:

- 25           (1) the actions taken by the County and the Sheriff during the review  
26 period to implement this Agreement including the status of ongoing  
27 and continuous improvement activities;

- 1 (2) responses to concerns or recommendations made in prior reports by
- 2 the Monitor;
- 3 (3) a summary of any audits related to the provisions of this Agreement
- 4 that were completed in the reporting period; and
- 5 (4) relevant trend data including the information described in Paragraphs
- 6 61 and 77(a).

7 (b) Self-Assessment Status Reports prepared pursuant to this Paragraph will  
8 be treated as confidential and not further disclosed or attached to any court  
9 document, unless filed under seal with Court approval, without the consent of the  
10 County and the Sheriff or by order of the Court. The Monitor, SMEs, and other  
11 monitoring staff, however, will be permitted to use the information contained in  
12 the Self-Assessment Status Reports to prepare the Monitor's reports to the Court.

13 **D. Independent Monitor**

14 93. In order to assess and report on the implementation of this Agreement  
15 and whether the implementation is having the intended beneficial impact on  
16 conditions at the Jails, the Monitor, the SMEs, and their staff will:

- 17 (a) conduct the audits, reviews, and assessments specified in this
- 18 Agreement;
- 19 (b) review County and Sheriff policies, procedures, training curricula, and
- 20 other documents related to this Agreement developed and
- 21 implemented pursuant to this Agreement;
- 22 (c) conduct such additional audits, reviews, and assessments consistent
- 23 with this Agreement as the Monitor and the Parties jointly agree are
- 24 appropriate, or in the case of a dispute which the Parties cannot in
- 25 good faith resolve, as ordered by the Court; and
- 26 (d) evaluate the implementation of Section V.S. of this Agreement
- 27 concerning use of force consistent with the Settlement Agreement and
- 28 Implementation Plan-approved in *Rosas*.

1           94. The Parties have selected Richard Drooyan as the Independent  
2 Monitor. The Monitor and his staff will not, and are not intended to, replace or  
3 assume the role and duties of the County or the Sheriff and will have only the  
4 duties, responsibilities, and authority conferred by this Agreement.

5           To assess and report whether the provisions of this Agreement have been  
6 implemented, and whether the County and the Sheriff are in compliance with the  
7 substantive provisions of this Agreement, the Monitor will:

8           (a) evaluate the implementation of Section V (“Substantive Provisions”)  
9 of this Agreement and, where applicable, the Settlement Agreement  
10 and Implementation Plan approved in *Rosas*;

11           (b) conduct specific audits, reviews, and assessments consistent with this  
12 Agreement or otherwise if the Parties agree in writing; and

13           (c) prepare reports as provided in this Agreement.

14           95. The Parties have also selected Bruce C. Gage, M.D., and Manuel  
15 David Romero as Subject Matter Experts (“SMEs”). The SMEs and their staff will  
16 not, and are not intended to, replace or assume the role and duties of the County or  
17 the Sheriff and will have only the duties, responsibilities, and authority conferred  
18 by this Agreement. The SMEs will, in conjunction with the Monitor, assess  
19 compliance with the substantive provisions of this Agreement by providing  
20 expertise within the scope of their subject matters.

21           96. The Monitor and/or SMEs may hire or contract with additional  
22 persons with knowledge or expertise not already provided by the SMEs, or where  
23 delegation to a subordinate staff member would be appropriate, as reasonably  
24 necessary to perform the tasks assigned by this Agreement. The Monitor will  
25 notify the County, the Sheriff, and DOJ in writing when the Monitor or SMEs are  
26 considering such additional persons. The Parties will have an opportunity, if  
27 desired, to interview the candidate(s) and request reasonable information about the  
28 candidate’s background and experience. If the Parties agree to the Monitor’s

1 proposal, the Monitor or SMEs will be authorized to hire or contract such  
2 additional persons. If the Parties do not agree to the proposal, the Parties will have  
3 ten business days to disagree with the proposal in writing. The Parties will not  
4 unreasonably withhold approval. If the Parties are unable to reach agreement  
5 within ten business days of receiving notice of this disagreement, the Court will  
6 resolve the dispute.

7 97. If not already developed by the Monitor and SMEs and agreed-to by  
8 the Parties before the execution of this Agreement, within three months of the  
9 appointment of the Monitor and SMEs by the Court, the Monitor and SMEs will  
10 develop a plan for conducting the above audits, reviews, and assessments, and will  
11 submit that plan to the Parties for review and approval. The plan will:

- 12 (a) set out a methodology for reviewing each of the substantive  
13 provisions of this Agreement, including which provisions will be  
14 assessed together, if any, and the thresholds for achieving Substantial  
15 Compliance; and  
16 (b) set out a schedule for conducting the assessments required by this  
17 Agreement.

18 98. The Monitor, SMEs, and any person hired or contracted to assist the  
19 Monitor or SMEs will be subject to (a) the supervision and orders of the Court  
20 consistent with the terms of this Agreement; (b) the terms of this Agreement; (c)  
21 any applicable law; and (d) any security protocols while in the Jails.

22 99. The County and the Sheriff will bear all reasonable fees and costs of  
23 the Monitor, the SMEs, and their staff. Travel, lodging, and per diem expenses  
24 will be reimbursed at the same rate as provided for County employees. In the  
25 event that any dispute arises regarding the reasonableness or payment of the  
26 Monitor's, SMEs', or their staff's fees and costs, the Parties and the Monitor will  
27 attempt to resolve the dispute cooperatively before seeking the assistance of the  
28 Court.

1           100. At the request of the County and the Sheriff, and with the consent of  
2 the DOJ, the Monitor, SMEs, and their staff may provide technical assistance.  
3 Such assistance may not interfere with the Monitor's or SMEs' duties under this  
4 Agreement, create additional duties or obligations that are enforceable under this  
5 Agreement, or otherwise alter or modify the terms of this Agreement.  
6 Additionally, whenever the County or the Sheriff identifies and implements its  
7 own quality improvement measures that are not related to any of the terms of this  
8 Agreement, those quality improvement measures will not be monitored or enforced  
9 under this Agreement.

10           101. Should all the Parties agree that the Monitor, a SME, or a member of  
11 their staff has exceeded his or her authority or is not fulfilling his or her duties in  
12 accordance with this Agreement, the Parties may petition the Court for the  
13 immediate removal and replacement of the Monitor, SME, or staff person. After  
14 good faith attempts to resolve such issues informally, any Party may petition the  
15 Court for the removal of the Monitor, a SME, or any member of their staff, for  
16 good cause, which may include, but is not limited to: gross neglect of duties;  
17 willful misconduct; inappropriate personal relationship with a Party, any Party  
18 employee, or prisoner; conflicts of interest; any criminal conduct; or any  
19 significant violations of security protocols during the pendency of this Agreement.

20           102. The Parties recognize the Monitor and SMEs may have existing  
21 clients who may now be, or in the future may be, adverse to the County or the  
22 Sheriff in transactions or litigation. For the duration of this Agreement, however,  
23 unless such conflict is waived by all Parties, the Monitor, the SMEs, and their staff  
24 will not accept any new employment or retention for consulting services regarding  
25 alleged actions or inactions by the County or the Sheriff, or any County or Sheriff's  
26 employee, including any actions or inactions involving any prisoner that present a  
27 conflict of interest with the Monitor's, SME's, or staff member's responsibilities  
28 under this Agreement, including being retained (on a paid or unpaid basis) by any

1 current or future litigant or claimant, or such litigant's or claimant's attorney, in  
2 connection with a claim or suit against the County, the Sheriff, or their  
3 departments, officers, agents, or employees. Similarly, the Monitor, the SMEs,  
4 and their staff will not accept employment or provide consulting services (on a  
5 paid or unpaid basis) by any Defendant to this matter to act as a defense witness in  
6 connection with a private claim or suit against the County, the Sheriff, or their  
7 departments, officers, agents, or employees. This provision does not apply to any  
8 proceeding before a court related to performance of contracts or subcontracts for  
9 monitoring this Agreement.

10 **E. Access and Confidentiality**

11 103. With the exception of documents within the attorney-client and  
12 attorney-work-product privileges, and notwithstanding the confidentiality  
13 restrictions of the Health Insurance Portability and Accountability Act ("HIPAA"),  
14 the California Confidentiality of Medical Information Act (Civil Code § 56, *et*  
15 *seq.*), and California Welfare and Institutions Code § 5328 (related to  
16 confidentiality of mental health records), the Monitor, SMEs, their staff, and the  
17 United States, its attorneys, consultants, and agents will have full and complete  
18 access to the Jails and all relevant individuals, facilities, prisoner medical and  
19 mental health records, documents, data, and meetings related to the provisions of  
20 this Agreement.

21 104. Other than as expressly provided in this Agreement, the Monitor, the  
22 SMEs, their staff, and DOJ will maintain confidential all, and will not distribute or  
23 disclose any, non-public information provided by the County and the Sheriff  
24 pursuant to this Agreement. This Agreement will not be deemed a waiver of any  
25 privilege or right the County or the Sheriff may assert, including those recognized  
26 at common law or created by statute, rule, or regulation, against any other person  
27 or entity with respect to the disclosure of any document or information.

28

1       **F. Public Statements, Testimony, and Records**

2           105. Except as required by the terms of this Agreement, an order from the  
3 Court, the express written agreement of all Parties, or at meetings of the County of  
4 Los Angeles Board of Supervisors, the Monitor, SMEs, and their staff will not  
5 make any public or press statements (at a conference or otherwise), issue findings,  
6 offer expert opinion, or testify in any other litigation or proceeding regarding any  
7 matter or subject that he or she may have learned as a result of his or her  
8 performance under this Agreement. If the Monitor, SMEs, or any of their staff  
9 receive a subpoena, he or she will promptly notify the Parties and thereafter advise  
10 the subpoenaing court of the terms of this Agreement.

11           106. The Monitor, SMEs, and their staff will be permitted to initiate and  
12 receive ex parte communications with all Parties.

13           107. The Monitor, SMEs, and their staff are not a State, County, or local  
14 agency, or an agent thereof, and accordingly, the records maintained by them, or  
15 any of them, will not be deemed public records subject to public inspection. If the  
16 Monitor, SMEs, or any of their staff receive a request for inspection of their  
17 records related to this Agreement, he or she will promptly notify the Parties.

18           108. This Agreement is enforceable only by the Parties. No person or  
19 entity is intended to be a third-party beneficiary of the provisions of this  
20 Agreement for purposes of any civil, criminal, or administrative action, and  
21 accordingly, no person or entity may assert any claim or right as a beneficiary or  
22 protected class under this Agreement.

23       **G. Monitoring Reports**

24           109. Every six months, the Monitor will file public written reports with the  
25 Court describing the steps taken by the County and the Sheriff to implement this  
26 Agreement and evaluating the extent to which the County and the Sheriff have  
27 complied with this Agreement. Specifically, the Monitor and SMEs will evaluate  
28 the status of compliance for each substantive provision of this Agreement using the

1 following standards: (1) Substantial Compliance; (2) Partial Compliance; and (3)  
2 Non-compliance. In order to assess compliance, the Monitor and SMEs will  
3 review a sufficient number of pertinent documents to accurately assess current  
4 conditions, interview all relevant staff, interview a sufficient number of prisoners  
5 to accurately assess current conditions, and take other reasonable actions consistent  
6 with this Agreement, as needed, to fulfill their responsibilities under this  
7 Agreement. The Monitor, the SMEs, and their staff will be responsible for  
8 independently verifying representations from the County or the Sheriff regarding  
9 progress toward compliance, and examining supporting documentation. Each  
10 monitoring report will describe the steps taken by members of the monitoring team  
11 to analyze conditions and assess compliance, including reference to the documents  
12 reviewed and individuals interviewed, and the factual basis for the Monitor's and  
13 SMEs' findings. Such reports and findings will not be admissible by or against the  
14 County or the Sheriff in any proceeding other than a proceeding related to the  
15 enforcement of this Agreement initiated and handled exclusively by the County,  
16 the Sheriff, or the United States.

17 110. At least 30 days before the anticipated filing of such reports, the  
18 Monitor will provide the Parties with a draft copy and an opportunity to respond.  
19 The Monitor will consider the Parties' responses and make appropriate changes, if  
20 any, before filing. The Parties may file separate responses with the Court within  
21 15 days after the filing by the Monitor although nothing in this Agreement will be  
22 construed to require the filing of such responses. All public court filings by the  
23 Monitor and any Party will be written with due regard for the privacy interests of  
24 individual prisoners and staff and the interest of the County and the Sheriff in  
25 protecting against disclosure of information not permitted by this Agreement.

26 111. Except for the provisions of Section V.S. of this Agreement that have  
27 different Compliance Periods under the Settlement Agreement, Implementation  
28 Plan, and Monitoring Protocols approved in *Rosas*, upon the Monitor's and SMEs'

1 conclusion that the County and the Sheriff have achieved and maintained  
2 Substantial Compliance with a substantive provision of this Agreement for a period  
3 of twelve (12) consecutive months, the Monitor and SMEs will no longer be  
4 required to assess or report on that provision. Where the Monitor and SMEs  
5 conclude that the County and the Sheriff have achieved and maintained Substantial  
6 Compliance with a substantive provision of this Agreement, as described  
7 immediately above, at one Jail facility but not at other facilities, the Monitor and  
8 SMEs will no longer be required to assess or report on that provision as it applies  
9 to the facility found to be in sustained compliance. The Parties expect that there  
10 will be multiple independent operative compliance periods under the supervision  
11 of the Monitor.

12 112. If the Monitor identifies a critical and time sensitive issue that the  
13 County or the Sheriff should address during a six-month reporting period and that  
14 should not be delayed until the time the Monitor must provide the Parties with a  
15 draft copy of the monitoring report, the Monitor will provide the Parties with a  
16 verbal report on the critical issue as soon as possible, and the Monitor will provide  
17 a written report to the Parties within 30 days of the Monitor's identification of the  
18 critical issue.

19 **H. Court Jurisdiction, Modification, Enforcement, and Termination**

20 113. The Court shall retain jurisdiction over the implementation of this  
21 Agreement at the existing Jails or any other facility used to replace or supplement  
22 the Jails for all purposes.

23 114. The County and the Sheriff will ensure that all of the terms in this  
24 Agreement are implemented. Unless otherwise provided in a specific provision of  
25 this Agreement, the implementation of this Agreement will begin immediately  
26 upon the Effective Date.

27  
28

1 115. Unless otherwise agreed to under a specific provision of this  
2 Agreement, the County and the Sheriff will implement all provisions of this  
3 Agreement within six months of the Effective Date.

4 116. To ensure that the substantive provisions of this Agreement are  
5 implemented in accordance with the terms of this Agreement, the Court will retain  
6 jurisdiction to enforce this Agreement only until either:

7 (a) the County and the Sheriff have achieved and maintained Substantial  
8 Compliance with each and every substantive provision of this  
9 Agreement for a period of twelve (12) consecutive months (or other  
10 time period provided in a specific provision of this Agreement or the  
11 relevant Compliance Period under the Settlement Agreement,  
12 Implementation Plan, and Monitoring Protocols approved in *Rosas*);  
13 or

14 (b) the Monitor, with Court approval, determines that the overall  
15 objectives and goals of this Agreement have been met even where the  
16 specific requirements of substantive provisions of this Agreement may  
17 be only in Partial Compliance.

18 Either of the conditions described in sub-paragraphs (a) or (b) above will be  
19 deemed to fully satisfy this Agreement. At that time, the County and the Sheriff  
20 may seek to terminate this Agreement with the Court consistent with the  
21 requirements of the Prison Litigation Reform Act, 18 U.S.C. § 3626(b).

22 117. The United States acknowledges the good faith of the County and the  
23 Sheriff in committing to the reforms set forth in this Agreement. The United  
24 States, however, reserves the right to seek enforcement of the provisions of this  
25 Agreement with the Court if it determines that the County or the Sheriff has failed  
26 to substantially comply with any substantive provisions of this Agreement. Before  
27 pursuing any remedy with the Court, the United States agrees to give written notice  
28 to the County and the Sheriff in accordance with the Local Rules of the Central

1 District of California. The County and the Sheriff will have 30 days from receipt  
2 of such notice to cure the alleged failure (or such additional time as is reasonable  
3 due to the nature of the issue and agreed upon by the Parties). During the 30-day  
4 period, the Parties will meet and confer in good faith to resolve any disputes  
5 regarding the alleged failure or to otherwise explore a joint resolution. The  
6 Monitor and SMEs may assist the Parties in reaching a mutually agreeable  
7 resolution to the alleged compliance failure, including facilitating conference  
8 meetings and providing relevant factual assessments.

9 118. In case of an emergency posing an imminent and serious threat to the  
10 health or safety of any prisoner or staff member at the Jails, the United States may  
11 omit the notice and cure requirements set forth above and seek enforcement of the  
12 Agreement with the Court.

13 119. The Parties may jointly stipulate to make changes, modifications, and  
14 amendments to this Agreement, which will be effective absent further action from  
15 the Court, 30 days after a stipulation signed by all of the Parties has been filed with  
16 the Court. Any Party may seek to modify this Agreement with the Court if that  
17 Party establishes by a preponderance of the evidence that a significant change in  
18 the law or factual conditions warrant the modification and that the proposed  
19 modification is suitably tailored to the changed circumstances.

20 120. The Parties agree to defend the provisions of this Agreement. The  
21 Parties will notify each other of any court or administrative challenge to this  
22 Agreement. In the event any provision of this Agreement is challenged in any state  
23 court, removal to a federal court shall be sought by the Parties.

24 121. The County and the Sheriff agree to promptly notify DOJ if any term  
25 of this Agreement becomes the subject of collective bargaining consultation and to  
26 consult with DOJ in a timely manner regarding the position the County or the  
27 Sheriff takes in any collective bargaining consultation connected with this  
28 Agreement.



1 Respectfully submitted this \_\_\_ day of \_\_\_\_, 2015.

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For the UNITED STATES OF AMERICA:

LORETTA E. LYNCH  
Attorney General

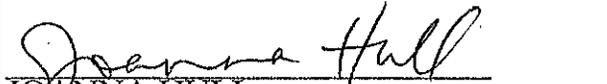
  
EILEEN M. DECKER  
United States Attorney

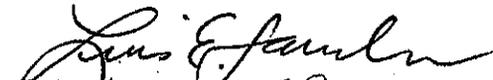
  
MARK KAPPELHOFF  
Acting Deputy Assistant Attorney  
General

LEON W. WEIDMAN  
Assistant United States Attorney  
Chief, Civil Division

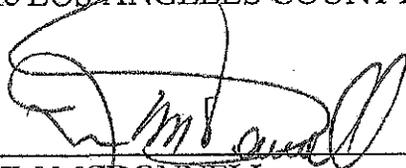
  
ROBYN-MARIE LYON MONTELEONE  
Assistant United States Attorney  
Assistant Division Chief  
Civil Rights Unit Chief, Civil Division

  
JUDITH C. PRESTON  
Acting Chief

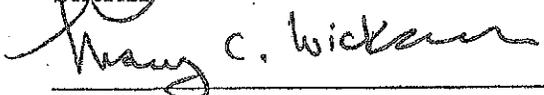
  
JOANNA HULL  
Assistant United States Attorney  
U.S. Attorney's Office for the  
Central District of California  
300 North Los Angeles Street, Suite 7516  
Los Angeles, California 90012

  
LAURA L. COON  
Special Counsel  
LUIS E. SAUCEDO  
CATHLEEN S. TRAINOR  
Trial Attorneys  
U.S. Department of Justice  
Civil Rights Division  
Special Litigation Section  
950 Pennsylvania Avenue, NW  
PHB 5026  
Washington, D.C. 20530

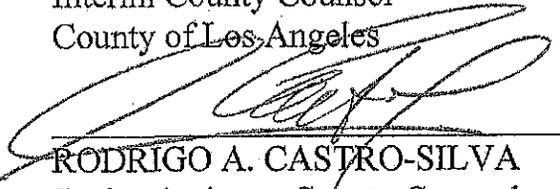
1 For the COUNTY OF LOS ANGELES and the LOS ANGELES COUNTY  
2 SHERIFF, in his official capacity:

  
\_\_\_\_\_

JEM MCDONNELL  
Sheriff

  
\_\_\_\_\_

MARY C. WICKHAM  
Interim County Counsel  
County of Los Angeles

  
\_\_\_\_\_

RODRIGO A. CASTRO-SILVA  
Senior Assistant County Counsel  
County of Los Angeles

15 SO ORDERED this \_\_\_\_\_ day of \_\_\_\_\_, 2015.

\_\_\_\_\_  
UNITED STATES DISTRICT JUDGE

28

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL**

**AUGUST 11, 2015**

**Expanding Effective Diversion Efforts in Los Angeles County**

For more than a year, the Board of Supervisors (Board) has demonstrated its commitment to improving the treatment of persons with mental illness and substance abuse challenges, while preserving public safety. A successful jail diversion approach would re-direct individuals with serious mental illness and co-occurring substance use disorders from the criminal justice system to an integrated treatment system.

On May 6, 2014, the Board adopted a motion directing several departments, under the leadership of the District Attorney, to move expeditiously toward establishing a comprehensive diversion program for Los Angeles County (County). The Board supported the District Attorney’s leadership in convening a broad County workgroup to conduct a comprehensive assessment of the existing mental health diversion programs used by the County, and currently available permanent supportive housing.

On July 29, 2014 and on April 14, 2015, respectively, the Board continued to demonstrate its commitment to diversion efforts in the County by approving \$20 million in the FY14-15 Budget and an additional \$10 million in the FY 15-16 Budget.

On June 9, 2015, the Board suspended the Jail Master Plan and instructed the Interim Chief Executive Officer to consider community-based alternative options for treatment, including but not limited to mental health and substance abuse treatment.

Also on June 9, 2015, the Board moved to create a single, integrated jail health organizational structure and shift the entire Sheriff’s Department Medical Services Bureau supervision and budget, including positions and Department of Mental Health staff services, to

**- MORE -**

**MOTION**

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 2**

the Department of Health Services (DHS). The action was intended to dramatically improve quality and coordination of care while better facilitating successful re-entry into the community.

Data supports that it is prudent to invest taxpayer resources in a comprehensive diversion program that promotes integrated community care. Diversion efforts can be more effective than jails at treating mental illness, enhancing public safety, reducing repeat offenses and producing better outcomes. For these reasons, diversion alternatives, including the development of permanent supportive housing and integrated services, have been advanced in the context of the Board's consideration of replacing the antiquated Men's Central Jail with modernized correctional treatment centers for men and women. With the Board's recent acceptance of the MacArthur Foundation Safety and Justice Challenge, the Sheriff and Board reaffirmed their joint commitment to find ways to safely reduce incarceration in jails.

The District Attorney's well-researched report entitled Providing Treatment, Promoting Rehabilitation and Reducing Recidivism: An Initiative to Develop a Comprehensive Plan for Los Angeles County includes findings derived from the efforts of the District Attorney's Criminal Justice Mental Health Advisory Board and various working groups.

Among other things, the District Attorney's comprehensive report describes how diversion needs to occur across "sequential intercept" points defined as:

Intercept One: Law Enforcement/Emergency Services, when the justice system first contacts an individual, before arrest.

Intercept Two: Post-Arrest/Arrest, as the prosecuting agency decides whether or not to file criminal charges.

Intercept Three: Courts/Post-Arrest/Alternatives to Incarceration, when the criminal charges are resolved either by a dismissal, a guilty plea or a trial.

Intercept Four: Community Reentry, when the individual is released back into the community.

Intercept Five: Community Support, when the person continues to have access to resources to facilitate successful reintegration into the community.

The report also identifies gaps, potential programs and successful existing programs that need further support.

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 3**

The time for action is now. The first step is to create a leadership structure to implement the various working group recommendations, supported by dedicated resources and the tremendous existing expertise of County departments. This leadership team should recommend policies and priorities, enhance integration across departments, and coordinate crisis intervention as well as discharge planning. This leadership team should also develop standardized tools that can be used across the County and judicial system for triage and prioritization.

DHS is well-poised to act as a home for these comprehensive diversion efforts. DHS has been tasked with delivery of all inmate health, mental health and substance abuse services. The DHS' Housing for Health Programs established the Flexible Housing Subsidy Pool in early 2014, as well as ongoing contracts for Intensive Case Management and Property Management. Housing for Health has already housed almost 1,000 medically fragile homeless persons. Through its Flexible Housing Subsidy Pool, DHS is expected to provide housing subsidies for at least 2,400 persons, who will be linked with wrap-around, intensive case management services. Housing for Health is housing former inmates who are on probation, with funding from the Probation Department to provide rapid re-housing interventions.

**WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:**

1. Improve coordination and implementation of diversion efforts throughout Los Angeles County (County) by executing the following:
  - a. Establish a Director of the Office of Diversion position within the Department of Health Services (DHS) who would be responsible for oversight and coordination of all County-wide diversion of persons who have mental illness or substance abuse issues, and persons who are homeless or at risk of becoming homeless upon discharge. This position shall coordinate closely with the Jail Care Transitions Director.
  - b. Allocate 5 new positions to the Office of Diversion, which shall include expertise in housing, health, mental health/alcohol and drug prevention and legal/justice issues.

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 4**

- c. Direct County Counsel to work with the Interim Chief Executive Officer to draft a County ordinance within 60 days and take any other actions necessary to create the Office of Diversion.
  - d. Establish a Permanent Steering Committee that is convened by the Interim Chief Executive Officer, and is co-chaired on an interim basis by the District Attorney and Director of Health Services pending hire of the Director of the Office of Diversion. This Permanent Steering Committee shall consist of one leadership representative from each of the following departments: Chief Executive Office, Superior Court, Public Defender, Alternative Public Defender, District Attorney, Sheriff's Department, Probation, Fire Department, Department of Mental Health, Substance Abuse Prevention and the Control division of the Department of Public Health, and DHS. The purpose of this advisory committee to the Office of Diversion is to develop and drive forward recommendations so diversion seamlessly occurs across all intercepts.
    - i. The Permanent Steering Committee shall meet at least on a monthly basis;
    - ii. The Permanent Steering Committee shall work in collaboration with and be informed by the working groups established by the District Attorney.
2. Task the Office of Diversion and Permanent Steering Committee to identify or create a more standardized diversion assessment tool that all County departments (including the Superior Court) and key private provider partners will use to triage persons with mental illness and substance abuse issues, and persons who are homeless, to determine which services (including housing) are most appropriate.
    - a. Report back in writing on recommendations, including proposed roll-out, priority populations, projects and training, within 60 days of the Permanent Steering Committee's first meeting. Priority populations should include the elderly (ages 62 and older) and veterans.
  3. Direct County Counsel to draft a Memorandum of Understanding between all members of the Permanent Steering Committee, the Sheriff's Department (and any

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 5**

other interested local police departments), and the Los Angeles Homeless Services Authority on how they will work together to appropriately divert persons with mental health, substance abuse and/or physical health issues, and/or who are at risk of homelessness when encountered by law enforcement and emergency services.

4. Direct the Interim Chief Executive Officer (CEO) to create a diversion fund made up of the following funds and allocate it to the new Office of Diversion:
  - a. 50% of Senate Bill (SB) 678 funds that have accumulated in the Community Corrections Performance Incentives (CCPI) Special Revenue Fund and 50% of all future SB 678 funds that are received by the County beginning in FY 2015-16;
  - b. 50% of all new Public Safety Realignment/Assembly Bill 109 (AB 109) funds that are received in excess of the amounts budgeted in the FY 2015-16 Adopted Budget;
  - c. \$20M set aside in the FY 2014-15 Supplemental Budget pursuant to the Board of Supervisor's (Board) July 29, 2014 action;
  - d. \$10M set aside in the FY 2015-16 Recommended Budget pursuant to the Board's April 14, 2015 action;
  - e. All new funding allocated by the Board for the purposes of diversion as defined above;
  - f. All revenue earned, generated or drawn down as part of delivering diversion services so that those funds further diversion efforts and do not replace money allocated for other programs; and
  - g. The County Counsel and Interim CEO should report back to the Board in writing within 30 days with any concerns or issues identified regarding the proposed transfers.
5. Direct the Director of the Office of Diversion, within 90 days from adoption of this motion, in coordination with the Permanent Steering Committee, to report back to the Board with specific written recommendations related to the allocation of the

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 6**

diversion funds such that any funding restrictions applicable to any of the financing sources are adhered to so that at least 1,000 individuals are diverted across all intercepts and the diversion funds are dedicated as follows:

- a. 40% for housing;
  - i. Housing funds shall be allocated for rapid re-housing, permanent supportive housing, higher levels of care including board and care facilities and with provisions within each allocation for crisis housing pending placement.
  - ii. Housing shall include related integrated supportive services, such as case-management, mental health treatment, substance abuse treatment, job training and connections to community-based services.
  - iii. These housing activities shall be implemented in coordination with the Single Adult Model and Coordinated Entry System.
- b. 50% for the otherwise unmet costs of expansion of existing successful or implementation of promising diversion and anti-recidivism programs, especially those administered in community settings, such as:
  - i. Development of locked, secure, and unlocked mental health treatment beds, including, skilled nursing facilities, institutions for mental diseases and those able to handle dually diagnosed persons.
  - ii. Expansion of successful integrated health programs such as mental health urgent care centers, multidisciplinary integrated teams, forensic full service partnerships, wellness center slots, field capable clinical services in alternative settings;
  - iii. Development of jail mental health teams in Public Defender and Alternate Public Defender offices;
  - iv. Expansion of diversion and alternative sentencing projects, like those currently in the Van Nuys and San Fernando courts;
  - v. Expansion of the Just-in-Reach program, including the launch of a Pay-for-Success initiative; and

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL  
AUGUST 11, 2015  
PAGE 7**

- vi. New sobering center programs, with the first to be located in the Skid Row area, as well as residential detox and treatment programs.
  - c. 10% for overhead, staffing, consultants, evaluation, and training, including crisis intervention training for law enforcement.
  - d. \$20,188,910 of SB 90 reimbursement shall be set aside to expand community -based capacity for specialized substance use treatment services.
  - e. Include in the report back any recommended adjustments to any assigned percentage allocations identified above, especially given any concurrent or updated analysis on gaps and capacity needs.
6. Direct the Director of the Office of Diversion and the Interim CEO to report back in writing in 90 days on how to develop a pipeline of no less than 1,000 permanent supportive housing units over the next five years to support a jail diversion program, including evaluating whether the County has available property within or in close proximity to its medical campus sites that it can make available for development of permanent supportive housing.
7. Direct the Director of the Office of Diversion and the Interim CEO to work with the District Attorney and report back in writing in 90 days on a proposed plan to evaluate the efficacy of this diversion initiative.

###

(YV/DW)

MOTION BY MAYOR MICHAEL D. ANTONOVICH

AUGUST 11, 2015

**Amendment to Item 49-C:**

The recent independent study by Health Management Associates and Pulitzer/Bogard & Associates ("HMA report") recommended that the Board move forward with the replacement of the Men's Central Jail with a Consolidated Correctional Treatment Facility (CCTF) with a bed capacity between 4,600 and 5,060. The prior independent study by Vanir Construction Management recommended a bed capacity of approximately 4,885. The HMA report also projected an increase in the jail bed need for the medical/mental health population to 6,722 without implementation of best practices by 2025. Thus, the jail plan and diversion strategies must go hand-in-hand to protect public safety and properly treat and divert offenders who can be safely supervised and treated in the community.

The County's jail system now houses inmates with longer sentences and greater medical and mental health treatment needs since the implementation of AB 109. The wave of the future for corrections is not simply to house offenders but to provide robust services and programs, including increased educational and vocational opportunities. Most of the County's existing jail facilities were built more than 50 years ago and are not conducive for programming and treatment services. Thus, once the CCTF is operational, the total jail capacity can be adjusted based on the successes of diversion and aging and costly facilities can be downsized or closed, as appropriate.

- M O R E -

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

**I, THEREFORE, MOVE** that the Board of Supervisors direct the Interim Chief Executive Officer (CEO) to:

1. Immediately notify the contractors (AECOM and DLR) to resume work on the Consolidated Correctional Treatment Facility (CCTF) and Mira Loma which was halted by the Board on June 9;
2. Ensure that the CCTF and Mira Loma projects move forward simultaneously as a single project , including the timing of awarding the design-built construction contracts and a local worker hire requirement for the CCTF;
3. Reduce the previously approved capacity of the CCTF from 4,885 to 4,600 beds with the majority of the beds dedicated for mental health treatment and substance abuse detoxification needs;
4. Provide the state Public Works Board all documents required to establish Mira Loma as a project and maintain eligibility in the AB 900 grant program provided item 2 above is upheld; and
5. Provide status reports to the Board on a quarterly basis or as significant developments occur.

I, FURTHER, MOVE that the Board of Supervisors request the Interim CEO to work jointly with the Sheriff to provide a written report in 6 months that identifies facilities that are the oldest and most costly to operate and can be downsized or closed in the future to offset any increases in bed capacity at CCTF.

# # #

MDA:apo  
consolidatedcorrectionaltreatmentfacility

AMENDMENT BY SUPERVISOR HILDA L. SOLIS

August 11, 2015

The name of the office should be the Office of Diversion *and Re-Entry* instead of the Office of Diversion.

The proposed Permanent Steering Committee should include:

- The Los Angeles City Attorney's Office
- Significantly more community representation, at least:
  - One representative from a mental health service provider
  - One representative from a mental health advocacy organization

The Office of Diversion and Re-Entry should be jointly responsible, with the Sheriff's Department, for developing the application for the second phase of the MacArthur grant.

###

HLS:bp

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

MOTION BY MAYOR MICHAEL D. ANTONOVICH

AUGUST 11, 2015

**AMENDMENT TO ITEM #49-C:**

I, **THEREFORE, MOVE** that the Board of Supervisors require that development and expansion of treatment services and housing capacity in the community include a robust community outreach and input from those residing in the surrounding neighborhoods and are directly affected.

# # #

MDA:tbo  
diversionamendment49c081115

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

**I, THEREFORE MOVE** that the Board:

5. Instruct the Director of the Office of Diversion, ~~within 90 days from adoption of this motion~~ within 90 days from the hiring of the Director of the Office of Diversion, in coordination with the Permanent Steering Committee, to report back to the Board with specific written recommendations related to the allocation of the diversion funds such that any funding restrictions applicable to any of the financing sources are adhered to so that at least 1,000 individuals are diverted across all intercepts and the diversion funds are dedicated as follows:

6. Instruct the Director of the Office of Diversion and the Interim Chief Executive Officer to report back in writing ~~in 90 days~~ within 90 days from the hiring of the Director of the Office of Diversion on how to develop a pipeline of no less than 1,000 permanent supportive housing units over the next five years to support a jail diversion program, including evaluating whether the County has available property within or in close proximity to its medical campus sites that it can make available for development of permanent supportive housing; and

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

7. Instruct the Director of the Office of Diversion and the Interim Chief Executive Officer to work with the District Attorney and report back in writing in ~~90 days~~ report back in writing within 90 days of the hiring of the Director of the Office of Diversion on a proposed plan to evaluate the efficacy of this diversion initiative.

# # #

HLS/bp

AMENDMENT TO S1, ITEM C MOTION BY  
SUPERVISORS KUEHL AND SOLIS

September 1, 2015

**I, THEREFORE, MOVE** that the Los Angeles County Sheriff's Department and the Los Angeles County Department of Public Health establish a gender-responsive advisory board, consisting of county staff, Board of Supervisor representatives, advocates, experts in managing female inmates, previously incarcerated persons and designated inmates, to review the program model at Mira Loma to ensure that the programming is evidence-based in reducing recidivism. This committee should further evaluate strategies to reduce the negative impact of locating the Mira Loma facility away from downtown Los Angeles, including the use of contract transportation for visitors, the use of videoconferencing for attorney consultation, encouraging family reunification and reduction in transportation time for court appearances. Additionally, this committee should examine national best practices for visiting and family reunification in that it is clear, as demonstrated by research, that inmates who remain connected to family and positive influences in their lives are more successful upon reentry. This advisory board is to report back to the Board of Supervisors in 180 days.

S: SG/Mira Loma

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

AMENDMENT BY SUPERVISOR HILDA L. SOLIS  
AND SUPERVISOR SHEILA KUEHL

September 1, 2015

**WE, THEREFORE MOVE** that the Board:

1. Request that the Sheriff draft and present to the Board for review a Scope of Work (and a cost estimate) for a long-term scenario-based strategic plan for the Los Angeles County Jail System within 180 days. This plan should consider the implications and strategic responses for a future in which the jail population significantly increases or decreases.

# # #

HLS/bp  
SK/sg

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

MOTION BY MAYOR MICHAEL D. ANTONOVICH

SEPTEMBER 1, 2015

**AMENDMENT TO SUPERVISOR KUEHL AND SOLIS' RECOMMENDATION FOR GENDER-RESPONSIVE ADVISORY BOARD FOR THE MIRA LOMA DETENTION FACILITY**

I, THEREFORE, MOVE that the Board of Supervisors consider using existing county owned facilities that are in close proximity to downtown Los Angeles as options for expanding capacity for community-based treatment services for the mentally ill, substance abusers or for re-entry purposes in the future.

# # #

MDA:amg

MOTION

SOLIS \_\_\_\_\_

RIDLEY-THOMAS \_\_\_\_\_

KUEHL \_\_\_\_\_

KNABE \_\_\_\_\_

ANTONOVICH \_\_\_\_\_

AMENDMENT BY SUPERVISOR MARK RIDLEY-THOMAS

September 1, 2015

I, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

Include the Medical Services Bureau, consisting of the Department of Health Services, Department of Mental Health and the Department of Public Health, in collaboration with the Sheriff’s Department, for the development of a long-term strategic plan related to the Los Angeles County Jail System and jail population management.

# # # #

(DJJ)

MOTION

SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____



Los Angeles County  
Board of Supervisors

March 14, 2016

Hilda L. Solis  
First District

Mark Ridley-Thomas  
Second District

Sheila Kuehl  
Third District

Don Knabe  
Fourth District

Michael D. Antonovich  
Fifth District

TO: Supervisor Hilda L. Solis, Chair  
Supervisor Mark Ridley-Thomas  
Supervisor Sheila Kuehl  
Supervisor Don Knabe  
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.  
Director

SUBJECT: OFFICE OF DIVERSION AND RE-ENTRY  
STATUS REPORT

Mitchell H. Katz, M.D.  
Director

Hal F. Yee, Jr., M.D., Ph.D.  
Chief Medical Officer

Christina R. Ghaly, M.D.  
Deputy Director, Strategy and Operations

On August 11, 2015, Supervisors Ridley-Thomas and Kuehl introduced a motion to improve the coordination and implementation of diversion efforts throughout Los Angeles County (LA County). The Board of Supervisors (Board) approved the motion on September 1, 2015, and directed the following:

313 N. Figueroa Street, Suite 912  
Los Angeles, CA 90012

Tel: (213) 240-8101  
Fax: (213) 481-0503

[www.dhs.lacounty.gov](http://www.dhs.lacounty.gov)

- 1) Establish a Director of the Office of Diversion and Re-Entry (ODR) position within the Department of Health Services (DHS) who would be responsible for oversight and coordination of all Countywide diversion of persons who have serious mental illness or substance use disorder (SUD) issues, and who are homeless or at risk of becoming homeless upon discharge, with this position to coordinate closely with the Jail Care Transitions Director;
- 2) Allocate five new positions to the ODR, which shall include expertise in housing, health, mental health/alcohol and drug prevention and legal/justice issues;
- 3) Establish a Permanent Steering Committee (PSC) that is convened by the Chief Executive Officer and is co-chaired on an interim basis by the District Attorney and the Director of Health Services pending hire of the Director of the ODR. The PSC is to consist of one leadership representative from each of the following Departments: Chief Executive Office (CEO), Superior Court, Public Defender (PD), Alternate Public Defender (APD), District Attorney (DA), Sheriff (LASD), Probation, Fire, Mental Health (DMH), Substance Abuse Prevention and the Control (SAPC) and DHS, and also include a member of the Los Angeles City Attorney's Office and a member from the City Attorney's Association. The PSC should also have significant and meaningful

*To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.*

[www.dhs.lacounty.gov](http://www.dhs.lacounty.gov)



community representation with at least one representative from a mental health service provider and one representative from a mental health advocacy organization. The purpose of the PSC is to advise the ODR and to drive forward recommendations so diversion seamlessly occurs across all intercepts. The PSC shall meet at least on a monthly basis and work in collaboration with and be informed by the working groups established by the DA;

- 4) Create a diversion fund and allocate it to the new ODR, with the Interim County Counsel and the Chief Executive Officer to report back to the Board in writing within 30 days with any concerns or issues identified regarding the proposed transfers.

This memo is intended to provide an update regarding the work of the ODR, a new division within DHS. The memo also serves to share ODR's initial plan for utilizing a portion of the funding provided by the Board in order to build programs that effectively divert persons with serious mental illness and SUDs who encounter the criminal justice systems.

### **Organizational Structure**

On October 6, 2015, your Board approved establishing a Director, ODR (UC) position within DHS. On November 9, 2015, the position was posted to the DHS Human Resources site. DHS has shared the job announcement broadly and we have received five applications and certified three applicants to an eligible list. The Board approved the amendment to the County Ordinance that officially created the ODR on November 17, 2015. In addition to the Director position, DHS in partnership with CEO Classification has established five positions subordinate to the Director position in order to facilitate the work for the ODR. We currently have an Interim Director and two other staff. DHS Human Resources staff is currently working on the job announcements and will begin recruitment. Attached is the current proposed organizational chart for ODR. It has been shared with each Board office and CEO staff.

### **Permanent Steering Committee (PSC)**

Six PSC meetings have been held since September 2015. The interim ODR Director co-chairs each meeting with the DA's office. All meetings have been well attended and productive. In November 2015, DHS requested that each Board office nominate two community members to the PSC. In December 2015, community representatives began attending the PSC as members. We look forward to involving approximately 10 community representatives on the PSC and firmly believe that the success of Countywide diversion efforts requires broad based involvement from communities and community-based service providers/partners.

To date, the focus of the PSC meetings have included discussions about the membership of the PSC and how the PSC will act to advise the ODR on an ongoing basis, funding for ODR, including spending priorities, and discussions about the diversion and re-entry programs ODR is developing and those it will partner to support.

## Funding

On September 29, 2015, as part of the FY 2015-16 Supplemental Budget, the County created a new budget unit in the General Fund for Diversion and Re-entry, consistent with input from County Counsel. The combined adjustments of multiple funding sources have provided the Diversion and Re-entry budget unit with appropriation authority of \$63.5 million of one-time funding and \$25 million of ongoing funding. Of the one-time funding, \$60.2 million is Net County Cost (NCC). Of ongoing funding, \$10 million is NCC.

The Board motion establishing ODR specifies that of the total ODR funding, 50% is dedicated to programming and support to entities who drive diversion (i.e., community service providers, courts, clinical departments, LASD, Probation); 40% to housing to support the creation of at least 1,000 units of permanent supportive housing as well as a focus on interim, bridge or other housing such as board and care or clinically enhanced housing; and 10% to training, staff and evaluation.

In addition to the ODR funding already captured above, ODR is currently anticipating funds from SB 678 and the County's Homelessness Initiative to be available for diversion services. See below for the specifics:

### SB 678 and ODR

In November 2015, ODR and Probation staff began discussing how SB 678 funding and program planning will support Countywide diversion and re-entry efforts. In brief, SB 678 allocates funds to the Chief Probation Officer of each county to facilitate the provision of supervision, sanctions and services in an effort to improve outcomes for felony offenders on probation. Funds allocated for this purpose must be used to provide supervision and rehabilitative services consistent with evidence-based community corrections practices and programs. To this end, included in Probation's proposed SB 678 multi-year spending plan is a recommendation that approximately \$18.8 million in one-time funds be set aside on a fee-for-service basis to enable ODR to work with other County departments to support the services and housing needs of all felony probationers with an emphasis on moderate to high-risk felony probationers, the target population of SB 678 funding. The programs that could potentially be supported with SB 678 funds may include:

- Mental health services including Cognitive Behavioral Therapy (CTB);
- Substance use disorder (SUD) services;
- Housing services and access to housing subsidies;
- Job training and employment services;
- Transportation;
- Life skills training; and
- Program evaluation consistent with SB 678 requirements

Probation has identified CBT and SUD services as the components most appropriate for the ODR to facilitate. Housing services are intended to be supported through SB 678 funding provided to the County's high priority Homelessness Initiative(s). The SB 678 proposed spending plan is pending discussion with the Board and CEO in anticipation of formal approval in April, 2016.

### ODR and County's Homelessness Initiative

On February 9, 2016, the Board heard and adopted the CEO's report entitled "Recommended Strategies to Combat Homelessness". Among the 47 adopted strategies, many have either a direct focus on the work of the ODR or will have an impact. More specifically, Recommendations D2 and D4, Expand Jail In-Reach and Regional Integrated Re-entry Networks – Homeless Focus put the ODR in a leading role for implementation. These initiatives will bring \$2.8 million from the County's Homelessness Initiative funding and \$5 million from Assembly Bill (AB) 109 funding to ODR to support the development of the integrated re-entry networks and expand jail in-reach, in partnership with LASD.

### Diversification and Re-entry Efforts

Since the ODR was established in the fourth quarter of 2015, interim staff members have focused on identifying priority programs to implement. Over the first six months, ODR has provided support to many existing projects and programs and in other instances, began to implement new programs. The following is a highlight of many of the projects or programs ODR has focused on and lists the category of funding that each effort is attributed to: training, program or housing.

- 1) Investment in Crisis Intervention Training (CIT) for LASD patrol (Training): In California and throughout the country, recent high-profile encounters between law enforcement officers and mentally ill persons have highlighted the need for additional mental health training for patrol personnel to enhance competence when interacting with mentally ill or substance using persons. In May 2015, the President's Task Force on 21<sup>st</sup> Century Policing recommended law enforcement agencies make CIT a part of both basic recruit training and in-service training. The goals of CIT include reducing use of force in the field; improving the linkage of persons with mental illness and SUDs to services rather than booking and incarceration; and reducing recidivism. Already, LASD provides a training similar to CIT to all deputies in the custody division. ODR has made it a priority to work with LASD to support CIT training for patrol deputies.

The current CIT roll-out plan is to provide 32 hours of in-classroom mental health training to patrol deputies. The core elements of CIT include training on mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. Funding details for CIT are addressed below.

- 2) Expansion of Mental Health Evaluation Teams (MET) throughout the County (Program): Since 2010, calls to LASD that involve a mentally ill person have increased by 55%. Nearly 40% of all LASD use of force incidents involves a mentally ill person. The LASD currently partners with DMH in offering specially-trained field units, called a Mental Evaluation Team (MET), to deal with mentally ill community members in crisis (e.g., barricaded suspects, suicides in progress, other self-inflicted injuries). A MET consists of a Deputy Sheriff and a DMH Clinician who

respond in an unmarked Sheriff's vehicle. MET provides crisis intervention techniques to diffuse potentially volatile situations, prepares appropriate documentation to assist custodial agencies in the placement of the mentally ill, acts as a liaison to community and judicial agencies, and gives court testimony regarding the mental health or emotional stability of mentally ill persons. MET assist patrol personnel, ideally trained in CIT, by arranging placement or providing transport for an individual to an appropriate facility. MET reduce the potential for use of force incidents and provide mentally ill persons with an immediate clinical assessment and related mental health services (acute inpatient hospitalization to private and County hospitals or services through the Urgent Care Centers (UCC), linkage, intensive case management, training, etc.). Through MET, mentally ill persons are diverted from incarceration and/or hospitalization, when appropriate, and instead are provided alternative care in the least restrictive environment through a coordinated and comprehensive approach.

The expansion of MET within the LASD will augment an already growing number of similarly trained and staffed law enforcement teams around the County including the 32 System-wide Mental Assessment Response Teams (SMART) in Los Angeles Police Department and the 17 mental health response teams housed within many local city law enforcement agencies. Additionally, DMH has three clinicians assigned to the LASD Metropolitan Transit Authority (MTA)-Crisis Response Unit and two clinicians with the LASD Community College Bureau. Funding for MET expansion is detailed below.

- 3) Sobering Center (Program): ODR is working to develop plans for the County's first "Sobering" Center, to be located in the Skid Row area. The center's goals are to provide a safe environment, health monitoring and connection to services for individuals experiencing acute intoxication from alcohol or other substances who might otherwise be cited or arrested by law enforcement or admitted to an emergency room or psychiatric emergency room. A site has been identified and a workgroup consisting of the DHS, DMH, SAPC, LASD, LAPD and LAFD has been defining the scope of services, to include an integrated care model. The center is expected to have a capacity of 40-50 beds and an average length of stay of 8-24 hours, with some individuals staying up to 48 hours as staff work to connect them to SUD treatment, bridge housing and other services. The center is anticipated to open during the late summer or early fall of 2016. Funding for this first sobering center is detailed below.
- 4) Implementation of the Mentally Ill Offender Crime Reduction (MIOCR) grant program (Program): MIOCR is a collaboration between DHS, DMH, SAPC, LASD, DA, PD, and Probation to provide jail in-reach, enhanced discharge planning and linkage to community services for 30 jail inmates per year with mental illness and co-occurring physical health or SUDs. A total of \$1.8 million in funding is available over three years and will be managed and administered through ODR. A critical program element will be the 30 Full Service Partnership program slots DMH will provide as an in-kind match. Items are currently being allocated for the four-person interdisciplinary project team, and staff recruitment has begun.

- 5) Proposition 47 implementation (Program and Housing): ODR has been involved in the work focused on Proposition 47 implementation in LA County. Specifically ODR is leading the work to set Countywide priorities for funding that might be available from the State to implement Proposition 47 locally. ODR is also participating with the CEO and Community and Senior Services to develop a GIS map of Prop 47 clients and existing public and private service providers. Finally, ODR in partnership with SAPC has worked with the City Attorney's Office on creating a pilot program for approximately 15 enrollees wherein a shortened course of substance use treatment, on the order of 16 weeks, could be provided to potential eligible participants. The pilot will essentially test the efficacy of a 12 to 16-week as opposed to a much longer treatment program. The treatment program will be augmented by providing access to housing and job training, as needed by participants.
  
- 6) Assessment and referral support for four new Community Collaborative Courts (CCCs) (Program): ODR has begun to work with the Los Angeles Superior Courts to help support the new CCC model. The intention is to provide the Courts with staff support to help guide assessments and planning for specific clients. Also, the ODR will support these Courts with slots or beds in specific programs so that clients can be seamlessly and immediately referred into programs that have been deemed clinically appropriate and acceptable to all parties involved in determining the client's diversion plan. DMH as well as SAPC will also directly participate in supporting these Courts. There is a great opportunity to learn from this focused work with the four CCCs. This learning can be spread to other courts across the County focused on diversion options.
  
- 7) Misdemeanor Incompetent to Stand Trial (MIST) Community-Based Restoration (MIST CBR) project (Program): Since the inception of the ODR in August, ODR has launched a successful project called the Misdemeanor Incompetent to Stand Trial Community-Based Restoration Program (MIST CBR). Previous to our efforts, on any given day, approximately 200 inmates charged with misdemeanors, frequently crimes of poverty such as trespassing, are housed in our jail and have been declared incompetent to stand trial due to a serious mental disorder. This group of inmates primarily consists of chronically homeless, mentally ill persons often in high observation housing (HOH), a designated area of the jail, who are generally the most impaired inmates within our jail system. Led by ODR, which closely coordinates the effort by several County departments, including the Mental Health Court (Department 95), the DMH Countywide Resource Management team, the Jail Mental Health providers, the Public and Alternate Public Defenders, the DA, the LASD custody leadership team and community outpatient and inpatient providers, we have referred over 100 MISTs as of this writing, and 80 have been conditionally released to the appropriate level of care and followed intensively. This has reduced the overall MIST population in the jail from 200 on any given day to about 150. This effort has required partnerships that have never before existed in the County and procedures/actions that have never before taken place. Many new inter-departmental policies and relationships have been created to support this program. Our goal is to no longer house the majority of this population in the jail, but instead in the community. The MIST CBR effort has also set the foundation for the focused work on other populations currently incarcerated or stuck in the criminal justice

system whose mental health or substance use disorders are under-addressed and undertreated by virtue of the lack of assessment, treatment options and/or systematic focus on connecting them to care. We will build on the MIST CBR effort so to transition more low-level offenders who are currently incarcerated and move them into community-based treatment and services.

- 8) Normandie Village East (Program): A pilot project between DMH and LASD, Normandie Village East provides an Enriched Residential Services (IMD Step Down) program to AB109 inmates with intensive mental health needs, who have 60-90 days left to serve on their sentence. Participants are monitored via an electronic monitoring anklet and housed in a licensed Adult Residential Facility that serves up to 42 individuals at any given time. Gateways Hospital and Mental Health Center provides residential and mental health services to the participants who will receive specialized, intensive residential program services addressing their substance abuse and mental health care needs. DMH and LASD have partnered with ODR to ensure that we maximize the availability of this resource by referring a sufficient number of inmates who meet program criteria. In future years, when initial program funding is spent, ODR will consider further supporting this program.
- 9) Creation of policies and agreements with the Courts, Public Defenders, Alternate Public Defenders and District Attorney's offices (Program): ODR is exploring how pre-sentenced inmates in County jail with serious mental illness or SUDs can be moved quickly into treatment beds which will be enhanced by sufficient community-based navigation and stabilization supports so to avoid re-incarceration and clinical de-compensation. A first project is exploring the use of a 30-bed acute inpatient psychiatric unit at a local private community hospital to be used for current inmates who require treatment under an involuntary hold and who could, after a period of stabilization, safely return to their communities with wrap around support. If this first project is successful, there is potential to expand with similar programs in other parts of the County.
- 10) Expansion of residential drug treatment programs such as provided at Prototypes (Program): On October 6, 2015, your Board instructed County departments that provided AB 109 treatment and support services to expand the pool of eligible populations that can be served utilizing AB 109 funding. In response, ODR and SAPC initiated discussion with Prototypes, a community-based SUD treatment program specializing in serving women, to expand residential treatment accessibility in its Second Chance Women's Reentry Court (WRC) program. The WRC provides women facing a return to State prison or lengthy jail terms with the opportunity to enter residential SUD treatment followed by outpatient treatment, re-entry planning, and aftercare services. SAPC applied its delegated authority to augment Prototypes' AB 109 contract for FY 2015-16 to add 12 additional beds for diversion and re-entry populations. DPH then worked with the PD's Office to identify and place incarcerated women eligible for the WRC who also met the expanded population criteria. Since January 2016, 11 incarcerated women that were previously waitlisted were admitted to the Prototypes WRC. Using programs with capacity, like Prototypes, is an important strategy for ODR. Although additional program capacity

is surely needed, the first step in successful diversion activities is to fully utilize existing capacity.

- 11) Expansion of Institutions for Mental Disease (IMDs) and enhanced residential settings (Program): The ODR has been considering, in partnership with DMH, the role of expanding mental health beds to achieve the mission of diverting eligible clients into community-based programs. There is no doubt that an expansion of community mental health beds is needed to accommodate clients pre-booking and post-booking. Currently ODR is working with DMH to assess current capacity in both unlocked and locked settings to accommodate ODR target clients. Once this assessment is complete, we will propose how some proportion of ODR service funding can be used to maximally expand the number of beds available for diversion and re-entry purposes. One key strategy will be to work with DMH in creating and/or identifying beds that are able to draw down federal funding through Medicaid – this is generally unlocked but service-enriched housing.
- 12) Pay for Success (Program and Housing): The ODR and DHS' Housing for Health program, in collaboration with the CEO and LASD, currently lead LA County's Pay for Success (PFS) initiative. The initiative will focus on the end-to-end provision of holistic, supportive jail in-reach and post-release permanent supportive housing services to 300 homeless LA County inmates who have frequent contact with the criminal justice system as well as complex physical and/or behavioral health conditions that contribute to negative housing and criminal justice/recidivism outcomes.

Homelessness and incarceration are mutual risk factors, and evidence suggests that recently released inmates who are homeless are at greater risk for recidivism than those who are stably housed following release from custody. Combined with limited/low income and criminal history, offenders reentering society who suffer from complex physical and/or behavioral health conditions face significant barriers in securing stable housing and continuing needed treatment, resulting in higher rates of recidivism, homelessness, and poor health outcomes.

The intervention consists of two linked components: pre-release jail in-reach supportive services and immediate interim housing in anticipation of permanent supportive housing upon release from jail. The jail in-reach services will be carried out by DHS contracted intensive case management services providers. These providers will connect clients to interim housing immediately upon release from jail and then to permanent supportive housing. Once the client is housed, the original jail in-reach service provider will continue to provide intensive case management services to help the client maintain their housing and to support their health and well-being through connection to physical health, mental health, and substance use treatment services. Permanent supportive housing, a key component of the program, will be provided through the DHS's Flexible Housing Subsidy Pool (FHSP). The FHSP program is operated by Brilliant Corners, also a DHS contracted provider, and provides housing location services, ongoing rental subsidy payments, and housing retention services.

The LA County PFS initiative builds on the existing Just In Reach (JIR Pilot and JIR 2.0) program, a collaboration between the Corporation for Supportive Housing (CSH) and the LASD. JIR was first launched in 2008 and provides jail in-reach services and connection to leveraged supportive housing resources. CSH will serve as the PFS intermediary with technical assistance from Third Sector Capital Partners.

The County team and partners are developing a work plan for the project construction phase through expected program launch by July 2017, or earlier, if the deal structuring and fundraising efforts are completed ahead of schedule. The estimated cost of the intervention is \$21.2 million to serve 300 individuals over the five year PFS funding term. DHS and its partners submitted a grant application for \$2 million in funding to the Board of State and Community Corrections, a grant application for \$1.3 million in funding to the federal Housing and Urban Development and Justice Departments, and have also engaged various philanthropic partners in support of the PFS initiative. The PFS initiative is being arranged through the strong guidance of the Board offices as this type program arrangement is new not only in the County but across the Country.

- 13) Connecting Criminal Justice and Health Care Initiative (Training and Program): Los Angeles County was selected as one of two jurisdictions from across the nation to participate in a promising learning collaborative led by the Urban Institute and Manatt Health Solutions entitled *Connecting Criminal Justice and Health Care*. DHS submitted an application in December that included many partners such as the LASD, LA Care Health Plan, California's Department of Health Care Services and California Department of Corrections and Rehabilitation.

The learning collaborative has three areas of focus: (a) advancing efforts to enroll eligible inmates in Medicaid; (b) improving re-entry services for those with health issues that need services upon release; and (c) exploring opportunities to increase the impact of Medicaid in supporting health services to those in custody. The Urban Institute-led review committee chose the Los Angeles application over dozens of others in large part due to the transformative work the Board has already moved forward over the past 12 months. Specifically, the review panel cited the creation of the Integrated Jail Health Services initiative as well as the important work of the Office of Diversion and Re-entry as particularly promising opportunities to allow Los Angeles to become a leading example in the nation for how to serve justice involved populations.

We look forward to the many hours of free, high-quality, consulting services and the exposure to best practices from other jurisdictions which we will receive through the learning collaborative. These supports should help us advance our work in Los Angeles more swiftly.

- 14) Integrated Re-entry Network: A planning effort involving DHS, LA Care, HealthNet, DMH, SAPC, LASD, Probation,, and selected community partners is currently underway to explore the development of a "re-entry network" of health care providers to serve individuals returning to the community from jail. The group has been working to identify gaps in services for the re-entry population and has

recommended an initial focus on the following populations: those who are medically fragile or have chronic health conditions, pregnant women, those on psychotropic medications, and those with a SUD, including those who may benefit from Medication Assisted Therapy (MAT). The initial vision for a network includes identifying one or two sites for immediate follow up care upon release, implementing seamless sharing of patient records between jail and re-entry providers, incorporating community health workers to help newly released individuals link to care, and providing either integrated services or robust links to mental health, SUD, housing, case management and other social services in the community.

### **ODR Housing (40% of ODR budget)**

The Board motion which established the ODR was specific in regards to the types of housing and the housing-related services ODR funding should support. Housing funds shall be allocated for rapid re-housing, permanent supportive housing, higher levels of care including board and care facilities and with provisions within each allocation for crisis housing pending placement. Housing shall include related integrated supportive services, such as case management, linkage to mental health and substance abuse treatment, job training and connections to community-based services. The motion also specifically called for ODR to establish no less than 1,000 units of permanent supportive housing over five years for diversion purposes.

In order to achieve these goals, ODR will partner with DHS' Housing for Health division. A key ODR position is the ODR Housing Director who reports directly to the ODR, Deputy Director. The ODR will also fund 2.0 FTE Staff Analysts to support the development of the ODR housing program and portfolio.

Based on initial ODR funding, funds available for housing include \$25.4 million in one-time funds and \$10 million in ongoing funding. Over the five year timeframe included in the motion, there is a total of \$75.36 million available to support housing activities during this five-year period. For purposes of budgeting, it is assumed that a residential slot (for both interim and permanent housing) has an average annual cost of \$18,000 per year inclusive of support service costs (Intensive Case Management Services) and operating or rental subsidies. ODR will seek to offset County funding with federal funding in the form of federal housing vouchers or Medicaid funding, when possible.

### **Interim and Permanent Housing Cost Projection**

The chart below includes the cost of providing 200 slots of housing each year (including support services and move-in costs) for five years for a total of 1,000 slots. It assumes a steady ramp up of approximately 17 units per month over the five-year period.

Year	Total number of housing slots	Cost
1	200	\$2,383,000
2	400	\$5,983,000
3	600	\$9,583,000
4	800	\$13,183,000
5	1000	\$16,783,000
<b>Total</b>	<b>1000 units over 5 year period</b>	<b>\$47,915,000</b>

Staffing Needs for Housing for Health

The following additional staff are needed for the DHS Housing for Health division to develop and implement the additional interim and permanent supportive housing slots:

Position	Role	Description
Staff Analyst #1	Project Manager	New project development, implementation, and contract monitoring.
Staff Analyst #2	Access and Referral Specialist	Managing interim housing beds and permanent housing for diversion and re-entry individuals.

The cost of these new staff is calculated at \$238,256 per year including salaries and benefits or \$1,191,280 for 5 years.

First year costs for 200 interim and permanent supportive housing slots and staffing will total \$2,621,256. To achieve 1,000 units of PSH over 5 years, the total interim and permanent supportive housing and staffing cost is approximately \$49.25 million of the \$75.36 million available for these and other housing needs. ODR leadership will be developing a long range housing spending plan that continues to grow toward 1,000 units of PSH and also creates other housing for diversion purposes such as sober living environments and clinically-enriched housing.

Infrastructure Development

- 1) Program Database/Inventory: The CEO will lead the efforts to maintain an inventory of existing diversion programs organized by five distinct intercept points: Law Enforcement/Emergency Services, Post Arrest/Arrestment, Courts/Post-Arrestment/Alternatives to Incarceration, Community Re-entry, and Community Support. This inventory will serve as a tool to assess available resources, identify gaps in services, and determine points of interception at which an intervention can be made to prevent individuals with mental illness or SUDs from entering or penetrating deeper into the criminal justice system. ODR will support the CEO in this formative stage and soon take over the maintenance and oversight of the inventory. It will be used to help identify gaps and opportunities for development of ongoing diversion programming and strategies.

- 2) Diversion Assessment Tool: The ODR has led an effort involving LASD, Probation, SAPC, DMH and DHS to create a Countywide assessment tool to be used in-custody, in the field, in a program or in a courtroom, so to establish a consistent way to identify diversion opportunities for potentially eligible clients and connect these clients with appropriate services in an immediate and simple manner.
- 3) Diversion Dashboard: The ODR has created a very simple dashboard to update the number of persons diverted from jail or prison as a result of ODR's efforts and partnerships. This dashboard will be shared each month at the ODR PSC.
- 4) Diversion Database: ODR staff have created an encrypted, secure, web-based system for tracking diversion participants and referring them into programs quickly and efficiently. This database has been vetted by DHS, the LA Superior Court and County Counsel. Due to its success as an essential tool for patient releases in the MIST CBR program, ODR is expanding its use to other programs in which persons are released from the jail into treatment and housing programs. Using this same database in the courts and other venues where diversion is possible is also being considered.
- 5) Evaluation: The evaluation framework for ODR efforts is still in development. Initial metrics we will track will all be person-level and will include number of persons diverted from jail; number enrolled into a treatment or housing program, number who leave their treatment or housing programs (for those who have specific placements) and; number who are re-arrested or recidivate.

### **Funding Priorities for the Remainder of FY 2015-16 and for FY 2016-17**

ODR has received a number of budget requests from various partners to fund diversion related programs. As these requests come to our attention, they are being considered as a part of the larger ODR strategic planning process. Three efforts are being put into the FY 2016-17 recommended budget. Additional efforts are being finalized and will be included in the FY 2016-17 Final Changes budget or the FY 2016-17 Supplemental Budget.

### **Recommended Budget**

- 1) Crisis Intervention Training: LASD has proposed that ODR support a plan to provide a 32-hour training to approximately 2,161 patrol personnel over the next six years. These 2,161 patrol personnel will be joined each year by hundreds of Sheriff Deputies who transition from the custody areas into patrol and who, in their custody roles, have received a similar training to CIT to ensure they were equipped to manage mental illness of individuals in custody. Depending on the rate of custody to patrol transition, at the end of six years between 4,000 and 5,000 patrol deputies will have received mental health training and requisite maintenance training, consisting of an eight hour training every three years, so the skills stay fresh and up to date. The total investment for the six-year training plan will be offset by approximately \$6.4 million of ODR funding disbursed at \$1.4 million in the first year and \$1 million in each of the last five years. The ODR funding will augment the revenue that LASD

will receive because a portion of the training has been built into the contract city cost model as well as the departmental support through existing resources the Sheriff has committed to ensuring a sufficient number of patrol deputies receive the CIT training.

- 2) Housing: ODR will transfer \$2,621,256 to Housing for Health for two Staff Analysts and year one funding for supportive housing for 200 diversion eligible participants.
- 3) Sobering Center: The current planned sobering center, described above, sited adjacent to the Skid Row area downtown will have capacity of 40-50 clients at a time. Estimated length of stay is less than 24 hours. The current estimated project cost with one-time start up and first-year operating expenses is approximately \$4.8 million, with \$1.7 million in one-time costs and \$3.1 million in ongoing costs. We anticipate opening in the late summer or early fall of this year.

#### Final Changes Budget

- 1) MET expansion: In order to provide sufficient coverage and service to LASD's vast geographical area and population, a phased MET expansion is being proposed. Phase I of the MET expansion will be to go from five funded teams to ten. ODR will provide \$1.81 million to LASD and \$464,100 to DMH to fund the Phase I expansion. During the expansion in FY 2016-17, LASD, DMH and ODR will work together to evaluate the impact of the first phase of expansion and determine whether changes are needed for the planned expansion in future years.
- 2) Expansion of Mental Health beds: We anticipate earmarking roughly \$3-5 million in ODR funding to support the expansion of IMD and acute beds needed to prevent the incarceration or ongoing incarceration of persons with serious mental illness. Many of these individuals are currently in jail. The precise funding allocation will be based on the ability to identify vacant beds that can be used for this purpose. Included in this planning process is an assessment of expanding acute psychiatric bed capacity within our DHS operated County hospitals. Also, DMH is exploring the development of ODR Psychiatric Health Facilities (PHFs) which can provide care comparable to an acute psychiatric facility as well as purchasing additional forensic IMD beds.
- 3) Expansion of assessment staff and other staff: Staff are needed to help in many areas of diversion. For example, custody staff are needed to help support jail in-reach and court-related efforts. These staff will likely be embedded in court linkage, jail linkage or in the creation of a SUD linkage program. At this time, there is not a specific, fully vetted budget request for such positions. In all likelihood, we will make this budget submission for the FY 2016-17 Supplemental Budget.

#### Other Updates

##### McArthur Award Update

On January 25, 2016, the Los Angeles County MacArthur Safety and Justice Challenge (SJC) working group, led by LA County Assistant Sheriff Terri McDonald, completed its final

task in the grant selection process: the structured interview. During this interview the SJC team took the opportunity to reiterate the innovative steps taken by the County to reduce the jail population, provide community-based treatment and re-entry services, and enhance public safety; as well as to elaborate on the proposed initiatives which would be facilitated through a grant award:

- A significant expansion of the Bail Deviation process is to facilitate the release of potentially thousands of arrestees prior to arraignment each year through own recognizance (OR) release or reduced bail. This will be accomplished by automatically screening arrestees (scaling up from 17% currently screened to 100%) using a validated static risk assessment tool.
- The creation of a new Resource Release Program (RRP) to further increase the use of pretrial release for those defendants who do not qualify for release at the bail deviation stage or at arraignment. In close collaboration with the Defense Bar, RRP would facilitate these releases through the innovative and centralized coordination of community-based resources. This will enable Defense attorneys to more efficiently and effectively pursue a Detention Review Hearing to advocate for their clients' release
- Post-sentencing, the use of grant funds to increase the number of inmates in community-based Alternative to Custody (ATC) treatment programs, including an innovative program for mothers of young children.

The MacArthur Foundation has indicated they will announce the award recipients in mid-March 2016.

### *The Stepping Up Initiative and The Council of State Governments*

ODR has assembled a team to join the National Association of Counties (NACo), the Council of State Governments (CSG) Justice Center, and the American Psychiatric Association Foundation (APA Foundation) in leading a national initiative to help advance counties' efforts to reduce the number of adults with serious mental illness and co-occurring SUDs in jails. With support from the U.S. Justice Department's Bureau of Justice Assistance, the initiative builds on the many innovative and proven practices being implemented across the country.

On February 9, 2016, the Board passed a Resolution to participate in the National Stepping Up Initiative. According to the resolution, the County, "is now well-poised to assume a leadership role nationally. The stated goals of the Stepping Up Initiative are to convene expert leaders and decision makers; commence a dialogue regarding data, treatment and service capacity; and create an action plan with measurable outcomes to safely reduce the number of people with mental illnesses in the jails. The Stepping Up Initiative complements this Board's existing practices and goals regarding mental health diversion."

The ODR team will be joining the National Summit to advance county-led plans to reduce the number of people with mental illnesses in jails in the spring of 2016 in Washington, DC, that includes counties that have signed on to the Call to Action, as well as state officials and community stakeholders such as criminal justice professionals, treatment providers, people with mental illnesses and their advocates, and other subject-matter experts.

From February 29 to March 2, 2016, staff from the CSG spent time with ODR in order to better understand our current processes and policies and provide some advice on key areas to address as we pursue an aggressive and innovative diversion and re-entry agenda. In addition, CSG visited a DMH urgent care center and the BJA CARE program during their time in Los Angeles. This is further testimony of the leading role Los Angeles plays in the national conversation. We anticipate a report from the CSG team soon.

### **Next Steps**

County departments and stakeholders will continue to collaborate under the leadership of the ODR on the above-listed initiatives as well as a variety of different opportunities which emerge as the diversion work spreads across the County.

As an immediate next step, the ODR will work to create a budget submission to the CEO to provide funding for aspects of the programs and initiatives outlined above. We are also helping review and prioritize the budget requests of other departments where the activities funded through those requests impact the County's overall diversion and re-entry efforts.

If you have any questions or require additional information, please contact Mark Ghaly, M.D., Deputy Director of Community Health and Integrated Programs and Interim Director, Office of Diversion and Re-entry, at (213) 240-8107 or [mghaly@dhs.lacounty.gov](mailto:mghaly@dhs.lacounty.gov).

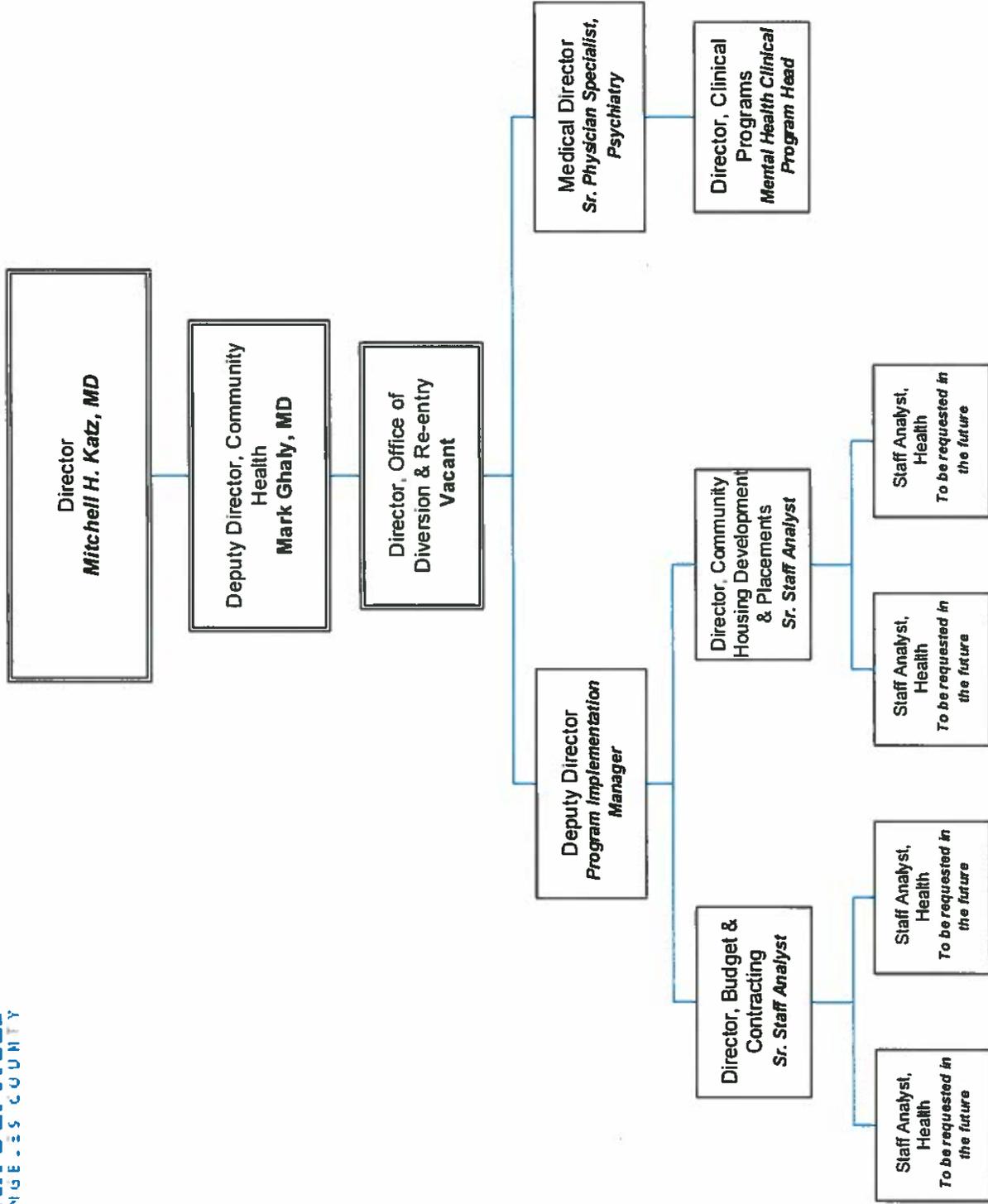
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### **Attachment**

- c: Chief Executive Office
- County Counsel
- Executive Office, Board of Supervisors
- ODR Permanent Steering Committee



**OFFICE OF DIVERSION AND RE-ENTRY**



Mark Ghaly, MD  
Deputy Director, Community Health

Date



JACKIE LACEY  
LOS ANGELES COUNTY DISTRICT ATTORNEY

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HALL OF JUSTICE  
211 WEST TEMPLE STREET, SUITE 1200 LOS ANGELES, CA 90012-3205 (213) 974-3500

August 4, 2015

TO: Mayor Michael D. Antonovich  
Supervisor Hilda L. Solis  
Supervisor Mark Ridley-Thomas  
Supervisor Sheila Kuehl  
Supervisor Don Knabe

FROM: Jackie Lacey   
District Attorney

SUBJECT: **PROVIDING TREATMENT, PROMOTING REHABILITATION AND  
REDUCING RECIDIVISM: AN INITIATIVE TO DEVELOP A  
COMPREHENSIVE PLAN FOR LOS ANGELES COUNTY  
(Board Agenda of May 6, 2014)**

This report responds to your May 6, 2014 Board motion requesting the District Attorney work in conjunction with the Sheriff, Fire Chief, Directors of the Department of Mental Health, Health Services, Public Health, Veterans Affairs, and Public Social Services, Public Defender, Chief Probation Officer, Chief Executive Office, Alternate Public Defender, and Executive Director of the Countywide Criminal Justice Coordination Committee to conduct a comprehensive assessment of the existing mental health diversion programs used by the County of Los Angeles and currently available permanent supportive housing.

The attached report, developed by the above listed public officers, collectively known as the Criminal Justice Mental Health Advisory Board (Advisory Board) analyzes the need for mental health and substance abuse diversion services along the criminal justice continuum. The recommendation developed by the Advisory Board provides for a comprehensive mental health diversion program for each stage of the criminal justice continuum.

The initial step to preventing unnecessary incarceration and improving the outcome for the mentally ill who come into contact with the criminal justice system is to improve the contact with first responders. This can be accomplished by a county-wide commitment to Critical Incident Training and the pairing of law enforcement and mental health professionals that will increase the provision of appropriate services and decrease the likelihood of violent confrontation. It is not enough for first responders to know that alternatives to incarceration are needed, the appropriate facilities must be available. A comprehensive list of the existing housing and the need for additional bed space is discussed. While there are existing diversion programs throughout the court system, successful diversion plans require stable housing, comprehensive medical, mental health and addiction recovery services, as well as job training and placement.

Each Supervisor  
August 4, 2015  
Page 2

This report identifies gaps in these service areas and sets forth a plan of action to move Los Angeles County forward.

The goal of mental health diversion is to treat mentally ill criminal defendants safely and appropriately, providing the supportive social and medical services these individuals need in order to build healthy and productive lives, free of criminal activity and substance abuse, while ensuring public safety. Together, Los Angeles County can muster the will and the resources needed to accomplish this goal.

I look forward to providing the Board a report on our progress in the implementation of the mental health diversion programs.

If you have any questions or would like additional information, please let me know.

jm

Attachment

c: Executive Office, Board of Supervisors  
Chief Executive Office, Sachi A. Hamai  
Criminal Justice Mental Health Advisory Board  
Alternate Public Defender, Janice Y. Fukai  
Countywide Criminal Justice Coordination Committee, Mark Delgado  
Department of Mental Health, Marvin J. Southard, D.S.W.  
Los Angeles City Attorney's Office, Mike Feuer  
Los Angeles County Mental Health Commission, Terry Lewis-Nwachie, M.S.  
Los Angeles Fire Department, Daryl L. Osby  
Los Angeles Police Department, Charlie Beck  
Los Angeles Public Health Department, Cynthia A. Harding, M.P.H.  
National Alliance on Mental Illness, Mark Gale  
Probation Department, Jerry E. Powers  
Public Defender's Office, Ronald L. Brown  
Sheriff's Department, Jim McDonnell  
Superior Court, Sherri R. Carter  
United States Attorney's Office, Eileen M. Decker

# MENTAL HEALTH ADVISORY BOARD REPORT A BLUEPRINT FOR CHANGE



JACKIE LACEY  
District Attorney

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August 4, 2015

# TABLE OF CONTENTS

<b>STATEMENT OF PURPOSE .....</b>	<b>1</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL .....</b>	<b>9</b>
Intercept One: Law Enforcement/Emergency Services .....	9
Intercept Two: Post-Arrest/Arraignment .....	10
Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration.....	10
Intercept Four: Community Reentry .....	10
Intercept Five: Community Support .....	11
<b>CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS .....</b>	<b>12</b>
Law Enforcement Working Group (Intercept One).....	13
Community Based Restoration Working Group (Intercept Three).....	13
Criminal Justice Working Group (Intercepts Two and Three) .....	13
Treatment Options and Supportive Services Working Group (Intercepts One through Five) .....	14
Pre-Booking Diversion Working Group (Intercept One) .....	14
Data and Systems Connectivity Working Group (Intercept One through Four) .....	15
Long Beach Mental Health Diversion Working Group (Intercepts One through Five) .....	16
<b>CRISIS INTERVENTION TEAM (“CIT”) TRAINING.....</b>	<b>17</b>
<b>CO-DEPLOYED LAW ENFORCEMENT TEAMS.....</b>	<b>20</b>
<b>MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS.....</b>	<b>22</b>
<b>OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS .....</b>	<b>24</b>
Law Enforcement Hospital Beds .....	24
Institutions for Mental Diseases (“IMD” beds) .....	24
Crisis Residential Treatment Programs .....	24
Full Service Partnerships (“FSP”) .....	25
Field Capable Clinical Services (“FCCS”).....	25
Wellness Centers.....	25
Assisted Outpatient Treatment Program (“AOT”) .....	25

<b>PERMANENT SUPPORTIVE HOUSING AND OTHER HOUSING OPTIONS .....</b>	<b>26</b>
Permanent Supportive Housing .....	26
Bridge Housing .....	28
Shelter Plus Care.....	28
Department of Mental Health Shelter Plus Care.....	28
HUD-VASH Vouchers .....	28
Rapid Re-Housing.....	28
Mental Health Services Act (“MHSA”) Housing Program .....	28
Coordinated Entry System .....	29
Department of Health Services – Flexible Housing Subsidy Pool .....	29
Breaking Barriers Program .....	29
Just In Reach Program .....	30
<b>CO-OCCURRING SUBSTANCE ABUSE DISORDERS .....</b>	<b>33</b>
Alcohol and Drug Free Living Center Services.....	32
Co-Occurring Integrated Care Network (“COIN”).....	32
Probation Department Co-Occurring Caseloads.....	32
Co-Occurring Disorders Court (“CODC”) .....	33
Women’s Community Reintegration Services and Education Center (“Women’s Center”) .....	33
Men’s Integrated Reentry Services and Education Center (“Men’s Center”) .....	33
Sobering Centers.....	33
Residential Medical Detoxification Services.....	33
Residential Treatment Services.....	34
IMD Beds Designated for Co-Occurring Disorders .....	34
<b>IMPACT OF PROPOSITION 47.....</b>	<b>35</b>
<b>CURRENT JAIL PROGRAMS AND RESOURCES .....</b>	<b>36</b>
LASD Population Management Bureau .....	36
Affordable Care Act Program.....	36
Jail Mental Evaluation Teams (“JMETS”).....	36
AB 109 Mental Health Alternative Custody Pilot Program .....	37
LASD Inmate Services Bureau, Education Based Incarceration Unit (“EBI”).....	37
Restoration of Competency “ROC” Programs .....	37
Jail Linkage Program .....	37
Mental Health Forensic Outreach Teams (“FOT”).....	37
Public Defender and Alternate Public Defender Jail Mental Health Team .....	37
<b>CURRENT COURT PROGRAMS AND RESOURCES.....</b>	<b>39</b>
Department of Mental Health Court Linkage/Court Liaison Program .....	39
Mental Health Court/Department 95 .....	39
Veteran’s Court.....	40
Santa Monica Homeless Court Program.....	40
Homeless Court Clinic.....	40

**EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES.....41**

Criminal Justice Mental Health Diversion Permanent Planning Committee.....41

Sheriff’s Department Mental Evaluation Bureau .....41

Countywide Adult Justice Planning and Development Program.....41

Forensic Additions to Existing Mental Health Programs .....41

Reentry Referral and Linkage Network of Care .....41

**RECOMMENDATIONS.....43**

CIT Training .....43

Mental Health Treatment Resource Expansion, Priority .....43

Permanent Mental Health Diversion Planning Committee.....43

Public Health/Health Services Treatment Resource Expansion .....43

Housing Services Enhancements .....43

Co-Deployed Teams .....44

Data Improvements .....44

Public Defender and Alternate Public Defender Jail Mental Health Teams .....44

Mental Health Treatment Resource Expansion, Lower Priority.....44

LASD Mental Health Bureau.....44

**CONCLUSION .....45**

**ATTACHMENT 1 .....46**

# CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD REPORT

## STATEMENT OF PURPOSE

In Los Angeles County, mentally ill offenders may be incarcerated in the county jail for significant periods of time. Many of these offenders also suffer from co-occurring substance abuse disorders and chronic homelessness. For lower-level crimes, when mental health treatment can appropriately take place somewhere other than the jail while preserving the safety of the public, continued incarceration may not serve the interests of justice. The jail environment is not conducive to the treatment of mental illness.

As stated in this Board's Motion, dated May 6, 2014, *“Diversion can address the untreated mental illness and substance abuse that is often the root cause of crime. By providing appropriate mental health services, substance abuse treatment, and job readiness training, as well as permanent supportive housing when it is needed, the mentally ill are stabilized and less likely to commit future crimes.”* Such positive interventions can not only change the lives of mentally ill offenders but also others, including family members, victims whose future harms can be prevented and the community as a whole.

In addition to the ethical implications of incarcerating mentally ill offenders, there are also fiscal ones. Our jail is a scarce resource which must be used wisely to house those who pose a danger to public safety, or for whom incarceration is otherwise necessary and appropriate.

Our jail should not be used to house people whose behavior arose out of an acute mental health crisis merely because it is believed—whether correctly or otherwise—that there is no place else to take that person to receive treatment instead. Indeed, even in instances in which it could arguably cost more to divert such mentally ill persons from the jail, it is still the right thing to do.

Mental health diversion is not a jail reduction plan. Although a successful mental health diversion program could result in some reduced need for jail beds in years to come, there will always be a need for mental health treatment to take place within the jail. That is because offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious and violent crimes including the ultimate crime of murder. Due to the nature of charges pending and their level of dangerousness, violent offenders may need to be housed at the county jail while they receive mental health treatment. Indeed, under current jail conditions, those mentally ill offenders must be carefully handled and monitored to prevent them from posing a danger to themselves and other inmates while they are incarcerated.

Mental health diversion also must not come at the price of victims' rights. It is not just a priority, but a given, that the rights of victims will be preserved while efforts are being made to enhance mental health diversion.

Should any future reduction in the jail population occur as a result of the mental health diversion project, it would enable serious and violent felony offenders who are not mentally ill to serve a

longer percentage of their sentences. Such a result would enhance public safety, but would not reduce the need for jail beds.

In the criminal justice system, the term “diversion” is often used as a legal term of art to describe alternative programs which prevent someone from suffering a criminal conviction. This report uses the term “diversion” more broadly. As used in this report, diversion includes all circumstances ranging from pre-arrest to post-conviction, in which mentally ill persons can be prevented from entering the jail at all, can be redirected from the jail into treatment, or can receive linkage to services (during and after incarceration) to help prevent them from returning to custody.

Viewed through this lens, mental health diversion is not new, but is alive and well in Los Angeles County. For some years, various key individuals, public entities, and community based organizations have planned, developed, and implemented programs that prevent mentally ill individuals from being incarcerated and instead divert them into community-based mental health treatment. However, these efforts have often gone unrecognized, due to a lack of general knowledge. What is new is the current active collaboration and commitment to this project which is shared by all of the stakeholders. A spirit of communication, innovation, and enthusiasm exists for this project which is unprecedented. With the allocation of additional resources, our County will be able to improve upon what is already being done.

Progress is being made on the issue of how to most effectively divert mentally ill offenders from the jail, but it is a large task that will not happen overnight. The experiences of other large jurisdictions which have faced this problem have taught us that steady, incremental progress can and will work over time.

The District Attorney’s Office provides the following report regarding the continuing work of the Criminal Justice Mental Health Advisory Board, as directed by this Board’s Motion dated May 6, 2014. This report will discuss existing efforts, identify gaps in services and suggest priorities for how to improve mental health diversion efforts on an ongoing basis.

## **EXECUTIVE SUMMARY**

### **Statement of Purpose**

The Criminal Justice Mental Health Advisory Board was convened to safely divert non-violent mentally ill offenders from the jail, into community treatment options. This is an ambitious, long-term goal which will take time and fiscal resources to fully effectuate.

Mental health diversion is not a jail reduction plan. There will always be the need for mental health treatment to take place in the jail, since offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious crimes, violent crimes and even the ultimate crime of murder.

### **Criminal Justice Mental Health Advisory Board and Working Groups**

Over the past year, the Advisory Board has made significant progress in assessing mental health resources and identifying strengths, weaknesses and priorities for improvement. Local stakeholders participated in a “Summit” and a “Mini-Summit” which introduced them to the “sequential intercept model” of mental health diversion planning. The sequential intercept model identifies all “intercept points” along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place. The five intercepts are: (1) Law Enforcement/Emergency Services First Contact; (2) Post-Arrest/Arrest; (3) Courts/Post-Arrest/Alternatives to Incarceration; (4) Community Reentry; (5) Community Support.

Using the sequential intercept model as an aid to discussion, the Advisory Board has met regularly over the past year. Most recently, the Advisory Board has begun to create and deploy Working Groups, which are designed as active problem solvers for subject areas deemed worthy of further study. The Working Groups are dynamic in nature and will evolve over time as current problems are solved and new ones are identified. The current Working Groups are: (1) Law Enforcement Working Group; (2) Community Based Restoration Working Group; (3) Criminal Justice Working Group; (4) Treatment Options and Supportive Services Working Group; (5) Pre-Booking Diversion Working Group; (6) Data and Systems Connectivity Working Group; (7) Long Beach Mental Health Diversion Working Group.

### **Data Collection and Sharing**

Data collection and data sharing must be made a priority. It will also be necessary to establish metrics so that the efficacy of mental health diversion can be evaluated on an ongoing basis. These issues will be addressed in the Data and Systems Connectivity Working Group from an inter-departmental perspective.

### **Crisis Intervention Team (“CIT”) Training**

Training is the most important priority for mental health diversion, because change cannot be effectuated without it. The first opportunity to divert a mentally ill person is when first responders encounter a person at the scene. At that point, law enforcement officers can take the person to a

community treatment option instead of the jail, but how the situation unfolds and whether the mentally ill person is arrested can be highly dependent upon how the first responders are trained.

The original Crisis Intervention Team (“CIT”) training was a 40 hour model, which is fully endorsed by the Advisory Board and by the District Attorney. CIT training will help to raise awareness of and sensitivity to mental health issues and provide law enforcement officers with the tools necessary to interact more effectively and compassionately with mentally ill persons in the field. Educating law enforcement officers about community based treatment options will encourage them to use those options in lieu of arrest and booking. Skills training to defuse potentially violent situations will make those encounters safer for both law enforcement and mentally ill persons alike and help to prevent encounters from turning violent or even fatal. In addition, CIT training will lead to decreased litigation and judgment costs.

Over the next six years, the LASD has created an ambitious plan to have 5,355 patrol deputies complete the full 40 hour CIT training. For smaller law enforcement agencies, an alternative 16 hour model will be available under the auspices of the District Attorney and Criminal Justice Institute, commencing in January, 2016.

## **Co-Deployed Law Enforcement Teams**

The Department of Mental Health has paired with a total of seventeen different law enforcement agencies in the field, to provide crisis intervention services. The co-response model pairs a licensed mental health clinician with a law enforcement officer. Together, they jointly respond to patrol service requests where it is suspected that a person might have a mental illness, so that appropriate referrals to treatment facilities can be made. These teams have been universally praised by mentally ill persons who have interacted with them, and family members who have seen their loved ones treated with compassion and understanding.

These specially trained co-deployed teams are known as Mental Evaluation Teams (“MET”) by the LASD and as the System-wide Mental Assessment Response Team (“SMART”) by the LAPD. Regardless of the name, the demand for services is so great that there are not enough teams to provide sufficient coverage. Therefore, the Advisory Board recommends both expanding the MET and SMART teams, as well as providing CIT training for all officers whenever possible.

## **Mental Health Urgent Care Centers: The First 24 Hours After a Mental Health Crisis**

When a law enforcement officer encounters a mentally ill person in the field, the choice is to either take the person to a crowded emergency room and possibly wait for an average of 6 to 8 hours, or arrest the person, book the person into the county jail, and return to their duties within the hour.

Mental health Urgent Care Centers (“UCCs”) provide another option. UCCs are acute care mental health facilities where mentally ill persons can be taken for specialized evaluation, but their stay must be less than 24 hours. Investing in UCCs takes the pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. DMH currently has underway a plan to add three additional

UCCs to be located near Harbor UCLA, the San Gabriel Valley and the Antelope Valley. The Advisory Board endorses this plan.

### **Other Treatment Options: After the First 24 Hours**

After a law enforcement officer has transported a mentally ill person to an Urgent Care Center, the person should then be linked to appropriate inpatient or outpatient mental health treatment options. Los Angeles needs the right combination of treatment services to serve the mentally ill population, and good linkage to those services. Current treatment options include law enforcement hospital beds, Institutions for Mental Diseases (“IMD” beds), Crisis Residential programs, Full Service Partnerships (“FSPs”), Field Capable Clinical Services, Wellness Centers and the Assisted Outpatient Treatment program.

In order for mentally ill persons to be diverted from the jail into community based treatment options, those treatment resources must be adequate to address a mental health crisis both during and after the first 24 hours. Therefore, the Advisory Board recommends increased mental health treatment resources in each of these categories.

### **Permanent Supportive Housing and Other Housing Options**

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system, and to remain incarcerated, than those who have a stable housing environment. It is also more difficult to engage homeless mentally ill individuals with treatment, resulting in high-cost utilization of medical, emergency and mental health care systems which could have been avoided by providing permanent supportive housing.

There are a variety of housing options and programs available, such as bridge housing, Shelter Plus Care, federal housing vouchers, Rapid Re-Housing and the Mental Health Services Act (“MHSA”) Housing Program. However, there are clearly insufficient resources in the area of permanent supportive housing.

The Department of Health Services has created an innovative rent subsidy program called the Flexible Housing Subsidy Pool, which provides permanent supportive housing. The Flexible Housing Subsidy Pool allows a provider to contract for housing, providing a range of options that include intensive case management, wrap-around services and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history, and the restrictive federal definition of homelessness does not apply.

The Advisory Board recommends a significant investment in a variety of permanent supportive housing beds to be dedicated to mentally ill offenders, both through the Flexible Housing Subsidy Pool and through the Department of Mental Health Specialized Housing Program. It is also recommended that a Mental Health Diversion County Housing Director position be created to administer these beds and generally oversee housing issues related to mentally ill offenders.

## **Co-Occurring Substance Abuse Disorders**

Up to 80 percent of mentally ill offenders also suffer from co-occurring substance abuse disorders. As a practical matter, someone who is actively high on drugs or alcohol may be violent and combative, and will not immediately be amenable to mental health treatment or able to be received at an Urgent Care Center.

Therefore, an increased investment in services to help stabilize mentally ill offenders is recommended. In particular, Sobering Centers which would be able to be accessed by first responders should be pursued by the County. In addition to Sobering Centers, there is also a need for Residential Detoxification Services.

Additional investment in residential drug treatment services is also recommended, to provide substance abuse treatment for up to 90 days.

Finally, for the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring disorders, so 40 additional beds are recommended.

## **Current Jail Programs and Resources**

This report catalogues and describes the existing jail programs which are most relevant to mental health diversion. Of particular interest is the proposed expansion of the Public Defender and Alternate Public Defender Jail Mental Health Team. This innovative jail program is aimed at a broader, more holistic representation of mentally ill offenders who are housed at the county jail.

The Advisory Board supports this request for psychiatric social workers and clinical supervisors. Clients are much more likely to be forthcoming and cooperative with a psychiatric social worker assigned to their own legal team than with a clinician who is not. Enhancing this relationship could greatly assist in the evaluation of appropriate placement options outside of the jail.

## **Current Court Programs and Resources**

Next, this report catalogues and describes the existing court programs which are most relevant to mental health diversion. One such program is the Department of Mental Health Court Linkage/Court Liaison Program, a collaboration between DMH and the Superior Court in which clinicians are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system. Last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options. The Advisory Board endorses the expansion of this program.

## **Expansion of Mental Health Diversion Related Staffing and Services**

The Advisory Board also proposes the creation of a new, permanent planning committee. Based on the experiences of other jurisdictions, mental health diversion will be a long-term project for years to come. Therefore, a permanent leadership structure will be necessary.

The Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as-needed basis. These personnel would be management-level employees, with significant operational experience, who could bridge the gap between high-level policy recommendations and actual implementation decisions.

## **Recommendations**

Based on this report, the Advisory Board recommends the following actions:

- 1. Fund CIT Training.**
- 2. Expand Primary Mental Health Treatment Resources. (Urgent Care Centers; Crisis Residential Treatment Programs; "Forensic" or "Justice Involved" versions of Full Service Partnerships; Field Capable Clinical Services and Wellness Centers; IMD beds for co-occurring disorders; DMH administrative staffing items; Court Linkage expansion).**
- 3. Establish the Permanent Mental Health Diversion Planning Committee.**
- 4. Expand Public Health/Health Services Treatment Resources. (Sobering Centers and Residential Substance Abuse Treatment facilities).**
- 5. Enhance Housing Services. (Create Mental Health Diversion County Housing Director; fund permanent supportive housing beds both within the Department of Health Services Flexible Housing Subsidy Pool and within the Department of Mental Health Specialized Housing Program).**
- 6. Expand Co-Deployed Teams.**
- 7. Prioritize Data Improvements to Enhance Data Collection, Data Sharing and Performance Metrics.**
- 8. Establish the Public Defender and Alternate Public Defender Jail Mental Health Team.**

- 9. Expand Secondary Mental Health Treatment Resources. (Men's Integrated Reentry Services and Education Center; Co-deployed DMH personnel at Probation Offices on a pilot project basis).**
- 10. Fund the LASD Mental Health Evaluation Bureau. (Fiscal Year 2016-2017).**

## **LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL**

On May 28, 2014, a Countywide Mental Health Summit (*hereafter the "Summit"*) was convened. Policy Research Associates was employed as a consultant to assess existing mental health resources in Los Angeles County, identify strengths and weaknesses, and help identify priorities for improvement.

Initial funding for the Summit was provided by the California Endowment and by the Aileen Getty Foundation, and it was hosted by the USC Gould School of Law. The Summit was attended by a myriad of stakeholders, including the District Attorney's Office, the Department of Mental Health ("DMH"), the Sheriff's Department ("LASD"), the Superior Court, the Public Defender's Office, the Alternate Public Defender's Office, the Probation Department, the Executive Director of the CCJCC, the Chief Executive Office, the Los Angeles Fire Department, the Los Angeles Public Health Department, the Los Angeles City Attorney's Office, the United States Attorney's Office, the Los Angeles County Mental Health Commission, the National Alliance on Mental Illness ("NAMI") and dozens of others.

On July 8 and 9, 2014, a smaller series of local stakeholder meetings took place (*hereafter, the "Mini-Summit"*). The Mini-Summit was convened so that further evaluation of existing mental health resources and recommendations for improvements to services could take place in a more focused setting.

During both the Summit and Mini-Summit, participants were introduced to the "*sequential intercept model*" of mental health diversion planning which has been successfully utilized in other jurisdictions, including Miami-Dade County, Florida. The sequential intercept model identifies all places or "*intercept points*" along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place.

Because our system is so large and complex, there has necessarily been a high degree of specialization by individuals whose work takes place at completely different intercept points of this model. The sequential intercept model has clarified and focused local discussion and helped flush out interplay between the different decision points. *For example, a decision made regarding the length of custody imposed as part of a criminal sentence (such as 90 days versus 120 days in the county jail) can legally foreclose certain public healthcare and housing benefits from being available to a person later upon their release, solely as a result of the length of time spent in custody.* Learning more about this type of systemic interplay will help inform policy decisions made in the criminal justice system. The following is an introduction to the sequential intercept model.

### **❖ Intercept One: Law Enforcement/Emergency Services**

Intercept One is the first justice system contact with an offender, before an arrest. First contact may include a call to a 911 operator by a family member, an on-site evaluation by a paramedic, or a law enforcement response to a crime in progress. Pre-booking diversion is essentially an evaluation of whether a situation is truly criminal or non-criminal in nature,

and it occurs at Intercept One. If a person is diverted to treatment instead of jail at this intercept, there will be no arrest and no case will be presented to a prosecutor for consideration.

### ❖ **Intercept Two: Post-Arrest/Arraignment**

After first contact, an offender is typically taken to the county jail. Next, the prosecuting agency decides whether to file criminal charges or decline charges. The period of time between an offender's arrest and their first appearance in court at arraignment is locally referred to as "second chance" diversion, because regardless of the original determination in the field, a prosecutor independently reevaluates whether an incident should be handled criminally or non-criminally.

If a prosecutor declines to file a criminal case, the person will be released, possibly without services. This lack of services is problematic, and possible solutions are being explored during ongoing discussions. If criminal charges are brought, the mentally ill offender appears in court at an arraignment, a criminal defense attorney is appointed or retained and a judge will either release a person on their own recognizance or set bail. Diversion at Intercept Two minimizes custody time, because it takes place early in the process, and may or may not include a criminal conviction. Not all offenders are suitable for diversion at Intercept Two, because less information is known at arraignment than later, and some decisions must be made more deliberatively.

### ❖ **Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration**

If a criminal case is not resolved at arraignment, other court proceedings take place. Ultimately, a criminal case may resolve either by a dismissal, a guilty plea or a trial. A sentence may include a combination of custody and supervision.

Depending on the mental health and criminogenic factors involved, some offenders will need the structure provided by formal supervision in order to be successfully diverted from custody. Thus, a dismissal will not be suitable in every case. Instead, diversion efforts at this intercept can also employ alternatives to incarceration as a sentencing choice upon conviction. Within Intercept Three, there is also a special class of offenders who are so acutely mentally ill that they are declared incompetent to stand trial. When that happens, criminal proceedings are suspended and jurisdiction transfers to the Mental Health Court, Department 95. Offenders who are incompetent to stand trial present unique issues which are distinct from other mentally ill offenders.

### ❖ **Intercept Four: Community Reentry**

Whether a person is criminally convicted or not, if they are taken into custody, at some point they will be released back into the community. Appropriate discharge planning, including jail "in-reach" efforts, can greatly assist in successful reentry.

Intercept Four issues include where a person will live, whether they will be able to support themselves, what access to mental health and other health services they will have, whether

or not they will be supervised by the criminal justice system and the like. For example, if a person is receiving medication, a plan should be put into place so that they are linked with mental health services and their course of medication can continue uninterrupted.

❖ **Intercept Five: Community Support**

This Intercept focuses on the person's continued and permanent access to resources, after the transition from jail to the community. Ongoing peer and family support are important.

The need for permanent supportive housing is another significant policy issue, which will be discussed separately in this report. Although transitional housing can help get a person back on his or her feet, some mentally ill offenders will need more assistance than transitional services can provide. Appropriate needs evaluations can assist in determining the need for more permanent resources.

Using the sequential intercept model, existing programs and priority needs were incorporated into the Policy Research Associates report, which is attached as Attachment 1. Those priorities have continued to inform further discussion during Criminal Justice Mental Health Advisory Board meetings, which have addressed issues relating to each of the intercept points.

## **CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS**

Since the District Attorney provided her interim report to this Board on November 12, 2014, she has led the Criminal Justice Mental Health Advisory Board (*“Advisory Board”*) as the chair of monthly stakeholder meetings. The Advisory Board collaboration has produced significant early successes.

First, a new court diversion pilot project was created at the San Fernando and Van Nuys courts, the Third District Diversion and Alternative Sentencing Pilot Project (*“Third District” project*). The Third District project can assist up to 50 criminal defendants at a time who are chronically homeless and suffer from a serious mental illness. This program is based on the “Housing First” model, which provides supportive housing first, thereby creating an environment conducive to treatment for individuals to combat their mental illnesses and co-occurring substance use disorders. The Housing First model motivates offenders to succeed, because they want to keep the housing provided through the program rather than return to the streets.

Eligible crimes for the Third District program include both misdemeanors and felonies. Defendants charged with misdemeanors earn a full dismissal of their charges following successful completion of a 90 day diversion program, without having to plead guilty. For felony crimes, a defendant must initially enter a plea of guilty or no contest and complete an 18-month program; upon successful completion, an offender earns early termination of probation and dismissal of charges. This ongoing pilot project was a collaboration between the Department of Mental Health, District Attorney, Public Defender, Alternate Public Defender, Indigent Criminal Defense Appointments Program, Los Angeles City Attorney’s Office, Superior Court, Probation Department, Department of Public Health, LASD, San Fernando Valley Community Mental Health Center and Department of Veteran’s Affairs. In June, 2015, the stakeholders met once again to refine the selection criteria for the program in order to serve more participants.

Also in June, 2015, Los Angeles County was awarded a competitive Mentally Ill Offender Crime Reduction (*“MIOCR”*) grant for \$1.8 million dollars. This grant will address the problem of “offender tri-morbidity” by diverting these at-risk offenders from custody. Tri-morbid offenders have three factors which can lead to their early demise: They are mentally ill, suffer from substance abuse and are medically fragile.

The MIOCR grant proposal submitted by Los Angeles was ranked first among all of the jurisdictions which competed for funding. Perhaps the greatest strength of the Los Angeles County grant proposal was the extensive collaboration which went into it. The District Attorney’s Office applied for the grant as the lead department on behalf of the collaborative team. The Board of State and Community Corrections (*“BSCC”*) has provided a contract which was received and executed by the District Attorney’s Office in accordance with the July 1, 2015 implementation date.

The Advisory Board is currently meeting every other month in order to more effectively deploy and support specialized Working Groups. These Working Groups are practical problem-solvers whose subject areas were deemed worthy of further study in detail. The Working Groups are dynamic in nature, and will evolve over time as current problems are solved and new ones are identified.

❖ **Law Enforcement Working Group. (Intercept One)**

This group is chaired by Chief Jim Smith of the Monterey Park Police Department. The Law Enforcement Working Group has developed training for first responders, who include law enforcement officers, dispatch employees, fire department personnel and others. The training is modeled after the Crisis Intervention Team Training (“CIT”) model which originated in Memphis, Tennessee. The Law Enforcement Working Group has made substantial progress on CIT training over the past year, which will be discussed separately in this report.

❖ **Community Based Restoration Working Group. (Intercept Three)**

The Community Based Restoration Working Group (“Restoration Working Group”) is chaired by Judge James Bianco, who is the bench officer assigned to Department 95, Mental Health Court. The Restoration Working Group convened to consider treatment options for offenders who are mentally incompetent to stand trial. These offenders are often actively psychotic, cannot care for themselves, and have been found incompetent to stand trial because their mental illness is so acute that they cannot understand the nature of the criminal charges against them or rationally assist their defense attorneys.

In particular, the Restoration Working Group has focused on the population of misdemeanor incompetent to stand trial (“MIST”) defendants. There are currently a total of about 130 MIST defendants in the county jail. The MIST population is a priority because these offenders are being held on misdemeanor charges and but for their mental illnesses, would likely have already completed their criminal cases and been released. On the other hand, criminal charges cannot simply be dismissed for a variety of legal and practical reasons.

The Restoration Working Group is piloting an ambitious project to divert up to 100 MIST defendants from the jail for treatment in the community. At this time, appropriate residential treatment beds are being identified and an individualized plan is being created for each MIST offender, depending on their needs. However, due to the nature of this population, there may not be an appropriate treatment setting for each of these offenders, who require extensive care and monitoring.

The Restoration Working Group will explore whether it would be feasible to place some of these MIST defendants into a skilled part nursing facility, which is a facility akin to a nursing home, but for persons who are anticipated to recover. Los Angeles County does not currently have any skilled part nursing facilities. At this time, it is not yet known if there is a sufficient population which would need such a facility to justify the creation of one in our County.

❖ **Criminal Justice Working Group. (Intercepts Two and Three)**

The Criminal Justice Working Group is chaired by Judge Scott Gordon, who is the Assistant Supervising Judge of the Criminal Division. The Criminal Justice Working Group was formed to address court and jail-related issues.

Initially, the group will design a pilot project to divert up to 100 defendants from the county jail into community based treatment options as alternative sentencing. In contrast to the MIST defendants, who are under the jurisdiction of the Mental Health Court, the Criminal Justice Working Group will focus on defendants who remain under the direct jurisdiction of the criminal courts.

The Criminal Justice Working Group will also address justice stakeholder training for prosecutors, defense attorneys and others in the justice system— even judges. These training recommendations will educate stakeholders regarding the benefits of mental health diversion, legal issues, available resources and the like. The Criminal Justice Working Group will also consider related issues such as victims' rights. It is anticipated that the Criminal Justice Working Group will provide a ready forum to address any local procedural or policy issues regarding case processing which will arise during all phases of the mental health diversion project on an ongoing basis.

❖ **Treatment Options and Supportive Services Working Group. (Intercepts One through Five)**

The Treatment Options Working Group is chaired by Flora Gil Krisiloff, Department of Mental Health. It will seek to maximize the use of existing treatment resources and to develop new options in the future.

Available treatment resources are a universal need which is critical for successful diversion efforts at every intercept point. Los Angeles County does not simply need “more beds” but rather, the right kind of beds in the right combination to serve a mentally ill offender population which is very diverse in its needs. Notwithstanding that diversity, the Treatment Options Working Group will identify common problems which are amenable to solution.

The Treatment Options Working Group will consider treatment options broadly, both in the jail as well as upon reentry. This discussion will include the intersection of mental health, substance abuse and the need for supportive housing. One idea to be explored is the development of multi-disciplinary teams to ensure the delivery of integrated services to homeless and mentally ill clients. The Treatment Options Working Group will be empowered to generate recommendations for best practices.

❖ **Pre-Booking Diversion Working Group. (Intercept One)**

The Chair of this group is to be determined. The Pre-Booking Diversion Working Group will address practical issues regarding how offenders can appropriately be selected for pre-booking diversion rather than brought to jail. The Pre-Booking Diversion Working Group will also examine the “second chance” time period for diversion after booking, but before criminal charges have been filed.

This discussion will be more nuanced than merely creating a list of criminal offenses that are either included or excluded for diversion, even if that could be definitively done. Some individualized evaluation of each offender must necessarily take place, such as what circumstances brought them to the attention of law enforcement, the severity of their mental

illness, whether they have housing and available support persons, and the like. The Pre-Booking Diversion Working Group will generate protocol recommendations and discuss strategies for success based on all of the relevant factors.

The Pre-Booking Diversion Group will also critically examine how and why welfare related calls which are initially non-criminal in nature can transform, resulting in a county jail booking and criminal case. Successfully preventing entry into the jail at this intercept point could reduce the incompetent to stand trial population in the jail, and in particular, the MIST population who are booked on misdemeanor charges and can remain in the jail for some time.

❖ **Data and Systems Connectivity Working Group. (Intercepts One through Four)**

This group is chaired by Todd Pelkey, who is the Chief of the District Attorney Systems Division. The Systems Working Group will discuss data collection and data sharing issues, including appropriately maintaining privacy and patients' rights.

Systems solutions can help create better linkage to available services. "Linkage" means more than simply making an appointment. For example, after incarceration, the treatment provider who receives the client needs information about the treatments which were provided to the client while incarcerated, in order to avoid unnecessary duplication and give the person what they need. Equally important, upon return to jail, knowledge about a client's recent clinical history can potentially reduce risk and speed the delivery of services.

In our County, the Sheriff's Department, Probation Department and Department of Health Services all use Cerner Health Information Systems. The Cerner Hub is software which can facilitate transparent exchange of clinical information between participating implementation sites. Netsmart, the health information vendor for the Department of Mental Health, is currently involved in discussions with Cerner to enable Netsmart systems to participate in health information exchange through the Cerner Hub. If successfully deployed, Los Angeles would be among the first sites to use this approach in production. Adding DMH to the Cerner Hub community would greatly simplify the task of coordinating care for clients shared among the participating departments.

By early 2016, the Department of Health Services will complete its implementation of the Online Read-time Centralized Health Information Database ("ORCHID"). ORCHID is an electronic health record system which provides a unique identifier for each patient to track his or her services throughout the clinical specialties and patient care venues. ORCHID is built on a platform that will also be used by the Sheriff's Department Medical Services Bureau and the Probation Department's Juvenile Health Services, to enable real-time access to patient records for their shared patients. In a separately pending motion, this Board is considering whether it would be better to pursue system linkage solutions or to integrate all electronic health record systems into a single platform.

The Systems Working Group will also consider possible use of the Justice Automated Information Management System ("JAIMS"), which was developed after the enactment of AB 109, to possibly store or share anonymized data related to mental health diversion.

Perhaps the most important topic to be discussed by the Systems Working Group will be how data collection and data sharing will inform evidence-based practices. Over the long term, data regarding mental health diversion will be crucial, in order to record what is being done here and preserve it for analysis by outside experts. Indeed, our ongoing mental health diversion efforts must be data driven so that we can quantify our successes, identify trends and learn from our experiences. It is anticipated that in the future, the Systems Working Group will be able to identify systems related gaps which could be remedied by additional fiscal resources.

❖ *Long Beach Mental Health Diversion Working Group. (Intercepts One through Five)*

This group is chaired by Kelly Colopy, who is the Director of the Long Beach Department of Health and Human Services. The Long Beach Working Group was convened to discuss issues specific to Long Beach, which is the second largest city in the County. The group will create and launch a Long Beach pilot project, which is especially appropriate because Long Beach has its own Police Department, City Prosecutor, and Health and Human Services Department. There are 88 municipalities within the County of Los Angeles, and each of these locations feeds mentally ill offenders into the county jail. Therefore, the experiences of cities such as Long Beach are important to the overall mental health diversion project.

## **CRISIS INTERVENTION TEAM (“CIT”) TRAINING**

Training is currently the single most important priority, because change cannot be effectuated without it. Law enforcement training will raise awareness of and sensitivity to mental health issues, and provide law enforcement officers with concrete tools to interact more effectively and compassionately with mentally ill persons in the field.

There are several benefits to Crisis Intervention Team training (“CIT” training). First, educating law enforcement officers about community based treatment options will encourage them to use those options instead of booking mentally ill persons into the jail. Skills training in field interactions—in particular, how to defuse potentially violent situations—makes these encounters safer for both law enforcement and mentally ill persons alike, and helps to prevent encounters from turning violent or even fatal.

This is not only a more enlightened approach, but it is also a fiscally wise one. CIT training means that law enforcement officers will be less likely to suffer from workplace related injuries and disabilities. Based on the experiences of other jurisdictions, CIT training will also pay for itself over time, in reduced litigation and judgment costs. The LASD has estimated that up to 40 percent of use of force incidents may involve mentally ill persons.

The original, highly successful CIT training was based on a 40 hour model. However, this can impose a heavy burden on law enforcement agencies. Logistically, CIT training requires law enforcement agencies not only to send personnel to the training for a week, but also to provide backfill coverage while those officers are gone. Indeed, that can be the largest cost involved. This can be quite challenging for law enforcement agencies, whether they are large or small.

The District Attorney fully endorses the full 40 hour CIT training model whenever it can be employed, but recognizes the practical realities involved and the need for flexibility. Accordingly, the Law Enforcement Working Group has developed an alternative 16 hour CIT training program for local implementation in Los Angeles County. In developing the 16 hour CIT training model, the District Attorney’s Office contributed technical and resource assistance through the Criminal Justice Institute, which is a training entity administered through the District Attorney’s Office. The Law Enforcement Working Group has identified key training priorities, developed a proposed curriculum, and recruited trainers.

On June 3, 2015, the Law Enforcement Working Group staged a successful half day “Train the Trainers” event at the Burbank Fire Department Training Center. Once fully online, local CIT training will be scheduled as two 16 hour training sessions per month, serving a maximum of 25 participants per training session, for a minimum of one year, and is currently planned to continue indefinitely. Due to the sheer scope of this training effort, these sessions will require a multitude of trainers from a variety of agencies and backgrounds, some of whom will work as teams and others who will rotate in and out of service. These trainers will include representatives from DMH, the LAPD, and the National Alliance on Mental Illness (“NAMI”) whose family members, close friends, and themselves have been impacted by mental illness.

Also due to the magnitude of this training effort and ancillary issues associated with it, the District Attorney has identified an immediate need for a Training Liaison who would be hired

as a District Attorney employee. Because CIT training is at its heart a law enforcement concern, the Training Liaison would ideally be either a current or retired high-level managerial law enforcement officer. The District Attorney is currently considering candidates for this position. In addition, the District Attorney requests funding for a Management Assistant position. The Management Assistant position is necessary in addition to the Training Liaison to assist with administrative tasks related to scheduling and organizing the training. In addition to the law enforcement aspect of the anticipated training burden, there will also be significant training needs on an ongoing basis for stakeholders such as attorneys and even judges.

The District Attorney's Office is also working directly with the state Peace Officer Standards and Training Commission ("POST") to seek approval of the 16 hour CIT training curriculum. POST approval is anticipated and if granted, actual CIT training programs may be presented as soon as January, 2016.

The value of CIT training is universally recognized by the law enforcement community. In fact, the larger local law enforcement agencies are each already planning to satisfy their own training needs. For example, the District Attorney is informed that the LAPD, which has embraced CIT-type training for some time, plans to present additional training sessions at least once a month during the next year. The CHP already has underway its own plan to provide a 12 hour block of CIT training to each of its officers statewide.

The Sheriff's Department has proposed a comprehensive six-year plan to incrementally train each of its 5,355 patrol deputies in the full 40 hour CIT training. Although deputies receive six hours of mental health training as new recruits in the Academy, this is not adequate to prepare them for the numerous contacts with mentally ill persons that actually occur once they are deployed as deputies. The Sheriff's Department has created a three-part plan to better train its deputies.

First, the Sheriff's Department is currently providing Baseline Training (3 hours) and Intermediate Training (8 hours) to deputies. As of June 8, 2015, more than 1,200 patrol deputies have received the Baseline Training, which provides an overview of mental health issues that first responders encounter in the field and strategies which may apply to specific situations. The Intermediate Training is a mental health awareness class, which provides students with the tools to better recognize symptoms and behaviors associated with mental illness and fundamentally, to understand that behavior engaged in by a mentally ill person relates to a medical condition that the person has not chosen to have. Students are also taught how to better communicate with mentally ill persons. As of June 8, 2015, more than 700 personnel have attended the Intermediate Training. Finally, the Sheriff's Department plans to provide a 40 hour Advanced Training, to be conducted 40 weeks per year with a class size of 24 students. The Advanced Training is true CIT training. Topics covered will include: Mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. During Fiscal Year 2015-2016, the LASD will send 480 patrol personnel to CIT Training. Deputies who complete the training will return to their patrol areas and be available to respond to and assist with incidents involving mentally ill persons when co-deployed Mental Evaluation Teams (discussed in the next section) are not available. The value of this ambitious plan cannot be overstated.

Because each of the larger law enforcement agencies are already planning their own independent CIT training programs, the participants in the 16 hour CIT training sessions sponsored by the District Attorney and Criminal Justice Institute will largely be drawn from the 48 smaller police agencies in the County.

Simply stated, CIT training is a good idea whose time has finally come, one which is worthy of the full support of this Board.

## **CO-DEPLOYED LAW ENFORCEMENT TEAMS**

The Department of Mental Health's Emergency Outreach Bureau has teamed with law enforcement agencies in the field, to provide crisis intervention services throughout Los Angeles, various municipalities, and the unincorporated areas of the County. This co-response model pairs a licensed mental healthcare clinician with a law enforcement officer. Together, they jointly respond to 911 calls and patrol service requests where it is suspected that a person might have a mental illness, make appropriate referrals to treatment facilities, and facilitate hospitalization when necessary.

These specially trained, co-deployed field teams are known as Mental Evaluation Teams ("MET") by the Sheriff's Department and as the System-wide Mental Assessment Response Team ("SMART") by the LAPD. Regardless of the name by which the co-deployed teams are known, the mission and partnership with the Department of Mental Health remain the same. DMH has estimated that these teams may contact over 6,500 mentally ill persons per year.

In addition to partnering with the LASD and LAPD to deploy the MET and SMART teams, DMH has also partnered with a total of fifteen other law enforcement agencies which also employ co-deployed teams: Alhambra Police Department; Bell Gardens Police Department; Burbank Police Department; City of Bell Police Department; City of Vernon Police Department; Downey Police Department; Gardena Police Department; Hawthorne Police Department; Huntington Park Police Department; Long Beach Police Department; Pasadena Police Department; Santa Monica Police Department; Signal Hill Police Department; South Gate Police Department; Torrance Police Department. Also, the Metropolitan Transit Authority ("MTA") contracts with the LASD for four Crisis Response Teams, funded by the MTA. These four teams primarily serve homeless individuals and respond to critical incidents involving mentally ill persons on public transportation such as buses and trains. DMH also has plans underway to partner with six additional law enforcement agencies on co-deployed teams, once appropriate memoranda of understanding are approved and executed.

Co-deployed teams roll out in the field and use their specialized training and experiences to help to defuse potentially violent situations. The teams respond to persons in crisis, barricaded suspects, suicides in progress such as jumpers, and a variety of other volatile situations. The MET teams are praised by both mentally ill persons who have interacted with them, and family members who are grateful to have seen their loved ones appropriately treated with compassion and understanding. Co-deployed teams are a bright spot in the ongoing relationship between law enforcement and the communities that they police.

Unfortunately, the demand for services is so great in Los Angeles that there are never enough co-deployed teams to respond. Because the team coverage areas currently occupy such a large geographic area of the County, there is often a lengthy response time. The co-deployed teams certainly cannot respond to every call which involves a possible mental health issue. That is why, in addition to adding new MET teams, the LASD has also focused on improving mental health training for all of its deputies, a wise investment in the future.

The Sheriff's Department currently has only eight MET teams to cover the entire County, and would need at least a total of twenty-three to provide sufficient coverage and services for the vast

geographic area and population involved. Both the Department of Mental Health and LASD propose the expansion of these teams.

In addition, plans are currently underway for the LAPD to add one additional SMART team per shift per Bureau, for a total of sixteen additional teams. The Department of Mental Health will provide clinicians for each of these teams.

## **MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS**

The following problem is presented every day in Los Angeles County. Upon encountering a mentally ill offender in the field, a law enforcement officer faces a choice. The officer could take the person to a crowded hospital emergency room, and possibly wait for an average of 6 to 8 hours there, during which time their assigned patrol area would lack coverage. Or, the officer could take the person to jail, book them there, and be back out on patrol within the hour.

In order to successfully divert mentally ill offenders from the jail, there must be places to take them where they can receive treatment instead. In addition, sufficient resources must be invested into those alternative treatment locations so that they are not overloaded by demand.

Mental Health Urgent Care Centers (“UCCs”) are the logical resource to fill this gap. Urgent Care Centers are acute care provider locations, where a mentally ill person can be taken so that their needs can be evaluated. Urgent Care Centers are not residential facilities. In fact, a person can only remain at an Urgent Care Center for a maximum time period which is less than 24 hours.

During that initial 24 hour window of time, a crisis can be averted. A person can be stabilized and allowed to go home, if they have housing and a support system. On the other hand, a person might be unable to care for themselves and need to be civilly committed on a 72 hour hold (commonly called a “5150 hold” since it is authorized by Section 5150 of the Welfare and Institutions Code). Or, the person’s mental health needs could fall somewhere in the middle, and they can be linked to other services such as recovery-oriented community-based resources.

Because these UCCs specialize in mental health care, they are capable of making mental health determinations promptly and professionally. Investing in adequate mental health UCCs takes pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. The mental health UCCs provide integrated services, including treatment for co-occurring substance abuse disorders. The Department of Mental Health currently has four UCCs, and a fifth is already slated to be reopened in November, 2015. Of these, two are currently designated under the Lanterman-Petris-Short Act (“LPS designation”) and operate twenty-four hours a day, seven days a week. A facility must be designated under the LPS in order for 5150 holds to be made. DMH already has plans in place to have all of the mental health UCCs in the County, both current and future, designated under the LPS. Each of these UCCs are located in close proximity to hospitals.

The Department of Mental Health is planning to add three additional UCCs to be located near Harbor UCLA, the San Gabriel Valley, and the Antelope Valley, which will serve an additional 54 individuals at any given time. These UCCs will operate twenty-four hours a day, seven days a week. It is anticipated by DMH that these three new UCCs will serve approximately 49,275 persons per year. It is estimated that between 15 and 20 percent of those individuals would have otherwise been incarcerated. These three additional UCCs will primarily be used as assessment and staging facilities for the Assisted Outpatient Treatment program (discussed in the following section) and proposed pre-booking diversion.

The mental health UCCs are a prudent and necessary investment of resources, but cannot be used in every situation. For example, mentally ill persons who are actively under the influence may not

appropriately be taken directly to UCCs. Therefore, there is also a significant separate need for stabilization and detoxification services to be offered at Sobering Centers and Residential Detoxification Centers, as well as longer term Residential Drug Treatment, as discussed later in this report in the section entitled, “Impact of Co-Occurring Substance Abuse Disorders.”

## **OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS**

After a law enforcement officer has transported a mentally ill person to a mental health Urgent Care Center, what happens next—after the first 24 hours—is also important. Ideally, the person would be linked to appropriate mental health treatment, whether inpatient or outpatient. On the other hand, if a gap in services occurs, law enforcement could receive another call about the same person. Clearly, this would increase the likelihood that upon a second or subsequent call, the person might then be transported to the jail instead.

Los Angeles needs the right combination of treatment options to serve the mentally ill population, and good linkage to those services. There are several different types of mental health treatment services currently available, as follows.

**Law Enforcement Hospital Beds** The Department of Mental Health provides some dedicated acute psychiatric inpatient services, specifically for uninsured individuals who are brought in by law enforcement. These facilities are located at Aurora Charter Oak Hospital in Covina and College Hospital in Cerritos. The law enforcement bed program serves approximately 300 mentally ill individuals per year.

**Institutions for Mental Diseases (“IMD” beds)** Institutions for Mental Diseases are licensed long term care psychiatric facilities which may be locked, and are similar to hospital beds. The Department of Mental Health contracts with these IMD facilities to provide care for persons who no longer meet the criteria for acute care but are not clinically ready to live in a board and care facility or other less restrictive treatment settings. Most IMD residents have received services in the past, have had failed board and care placements, and have been in and out of County hospitals, jails, or other IMD beds. They include the most severely mentally ill persons who typically may be the subject of conservatorships.

**Crisis Residential Treatment Programs** Crisis Residential Treatment Programs have been nationally recognized for over 25 years as an effective model for diversion from psychiatric emergency rooms and as a “step-down” from inpatient hospital and jail care. Mentally ill persons can stay at adult crisis residential treatment programs for up to thirty days, but the usual expected stay is ten to fourteen days. These facilities are not locked, but offer augmented supervision and intensive mental health services.

The County currently has only three Crisis Residential Treatment Programs with a total of 34 beds that provide housing and very intensive mental health services and support for those mentally ill individuals who can benefit from additional stabilization and linkage to ongoing community-based services.

The Department of Mental Health is currently using SB 82 funds to develop and implement 35 additional Crisis Residential Treatment Programs for a total increase of 560 beds. DMH estimates that these additional beds will serve an estimated 17,030 additional people per year, based on an average 12 day length of stay.

**Full Service Partnerships (“FSP”)** The Full Service Partnership Program serves individuals with mental illness who need intensive, integrated wrap-around services. These are individuals whose criminal justice and psychiatric histories place them at risk of institutionalization, frequent psychiatric hospitalizations, homelessness and incarceration. FSP services support individuals as they transition to lower levels of care and participants engage in the development of their treatment plan which is focused on wellness and recovery. The treatment team is available to provide crisis services to a client twenty four hours a day, seven days a week. FSP providers may be community based organizations or others who contract with the Department of Mental Health. Though comprehensive, these services cannot be used for everyone due to cost issues.

**Field Capable Clinical Services (“FCCS”)** The Field Capable Clinical Services program is a field-based service program, which assists persons who are either graduating from Full Service Partnerships or were never in need of that level of intensive support and individualized case management. The treatment team is available twenty-four hours a day, seven days a week by telephone to provide crisis services to the client.

**Wellness Centers** The Wellness Center Program is an outpatient clinical service, for persons who are either graduating from Full Service Partnerships or Field Capable Clinical Services, or were never in need of that level of support. Wellness Center services support individuals in the community.

**Assisted Outpatient Treatment Program (“AOT”)** Assembly Bill 1421 established the Assisted Outpatient Treatment Demonstration Project Act of 2002 (“Laura’s Law”). Laura’s Law created a process for the courts, probation, and the mental health systems to order supervised outpatient treatment of mentally ill adults who would otherwise resist treatment. The Assisted Outpatient Treatment Program can also be used on a voluntary basis by participants who are engaged in their own treatment.

In May 2015, the Department of Mental Health fully implemented an Assisted Outpatient Treatment program and expanded its intensive Full Service Partnership network by 300 slots and its enriched residential services network by 60 slots. The Assisted Outpatient Treatment Team screens requests, conducts extensive outreach to engage patients, develops petitions and manages the court processes to connect Assisted Outpatient Team enrollees with Full Service Partnerships or enriched residential services that have dedicated funding for these persons.

## **PERMANENT SUPPORTIVE HOUSING AND OTHER HOUSING OPTIONS**

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system than those who have a stable housing environment. In addition, once they do come into the justice system, they are much more likely to remain in custody than be released on bail or their own recognizance. Because they lack a stable residence, officers are more likely to take them to jail than issue a citation, and judges are more likely to conclude that they will fail to appear for a future court date and order them to remain in custody.

It is also more challenging to consistently engage homeless individuals in treatment services, and too often, their connections with the County's system of care are precipitated by crisis situations and law enforcement contacts rather than being guided by an established treatment plan. The result is high-cost utilization of medical, emergency, and mental health care systems by homeless mentally ill individuals, as well as their increased likelihood of cycling in and out of the criminal justice system.

As such, a discussion of appropriate housing models for mentally ill, justice-involved populations is integral to any mental health diversion and re-entry effort. In particular, the availability of permanent supportive housing is critical to stem the tide of recidivism. The provision of safe, stable, and affordable housing—with necessary supportive services—has been found to be one of the most effective strategies for reducing recidivism.

In response to the direction of this Board's May 6, 2014 motion, the following sections provide an inventory of currently available permanent supportive housing in the County, an assessment of housing service gaps identified for people with severe mental illness, and recommendations for addressing permanent supportive housing needs.

**Permanent Supportive Housing** Permanent supportive housing is affordable housing with indefinite leasing or rental assistance, combined with supportive services designed to assist homeless persons who suffer from disabling conditions to achieve housing stability. Permanent supportive housing service providers proactively engage tenants and offer treatment plans. The supportive services made available are voluntary and participation is not a requirement of maintaining eligibility for the permanent housing.

The premise of permanent supportive housing is that the effectiveness of mental health, substance abuse disorder, and other treatment interventions is significantly limited when individuals are homeless and in unstable living environments. In contrast, providing homeless, mentally ill individuals with stable, supportive housing promotes better outcomes with regard to health, public safety, and personal dignity among the housed individuals.

There are three types of permanent supportive housing models: Single-site based, mixed-population, and scattered-site models.

- A. Single-Site Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building with all units occupied by supportive housing residents and with the benefit of on-site supportive services.
- B. Mixed-Population Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building where a portion of the units are set aside for supportive housing residents and may include on-site supportive services. Both single site and mixed population models of permanent supportive housing are traditionally produced using community development or affordable housing financing.
- C. Scattered-Site Model Permanent Supportive Housing** This is financial rental assistance funds provided directly to residents who then secure rental housing from private landlords in the community. The most common program which provides this form of supportive housing is the federal Housing Choice Voucher (“Section 8” program). Supportive services are then provided directly to tenants through mobile teams in the community.

To provide an inventory of available permanent supportive housing, this report relied upon data reported by the Los Angeles Homeless Services Authority (LAHSA). LAHSA is an independent Joint Powers Authority which was created in 1993 by the City and County of Los Angeles. LAHSA operates as the lead agency for the Los Angeles Continuum of Care and is responsible for collecting an annual Housing Inventory Count information of all beds and units in the Continuum of Care’s eight Service Planning Areas.

The 2015 Housing Inventory Count has been completed, but has not yet broken down the data into a detailed analysis. Therefore, this report relies upon both 2014 and 2015 data, as identified below:

- 17,172 total permanent supportive housing beds of varying type (2015 Housing Inventory Count);
- 3,606 permanent supportive housing beds which are expressly set aside for individuals who are chronically homeless, mentally ill, returning from jail, or multi-diagnosed (2014 Housing Inventory Count);
- 4,285 permanent supportive housing beds which are uncategorized, so it is unclear whether or not they would be available to the criminal justice mentally ill offender population (2014 Housing Inventory Count);
- 1,903 “other permanent housing” beds, which do not include supportive services, and are thus not actually considered to be permanent supportive housing in the total count (2014 Housing Inventory Count).

Notwithstanding these figures, there remains a significant gap between the available housing and the demand for housing options for the homeless and mentally ill population. In addition to permanent supportive housing, there are other kinds of housing as well, which are described as follows. However, substituting temporary or transitional housing for permanent housing, when permanent housing is truly necessary, does not solve the ultimate problem and can result in more transition points where people can fall between the cracks.

**Bridge Housing** Bridge housing is temporary housing for people in need while a housing navigation team works with clients to secure appropriate permanent supportive housing once it becomes available. Bridge housing has no set maximum stay and is generally provided through local, accessible service organizations within the Continuum of Care. By minimizing barriers to participate, clients are encouraged to move from the streets into a safe bed. Having a stable location greatly assists clients to keep meetings and appointments.

**Shelter Plus Care** Shelter Plus Care provides federally subsidized housing through a services-match grant for individuals and families who meet the Department of Housing and Urban Development's ("HUD") definition of homelessness. The supportive services match must be equal to or greater than the rental assistance award. These grants allow a variety of housing rental situations. To be eligible, a person must be homeless, with a mental illness, substance abuse problem, HIV/AIDS, or a dual diagnosis. Shelter Plus Care does not require a background check.

**Department of Mental Health Shelter Plus Care** This is similar to Shelter Plus Care housing, but participants must be Department of Mental Health clients. DMH contracts with the Housing Authority of the City of Los Angeles ("HACLA") and the Housing Authority of the County of Los Angeles ("HACoLA"), to provide Shelter Plus Care certificates to eligible clients. To be eligible, individuals must be at least 18 years of age, meet the HUD criteria for homelessness, have a diagnosis of severe and persistent mental illness, including a co-occurring substance use disorder, and agree to maintain active contact with DMH for case management and other mental health services for as long as the certification is valid (at least five years).

**HUD-VASH Vouchers** This is a veteran's housing program, which combines Section 8 rental assistance vouchers with case management and clinical services, which are provided by the Los Angeles Veterans Affairs Medical Center ("Medical Center"). Clients must be Veterans Affairs Supportive Housing ("VASH") eligible veterans. The Medical Center determines whether homeless veterans and families are eligible for VASH benefits. The local housing authority determines eligibility for the rental subsidy. As a condition of the program, participants must receive case management services from the Medical Center.

**Rapid Re-Housing** This program is designed to help persons who recently became homeless, not the chronically homeless. It quickly provides housing, so recipients may pursue employment, health and social service needs and get back on their feet.

**Mental Health Services Act ("MHSA") Housing Program** There are a total of 976 Mental Health Services Act funded units which are an option for some homeless mentally ill offenders returning to the community from custody, but some offenders will not qualify based on their criminal history. If an offender is enrolled in a Full Service Partnership program, they are eligible to receive assistance with their housing needs, and in these situations the Department of Mental Health can provide a subsidy by using MHSA funds to rent a unit from a private property owner. Under this program, DMH requires that the tenant be engaged in mental health treatment, and the housing developments must provide onsite supportive services.

In addition to permanent supportive housing, there are various short term stay beds in the County such as emergency shelters. However, they cannot effectively be used for mental health diversion from the jail since they are too uncertain and short term in nature—since they are usually first-come, first-served, a spot is not certain even on a day-to-day basis.

There are several significant efforts currently in progress within the County, regarding housing services.

**Coordinated Entry System** The Coordinated Entry System is an effort to capture and electronically input data from clients and landlords to create a real-time list of individuals experiencing homelessness in our communities, and to quickly triage and efficiently match these individuals to available housing resources and services that best fit their needs. Clients are surveyed using an assessment tool known as the “VI-SPDAT,” which provides a survey score. Clients identified with the greatest need of a particular housing type are referred to eligible housing opportunities as they become available. The Coordinated Entry System relies on the Homeless Management Information System, which is a federally mandated database used to collect information on homelessness. Housing providers that receive any federal HUD funding are required to input their available units by type, subsidy, eligibility criteria and number of units into the system, to ensure an accurate inventory of beds available for potentially qualifying tenants. All homeless service providers are encouraged to participate even if they do not receive federal funding. As of September 2014, LAHSA reported a participation rate of 65% for emergency shelter programs, 67% for transitional housing programs and 83% for permanent housing programs.

**Department of Health Services - Flexible Housing Subsidy Pool** The Flexible Housing Subsidy Pool is a rental subsidy program which currently provides permanent supportive housing to patients who are homeless and have experienced two or more hospital visits in one year. This program allows the provider to contract for housing, providing a range of options that include intensive case management, wrap-around services, and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history and the restrictive federal definition of homelessness does not apply. DHS has established a goal of securing 10,000 permanent supportive housing units for this program.

**Breaking Barriers Program** Breaking Barriers was jointly launched by the Probation Department and the Department of Health Services in June, 2015. It is a two-year pilot program to provide rapid re-housing and case management services for eligible offenders supervised by the Probation Department. These offenders are homeless, have been identified as moderate to high risk of re-offending, and have expressed a desire to seek full-time employment. Each client is provided intensive case management, employment services, a housing unit and a rental subsidy, with the client contributing a percentage of their monthly income towards the rent. Once stabilized, participants work to successfully “transition in place,” eventually taking over the full rental payment amount so that they can continue to reside in their unit once participation in the program expires. The maximum length of program participation is 24 months, with case management aftercare services continuing for 3 months after program completion.

**Just In Reach Program** This Sheriff's Department program was developed to improve custody discharge planning for homeless individuals who repeatedly cycle through the jail, primarily due to their homelessness. Just In Reach targets individuals who are either currently homeless or at risk of homelessness, repeat offenders, and those who are charged with lower level offenses; specifically, offenders who have been in jail three times in the last three years and who have been homeless three times in the last five years. The program offers participants comprehensive assessments, case plans, and linkage to community services to assist participants to secure permanent supportive housing and remain self-sufficient.

Notwithstanding each of these resources and programs which are currently underway, significant gaps in services remain: Los Angeles County currently has no permanent supportive housing dedicated to the justice-involved population with mental illness.

Permanent supportive housing beds are needed to serve this specific population, who currently face many barriers to successful re-entry, such as housing restrictions based on their history of incarceration and long housing wait lists. This population currently must independently apply for supportive housing through the standard homeless service delivery system.

Even with an investment into additional permanent supportive housing, it is clear that some homeless mentally ill offenders exiting custody would not have immediate access to a permanent supportive housing placement until a spot becomes available in the system that could be matched to meet their individualized service needs.

This is particularly true because there are a myriad of legal definitions and requirements which may apply, especially for federally funded housing programs, which often restrict participation based upon criminal background checks and make it difficult for the justice involved homeless population reentering the community to stabilize.

For example, for programs funded under federal HUD guidelines, the federal definition of homelessness applies. Under that definition, inmates who serve 90 days or more of custody in the county jail do not qualify as homeless, even if they were homeless before they entered the jail. Instead, they would have to reestablish homelessness, such as by going to an emergency shelter, before being processed onto a list for appropriate housing.

There is also a federal housing restriction which would prevent a person who is being released from jail from returning to live at their original home, if it would mean cohabiting with a family member who holds a Section 8 voucher. This means that even when there is a family member of a mentally ill person who is willing to have them, it would prevent them from being welcomed back into the home. Instead, the mentally ill offender would have to compete for their own permanent supportive housing or face homelessness.

To address these gaps, the County should also secure additional bridge housing capacity for this specific population. Bridge housing would provide a safe bed for the population of justice involved homeless individuals exiting custody until appropriate permanent supportive housing can be secured.

Additional investment should also be made into subsidized housing through the Flexible Housing Subsidy Pool, Shelter Plus Care and DMH Shelter Plus Care programs to provide the County with the flexibility to quickly and strategically invest in housing and services based on need and availability. Focusing on connecting these resources to the most difficult to house population would help to break the cycle of returns to custody.

The following housing-related recommendations are made to this Board:

1. Allocate sufficient funding to the Flexible Housing Subsidy Pool for 200 permanent supportive housing scattered site units for a five-year period. These will provide immediate access to housing for the mentally ill population leaving custody;
2. Allocate sufficient funding to the Flexible Housing Subsidy Pool for rapid re-housing rental assistance for 200 people for a five-year period;
3. Allocate sufficient funding to contract for 200 units to be subsidized by the federal Rental Assistance Program that are prioritized for qualifying mentally ill offenders exiting custody in need of permanent supportive housing;
4. Allocate sufficient funding for 400 supportive housing units to be provided through new construction or rehabilitation of single site or mixed population developments;
5. Allocate sufficient funding within the Department of Mental Health Specialized Housing Program to add housing subsidies for approximately 300 individuals to be housed in permanent supportive housing and 200 individuals to be placed in bridge housing while participating in Full Service Partnership, Field Capable Clinical Services and Wellness Center treatment services. It is anticipated that this funding would allow DMH staff to negotiate with private housing providers on behalf of inmates to pay for move-in costs and provide rental assistance.

It is recommended that a Mental Health Diversion County Housing Director position be created to generally oversee housing issues related to mentally ill offenders who are justice involved. Housing issues are often fragmented due to the different entities involved at the city, county, state and federal level; for example, the Housing Authority of the City of Los Angeles (“HACLA”); Housing Authority of the County of Los Angeles (“HACoLA”) and the Los Angeles Homeless Services Authority (“LAHSA”). If appointed, the proposed Mental Health County Housing Director would serve as a member of the Permanent Mental Health Diversion Planning Committee, discussed more fully in this report in the section entitled “Proposed Expansion of Mental Health Diversion Related Staffing and Services.”

## **CO-OCCURRING SUBSTANCE ABUSE DISORDERS**

As instructed by this Board's motion dated May 6, 2014, the stakeholders have assumed as a goal the diversion of a total of 1,000 mentally ill offenders from the jail into community based treatment options, although that certainly will not happen overnight. According to the Department of Public Health and the Department of Mental Health, approximately 80 percent of those persons may have a co-occurring substance abuse disorder involving drugs, alcohol or both. This would require planning for the appropriate service referrals and placement of approximately 800 additional mentally ill offenders also suffering from substance abuse problems.

The Department of Public Health, the Department of Mental Health and the Sheriff's Department all agree that mental illness with co-occurring substance abuse disorder is a priority problem among this offender population which presents specialized treatment challenges. For example, mentally ill offenders who suffer from substance abuse disorders may need stabilization and/or medically managed care in a Sobering Center, Residential Detoxification or Residential Drug Treatment Program before accessing appropriate mental health treatment. Mentally ill persons suffering from untreated substance abuse disorders are less likely to accept available mental health resources and engage in their own mental health treatment.

The following current programs and resources relate specifically to co-occurring substance abuse disorders:

**Alcohol and Drug Free Living Center Services** Currently, the Department of Public Health offers alcohol and drug free living center ("ADFLC") services in limited capacity for clients who are enrolled in outpatient substance abuse disorder outpatient services. These are housing facilities where clients recovering from alcohol and drug problems reside, and the presence of and use of alcohol or drugs, other than prescribed drugs, is forbidden. This type of housing environment is suitable for individuals with a stable co-occurring disorder condition.

**Co-Occurring Integrated Care Network ("COIN")** This court-based program is a collaboration between the Department of Public Health, the Department of Mental Health and the Superior Court. The COIN program serves the needs of AB 109 offenders who have a co-occurring chronic substance abuse disorder coupled with a severe and persistent mental illness, by making intensive, inpatient services available. The Probation Department and the Parole Revocation Court identify offenders who are at a high risk for relapse and would benefit from integrated substance abuse and mental health treatment. The COIN program was established in 2013, but recently expanded in early 2015 to serve clients in an additional two service areas. Twenty beds are reserved specifically for AB 109 supervised persons with co-occurring disorder.

**Probation Department Co-Occurring Caseloads** The Probation Department has developed Co-Occurring Caseloads. Persons with mental health issues and co-occurring substance abuse disorders who are under court supervision are identified, and provided with a Deputy Probation Officer who specializes in these issues. The Deputy Probation Officers assigned to this caseload are provided additional training in order to build a knowledge base of what services are available in the community for these supervised persons, and how to

more effectively supervise them. The Probation Department developed a 20 hour course on this subject entitled “Case Management of AB 109 Clients with Co-Occurring Disorders” which was available to both Deputy Probation Officers and Supervising Deputy Probation Officers.

**Co-Occurring Disorders Court (“CODC”)** Co-Occurring Disorders court is an option for offenders who have failed at previous attempts at substance abuse treatment and who have a severe or persistent mental illness. Specified low-level felony charges are eligible for this program. The court requires a guilty plea, followed by 90 days at the Antelope Valley Rehabilitation Center and then placement into a full service partnership which includes medication, housing, benefits evaluation, and educational and vocational assistance.

**Women’s Community Reintegration Services and Education Center (“Women’s Center”)** The Women’s Center is a jail in-reach program for women with mental health needs who are being released from jail at the Century Regional Detention Facility. These women struggle with histories of repeated arrests and incarcerations, persistent mental illness and co-occurring substance abuse disorder, domestic and community violence, unemployment, financial instability and children in out-of-home placement. Through the Department of Mental Health, the Women’s Reintegration Center provides release planning groups, one-to-one interviews, and outpatient services upon release to equip these women with the life skills necessary to succeed outside of jail.

There currently does not exist an analogous men’s program. However, the Department of Mental Health already has a plan underway to add one as follows:

**Men’s Integrated Reentry Services and Education Center (“Men’s Center”)** The Men’s Center will serve men with mental illnesses and co-occurring substance abuse disorders being released from Men’s Central Jail or Twin Towers Correctional Facility. The Men’s Center will be able to serve up to 40 clients at a time, assuming an average length of stay in the community for 59 1/2 days. The Men’s Center will not only provide an innovative model of care for men who struggle with their mental illnesses and other life issues, but will also serve as an education and training center for a variety of integrated care providers and interns.

Four key gaps in services have been identified relating to the co-occurring disorder population, for which additional resources are recommended:

- 1. Sobering Centers** Los Angeles County currently does not have any Sobering Centers, which would provide a place for first responders to take mentally ill persons who are not suitable to be brought to an Urgent Care Center, as an alternative option to jail. The typical model for a Sobering Center would be an 8 hour stay before being referred to other services.
- 2. Residential Medical Detoxification Services** These residential facilities are directed toward the care and treatment of persons in active withdrawal from alcohol and/or opiate dependence, for up to 14 days.

- 3. Residential Treatment Services** Residential treatment facilities provide a structured, 24 hour a day environment which are non-institutional and non-medical, but provide rehabilitation services to clients suffering from substance abuse disorders. Clients can stay for up to 90 days, and more days may be required with clinical justification.
  
- 4. IMD Beds Designated for Co-Occurring Disorders** For the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring substance abuse disorder, who are in need of treatment in a secure setting. The Department of Mental Health is requesting funding for 40 additional IMD beds for individuals with co-occurring disorders rather than have them remain in the jail. These beds could serve individuals with criminal justice histories who are placed on conservatorships.

## **IMPACT OF PROPOSITION 47**

On November 5, 2014, Prop. 47 was enacted by the voters of California. Prop. 47 reduced common felony theft and drug possession offenses to misdemeanors. Although the long-term impact of Prop. 47 on the jail population and mental health diversion efforts cannot completely be known at this time, two observations can be made.

First, Prop. 47 did not result in any immediate reduction in the mentally ill population in the jail even though the total jail population has dropped. To the contrary, the mentally ill population has gradually increased. According to the Sheriff's Department, the average jail population mental health count in 2013 was 3,081 total inmates; in 2014, it was 3,467 total inmates; and as of June 16, 2015, it was 3,614 total inmates. This could be the result of an overall increase in the mentally ill population in the County, but may also be a result of more diagnoses being made due to increased attention and sensitivity to this issue. Regardless of the reasons for this increase in the mental health population, the numbers are certainly not any lower after Prop. 47.

Second, Prop. 47 crimes by definition are non-violent and lower-level. Presumably, this could make it more difficult to identify offenders for mental health diversion, since there would be fewer non-violent felony offenders in the county jail to choose from for diversion. It is difficult to reconcile these competing observations. Further analysis of the mentally ill jail population may shed light upon these issue and guide further discussion regarding diversion.

On June 9, 2015, this Board instructed the interim CEO to provide an independent analysis of the actual number of treatment beds and other beds needed at the new Consolidated Correctional Treatment Facility ("CCTF") and to conduct a capacity assessment of all community-based alternative options for treatment including, but not limited to, mental health and substance abuse treatment.

## **CURRENT JAIL PROGRAMS AND RESOURCES**

There are currently a variety of jail programs which provide mental health treatment for those who are currently incarcerated, seek to link them to services upon their release, or are alternative custody programs. In particular, the following current efforts are noteworthy.

**LASD Population Management Bureau** The Sheriff's Department has enhanced its transitional services systems through collaboration with the Department of Mental Health and Jail Mental Health Services. The LASD works with Jail Mental Health case managers to process vital records such as birth certificates and California ID cards. This is a preliminary step to completing Affordable Care Act (Medi-Cal) enrollment. With the assistance of the Department of Public Social Services, benefits are effective the day of release from custody.

If a mentally ill inmate is entitled to Homeless General Relief, a coordinated release is conducted and the client is driven to the Department of Public Social Services immediately following release to receive their General Relief benefits. Additionally, through a collaborative effort with Jail Mental Health Services, the inmate is linked with services such as emergency shelter before their discharge date, so that they will have someplace to live when they are released.

In fact, the Sheriff's Department has consistently provided transportation assistance to take offenders from the jail directly to a myriad of services, including mental health services, residential substance abuse programs, transitional housing, emergency shelters, employment services, social services, mother-infant residential programs, veteran-specific programs, parolee substance abuse service, HIV services, temporary financial assistance and food benefits to families and individuals. This transportation service has filled a gap to greatly assist offenders to connect with needed services upon their release.

**Affordable Care Act Program** On July 1, 2014, the Sheriff's Department began the Affordable Care Act ("ACA") Project. This is a two-year grant program in collaboration with the Departments of Mental Health, Public Health, Health Services and Public Social Services. All sentenced inmates who are within 60 days of their release date are contacted and assisted to complete and submit Medi-Cal applications, which are processed within 45 days of their release. Inmates who require hospitalization outside of the custody environment, or who are in community treatment with electronic monitoring, can use their benefits as a source of payment for care. As of May, 2015, a total of 8,175 applications were taken and 1,766 inmates received benefits upon their release from custody.

**Jail Mental Evaluation Teams ("JMETs")** The JMETs are co-deployed teams where DMH clinicians are paired with Sheriff's personnel within the jail, just as the MET teams are co-deployed teams in the field. The JMETs oversee care of inmates in the general population who are on psychiatric medications but are not severely mentally ill and do not require specialized mental health housing. The JMETs also regularly go through the jail to promptly identify inmates who were not identified as having mental health problems upon their initial intake at the jail, or who have decompensated while incarcerated, so that they can receive services.

**AB 109 Mental Health Alternative Custody Pilot Program** The Sheriff's Department is currently working with the Department of Mental Health on a new alternative to custody program, which will have a 42 bed capacity. The location, Normandie Village East, is a licensed adult care residential facility which is a "step-down" from higher levels of care.

AB 109 offenders who have been incarcerated for low-level and non-violent offenses that appear to be a result of their mental illnesses will be eligible. Referrals to the program will be accepted from various sources including Jail Mental Health Services, the Department of Mental Health Court Linkage Program and the LASD. Admissions will be authorized through the DMH Countywide Resource Management Center. Program participants will be electronically monitored. Criteria are currently being developed to select participants, and discussions are ongoing regarding appropriate mental health programming. There is a October, 2015 goal for implementation.

**LASD Inmate Services Bureau, Education Based Incarceration Unit ("EBI")** The Sheriff's Department has expanded its mental health programming services to both the male and female population. Currently, the LASD provides mental health programming to over 200 mentally ill inmates a week. This includes specific life skills classes taught by the Five Keys Charter School and by other outside volunteers. Exploratory discussions are underway regarding how to better organize and present material to optimize time and access to sub-groups within the mentally ill population. The LASD is also deploying "comfort dogs" to visit the mental health floors on a regular basis.

**Restoration of Competency "ROC" Program** Ordinarily, felony offenders who are mentally incompetent to stand trial receive mental health treatment at a state hospital, to restore them to competency. However, there are so few state hospital beds that there is a waiting list for treatment, resulting in lengthy delays while these persons remain in custody, awaiting treatment. At any given time, Los Angeles may have up to two hundred felony inmates who are incompetent to stand trial. In response to this problem, the LASD has entered into a contract with the San Bernardino County Sheriff's Department and Liberty Healthcare regarding services to restore these defendants to mental competency.

The Restoration of Competency "ROC" Program has a 76 bed capacity and is anticipated to be implemented this summer. The ROC program is an intensive, individualized treatment program comparable to restoration services at a state hospital. Treatment is provided by an array of mental health professionals. The sooner offenders can be restored to mental competency, the sooner they can move through the justice system and complete their criminal cases. This program is entirely funded by the state.

**Jail Linkage Program** Inmates with mental illness require specialized assistance with release planning. The Department of Mental Health Jail Linkage Program works throughout the jail system with clients who require all levels of release planning assistance, from minimal to comprehensive. Jail Linkage personnel coordinate with Jail Mental Health Services, with Department of Mental Health Countywide Resource Management for AB 109 clients, and with the LASD Community Reentry Resource Center, which was created by the Sheriff's Population Management Bureau in 2014 as an information source for all inmates being released.

**Mental Health Forensic Outreach Teams (“FOT”)** Many inmates with mental illness do not successfully transition to treatment and services in the community, which increases the possibility of recidivism. Forensic Outreach Teams under contract with the Department of Mental Health assist approximately 1,260 inmates annually who are released from county jails upon the completion of AB 109 sentences.

Forensic Outreach Teams can provide both jail in-reach and intensive short-term case management for up to 60 days after release, for persons referred to contracted AB 109 providers. Jail in-reach efforts help to build relationships with inmates before they re-enter the community. Building trust in providers and the health care system can help offenders comply with treatment recommendations regarding health, mental health, and/or substance abuse issues. After release, the Forensic Outreach Teams provide additional assistance for successful linkage to community services.

**Public Defender and Alternate Public Defender Jail Mental Health Team** The Public Defender has conceived and proposed an innovative new jail program aimed at a broader, more holistic legal representation of detained mentally ill offenders who are housed at the county jail. Public Defender clients would be referred through their existing attorney of record, by the existing Public Defender Mental Health Unit, or otherwise. Once referred, the clients would be evaluated by in-house psychiatric social workers, so that the Public Defender’s Office could begin to engage proactively with their clients at the earliest possible stage of the criminal justice process. This type of expert assistance would enable the Public Defender’s Office to actively collaborate with other justice stakeholders such as the Sheriff’s Department and Department of Mental Health.

The Public Defender has also requested the addition of psychiatric social workers to be housed at their branch offices throughout the County. Both the jail social workers and the branch social workers would be well-placed to efficiently communicate “real-time” information about their clients’ mental state to assigned attorneys in courts and therefore address longstanding gaps in communication from county jail to courtroom personnel, including judges and attorneys. This increased communication will reduce case continuances, expedite case processing, better facilitate the delivery of mental health services, reduce jail overcrowding, and improve the overall administration of justice.

The Advisory Board supports this proposed new program not only for Public Defender clients, but also for offenders who are represented by the Alternate Public Defender as well. Clients who suffer from mental illnesses and are interviewed in the jail are much more likely to be willing to be frank and forthcoming with a psychiatric social worker who is assigned to their own legal team, than with a clinician who is not. Indeed, mentally ill clients commonly fail to fully cooperate with Department of Mental Health personnel or admit their active symptoms, such as visual and auditory hallucinations, due to the nature of the jail environment and their own concerns that making such admissions could be used against them and possibly result in additional incarceration.

Therefore, the Advisory Board believes that this proposal has merit and should be supported by this Board.

## **CURRENT COURT PROGRAMS AND RESOURCES**

**Department of Mental Health Court Linkage/Court Liaison Program** The Court Linkage program is a collaboration between the Department of Mental Health and the Los Angeles County Superior Court. Court Linkage is staffed by a team of 21 mental health clinicians who are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system.

Through the Court Linkage Program, there is a specialized program by which offenders can be placed in licensed, long term psychiatric care (“IMD”) beds. The specialized Court Linkage IMD bed program serves 50 individuals at any given time who are pre-adjudicated and agree to receive treatment in lieu of sentencing. The program served 112 individuals in Fiscal Year 2013-2014. Although full figures for Fiscal Year 2013-2014 are not yet available, last year’s figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 possible referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options, which were discussed in detail in the preceding section entitled, “Other Treatment Options: After the First 24 Hours.”

There are several reasons why not every offender who is contacted by the Court Linkage Program can actually be diverted: Some refuse services; some are sentenced by the court to state prison or otherwise in a way that would foreclose treatment; some may not have an available treatment option which matches their mental health needs; some may have an available treatment option from a mental health perspective, but one which is not acceptable to the court and counsel from a public safety perspective. Again, it bears emphasis that not every mentally ill offender can safely be removed from a custodial setting.

However, the fact that more than half of the offenders contacted by the Court Linkage Program are able to be diverted is a significant success, which is worthy of attention. The Court Linkage Program is a resource which may benefit from additional expansion of assigned personnel in future years. The District Attorney’s Office is currently preparing a new office policy memorandum to ensure that each of the office’s deputies is aware of the efforts made by the Court Linkage Program and appropriately coordinates with the Department of Mental Health so that they can evaluate mentally ill offenders for potential diversion opportunities.

The Court Liaison Program provides ongoing support to families and educates the court and the community at large regarding the specific needs of mentally ill individuals. Mental Health Court Liaison services include on-site courthouse outreach to defendants, individual service needs assessments, providing information to individuals and the court about appropriate treatment options, development of post-release plans, linkage of individuals to treatment programs, expedited mental health referrals, and providing support and assistance to defendants and families in navigating the court system.

**Mental Health Court/Department 95** The Los Angeles County Mental Health Court handles matters which are referred from criminal courts throughout the County. The court is staffed with lawyers from the District Attorney’s Office, Public Defender and Alternate Public Defender. Department 95 handles a wide range of proceedings, including issues relating to mental incompetence to stand trial, post-conviction defendants who were adjudicated as not guilty by

reason of insanity, or alleged to be a mentally disordered offender (“MDO”) and are the subject of a petition for restoration or an extension of a parole commitment.

The 2014 Superior Court Annual Statistics Report provides a snapshot example of the volume of matters handled in Department 95. In 2014, an average of 198 new cases per month were sent to Department 95 upon the issue of incompetence to stand trial; this does not include the cases carried over from 2013. The total number of cases under the supervision of the Mental Health Court during 2014 was 118,551.

**Veteran’s Court** Veteran’s Court is a diversion program for veterans charged with felonies who suffer from post-traumatic stress disorder or traumatic brain injury. Most of the veterans in this court have alcohol or drug addiction problems and if these problems were caused or exacerbated by military service, the veteran will be considered for the program. Veterans from all areas of the county are eligible to participate. A guilty plea is required and a dismissal is the usual result for successfully completing the program. All costs of housing, transportation and treatment are borne by the Veterans’ Administration.

**Santa Monica Homeless Court Program** This program, operated by the Santa Monica City Attorney’s Office in coordination with the Superior Court, is available to homeless individuals who have quality of life or other minor misdemeanor charges pending. Following the successful completion of a 90 day program, charges are dismissed. Services such as mental health treatment, substance abuse assistance, job placement, and assistance in finding permanent supportive housing are provided through the City of Santa Monica and are largely funded through annual grants.

**Homeless Court Clinic** This program, operated by the Los Angeles City Attorney in coordination with the Superior Court, serves adults who are either homeless or at risk of homelessness, who may also suffer from mental illness, substance/alcohol addiction, co-occurring disorders, or are veterans. The program helps to resolve legal barriers to care and connect them with appropriate service providers to address the challenges that they face on the road to recovery, including permanent supportive housing. In exchange for community obligation hours worked by participants, certain traffic and quality of life offenses, such as low-level misdemeanor charges, warrants and fines can be resolved. These clinics operate as mobile one-day events where participants are assisted by a myriad of stakeholder representatives and service providers.

## **EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES**

In addition to the need for additional resources earmarked for CIT training and co-deployed MET teams, as well as expansion of the mental health Urgent Care Centers, Crisis Residential beds and other available treatment services, the following improvements are also proposed.

**Criminal Justice Mental Health Diversion Permanent Planning Committee** Based upon the experiences of other large jurisdictions, it is anticipated that mental health diversion will be a long-term project for some years to come. The Advisory Board and Working Group participants are committed to the project, but cannot reasonably devote full-time attention to it, since each has other primary job duties which are also important. The District Attorney fully and personally supports this effort and is committed to leading it indefinitely.

It will be necessary to dedicate additional permanent employee positions to fully implement mental health diversion. This cannot be accomplished by any one person given the nature and magnitude of the anticipated workload, and the need for collaborative input. Therefore, the Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as needed basis. These personnel would be management-level employees, with significant operational experience, to be able to bridge the gap between high-level policy recommendations and actual implementation decisions.

In addition to the employee needs related to the Permanent Planning Committee, both the Sheriff's Department and the Department of Mental Health are requesting additional funding for employees and other costs, as follows:

**Sheriff's Department Mental Evaluation Bureau** In future years, the Sheriff's Department proposes to establish a new Mental Evaluation Bureau in order to enhance current services to mentally ill persons. For example, a serious problem exists involving mentally ill persons who are the subject of repeated calls for service, which cost the County millions of dollars in emergency resources without positive outcomes.

The new Mental Evaluation Bureau would operate 24 hours a day, seven days a week. Upon encountering a mentally ill person in crisis, patrol deputies could communicate with Desk Operations Triage to coordinate service calls and determine whether the co-deployed MET teams would roll out. If the Triage Desk determined that a call involves a person who was the subject of frequent calls for intervention, a referral to a Consolidated Case Management Team would be made.

The Sheriff's Consolidated Case Management Team would help manage cases that involve persons with a history of violent criminal activity caused by mental illness, and cases that involve persons whose mental illness has caused numerous responses by law enforcement or the deployment of substantial resources. The Consolidated Case Management Team would be the liaison point with the Homicide Bureau-Missing Persons Unit to determine whether a missing

person had been placed on a 5150 hold. The Consolidated Case Management Team would also manage a database to track and update contacts with mentally ill persons and other data which would help to evaluate and improve departmental crisis responses. Finally, the Consolidated Case Management Team would attempt to link mentally ill offenders with available resources.

The Mental Evaluation Bureau would also include a Crisis Negotiations Team, Training Unit and Community Relations Unit. The Crisis Negotiations Team would handle situations involving hostage takers, barricaded suspects, and other persons who pose an immediate, violent threat to themselves or the community.

The Training Division would create and maintain a Mental Health Training Manual, review use of force incidents involving mentally ill persons, review and revise office policies regarding contacts with mentally ill persons, and conduct both basic mental health training and CIT training. The Community Relations Unit would act as a liaison with the Department of Mental Health, other stakeholders and the community in implementing jail diversion programs.

The Mental Evaluation Bureau would be co-supported by the Department of Mental Health. The total staffing request for the Mental Evaluation Bureau is currently estimated at 68 Sheriff's Department personnel and 32 Department of Mental Health personnel. However, funding will be requested from the County no sooner than Fiscal Year 2016-2017.

**Countywide Adult Justice Planning and Development Program** The Department of Mental Health also requests four additional administrative staffing items to help conceptualize, develop and implement the jail diversion plan. This program infrastructure would help ensure that a wide range of mental health programs are made available at all intercepts in the criminal justice system, and to oversee the existing Mental Health Jail Linkage Program and Court Linkage Programs, which have been discussed separately in preceding sections of this report.

**Forensic Additions to Existing Mental Health Programs** As previously described, the Department of Mental Health already has services which were designed for the non-criminal population, but proposes to expand with separate "Forensic" or "Justice Involved" versions of the same programs, which would permit a specialized focus on the criminal justice population: Full Service Partnership, Field Capable Clinical Services and Wellness Centers.

**Reentry Referral and Linkage Network of Care** This proposal is a computer systems network solution designed for the Department of Mental Health, building on existing Jail Linkage and Countywide Resource Management Programs. Ideally, this would be an easily accessible online resource which could: (1) capture and store the assessments of post-release needs of mentally ill inmates; (2) identify service providers to meet the needs; (3) consolidate referral information for each inmate in a format that can be easily printed and shared with an inmate; (4) communicate electronically with service providers to make the referrals; (5) receive electronic responses back from service providers regarding referrals, such as acknowledgement of receipt and confirmation of placement; (6) allow electronic communication with the clients upon their release.

## **RECOMMENDATIONS**

Based on this report, the Advisory Board recommends the following:

### **1. CIT Training**

- Train 5,355 patrol deputies in the full 40 hour CIT Training over the next six years;
- Support the 16 hour CIT training program under the auspices of the District Attorney and Criminal Justice Institute;
- District Attorney Training Liaison and District Attorney Management Assistant.

### **2. Mental Health Treatment Resource Expansion, Priority**

- Add three new Department of Mental Health Urgent Care Centers;
- Add 35 new Crisis Residential Treatment Programs;
- Add “Forensic” or “Justice Involved” versions of Full Service Partnerships, Field Capable Clinical Services and Wellness Centers; in the alternative, increase the staffing of current programs to support anticipated pre-booking diversion of mentally ill offenders;
- 40 additional IMD beds designated for co-occurring disorders;
- Four Additional DMH administrative staffing items;
- Additional Court Linkage personnel.

### **3. Permanent Mental Health Diversion Planning Committee**

- Create and maintain the Permanent Planning Committee.

### **4. Public Health/Health Services Treatment Resource Expansion**

- Sobering Centers;
- Residential Medical Detoxification Services;
- Residential Substance Abuse Treatment Facilities.

### **5. Housing Services Enhancements**

- Create Mental Health Diversion County Housing Director position.
- 200 permanent supportive housing beds through Flexible Housing Subsidy Pool for five years;
- 200 rapid re-housing beds through Flexible Housing Subsidy Pool for five years;
- 200 units to be subsidized by federal monies;
- 400 supportive housing units through new construction or rehabilitation;
- Fund within the Department of Mental Health Specialized Housing Program, 300 housing subsidies for permanent supportive housing and 200 housing subsidies for bridge housing.

## **6. Co-deployed teams**

- MET team expansion of 15 additional teams to a minimum total of 23 teams.
- SMART team expansion of 16 additional teams, to a minimum total of 34 teams.

## **7. Data improvements**

- Development of Cerner Hub inter-departmental interface or other solution to data sharing problems;
- Department of Mental Health Reentry Referral and Linkage Network of Care.
- Based upon these data sharing solutions, set aside funds for a consultant to be employed which can assist the County with metrics which will allow management by outcomes to take place.

## **8. Public Defender and Alternate Public Defender Jail Mental Health Teams**

- Jail based psychiatric social workers and supervisors;
- Branch based psychiatric social workers and supervisors.

## **9. Mental Health Treatment Resource Expansion, Lower Priority**

- Men's Integrated Reentry Services and Education Center;
- Co-deployed Department of Mental Health personnel at Probation offices, to be commenced on a pilot project basis at five offices which span the geographic boundaries of the county.

## **10. LASD Mental Health Bureau**

- Establish the new Mental Health Bureau. (Fiscal Year 2016 - 2017)

## **CONCLUSION**

Various counties, municipalities, and metropolitan areas across the country have commenced the journey towards improving the interface between the low level mentally ill criminal offender and the criminal justice system. The keys to their success have been making modest, pragmatic first steps to improve systemic responses to the problem; the “all in” collaboration of the pertinent criminal justice system partners; and the willingness to make a long term commitment to the goal of improving the plight of mentally ill offenders in the criminal justice system.

Through the work of the Criminal Justice Mental Health Advisory Board, unprecedented collaboration has been demonstrated by the criminal justice system partners. Further, the many efforts to date by public and private entities to treat mentally ill persons in Los Angeles County has been laudable. What is needed at this critical juncture is the integration, coordination, and expansion to scale of these resources. This report represents a plan for going forward. Being ever mindful of public safety and victims’ rights, it is time to take the next steps in the long journey.

Los Angeles County District Attorney's Office

## Sequential Intercept Mapping Report – LA County, CA

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### Executive Summary

Prepared by: Policy Research Associates, Inc.  
Hank Steadman, Ph.D.  
Dan Abreu, M.S., C.R.C., L.M.H.C.  
Travis Parker, M.S., L.I.M.H.P., C.P.C.

The Los Angeles County District Attorney's Office contracted with Policy Research Associates, Inc. (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA. On May 28, 2014, approximately 100 participants attended a county-wide summit/kickoff held to begin this process and address the significant issue of persons with behavioral health disorders involved in the criminal justice system. Additionally, there were 46 cross-systems partners from mental health, substance abuse treatment, health care, human services, corrections, advocates, consumers, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts that participated in the Los Angeles County Sequential Intercept Mapping and priority planning on July 8, 2014.

There is a longstanding recognition that persons with behavioral health disorders are over-represented in the criminal justice system. The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The recommendations that follow are informed by the work of PRA over the last 18 months in Chicago, Illinois; New Orleans, Louisiana; New York City, New York; as well as Miami, Florida. In addition, PRA has provided training and technical assistance to over 100 jurisdictions, Tribes, and states across the United States. The recommendations stemming from the Los Angeles County Sequential Intercept Mapping are timely, as they also support many of the recommendations set forth in the 2011 Administrative Office of the Courts Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. Additionally, the California Mental Health Wellness Act of 2013 supports the work and recommendations of the cross-systems Sequential Intercept Mapping group in that it ensures key behavioral health and criminal justice collaborators are involved in the planning and implementation of key strategic initiatives needed to improve the lives and outcomes of justice involved individuals with behavioral health disorders.

The products of the Sequential Intercept Model workgroup culminated with the recommendation of formalizing a county wide planning body to address the needs of justice involved persons with co-occurring mental health and substance use disorders being the number one priority. PRA concurs with this as the top priority, as formalized planning bodies promote the needed communication, collaboration and coordination which must be present in order for quality diversion programs and efforts to occur. Los Angeles County currently has a number of mental health and criminal justice initiatives that already involve criminal justice partners and can either directly support the work of the county wide planning body or that can be integrated with the work of the planning body. Existing efforts include, but are not limited to: Integrated Behavioral Health Information Systems (IBHIS); The Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal; CSH/Department of Mental Health (DMH) funded Emergency Room diversion programs; and Advancing Safe and Healthy Homes Initiatives/DMH Healthy Homes Initiative. It will be critical for this county wide planning body to not only consider how it will relate to these on-going planning efforts, but also how it will influence the planning and implementation of future efforts.

The quality and growth of this formalized planning body is strongly supported by the second priority, which calls for the utilization of data analysis and data matching to better inform decisions regarding diversion opportunities for justice involved persons with behavioral health disorders. Additionally, the second priority recommends the creation of a criminal justice/mental health technical assistance/resource center. PRA concurs with the priority level of this recommendation and has extensive experience working with Centers of Excellence, including those in Ohio, Illinois, Florida and Pennsylvania. Los Angeles currently has a number of key experts county-wide who can be utilized to implement its specialized center for communication, coordination and collaboration.

At the conclusion of the Los Angeles County systemwide summit and Sequential Intercept Mapping workshop, PRA took note that there are several on-going initiatives, some of which have been identified above, that currently address identified gaps or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified. Rather than taking a heavy focus on the development of new initiatives and resources, PRA is instead utilizing an “adapt and expand” approach to the priorities and recommendations stemming out of the gaps identified during the Sequential Intercept Mapping workshop. This “adapt and expand” approach is designed to not only improve county-wide system response to justice involved persons with behavioral health disorders, but also to create additional capacity to better reach and engage this underserved population of individuals in Los Angeles County.

At **Intercept 1**, PRA recommends that Los Angeles County enhance/expand law enforcement’s specialized response and mental health crisis response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams

(CIT). There are also insufficient resources available for Los Angeles County's Psychiatric Mobile Response Teams (PMRT). Participants in the Summit Workshop and Mapping Workshop were satisfied with the quality of these law enforcement specialized response and mental health crisis response teams; however, multiple participants cited examples noting the need for additional resources and expansion to better serve and have a broader impact for justice involved individuals with behavioral health disorders. PRA makes this recommendation based upon our extensive nationwide work with specialized law enforcement and mental health crisis response systems such as CIT, as well as our current work with Intercept 1 Early Diversion Substance Abuse and Mental Health Services Administration (SAMHSA) grantees in Colorado, Tennessee and Connecticut. It will be important for Los Angeles County to include criminal justice/behavioral health partners such as law enforcement, crisis stabilization centers, and psychiatric emergency departments in these enhancement/expansion planning meetings.

At **Intercept 2**, PRA recommends the expansion of diversion opportunities at arraignment and the improvement of screening efforts for diversion at later stages. The DMH Mental Health Court Linkage Program is an innovative resource that Los Angeles County has operated for 10 years. Mapping workshop participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of this program was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and the Court Linkage Program regarding diversion philosophy. It is also recommended at Intercept 2, that Los Angeles County implement a Probation Pre-Trial Release program. There is a notable absence of Intercept 2 diversion opportunities present for justice involved persons with behavioral health disorders in Los Angeles County. PRA has seen the value of diversion efforts at this Intercept based upon our work over the last dozen years with just under 20 SAMHSA grantees from across the United States engaged in Targeted Capacity Expansion (TCE) jail diversion efforts.

At **Intercept 3**, PRA recommends the expansion of post-arraignment diversion opportunities for defendants with behavioral health disorders who are charged not only with misdemeanors, but also low level felony offenses. Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the DMH Court Linkage Program, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase potential diversion opportunities at Intercept 3. In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Linkage Program and defense counsel to present a diversion plan to the courts. Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as the housing and employment barriers which are often present for individuals post-incarceration. For justice involved persons with behavioral health disorders, these collateral sanctions also impede recovery. Specialty courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be very effective as well. For more serious felony level charges, persons can be sentenced to probation with conditions tailored to mental health treatment if appropriate.

At **Intercept 4**, PRA recommends expanding the capacity of the DMH Jail Navigator program as well as the capacity of existing reentry programs found through providers such as: Just In Reach, the Los Angeles City Attorney's Office HALO Program, Women's Reentry Court, and the Los Angeles Sheriff Department's Community Reentry Center. Both the Summit and Mapping workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time frames with which to link individuals to needed services at the point of reentry, including behavioral health and support services.

At **Intercept 5**, PRA recommends the provision of training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Health Interventions. Other than housing, which was a gap across all Intercepts, there were not any specific gaps or priorities identified in this Intercept. There are many Best Practices and innovative programs operating within Los Angeles County at this Intercept, including specialized mental health Probation Department caseloads, co-location of mental health staff in Probation Department offices and peer-run programs for Probation clients. The Probation Department performs risk assessments to determine supervision and program needs utilizing RNR principles to manage caseloads. It is important to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Training to include behavioral health providers in order to insure that criminogenic needs are addressed in behavioral health settings.

The prevalence of individuals with behavioral health disorders in jails and prisons is higher than in the general population. PRA has seen that, on a national level, alternatives to incarceration have gained momentum as a humane and cost effective strategy to reduce criminal justice costs and improve access to needed services and supports without compromising public safety. The early identification of individuals with behavioral health needs at each level or Intercept of contact with the criminal justice system can improve not only their access to care, but also long-term treatment outcomes. The effects of these types of interventions are increasingly showing promise with benefits to society and the potential for long term cost savings.

Los Angeles County District Attorney's Office

## Sequential Intercept Mapping Report – LA County, CA

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Prepared by: Policy Research Associates, Inc.  
Hank Steadman, Ph.D.  
Dan Abreu, M.S., C.R.C., L.M.H.C.  
Travis Parker, M.S., L.I.M.H.P., C.P.C

## **Acknowledgement**

*PRA wishes to thank the Los Angeles County District Attorney's Office for the assistance with the coordination of this event.*

## **Introduction:**

The Los Angeles County District Attorney's Office contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA.

## **Background:**

The *Sequential Intercept Mapping workshop* has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, M.S., C.R.C., L.M.H.C., and Travis Parker, M.S., L.I.M.H.P., C.P.C., Senior Project Associates for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

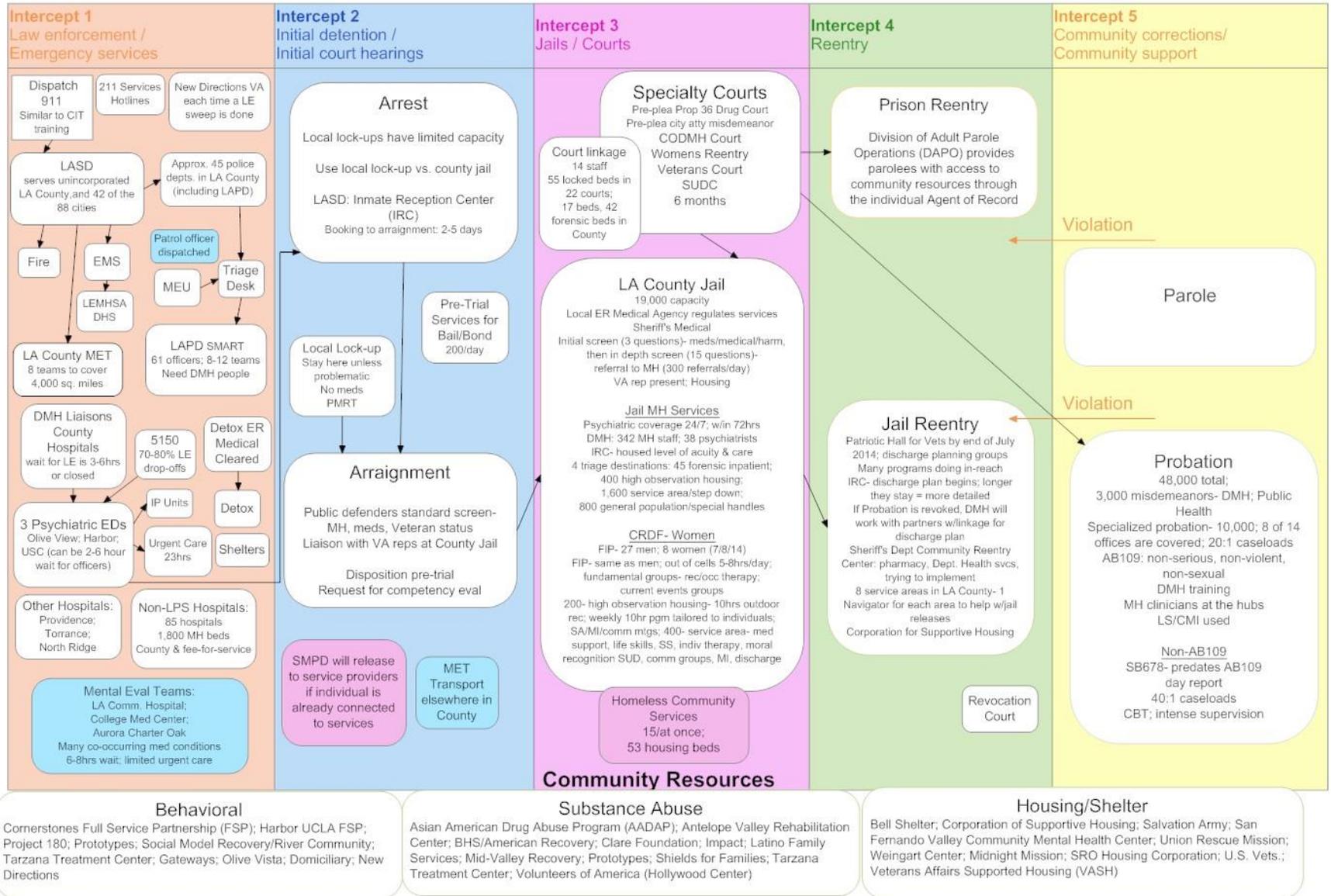
Forty-six (46) people were recorded present at the LA County SIM.

Follow-Up to Mental Health Summit  
Sequential Intercept Mapping and Action Planning Workshop  
Los Angeles County District Attorney's Office  
July 8, 2014

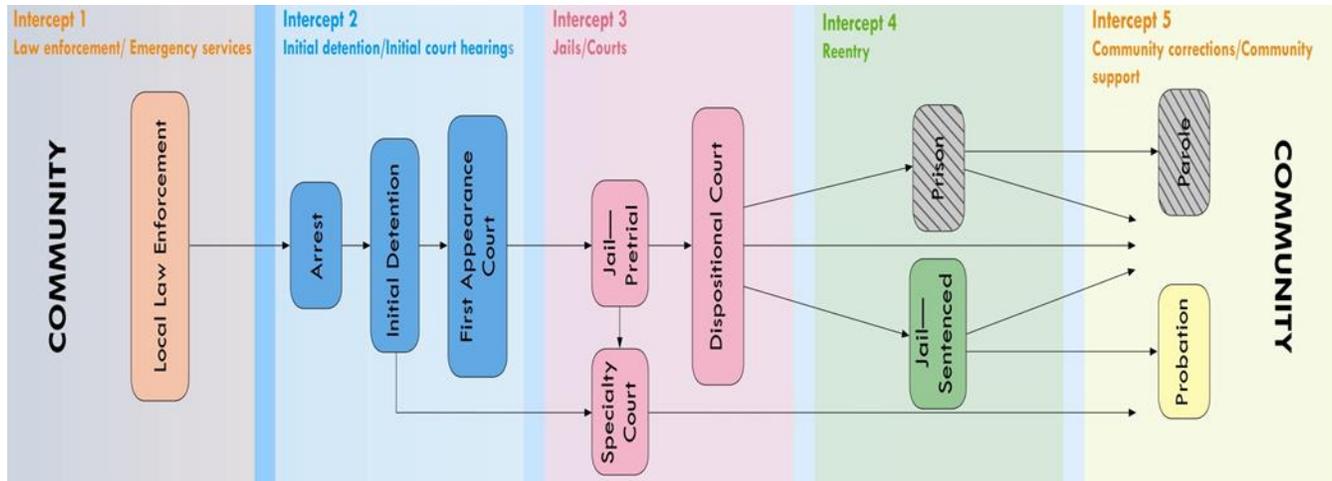
<b>8:00- 8:30a.m.</b>	<b>REGISTRATION AND CONTINENTAL BREAKFAST</b>
<b>8:30 – 8:45 a.m.</b>	<b>WELCOME BY DISTRICT ATTORNEY JACKIE LACEY</b>
<b>8:45 – 9:45 a.m.</b>	<b>REVIEW SUMMIT BREAKOUT GROUP PRIORITIES</b>
<b>9:45 – 10:00 a.m.</b>	<b>BREAK</b>
<b>10:00 a.m. – 12:00 p.m.</b>	<b>MAPPING L . A . EXCERCISE FOR INTERCEPTS I, II/III, AND IV/V</b>
<b>12:00- 1:00 p.m.</b>	<b>LUNCH</b>
<b>1:00- 2:30 p.m.</b>	<b>MAPPING L . A . (Cont.)</b>
<b>2:30 – 2:45 p.m.</b>	<b>BREAK</b>
<b>2:45 – 3:15 p.m.</b>	<b>REFINE AND VOTE ON PRIORITIES</b>
<b>3:15- 4:00 p.m.</b>	<b>ACTION PLANNING IN INTERCEPT GROUPS</b>
<b>4:00 – 4:30 p.m.</b>	<b>REPORT-OUTS TO FULL GROUP</b>

*Special thanks to the California Endowment and the Aileen Getty Foundation  
for their generous support.*

# Los Angeles County Sequential Intercept Map



# Intercept 1



## Resources

- Long Beach Police Department has one Mental Evaluation Team (MET) available per day (usually for one shift between 7 a.m. and 1 a.m. depending upon the day of the week).
- Local police departments or the Sheriff’s Department will “triage” calls as they come in and determine if the fire department, Emergency Medical Services, etc. is needed for a response as well.
- LA County: 23 Sheriff’s stations to serve 42 out of the 88 cities in LA County. Eight (8) MET teams, but only 2-3 on at any given time
- The LAPD dispatcher received Critical Incident Team-like training course. Thirty (30) or more are on duty in the San Fernando Valley.
  - SMART Team can be dispatched upon patrol’s request; 8-12 teams per day; 61 staff members.
  - Patrol must contact EMS for direction.
- There are 99 hospitals scattered throughout LA County.
- Long Beach has hospitals; however they have limited psychiatric capacity.
- The Urgent Care Center is a possible alternative to the Emergency Department, although there are capacity issues.
- Private hospitals (Providence) cannot release individuals, which is easier for law enforcement.

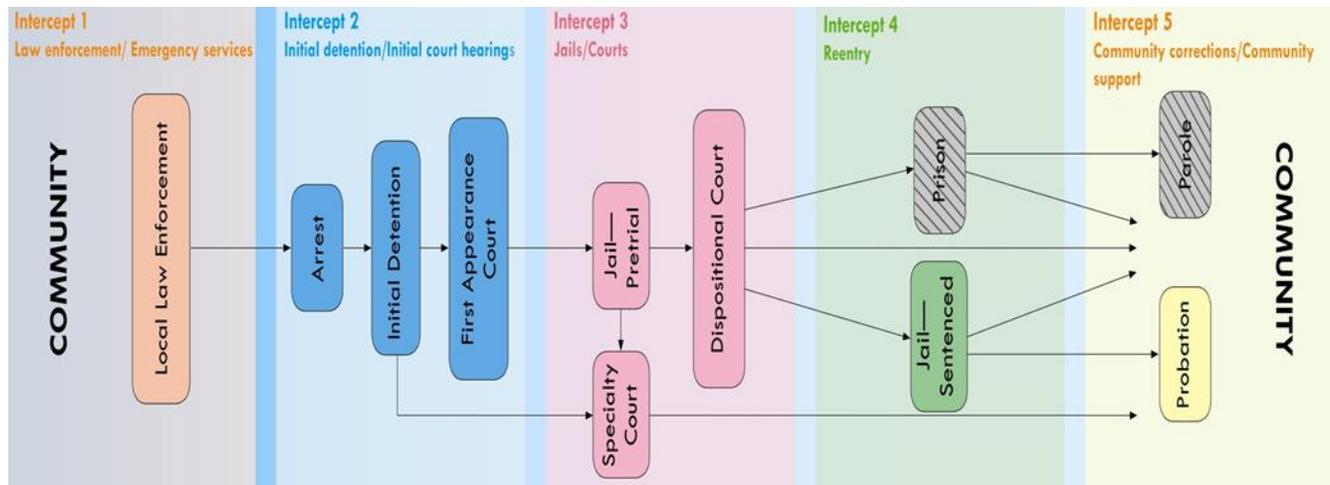
- Aurora Charter Oak and College Hospital-Cerritos have 6 law enforcement beds each, as well as 3 for youth.
- Psychiatric Emergency Departments offer some system decompression and serve as a valuable resource for law enforcement.
- County-wide resource management
- Department of Mental Health liaisons are available/working in inpatient units and Emergency Departments for linkage, as well as linkage/referrals for those without insurance.
- The Corporation for Supportive Housing and the Department of Health Services co-fund an emergency room diversion program.
  - CSH funds 15 hospitals
  - DHS funds 3 hospitals
- County hospital has DMH/DHS databases. A new Integrated Behavioral Health Information Systems data system is on the way.
- AB 1424- Family Form: “You shall take family information about mental illness”
- Street to Home (FUSE): housing voucher and mental health services
- The University of Southern California has an integrated urgent care facility.
- Santa Monica has mental health staff within the police precinct.
- West LA (Skid Row) has a clinician within the police precinct.

## Gaps

- Long Beach PD patrol officers have limited training.
- Once the Long Beach MET has been activated, patrol officers are on their own if a psychiatric crisis arises in the meantime.
- The LAPD SMART Teams function 20 hours per day. During the remaining 4 hours each day, the triage of psychiatric crisis calls transitions to the command post.
- It is often more time efficient for law enforcement to book an individual into jail on a minor charge in order to get back into service more quickly, rather than spend many hours waiting in a psychiatric emergency department for the individual to be seen.
- While there are approximately 1,800 hospital beds throughout LA County for psychiatric purposes, only a small percentage of those beds can actually be accessed by individuals who are uninsured or who most frequently come into contact with law enforcement.
- 70-80% of law enforcement drop offs are at the Emergency Department.

- The police can wait up to 3-5 hours in psychiatric emergency departments due to capacity issues. Law enforcement cannot go back into service until the individual is seen by a psychiatrist. Long Beach does not have the resources for a 6-8 hour wait, as staff are working 10 hour shifts.
- Capacity issues at the emergency department cause delays/waits for law enforcement.
- The Volunteers of America Center had a detox program which lost funding.
- Long Beach does not have a practical and available detox facility.
- There are a lack of emergency department and inpatient hospital discharge planning options. Some are referred to urgent care, while others are referred to inpatient treatment or rehabilitation beds.
- There is not a service capacity priority given to persons who are discharging from emergency departments or hospitals for community based treatment.
- There is often a “communication gap” between social workers, community agencies and family members in assisting an individual during their transition from hospital-based to community-based care. If the individual does not sign a release of information form, the social worker will typically not speak with anyone, even in instances of care transitions, coordination, etc. This frequently causes stress and poor outcomes for individuals who already cycle in and out of the criminal justice system, as well as costly, more intense behavioral health treatment settings.
- There is a lack of state support for Crisis Intervention Teams (CIT).
- Private facilities have difficulty with discharge planning and poor family access.
- Law enforcement/crisis response is needed for Veterans.
- Long Beach Urgent Care is not designated to evaluate and treat persons involuntarily detained for mental health reasons under the Lanterman-Petris-Short (LPS) Act.
- Urgent care facilities are needed throughout LA County.
- Centralized drop off locations for law enforcement are needed throughout LA County in an effort to make early diversion a reality.
- Long Beach brings inebriates to jail instead of to a detox center/facility.

# Intercepts 2 & 3



## Resources

- Psychiatric Mobile Response Teams consist of Department of Mental Health licensed clinical staff assigned to a specific Service Area in Los Angeles County. These licensed clinical staff have the authority to initiate applications for evaluation of involuntary detention.
- The LAPD has access to 21 local lock up facilities throughout the county.
- The Long Beach- MET team can provide reach-in services when individuals are already in lockup and state that they feel like harming or killing themselves.
- Santa Monica- the individuals can be released from local lock-up to a known provider.
  - Ocean Pacific Community Center
  - St. Joseph Center
- LASD Inmate Reception Center (IRC)
  - A 15 question screen is utilized
  - 1,000 booked daily; 1/3 are referred
  - 342 mental health staff (of which 38 are psychiatrists)
  - 24/7 psychiatric coverage
- The Public Defender screens for mental health/veteran status.
- Veterans resources
  - Long Beach/LA for resources
- The LA County Jail has psychiatric coverage 24/7/365, either in person or over the telephone.

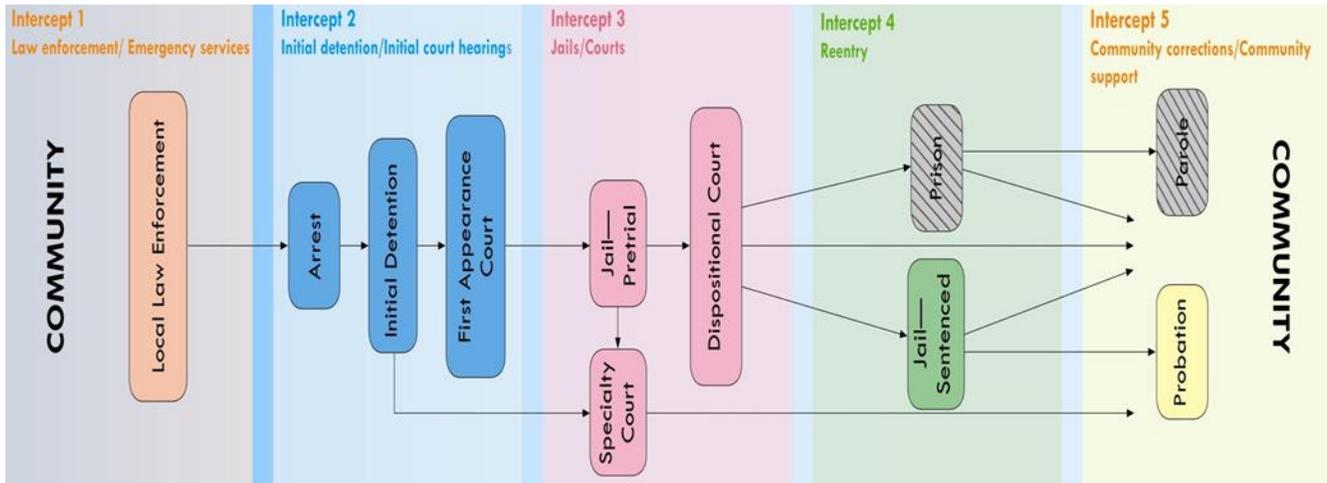
- Co-occurring disorders court diversion is available.
- Mental Health Court Linkage Program has 14 staff members serving 22 courts in LA County to assist with diversion and release to services.
- Sentenced offenders Drug Court- Homeless Community Court- Santa Monica; last created specialty court in 2006-2007 (felonies, generally nonviolent)
- Co-occurring Drug Court- Proposition 36- LA countywide post-conviction
- Specialty courts: Women’s Reentry, Veteran’s Court, Mental Health Court
  - All generally accept non-violent felonies.
- AB 109
- Revocation
- Department 95
- Mobile crisis with housing vouchers
- Integrated clinics
- Institutes of Mental Disease (IMD) step down programs- residential treatment and living situations
- Abandoned property could be used for housing.
- Shared/congregate housing
- Innovative locally-funded (non-HUD) housing models
- Funding is available to match with people who meet criteria.
- Co-located probation and treatment or peer support groups

## Gaps

- There is no medication in lockup; this poses problems, particularly on weekends.
- At the LA County Jail, it can take up to 72 hours for an individual to be seen for needed psychiatric medications.
- Long Beach- no assessment or clinical presence
- Develop strategies for multi-disciplinary and collaborative approaches.
- No formalized Intercept 2 diversion exists at the current time.
- It is extremely rare for the Mental Health Court Linkage Program to get someone into services at the point of arraignment court.
- At the time of lockup, there is a heavy reliance primarily upon the individual to self-report key health information.
- No supervised Pretrial Release Program

- No pre-plea diversion
- Specialty courts have very limited capacity and only address a small fraction of cases which could go to specialty courts.
  - Funding is needed to expand capacity.
  - Very restrictive criteria to get into specialty courts
  - Lack of service providers to work with/be dedicated to specialty court participants
- Specialty courts are post-conviction courts; this allows the person to penetrate the criminal justice system even farther.
- Jail-based diversion via non-specialty courts is needed.
- Additional funding for court linkages is needed.
- The capacity of courts and treatment services has remained the same for the last 10-15 years.
- Small numbers of Supportive Housing slots
- Housing requirements are very restrictive for persons with mental health issues and criminal histories.
- The housing demand is much greater than the supply.
- “Not in my backyard” (NIMBY) housing issues throughout LA County

# Intercepts 4 & 5



## Resources

- 211 services hotline
- Patriot Hall Veterans
- 30-45 days of notice from jail release- can get on the medical list to make certain they leave the jail with a paper MediCal card
- Families are part of the solution.
- Track recidivism rates
- Jail and court linkages work together.
- The LA Sheriff's Department has a Community Reentry Center that has been open since July 2014.
  - Referrals to job centers, substance abuse treatment, assistance with benefits, mental health services and health insurance
- The LA County Jail can keep persons for up to 16 hours after their scheduled release date for further discharge planning/transitioning.
- Productive programs are now in place at the jail for mental health.
- Mental health clinicians are embedded within the Probation Department.
  - Receive information from the prison/jail; transfer information to providers

- 35% are rearrested
- Area offices in multiple locations
- Probation has assumed parole functions with AB 109- Specialized probation- 10,000; 8 of 14 offices are covered with specialized probation; 20:1 caseloads
- Mental health is co-located at Probation Department hubs.
- AB 109 funds the services.
  - Not for the other 48,000 on supervision
  - Work with the Department of Mental Health to establish training on recognizing mental health
- Day Reporting Centers- the state allocated funding to counties for evidence-based practices for adults.
- Probation uses the Level of Service/Case Management Inventory to determine needs and risk assessment.
- Probation is exploring the utilization of SB 678 funds (which predates AB 109) to develop services for the probation population which has served time in state prison and is not AB 109 eligible.
- The National Alliance on Mental Illness could be better utilized to connect individuals discharging from incarceration with their families or other key supports who will be critical to their success and increased community tenure.

## Gaps

- Lack of immediate/emergency housing
- Prison release: family connections need to be made sooner; a warm handoff to the families is needed at discharge.
- Little lead time for the jail navigator to put services in place
- Each Service Area has a jail navigator, but oftentimes they are overwhelmed. For example, San Fernando only has one jail navigator for the entire area.
- The LA Sheriff's Department Community Reentry Center is only able to be open 5 days per week.
- The jail has many services, but many inmates have not heard of reentry services.
- With so many inmates incarcerated at the LA County Jail, it is often difficult for good discharge planning and handoffs to occur.
- Probation is generally not available for misdemeanor offenders. Misdemeanor diversion is strongly needed.

- Dr. Frank Pratt (Medical Director for the LA County Fire Department) discussed how being on MediCal offers fewer physical and behavioral health treatment options than having no insurance coverage in some instances.
- There is a need for more Integrated Health Homes. Existing Integrated Health Homes are underdeveloped at this time.

## **Priorities for Change as Determined by Mapping Participants**

- Training for all criminal justice professionals in the system- multi-disciplinary and holistic (17 votes)
- Expand capacity for treatment- continuum of care- for justice-involved persons (16 votes)
  - How much is needed?
  - What is the population?
- Data study to examine services needed, capacity needed, populations most in need, etc. (12 votes)
- Better communication/coordination between all system partners/data system/remove silos; develop policies and procedures to guide capacity utilization; develop resource database (10 votes)
- Crisis Alternative Centers/Crisis Stabilization Centers- law enforcement, families, individuals (9 votes)
- Expand housing for justice-involved persons (8 votes)
- Funding for initiatives and sustainability (4 votes)
- Define future configuration of Mental Health Court/Court Diversion (3 votes)
- Implement a pre-booking diversion program. Shorter drop-off times for law enforcement (3 votes)
- Creation/re-creation of an Intercept 2 diversion point (2 votes)
- Public education about behavioral health, homelessness, stigma, etc. (1 vote)
- Expand/enhance co-response models Psychiatric Mobile Response Teams, SMART, etc. (1 vote)

## RECOMMENDATIONS:

Participants in the Summit and Sequential Intercept Mapping Workshop (SIMW) showed genuine interest and commitment to improve the continuum of resources available to justice involved persons with behavioral health disorders. Los Angeles County has many exemplary programs and strategies on which to build. As noted below, there are several on-going initiatives that currently address gaps identified in the report (e.g., SB 82) or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified.

Rather than focusing on the development of new initiatives and resources, the focus of the 11 recommendations listed below is to “Adapt and Expand.”

1. *Formalize a County Wide Planning Body to address the needs of justice involved persons with co-occurring mental health and substance use disorders.*

This recommendation is consistent with Recommendation 5 (p.19) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report (April 2011).

[http://www.courts.ca.gov/documents/Mental\\_Health\\_Task\\_Force\\_Report\\_042011.pdf](http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf)

The first and fifth ranked priorities from the SIMW, as voted on by the participants, identified the need for improved cross system training, communication and planning. Workshop participants expressed the need for on-going dialogue, joint planning and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state, county and municipal level change. An LA County planning body should coordinate activities with the Task Force for Criminal Justice Collaboration on Mental Health Issues, which is prepared to implement recommendations from its 2011 report.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

Los Angeles County has 88 cities, 7 of which have over 100,000 residents. As a result, Criminal Justice/Mental Health resources, needs and strategies across the county vary widely. Development of additional localized planning structures to coincide with Department of Mental Health (DMH) Service Areas, judicial districts or municipal regions may facilitate planning, development and the implementation

of programs. Existing DMH Systems Flow Charts can also prove useful in supporting some of this work (Appendix 1).

*2. Data Analysis/Matching; Add a County CJ/MH Technical Assistance/Resource Center.*

The fourth highest priority identified during the SIMW was to utilize data to inform decisions. Across Intercepts there has been limited data collection and sharing of existing data regarding persons with mental illness in the justice system. Without adequate screening and data collection, it is difficult to identify and prioritize service needs, plan interventions, and target resources for the highest need and highest risk populations.

Participants acknowledged having data on existing programs, but data is not routinely analyzed to inform planning priorities, often due to a lack of resources and data not being strategically disseminated to interested stakeholders.

Resources to address data collection/analysis strategies include:

- The Urban Justice Institute published “Justice Reinvestment at the Local Level Planning and Implementation Guide”  
<http://www.urban.org/publications/412233.html>

The guide offers an excellent overview of planning, data collection and justice reinvestment strategies across the criminal justice system.

- The “Mental Health Report Card” used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes  
<http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx>
- Data matching between jail admission data bases and community provider databases, as is done in Maricopa County, AZ as described in, “Using Management Information Systems to Locate Persons with Serious Mental Illnesses and Co-occurring Disorders in the Criminal Justice System for Diversion” [http://gainscenter.samhsa.gov/pdfs/jail\\_diversion/using\\_mis.pdf](http://gainscenter.samhsa.gov/pdfs/jail_diversion/using_mis.pdf) and in the Illinois Jail Data Link Program, (Appendix 2).
- In 2013, the LA County DMH Jail Team developed a Pre-booking Diversion Proposal, “An Open Door to Recovery” which included a prevalence study of potentially divertible individuals

in Antelope Valley and Long Beach. The study's conclusion was that 72 individuals per day were potentially divertible from jail. This analysis is an excellent example of how data can confirm need and focus system resources. (Appendix 3)

The first and fifth ranked priorities by the participants identified the need for better cross system training, communication and planning. Recommendation 1 focuses on the need for a criminal justice/mental health planning structure.

With a county as large and complex as Los Angeles, there is a need for a resource center where criminal justice/mental health resources, events, and Initiatives can be centralized to:

- Disseminate information
- Track diversion activity
- Publish performance outcome measures
- Aid in planning
- Provide published resources
- Provide Technical Assistance and Training

Such a center can be modeled after technical assistance centers (Centers of Excellence - CoE) in the following states:

- Ohio Coordinating Center of Excellence (CCOE) <http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence>
- Illinois Center of Excellence for Behavioral Health and Justice  
University of Illinois Rockford  
<http://www.illinoiscenterofexcellence.org/>
- University of South Florida, Criminal Justice Mental Health Reinvestment Technical Assistance Center <http://www.floridatac.com/>
- Pennsylvania Mental Health and Justice CoE  
<http://www.pacenterofexcellence.pitt.edu/>

*3. Integrate Task Force Activities with system wide initiatives.*

LA County has a number of mental health and criminal justice initiatives that can either directly support the work of the Task Force or that can be integrated with the work of the Task Force. Some of these initiatives already involve criminal justice partners. It will be critical for this Task Force to not only consider how it will relate to on-going planning efforts, but also how it will influence the planning and implementation of future efforts. Existing efforts include, but are not limited to:

- Healthy Way LA
- Integrated Behavioral Health Information Systems (IBHIS)
- Mental Health and Wellness Act of 2013
- AB 109 Funding
- Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal (Appendix 4)
- CSH/DMH funded Emergency room diversion programs
- Policy Research Associates through its SAMHSA GAINS Technical Assistance Center recently provided a Train the Trainer event: *How Being Trauma-Informed Improves Criminal Justice System Responses*. The lead agency for the event was Tarzana Treatment Centers, which provides Seeking Safety Training as part of the Healthy Way LA initiative and provides outreach recruitment services into the jail for transitional housing programs. For a list of trainees at the recent event see Appendix 5.
- Program planning for LA County's new jail
- Advancing Safe and Healthy Homes Initiative/DMH Healthy Home Initiatives

*4. Integrate Peer Programs and Peer Support Staff into planning and service delivery.*

This recommendation is consistent with Recommendation 73 (p.42) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. The California Health Report recently published an article regarding Peer Respite Centers (Appendix 6). The programs described are excellent examples of utilization of peer models and an opportunity to adapt and expand existing programs.

Participants reported peer involvement in service delivery at various Intercept points.

Peer involvement in the Summit and Mapping Workshop was minimal. It is recommended that peers be formally involved in planning efforts moving forward. Depending on whether or not peers are currently employed, they may need stipends to travel to meetings, for meals and/or be paid for their time.

*5. Expand screening for Veterans across Intercepts. Allow early diversion and misdemeanor alternatives for Veterans.*

There is currently a felony, post-conviction Veterans Court in LA County. While this program is an important component of diversion alternatives for Veterans, providing diversion for misdemeanors, as well as lesser felony offenses earlier in the court process will allow for earlier intervention and likely better outcomes for Veterans. [It should be noted here, as well as throughout this document, “diversion” means diversion from jail or prison, as opposed to the more narrowly circumscribed statutory authorized diversion set forth in California Penal Code section 1000 et seq.]

Using the “Adapt and Expand” philosophy, LA County already has substantial resources for Veterans. Aside from the Department of Veterans Affairs services, the following programs, for example could be adapted, expanded or linked to diversion activities:

- Los Angeles City Attorney’s Office HALO program
- Los Angeles City Attorney’s Office VALOR program
- Patriotic Hall

In addition, the Department of Mental Health has Veteran specific mental health programs which could service Veterans who are not eligible for VA services or who do not wish to utilize VA services.

*6. Consider broad approaches to improving accessible housing for justice involved individuals.*

This recommendation is consistent with Housing Recommendations (pp.43 and 44) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Both Summit Participants and Mapping Workshop participants identified housing as a critical gap across Intercepts.

LA County is fortunate to have the Corporation for Supportive Housing as a stakeholder and they have already proposed housing strategies for justice involved individuals (Appendix 4).

## INTERCEPT SPECIFIC RECOMMENDATIONS:

### Intercept 1

*7. Enhance/Expand Police Specialized Response and Mental Health Crisis Response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams (CIT).*

This recommendation is consistent with Recommendations 7 and 8 (pp.19 and 20) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Expansion of specialized police response (e.g., SMART, MET, CIT) and improved crisis response was the third highest ranked priority identified in the SIM Mapping Workshop. In addition, participants in the Mental Health Summit, Intercept 1 Workgroup also identified insufficient resources for Psychiatric Mobile Mental Response Teams (PMRT) and crisis response options as gaps.

Participants in both the Summit Workshop and Mapping Workshop were satisfied with police specialized response teams, but noted that the LAPD SMART Team responds to approximately 35% of all calls. Elsewhere in the County, specialized police response is available in Long Beach and Santa Monica, as well as through the Los Angeles Sheriff's Department, which has 8 MET teams.

Participants in the Summit Workshop and the Mapping Workshop identified lack of crisis response options, especially crisis stabilization units as a significant gap. The Long Beach Police Department in particular identified long wait times (up to 6-8 hours) in area emergency departments as a significant issue. Participants noted that waiting for an available psychiatrist in the psychiatric emergency departments often accounted for delays. Lengthy delays for these types of important diversionary services often leave law enforcement with the difficult decision of whether to spend several hours "out of service" with a person while he or she waits to be seen in an emergency department or a psychiatric emergency department or, in the alternative, to take the person into custody, book him or her into a local jail, and return to service. The Psychiatric Mobile Mental Response Teams were also seen as valuable partners, but participants noted that there were insufficient resources to meet demands.

The Department of Mental Health has several initiatives underway to address this recommendation (Appendix 7).

Representatives from the City of Long Beach also identified a lack of a detoxification (sobering) facility, which has resulted in serial inebriates being incarcerated. San Diego has had a successful Serial Inebriate Program for several years and information about their program can be found at:

<http://www.sandiego.gov/sip/index.htm>

## **Intercept 2**

*8. Expand diversion opportunities at arraignment and improve screening for diversion at later stages:*

- *Bring the Department of Mental Health Court Liaison Teams to scale.*
- *Improve alignment regarding diversion at this intercept among stakeholders.*
- *Implement a Probation Pre-Trial Release Program*

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Systemic screening for mental health issues and Veteran status is not present at the first court appearance or arraignment. Key mental health screening partners at this diversion point are defense counsel and the Probation Department. Resources may have to be added to these agencies to enhance screening and referral.

The DMH Mental Health Court Linkage Program is an innovative resource that LA County has operated for 10 years. Participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of the DMH Court Liaison Program, a component of the Mental Health Court Linkage Program, was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and Court Liaison Program regarding diversion philosophy.

Participants also expressed the opinion that housing was a barrier to diversion at this Intercept. While housing would likely improve successful diversion, diversion can be successful with individuals who are homeless, as demonstrated by the New York City CASES Transitional Case Management Program (Appendix 8). Reports from the Court Liaison Program also indicate that successful diversion can be accomplished with individuals who are homeless.

Diversion programs which emphasize engagement strategies, direct linkage, focus on immediate needs, and prompt access to community services can be successful even when there are not significant court sanctions available.

People with mental illness have more bail risk factors and are more likely to be remanded to jail. Pre-trial supervision programs allow for greater access to pre-trial release for persons with mental illness.

When additional court leverage is preferred, implementation of a Probation Department pre-trial supervision program can reassure the court that individuals are appropriately monitored and held accountable for adhering to release conditions.

### **Intercept 3**

*9. Expand post-arraignment diversion opportunities for defendants charged not only with misdemeanors but also felonies.*

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the Court Liaison Teams, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase diversion opportunities.

In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Liaison Team and defense counsel to present a diversion plan to the courts.

Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as barriers to employment, housing, court fines, access to public benefits and voting rights. The Legal Action Center's ***After Prison: Roadblocks to Reentry*** (<http://www.lac.org/roadblocks-to-reentry/>) is an excellent review of sanctions which create employment and housing barriers and impede recovery.

Specialty Courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be effective. For more serious charges, persons can be sentenced to Probation with appropriate conditions.

Court Self-Help Centers could help address the unplanned releases from courts (see "Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report" Recommendation 39, p.30).

#### **Intercept 4**

*10. Expand DMH Jail Navigator capacity and capacity of existing reentry programs.*

Both the Summit and Mapping Workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time-frames with which to link individuals to services. Other providers include, but are not limited to:

- Just In Reach
- HALO Program
- Women’s Reentry Court
- LASD Community Reentry Center

#### **Intercept 5**

*11. Provide training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Interventions.*

This recommendation is consistent with Recommendations 57, 60, 62, 63 and 64 (pp. 36-37) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Other than housing, which was a gap across all Intercepts, there were no specific gaps or priorities identified for this Intercept. There are many best practices and innovative programs operating at this Intercept, including specialized mental health Probation caseloads, co-location of Department of Mental Health staff in Probation Department offices and peer-run programs for Probation clients.

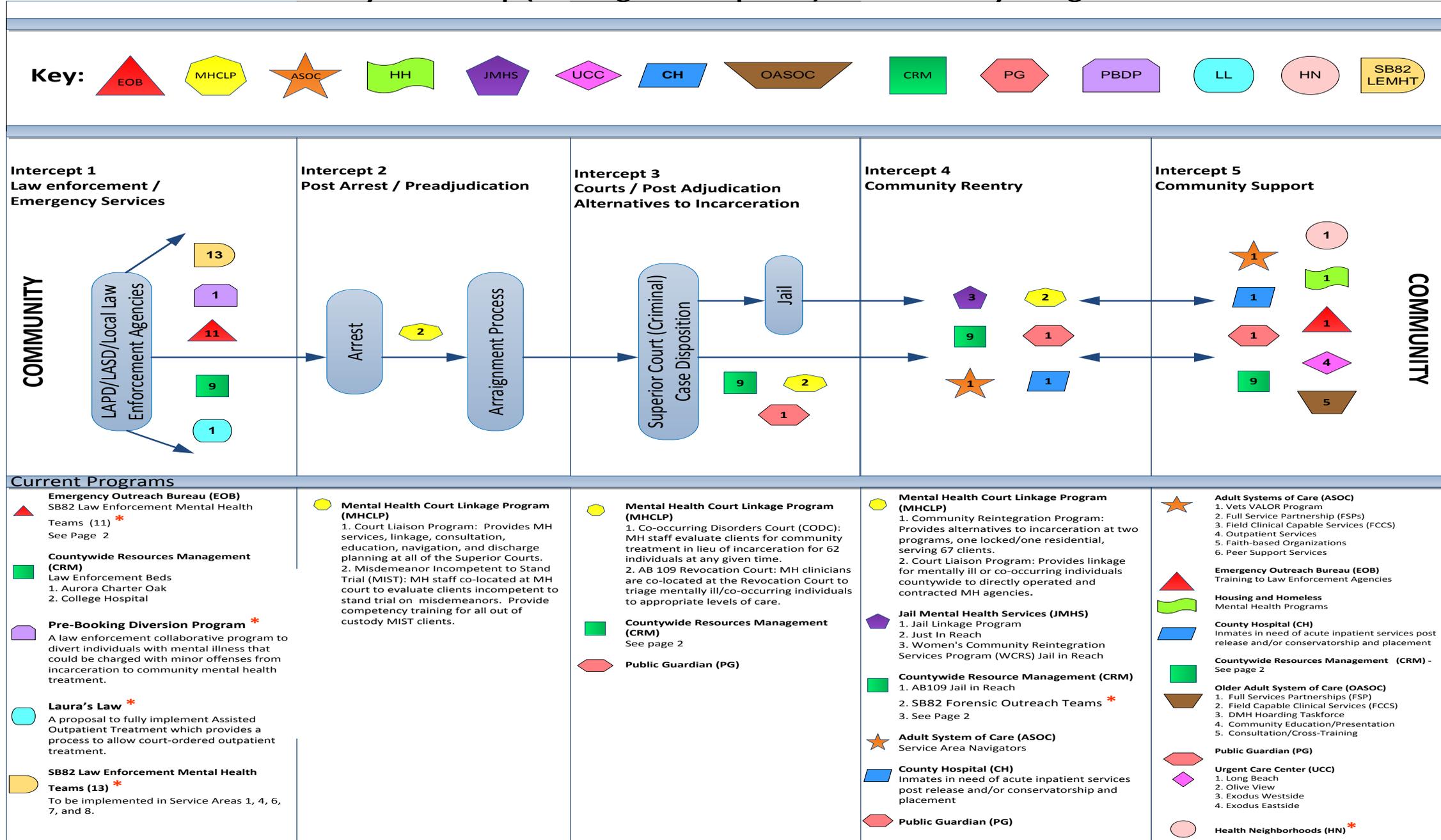
The Probation Department performs risk assessments to determine supervision and program needs utilizing the Risk, Need, Responsivity (RNR) principle. This principle targets specific criminogenic risk factors to reduce recidivism and guide the intensity of supervision required.

[https://cpoc.memberclicks.net/assets/Realignment/risk\\_need\\_2007-06\\_e.pdf](https://cpoc.memberclicks.net/assets/Realignment/risk_need_2007-06_e.pdf). It is important for the Probation Department to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Treatment interventions which insure that criminogenic needs are addressed in behavioral health settings.

# Appendix 1:

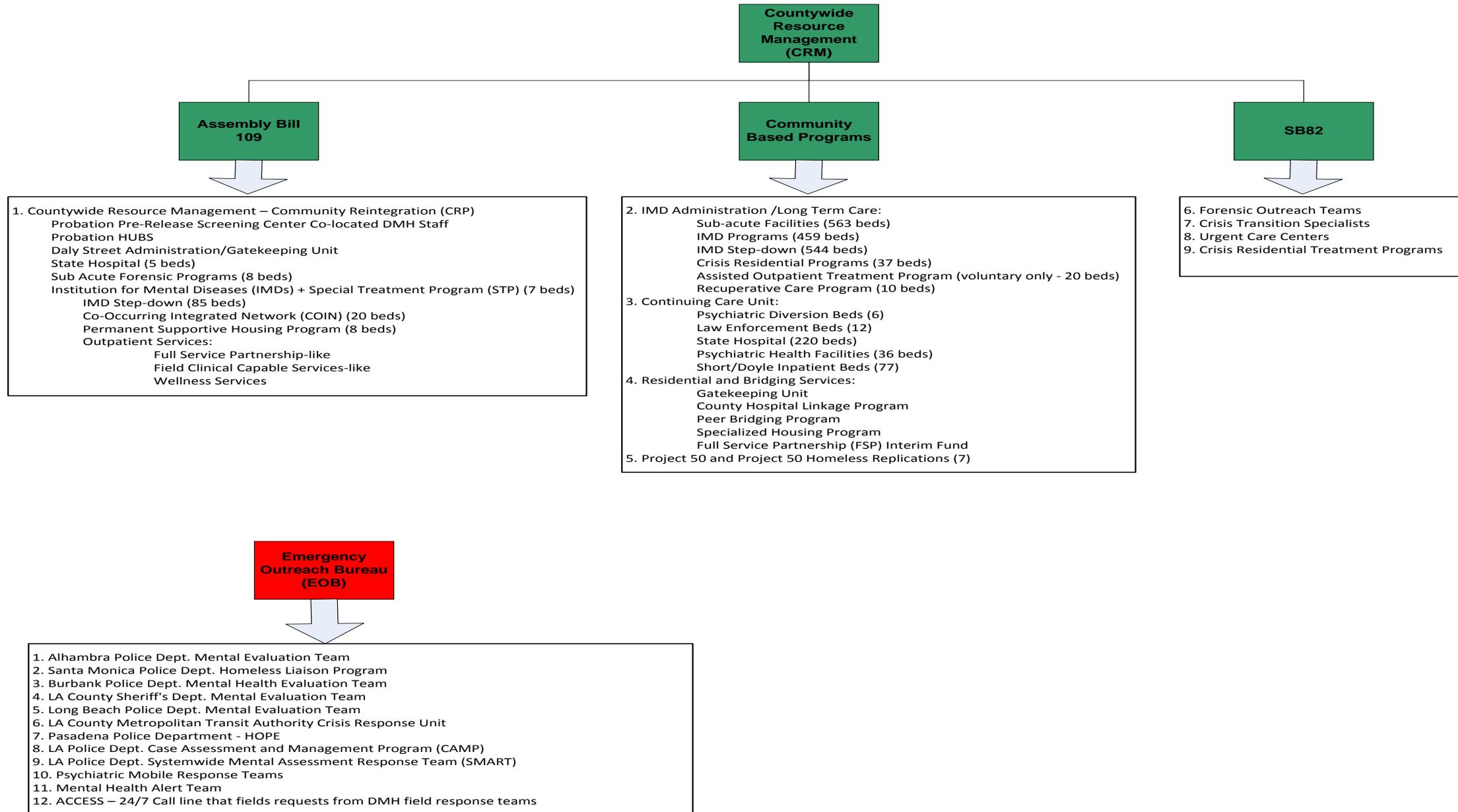
## LA DMH Systems Map

# County of Los Angeles – Department of Mental Health Systems Map (Existing and Proposed) – Diversion by Design



\* Proposed

# County of Los Angeles – Department of Mental Health Systems Map (Current)



# Appendix 2:

## IL Jail Data Link

## Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

## Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Health.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

## Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted **Public Act 91-0536** which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted **Public Act 094-0182**, which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

## Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- <https://sisonline.dhs.state.il.us/JailLink/demo.html>
  - UserID: cshdemo
  - Password: cshdemo
  - PIN: 1234

## Program Partners and Funding Sources

- **CSH's Returning Home Initiative:** Utilizing funding from the Robert Wood Johnson Foundation, provided \$25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- **Illinois Department of Mental Health:** Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- **Cermak Health Services:** Providing mental health services and supervision inside the jail facility.
- **Cook County Sheriff's Office:** Assisting with data integration and coordination.
- **Community Mental Health Agencies:** Fourteen (14) agencies statewide are entering and receiving data.
- **Illinois Criminal Justice Authority:** Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- **Proviso Township Mental Health Commission (708 Board):** Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- **University of Illinois:** Performing ongoing evaluation and research

## Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

## Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

## About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see [www.csh.org/contactus](http://www.csh.org/contactus).

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.



Corporation for Supportive Housing  
Illinois Program  
205 W. Randolph, 23rd Fl  
Chicago, IL 60606  
T: 312.332.6690  
F: 312.332.7040  
E: [il@csh.org](mailto:il@csh.org)  
[www.csh.org](http://www.csh.org)

# Appendix 3:

## Pre-Booking Diversion Proposal

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH  
PRE-BOOKING DIVERSION PROPOSAL  
"AN OPEN DOOR TO RECOVERY"**

September 2013

**BACKGROUND**

The Department of Mental Health (DMH) is a participant in a variety of collaborative criminal justice projects including law enforcement/mental health crisis intervention teams such as Mental Evaluation Teams (MET) and the Systemwide Mental Assessment Response Team (SMART), the Mental Health Court Linkage Program and most recently the Assembly Bill (AB) 109 Realignment Program. These interagency partnerships address the special needs of persons with mental illness who become involved with the criminal justice system. DMH is proposing to enhance its partnerships with law enforcement entities and the criminal justice system through the implementation of two pre-booking jail diversion programs, initially as pilot projects serving the Long Beach (LB) and Antelope Valley (AV) areas, and subsequently to be extended throughout Los Angeles County, utilizing the experience gained through the pilot projects.

The need for a pre-booking diversion program is significant. Police response to calls involving individuals with mental illness takes more time to complete than calls involving individuals who are not mentally ill. In the Los Angeles County jails, the cost to provide mental health treatment, as well as custodial care, to a daily census of over 2900 inmates with mental illness is substantial. Incarceration disrupts treatment in the community, impedes recovery, and may result in the exacerbation of symptoms. Defendants who are mentally ill and unable to afford bail have been found to spend longer times in custody than those that are not suffering from mental illness. Their court cases often take multiple court appearances to adjudicate, adding costs to the judicial system. A pre-booking interagency diversion program would provide a means of reducing the number of individuals entering the criminal justice system and a safety measure for individuals experiencing crisis.

Pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country. Research indicates that these programs produce positive outcomes for persons with mental illness and for the community. The principal goal of the proposed project is to link individuals with mental illness to recovery services at the first point of contact with the criminal justice system as an alternative to repetitive incarcerations.

In August 2013 DMH Jail Mental Health Staff conducted a prevalence study to determine the number of potential mentally ill males incarcerated from the AV and LB areas that might benefit from a pre-booking diversion program. Findings indicate that 14% of those arrested for felonies and 33% of those arrested for misdemeanor charges may be more appropriately served by mental health treatment rather than incarceration (See Attachments 1 and 2).

## **PROJECT DESCRIPTION**

The proposed LB and AV pilot projects would be housed in Urgent Care Centers (UCC) located in the AV and LB areas. The UCCs would serve as the entry point for the AV and LB Police Departments to link individuals to mental health services in lieu of their being charged with low level offenses. UCCs typically provide up to 24 hours of intensive crisis services and immediate care, including referrals to community based solutions, to individuals who otherwise would be brought to emergency rooms. The AV and LB UCCs would be expanded to allow specially trained law enforcement to divert individuals to mental health services whose low level offenses appear to be the result of or associated with their mental illness and who voluntarily agree to treatment. The diversion project would have the ability to link clients to needed services directly, including all levels of mental health care, health services, substance abuse treatment, housing, benefits (re)establishment, education and employment, and social services. The UCCs would be designated to receive or place individuals on 72-hour holds.

The goals of the Program are as follows:

- Enhanced coordination among law enforcement, mental health and other participating agencies
- Improved access to services for people with mental illness
- Diversion of people with mental illness from the criminal justice system
- Improved efficiency of police response to mental health related calls

DMH will use established partnerships to develop the proposed projects. As a first step, DMH plans to engage stakeholders such as the AV and LB Police Departments and law enforcement/mental health teams, the City Attorneys, the District Attorneys and Countywide Criminal Justice Coordination Committee to support the project. Once support is secured for the projects, a work group would be needed to coordinate tasks such as establishing agreements among participating agencies in each geographical area; identifying target populations and offenses; establishing program capacity and notification protocols when at capacity; developing training for police dispatchers and

specialized police officers; delineating the range of mental health and other services to which participants could be linked; establishing protocols, including information sharing; defining data tracking and outcome measures; and identifying funding sources.

This proposal would leverage existing County and local services - UCCs, other mental health providers and the mental health/law enforcement teams - to implement the programs. In addition to leveraging existing services, the projects will require additional funding including AB 109, Mental Health Services Act (MHSA) and Senate Bill (SB) 82. It is anticipated that both projects will require capital development and services funding including UCC staffing, recruitment, training, and development of enriched residential capacity to serve this population. Included in the UCC staffing will be a short-term case management team that can immediately house program participants if needed, provide treatment for mental health and co-occurring substance abuse disorders and follow participants for up to two months until connected to community services and supports. The timeline for the implementation of the AV pilot will be lengthier than LB pilot due to the need to develop a new UCC in the area.

Anticipated outcomes of the program include:

- Reduction in arrest for minor offenses of persons with mental illness
- Increased access to mental health services for individuals who come into contact with law enforcement
- Increased satisfaction of persons with mental illness with law enforcement services
- Increased training of police officers on recognizing mental health symptoms and resources.

Following successful implementation of these pilot projects, DMH envisions working with its partners to expand the programs in order to offer law enforcement personnel countywide a means to redirect people with mental illness away from the criminal justice system to recovery-based community treatment and services and to promote an end to the cycles of repeated incarcerations.

**Pilot: Identification of Potential  
Correctional Mental Health Clients  
for Pre-Booking Diversion**

**Method:** A prevalence study was conducted on August 5, 2013. All incarcerated inmates from Service Area 1 and 8 (Antelope Valley and Long Beach) were surveyed.

Total	N = 169	
Felony	N = 133	77%
Misdemeanor	N = 36	21%

**Recommended Diversion Exclusions**

**Arrest Charge**

1. Murder, Attempt Murder
2. ADW with use of firearm and/or GBI
3. Robbery 1<sup>st</sup> and 2<sup>nd</sup> degree
4. Manslaughter, 1<sup>st</sup> or 2<sup>nd</sup> degree
5. Any sexual offense
6. Any child offense
7. Domestic violence
8. Arson
9. Battery GBI
10. Kidnapping, False Imprisonment, Car jack
11. Co Ret. (State Hosp. Returnees)
12. All other offenses with 4 or more previous arrest as determined by CII (Criminal Information Index)

**Felony Charge**

Excluded by criteria	N = 48	36%
County Returnees	N = 11	8%
CII 4 or more (criminal charge)	N = 38	29%
CII 4 or more (drug charge)	N = 17	13%
Acceptable for Diversion	N = 18	14%

### Misdemeanor Charge

Same exclusion criteria as for felonies, but previous arrests by CII increased to 10 with no previous arrest constituting any of above exclusions (item 1 – 11).

### Misdemeanor Results

**N = 36**

Excluded by criteria	N = 19	53%
County Returnees	N = 5	14%
Acceptable for Diversion	N = 12	33%

Total (Felony and Misdemeanor) acceptable for Diversion = 30 18% of whole sample  
(e.g. based on 400 bookings in a day 72 would be diverted from jail)

These diversion criteria are considered to be based on conservative criteria.

2.

**Discussion**

Pilot study results regarding the possible diversion of mental health arrestees from incarceration are very promising, but these data must be viewed in context. First, subjects were selected from 2 Los Angeles County Service Areas (Antelope Valley and Long Beach). Due to possible variances in personal and demographic differences, these results may not be readily generalizable to different County Service Areas, (e.g. Downtown). Additionally, these data were collected via a "spot prevalence" count of mental health men incarcerated on a single date. Length of jail stay was not determined. Positive diversion factors tend to correlate with short jail tenure and vice versa. This factor needs further exploration and may well result in an increase in the percentage of potential diversion candidates.

The concept of diversion of the mentally ill from incarceration is clearly supported by these preliminary data and has very broad and promising ramifications for appropriate community based treatment of the mentally ill.

**Appendix 4:**  
**CSH Mental Health, Jail**  
**Diversion and**  
**Supportive Housing**  
**Proposal**



## Mental Health, Jail Diversion, and Supportive Housing:

### A Model for Community Integration and Stabilization

July 2014

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#### Introduction

Men and women experiencing homelessness and suffering from mental illness are substantially more likely be involved with the criminal justice system than those individuals who live with mental illness, but are stably housed. For these men and women access to supportive housing (stable, safe, affordable housing combined with supportive services, mental health treatment and healthcare) has the single greatest impact on their likelihood of recidivating. A stable home in the community not only provides safety, security and shelter, but allows a level of stability, dignity and community integration that cannot be provided by any other intervention.

#### Supportive Housing

Supportive housing is an evidence-based practice that reduces homelessness and improves health outcomes for individuals experiencing long term homelessness and disabling conditions. By definition supportive housing is affordable housing combined with a wide array of supportive services. The housing is not time-limited. Tenants rent apartments and sign a lease that grants them full protection under state and local tenant landlord laws. Tenants can stay in their apartments as long as they choose granted that they do not violate the conditions of their lease. The housing affordability is generally provided through rental assistance in the form of the Housing Choice Voucher program or other federal and local rental assistance programs that allow tenants to pay rent based on 30% of their income regardless of how low their income may be or in some cases lack of any income at all.

Supportive housing is linked to comprehensive voluntary and flexible supportive services, behavioral healthcare and primary healthcare that is based on the tenants' needs and preferences. While the housing and services are linked, tenants are not required to participate in services. Services are completely voluntary and tenants cannot be asked to leave their housing because of their lack of participation in services or adherence to treatment plans. Services are provided using a proactive approach, where service providers actively engage tenants and develop treatment plans based on tenants' preferences.

To understand what supportive housing is, it is instructive to also understand what supportive housing is not. Supportive housing starkly differs from transitional housing, shelters, sober living programs, group homes or board and care facilities, including the following:

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Supportive Housing Tenants	—versus—	Transitional Housing Residents
<ul style="list-style-type: none"><li>• Sign a lease (or sublease if master-leased) with landlord, have rights &amp; responsibilities of tenancy under state &amp; local law, are free to come &amp; go or have guests</li><li>• Have no restrictions on length of tenancy, can remain in apartment as long as complying with lease terms &amp; desires to remain in apartment</li></ul>		<ul style="list-style-type: none"><li>• Do not have leases, have no rights under landlord-tenant law, have restrictions on coming &amp; going, as well as guests</li><li>• Do not determine their own length of stay (program decides length of stay)</li></ul>

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<b>Supportive Housing Tenants</b>	<b>—versus—</b>	<b>Transitional Housing Residents</b>
<ul style="list-style-type: none"> <li>• May participate in accessible, usually comprehensive, flexible array of services tailored to needs of each tenant, with a case manager on call 24/7</li> <li>• Are not required to participate in services as a condition of tenancy, of admission into housing, or of receipt of rental subsidies</li> <li>• Have rent based on income, in compliance with federal affordability guidelines (30-50% of income).</li> <li>• Work closely with services staff who collaborate with (but are usually separate from) property management staff to resolve issues to prevent eviction</li> <li>• Live in housing that meets federal quality standards for safety &amp; security</li> <li>• Usually occupy own bedroom, bathroom, and kitchen &amp;, if sharing common areas, choose own roommates</li> <li>• Are protected by Fair Housing law</li> </ul>		<ul style="list-style-type: none"> <li>• Service availability varies from program to program, without choice in services</li> <li>• Are required to participate in services, or cannot remain in program or access subsidy</li> <li>• May be asked to pay rent based on program's guidelines, not based on federal affordability guidelines</li> <li>• Often have no advocate for resolving issues that may lead to eviction, as service providers usually the same as staff running home</li> <li>• May live in substandard conditions</li> <li>• Have no choice over housemates, usually share bedroom with at least one (usually multiple) other tenants</li> <li>• Are not protected by Fair Housing law</li> </ul>

Supportive housing is community-based housing that can be provided in a single-site, or congregate, based model, mixed-population model, or a scattered-site model. Single-site supportive housing is a traditionally a single multi-family apartment building where all apartments are occupied by supportive housing residents. Single-site supportive housing is traditionally produced using community development or affordable housing financing and has the benefit of including on-site supportive services.

Mixed-population supportive housing is traditionally a single multi-family apartment building where a portion of the apartments are set-aside for supportive housing residents. Mixed-population models tend to combine traditional affordable housing dedicated to working families or individuals with a smaller or equal portion of apartments dedicated to supportive housing residents. Mixed-population developments are also traditionally produced using community development or affordable housing financing. Depending on the number of apartments dedicated to supportive housing residents these developments may or may not include on-site supportive services.

Scattered-site supportive housing is provided by dedicating tenant-based rental assistance to supportive housing residents who then secure rental housing from private landlords in the community. The most common program providing this form of supportive housing is the Housing Choice Voucher, or Section 8, program. In this model services are provided through mobile teams who provide services to tenants throughout the community.

Each of the models described above include unique opportunities and challenges. Some service providers prefer providing on-site services through a single-site model. While others prefer the community integration provided through scattered-site models. Similarly, some public agencies prefer the community development opportunities and increased housing supply produced by single-site models, while others prefer the speed of scattered-site approaches.

Across the country we have learned that communities need all models. Programs to expand supportive housing should include multiple approaches.

Los Angeles County currently has no supportive housing dedicated to justice-involved individuals. Today justice-involved individuals access supportive housing through the homeless service delivery system and by independently applying for housing. As a result, justice-involved individuals face long wait lists and may be denied housing as a result of their history of incarceration. Any strategy to divert individuals experiencing mental illness from entering or returning to jail must include the provision of new supportive housing.

**Financial Modeling**

CSH has prepared a financial model based on providing 1,000 new units of supportive housing for justice involved individuals. Each model includes housing, as well as supportive services and program administration. 400 of these supportive housing units would be provided through new construction or rehabilitation of single-site or mixed population developments. This model assumes leveraging community development and affordable housing financing including project based rental assistance provided by public housing authorities.

600 of these supportive housing units would be provided through a scattered-site model. CSH recommends investing in an existing Department of Health Services program, the Flexible Housing Subsidy Pool. The Flexible Housing Subsidy Pool has infrastructure in place today, which would allow virtual immediate access to housing. The Flexible Housing Subsidy Pool is also designed for a similar population, frequent users of LA County health services who, by in large, also suffer from mental illness, substance use disorders and histories of trauma.

Each model assumes a 5-year operating cycle. It should be noted that supportive housing is not time limited. These models would need a new investment at the end of the 5-year operating cycle to continue. For the new construction/rehabilitation model this would require an investment in social services only because the rental assistance is provided by the federal government. The Flexible Housing Subsidy Pool would require an additional investment in both rental assistance and social services.

<b>Permanent Supportive Housing New Construction/ Rehabilitation</b>	400 Units	5-Year Cost
Capital Subsidy	\$75K/unit*400	\$30,000,000
Integrated Case Management Services	\$400/mon*60 mon*400 people	\$9,600,000
Program Administration	1 FTE/5 years	\$500,000
<b>Total</b>		<b>\$40,100,000</b>

\*Assumes leverage of Project Based Section 8 or Shelter Plus Care and traditional affordable housing capital financing including Low Income Housing Tax Credits

<b>Flexible Housing Subsidy Pool</b>	600 Units	5-Year Cost
Move-in Assistance	\$2,000*600 people	\$1,200,000
Rental Assistance	\$800/mon*60 mon*600 people	\$28,800,000
Program Coordination	\$125/mon*60 mon*600 people	\$4,500,000
Integrated Case Management Services	\$400/mon*60 mon*600 people	\$14,400,000
Program Administration	1 FTE/5 years	\$500,000

<b>Total</b>		<b>\$49,400,000</b>
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## **Funding Sources**

There is no magic bullet to fund supportive housing. That said, funding sources do exist that could offset a portion of the cost of this model.

### *County-Owned Land*

The County owns large parcels of land, such as medical centers, that may include properties that are being under-utilized. This land could be made available to supportive housing developers to help offset the cost of development.

### *Medi-Cal*

The majority of justice-involved individuals in the County became eligible for Medi-Cal under the Affordable Care Act beginning January 1, 2014. Medi-Cal can reimburse providers for a portion of case management, mental health treatment, primary healthcare and even substance abuse treatment. While Medi-Cal reimbursement is limited, there is a new option in the Affordable Care Act called Health Homes that could provide more comprehensive coverage for services. The state passed a bill, AB 361, in 2013 to implement this option of the Affordable Care Act and will soon begin a planning process for implementation.

### *Mental Health Services Act*

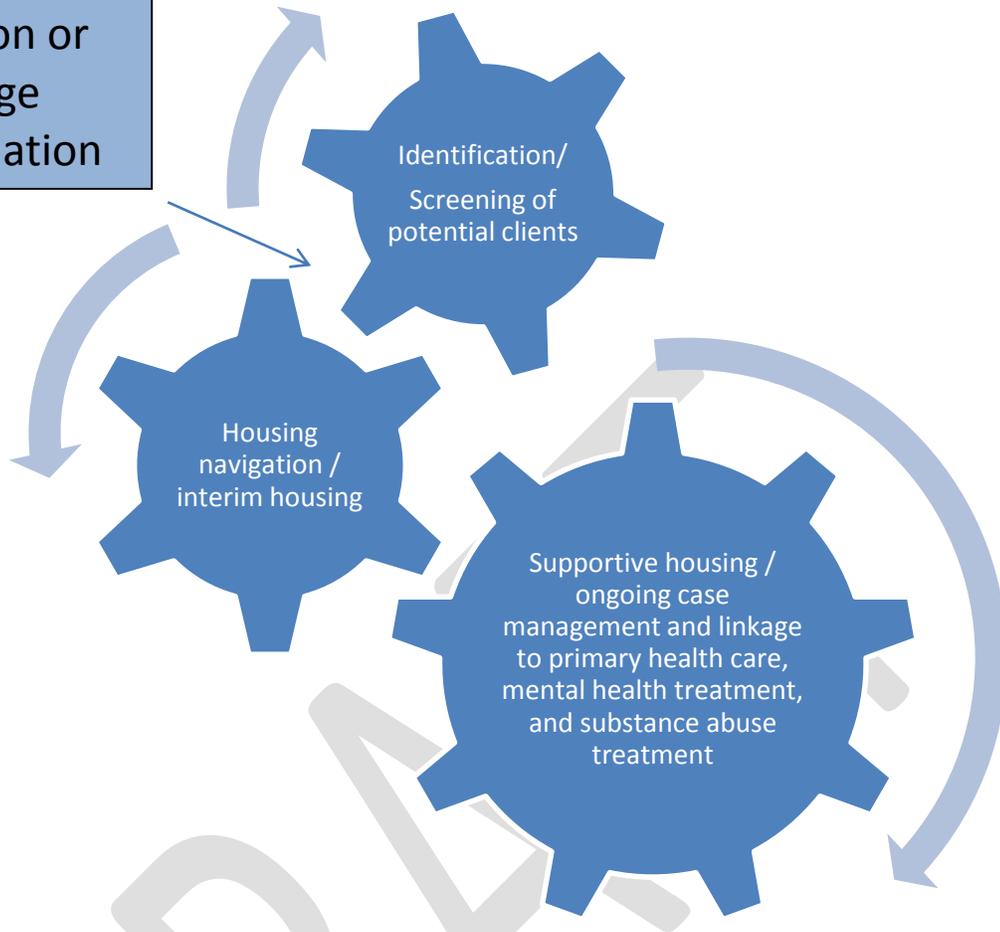
The Mental Health Services Act also includes funding that could be utilized to offset the cost of services. The Department of Mental Health currently has a program called Integrated Mobile Health Teams that combines Medi-Cal reimbursement with MHSA Innovations funding to fund a package of services that is similar to the integrated case management services included in the models above.

## **Linkages to Supportive Housing**

Supportive housing works as diversion and discharge strategy when clients are effectively linked to supportive housing. Effective linkage is dependent on comprehensive programs that include the following components:

- Targeted and easily-implemented screening tools to identify clients
- Warm-hand off to Housing Navigators, who begin engagement in the court-room, jail, hospital or crisis stabilization unit
- Immediate access to low-barrier interim housing
- Immediate assistance with identification documents and housing application process
- Case management provided through a “whatever-it-takes” approach including transportation, food assistance, etc.
- Housing placement and ongoing intensive case management
- Linkage to primary healthcare, behavioral healthcare, and substance abuse treatment
- Connections to community, education, employment and family re-unification

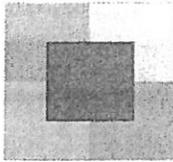
Diversion or  
discharge  
coordination



CSH has implemented two programs that utilize this model to connect individuals in institutions to supportive housing in Los Angeles County. The **Just in Reach 2.0 project** connects individuals experiencing long-term homelessness in LA County jails to supportive housing through the provision of in-reach, discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. The **10<sup>th</sup> Decile project** (including the Frequent Users System Engagement program and the Social Innovation Fund program) connects individuals experiencing long-term homelessness who are frequent users of the healthcare system to supportive housing through the provision of discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. Both of these programs are ideal models for future diversion and re-entry programs.

# Appendix 5:

## LA Trauma TTT Participants



**SAMHSA's GAINS Center**  
**How Being Trauma-Informed Improves Criminal Justice System Responses**  
**Train-the-Trainer Event**  
Los Angeles County, CA • July 15-16, 2014

**PARTICIPANT LIST**

**Carol Bishop**

Clinical Supervisor  
Tarzana Treatment Centers  
7101 Baird Avenue  
Reseda, CA 91335  
Phone: 818-342-5897 ext. 2195  
Email: cbishop@tarzanatc.org

**Kasey Bogoje**

Clinical Supervisor  
Tarzana Treatment Centers  
44443 N. 10th Street West  
Lancaster, CA 93534  
Phone: 661-726-2630 ext. 4308  
Email: kbogoje@tarzanatc.org

**Cheryl Branch**

CEO  
LA Metropolitan Churches  
3320 S. Central Avenue  
Los Angeles, CA 90011  
Phone: 323-273-4586  
Email: cherylbranch@gmail.com

**Stephen Brodi**

Parole Agent II  
CA Dept. of Corrections & Rehabilitation  
21016 Pathfinder Road, Suite 200  
Diamond Bar, CA 91765  
Phone: 626-840-1139  
Email: stephen.brodi@cdcr.ca.gov

**Nancy Chand**

Deputy Public Defender  
Public Defender's Office  
210 W. Temple Street  
Los Angeles, CA 90012  
Phone: 213-974-2837  
Email: nrichards-chand@pubdef.lacounty.gov

**Mark Faucette**

California Community Relations  
Amity Foundation  
3745 South Grand Avenue  
Los Angeles, CA 90007  
Phone: 559-786-1000  
Email: mfaucette@amityfdn.org

**Santiago Flores**

Parole Agent II  
CA Dept. of Corrections & Rehabilitation  
21015 Pathfinder Road, Suite 200  
Diamond Bar, CA 91765  
Phone: 310-991-2490  
Email: santiago.flores@cdcr.ca.gov

**Fabian Garcia**

Regional Program Coordinator  
City of Los Angeles  
200 N. Spring Street  
Los Angeles, CA 90012  
Phone: 231-880-7101  
Email: fabian.garcia@lacity.org

**Art Gutierrez**

Custody Officer  
Los Angeles Sherriff's Department  
4700 Ramona Boulevard  
Monterey Park, CA 91754  
Phone: 213-893-5248  
Email: A2gutier@lasd.org

**Karla Martinez**

GRYD Case Manager  
CISG LA  
8743 Burnet Avenue  
North Hills, CA 91343  
Phone: 818-891-9399 ext. 111  
Email: kmartinez@cisgla.org

**Armond Oganessian**

Deputy  
Los Angeles Sherriff's Department  
4700 Ramona Boulevard  
Monterey Park, CA 91754  
Phone: 213-893-5248  
Email: aoganes@lasd.org

**Giovanni Oliva**

Case Manager  
El Centro del Pueblo  
1157 Leomyne Street  
Los Angeles, CA 90026  
Phone: 213 483-6335 ext. 117  
Email: goecdp@gmail.com

**Enrique Rodriguez**

Regional Program Coordinator  
GRYD  
200 N. Spring Street  
Los Angeles, CA 90012  
Phone: 213-304-5778  
Email: rodriguez.enrique.j@gmail.com

**Isadora Romero**

Psychiatric Social Worker II  
Public Defender's Office  
4848 East Civic Way, 3rd Floor  
Los Angeles, CA 90022  
Phone: 323-780-2072  
Email: iromero@pubdef.lacounty.gov

**Jimmy Singh**

Research Analyst II  
Dept. of Public Health – SAPC  
100 South Fremont Ave., Bldg. A-9E 3<sup>rd</sup> Fl.  
Alhambra, CA 91801  
Phone: 626-299-3214  
Email: jisingh@ph.lacounty.gov

**Willette Stewart**

Sup. Deputy Probation Officer  
LA County Probation  
23759 West Valencia Blvd., Rm. 20  
Valencia, CA 91355  
Phone: 661-253-7278  
Email: willette.stewart@probation.lacounty.gov

**Shirley Torres**

Reentry Director  
Homeboy Industries  
Email: storres@homeboyindustries.org

**H. Dawn Weinberg**

Director  
LA County Probation  
9150 E. Imperial Highway  
Downey, CA 90242  
Phone: 562-714-9154  
Email: dawn.weinberg@probation.lacounty.gov

**Debby Westcott**

Deputy Probation Officer II  
LA County Probation  
9150 E. Imperial Highway  
Downey, CA 90242

**Raymundo Zacarias**

GRYD Supervisor  
CISG LA  
8743 Burnet Avenue  
North Hills, CA 91343  
Phone: 818-891-9399 ext. 121  
Email: rzacarias@cisgla.org

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**SAMHSA'S  
GAINS CENTER**

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**Jackie Massaro**

Senior Consultant  
SAMHSA's GAINS Center for Behavioral  
Health and Justice Transformation  
Policy Research Associates, Inc.  
345 Delaware Avenue  
Delmar, NY 12054  
Phone: 518-634-7363  
Email: jmassaro.step@gmail.com

**Travis Parker**

Senior Project Associate  
SAMHSA's GAINS Center for Behavioral  
Health and Justice Transformation  
Policy Research Associates, Inc.  
345 Delaware Avenue  
Delmar, NY 12054  
Phone: 402-437-4282  
Email: twparker@magellanhealth.com

# Appendix 6:

## Peer Respites

# Peer respites for mental health consumers prevent hospitalizations

*August 12, 2014*

By Lynn Graebner

As people with mental health crises overwhelm California's hospitals, jails and homeless shelters, counties across the state are gradually embracing residential respite houses located in neighborhoods and staffed by peers — people who have been consumers of the mental health system.

For people on the verge of a crisis, staying at a peer-run respite, typically for a couple of days or up to two weeks, can help them recover with support from people who have had similar experiences.

That can prevent incarceration or forced hospitalization, which often damages family relationships and can cause the loss of housing or jobs, said Yana Jacobs, chief of outpatient adult services for Mental Health and Substance Abuse Services at the Santa Cruz County Health Services Agency.

California has three peer-run respites, two in Los Angeles County and one in Santa Cruz. San Francisco and Santa Barbara Counties are in the process of opening respites and Alameda County is considering one.

The latter three would likely be largely staffed by peers but not considered peer-run as peers probably won't be in administrative positions. That distinction makes a big difference, say advocates.

"If respites are run by the traditional system, even peer workers can start behaving like clinicians," said Oryx Cohen, Director of the Technical Assistance Center at the National Empowerment Center, a Massachusetts-based nonprofit peer-run mental health organization.

Without peers at the helm, hierarchical administrations can undermine shared decision making; the sense of clients and support staff being equals, each having something to offer and the dropping of clinical labels.

The peer-run model is growing throughout the country with 12 peer-run respites and two hybrid programs in 11 states. Six more are planned and funded, said Laysha Ostrow, a postdoctoral fellow at Johns Hopkins Bloomberg School of Public Health.

Growth is slow but steady. One barrier is the stigma that mental health consumers can't handle crisis situations, Cohen said.

"Departments of mental health and behavioral health just need to be educated and need to see that this is a viable alternative," he said.

It has been for Asha Mc Laughlin, who knows well the trauma of being hospitalized. She suffers post-traumatic stress disorder, major depression and anxiety due to being abducted, raped and threatened with murder when she was 16. Chronic back pain also plagues her mental health.

She's spent a lot of time in psychiatric hospitals in the past, but rarely uses them now since finding the Second Story peer respite in Santa Cruz three years ago.

Peer counselors there are trained in the Intentional Peer Support method and, unlike psychiatrists, can share their own experiences, alleviating some of the isolation people feel, and creating relationships that are mutually supportive.

"It seems there's just automatic healing in that," Mc Laughlin said. "And when my understanding supports them, it means a lot to me."

At Second Story guests talk conversationally with peer counselors, handle their own meds, cook meals and can join or lead group sessions ranging from art and meditation to dealing with conflict and alternatives to suicide.

"We've found that when we treat people like responsible adults they behave like responsible adults," said Adrian Bernard, one of the administrators and a peer counselor.

"We have had a huge amount of success getting people out of the [mental health] system," he said.

San Francisco is one of the latest cities experimenting with peer respites. Its Department of Public Health plans to launch a psychiatric respite next to San Francisco General Hospital and Trauma Center this fall, said Kelly Hiramoto, acting director of Transitions at the San Francisco Department of Public Health.

San Francisco desperately needs these types of alternatives to hospitalization, incarceration and homelessness. Last year the city had almost 800 jail inmates diagnosed with a psychotic, bipolar or major depressive disorder, reported San Francisco Mayor Edwin M. Lee's office.

The San Francisco respite is one of several remedies the city is trying. It will start with four beds with room to grow to 12 or 14, and five peer counselors as well as six entry-level mental health rehabilitation workers, Hiramoto said.

The city didn't go as far as some local mental health advocates had hoped, but they say it's a start.

"We're very supportive of the psychiatric respite. We think that's a great thing that will fill a gap," said Michael Gause, Deputy Director, Mental Health Association of San Francisco, a nonprofit advocacy organization. But they would also like to see a pure peer-run respite, he said.

Several other counties are also getting their feet wet. In the last year two peer-run respites have opened in Los Angeles County, Hacienda of Hope in Long Beach and SHARE! Recovery Retreat in Monterey Park. They're both funded by the Los Angeles County Department of Mental Health Innovations Program as three-year pilots.

Santa Barbara County has approved a largely peer-staffed respite and is seeking a site, said Eric Baizer, with the Santa Barbara County Department of Alcohol, Drug and Mental Health Services.

And Manuel Jimenez, director of Alameda County Behavioral Health Care Services, said a stakeholder group has proposed a peer-staffed respite for his county and he's supportive.

Statewide, California had less than half the national average of psychiatric beds per capita as of 2007, according to a 2010 report by the California Mental Health Planning Council, an advisory body to state and local government.

Respite could help fill that gap. Crisis residential programs, including peer respites, cost roughly 25 percent of hospital inpatient care and are often more effective, the report states.

Jacobs said one of the reasons these respites are successful in reaching people is they don't focus on diagnosis. She believes only about 25 percent of people being diagnosed schizophrenic actually are.

"The rest have trauma and are being labeled," she said. "You don't want to tell someone they have a serious mental illness and will be disabled the rest of their lives."

Bernard, for example, hears voices but hasn't been hospitalized since 2003.

"Now I have a community around me and three or four times they've kept me from going to the brink," he said.

Jason Davis, who first came to Second Story as a guest and is now a peer counselor, agreed that the enormous camaraderie there is what helped him overcome his paranoia.

"I support the house and the house supports me," he said.

The nonprofit Human Services Research Institute is doing a five-year evaluation of Second Story, required by the grant it received from the federal Substance Abuse and Mental Health Services Administration. Early analysis suggests a reduction in use of high-cost hospitalizations and other emergency services by those who use the respite, said Bevin Croft, Policy Analyst for the organization.

That's certainly true for Bernard, Mc Laughlin and Davis since joining the Second Story community.

"For the first time in my life I feel like people understand me and can support my growth," Bernard said.

<http://www.healthycal.org/archives/16402>

# Appendix 7: DMH Fact Sheet

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**  
**Investment in Mental Health Wellness Act of 2013 Fact Sheet**  
**December 2013**

**OVERVIEW**

In June of 2013, Governor Jerry Brown signed the Investment in Mental Health Wellness Act of 2013 (MHWA) into law. MHWA establishes new grant opportunities that funds California counties or their nonprofit/public agency designates to develop mental health crisis support programs. The MHWA provides \$142.5 million in capital funding and \$6.8 million for mobile crisis support teams to increase the capacity for client services, crisis intervention and stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The California Health Facilities Financing Authority (CHFFA) will support capital improvement, expansion and limited start-up costs. The County of Los Angeles (County), along with Tri-City Mental Health Authority is eligible for \$40 million of these funds including an additional \$1.9 million for mobile crisis support teams.

**PROPOSED PROGRAMS**

Utilizing the capital funding from the MHWA, the County of Los Angeles Department of Mental Health (DMH) intends to develop five new Psychiatric Urgent Care Centers and establish 10-15 Crisis Residential programs in each of the eight Service Areas (SA). Additionally, there will be an expansion of our current mobile crisis support teams throughout the county.

***Urgent Care Centers***—Provide short-term (23 hour), crisis intervention services to individuals 13 years and older who would otherwise be taken to or access care in emergency rooms.

DMH currently utilizes four adult urgent care centers:

- Olive View—SA2
- Eastside Exodus Urgent Care Center—SA 4
- Westside Exodus Urgent Care Center—SA5
- La Casa Mental Health Urgent Care Center—SA8

The MHWA would fund an additional five urgent cares to be located on the campus of Harbor UCLA Medical Center, SA 7, the Antelope Valley, the greater Hollywood area, and SA 3. A UCC at Martin Luther King, Jr. Medical Center is also scheduled to open early 2014.

***Crisis Residential Programs***—Each program serves 10-12 persons for an average of 10-14 days. This program provides immediate, structured housing and supportive mental health services, most frequently as an alternative to extended acute psychiatric hospitalizations.

DMH currently funds three crisis residential programs:

- Hillview Crisis Residential Program—SA 2
- Didi Hirsch Excelsior House—SA 8
- Didi Hirsch Jump Street—SA5

DMH proposes to increase crisis residential bed capacity by 160 beds countywide through the development of approximately 10-15 new crisis residential programs

**Mobile Crisis Support**—DMH operates a psychiatric mobile emergency response system twenty-four hours per day, seven days per week. The Emergency Outreach Bureau has several programs that provide field response services including Psychiatric Mobile Response Teams (PMRT), Law Enforcement Teams (LET), School Threat Assessment and Response Team (START), and Homeless Outreach Mobile Engagement (HOME).

The \$1.9 million for mobile crisis support teams will expand the field response operations personnel. In addition, there is a total of \$500,000 that can be used for the purchases of vehicles for these teams.

### **EVALUATION CRITERIA**

CHFFA will evaluate an applicant's ability to meet the following criteria:

1. Project\* expands access to and capacity for community based mental health crisis services that offer relevant alternatives to hospitalization and incarceration.
2. Application demonstrates a clear plan for a continuum of care before, during, and after crisis mental health intervention or treatment and for collaboration and integration with other health systems, social services, and law enforcement.
3. Identifies key outcomes and a plan for measuring them.
4. Project is feasible, sustainable and ready or will be feasible, sustainable and ready within six months of the Final Allocation.

\* Project means startup or expansion of Program(s) and acquisition, construction, renovation or financing of capital assets; or equipping and staffing a Mobile Crisis Support Team.

# Appendix 8:

## CASES TCM Program Brief



## SUCCESSFULLY ENGAGING MISDEMEANOR DEFENDANTS WITH MENTAL ILLNESS IN JAIL DIVERSION: THE CASES TRANSITIONAL CASE MANAGEMENT PROGRAM

### Goals of this document:

- Provide a description of the development and operation of an alternative-to-incarceration program for repetitive misdemeanants
- Outline the strategy used by the program to promote engagement with behavioral health services through case management
- Review the program's effectiveness in reducing arrests, compliance with the court mandate, and linking participants to long-term treatment services
- Explain the role of positive court relations, standardized court screening, same-day engagement, and flexibility of service provision in the program's success.

Individuals convicted of misdemeanor offenses receive relatively modest punishment within the criminal justice system. As a result, programs that divert misdemeanants with mental disorders into treatment services lack judicial leverage to counter noncompliance. Yet misdemeanor cases constitute a huge burden for criminal courts. For example, in 2007, misdemeanor cases accounted for three-quarters of all arraignments in the Manhattan Criminal Court. The behavioral, medical, and public safety implications of noncompliance present courts and service providers with a need for more effective engagement strategies.

The Center for Alternative Sentencing and Employment Services (CASES) launched the Transitional Case Management (TCM) alternative-to-incarceration program in 2007 for misdemeanor defendants in Manhattan Criminal Court. TCM has received funding from the New York City Department of Correction, New York Mayor's Office of the

Criminal Justice Coordinator, Bureau of Justice Assistance Justice and Mental Health Collaboration Program, Jacob and Valeria Langeloth Foundation, van Ameringen Foundation, Schnurmacher Foundation, and the Manhattan Borough President's Office. TCM provides screening, community case management, and coordinated support for individuals with mental disorders or co-occurring mental and substance use disorders at risk of jail sentences.

### Background

CASES clinical staff identify participants in arraignment, before sentencing, and also while completing a day custody program court mandate after sentencing. The participants are individuals with mental disorders or co-occurring mental and substance use disorders who have completed three days in the day

custody program or are mandated by the court to participate in three or five community case management sessions as an alternative to incarceration.

Participants recruited from the day custody program voluntarily enter TCM after completing the court mandate. Defendants mandated to TCM directly from court can voluntarily continue in the program for up to three months after satisfying the court mandate. TCM is staffed by a psychologist responsible for court-based screening and project coordination, a licensed social work supervisor, a bachelor-level substance abuse case manager, and a part-time forensic peer specialist.

## Participants

TCM enrolled 178 individuals from July 2007 through November 2010. Approximately three-quarters (78%) of participants were male. The mean age of participants was 40. About half (56%) were Black, 25% were Hispanic or Latino, 12% were White, 2% were Asian, and 5% were multi-ethnic.

The majority of participants had a psychiatric diagnosis of bipolar disorder (38%), depressive disorder (20%), or schizophrenia (19%). Most participants (85%) had a co-occurring substance use disorder. Ninety-five participants (53%) were homeless upon entry into TCM.

TCM participants had an extensive criminal history, with a mean of 27 lifetime arrests and a mean of 3.6 arrests in the past year. Every participant had at least one prior misdemeanor conviction and 53% had one or more prior felony convictions.

The conviction that preceded enrollment in TCM was for a property crime in about

half of the cases (51%). One-quarter (25%) were convicted of possession of a controlled substance. Seventeen percent (17%) were convicted of a crime against a person.

## Outcomes

### Rearrest

In the year after program entry, the participants experienced 2.5 mean arrests. This figure, compared with 3.6 mean arrests in the year prior to program entry, represents a 32% reduction between the two periods. This reduction is statistically significant at the  $p < .001$  level. Seventy-two percent (72%) of participants were arrested at least once in the year after program entry.

Pre-Entry and Post-Entry Mean Arrests for TCM Participants, by Lifetime Arrests (n=178)

Lifetime Arrests	No.	%	1 Year Pre	1 Year Post
0-3	15	8.4	1.3	0.3
4-10	32	18.0	2.4	0.7
11-20	33	18.5	3.5	2.2
21-40	62	34.8	4.2	3.1
≥41	36	20.2	5.1	4.2
<b>Total</b>	<b>178</b>	<b>100.0</b>	<b>3.6</b>	<b>2.5</b>

Participants with more lifetime arrests experienced an attenuated reduction in arrests between the two periods. Participants with the most lifetime arrests (41 or more) experienced only an 18% reduction in mean arrests prior to and after program entry. Yet participants with three or fewer lifetime arrests experienced a 75% reduction in mean arrests. Mean arrests fell 70% for participants with 4 to 10 lifetime arrests, 37% for participants with 11 to 20

lifetime arrests, and 25% for participants with 21 to 40 lifetime arrests.

### **Compliance and Service Linkage**

The majority (82%) of the mandated participants successfully completed the court mandate, and 85% of those participants chose to continue to receive case management services beyond the mandated period. On average, participants took part in 16 voluntary case management sessions over the course of 156 days. Thirty-nine percent (39%) of the TCM participants were linked to long-term services prior to TCM program enrollment, and the program linked and transferred 25% of participants to long-term treatment services.

## **Keys to Program Success**

### **Positive Court Relations**

The TCM program benefits from having a professional clinician maintain a daily presence in the arraignment parts. This criminal justice-savvy individual is readily available to administer the screening protocol, engage with defense counsel, and provide pertinent information to judges to advocate for defendants who are eligible for the program. The clinician fine-tunes the program's court operations in response to feedback from defense counsel and the judges.

### **Standardized Court Screening**

The clinician administers the structured screening protocol in the courtroom interview pens to all referred defendants. The 75-minute protocol reviews mental health (Mental Health Screening Form III) and substance use (Texas Christian University

Drug Screen II), psychosocial domains, risk factors, court mandate conditions, and program expectations and goals. As a result, the clinician is able to determine whether a defendant is eligible for TCM during the period before the individual appears before the judge. The majority of defendants referred by defense counsel and judges are eligible for TCM.

### **Same Day Engagement**

The TCM case management protocol calls for immediate engagement of new participants in a standardized orientation protocol. The objective of the protocol is to increase the likelihood a new participant will engage in the case management services. Participant engagement begins with an orientation session that takes place immediately after release from court (participants referred from the day custody program are oriented on the day of admission). The project coordinator introduces the participant to project community staff. An evaluation of the participant is provided to staff, with a focus on immediate needs, risk factors, and details about the court mandate.

### **Flexibility in Service Provision**

The high engagement in services is attributed to TCM's flexibility in delivering services to participants. TCM has the capacity to provide the frequency and duration of service contacts to participants based on their immediate and ongoing needs. Program participants are seen by program staff as often as needed in any community setting convenient for the participant. They are seen if they arrive late or miss an appointment. The participants are welcomed by the program whenever they arrive or make contact with the staff to obtain services.

## Conclusion

The TCM program points to the value of case management services to support reductions in the criminal recidivism of people with mental disorders or co-occurring mental and substance use disorders arrested for misdemeanor crimes. The program is now working to enhance the nature of its case management services with the use of a validated risk and need instrument. This will provide the staff with specific information regarding the criminogenic needs of their clients that should be addressed with services to achieve greater reductions in recidivism.

## For More Information...

For more information, contact:

Allison Upton, PsyD  
Program Coordinator, Criminal Court  
CASES  
646.403.1308  
aupton@cases.org

## Reference

Criminal Court of the City of New York.  
(2008). *2007 annual report*. New York:  
Office of the Administrative Judge of New  
York City Criminal Court.

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<http://www.langeloth.org>

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<http://www.prainc.com>