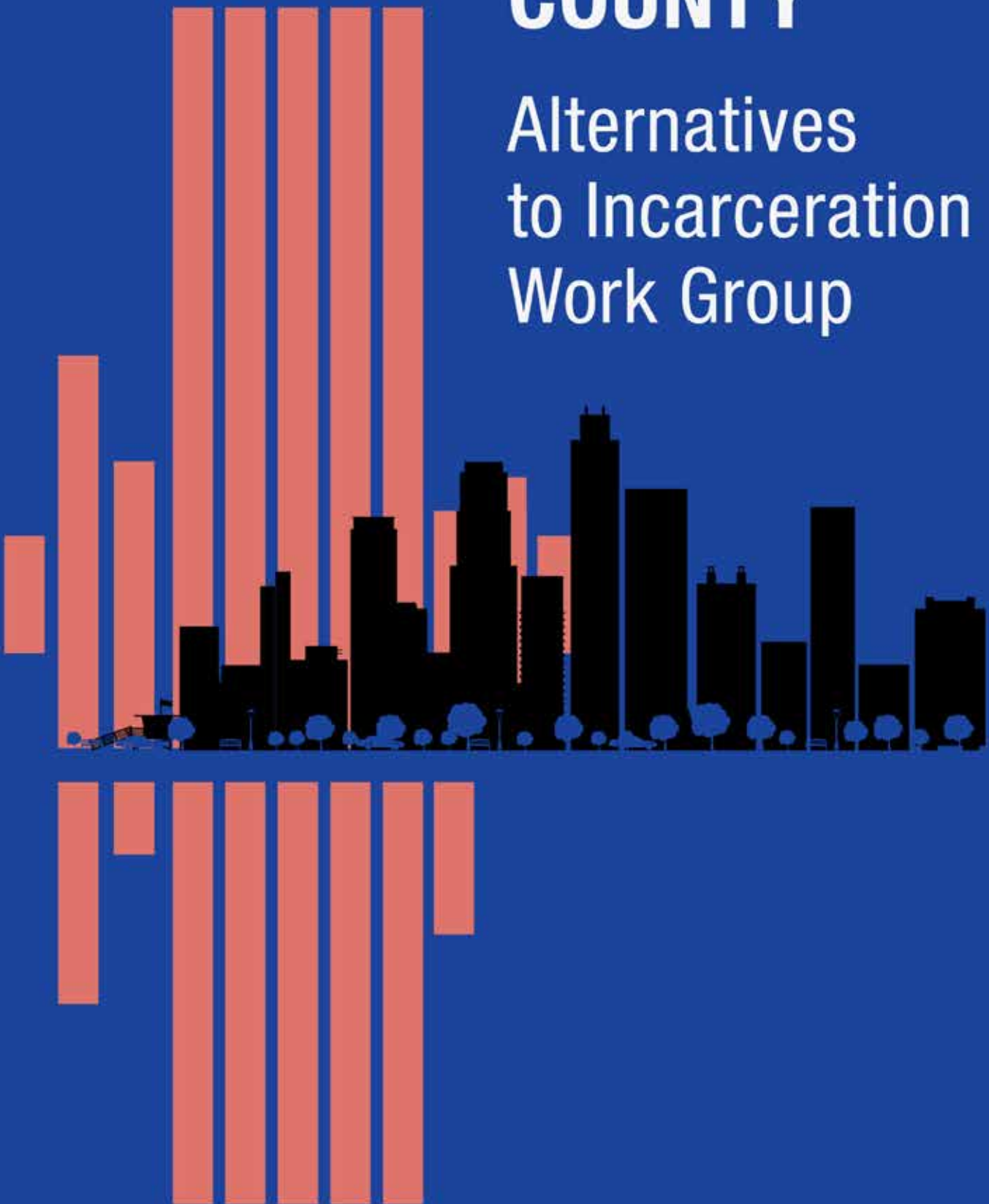


LOS ANGELES COUNTY

Alternatives to Incarceration Work Group



LOS ANGELES COUNTY

Alternatives to Incarceration Work Group

Interim Report—June 2019

Letter from the Chair

On behalf of the 26 voting members of the Alternatives to Incarceration Work Group—and the dozens of community members who have participated in our discussions thus far—I respectfully submit our 90-day, interim report to the Board for consideration. The report before you is organized as follows:

- Acknowledgments
- The Executive Summary
- Introduction
To provide history, context, relevant data and literature review on the matter of incarceration in Los Angeles County and nationally
- Recommendations
Organized by the five ad hoc Committees who focused on the key areas of needed work: Community-Based System of Care, Justice System Reform, Data & Research, Funding, and Community Engagement
- Next Steps and Conclusion
- Appendix
This includes Racial Equity Analyses

I am using the prerogative of this letter from the Chair to highlight some key themes that stand the risk of being hidden among the 14 goals and 100+ recommendations of the Work Group, as well as pointing out a couple of important tensions.

The first theme is on the matter of appreciation and gratitude for your leadership as a Board. The fact that the Board unanimously supported the resolution to create the Alternatives to Incarceration (ATI) Work Group—and thoughtfully blended the perspectives of County departments and system leaders with those of community representatives and advocates—constituted a powerful statement about how impacted communities must be part of reform conversations. Even in this initial 90-day period, from my perspective as Chair, it has been remarkable and gratifying to observe how formerly incarcerated members of our community are sitting at the very same table with, for example, a representative of the County Sheriff’s Department or the District Attorney’s Office—the very law enforcement agencies that once arrested, tried, and sentenced, and incarcerated that very community member. They are now working shoulder-to-shoulder in the development of goals to transform the system. Certainly, these individuals don’t always agree with one another, but all members of the ATI Work Group are leaning into the Board’s “Care First, Jail Last” mantra. The Board provided our

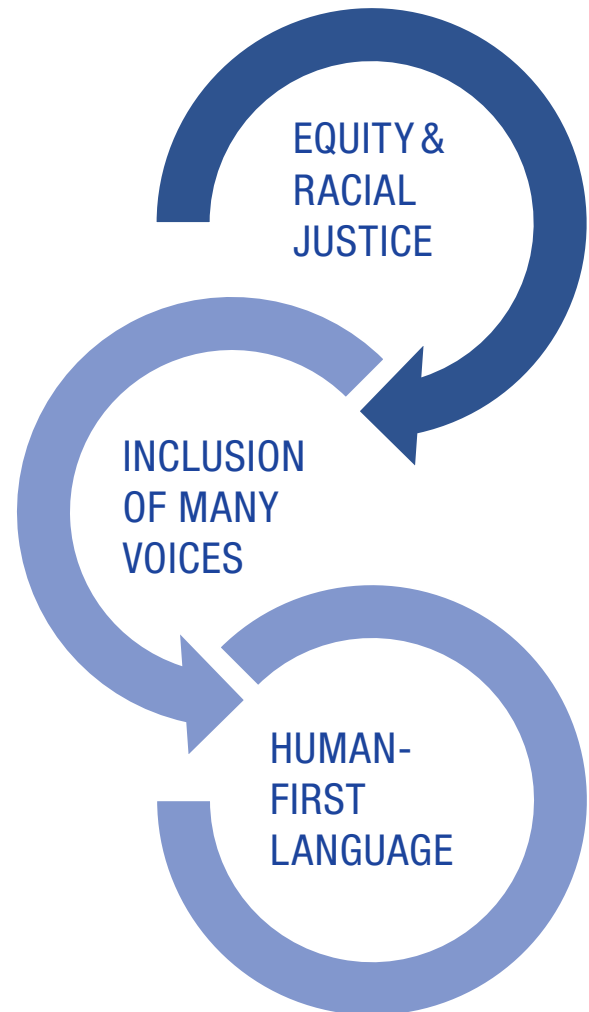
community with a very important space to have a historically significant and critical set of conversations, and watching these conversations unfold has been inspiring and meaningful to me as Chair. In the spirit of your resolution that created the ATI, we have attempted to implement a process that is governed by the principles of inclusion, transparency, candor, and respect. Community has been at the table as equal partners, and you will see recommendations to build opportunities for greater community engagement in the months ahead.

Secondly: the matter of race. As you are well aware, no policy and systems reform effort about incarceration can move forward with integrity and responsibility by glossing over the role that structural racism has played in the era of mass incarceration in our nation's history. As the result of a half-day retreat on this topic—and inspired by a brilliant and insightful presentation by UCLA author-professor-researcher Dr. Kelly Lytle Hernandez of our ATI Work Group—the Work Group endorsed the need for a racial equity analysis as a lens to inform the goals and recommendations emerging from each of the Ad Hoc Committees. This work is included in the Appendix section of the report.

Thirdly, it is the Chair's impression that against the backdrop of a national set of policy conversations on justice reform—our Los Angeles County is on the right track and has made some important strides towards the vision of a re-imagined justice system that works on behalf of community safety and well-being. The creation of the County Office of Diversion and Re-Entry (ODR), following District Attorney Jackie Lacey's important 2015 report on Mental Health Diversion and The Sequential Intercept Model approach, has been unanimously hailed as an important development—one that integrates the roles that the Courts, behavioral health services, and housing supports all play in helping to navigate our system away from a punishment mindset towards one of prevention and support. Moreover, and relatedly, the leadership you are providing on juvenile justice system reform and diversion is being closely watched and supported by the broader community. In my individual and collective listening sessions with members of the ATI, I am hearing the Board being compelled to drive faster, push harder, and do more. As you will see among the dozens of recommendations in this 90-day report, we need more mental health professionals teamed with Sheriff Deputies in responding to 911 calls, and all—not just some—law enforcement officers trained on behavioral crisis intervention; we need more clinicians and navigators working in direct partnership with the Courts to link clients to needed services; we need more community-based mental health urgent care centers to divert impacted community members to; we need more community-based substance use treatment services to respond to the escalating issues of hopelessness and addiction in our communities; and, we need more housing services for impacted populations. ATI members generally agree that we're on the right track as a County—but as we strategize for the long-term, the sense of urgency for action is palpable. As a representative of a County law enforcement agency remarked to me,

“We must stop releasing people from the jail into homelessness.”

The interim report of the ATI Work Group begins to lay out the roadmap to a destination: a re-imagined system of care where health care is the first priority, and jail is the last resort. Community members in the ATI process are calling for a transformation of our entire system, so that it becomes centered on public health-laden alternatives to incarceration. Internationally, we have seen Portugal, Italy, and Scandinavian nations successfully implement and scale this approach. Here in the U.S., innovative models in New York City, New Jersey, Washington D.C., Ohio, Kentucky, and Missouri are demonstrating that systemic reforms are achievable—although the struggle to get to “scale” is a common theme. As part of the national, MacArthur Foundation-supported Safety & Justice Challenge, LA County is among the communities at the vanguard of reform efforts. It appears that the real push for ending mass incarceration nationally will emanate from a collective of local and regional efforts—rather than from Congress or the White House.



In the aggregate, the goals and recommendations in this report—ranging from granular and specific to broader and more sweeping—describe a transformational shift to a system of alternatives to incarceration that, in the final analysis, possesses the following characteristics:

- Care first
- Human-centered
- Community-based
- Integrated and networked
- Needs and strengths-based, rather than "risk-assessed"
- Public health—prevention-and-supports-driven and,
- “Decentralized”—as a system of care; the members of the ATI envision a system with a countywide network of “restorative villages” and restorative centers—and fewer jail beds.

Critical on the roadmap to realizing this vision: ATI members agree that our county lacks an adequate community-based infrastructure of services and supports designed to address the “social determinant” needs of impacted families and communities—jobs and job training, housing supports, behavioral health needs, restorative and rehabilitative services—and a robust capacity-building strategy for these community services, and the organizations who can deliver them—will be required.

Additionally, there are two elephant-sized questions in the room of this reform-and-transform journey. The first is that while our County is clearly on the right track, the Board will need to get more intentional and assertive on the matter of Bail Reform and Pretrial Services. It is my impression that there is a next leap that must be taken, one that is consistent with the leadership the Board exerted when the highly-regarded ODR was created three years ago—some game-changing development needs to happen on this front. Our report’s recommendations speak to the importance of needed progress in Pretrial services—but opinions vary among ATI members about HOW to do it. San Francisco County has contracted with a nonprofit organization to coordinate such services, while Santa Clara County has a County agency specifically tasked to provide the services; each model appears to work. I understand that there is state legislation and a competing statewide ballot initiative brewing on this matter that complicates things, but merely sitting and waiting for these issues to play out in Sacramento will not serve our boldness well.

The second is the matter of design and architectural plans to replace the downtown Men’s Central Jail complex. It is not in the charge of our Work Group to offer any recommendations to the Board specific to this issue; it is my sense that the ATI Work Group should remain singularly and resolutely focused on imagining and driving towards an alternative system of care. That said, some community members of the ATI Work Group, along with community leaders attending the meetings, have pressed me in my role as chair to provide some opportunity to weigh in on the Jail design and construction issue as part of our deliberations. While I have resisted such exhortations, in the spirit of transparency, I pass these concerns along to you for consideration. The sentiments of community leaders on this matter can principally be summed up as two concerns: in a resource-and-budget constrained environment, community representatives seek to divest from the bricks-and-mortar of a large jail, and invest in building the capacity of community-based services; secondly, the re-building of a large-sized downtown jail or mental health institution appears to run counter to the vision of a community-based, care-first, integrated system of care.

Our final report, due to you by December, will build from the goals and recommendations in this 90-day report, and deliver an implementation plan with considerations for financing and funding approaches in the years ahead.

In closing, I want to extend my appreciation to every member of the ATI Work Group, as they contributed to the development of a 90-day report that was equal parts inspiring and “mad-dash.” The offices of the CEO and ODR—and in particular, people named Diana Zuñiga, Karen Tamis, Corrin Buchanan, Tamu Jones and retired Judge Peter Espinoza—have been a joy to work alongside, and supportive in my role as Chair. Rigoberto Rodríguez has led our facilitation process with a full-participation, values-based orientation that the Board would be proud of. And let’s not forget the contributions of our colleague Mark Ghaly, who has been invaluable to me in the transition.

I look forward to engaging further in discussion, and I feel privileged to be entrusted with the stewardship of this process.

A handwritten signature in black ink, appearing to read 'Bob Ross', with a stylized, flowing script.

Dr. Bob Ross
Chair, ATI Work Group

ATI ACKNOWLEDGEMENTS

ATI Acknowledgements

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Dr. Robert Ross, The California Endowment

ATI Ad Hoc Committee Co-Chairs:

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- > Dr. Jonathan Sherin, Department of Mental Health

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- > Dolores Canales, The Bail Project
- > Dr. Barbara Ferrer, Department of Public Health

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- > Dr. Kristen Ochoa, Office of Diversion and Reentry

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- > Mark Delgado, The Countywide Criminal Justice Coordination Committee
- > Karren Lane, The Weingart Foundation

Justice System Reform

- > Peter Espinoza, Office of Diversion and Reentry
- > Commander Cheryl Newman-Tarwater, Los Angeles County Sheriff's Department

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- > Dr. Kelly Lytle-Hernandez, UCLA
- > Peter Eliasberg, ACLU Foundation of Southern California

District 2 Community Stakeholders

- > Dr. Herbert K. Hatanaka, Special Service for Groups Inc.
- > Karren Lane, Weingart Foundation

District 3 Community Stakeholders

- > Eunisses Hernandez, JustLeadershipUSA
- > Dr. Robert Ross, The California Endowment

District 4 Community Stakeholders

- > Brittney Weissman, National Alliance on Mental Illness—Los Angeles
- > Dolores Canales, The Bail Project

District 5 Community Stakeholders

- > Jimmy Wu, InsideOUT Writers
- > LaWanda Hawkins, Crime Victims United

- > Tim Belavich, Department of Health Services
- > Dolores Canales, The Bail Project
- > Michael Castillo, County Homeless Initiative
- > Elizabeth Cohen, Office of Strategic Partnerships
- > Dr. John Connolly, Department of Public Health
- > Mark Delgado, Countywide Criminal Justice Coordination Committee
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- > Ruben Marquez, Public Defender's Office
- > Commander Cheryl Newman-Tarwater, Sheriff's Department
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- > Dr. Jonathan Sherin, Department of Mental Health
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Participating Government Agencies:

- > City of Long Beach Justice Lab
- > City of Los Angeles
- > County of Los Angeles Office of the County Counsel
- > Countywide Criminal Justice Coordination Committee
- > Los Angeles County Alternate Public Defender's Office
- > Los Angeles County Arts Commission
- > Los Angeles County Board of Supervisors

- > Los Angeles County Chief Executive Office
- > Los Angeles County Chief Executive Office—Center for Strategic Partnerships
- > Los Angeles County Chief Executive Office—County Homeless Initiative
- > Los Angeles County Department of Children and Family Services
- > Los Angeles County Department of Health Services
- > Los Angeles County Department of Health Services—Office of Diversion and Reentry
- > Los Angeles County Department of Mental Health
- > Los Angeles County Department of Public Health
- > Los Angeles County District Attorney's Office
- > Los Angeles County—Health Agency
- > Los Angeles County Probation Department
- > Los Angeles County Public Defender's Office
- > Los Angeles County Workforce Development, Aging, & Community Services
- > Los Angeles Homeless Services Authority
- > Los Angeles Police Department
- > Los Angeles Sheriff's Department
- > Los Angeles Superior Court
- > Mayor's Office of Reentry
- > Service Area Advisory Committee—Department of Mental Health

Participating Organizations and Institutions:

- > ACLU—Southern California
- > Allison and Partners PR
- > Amity Foundation
- > A New Way of Life
- > Anti-Recidivism Coalition
- > Ascent
- > Ashram LA
- > Beit T'Shuvah
- > Bend the Arc

- > Bunche Center for African American Studies
- > Californians United for a Responsible Budget
- > Center for Court Innovation
- > Center for Living and Learning
- > Collective REMAKE
- > Community Clinic Association of Los Angeles County
- > Community Coalition
- > Crime Victims United
- > Critical Resistance
- > Dignity and Power Now
- > Flintridge Center
- > Gender Justice LA
- > Green Thumb Youth
- > Harriett Buhai Center for Family Law
- > Helpline Youth Counseling, Inc.
- > Incarcerated Workers Outreach Committee
- > InsideOUT Writers
- > Justice LA
- > JustLeadershipUSA
- > LA Voice
- > Los Angeles Chamber of Commerce
- > Mass Liberation
- > NAMI
- > NAMI Urban LA
- > New Opportunities
- > Race Forward
- > SEIU 721
- > Sex Workers Outreach Project
- > Special Service for Groups
- > St. John's Wellchild
- > Stoff Consulting
- > The Advancement Project
- > The Bail Project
- > The Community Action League

- > Timelist
- > Transgender Service Provider Network
- > TransLatina Coalition
- > University of California Los Angeles
- > Urban Peace Institute
- > Vera Institute of Justice
- > Williams College
- > Young Women's Freedom Center
- > Youth Justice Coalition
- > Second Call

Philanthropy

- > LAC+USC Medical Center Foundation
- > The California Endowment
- > The Ralph M. Parsons Foundation

Special thanks to Dr. Mark Ghaly who initiated the ATI Work Group as chair and the ATI Planning Team. ATI Planning Team includes: Peter Espinoza (Office of Diversion and Reentry), Corrin Buchanan (Office of Diversion and Reentry), Diana Zuñiga (Whole Person Care), Karen Tamis (Consultant with Department of Health Services), Tamu Jones (The California Endowment), and Rigoberto Rodriguez (Consultant and Facilitator for the ATI Work Group). Thank you also for the support of Stephanie Stone (Whole Person Care), Maiya Guillory (Office of Diversion and Reentry), Mayra Ramirez (Whole Person Care), Jeannette Johnson (Whole Person Care) and all the individuals that have engaged in the process.

Table of Contents

Executive Summary 14

Introduction 25

Recommendations 44

Next Steps 90

Appendix 93

Notes 137

EXECUTIVE SUMMARY

Executive Summary

In 90 days, the ATI Ad Hoc Committees developed 14 goals, along with numerous recommendations and strategies for how to achieve those goals, for this interim report. They are all aimed at providing treatment and services to those in need, instead of arrest and jail. Although created through separate consensus-building processes, it is striking how similar the themes are across the goals, and how they point toward a cohesive vision of a more fair and effective justice system throughout Los Angeles County. These are the themes and phrases that are repeated throughout this report:

- **SCALE, EXPAND, INCREASE RESIDENTIAL SERVICES**
Expand and increase community-based, holistic and residential care and services and make sure they are accessible to everyone in need.
- **INCREASE COMMUNITY CAPACITY & SERVICE COORDINATION**
Sustainably build community capacity and service coordination equitably across the County while utilizing a Community Health Worker or peer support approach.
- **AVOID LAW ENFORCEMENT RESPONSES TO BEHAVIORAL HEALTH SITUATIONS**
Use every means possible to avoid a law enforcement response to individuals experiencing homelessness, mental health and/or substance use disorders. If law enforcement is called, give officers the tools they need to recognize and respond appropriately to individuals experiencing behavioral health crises and connect them to community-based treatment and services, whenever possible.
- **SUPPORT PRETRIAL RELEASE AND DIVERSION**
If charges are filed and individuals are booked into jail custody, utilize every opportunity available to support pretrial release and diversion into meaningful services at every stage of the court process, and for those convicted, provide alternative placements into effective treatment and services, instead of time in jail.
- **INCLUDE THE PEOPLE MOST IMPACTED BY THE JUSTICE SYSTEM IN JUSTICE POLICY WORK**
Support and compensate the integration of people impacted in the justice system through community engagement, data collection, and advisory roles.

All of these goals must be informed by meaningful engagement with the communities and individuals currently and historically most impacted by the criminal justice system; tracked and measured and made publicly available to ensure accountability; and supported through leveraging existing or developing creative and flexible funding sources. The ad hoc committees conducted detailed analyses for every recommendation, and reviewed them all using the Government Alliance on Racial Equity Tool, in keeping with the ATI guiding values, to integrate explicit consideration of racial equity in this work. This substantive information is provided in the body and appendices of the report.

Like most jurisdictions across the nation, LA County has decades of experience with the status quo—arrest, incarcerate, and repeat—for our community’s most medically vulnerable and socially marginalized members.¹ If we can successfully achieve the 14 goals of the ATI Work Group (some immediate, others over time), we can redefine the roles of our healthcare and criminal justice systems. We can commit to no longer relying on our law enforcement agencies, courts and jails to function as our social safety net, and instead reinvest in our communities to build a robust system of care—led by our health systems, social service agencies, community and faith-based organizations, and informed by formerly incarcerated individuals and their loved ones—to provide the housing, social services, medical and mental health care that will allow our communities to thrive.

With this vision,
LA County
will provide
care and services first,
and jail as a last resort.

Community-Based Systems of Care (CBSOC)

The County's current system of community-based alternatives to incarceration for people living with mental health disorders is not equipped to prevent their criminalization. Instead, there is a revolving "system of care" that flows from crisis and hospitalization to homelessness and jail—and sometimes death. Our system is difficult to navigate, exists in silos, and does not meet the whole person needs of people with behavioral health needs in our communities. The current approach can often isolate people with harmful results, rather than helping them integrate into our communities using systems that prioritize dignity, promote wellbeing, and provide meaningful opportunities to be active community members of Los Angeles County.

The lack of community-based services and alternatives to incarceration in the County for people with mental health disorders has resulted in overburdened emergency rooms and jail towers full of people suffering from varying mental health symptoms. The delivery of mental health services in jail and other carceral settings exacerbates mental health disorders and oftentimes subjects people to additional trauma. The Federal Department of Justice (DOJ) acknowledges that people confined to the County Jail who have mental health disorders were failed by other systems, and that they would be safely and more effectively served in community-based settings at a lower cost to the County.²

Currently, people with mental health disorders are not provided with the holistic care that address all the social determinants of health. We must invest in prioritizing access to health care services, availability of resources to meet daily needs (e.g., safe housing and transportation), as well as access to educational, economic, and employment opportunities with family and community reintegration. An integrated, decentralized system of care that addresses mental health disorders and the social determinates of health will create social and physical environments that promote good health for all community members—a position supported by public health experts across the nation.

The American Public Health Association "recommends the following actions by federal, state, tribal, and local authorities: (1) eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations), (2) institute robust law enforcement accountability measures, (3) increase investment in promoting racial and economic equity to address social determinants of health, (4) implement community-based alternatives to addressing harms and preventing trauma, and (5) work with public health officials to comprehensively document law enforcement contact, violence, and injuries".³ Developing a system of care that is easily accessible, decentralized, and has the capacity to serve thousands of

people throughout the County can end the County’s reliance on jails and law enforcement while ensuring that people with mental health disorders are thriving with dignity and living lives that are restored, not restricted, by ecosystems of care. Care first, and jail only as a last resort.

	GOALS	DESCRIPTION
1A	Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health	Develop policies and expand programs that ensure that people with mental health disorders and substance use disorder, their loved ones, and community members have multiple points of access to the full continuum of services and that match the individual’s current needs (from low to high levels of care) through a combination of County-operated and not-for-profit community-based organizations services throughout Los Angeles County while creating alternatives to incarceration at every level of the criminal justice system. This recommendation impacts intercept zero (which enables people to access services before any contact or involvement with the criminal justice system has occurred) and intercept five (prevent recidivism). All services should be implemented in a need-aligned and equitably-distributed manner.
1B	Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health	Remove barriers to accessing all necessary and complimentary integrated not for profit community-based services related to mental health disorders, substance use disorders, and poor social determinants of health while providing community members with the necessary tools, support, and incentives to attend and participate in services.
2A	Expand the Community-Based System of Care	Scale up effective culturally competent mental health and substance use models that are community-based that already exist at critical intercepts with a priority on intercepts zero and five that enable people to access services before any criminal justice system involvement. Develop contracting policies and procedures that make it less difficult for culturally competent nonprofit community partners to become part of the funded integrated system of care and invest in those relationships longterm. Develop capacity among local providers to compete for County contracts and provide high quality services. Address the distribution of resources by the geographic and racial impact of services equitably.
2B	Expand the Community-Based System of Care	Remove barriers that prevent not for profit community-based service providers from accessing County funding, contracting opportunities, technical assistance, and incubation opportunities.

3	Coordinate Community-Based Services	Create an Alternatives to Incarceration Coordination Initiative within the County governance structure to oversee program implementation and equitable distribution of resources. The Initiative would create policies and procedures to connect all County capacity building and services provision efforts. This Initiative would create linkages in service provision for County departments, non-profit community-based service providers and the community at large so that mental health disorders, substance use disorder, and poor social determinants of health are supported and treated through an integrated model.
4	Expand Community Health Worker and Peer Support Models to Provide Holistic Support	Will be further developed by Community Health Workers across Los Angeles County.

Justice System Reform

The Los Angeles District Attorney has spearheaded many of LA County’s recent efforts to provide treatment instead of incarceration for people with serious mental health disorders. County health agencies, community treatment providers and advocacy organizations, along with the Los Angeles Superior Court, the Public Defender and Alternate Public Defenders’ Offices, the Probation Department, the Los Angeles Sheriff’s Department (LASD), the Los Angeles Police Department (LAPD), and other local law enforcement agencies, have also been working hard to provide more appropriate responses to the increasing numbers of people in our communities and on our streets who are experiencing mental health and/or substance use disorders.

There is much more work to do to shift from a punitive criminal justice response to a public health, trauma-informed approach to crisis. The goal is to prevent and reduce involvement with the criminal justice system in the first place—the system least equipped to provide appropriate care and treatment.

First, we must ensure that everyone, in every neighborhood in LA County, has access to effective substance use treatment and mental health care—as described by the CBSOC recommendations above. For those who do come into contact with the system, we must increase the opportunities for diversion and alternatives to jail custody at every point—from law enforcement contact in the field, to local police lockups, to the County Jail, and during every stage of the court process. We must ensure that law enforcement officers have the tools they need to respond safely and effectively; develop a system of widescale pretrial release and services; fully implement recent legislative reform greatly expanding pre-plea diversion for people with mental health

and/or substance use disorders, expand access to and the availability of effective diversion programs at every courthouse in the County; and for those still in custody, improve reentry practices and employ harm reduction strategies so that they can reintegrate successfully when they return to the community.

GOALS	DESCRIPTION
1 Improve Diversion Opportunities within the Court System	Formally implement recent legislative opportunities for earlier diversion away from the justice system for people with behavioral health needs, from the booking stage throughout the court process.
2 Reduce Pretrial Detention and Increase Services	Substantially and sustainably reduce pretrial incarceration of people with clinical behavioral health needs while strengthening public safety by instituting a presumption of release and using a public health approach that links accused persons to services and programs without additional justice system contact to reduce the financial burden on the accused by upholding the presumption of innocence. The broader goal is to reduce the entire pretrial population in comprehensive ways that recognize and address the disproportionate impacts of race, socioeconomic status, and other factors that contribute to pretrial detention.
3 Reduce and Improve Interactions between Law Enforcement and People with Mental health disorders; Increase Diversion Opportunities and Improve Training for Law Enforcement	Scale up mental health and community-based responses to behavioral health crises to substantially reduce contact between people with behavioral health needs who are in crisis and law enforcement. When there is contact between people with behavioral health needs who are in crisis and law enforcement, ensure that law enforcement has the training and partnership with behavioral health personnel to respond appropriately to each situation and to divert many more people into community-based treatment and services.
4 Increase and Improve Access to Treatment Services for Court-Involved Clients	Expand and ensure easy access and timely linkage to treatment services for clients involved in the court process to a broader range of behavioral health programs and expand the diversity and capacity of those programs. Create a flexible and integrative service model across the Departments of Mental Health, Health Services and Public Health, in order to provide the most responsive system possible to client's service and housing needs. Streamline the referral process from arraignment to disposition, and avail judges and attorneys of the general menu of options available to qualifying clients requesting mental health, substance use disorder, or co-occurring treatment services.

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| 5 | Improve Reentry Practices | Improve pre-release and reentry practices to ensure that individuals, including those with co-occurring mental health and substance use disorders, can transition directly from jail into appropriate community-based treatment and services. |
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Community Engagement

The Community Engagement Ad Hoc Committee was asked to plan a series of community mapping and listening sessions in selected communities to hear, elevate, and empower community members and gather information from community members and community organizations about available and needed services, supports, and policies that promote alternatives to incarceration. The committee seeks to understand what services and supports prevent incarceration and assist those re-entering their communities after incarceration. Where services are currently offered, the committee is interested in understanding who is being served and who has limited or no access to support. The committee recognizes that community members need access to health, services, good employment, affordable housing, and thriving communities and seeks to understand inequities in the distribution of resources and opportunities that promote well-being.

The Committee will organize workshops in seven communities that have been identified through the Million Dollar Hoods and the Advancement Project assessments as a sample of areas where there are significant needs and gaps in resources available to prevent and address high rates of incarceration. Workshops will be held in the following communities: South LA with a connection to Compton, the Antelope Valley with a connection to Lancaster, East LA, Long Beach, Pacoima, the San Gabriel Valley, and Pomona.

The ad hoc committee will design workshops that create a meaningful, intentional, and respectful environment for individuals and families that have been directly and indirectly impacted by incarceration to share information, identify challenges, and suggest opportunities for efforts aimed at preventing incarceration and addressing the needs of people re-entering after incarceration. Workshop participants also include key stakeholders such as service providers, advocacy organizations, and County health departments. The workshops will focus on soliciting and incorporating community feedback to shape recommendations for the final report and inform the full implementation of the roadmap for years to come.

To design a workable, effective alternative system to incarceration, it is necessary to meaningfully engage key stakeholders—primarily justice-impacted individuals and their families, though also including service providers and advocacy entities—in highly-impacted areas. This engagement will not function as a one-way,

reporting-out process nor to simply gather assent to solutions prepared by others. The ad hoc committee's submission of findings from the community workshops should not stand alone and apart in the final report but, rather, be woven throughout the report – and directly inform (or reshape) interim recommendations drafted by the other ad hoc committees.

GOALS	DESCRIPTION
1 Implementation of 7 community engagement workshops that elevate community recommendations	Seven workshops will be held across the County (South LA, East LA, Antelope Valley, San Gabriel Valley, Long Beach, Pacoima, and Pomona) to solicit recommendations and feedback from community members, particularly those most impacted by incarceration, about available and needed services, supports, and policies that promote alternatives to incarceration. Facilitated discussions and interactive activities will be offered at each workshop to understand what services and supports prevent incarceration and assist those re-entering their communities after incarceration. Stipends should be offered to community members to cover costs related to workshop participation, along with translation, childcare, and availability of resource staff to help connect participants to needed services.
2 Engagement of Currently Incarcerated People	Hold three workshops in the County and/or local jail system and one workshop in a juvenile hall to solicit feedback from individuals currently incarcerated in LA County. Workshop attendees should be able to participate without any risks; information gathered at the workshop will be treated as confidential and will be shared without attribution or identifying information. Additionally, incarcerated individuals should be allowed to provide information through anonymous surveys or postings that will be managed by the Health Agency. The Office of Diversion and Reentry, Department of Mental Health, the Sheriff's Department, and other partners should help plan for workshops to be held between June and December. The outreach for engagement of currently incarcerated people may also include connecting to family members who currently have a loved one incarcerated in Los Angeles County.
3 Advisory Collaborative of Impacted People	The creation of an advisory collaborative is necessary to ensure there is continuous feedback and accountability to the prioritized communities and LA County at large in the implementation of the comprehensive roadmap. The advisory collaborative will communicate community solutions to the ATI work group and can serve to review recommendations and drafts of the final report. The advisory collaborative can also interface with local law enforcement to support the communication of community needs and feedback after the workshops. Possible sources of support for the Advisory Collaborative include the Whole Person Care Re-entry Health Advisory Collaborative and the DPH Office of Violence Prevention Community Council.

Funding

The Alternatives to Incarceration Funding Ad Hoc Committee was established to assess and outline resources needed to implement recommendations by the Alternatives to Incarceration Work Group to scale up ATI services in the County.

In advance of recommendations from other work groups, the Funding Ad Hoc Committee drafted an at-a-glance matrix of key funding streams that can potentially support the ATI efforts. When developed, this document will identify funding streams, eligible uses, current County policy for utilization, and scale of funding available. While the ad hoc committee is not positioned to line-item budget recommendations from each fund, the matrix will help identify gaps and support the Board of Supervisors and Chief Executive Office in identifying potential sources of funding for this work.

To support the ATI effort, the Committee believes that the County should continue efforts to maximize resource availability in order to meet the full scope of ATI recommendations, including advocacy at the state and federal level.

The California Department of Health Care Services is beginning the process of identifying changes to the scope and populations covered by Medi-Cal as part of its new Medicaid waiver with the Federal Government that would take effect in 2021. The final waiver provisions will significantly impact the scope of services funded under the program and shape available resources for eligible individuals involved with the justice system.

GOAL		DESCRIPTION
1	Advocate for Medi-Cal Coverage	The County should advocate for changes that would expand services and populations covered by Medi-Cal to support integrated service delivery to system-involved individuals and their families, which could provide a source of sustainable funding to support ATI recommendations related to an integrated system of care.

Data & Research

The Data and Research Ad Hoc Committee committed to developing two jail population overviews with an emphasis on racial disproportionality for the interim report: one on the population of people in jail who have severe clinical mental health disorders and a second on the total jail population. These descriptions are guiding the ATI Work Group in their development of frameworks, funding, and recommendations. The committee used currently available data that includes, but is not limited to, the following: race, gender, age, charges, repeat bookings, geography (including where the court case is, where the arrest was made, self-reported data about where individuals live), homelessness (with limitations), mental health status, length of stay, number of pre-trial individuals, substance use disorder and co-occurring disorders, and serious medical needs. The committee also developed a recommendation on data transparency, and is compiling a comprehensive list of data needs to address for the final report that includes requests from the other ATI committees.

GOALS		DESCRIPTION
1	Improve data transparency	Expand justice data transparency including access, analysis, and metric design by those most impacted by the justice system.

INTRODUCTION

Introduction

Los Angeles County is re-imagining its criminal justice system. From operating the world's largest jail and de facto mental health facility to building a decentralized, restorative and robust community-based system of care and safer, healthier communities. From arresting and locking up people experiencing behavioral health crises—compounded by homelessness, poverty and trauma—to supporting people in accessing neighborhood-based treatment, housing, employment, family reunification, community health workers and other strengths-based supports. From punitive justice to restorative and healing justice. From a jail built to incarcerate people and communities of color to a system of justice that works to repair harm and equitably distribute resources where they are needed most. From a criminal justice response to our failure as a society to care for our most vulnerable members, to a public health approach, where care and services are provided first, and jail is a last resort.

Los Angeles County (LA County) operates the largest jail system in the United States, which imprisons more people than any other nation on Earth.⁴ Today, the County Jail holds nearly 17,000 people. Admissions to the LA County Jail remain stubbornly high in comparison to cities of a similar size (157,000 jail admissions in 2016 in L.A., compared to 78,000 in Chicago and 59,000 in New York).⁵ Approximately 5,300 people in the Jail have a serious mental disorder, and many more are experiencing mental health and substance use disorders—numbers that continue to grow.⁶

Incarceration in LA County is also a story of racial inequality. The County's justice system consistently and disproportionately impacts people of color. Of the County's ten million residents, 74 percent of people arrested are Black and Latinx. While only nine percent of LA County residents are Black, Black people make up 23 percent of all arrests.⁷ In a trend consis-

tent across the nation, racial disparities persist in LA County Jail admissions. Jail admissions of Black people are the most staggering—Black people comprise 29 percent of the jail population.⁸ Persons identified as Hispanic or Latinx are also disproportionately represented in the County Jail, comprising 52 percent of the jail population compared to 49 percent of the general LA County population.⁹

Black and Latinx people's over representation in the County Jail stands in stark contrast to the underrepresentation of White people in jail, with White people comprising 15 percent of the jail population compared to 27 percent of the total County population.¹⁰

The Twin Towers Correctional Facility is the largest mental health institution in the County,¹¹ but a jail setting exacerbates many symptoms of mental illness and prevents those who most desperately need medical, mental health, and/or substance use treatment

from receiving it. There is often an overlap between those suffering from severe mental health and/or substance use disorders and chronic homelessness.¹² Similarly, national research shows that a disproportionate number of people admitted to jails are sick,¹³ poor,¹⁴ homeless,¹⁵ young,¹⁶ and struggling with mental health¹⁷ and substance use disorders.¹⁸ Women are also a quickly growing demographic in the nation's jail system.¹⁹ The five most common charges for women in the County Jail system are substance use related.²⁰ In other words, the nation's jails are largely filled with sick, marginalized, and vulnerable populations.

Los Angeles residents booked into the LA County Jail come predominantly from five zip codes, representing South Central, Compton, Long Beach, and the Antelope Valley.²¹ As the County's Portrait of LA Report puts it, these zip codes are "struggling" and "precarious."²² In turn, it is little surprise that persons being booked into the LA County Jail most-frequently report their employment status as "unemployed."²³

Of note, many people in the County Jail system have yet to be found guilty of any crime, with 44 percent of them being held pretrial.²⁴ With a median length of stay of 10 days,²⁵ they are in jail long enough to suffer negative impacts,²⁶ but too short to receive meaningful services (to the extent that meaningful services can be delivered in a carceral setting). This means that some of the most vulnerable and sick individuals in the County are cycling in and out of jails and hospitals—using the most expensive County resources—without receiving the long-term care and services they need.

People who are arrested and charged with crimes, even minor property and public nuisance offenses that arise from being poor, living on the streets, and/or experiencing mental or substance use disorders, face a lifetime of barriers that prevent them from accessing basic needs like housing, employment, reuniting with family, health care, and other rights, benefits, and opportunities.²⁷ These "collateral consequences" devastate entire communities—resulting in vast sums of lost wages, an increase in families experiencing homelessness who cannot qualify for housing assistance, children going into foster care who cannot live with a parent with a criminal record, disenfranchisement and disengagement in civic life, among others,—and often last for generations.

Los Angeles County has an historic opportunity to break this cycle.

In 2015, LA County took its first steps to explore and develop diversion programs with the District Attorney's (DA) 2015 report "Blueprint for Change," and the Board of Supervisors' establishment of the Office of Diversion and Reentry (ODR). In just four years, through a variety of diversion programs, the courts have diverted approximately 4,000 people through pre-trial and mental health diversion programs, and ODR has successfully diverted an additional 3,000 people.

Concurrently, LA County has also invested in expanding youth diversion, expanded Mental Evaluation Teams which pair law enforcement with mental

health clinicians, opened psychiatric urgent care centers, developed a sobering center, and most recently, established a Mental Health Division within the DA's office, the first such division of its kind in a prosecutor's office in California. Additionally, in the last two years, the County has worked to employ individuals with lived experience in the justice system to serve as Community Health Workers through health agency employment and community-based providers.

The County has plans for restorative care villages located around the County to provide mental health crisis care and physical recuperative care to individuals who might otherwise end up on our streets; and the County is building an innovative multi-departmental behavioral health center that will provide a wide variety of new mental health and substance use treatment services on one of our largest health campuses.

Within the last five years the County has taken significant steps to support the most vulnerable people in our communities. In these four short years, thousands of people suffering from mental health disorders have been removed from the County Jail system and placed into supportive environments. Hundreds of people with substance use disorders and other behavioral health needs have been completely diverted away from the criminal justice system through pre-booking diversion into intensive case management and harm reduction programs. These projects have taken us a step closer to building a system of care that will fully support all community members. Along the way these diversion efforts and service ex-

pansion opportunities have been informed and supported by individuals with lived experience, community and advocacy organizations and their members, service providers and academic researchers.

LA County's efforts mirror other local, state and federal actions that are emphasizing treatment and rehabilitation over incarceration. The National Association of Counties and The Council of State Governments Justice Center is encouraging public sector partners to reduce the number of people with mental health disorders in jails, and several hundred counties have joined that effort.²⁸ The passage by California voters of recent ballot measures designed to reduce incarceration and help those with convictions reestablish stable lives speaks to voters' readiness to move in this direction. In 2018, state legislators passed significant early diversion and bail reform measures.²⁹ California's AB 1810 and SB 215 establish diversion for people with mental health disorders instead of prosecution—thereby shifting the onus of care from the criminal justice system to community-based systems of care.³⁰ These rapid changes at the local and state levels require that the County move forward flexibly in order to take advantage of new opportunities, while embracing a vision of a more effective justice system.

To continue this momentum, the LA County Board of Supervisors unanimously voted to establish the Alternatives to Incarceration (ATI) Working Group in February 2019, comprised of a broad range of public and community stakeholders, to develop a comprehensive

plan to build a more fair and effective justice system. LA County is ready to scale its successful programs and launch additional programs to ensure that it has the ability to divert and provide alternative health and sentencing options to people who would be more effectively treated in a diversion context rather than in a jail. Successful expansion of our diversion system and front-end approaches will allow the County to meet the stated goal of the Board of Supervisors to provide “treatment first and jail as a last resort,” and lead to a sustained and significant reduction in the County Jail population.

The ATI WG provides a vehicle for Los Angeles County to lead the nation to develop bold, effective and community-based responses, through a collaborative process, to provide long-term treatment and services to its most vulnerable residents, while improving community safety and strengthening and empowering individuals, families and communities. The ATI WG has the potential to help the County fully realize a public health approach to trauma and violence and to greatly reduce the number of people held in jail who would be much better served by healthcare and service providers.

This interim report, focused on expanding diversion and alternatives to incarceration for people with clinical behavioral health needs,³¹ represents the first 90 days of work by an unprecedented coalition of community and County stakeholders. A voting body of 26 members, comprising representatives from numerous County agencies and community stakeholders, joined

advocates, people with lived experience, members of the faith community, service providers and others in an intensive consensus-building process to re-imagine our justice system. This report is the first product of those efforts.

The report includes sections by local experts on incarceration, race and mental health. Dr. Kelly Lytle Hernandez, a Professor of History and African American Studies and Director of the Ralph J. Bunche Center for African American Studies at UCLA, is one of the nation’s leading experts on race, immigration, and mass incarceration. Dr. Lytle Hernandez describes the local, state and federal policies starting in the 1970s that led to mass incarceration in Los Angeles, the state of California and throughout the nation.

David Meyer, clinical professor at the USC Keck School of Medicine’s Institute of Psychiatry, Law, and Behavioral Science, former Chief Deputy Director of the Los Angeles County Department of Mental Health and former deputy public defender, is a nationally recognized expert on health law and medical-legal issues. Professor Meyer describes our society’s change in the treatment of people with mental health disorders over time, including deinstitutionalization and the promise of community systems of care, as well as the change in legal approach with a focus on self-determination and civil liberties, all of which provide context for the current crisis.

The report begins by describing the ATI WG process, structure, values and practices that guide this work.

It then provides some information about the mental health population in the jail, a description of the sequential intercept model, which is a framework for thinking about the interface between the criminal justice and health systems, and the research supporting a more humane and treatment-centered approach to behavioral health needs. The bulk of the report presents a series of recommendations, developed through consensus-building and analyzed using a racial equity lens, to reform the justice system and to build an effective community-based system of care throughout the County that provides care and services first, and jail as a last resort, while improving community safety. The report describes a strategy to expand meaningful community engagement in this work, including the voices of people currently incarcerated in the jail. It lays the groundwork for a detailed implementation plan in the final report that will include information about the resources needed to realize this vision. Lastly, it describes a plan to expand the mission of the group beyond people with clinical behavioral health needs to other groups of vulnerable people in custody, including women, members of the LGBTQ community and individuals who are gender non-conforming, families impacted by the justice system, and people who are socioeconomically disadvantaged whose needs would be better served in a therapeutic community setting, not in a jail cell.

We know what works.
This report lays out a
plan to substantially and
safely reduce the number
of people with clinical
behavioral health needs
in the County Jail. We
need brave leaders from
the County, the Court and
the Community to stand
together to get it done.
It is time to act.

ATI Process

The ATI has engaged in a three-month process to develop a coordinated, collaborative, and strategic foundational structure to generate the comprehensive plan the LA County Board of Supervisors requested in February of 2019. The mission of the Work Group is to provide the Los Angeles County Board of Supervisors a Road Map, with an action-oriented framework and implementation plan, to scale alternatives to incarceration and diversion so care and services are provided first, and jail is a last resort.

To develop a transparent and collaborative process the ATI planning team utilized five long-term goals included in the motion.

These goals include:

- Develop a vision, values, process and structure to guide the creation of a comprehensive plan to build a more effective justice system
- Utilize emerging data and recommendations from the range of studies and assessments currently being conducted to expand diversion and community treatment opportunities for justice-involved individuals
- Create a roadmap for expanding alternatives to incarceration and diversion while preserving public safety

- Analyze legislative and policy changes needed to advocate for the roadmap's full implementation

- Coordinate with related efforts to ensure that they are aligned with the County's goal of diverting people into treatment and not incarceration

To operationalize the mission and goals, each of the departments named in the motion that created the ATI WG identified a voting member and each Supervisor appointed two voting members. The CEO appointed Dr. Bob Ross, President of The California Endowment, as the Chair of the Work Group. The facilitator of the ATI Work Group established the decision-making process for the ATI Work Group by adopting the Gradients of Agreement Tool which allows the group to reach consensus on a proposed motion or action through a 60 percent threshold of endorsement.

The Work Group initially established four ad hoc committees including Community-Based System of Care, Justice System Reform, Funding, and Data & Research. Through Work Group meetings, the community requested a Community Engagement Ad Hoc Committee, which was established with the support of the chair and the planning team. The ATI Chair and planning team facilitated a process to reach consensus on three values to guide the work of the ATI Work Group: (1) equity and racial justice, (2) inclusion of many voices, and (3) human-first language.

The group then discussed tools and events to support the ATI Work Group in establishing practices to apply these values. The first event that created an opportunity for Community and County stakeholders to engage with the Work Group values was an ATI Retreat held on April 26, 2019 with a focus on equity and racial justice. The retreat included a talk on the history of incarceration in Los Angeles from Dr. Kelly Lytle Hernandez, a presentation on the impact of racial and geographic inequity on service access from Jon Kim of The Advancement Project, and an introduction the Government Alliance for Racial Equity (GARE) Toolkit³² by Julie Nelson of Race Forward. The Racial Equity Tool has now been adopted as a resource that each of the ad hoc committees are using to analyze and further develop their recommendations. Finally, we are in the process of incorporating the Criminal Justice Reform Phrase Guide³³ created by The Opportunity Agenda to practically apply the value of human first language.

The value of inclusion of many voices was integral to the creation of this interim report and will expand through the Community Engagement Ad Hoc Committee activities. In the current three-month process, over 270 people have engaged in the ATI Work Group efforts by participating in five Work Group convenings and/or 18 (5 CBSOC, 3 Funding, 3 Community Engagement, 4 Justice and 3 Data) ad hoc meetings, plus many more ad hoc small group meetings. This effort included 26 government departments and programs, 28 advocacy organizations, 21 community-based service providers, as well as indi-

vidual community members, philanthropists, and academics. The ad hoc committees each have two co-chairs and between 25–50 members who have led the development of the interim report recommendations and who will be engaged in the implementation and development of the final report. Participants of the ad hoc committees, in a consensus-building process, developed background analyses, goals and recommendations, which were presented to the full Work Group for inclusion in the interim report. The voting members deliberated on and endorsed the goals for the report at the May 23, 2019 meeting.

As we move into the next phase and the creation of the final report, we will continue to refine the Work Group structure, practically apply our Work Group values, support effective decision-making facilitation, and expand the outreach and engagement of a larger group of stakeholders.



The History of Mass Incarceration in Los Angeles

Prepared by Prof. Kelly Lytle Hernandez

May 16, 2019

California led the rise of mass incarceration in the United States, imprisoning more people than any other state in American history. Los Angeles County led California's carceral surge, sending more people to prison than any other County in the state and building the largest jail system in the nation.

Sentencing reform was the first trigger for the California's prison boom. In fact, amid a post-World War II trend, California's state prison population declined to fewer than 20,000 persons by the mid-1970s.³⁴ The number of people imprisoned in California was so low that policymakers began to discuss the total abolition of the state prison system.³⁵ Then, in 1976, California passed the Sentencing Reform Act. The 1976 Sentencing Reform Act was a consensus law, serving law-and-order demands for minimum sentences while addressing progressive concerns regarding racial disparities endemic to indeterminate sentencing practices. The new law pegged a fixed prison term of, say, two, eight, or ten years, to each offense and, then, required judges to assign a fixed, i.e. "determinate," sentence for each charge. By 1980, the state prison population was on the rise as people serving fixed and, typically longer, sentences spent more time behind bars.³⁶

Congress followed California's lead. In 1984, the United States Congress passed the Sentencing Reform Act, adopting determinate sentencing and mandatory minimums for federal offenses. In 1986, Congress adopted the Anti Drug Abuse Act, which doubled down on harsh sentencing for drug crimes by establishing the now-discredited 100-to-1 formula for crack vs. powder cocaine.

Meanwhile, a national trend toward intensifying street-level police practice swept an increasing number of people into local jails across the country. Namely, the War on Drugs focused police practice on arresting low-level street dealers, with a goal of ripping out the base of the nation's illicit drug economy. Similarly, the adoption of Broken Windows-style policing prioritized arresting people on relatively minor charges, with the goal of creating a sense of public order that suppressed the outbreak of more serious violations. The Los Angeles Police Department and the Los Angeles Sheriff's Department were both early adopters and national leaders in the War on Drugs and aggressive patrol practice.³⁷

Neither worked. The War on Drugs did not end the illicit drug economy and Broken Windows policing did not suppress more serious violations. In fact, drug usage remained steady during the drug war while violence surged in the nation's most aggressively policed communities.³⁸

Simultaneously, the federal government defunded mental health hospitals, without provisions for community-based clinics, forcing large numbers of persons struggling with mental illness into the streets where they were regularly subject to arrest. Similarly, deindustrialization destabilized urban cores across the United States, sending more people to the streets in search of work, housing, and community. Meanwhile, the federal government offered states and localities massive incentives to build new prisons, hire more police, and purchase increasingly militarized technologies, such as helicopters and tanks.³⁹

It was the perfect storm, the staging of a historically unprecedented and globally unmatched social crisis called “mass incarceration,” and the costs were staggering.

The rise of mass incarceration required enormous public resources. Since 1971, the United States has made a \$5.1T surplus investment in criminal justice, ramping up spending on the state prisons, local police and local jails far above 1971 levels. In California, state authorities have increased criminal justice spending by \$600B above 1982 levels.⁴⁰

But the costs of mass incarceration are more than fiscal. The human toll is also steep. For example, everything from school policing to parental incarceration has been causally linked to diminished educational outcomes for children in highly-policed communities while the confinement of a wage earner, even if just for a few days, reduces family income while consti-

tuting an additional household expense as families and loved ones scramble to pay legal fees, phone calls, and take time off of work and school for visitation. In turn, “families with an incarcerated family member are significantly more likely to live in poverty and experience homelessness than other families...”⁴¹

And none of these costs were equally distributed. In fact, the rise of mass incarceration indisputably landed most heavily in Black, Latino, and Native communities and especially upon the young, poor, unhoused, and mentally ill. Young African American men, in particular, were persistently more likely to be arrested, convicted, and imprisoned for a drug felony regardless of relatively equal rates of drug use. By the early 1990s, the racial disparities inherent to the War on Drugs and Broken Windows policing delivered clearly racialized results as one-in-four young Black men was incarcerated or system involved.⁴² And the female arrest rate broke away from historic norms, making women, particularly Black women, the fastest-growing imprisoned population in the United States.⁴³

In sum, the nation’s criminal justice strategy was not just expensive and a failure, it had systematically harmed vulnerable communities, namely youth, women, the impoverished, racialized minorities, and the mentally ill.

Rather than fix the broken criminal justice system, California, led by Los Angeles, doubled down, again leading the nation toward even more intensive police

practices and higher incarceration rates. In 1994, the passage of the Three Strikes law continued to drive up demand for prison beds in California. By 2000, California had built twelve additional prisons. By 2010, California had opened two more prisons, for a sum of 23 prisons in less than thirty years.^{44, 45}

Still the number of local arrests outpaced the state's prison construction boom, driving California's prison system to become dangerously overcrowded, operating at more than 200% by 2010. In 2011, the U.S. Supreme Court ruled that conditions inside California prisons violated the U.S. Constitution's protections against cruel and unusual punishment, ordering California to reduce overcrowding to no more than 137.5% above capacity.⁴⁶

In October 2011, the passage of A.B. 109, a.k.a. "Realignment," California courts began sentencing all persons convicted of non-violent, non-sexual, non-serious felonies to County jails instead of state prison, dramatically reducing the number of people sentenced to the state's overcrowded prisons.

In 2014, California voters passed Prop 47, which retroactively changed certain non-violent, non-serious felonies into misdemeanors, releasing thousands from prison while also making as many as one million California residents eligible to have their felony convictions downgraded to misdemeanors.

Today, sentencing reform is again radically transforming California's carceral landscape.⁴⁷ Recent re-

forms have driven the state's imprisoned population to fewer than 130,000 persons.⁴⁸ In Los Angeles, the daily County Jail population averages less than 17,000 persons.⁴⁹ Yet demographic disparities persist. The L.A. County Jail remains disproportionately Black, poor, sick, and young, and increasingly female.

The History of the Treatment of Individuals with Mental Illness in the Los Angeles County Jail

Prepared by David Meyer

May 27, 2019

Mental Health Care

Historically, California's approach to the care of people with mental illness reflected national trends. Prior to statehood in 1850, "insane" people were involuntarily held in detention facilities without meaningful treatment.⁵⁰ At its worst instance, these facilities consisted of jails and abandoned ships in harbors.⁵¹ During the mid 19th century, reformers such as Dorothea Dix succeeded in convincing governmental authorities to establish large institutional asylums (later state hospitals) to house people with mental illness who could not independently survive in the community.⁵² As a result, during the late 19th century, placement of individuals who had mental illness in remote asylums was the dominant approach to treatment.⁵³ Admission to these asylums was simply a matter of someone, frequently a law enforcement representative, presenting the person to a hospital for admission.⁵⁴ In answer to calls for reform, California created its first State Hospital for the treatment of mental illness in 1852 at Stockton.⁵⁵ Metropolitan State Hospital opened in 1916 in the Los Angeles County City of Norwalk⁵⁶ in response to overcrowding at Patton State Hospital in San Bernardino County.⁵⁷ The then Los Angeles County Hospital opened a separate mental hospital building on its campus (known as unit III) for both voluntary and involuntary (court committed) admissions during the 1940s. Hospitalization was the predominant means of

providing long-term care until California's enactment of the trailblazing Short-Doyle Act.⁵⁸

The need for mental health services in Los Angeles County paced the growth of California's population over the years.⁵⁹ However, prior to 1957, the locus of care and funding had been with the State of California; a consequence of the 18th century notion that people who had mental illness should be isolated in asylums.⁶⁰ 1957's Short-Doyle Act recognized the medical fact that isolation was counter productive to care and it began shifting both resources and responsibility from the state level to counties.⁶¹ At roughly the same time, first-wave anti-psychotic medications such as chlorpromazine and haloperidol were used successfully in the community to treat the symptoms of mental illness.⁶² This transition culminated in 1991 with the legislature enacting a series of statutes under the aegis of health and welfare "realignment." Among these statutes was the Bronzan-McCorquodale Act that established local community mental health services⁶³ and created local directors of mental health.⁶⁴ Funding was provided by the state to counties through an allocation from the local health and welfare trust within the state budget.⁶⁵ California began slowly closing its State Hospitals consonant with the transfer of responsibility for mental health care from State Hospitals to local systems of care;⁶⁶ something pejoratively called deinstitutionalization.⁶⁷

From the time first-wave anti-psychotic medications were introduced until the 1980s, treatment of mental illness focused on the reduction of psychiatric symptoms such as delusions, hallucinations, mania and depression. Advances in treatment and pressure from con-

sumers of mental health services (formerly “patients”) during the 1980s and 1990s led to modifications in these traditional “medical” approaches to the provision of care. These changes have come to be called recovery, or the recovery model. Recovery is based on the notion that large numbers of people who have mental illness can lead productive lives even while having symptoms, and that many will recover from their illnesses if provided with pertinent supports in the community.⁶⁸ The federal government adopted recovery as a national policy⁶⁹ beginning with the 1999 Report of the Surgeon General that stated “All services... should be consumer oriented and focused on promoting recovery.... [T]he goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life.”⁷⁰ Recovery services are characterized by supports such as the provision of housing, establishing finances and financial services, education, job training, social engagement and personal assistance with individualized social and health services.⁷¹ These support services “wrap-around” traditional medical approaches to treatment of symptoms.⁷²

The Los Angeles County Department of Mental Health was early to adopt recovery model approaches to care by implementing provisions of 1999’s AB 2034, a law that authorized ancillary spending for care. Far greater support for recovery services came in 2004 with the Mental Health Services Act.

Jail Mental Health Services

With the growth in Los Angeles County’s population came the growth of its jail population and increases in the numbers of people with mental illness in custo-

dy. Additional factors such as the rise in homelessness and the lack of outpatient mental health programs exacerbated this problem.⁷³ However, mental health treatment services were not available in the Los Angeles County Jail until the mid 1970s. Two events led to this. First, media coverage attracted the attention of the Los Angeles Grand Jury in 1972. The Grand Jury assessed care of people in jail custody who had mental illness and recommended mental health staffing for the jails in its annual report.⁷⁴ In response, under the direction of Roger Schock, M.D., the Department of Mental Health initiated a program to treat people in jail custody who had mental illness. The Board of Supervisors appropriated \$600,000⁷⁵ to fund four clinical mental health providers and ancillary services for treatment in jail facilities.⁷⁶ Care was provided to people in jail custody in the general population, so the services were denominated the Forensic Outpatient Program (FOP). Second, a federal civil rights lawsuit was filed against the County in 1975. The suit alleged multiple denials of civil rights by the Los Angeles Sheriff, including psychological abuse of and failure to treat people in jail custody who had mental illness.⁷⁷ The judgment ultimately rendered in that case did not reference mental health care.⁷⁸ But, the impact of the lawsuit did produce an increase in the numbers of clinicians and types of services provided by the Department of Mental Health.⁷⁹ This included the staffing of one treatment unit at the Metropolitan State Hospital to which people in custody who had mental illness and were charged with less serious crimes were transferred. Later, the Department of Mental Health opened a 35-bed male and female Forensic Inpatient Program

(FIP) in the Men's Central Jail to treat people in custody who were charged with more serious crimes.⁸⁰

Growth of the jail population of people with mental illness continued through the 1980s and into the 1990s. By the mid 1990s, the number of people in jail custody identified as needing care rose to 2500.⁸¹ However, the growth of mental health staff did not pace the need for care. After a series of suicides and negative events, in 1996 the United States Department of Justice (DOJ) initiated an investigation of the Los Angeles County Jail under the Civil Rights of Institutionalized Person's Act (CRIPA).⁸² Among the County's responses was a budget increase for the jail mental health programs of roughly \$26 million and a more than doubling to 200 of jail mental health staff.⁸³ In addition, the Twin Towers Correctional Facility (TTCF) opened with three floors dedicated to mental health care in the general population. A 50 bed FIP for acute care was opened in the adjacent Medical Services Building.⁸⁴ The CRIPA investigation produced an operations MOU in 2002 by which DOJ experts and County staff worked on massive improvements to mental health services. In 2013, the DOJ initiated another investigation of the jail related to separate issues. In 2015, the United States and the County of Los Angeles agreed to resolve both investigations with a settlement filing in federal District Court. The agreement contained detailed provisions related to mental health services.⁸⁵ Supervision of the agreement was placed under the jurisdiction of the court, which appointed a monitor to oversee implementation of the agreement's provisions.⁸⁶

As inferred above, the Board of Supervisors has made repeated efforts over the years to address the issues surrounding persons with mental illness in custody. Noteworthy in this respect is a 1991 effort by the Board to design a comprehensive approach to the problem. Under the leadership of then Supervisor Edmund D. Edelman, the Board established a taskforce to study what was, even then, a significant problem. In 1992, the taskforce studied the problem and in 1993 it submitted a report to the Board.⁸⁷ That report contained eleven recommendations for action, all pertinent to resolving today's problems related to people with mental illness who are in custody. Unfortunately, the recession of 2003–2006 and the retirement of Supervisor Edelman delayed action until the recent consolidation of mental health services in the jail and the creation of the DHS Office of Diversion and Reentry.

Recently, the Board of Supervisors has taken bold action to address and correct jail mental health issues. On June 9, 2015, the Board ordered the consolidation of jail mental health services under a new Correctional Health Director within the DHS.⁸⁸ The new structure is designed to enhance efficiencies, reduce duplication of efforts, and develop new clinical programs and care models.⁸⁹ Further, the Board created the Office of Diversion and Reentry (ODR) within the DHS on August 11, 2015 and further directed the Chief Executive Office to create a diversion fund within the County budget to support ODR programs.⁹⁰ The Board charged the ODR, working with an interdepartmental Permanent Steering Committee, to consolidate existing and create additional programs and projects. Specifically, ODR was directed by the Board to develop and expand

treatment services and housing capacity in the community for individuals with mental illness who might otherwise be placed in custody.

Civil Rights and Involuntary Care

Political movements championing rights for persons with disabilities have existed since the 19th century and became strong during the 20th century.⁹¹ At the federal level, this led to the passage of the Rehabilitation Act in 1973 and, most notably, the Americans with Disabilities Act in 1990.⁹² These laws prohibit discrimination against people with disabilities, including those having a mental illness. In addition, the Americans with Disabilities Act requires that “reasonable accommodations” be made by businesses and governments to enable access to publically available sites and services.⁹³ California independently enacted similar laws banning discrimination against people who have mental illness and other disabilities. These included the Unruh Civil Rights Act,⁹⁴ the Fair Employment and Housing Act⁹⁵ and the Disabled Persons Act.⁹⁶ Involuntary judicial commitment laws for individuals with mental illness were first enacted in California in 1903.⁹⁷ These laws contained rudimentary provisions to protect individuals proposed for commitment from denials of due process of law and unnecessary forced treatment.⁹⁸ Commitments were indefinite, subject to a provision that the person committed would be “...discharged if he has improved to such an extent that he is no longer in need of supervision treatment care or restraint.”⁹⁹ However, these civil commitment laws became, over time, little more than pro forma exercises in sending large numbers of people to state hospitals for little care.¹⁰⁰ In re-

sponse, the California legislature, under the leadership of Glendale Assemblyman Frank Lanterman, enacted the revolutionary Lanterman, Petris, Short Act (LPSA) in 1967.¹⁰¹

The LPSA replaced indefinite commitment with a series of short-term periods of assessment and treatment in “designated facilities.” Under the LPSA, three-day custodial assessment periods are permitted upon probable cause to believe that “...a person, as a result of mental health disorder, is a danger to others, or to himself or herself or gravely disabled.”¹⁰² Gravely disabled is specifically defined by the LPSA as “...A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.”¹⁰³ These provisions require observable behavior as criteria for involuntary treatment in lieu of the former commitment law’s vague standards.¹⁰⁴ After this assessment, that person may be certified for an additional 14 days of intensive involuntary mental health treatment by the professional staff of a facility designated by the state and the County to provide these services.¹⁰⁵ Additional periods of 30 days may be imposed for gravely disabled individuals,¹⁰⁶ 14 days for suicidal individuals¹⁰⁷ and 180 days for individuals who are dangerous to others.¹⁰⁸ Each of these periods of involuntary treatment is subject to detailed due process of law requirements to guard against improper forced care.¹⁰⁹ Additional safeguards are provided with respect to involuntary administration of anti-psychotic medications.¹¹⁰ Each period of involuntary care automatically terminates, foreclosing indefinite involuntary commitment in accordance with the legislative intent expressed in Welfare and Institutions Code §5001(a).

Long-term involuntary care for gravely disabled individuals under the LPSA is accomplished through a court-ordered conservatorship that terminates after one year, unless renewed annually.¹¹¹ Specific provisions of the LPSA empower a conservator to authorize care for a conservatee, including placement in a locked treatment facility.¹¹² Both the establishment of a conservatorship and the awarding of powers to the conservator are subject to extensive due process provisions and the right to a jury trial requiring proof beyond a reasonable doubt¹¹³ on the issue of whether the conservatee is gravely disabled.

300-500%

Severe mental illness is 3 to 5x higher in the criminal justice setting than in the general population.

Rikers Island, Cook County Jail and Los Angeles County Jail are considered the three largest mental health care providers in the country.

Source: <https://www.williamjames.edu/news/new-main-criminal-justice-and-behavioral-health-broadens-offerings-at-intersection-of-law-and-mental-health.cfm>

Description of the Mental Health Population in the LA County Jail

On a given day (April 30, 2019), 16,945 people are in custody in the LA County Jail.¹¹⁴ Of that total population, approximately 5,648 individuals or 30% reside in jail mental health housing, a percentage consistent over the last several years and with the percentage found within the California Department of Corrections and Rehabilitation (CDCR) state prison population. By contrast, according to The National Alliance on Mental Illness, approximately 1 in 25 adults (4%) in the U.S. experiences a serious mental health disorder in a given year.

Patients in the LA County Jail have different levels of acuity. Those with the most acute mental health needs represent those who are typically in the hospital or in the high observation settings of the jail. On any given day, there are 1,300 persons in high observation housing, and hundreds of those individuals are appropriate for acute hospitalization. A less acute, but still unstable population may require a range of services from inpatient to structured residential care and represents over 1,000 individuals.

Those in moderate observation housing in the jail on any given day are approximately 2,700 (2,400 men and 300 women); and those who are able to be in the general population while receiving psychotropic medication totals 1,420 patients (1,080 men; 340 women).

Additionally, there are approximately 200 persons with physical problems requiring Office of Statewide

Health Planning and Development (OSHPD) hospital level care who are housed in the jail Correctional Treatment Center (CTC).

An April 2019 Department of Health Services study of 500 patients in the custody of the LA County Jail indicated that 3,162 patients, or 56 percent of the total population, could be appropriate for community release if programs were appropriately scaled. An additional 45 individuals (7%) might be eligible for diversion given closer review of their cases. The study showed no significant differences with regard to race between the jail mental health population as a whole and those found appropriate, possibly appropriate and inappropriate for community release. It is also important to find treatment alternatives for the 37–44% of people who are ineligible for existing community release programs to reduce the number of people with serious mental health disorders.

Research Overview

In addition to the stark racial disparities that exist across the criminal justice system, it is well established that people with mental health disorders are overrepresented at all points in the justice system.¹¹⁵ The most recent data available from the Bureau of Justice Statistics showed that over one quarter of people in jail met the threshold for serious psychological distress and that nearly two thirds of people sentenced to jail met the criteria for drug dependence or abuse.¹¹⁶ Rates of comorbid mental health disorder and substance use disorder are high, yet people in jail often do not receive treatment and decades of research shows that

incarceration itself exacerbates health problems.¹¹⁷ This may be particularly problematic for people of color given research demonstrating that they are less likely to have access to mental health treatment in the community as well as within the criminal justice system.¹¹⁸

The long history of disconnect between criminal justice systems and public health systems has resulted in an ineffective default response of arrest, incarcerate, and repeat for some of society's most vulnerable members.¹¹⁹ Yet, there is a growing recognition that these systems must partner to change the narrative—to move away from decades of tough-on-crime policing and sentencing and to embrace more humane and impactful approaches to responding to people with mental health disorders (the vast majority of whom commit minor offenses).¹²⁰ What the Alternatives to Incarceration Working Group proposes for Los Angeles is consistent with national efforts aimed at addressing these disparities and creating a framework for integrated mental health, public health and criminal justice responses. There is increasing evidence of partnership across health and justice stakeholders as jurisdictions look to unravel mass incarceration and reduce the number of people with mental health disorders who come in contact with the justice system. From New York City to Miami-Dade County, from Memphis to Tucson—jurisdictions are trying innovative approaches, with a particular focus on reimagining crisis response systems and ensuring that people with mental health disorders are diverted to community-based care when possible.¹²¹

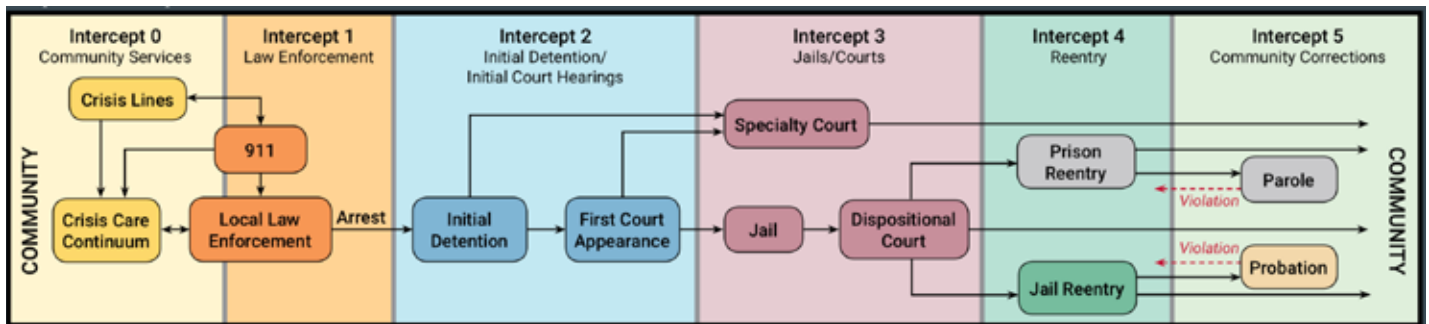
One way to think about how people with behavioral health needs move through the criminal justice system and what is needed to prevent justice involvement is by using the sequential intercept model (SIM)—a widely-used conceptual framework that addresses the interface between the criminal justice health, social service, and community-based systems.¹²² The SIM describes a series of opportunities for intervention that can prevent individuals with mental health disorders from becoming enmeshed in the criminal justice system. Such opportunities are located along various points of a continuum, from community-based services that focus on crisis response systems and pre-arrest models adopted by law enforcement; to pre-arrest and/or jail-based behavioral health screening, assessment and intervention; to services offered at reentry or located within community alternatives.¹²³

The five intercepts of the SIM depicted on the next page correspond with key decision points in criminal justice processing and offer insights into the strategies that can safely divert people with mental health disorders into effective community-based services that produce better outcomes for individuals, the community, and the justice system. Many of them can be implemented before someone ever ends up in jail. While many of these strategies are at various stages of development in communities across the country and the evidence base for many of them is therefore still emerging, there's no shortage of promising practices worth considering. There are responses rooted in the

“front end” of the system, looking at the crisis care continuum and responses to 911 calls.¹²⁴ There are responses that focus on what happens leading up to and at the point of arrest, with particular attention to how law enforcement officers are trained and how police officers can develop responses in collaboration with mental health providers (e.g., Crisis Intervention Team Training, co-responder models).¹²⁵ There are responses dedicated to earlier and better screening to identify behavioral health issues.¹²⁶ And, of course, there are responses rooted in robust community engagement, enlisting community leaders in building healthy neighborhoods and preventing justice system involvement altogether.¹²⁷

The SIM is not new to Los Angeles stakeholders.¹²⁸ Indeed, LA County has developed a number of programs that cover various points of the spectrum. And we see in the ATI Work Group recommendations opportunities to strengthen, scale, and build upon these programs to create a holistic system of care in Los Angeles County. In the next sections, we suggest many strategies—from large-scale overhauls, to scaling existing programs, to some very technical fixes to address specific barriers—that could transform the way LA County treats its most vulnerable community members.

The Sequential Intercept Model ¹²⁹



RECOMMENDATIONS

Interim Report Goals, Recommendations and Analysis

Table of Contents

Community-Based System Of Care—Ad Hoc Committee	46
Issues, Analysis, and Recommendations	46
Issue and Analysis	46
Goal 1A: Increase Access & Remove Barriers to Community-Based Services	47
Goal 1B: Increase Access & Remove Barriers to Community-Based Services	51
Goal 2A: Expand the Community-Based System of Care	53
Goal 2B: Expand the Community-Based System of Care	55
Goal 3: Coordinate Community-Based Services	55
Goal 4: Expand Community Health Worker & Peer Support Models	56
 Justice System Reform—Ad Hoc Committee	 58
Issues, Analysis, and Recommendations	58
Goal 1: Improve Diversion and Alternatives within the Court System	58
Goal 2: Reduce Pretrial Detention and Increase Services	61
Goal 3: Reduce and Improve Interactions between Law Enforcement and Mental Health; Increase Diversion and Expand Training for Law Enforcement	64
Goal 4: Increase and Improve Access to Treatment Services for Court-Involved People	71
Goal 5: Improve Reentry Practices	76
 Community Engagement—Ad Hoc Committee	 81
 Funding—Ad Hoc Committee	 85
 Data & Research—Ad Hoc Committee	 88

Note: The following goals, supporting analysis, and proposed recommendations to achieve those goals, were created by each of the ad hoc committees through multiple meetings and consensus-building activities. The ATI Work Group endorsed each of the goals and will further develop the recommendations during implementation planning. These goals were summarized in the Executive Summary and are provided in full detail in this section.

Community-Based System of Care Ad Hoc Committee

Issues, Analysis, and Recommendations

A. Issue

There is inadequate access to care and insufficient treatment capacity in Los Angeles County's mental health system. As a result, our jails have become a major provider of mental health services. In fact, it is estimated that roughly 1/3 of the LA County Jail population (over 5,000 people) has significant mental health needs. In particular, for decades now the acute and sub-acute systems of mental health care have been starved of resources and poorly managed leaving them woefully unprepared to meet current demands. In addition, outpatient clinical services and much needed reintegration programs that provide connections to community, housing and jobs are few and far between thereby setting up the jail system to become a default setting for people with serious mental health needs.

The County's current system of community-based alternatives to incarceration for people living with mental health needs is not equipped to prevent the criminalization of their illness. Instead, there is a revolving "system of care" that flows from crisis and hospitalization to homelessness and jail- and sometimes death. Our system is difficult to navigate, exists in silos, and does not meet the whole person needs of people with mental health and substance use disorders in our communities. The current approach can often isolate people with harmful results, rather than helping them integrate into our communities using

systems that prioritize dignity, promote wellbeing, and provide meaningful opportunities to be active community members of Los Angeles County.

B. Analysis

The lack of community-based services and alternatives to incarceration in the County for people with mental health needs has resulted in overburdened emergency rooms and jail towers full of people suffering from varying mental health symptoms. The delivery of mental health services in jail, and other carceral settings exacerbate mental health needs and often times subjects' people to additional trauma. The Federal Department of Justice (DOJ) acknowledges that people confined to the County jails who have mental health needs were failed by other systems, and these people would be safely and more effectively served in community-based settings at a lower cost to the County.¹³⁰

Currently, people with behavioral health needs are not provided with the holistic care that address all the social determinants of health. We must invest in prioritizing access to health care services, availability of resources to meet daily needs (e.g., safe housing and transportation), as well as access to educational, economic, and employment opportunities with family and community reintegration. An integrated, decentralized system of care that addresses mental

health needs and the social determinates of health will create social and physical environments that promote good health for all community members which has been supported by public health experts across the nation. The American Public Health Association “recommends the following actions by federal, state, tribal, and local authorities: (1) eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations), (2) institute robust law enforcement accountability measures, (3) increase investment in promoting racial and economic equity to address social determinants of health, (4) implement community-based alternatives to addressing harms and preventing trauma, and (5) work with public health officials to comprehensively document law enforcement contact, violence, and injuries”.¹³¹ Developing a system of care that is easily accessible, decentralized, and has the capacity to serve thousands of people throughout the County can end the County’s reliance on jails and law enforcement while ensuring that people with behavioral health needs are thriving with dignity and living lives that are restored, not restricted, by ecosystems of care. Care first, and jail only as a last resort.

C. Recommendations

Goal 1A: Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health

Description: Develop policies and expand programs that ensure that people with mental health disorders

and substance use disorders, their loved ones, and community members have multiple points of access to the full continuum of services and that match the individual’s current needs (from low to high levels of care) through a combination of County- operated and not-for-profit community-based organizations services throughout Los Angeles County while creating alternatives to incarceration at every level of the criminal justice system. This recommendation impacts intercept zero (which enables people to access services before any contact or involvement with the criminal justice system has occurred) and intercept five (prevent recidivism). All services should be implemented in a need-aligned and equitably distributed manner.

Goal 1A: Potential Strategies

1. Incorporate Families and Social Support Network

A. Expand family reunification models and connect families to low cost or no cost parenting groups.

B. Train people interested in learning how to support their loved ones while incentivizing this training with compensation, certificates, etc. Trainings can include how to access services, identify various degrees of crisis or intervention responses, identify resources while in the justice system, and others.

C. Compensate family members and caregiver for covering the cost of housing their loved one through a tax credit or stipend.

D. Create a system so that family members can participate in partial pay options for communityhousing (motel conversions, bridge, board and care, intentional community, shelter, scattered sites).

E. Support LPS mental health conservatorship and create a temporary conservatorship process for family members to support system navigation when appropriate. Training is not currently offered by OPG to assist family member conservators on system navigation. Refer families and clients coming with the challenges of living with serious mental health disorders to organizations that provide those services.

2. Educational, Economic, and Employment Support

A. Coordinate efforts with WDACS to think through other economic and employment opportunities.

B. Create a flexible fund for basic client needs such as obtaining birth certificates, transportation, identification, food, co-pays, and other client services, court fees, probation fees, legal documents, medication co-pays, DMV services, meeting co-pays, proper clothing, and other needs to support education and employment.

C. Expand supported employment opportunities, training, Psychological Testing and evaluation of clients' abilities for people with mental health disorders, substance use disorder and co-occurring disorders.

D. Establish a partnership with the state Department of Occupational Rehabilitation.

3. Prevention, Health, and Social Services

A. Housing

1. Create a master plan transition for individual when displaced.

2. Scale up Assembly Bill (AB) 109 bed capacity and Forensic Full-Service Partnership resources.

3. Expand successful housing models for individuals with mental health needs, including:

- Improve concept of, and number of beds for board and care facilities (also known as ARFs).
- Expand acute inpatient beds.
- Expand IMD sub-acute beds.
- Expand Enriched Residential Services (ERS) beds.
- Contribute to and/or offset the cost of families providing housing for their loved one.
- Expand the number of Forensic Inpatient Beds (FIP) in the community-based settings.
- Develop sober living homes that understand the needs of individuals with mental health treatment needs and are willing to work with these clients.
- Develop Clubhouse living facilities for people with severe mental disorders that can also act as intermediaries for supported employment.

- Expand interim and permanent supportive housing.
- Develop and expand subsidized housing alternatives for people with serious mental disorders enabling them to live with dignity on their SSI and/or disability checks.
- Scale up innovative programs that comprehensively provide housing, wraparound services, and career-track employment for justice-impacted individuals.

4. Landlord Support:

- Make it attractive for landlords to enter into partnership with County departments and providers.
- Provide staffing on housing site with an understanding of the neighborhood while resourcing the landlord and client.
- Increase relationship management for landlords and support landlord liaisons.

B. Mental Health:

1. Attract and support development of a workforce capable of delivering integrated health, mental health, substance use treatment through strategies such as recruitment and training of more health professionals; support of livable wages at community-based organizations to better enable parity with County-operated facilities; and expand community-based intervention teams to respond to the spectrum of mental health crisis that enable the warm hand off to give people

access to supportive services rather than jail or the hospital.

2. Direct 911 calls about behavioral health crises that do not require a law enforcement agency response toward the Department of Mental Health's ACCESS line in order to redirect individuals to intercept 0 services and mental health practitioners like PMRT, HOME, and E6 Homeless Teams. A system approach beyond 911 or ACCESS could be developed as an alternate destination for non-law enforcement calls.

3. Integrate and coordinate such efforts with One Degree—the health and wellness resource linkages website and app-based tool utilized by Whole Person Care in Los Angeles County.

4. Create coordinated service hubs in strategic locations across the 8 Service Planning Areas (SPA) where people can seek referral and/or immediate admission to a spectrum of services. These services, include but are not limited to, mental health, supportive housing via the coordinated entry system, triage to appropriate level of care, and/or substance use disorder services such as withdrawal management (formerly known as detox), Medications for Addiction Treatment (MAT), and recovery intake centers (also known as sobering centers); and explore opportunities to leverage similar existing sites operated by other County

departments that advance these same goals.

5. Expedite the expansion of Psychiatric Urgent Care Centers across all 8 SPAs while connecting them to aforementioned service hub network for warm hand offs to optimal services.

6. Increase capacity of the Office of the Public Guardian to investigate and manage Mental Health Conservatorships for individuals considered gravely disabled as a result of a mental health disorder.

7. Expand the Mental Health Court Linkage Program with additional staffing and beds for clients. Expand resources and case workers to every courthouse in County.

C. Substance Use Disorder Treatment:

1. Require that mental health clinicians build their capacity and expertise to provide integrated substance use disorder care with psychiatric treatment, including support for cross training efforts for all levels of clinicians.

2. Support risk reduction strategies when patients with mental health disorders continue substance use rather than removing psychiatric medications; and educate patients who use alcohol and/or opioids on MAT options (e.g., methadone, buprenorphine), and prescribe such medications and/or refer to an Opioid Treatment Program (OTP) when indicated.

3. Deliver integrated mental health and

substance use disorder (SUD) services, rather than parallel services such as adding on a psychiatrist to a SUD treatment plan.

4. Build partnerships between DPH-SAPC and DMH for residential Co-Occurring Disorder (COD) services.

5. Expand and create a decentralized system of recovery intake centers (also known as sobering centers) available to patients with only mental health disorder, only SUD, or co-occurring disorder service needs.

6. Support parity in substance use disorder as a chronic disease like other long-term physical and mental health conditions by implementing similar enhancements in the SUD system to better address the prevention and treatment needs of individuals with SUD only, which may include those with mild or moderate mental health conditions.

D. Primary Care:

1. Build a decentralized system of health campuses similar to the Martin Luther King Behavioral Health Center (MLK BHC) or the restorative care village at Olive View-UCLA Medical Center in Sylmar at other County hospitals, rehabilitation centers, and/or community service hubs.

4. Alternatives and Diversion

A. Scale up the District Attorney Mental Health

Division's partnership with the Office of Diversion and Reentry to successfully divert hundreds of individuals into permanent housing and long-term case management while partnering with community-based organizations as part of a comprehensive approach to addressing individuals' holistic needs.

1. Partnership with families, ensure workforce is trained to address the continuum of need, ensure that the individuals plans are culturally sensitive and include those not eligible for community-based diversion (i.e., violent felony charges).

2. Recovery Bridge Housing (Sober Living) and licensing should be included in the spectrum of offerings as well as in-patient and outpatient services.

3. In coordination with law enforcement and community-based service providers, expand pre-arrest / pre-booking diversion programs for people whose justice system involvement is driven by unmet behavioral health disorders.

B. Develop and expand diversion efforts at local jails within the County and sheriff sub-stations by connecting individuals to treatment or other health and social services in their local neighborhoods as an alternative to incarceration and as soon as intercept zero.

C. Establish effective restorative justice programs for the adult population by learning from exist-

ing County programs especially those serving youth. New funding should be aligned to scale-up these models, and County departments should change their practices to employ them instead of an arrest-and-incarceration approach wherever possible. Monitor to ensure restorative justice programs are fairly applied and culturally responsive.

D. Connect every individual who is diverted to DMH for care.

E. Frame as Whole Person Care, which includes: funding mental health services and substance use services, fund whole person services for justice involved individuals like violence prevention, gang intervention, art therapy, occupational therapy and other programs.

Goal 1B: Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health

Description: Remove barriers to accessing all necessary and complimentary integrated not for profit community-based services related to mental health disorders, substance use disorders, and poor social determinants of health while providing community members with the necessary tools, support, and incentives to attend and participate in services.

Goal 1B: Potential Strategies

1. Mental Health Disorder, Substance Use Disorder, Housing and other Health and Social Programs:

A. Remove time limits to service provisions that prevent access to long term treatment plans. For example, many Medi-Cal funded programs have short durations of service, leaving gaps when people lose eligibility. Gaps also exist around transportation to and affordability of services.

B. Integrate peer support organizations by working with them and sharing information, schedules and meeting information.

C. Work with families to help assess client's needs, provide one to one assistance for each client through various stages of treatment needs, connect them with County wide resources and housing programs, to various housing opportunities and programs, to employment and volunteer opportunities, to occupational therapy, to vocational rehabilitation, to LATC classes and to transportation to various appointments and meetings.

D. Work with various Housing State Funding (HCD), DHS Housing programs and Housing projects such as Villages of Cabrillo for people experiencing homeless and mental health disorders to address housing needs.

E. Provide real-time Full Service Partnership (FSP) availability throughout all service areas, keep a

real time database and track FSP successes and failures, and report these to DMH.

F. Establish a family feedback database to track services, providing information on what works and what doesn't to prevent incarceration and recidivism and promote recovery.

G. Incentivize organizations to expand services beyond 9am-5pm weekday only operating models through establishment and management of contract.

H. Remove barriers to treatment, employment, and recovery housing based on record of past convictions through state legislative intervention or updating County policies. For example, those with felony charges working through 5-year probation plea bargains can't get jobs and can't find housing outside of the County system. Even when they have stabilized and are doing well background checks will show they have a conviction record.

I. Advocate for payment reform within contracts to ensure providers can deliver treatment and support for all needs (mental, physical, housing, etc.) concurrently.

J. Create incentives for clients and support network to follow prevention and treatment plans. To help clients adhere to treatment plans, psychiatric and therapy services need to work with the client's personal needs and obstacles. Family involvement is crucial to treatment adherence and needs to

be part of provider policy. This will require DMH to modify its HIPAA policy to provider contracts to allow practitioners to talk to families. HIPAA allows practitioners to talk to families when the patient/client is incapacitated, and it would be in the best interest of the client to do so. California law follows HIPAA closely regarding the protection of personal health information.

Goal 2A: Expand the Community-Based System of Care

Description: Scale up effective culturally competent mental health and substance use models that are community-based that already exist at critical intercepts with a priority on intercepts zero and five that enables people to access services before any criminal justice system involvement. Develop contracting policies and procedures that make it less difficult for culturally competent nonprofit community partners to become part of the funded integrated system of care and invest in those relationships long term. Develop capacity among local providers to compete for County contracts and provide high quality services. Address the distribution of resources by the geographic and racial impact of services equitably.

1. Create less challenging and more reasonable procedures for not for profit agencies to contract with the County of Los Angeles
2. Fund Organizational Development and Capacity Building as an investment in building and sustaining the community-based system of care

3. Create equitable and diverse resources and target investments that address racial, cultural, gender and special population needs County-wide.

4. Re-orient systems and services to support a client-centered model of service.

Goal 2A: Potential Strategies

1. Incubate New Organizations, Services and Innovative Practices

A. Utilize and coordinate with the DMH Incubation Academy, WPC Capacity Building Program, LAHSA and other Capacity Building Programs to find and support smaller organizations in different service areas to qualify for and access County funding for reentry, mental health and substance use disorders, and co-occurring services through a long-term investment.

B. Provide training and technical assistance on how to become services providers which can include MediCal Fee Waiver information, Accessing County Funding, Accessing State Funding, Organizational Coaching, etc.

C. Generate seed funding for new organizations as incubatees (i.e. Acumen-patient capital/micro-loans, For Us by Us).

1. Utilize partnerships with philanthropy, business loans, flexible government dollars, pay for success models, and/or zoned area investment like in South Los Angeles

D. Promote existing service providers as potential incubators for smaller, newer service providers that have specialized expertise: cultural competence, neighborhood relationships, connections, etc.

E. Provide ongoing infrastructure support and professional development.

F. Incubate new innovating employment programs for people with serious mental health disorders.

2. Support Existing, Effective Models

A. Support effective models that are servicing people 24 hours a day, 7 days a week with a specialization. Support should be based on intensity, staffing, language and culture needs, lived experience staff, quality, accountability and attracting pay differential.

B. Gather feedback from service providers currently receiving County funding, and those who are not, to better understand continuing participatory hurdles as well as identifying County innovations that are making a positive impact.

C. Connect existing contractors to current and new capacity building resources that support them in sustaining their organizations and expanding best practices.

D. Generate flexible service delivery rules and payment reform to move to performance-based contracts instead of fee for service.

E. Dedicate funding to long-term and sustainable infrastructure support for community-based systems of care beyond service component like workforce development, basic infrastructure, incentives to grow, training, recruitment, and organizational development (administrative, contracting, finance, budgeting, etc.).

3. Promote Organizational Partnerships and System Integration

A. Insure a public private collaboration in all phases of planning, system oversight, implementation and evaluation.

B. Develop a uniform client data database across all County services that follows the person regardless of system access point.

1. Practical interface

2. Info following the client

3. Address clinician/privacy issues/consent around HIPAA

4. Create uniform database for different points of entry

5. Real-time data available to providers and public

C. Incentivize programs that work in strong partnership with other service providers to ensure more access to a wide variety of support systems that include large, medium, and small non-profits.

Goal 2B: Expand the Community-Based System of Care

Description: Remove barriers that prevent not for profit community-based service providers from accessing County funding, contracting opportunities, technical assistance, and incubation opportunities.

Goal 2B: Potential Strategies

1. Create a process for equitable resource and contract distribution with program offices across health and social service departments that take into account racial and cultural needs, gender, special populations and geographic needs.
2. Standardize a simplified, more accessible contracting process across agencies and departments while engaging in an outreach plan to connect service providers who might benefit from this reform. Following the lead of the Department of Health Services' work to drastically simplify its Master Services Agreement, all reentry-related County units should adopt this qualifying template and go further to reduce barriers.
3. Prioritize funding to organizations that work with special populations (people with sex offenses, transgender individuals, etc.).
4. Through the Community Engagement Workshops and the Reentry Health Advisory Collaborative develop dialogue and the creation of community-based alternatives.

Goal 3: Coordinate Community-Based Services

Description

Create an Alternatives to Incarceration Coordination Initiative within the County governance structure to oversee program implementation and equitable distribution of resources. The Initiative would create policies and procedures to connect all County capacity building and services provision efforts. This Initiative would create linkages in service provision for County departments, non-profit community-based service providers and the community at large so that mental health disorders, substance use disorders, and poor social determinants of health are supported and treated through an integrated model.

Goal 3: Potential Strategies

1. Equitable Distribution of Resources:
 - A. Develop a way to assess and improve racial equity and resource distribution by analyzing and utilizing a tool (Race Forward's Community Benefits Agreement, Racial Impact Tool, or Advancement Project's JENI/JESI, etc.) while involving County and community stakeholders in the process.
 - B. Support system impacted communities in equitably distributing and leveraging additional resources to sustain the health of the community.
2. Service Coordination

A. Create service connections with community-based organizations, County departments, and community members through regional coordination, information sharing, and providing toolkits and training resources for multi-agency case conferencing.

B. Set up a quarterly meeting with multiple stakeholders to communicate up to date ATI progress, discuss service and communication gaps, and highlight best practices.

C. Establish a recurring meeting with County departments to discuss policy impacts, resolve policy conflicts, and assess service eligibility barriers.

D. Develop an online mechanism for tracking identified problems and response progress through an accessible dashboard.

3. Education and Outreach

A. In conjunction with the Community Engagement Ad Hoc Committee work on asset mapping activities to increase the awareness of available CBOs and County resources, their specialty, and their capacity through online information and written outreach materials.

B. Develop on-line interface linking service providers and tracking service availability to elevate the tremendous amount of resources across LA that never get brought to bear and are disconnected (employment, housing, economic resources).

C. Develop a communications plan that focuses on campaign messaging, webinars, and social media tools to educate and inform community and County stakeholders about the different types of community-based solutions such as supportive prevention services, pre-release services, stabilization services, mental health crisis (including and excluding law enforcement), overdose prevention programs and diversion opportunities available through CBOs and the County Health Agency.

Goal 4: Expand Community Health Worker and Peer Support Models to provide holistic support.¹³²

Description

To be developed at a later point.

Goal 4: Potential Strategies

1. Increase CHW Employment:

A. Create education training and career advancement pathways by working with institutions like local community colleges and universities to create a certification or education credential for CHWs.

B. Create pathway for CHWs to move up into full-time, salaried County jobs with benefits (i.e., Eligibility Workers, Peer Support Group Facilitators, etc.) in order to support themselves and limiting contact with the justice systems

2. Increase the number of Community Health Workers (R-ICMS CHWs, WPC CHWs) and other peer navigators by hiring and training individuals with lived experiences (including justice involve-

ment, mental health needs, substance use disorder, and/or people who are experiencing homelessness) to follow through via warm hand off to immediate services needed when returning home. There is a significant need to expand the use of CHW's to ensure warm hand off to services.

3. Explicitly tailor County contracting to incentivize service providers to incorporate the community health worker model in their service delivery work which would expand service capacity, build cultural competency, improve client/provider trust, and provide vital career track possibilities for the formerly-incarcerated—as well as addressing the significant workforce needs of a scaled-up alternatives-to-incarceration infrastructure.

4. Increase points of contact/engagement for CHWs to connect with clients outside of justice involvement

5. Expand CHW case management to include the individual's family and loved ones who play the role of immediate support pre and post incarceration.

6. Support training resources for Community Health Worker Model

Justice System Reform Ad Hoc Committee

Issues, Analysis, and Recommendations

Case Processing

Goal 1: Improve Diversion and Alternatives within the Court System

Description: Formally implement recent legislative behavioral opportunities for earlier diversion away from the justice system for people with behavioral health disorders, from the booking stage throughout the court process.

Item 1: Improve Equal Access to Treatment Resources

A. Issue

There are insufficient community-based mental health treatment placements available, including locked facilities, to provide an alternative to custody for people with behavioral health disorders who have been arrested and charged with a crime but who are eligible for Penal Code section 1001.36/1370 Mental Health Diversion, and/or could be released from jail to an appropriate treatment program pending trial or disposition.

B. Analysis

Remapping the criminal justice path of an individual with a clinical behavioral health disorder who was arrested and is in jail requires access to sufficient community-based placements and to sufficient forensic psychiatrists and psychologists to conduct timely/expeditious mental competency evaluations and/or Penal Code sections 1001.36 and 1370 Diversion assessments. Additionally, there is an insufficient number of doctors who speak non-English languages to evaluate non-English speaking people who are currently incarcerated.

C. Recommendations

Item 1: Potential Strategies

1. Improve equal access to all treatment resources for justice-involved individuals, wherever they may be (in or out of custody).

A. Encourage the Board of Supervisors to direct DPH/DMH/DHS to change eligibility criteria to ensure that all existing and future mental health placement resources are available to all people with mental health disorders in all stages of the criminal justice process.

B. To conduct intensive and extensive outreach at medical schools and professional organizations for

qualified mental health forensics, providing incentive bonuses for bilingual experts.

C. Create a front-end system with behavioral health professionals that enables the prosecutor to make a determination to provide diversion instead of filing charges or filing reduced charges, including, but not limited to, coordinated sharing of behavioral health disorders without harming rights.

2. Involve the public more in the court/justice system, obtain input from community.

Item 2: Education of Justice Partners on Mental Health Diversion

A. Issue

Notwithstanding legislative enactment of Penal Code sections 1001.36 and 1370 Mental Health Diversion which allows the court to divert/place into community treatment an individual with a mental health disorder arrested and charged with a crime for behavior that was related to the individual's mental health disorder, justice partners are slow to address this change of legislative policy.

B. Recommendation

Item 2: Potential Strategies

1. Increase collaboration (not adversarial process) to enable better outcomes that are trauma informed and respect individual care and rights.

A. Conduct educational seminars for justice partners about mental health disorders and mental health treatment as a first step in changing the culture of the criminal justice system to one that seeks treatment first whenever possible, not incarceration and punishment for people.

Item 3: AB 1810—Mental Health Diversion

A. Issue

The criminal justice system does not currently have a robust system to truly provide AB 1810 Diversion.¹³³

B. Analysis

Persons with mental health and/or substance use disorders spend longer times in jail due to the time it takes prosecutors and/or defenders to identify potential mental health diversion. There are insufficient mental health assessment and diversion teams for the caseload and multiple criminal court locations.

Arraignment stage is a missed opportunity for the mental health evaluations and off-ramping into a potential AB 1810 diversion analysis. The Court requires a trusted set of mental health experts to provide an analysis of AB 1810 or post-plea diversion, robust warm hand offs for the success of the programs and persons involved, and good court reporting. The Office of Diversion and Reentry is crafting an AB 1810 pilot but this really needs to be in all of the courts. It is critical to have all of the properly curated group of prosecutors, defenders, courts, and mental health team to ensure success (mental health teams). The specialized mental health teams should receive joint trainings and jointly develop policies, etc. to establish trust and comradery.

C. Recommendations

Item 3: Potential Strategies

1. Create a robust AB 1810 and PC 1001.36 diversion system led by mental health teams in every courthouse or judicial district that starts the identification of eligible persons as early in the court process as possible and connects them to individualized community-based treatment services. Access to these diversion programs should be available to any individual eligible for diversion, without regard to the location of the judicial district in which the person was arrested.

Item 4: Filing Stage Diversion

A. Issue

The criminal justice system does not currently consider care and services at the Intercept 2 point (Initial Charges) through diversion/non-filings against persons exhibit substance abuse and/or mental health disorders.

B. Analysis

Inequities exist at the pre-filing stages. The pre-filing stage is an opportunity to divert people out of the criminal justice system into treatment. The prosecutor has discretion to file charges and at what level. However, most of the time, the prosecutor is not aware of the person's health conditions. However, many times the law enforcement agencies do have information that could assist with the prosecutor's filing versus diversion determination.

C. Recommendations

Item 4—Potential Strategies

1. Create a front-end system with mental health professionals that enables the prosecutor to make a determination to not file but to instead allow diversion.

Note—Divergence Point: Approaches for diversion opportunities for people with serious high-level violent felonies.

Pretrial / Bail Reform

Goal 2: Reduce Pretrial Detention and Increase Services.

Description: Substantially and sustainably reduce pretrial incarceration of people with clinical behavioral health disorders while strengthening public safety by instituting a presumption of release and using a public health approach that links accused persons to services and programs without additional justice system contact to reduce the financial burden on the accused by upholding the presumption of innocence. The broader intention is to reduce the entire pretrial population in comprehensive ways that recognize and address the disproportionate impacts of race, socioeconomic status, and other factors that contribute to pretrial detention.

A. Issue

Forty-four percent of the Los Angeles County Jail population is pretrial, which means they are incarcerated without a conviction.¹³⁴ There is also an average daily population of 5,300 people in the County Jail who are classified as having a mental health disorder. The overlap within these two populations gives rise to a subset of people who are not convicted, yet incarcerated, and require a system of care to treat their mental health needs. Approximately half of the people in jail mental health housing (which does not include people who may be taking psychotropic medications but who are housed in the general population) are considered to be pretrial.¹³⁵

LA County has seen an increase in the number of people held in the County Jail who need holistic behavioral health treatment and services in a therapeutic environment. It is widely agreed that a jail-based system of care is not conducive to improving mental health or treating substance use disorders; rather, it often exacerbates conditions.¹³⁶ The following discussion and analysis led to the proposed recommendations below which aim to meet the above stated goal of substantially and sustainably reducing pretrial incarceration of people with clinical behavioral health disorders.

B. Analysis

Pretrial detention exacerbates wealth and racial disparities by causing job loss; loss of housing; isolation from family and community, even the loss of children to the foster care system; destabilization of low-income communities of color; and threats to the health and safety of our most vulnerable populations, particularly of those with behavioral health disorders.¹³⁷ Short-term jail confinement causes trauma, exacerbates current mental health disorders, and can even cause mental health disorders where they were previously absent. The additional financial burden of release through money bail and fines and fees further destabilizes accused individuals.

For those without the financial means to afford bail, this means a loss of freedom and pretrial incarceration while legally innocent. This impact is much worse on people with clinical behavioral health disorders, particularly those that are poor and whose financial conditions often lead to justice system contact.

Risk of failure to appear in court is also often cited as a reason to detain people pretrial. Sometimes people simply forget they must go to court, don't plan for it or do not fully understand the consequences of staying home. Others may have clinical conditions that impact their ability to appear in court but who would be able to do so with the right clinical supports.

Los Angeles County does not have a separate, independent pretrial entity tasked with reducing pretrial detention and connecting accused people with the services they need. Although the County has successfully launched diversion and reentry programs, these services provide for post-conviction assistance or for those who are incompetent to stand trial. The County has yet to fully address the conditions that cause continued law enforcement and justice system contact for people with behavioral health disorders earlier on in their legal proceedings.

We can look to models of pretrial reform in San Francisco County and Santa Clara County, jurisdictions which established independent pretrial services departments in 1976 and 1969 respectively. San Francisco County pretrial services is held by The San Francisco Pretrial Diversion Project (SF Pretrial), an independent nonprofit organization.¹³⁸ Santa Clara County's Office of Pretrial Services is an independent County agency established in 1969 which also compiles monthly statistics by tracking judges' release rates and defendant outcomes. These reports are shared with the courts, system partners, and the Board of Supervisors, allowing for continuous improvement, communication, and coordination. In 2013, Santa Clara expanded their court reminder system to use text and email notices (after they surveyed defendants on communication preferences), resulting in a 3% decrease in its failure to appear (FTA) rate. They have also been developing a pretrial app for defendants that will provide information on court dates, times, locations, supportive services, and other information.

C. Recommendations

Goal 2: Potential Strategies

1. Develop a Needs and Strengths-Based System of Pretrial Services: Establish decentralized cross-functional teams¹³⁹ to coordinate behavioral health needs and strengths assessments pre-booking and connect individuals with clinical behavioral health disorders to community-based systems of care through warm hand offs. Establish an independent cross-functional entity that is situated outside of any law enforcement agency. This cross-functional entity should be centered on a human centered, value-based, coordinated care model by incorporating personnel from various health departments, housing, employment, education, service providers, etc. to conduct needs and strengths assessments and connect people to a holistic set of services tailored to individual behavioral health disorders.

2. Expand Cite and Release Practices and Policies: When law enforcement agencies do come into contact with someone with clinical behavioral health disorders, they should cite and release at the point of contact and ensure a warm hand off to service providers whenever possible. For people with those needs who are taken to a police station, they should be assessed prior to booking for release, utilizing a needs and strengths assessment, with the presumption of release with a warm hand off to service providers.

3. Reduce Failure to Appear: Support the return to court, especially for those with clinical behavioral health disorders, with:

- A. Text and telephone reminders (provide cell phones and/or service as needed making sure correct number is on file), explaining potential consequence of non-appearance (and making sure to address any issues that may prevent lack of understanding);
- B. Transportation (via vouchers, ride sharing, etc.);
- C. Childcare;
- D. Evening court hours so employment is not impacted;
- E. Clear verbal and written instruction that assure that the person truly understands what they need to do and where they need to be (if they are unable to comprehend link with social services or advise PD);
- F. A good line of communication with their public defender, who will also require more support. (the PD should, from interviews with the client, be determining a need for mental health support pre-trial); and
- G. A speedy court date, especially for those needing long term services. (specifically, behavioral health treatment).

Mental Health & Law Enforcement

Issues, Analysis, and Recommendations

Goal 3: Reduce and Improve Interactions between Law Enforcement and Mental Health; Increase Diversion Opportunities and Expand Training for Law Enforcement

Description: Scale up mental health and community-based response to behavioral health crises to substantially reduce contact between people with behavioral health disorders who are in crisis and law enforcement. When there is contact between people with behavioral health disorders who are in crisis and law enforcement, ensure that law enforcement has the training and partnership with behavioral health personnel to respond appropriately to each situation and to divert many more people into community-based treatment and services.

Item 1: Crisis Response

A. Issue

Expanding access to effective crisis response that reduces the number of people with mental health and substance use disorders interacting with law enforcement, getting arrested, booked into jail, being charged, etc.

B. Analysis

The Subcommittee agreed that there were substantial barriers to people accessing effective non-law enforcement response for behavioral health crises, including significant wait times for callers calling DMH's ACCESS (Access to Community Care and Supportive Services) 24/7 line. These barriers are a problem because many situations do not need law enforcement response, law enforcement response may increase the likelihood of the situation escalating, and law enforcement responders are more likely to make arrests and book people into jail, thereby increasing the number of people with behavioral health disorders in the jails.

One best practice/model is Eugene, Oregon's CAHOOTS program in which 911 operators funnel almost 20% of 911 calls to teams of psychiatric social workers rather than to law enforcement. There are, however, significant barriers to implementing this model in Los Angeles. One is that DMH has a separate ACCESS line that is not integrated into Los Angeles County's 911 system, and also 911 operators who conclude that calls to their system would be best handled by DMH Psychiatric Mobile Response Teams (PMRT) cannot directly contact a DMH ACCESS operator, but must instead go through the same automated phone tree that members of the public encounter when they call the ACCESS line.

C. Recommendations

Item 1: Potential Strategies

We propose a number of options for increasing non-law enforcement responses to behavioral health crises.

1. Improving staffing of DMH ACCESS line to minimize caller wait times;
2. Integrating DMH ACCESS line with 911, or alternatively providing a mechanism whereby 911 dispatch can gain direct access to DMH ACCESS line so they can expeditiously refer calls they conclude do not require law enforcement response;
3. Increase the number of DMH Psychiatric Mobile Response Teams (PMRT) to reduce service wait times;
4. Increase the number of crisis beds available in the County and implement a data base that tracks the beds available at each treatment facility to avoid delays and calling multiple hospitals to secure a bed;
5. Increase the ambulance contracts to improve response time;
6. Ensure 911 operators are sufficiently trained in mental health crisis assessment to identify behavioral health crisis calls that do not require a law enforcement response. 911 operators should be trained about LAPD-Mental Evaluation Unit (MEU) Line, LASD-MET Triage Desk, 211, ACCESS Line, Public Health Line and DHS Call line resources;
7. Creating a third option for behavioral health crises, e.g., increase level of mental health services provided by CBOs possibly accessed through mobile app or dedicated phone line; and
8. Invest in public education campaign to encourage people to use DMH ACCESS line, CBO network, or suicide prevention hotlines when appropriate rather than 911 for behavioral health crises.

Item 2: Collaborative Law Enforcement and Mental Health Clinician Teams

A. Issue

While there has been an increase and additional expansion is underway, there are not enough MET / SMART/ Independent Police Departments co-response¹⁴⁰ teams to respond to all of the mental health-related calls received that require a response that includes law enforcement personnel. Some other Los Angeles County law enforcement agencies have no DMH/law enforcement co-response teams and other have co-response teams available only during daylight hours. Slow response time means fewer officers in the field will call the teams, not wanting to wait for them to arrive, and many people will not benefit from this effective intervention.

B. Analysis

Ideally, there should be enough SMART, MET and other co-response teams to respond to 90% in crises and arrive in time to help positively impact the outcome of the incident. Mental Evaluation Teams (MET) receive more than 700 hours of formal training and certifications to two (2) national standards with regard to nonviolent crisis intervention. MET personnel are trained to such a degree that they are nationally certified instructors in crisis de-escalation. Having a MET unit available and able to respond with patrol deputies to reported crises is like sending the equivalent of a mental health SWAT team to help patrol officers/deputies. It is no surprise then why crises are generally resolved more favorably, without uses of force, when MET or SMART units are on scene to help de-escalate.

For the Sheriff's Department, more than half (53%) of all 6,755 crises that resulted in a WIC §§ 5150 or 5585 "hold" in 2018 were handled by patrol deputies alone without MET support, due to insufficient MET staffing. The Civilian Oversight Commission has recommended a minimum of 60 MET units; whereas, today LASD MET comprises just 33 regional units. A similar number of crises calls that did not rise to the level of a WIC §§ 5150 or 5585 "hold" in 2018 were also handled by patrol officers without MET support.

MET and SMART law enforcement/DMH co-response teams are extremely effective in de-escalating conflict between law enforcement and individuals with mental health needs and can help connect people to appropriate (and ongoing) treatment and services, instead of further justice system involvement. In its 2018 report, LASD MET teams demonstrated a significant decrease in use of force incidents and cost savings to the County. Fewer than 5% of calls handled by MET, SMART, and other Independent Police Department/DMH co-response teams resulted in arrest while 95% of cases received community-based referrals or services.

C. Recommendations

Item 2: Potential Strategies

1. Substantially increase the number of police / mental health collaborative response teams (SMART/MET) throughout the County—LAPD, LASD (60 minimum) and all other law enforcement agencies, to meet the growing need, as well as increase the availability of co-response teams in departments where such teams are currently available only during daytime hours. The majority of all mental health involved crisis calls to law enforcement should be responded by co-response teams on a 24-hour basis, seven days a week (24/7). This includes LASD/MET, LAPD/SMART, and Independent Police Departments' MET teams.

2. Implement non-crisis mobile response teams to address the gaps, as they have been identified:

A. To provide timeliness of response, follow through with clients in crisis who do not meet criteria for involuntary hospitalization. An important need for these teams is to intervene at the earliest moment possible, responding out into the field to support and take action on client and family needs. If the teams are able to address an urgent crisis and begin to provide services, supports and linkage, emergent crises and involuntary psychiatric hospitalization can be averted, thus achieving decreased trauma on the clients and families and decreased inpatient costs for the County and Law Enforcement.

B. Have peers as members of the mobile response teams, as long as it is clinically warranted. The teams will respond to clients and families with the position of attempting to keep the client out of the hospital/jail and providing ongoing support and linkage to services. Peers will create an additional level of trust from the clients and allows strong relationships to develop between the teams and clients.

Item 3: Alternative Clinical Settings

A. Issue

Individuals, families and law enforcement officers need more options for where to bring or refer people experiencing behavioral health crises. The County lacks a range of options for most communities all over the County, for people who do not meet 5150 criteria but need treatment and services of some kind.

B. Analysis

From service providers to law enforcement, there is a critical need to have accessible centers where people can go for services, be dropped off in times of need and or/crisis, and check in with health professionals with whom they are more likely to report accurate details about current needs, thus enabling better services and notifications to loved ones if possible. For example, the County does not have a behavioral health Urgent Care Center in all the Service Area Locations; there is none in Service Area 1, 3 or 7, and the one in Service Area 2 operates only 12 hours. These centers should be able to receive patients quickly and efficiently, so law enforcement and collaborative teams can immediately return to the field to provide services.

C. Recommendations

Item 3: Potential Strategies

1. Develop and expand a decentralized range of clinical spaces throughout the County, including building a behavioral Urgent Care Center in Service Area Locations 1, 3, and 7 and having the one in Service Area 2 operate 24 hours a day, as well as the resourcing of current sites where there is capacity, that are accessible to law enforcement, families and individuals and provide a holistic service-based model informed by various health departments (DHS, DMH, Public Health) as well as CBO's identified by the Work Group. These spaces should be run solely by health and community-based organizations and include some combination of expanded sobering/detox centers, cooling off and respite centers, and mental health urgent care centers. Community health workers could conduct outreach to encourage individuals to utilize these centers and become engaged in a range of services (substance use treatment, housing, employment, etc.). Law enforcement and community members should be educated to understand these options as alternatives to 911 and arrest and jail.

Item 4: Community Education Campaign

A. Issue

Members of the public sometimes treat homelessness and mental health and substance use disorders as a law enforcement issue and seek law enforcement intervention to deal with the normal consequences of experiencing homelessness, such as living life in public on the street. This includes such things as movement into residential neighborhoods, sleeping and drinking in public, lack of sanitary facilities, lack of storage and cooking facilities, etc.

B. Analysis

Some of these issues can be addressed through supportive housing, shelters, substance use and mental health

treatment, but the fact is that there is not enough affordable housing and many individuals are forced to live on the street or in their cars. So how do we accommodate the competing needs/desires of individuals experiencing homelessness and local residents / business owners and de-escalate the friction that can develop in these situations?

C. Recommendations

Item 4: Potential Strategies

Work with community-based organizations and impacted individuals to develop a public awareness campaign to educate the public on what it means to be experience homelessness or have a mental health needs and to reduce the stigma associated with both. Incarceration should not be viewed as a solution to homelessness. The public should be educated as to non-law enforcement resources, such as the Department of Mental Health Access lines and community-based organizations; de-escalation teams such as the MET teams; the possibility of mediating disputes between people who are experiencing homelessness/residents/business owners, building relationships between the local community, law enforcement, community-based organizations, schools and mental health professionals. It would also be beneficial to have additional outreach workers to respond to these types of calls, with the support of law enforcement when required. There are a number of resources already in place, including the LA HOP Line which allows anyone in the community to make referrals for people who are experiencing homelessness or issues related to homelessness. LA HOP triages the referrals to determine who is the best entity to handle it, i.e. LAHSA, E6, HOME, etc.

Item 5: Crisis Intervention Team (CIT) Training

A. Issue

Provide specialized training to law enforcement first responders and 911 dispatchers and desk personnel to improve responses to behavioral health calls, with the goal of improving the safety of people experiencing crises, officers and others and connecting people with appropriate treatment and care instead of arrest and booking into jail custody.

B. Analysis

To date, only 20% of Sheriff's Deputies in patrol have completed CIT training. This training must be prioritized as a mandate for officers/deputies new to patrol (within their first year) as with the LAPD Mental Health Intervention Training. DeVRT (De-Escalation and Verbal Resolution Training) should continue to be a requirement for all custody deputies.

Continued training and refresher training is of the utmost importance for LASD, LAPD and all local law enforcement officers, both custody and patrol. There is not always the option of back-up and MET units, which makes the training of individual sworn officers/deputies essential in their responses to people in behavioral health crisis, to identify signs of a behavioral crisis, de-escalate potentially volatile situations, provide appropriate treatment and services to those in crisis and to prevent injury and loss of life. CIT training should connect police officers to community-based resources and peer responders and focus on developing those relationships so that officers can connect families and individuals to appropriate services and see these services as a treatment-first alternative to punitive responses such as arrest and jail. It has been proven that a training by an officer/deputy and clinician is highly effective as it demonstrates a unified effort.

C. Recommendations

Item 5: Potential Strategies

1. All law enforcement officers in Los Angeles County should be trained in a formal CIT curriculum that incorporates connections and networking with neighborhood-specific community-based resources with a treatment-first approach. LAPD has a 40-hour training that is taught by Officers and Clinicians. Other municipalities have a 16-hour training similar to LAPD's training.
2. New curriculum should be developed for 911 dispatchers and desk personnel. CIT refresher courses are needed to help ensure first responders practice the skills every year or two after the initial CIT training. Mandated refresher training should include the use of training simulators and/or live scenario training where officers/deputies must probably demonstrate their ability to de-escalate patients to ensure they are capable of doing so when on patrol.

Mental Health Court Programs

Goal 4: Increase and Improve Access to Treatment Services for Court-Involved People

Description: Expand and ensure easy access and timely linkage to treatment services for clients involved in the court process to a broader range of behavioral health programs and expand the diversity and capacity of those programs. Create a flexible and integrative service model across the Departments of Mental Health, Health Services and Public Health, in order to provide the most responsive system possible to client's service and housing needs. Streamline the referral process from arraignment to disposition, and avail Judges and Attorneys of the general menu of options available to qualifying clients requesting mental health, substance use disorder, or co-occurring treatment services.

Item 1: Client Access to Appropriate Level of Treatment

A. Issue

Client access to the appropriate level of treatment based on a clinical determination regardless of court program.

B. Analysis

The group consensus was that when developing a treatment plan for each client it is most important that decision-making be “client-focused” rather than “court program” focused. Clients should be able to access the appropriate personal level of care as the priority. Court programs should be able to choose from the County's available treatment resources what services will be in the clients' best interest clinically regardless of where the referral is originated.

Today's diversion and alternatives to incarceration programming is comprised of different entities (ODR, DMH, SAPC, etc.) that have different resources and treatment responses under their specific jurisdictions. Therefore, someone in an ODR program might not have easy access to another level of program or treatment not provided by ODR. For example, if one needed a secure facility environment for appropriate treatment services such as provided by Olive Vista in Pomona, it may not be easily included for the ODR client. Likewise, someone graduating from a Court Linkage program may not have adequate access to DMH or ODR housing. These are bureaucratic and funding roadblocks that do not put the client first.

C. Recommendations

Item 1: Potential Strategies

1. Increase the capacity of alternative treatment programs for individuals with justice involvement (Intensive Outpatient, secure Mental Health Residential Treatment Facilities, Dual Diagnosis Residential Treatment Facilities, IMDs). Expand and integrate court-based services in terms of “staffing on the ground” in order to service as many individuals as possible as rapidly as possible.

Item 2: Consistent Diversion Practice

A. Issue

There is currently no coherent strategy that clearly identifies protocols to refer individuals to the diversion programming that will assist that person most effectively. Current placements appear to the public as random and not based on clinical or other individual needs.

B. Analysis

Our Work Group could not identify a coherent strategy that explains why cases “land” where they do.

Should there be a protocol that identifies best practices in referring diversion cases to a specific program? Current practice appears almost random and, again, does not put the needs of the client first, but rather the needs of the criminal justice system first. Such protocols should be clear and transparent to the community, so the right individual is referred to the appropriate entity that can assist that individual with the most effective resources for that person.

C. Recommendations

Item 2: Potential Strategies

1. Develop a coherent strategy for directing clients to the appropriate court-based program at the inception of the diversion dialogue. The decision to refer an individual with serious mental health needs to a particular program or service should be based upon the best fit available and amenable to the client.

Item 3: Real-Time Data System Depicting Diversion Resources

A. Issue

Our existing mental health courts have carefully planned for the resources (housing, treatment, etc.) that will be required to adequately serve their participants. The linkage that connects our designated mental health

courts to treatment resources is defined by the development of the program. This is not the case for the remainder of the County's criminal justice courts.

B. Analysis

We spent most of our discussion on the Court Linkage Program and general concepts. Time constraints did not allow us to brainstorm how, under AB 1810, all Superior Courts will need to access treatment resources for their participants. There has been no initial preparation linking treatment, housing, mental health and SUD treatment resources to the overall criminal court system that will be participating in PC 1001.35-.36 cases. How will all of the non-Mental Health Courts cope with the complexity and geography of our County's treatment resources?

As defendants pass through our regular criminal court system, there has been no advance linkage of treatment, housing, and other resources to all of the County court houses. How will a judge and the court team be advised of what resources are available in their area and the availability of a particular program in real time? Who will arrange for easy access by the court and the individuals to be served?

C. Recommendations

Item 3: Potential Strategies

Improve awareness of existing Mental Health Court Program resources (and availability thereof) among judicial officers and court personnel (e.g. utilize software to develop a real-time map of all existing alternative placements)

Item 4: Underutilization of Conservatorships

A. Issue

Conservatorships and temporary conservatorships are underutilized to transition currently incarcerated people to long-term care in the community.

B. Analysis

Historically, the Los Angeles County Conservatorship Investigator refused to initiate conservatorships for people in jail custody, arguing that jail is a “suitable alternative” to Lanterman-Petris-Short (LPS) conservatorship (see W.I.C. §5354). This meant that conservatorship could not be established until an individual was released from custody. Many, if not most, of these individuals would not receive discharge and transition services and the establishment of a conservatorship would require new 5150/5250 hospitalizations.

Two significant statutory changes in 2018 support early intervention with conservatorships. W.I.C. §5352.5(a) was amended to provide that “The custody status of a person who is subject to the conservatorship investigation shall not be the sole reason for not scheduling an investigation by the conservatorship investigator.” In addition, Penal Code §1001.35 implemented a new state policy favoring diversion of criminally charged people with mental health needs into local treatment services. These changes call for increased initiation of LPS conservatorships for qualified individuals.

C. Recommendations

Item 4: Potential Strategies

1. Formalize and implement the link between jail and conservatorships through a Board of Supervisors order stating a policy directing the use of LPS conservatorship for people in custody and people who have been diverted who, because of mental health needs, are considered gravely disabled under the statute.
2. Designate additional agencies (as permitted by current statute) to directly apply to the court for LPS conservatorship.
3. Separate the conservatorship investigator and public conservator functions so that each is independent and free from conflicts of interest.
4. Explore expanding forensic full-service partnerships under the aegis of additional County agencies.

Item 5: Conservatorship Processes

A. Issue

The current processes used to establish LPS conservatorships are mired in counterproductive tasks and are ill-suited to current clinical practice.

B. Analysis

The current processes used to establish conservatorship are based on a 50-year old model driven by a care system that no longer exists.

State hospitals are no longer the essential initiator of conservatorships. Institutions for Mental Disease are no longer a primary tool for long-term care and are largely disconnected from modern approaches to care such as the recovery model, supported decision-making and community supports.

C. Recommendations

Item 5: Potential Strategies

1. Conservatorship recommendations should be initiated by provider sources. Hospitalization should not be required to do this as sufficient statutory authority currently exists for the local mental health director and/or the director's designee(s) to initiate the conservatorship process. However, legislative change should be sought if there is resistance to initiating conservatorships from the community.
2. The current LPS conservatorship investigator should be required to collect and track efficiency and effectiveness data. Based on these data, process simplification and task reduction should be undertaken to improve the initiation and establishment of conservatorships. The metrics currently collected should be examined to determine whether they are adequate to serve this purpose. The DMH should establish a pilot project to test and validate these approaches. Process and outcomes data should be compared to current practices.
3. Support-based placement and wrap-around services may be considered as an alternative to IMD placement for conservatees. Similar options should be explored for placement during the conservatorship investigation and court process to facilitate clients being treated in the appropriate level of care. T-Con powers may be adequate to accomplish these tasks.
4. The statutory requirement of an individualized treatment plan within 10 days of the establishment of a conservatorship should be strictly enforced by the court (see W.I.C. §5352.6). That plan should be developed by the treatment provider and its tasks, deadlines and outcomes should be enforced by the court.

Reentry

Goal 5: Improve Reentry Practices

Description: Improve pre-release and reentry practices to ensure that individuals, including those with co-occurring mental health and substance use disorders, can transition directly from jail into appropriate community-based treatment and services.

Item 1: Release Dates

A. Issue

Unpredictability of release dates and after-hours releases of currently incarcerated.

B. Analysis

Release planning for currently incarcerated people who are experiencing mental health needs, substance use disorders, homelessness, medical conditions and other issues has expanded significantly in the last two years, with over 3,000 people at a time in LA County jails now receiving release planning services. One of the biggest barriers to success for these programs is the unpredictability of release dates and after-hours releases. Release planners expend considerable effort to secure a client's linkage to a community-based treatment or housing bed, only to discover that the client has been unexpectedly released early, and often in the middle of the night. In many cases, the bed is never accessed, the client is lost to follow up, and the opportunity for connection to services missed.

Approximately 40% of currently incarcerated people are pre-sentence, and approximately 20% are partially sentenced; for these people in custody, release dates are not predictable because their court process is ongoing. They may be released at any upcoming court date, and in many cases are released directly from court without returning to jail. People with mental health needs are required to return to jail to be cleared for release by a mental health clinician. While this is meant to help ensure safety, this often results in people with mental health disorders being released from jail late at night, after returning from court in the early evening and waiting to be cleared and processed out.

For currently incarcerated people who are sentenced, the Sheriff's Department (LASD) lists an expected release date on its web-based portal, but this date often turns out to be incorrect. In some cases, it may not reflect any additional open charges. Sentences may be shortened after milestone credits are applied from jail work programs and educational programs, and the credits are applied at irregular intervals depending on when class

providers submit attendance information. In some cases, the application of these credits triggers immediate release. LASD also reduces sentences for many people in custody due to overcrowding, based on a percentage of time to be served (current percentage is 10%). Individuals in custody who are sentenced in court to a short sentence may be released the same night due to the percent time calculation. There is no mechanism for an alert to be sent to release planning staff notifying them of changes in predicted release dates. Currently, release planners must manually look up each case individually on the LASD portal to check whether a date has been added or the prior date has been changed.

Releases during evenings, nights and weekends pose challenges for linking clients directly to services, because even though some services such as interim housing and residential treatment programs operate 24/7, almost none accept new clients for intakes after normal business hours.

Coordinated releases can be requested to schedule a release for a specific date and time window in cases where the person is being picked up by a community program, Probation, or is being transported directly to a program. These releases are arranged by social workers, medical case workers, and in-reach staff from community-based organizations, and are facilitated at the point of release by the LASD Community Transitions Unit (CTU). A CTU Custody Assistant hand-walks the person individually through each step of the release process to the waiting provider outside the jail door.

In 2014, California Senate Bill 833 was passed, which required jails to offer people the option of staying up to an additional 16 hours or until normal business hours, whichever is shorter. Jail release planners encourage currently incarcerated people to take this option if they are released at night; however, when offered, few people choose to stay longer. Century Regional Detention Facility (CRDF) which houses women does not conduct releases after 10:00 p.m. unless the person is being picked up by a verified person. However, men are released from LA County jails around the clock.

C. Recommendations

Item 1: Potential Strategies

1. Change release time policies for men to match those of women at CRDF, in order to ensure that people are not released overnight without the ability to link directly to programs or interim housing. As with women, men would be able to leave overnight if they have a safe place to go and verified transportation.

2. Provide funding to community-based organizations to expand intake hours for interim housing programs and treatment programs to include overnight and weekend hours.
3. Fund a transition center within a few blocks of the downtown jails, operated by a community-based organization and providing a welcoming place to stay overnight for people released after hours, with beds, food, showers, telephones, clothing, service navigation and transportation.
4. Implement more frequent LASD recalculation of release dates for fully sentenced clients receiving release planning services, or provide data needed for release planning staff to better calculate the dates. Develop and implement an automated mechanism to notify release planning staff of release date updates/changes for clients receiving release planning services.
5. Reallocate resources to allow for an increase in coordinated releases for clients exiting directly to programs, so that a specific time and date for release can be set and linkage facilitated.

Item 2: Co-Occurring Disorder (COD) Treatment Services in Jail

A. Issue

To provide currently incarcerated people with co-occurring mental health needs and substance use disorders with a better chance at successful reentry, specifically to reduce the likelihood of substance use relapse and increase linkage and adherence to treatment in the community.

B. Analysis

Per the Bureau of Justice Statistics, 64 and 63 percent of currently incarcerated people in the United States met clinical criteria for mental health needs and substance use disorders (SUD), respectively. Furthermore, 76 percent of currently incarcerated people with mental health needs also met clinical criteria for SUD. In Los Angeles County Jail, the Department of Health Services (DHS) Correctional Health Services (DHS-CHS) estimates that among the approximately 5,000 people with mental health needs in the jails on any given day, 76% have a co-occurring SUD, for an estimated 3,600 people with co-occurring disorders (COD). They also estimate that many more currently incarcerated people on any given day report issues with alcohol and/or opioid use.

Prior to May 2017 there were no addiction services in the jails. DHS-CHS now operates the Substance Treatment and Reentry Transition (START) program, which provides in-jail SUD treatment to approximately

500 clients on any given day. The START program operates in 4 different facilities: at Pitchess-South Facility serving the general male population, Men's Central Jail serving the gay and transgender population, CRDF serving the general female population, and Twin Towers serving men with co-occurring mental health and SUD diagnoses (COD). The program uses evidence-based practices including cognitive behavioral therapy and motivational interviewing.

There are currently 95 COD treatment slots in START. Given the estimate of 3,600 people with COD, if half of those people agreed to start services while incarcerated, a total of 1,800 slots at a time would be required to meet the need. Starting treatment in jail takes advantage of the time in custody to begin services and better sets up clients to successfully continue treatment in the community.

Medication Assisted Treatment (MAT) can help clients with alcohol and/or opiate use disorder better engage in treatment, reduce cravings and avoid relapse. Comprehensive MAT services have been shown to reduce death from overdose, HIV transmission, and ongoing substance use. Studies in re-entry populations have consistently demonstrated that offering MAT to correctional populations increases engagement in SUD treatment and MAT on release.

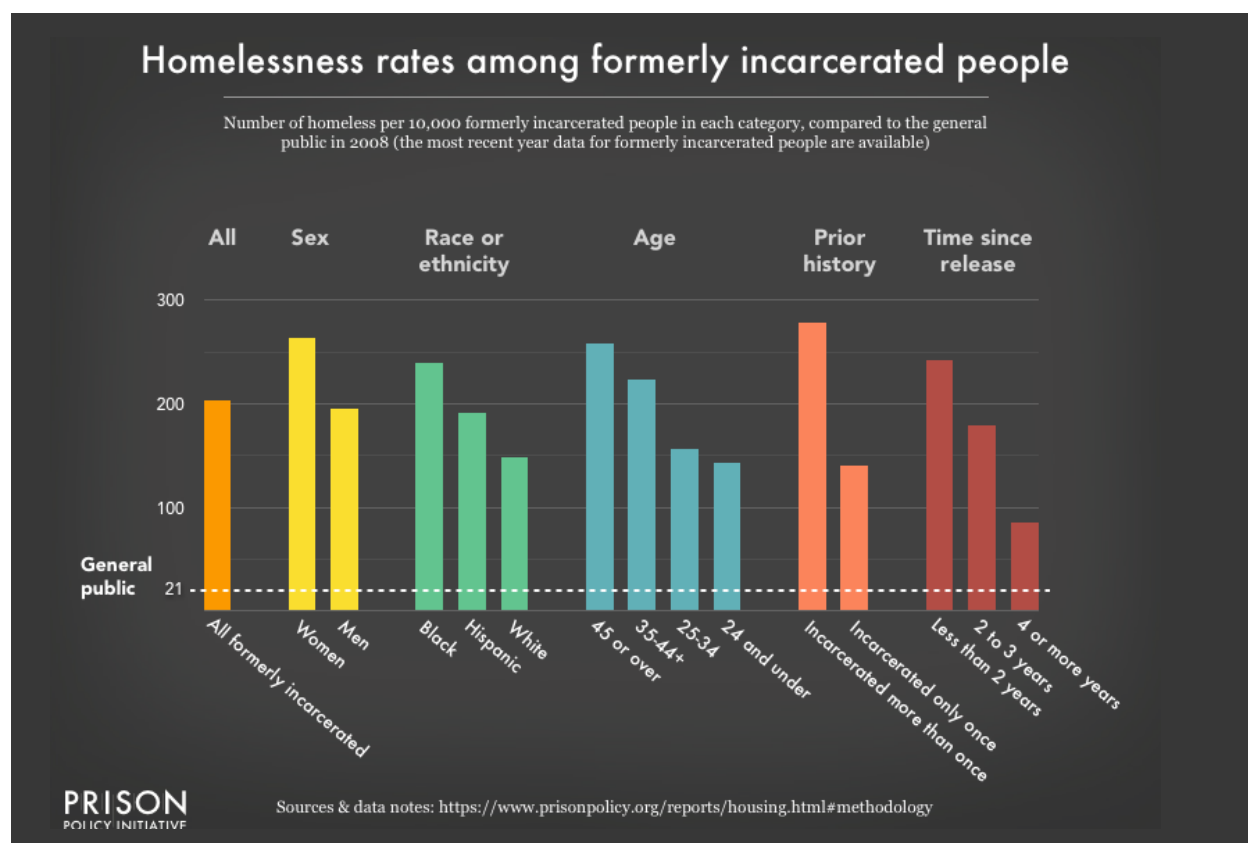
Currently in LA County jails, patients with alcohol and/or opiate use disorder are offered oral naltrexone, and pregnant women are offered buprenorphine. This is a good start but does not meet the level of a comprehensive MAT program. Community and correctional standards of care strongly recommend offering comprehensive MAT services, including buprenorphine, methadone, and long acting naltrexone, to correctional populations. These services can be safely implemented in the correctional setting and are evidence-based treatment and harm reduction strategies.

Finding SUD treatment beds in the community for individuals leaving jail is challenging. Many community providers have not previously accepted clients directly from jail. The Department of Public Health—Substance Abuse Prevention and Control program has been working to develop special referral mechanisms for this population and to identify agencies to accept them; however, only a very few agencies will accept clients with significant mental health needs.

C. Recommendations

Item 2: Potential Strategies

1. Explore ways to incentivize community treatment facilities to accept patients from jail with co-occurring mental health needs and SUD.
2. Expand access to START program SUD treatment services in County jails from the current 500 people in custody to at least 1,000 people in custody, with the goal of expanding to serve all those in need and an emphasis on currently incarcerated people with co-occurring mental health needs and SUD.
3. Expand and enhance MAT treatment services in the jails to provide:
 - A. A comprehensive withdrawal management program, including methadone and buprenorphine
 - B. Full spectrum MAT for opiate use disorder, including buprenorphine, methadone, and long-acting naltrexone
 - C. Specialty MAT clinics to allow patients to access patient-centered, harm reduction services on-site in the jail



Community Engagement Ad Hoc Committee

Issues, Analysis, and Recommendations

A. Issue

The Community Engagement Ad Hoc Committee has been tasked to plan a series of community mapping and listening sessions in selected communities to hear, elevate, and empower community members and gather information from community members and community organizations about available and needed services, supports, and policies that promote alternatives to incarceration. We seek to understand what services and supports prevent incarceration and assist those re-entering their communities after incarceration. Where services are currently offered, we are interested in understanding who is being served and who has limited or no access to support. We recognize that community members need access to health, services, good employment, affordable housing, and thriving communities and seek to understand inequities in the distribution of resources and opportunities that promote well-being.

The Committee will organize workshops in seven communities that have been identified through the Million Dollar Hoods and Advancement Project assessments as a sample of areas where there are significant needs and gaps in resources available to prevent and address high rates of incarceration. Workshops will be held in the following communities: South LA with a connection to Compton, the Antelope Valley with a connection to Lancaster, East LA, Long Beach, Pacoima, the San Gabriel Valley, and Pomona.

Community members living in these communities and surrounding neighborhoods, along with service providers, will be invited to elevate their own concerns and suggestions for improvements. Although these workshops are not able to touch every region impacted by incarceration, the hope is that we will be able to continue these conversations with others in different areas of the County as we envision, improve, and implement the Alternatives to Incarceration Roadmap.

B. Analysis

The ad hoc committee is focused on designing workshops that create a meaningful, intentional, and respectful environment for individuals and families that have been directly and indirectly impacted by incarceration to share information, identify challenges, and suggest opportunities for efforts aimed at preventing incarceration and addressing the needs of people re-entering after incarceration. Workshop participants also include key stakeholders such as service providers, advocacy organizations, and County health departments. The workshops

will focus on soliciting and incorporating community feedback to shape recommendations for the final report and inform the full implementation of the roadmap for years to come.

To design a workable, effective alternative system to incarceration, it is necessary to meaningfully engage key stakeholders—primarily justice-impacted individuals & their families, though also including service providers and advocacy entities—in highly-impacted areas. This engagement will not function as a one-way, reporting-out process nor to simply gather assent to solutions prepared by others. The ad hoc committee’s submission of findings from the community workshops should not stand alone and apart in the final report but, rather, be woven throughout the report—and directly inform (or reshape) interim recommendations drafted by the other ad hoc committees in advance of the community engagement.

C. Recommendation(s)

A. Workshop Process and Logistics

1. Elevate and honor community voices. The Alternatives to Incarceration Work Group and the Board of Supervisors affirm their intent to use community voices to inform choices and drive actual reform. Explicit commitments to follow-through—in terms of continuous community engagement on findings, recommendations, and implementation as the process moves along—would be an important step signaling that this community involvement is not an exercise but will drive change for the betterment of the entire County. Such assurances will not only build community goodwill and trust in the process—likely improving both the workshop’s outreach efforts and quality of responses—but will, ultimately, lead to alternatives that best suit local circumstances and are most apt to succeed in preventing, diverting from, and healing from incarceration here in Los Angeles County.

2. Include those most impacted by incarceration: The community engagement strategy will utilize a strength-based asset mapping approach while identifying gaps in services and resources. The ad hoc committee will connect to existing organizations, community advisory boards, and/or community facilitators to co-host workshops in the prioritized communities with a goal to elevate the leadership of people that have been impacted by the justice system. Outreach efforts will aim to ensure that vulnerable subpopulations such as formerly incarcerated people, LGBTQ, youth, family members of people who are incarcerated, houseless community members, and line staff in service organizations, are invited and able to fully participate in the workshops. Unions, schools, churches, service providers, and community organizations will be enlisted to both support outreach efforts to those most impacted by incarceration and to participate in the workshops. The workshops will also invite members of the Sheriffs Oversight

Committee, DPH Regional Health Teams and DMH Service Advisory Coordinating Committees (SACC) to participate, and build on recent outreach efforts of LAHSA, the DPH Office of Violence Prevention, WPC Collaboration Team, and other community-based organizations. While law enforcement will not be invited to attend the workshops, they will be informed about the meetings and asked to support community members wishing to participate. The workshop will include discussions on how to best work effectively with law enforcement and recommendations from the workshops will be subsequently shared with police and sheriff departments.

3. Support participants and equitable participation: To maximize community participation, stipends should be offered to community members to cover costs related to workshop participation, including childcare and transportation. The workshops will be held after work hours or on weekends to support greater involvement in the process, and healthy food should be offered. There is also a need to have childcare available during the workshop so that parents and caregivers are able to participate. The workshops will also follow ADA requirements and provide language translation. Resource tables and resource staff will be present at each workshop to link participants to available services related to housing assistance, legal assistance, entitlement programs, and health services.

The format at each workshop will include interactive activities so that all participants can fully engage and share their ideas, perspectives, and concerns. An opening speaker will ground the workshop and set the tone for the work we will try to accomplish. Community members will be recruited to serve as facilitators and facilitation training will be provided.

4. Provide on-going communication: Use social media and outreach activities to advertise the community workshops, and employ various strategies including robotic calls and emails to communicate with workshop participants. Ensure that appropriate feedback loops and media communication plans are developed in partnership with workshop participants so that individuals are engaged and aware of how information will be utilized for the ATI reports, as well as for any additional planning documents.

B. Engagement of Currently Incarcerated People

Hold 3 workshops in the County and/or local jail system and 1 workshop in a juvenile hall to solicit feedback from individuals that are currently incarcerated in LA County. Workshop attendees should be able to participate without any risks; information gathered at the workshop will be treated as confidential and will be shared without attribution or identifying information. Additionally, incarcerated individuals should be allowed to

provide information through anonymous surveys or postings that will be managed by the Health Agency. The Office of Diversion and Reentry, Department of Mental Health, the Sheriff's Department, and other partners should help plan for workshops to be held between June and December. The outreach for engagement of currently incarcerated people may also include connecting to family members who currently have a loved one incarcerated in Los Angeles County.

C. Advisory Collaborative of Impacted People

The creation of an advisory collaborative is necessary to ensure there is continuous feedback and accountability to the prioritized communities and LA County at large in the implementation of the comprehensive roadmap. The advisory collaborative will communicate community solutions to the ATI Work Group and can serve to review recommendations and drafts of the final report. The advisory collaborative can also interface with local law enforcement to support the communication of community needs and feedback after the workshops. Possible sources of support for the Advisory Collaborative include the Whole Person Care Re-entry Health Advisory Collaborative and the DPH Office of Violence Prevention Community Council.

Funding Ad Hoc Committee

The Alternatives to Incarceration Funding Ad Hoc Committee was established to assess and outline resources needed to implement recommendations by the Alternatives to Incarceration Work Group to scale up ATI services in the County.

While the funding needs assessment will be based on programmatic recommendations ultimately developed by partnering Work Groups, the Funding Ad Hoc Committee continues to lay the foundation for considerations that may be weighed and potential findings and recommendations. To that end, the Funding Ad Hoc Committee provides the following update for the ATI interim report.

Funding Landscape

In advance of recommendations from other Work Groups, the Funding Ad Hoc Committee has begun to draft an at-a-glance matrix of key funding streams that can potentially support the scaling up of ATI efforts. When developed, this document will identify funding streams, eligible uses, current County policy for utilization, and scale of funding available to the County. While the ad hoc committee is not positioned to line item budget recommendations from each fund, the matrix will help identify gaps and support the Board of Supervisors and Chief Executive Office in identifying potential sources of funding for this work.

Ad Hoc Committee Focus Areas

Based on initial discussions among its members and preliminary information from other ad hoc committees, the Funding Ad Hoc Committee has identified the following principles and areas for exploration that can guide funding recommendations.

Funding Principles—The Funding Ad Hoc Committee has developed a shared set of principles to guide its recommendations.

1. Racial and Geographic Equity—Does funding promote racial & geographic equity?
2. Care Integration—Do funding strategies adequately leverage multiple funding streams and support an integrated system of care?
3. Transparency—Does funding reflect transparency in public budgeting and spending, as well as input from stakeholders and communities?
4. Fiscal Sustainability—Are funding recommendations grounded in sound fiscal principles and practices that ensure the sustainability of programs and the overall County budget?

Scope of Services—A full spectrum of services will need to be funded to address ATI needs, including:

1. Substance use disorder treatment services, including medication assisted treatment
2. Mental health treatment services
3. Housing
4. Education and skills building
5. Employment development, placement, and ongoing support
6. Systems navigation services
7. Transportation
8. Family unification and support services
9. Community organizing to facilitate community education and engagement

Identifying and Leveraging Criminal Justice and Public Health Resources—To support the ATI effort, the County should continue to explore and review policies that maximize resource availability in order to meet the full scope of ATI recommendations. Areas that the Work Group and County can explore include, but are not limited to:

1. Partnerships across departments to maximize existing funding and integrate service delivery
2. Anticipated growth in funding streams that has not yet been allocated
3. The development of County policies and practices, when possible, that promotes the flexible use of funding in order to ensure that needed programming is provided to individuals, regardless of their case type or status
4. Legislative efforts and County advocacy strategies to maximize external funding, including Medi-Cal funding
5. Partnerships with philanthropic organizations, particularly for supporting infrastructure development in the community
6. Net County Cost (NCC) budget allocations
7. Calculation and reinvestment of justice savings
8. Grant opportunities

Effective Distribution of Resources—In addition to direct services to ATI participants, funding will need to address key collateral needs:

1. Capacity building efforts
2. Contracting/procurement facilitation
3. Data sharing efforts

4. Support for crime survivors
5. Support for individuals impacted by the justice system
6. Continued research and evaluation

Item: Medi-Cal Coverage**Issue**

To support the ATI effort, the County should continue efforts to maximize resource availability in order to meet the full scope of ATI recommendations, including advocacy at the state and federal level.

Analysis

The California Department of Health Care Services is beginning the process of identifying changes to the scope and populations covered by Medi-Cal as part of its new Medicaid waiver with the Federal Government that would take effect in 2021. The final waiver provisions will significantly impact the scope of services funded under the program and shape available resources for eligible individuals involved with the justice system.

Potential Strategies

The County should advocate for changes that would expand services and populations covered by Medi-Cal to support integrated service delivery to system-involved individuals and their families, which could provide a source of sustainable funding to support ATI recommendations related to an integrated system of care.

Data & Research Ad Hoc Committee

Goal: Expand justice data transparency including access, analysis, and metric design involving those most impacted by the justice system.

Recommendation

It is the recommendation of this Data and Research Ad Hoc Committee to expand justice data transparency including access, analysis, and metrics designed to prioritize continuous engagement of individuals and communities who are most impacted by both the justice system and systemic racism. The intended result of this recommendation is to provide real-time data sharing to build capacity in the communities most impacted by the justice system, to shift the power dynamic from government to community, increase the nimbleness of community responses, and improve accountability of agencies. As it stands now, the most impacted communities are not involved in the collection or analysis of the data which results in less meaningful and accurate information. The most impacted community members and providers can be the technologists, not just serve in a consultation role.

Provide paid training and employment to ensure that justice system impacted individuals are the technologists behind data collection and analysis;

Expand collaborative data collection to retrieve data necessary for services, programming, preventative measures, and alternatives to incarceration; Collect and promptly disseminate quality data – including diversion, alternatives to incarceration and reentry service scope, capacity, and funding support – necessary to enable public accountability. Likewise, capture and circulate relevant data to gauge how well Los Angeles County is diverting residents from incarceration or meeting their needs once incarcerated, with associated budgets. Data on individuals who have been diverted should be captured and analyzed in order to report accurate measurements of progress and to ensure the outcomes we are getting are both positive and sustainable. Ensure data is always disaggregated by race and ethnicity.

Data on pathways into and out of incarceration: There is a clear need for better understanding of who is being incarcerated in Los Angeles County, and therefore the level of capacity needed for a robust alternatives-to-incarceration approach. Notably, there are clear, direct, and well-substantiated links between mental health needs, homelessness, substance addiction, and incarceration, but public LASD data does not provide sufficient

information to understand the overlap between these populations, their respective average lengths of stay, and demographic information including race and ethnicity. Likewise, more specific and timely data is needed on who is being diverted from incarceration, and the extent to which these approaches reduce race-based disparities as well as reducing incarceration overall. Data needs also extend beyond the County to all arresting agencies, including LAPD.

Data on services for system-impacted people: Comprehensive information regarding County-supported services – such as inventorying current County contractors and subcontractors, populations served, current vs. potential capacity, allocation (and unspent reserve) levels, and geographic distribution of all services funded by these County contracts – will make it possible for the County and advocates to better assess current practices’ efficacy and equity while identifying clear opportunities for improvement. This data must include core diversion and re-entry services, but also the broader range of programs that serve people across all intercepts.

Tracking incarceration spending: The County’s status quo largely funds services and alternatives to incarceration with restricted revenues, including grants and state and federal funding streams, while devoting the lion’s share of flexible, locally generated revenues to incarceration. Better tracking and disclosure of the costs of the incarceration system, including per-bed spending, will help the County understand the tradeoffs of the current approach, and the potential advantages of scaling up non-incarceration alternatives that can free up savings for reinvestment. Cost savings, cost avoidance, and effectiveness can be also quantified in comparison to the costs of incarceration.

Additional Data: The Data and Research Ad Hoc Committee is compiling a comprehensive list of data needs to address for the final report that includes requests from the other ATI committees.

NEXT STEPS

Next Steps

The ATI Work Group will continue to meet monthly from June to December 2019, following the submission of the interim report to the Los Angeles County Board of Supervisors. The Work Group and Ad Hoc Committees will develop a six-month timeline to generate an implementation plan for the current goals and strategies by assessing operational and fiscal feasibility while utilizing the GARE Racial Equity Toolkit. Throughout this process the ATI WG and Ad Hoc Committees will develop additional topics, goals, and strategies that seek to scale diversion and alternative to incarceration opportunities for a broader range of individuals including women, LGTBQ and gender non-conforming people, based on additional group discussion.

The Community Engagement Ad Hoc Committee will incorporate community feedback acquired during the ATI meetings, seven community engagement workshops, and four workshops to engage currently incarcerated adults and youth. Feedback from the communities most impacted by incarceration and in need of prevention services will be integrated into the implementation plan for the interim report and the development of the final report. In this next phase, the Funding and Data & Research Ad Hoc Committees will begin to respond to some of the questions and requests that were identified in the racial equity statements from the Community-Based System of Care and Justice Reform Ad Hoc Committees. The Funding and Data & Research Ad Hoc Committees

will likely develop overarching recommendations that tangibly support the implementation plan for the interim report.

To support continuous communication with a broad group of stakeholders, the planning team is developing an ATI Work Group website. This website will allow for stakeholders to view materials generated by the Work Group and Ad Hoc Committees, support web-based feedback opportunities, and provide a calendar of events pertaining to Work Group efforts.

Finally, the ATI Planning Team will focus on improving the ATI structure and engagement strategies through a survey assessing the initial 3-month process and the additional meetings for the next six-month phase.

Conclusion

The ATI Work Group, an unprecedented collaboration of community advocates, formerly incarcerated people, County agency representatives, academics and researchers, has created and endorsed a clear vision of how to stop relying on our justice system to address our failure to provide adequate care and treatment for people with clinical mental health and/or substance use disorders. The 13 goals of this interim report clearly describe that vision—of decentralized, community and evidence-based, holistic services, provided equitably throughout the County, along with a drastic reduction in our reliance on law enforcement and courts as the default method of connecting our most vulnerable community members with treatment and services. If we turn this vision into tangible bricks and mortar, effective programs and services, improved policies and practices, we can substantially and sustainably reduce the number of people with clinical mental health and/or substance use disorders being arrested and booked into the County Jail, which will have immediate and lasting positive impacts on individuals, families and communities; improve community safety; and responsibly leverage limited taxpayer resources.

Some of the recommendations proposed can be implemented immediately without new resources or changes in legislation or policy, while others may take much longer and require significant resources, policy changes and program development. It is worth noting that it has been only four years since District

Attorney Jackie Lacey developed the “Blueprint for Change” and the Board of Supervisors created the Office of Diversion and Reentry. **In just four years, the Los Angeles Superior Courts have diverted approximately 4,000 people through pretrial and mental health diversion programs, and ODR has successfully diverted an additional 3,000 people—7,000 people who would otherwise have been sitting in a jail cell.**

This ATI vision represents a shift happening across the nation—from a criminal justice response to a public health approach to behavioral health crisis, where care and services are provided first, and jail is a last resort.

**We believe that LA County
can and should build this
reimagined system of
justice—where we reinvest
in our neighborhoods,
reduce costs and make all
of our communities
healthy and safe.**

APPENDIX

Community-Based System of Care Ad Hoc Committee Racial Equity Analyses

Goal 1A: Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health.

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Develop policies and expand programs that ensure that people with mental health disorders and substance use disorder, their loved ones, and community members have multiple points of access to the full continuum of services and that match the individual's current needs (from low to high levels of care) through a combination of County-operated and not-for-profit community-based organizations services throughout Los Angeles County while creating alternatives to incarceration at every level of the criminal justice system. This recommendation impacts intercept zero (which enables people to access services before any contact or involvement with the criminal justice system has occurred) and intercept five (prevent recidivism). All services should be implemented in a need-aligned and equitably distributed manner.

This proposal calls for a number of policy and budgetary decisions that would expand programs to increase equitable access and decrease criminalization of behavioral health issues. This would rely upon County agencies partnering with localized community-based providers in order to grow behavioral health service capacity and increase service utilization in balance with local needs.

2. What are the intended results (in the community) and outcomes (within your own organization)?

If acted upon, this proposal's cumulative recommendations would increasingly divert community residents from any interaction with law enforcement, while simultaneously better serving & healing those already directly impacted by the local criminal justice system. Service expansion—enabled by attendant funding reprioritization—would begin to reverse a harmful, racially-inequitable legacy of twinned disinvestment and criminalization in Los Angeles County.

The outcome for the community and organizations would be a more-equitable distribution of funds and resources based on race and geography. Key to this proposal would be recognition that just as the need for quality diversion and reentry services varies greatly across Los Angeles County, so too should County spending and resource expenditures be allocated not equally, but equitably—in order to best align available services with disparate need.

The proposal would seek to support communities in gaining access and awareness about existing programs. Funding and programmatic support for services would be directed to areas most in need and would emphasize support for locally-situated, community-based providers—expanding widely-dispersed capacity rather than merely growing a centralized conglomerate. These programs and services would employ, in a meaningful way, those with a direct past relationship to the criminal justice system—building a cadre of savvy, relatable, effective career-track staff who can better serve those in need while simultaneously advancing their own life prospects.

3. What does this proposal have an ability to impact?

- | | |
|--|--|
| <input checked="" type="checkbox"/> Children and youth | <input type="checkbox"/> Parks and recreation |
| <input checked="" type="checkbox"/> Community engagement | <input checked="" type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Contracting equity | <input type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Utilities |
| <input checked="" type="checkbox"/> Economic development | <input checked="" type="checkbox"/> Workforce equity |
| <input checked="" type="checkbox"/> Education | |
| <input type="checkbox"/> Environment | |
| <input type="checkbox"/> Food access and affordability | |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |
| <input checked="" type="checkbox"/> Jobs | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

Accurately assessing the varying impacts—and potential unintended consequences—of this proposal and its implementation would require additional, in-depth analysis on individual components in the context of broad (macroeconomic, planning, demographic, etc.) Countywide trends. In lieu of such analysis, we offer this cursory overview.

This proposal seeks to serve all residents and all regions as need exists throughout Los Angeles County, but particularly those groups and areas of the County that have suffered from a historical dearth of social resource investments and political empowerment. This burdensome legacy has led such communities to getting further and further ensnared in the criminal justice system rather than advancing toward greater health and prosperity.

The broader South LA region would be a specific focus due to its well-documented (via data such as the JENI in addition to decades of reports and community sentiment) high need for such services and its inequitable lack of public investment to offset this reality. Likewise, zones of high need for such services exist in communities throughout the County such as in East LA, Long Beach, Pacoima, the Antelope Valley, the San Gabriel Valley, and Pomona. All such communities are majority-nonwhite ones, predominantly black and Latino.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

Voluminous existing data and research literature [which could be supplied with additional time] indicates that the areas of high interest/impact for this proposal are not only predominantly communities of color, but that they have also been most negatively impacted (socially, economically, etc.) by decades of law enforcement strategies that have led to higher rates of localized incarceration. Wildly disparate arrest, incarceration, and probation rates bear out this on-going racial inequity that only compounds across generations.

This criminalization, paired with inadequate public (County, city, or philanthropic) investment to supply necessary service resources—particularly in the realm of behavioral health—has hampered such communities'

ability to provide opportunities that would divert residents from the criminal justice system and their ability to cope with the resultant local fallout from this pattern of incarceration.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

This proposal's multifaceted nature makes overarching performance level data compilation/assessment a challenge. Considerable, well-integrated data is needed to assess the proposal's overall viability and efficacy. It is difficult at this time to ascertain exactly what such data is now available—particular the multivariate, interdepartmental data required to fully assess this proposal. The drawn-out experience of the County's Justice Metrics Task Force illustrates the inherent challenges in such efforts. Yet, it should be noted, that some of the particulate data is already available, if uncoordinated, at the County level.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal? If so, how can you obtain better data?

There are considerable data gaps—including the basic need to understand the disparity among the sub-regions or different racial groups in accessing services. The toolkit will allow us to further analyze this and the community asset mapping through the Community Engagement Ad Hoc Committee will support us in understanding geographic needs. Through asset mapping workshops we hope to learn about what services people know exist. We seek to visualize the alignment of community and County service information on a map to analyze the amount of resources in the prioritized areas as well as the inequity and need through geography and race. The analysis of policies and practices of the current community-based solutions will help us figure out what the gaps in services are.

Finally, in order to better assess the proposal and to understand performance in terms of services, the County should collect and promptly disseminate quality data—including reentry service scope, capacity, and funding support—necessary to enable public accountability. In order to best assess racial equity impact, such data must always be disaggregated by race and ethnicity.

Examples of data required for performance assessment include inventorying current County contractors and subcontractors, populations served, current vs. potential capacity, allocation (and unspent reserve) levels, and geographic distribution of all services funded by these County contracts—will make it possible for the County and advocates to better assess current practices' efficacy and equity while identifying clear opportunities for

improvement. This data must include core diversion and re-entry services, but also the broader range of programs that serve people across all intercepts.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

The people that are most affected are individuals that have direct and indirect experience with incarceration such as formerly incarcerated people, currently incarcerated people, and their families. Though, it should be noted that providers—whether relevant County agencies or local, community-based ones—also will be impacted by this proposal.

Those who are directly system-impacted have been lightly involved in drafting this proposal via the ad hoc committee. The participation of representatives from community-based advocacy organizations (JusticeLA, LA Voice, etc.) serving and including the justice-impacted population helps in that regard but is—as yet—insufficient.

In order to arrive at the most impactful, effective service-based solutions, we need to expand this to engage additional directly impacted people with lived experience in the next phase of this process. This engagement should go beyond passive listening sessions or weighing in on predetermined proposals. Instead, that engagement should meaningfully inform the final proposals and on-going implementation plans.

2. What has your engagement process told you about the burdens or benefits for different groups?

The ATI engagement process thus far has informed us that service access is severely limited in many areas of the County, service eligibility and programming remains largely uncoordinated, it is difficult to access behavioral health supports without law enforcement agencies/justice-involvement, and that there is limited awareness about all the services and supports that are available—both amongst those in need and those ostensibly serving them.

Non-ATI engagement—and pointing to the need for enhanced engagement in the next phase of the ATI Work Group—in the form of focus groups has informed us that culturally-competent providers (particularly those with lived experience being subject to the local criminal justice system) are integral in the utilization and success of services for many communities of color. Likewise, such engagement has reinforced that for many communities suffering the burdens of poverty, discrimination, surveillance, and neglect—simply providing services does not necessarily equate to access. Thus, we must go beyond mere provision of services and build in means by which communities in greatest need can actually benefit from them.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

The ATI engagement thus far has illustrated that need for quality diversion and reentry services is both universal in Los Angeles County—but the spatial and racial variations in need are not generally mirrored in the allocation of resources.

Non-ATI focus groups have illustrated that in heavily impacted communities, there is broad consensus that simply layering on resources without fundamentally addressing the root causes of mass incarceration is a losing battle. Service enhancement cannot keep pace with the irresistible force of continually-expanding law enforcement spending that bears down on the very communities most in need of social investment to recover from said just-involvement. In short, we want to make sure that existing incarceration funds are shifted to whole person care, and that the recommendations do not inadvertently convey a recommendation to solely pursue new dollars for program expansion. While we recognize that overall the ad hoc groups have expressly recommended simply pursuing additional resources, we want to underscore the fundamental aspect of this historic opportunity to pivot to real whole person care for individuals, families, and communities.

If the answer to any of the above questions is no, what resources or actions are needed?

Goal 1B: Increase Access and Remove Barriers to Community-Based Services by addressing the Social Determinants of Health.

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Remove barriers to accessing all necessary and complimentary integrated not for profit community-based services related to mental health disorders, substance use disorders, and poor social determinants of health while providing community members with the necessary tools, support, and incentives to attend and participate in services.

We imply a budgetary impact through our statement describing the sub-topic goal or proposal since creating this initiative through a County governance structure will require a budget decision. Asking for a structure to be created to oversee the process will support implementation and will require some form of investment.

2. What are the intended results (in the community) and outcomes (within your own organization)?

If adopted, this proposal's recommendations would increasingly divert community residents from any interaction with law enforcement, while simultaneously better serving & healing those already directly impacted by the local criminal justice system.

Alternatives and Diversion measures would be expanded, strengthened, and enable greater access by community members through scaling up the district attorney mental health division's partnership with ODR; expanding jail diversion efforts; establishing effective restorative justice programs; and connecting every person who is diverted to DMH for care.

The outcome for system impacted men and women is a decrease in recidivism and an increase in utilization of whole person care supports toward self-sufficiency. The outcome for community and organizations is a

more-equitable distribution of funds and resources based on race and geography. The initiative seeks to support communities in having access and awareness about programs designed to strengthen long-term self-sufficiency.

3. What does this proposal have an ability to impact?

- | | |
|--|--|
| <input checked="" type="checkbox"/> Children and youth | <input type="checkbox"/> Parks and recreation |
| <input checked="" type="checkbox"/> Community engagement | <input type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Contracting equity | <input type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Economic Development | <input checked="" type="checkbox"/> Workforce equity |
| <input checked="" type="checkbox"/> Education | <input type="checkbox"/> Other |
| <input checked="" type="checkbox"/> Environment | |
| <input type="checkbox"/> Food access and affordability | |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |
| <input checked="" type="checkbox"/> Jobs | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in the specific geographic areas (neighborhoods, areas, or regions)? What are the racial demographics of those living in the area?

Yes, it will have impacts on several geographies including communities that are impacted by incarceration. Through the utilization of Million Dollar Hoods data we are able to see that there are multiple communities that are impacted including Lancaster, Palmdale, Compton, South Central, East LA, and Long Beach. Through Advancement Project data we also see that the Pomona and Pacoima are neighborhoods that could be impacted by the equitable distribution of resources process we are seeking. We must adopt and administer the racial equity tool to all initiative strategies in order to learn more about the racial and geographic needs across LA County.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

We recommend that the research and data ad hoc committee analysis and findings be integrated into the interim report and shared with the other Work Groups during the period from the interim report to the final report. Current available data, as well as this ad hoc committees anecdotal and empirical knowledge has guided this groups recommendations thus far.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

This will be evaluated through the implementation of recommendations and the initiative moving forward.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal?

If so, how can you obtain better data?

The data gaps include a need to understand the disparity among the sub-regions or different racial groups in accessing services. The toolkit will allow us to further analyze this and the community asset mapping, through the Community Engagement Ad Hoc Committee, will support us in understanding geographic needs. Through asset mapping workshops we hope to learn about what services people know exist. We seek to visualize community and County service information on a map to analyze the amount of resources in the prioritized areas, the inequity and need through geography and race, and what types of existing services are effective. The analysis of policies and practices of the current community-based solutions will help us figure out what the gaps in services are.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

The people that are most affected are individuals who contend with the insidious violence of poverty, and who have direct and indirect experience with incarceration such as formerly incarcerated people, currently incarcerated people, and their families. We have been able to involve people that are impacted by incarceration, people that utilize services, supportive service organizations, County departments, advocacy organizations, and academics through the current ad hoc committee and Work Group structure.

We need to expand this to engage additional directly impacted people with lived experience in the next phase of this process.

2. What has your engagement process told you about the burdens or benefits for different groups?

Immediate access to high quality supports and programs improves the likelihood of longer-term self-sufficiency.

We have learned that there is a lack of service coordination which creates duplicative work, a disjointed process for people trying to get help, and limited awareness about all the services and supports that are available. There are effective programs available in most communities with a need for more collaboration and community connections to them.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

Racial inequity is inextricably linked to individual, familial, and community poverty.

4. Adequate resources to ensure on-going data collection, public reporting and community engagement?

There are not enough resources for this, and it doesn't seem to be happening right now for people impacted by incarceration. Through the initiative, recommendations, and roadmap it is a good opportunity to create and sustain an on-going method to collect data, report publicly, and always engage the community.

5. If the answer to any of the above questions is no, what resources or actions are needed?

The County must immediately shift resources away from incarceration in order to prioritize on-going data collection, public reporting and community engagement. If this fundamental pivot does not occur, and the

urgency is not shared with all County departments, then we might squander this opportunity and revert back to piece-meal bureaucratic, low impact procedural changes. The County and community must all buy into the process and utilize the racial equity tool across programs.

Goal 2A: Expand the Community-Based System of Care

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Scale up effective culturally competent mental health and substance use models that are community-based that already exist at critical intercepts with a priority on intercepts zero and five that enables people to access services before any criminal justice system involvement. Develop contracting policies and procedures that make it less difficult for culturally competent nonprofit community partners to become part of the funded integrated system of care and invest in those relationships long term. Develop capacity among local providers to compete for County contracts and provide high quality services. Address the distribution of resources by the geographic and racial impact of services equitably.

The proposal is to expand and develop a culturally competent community-based system of care targeting the critical racial and social determinants of health that are known to be reflective of the incarcerated population.

- Black and Latinx individuals comprise 80% of the targeted incarcerated population that the proposal intends to divert and serve in the community;
- Behavioral health indicators (mental health and substance use disorder disparity and prevalence) and compounding risk indicators i.e. poverty, unemployment, education and homelessness

2. What are the intended results (in the community) and outcomes (within your own organization)?

Prioritize establishment of CBR programs that enable people to access services before any criminal justice system involvement i.e. scale up and develop effective culturally competent mental health and substance use models with a priority on intercepts zero and five and,

Invest in the development of promising and emerging community-based groups and organizations that can significantly add to a robust community-based system of care.

3. What does this proposal have an ability to impact?

- | | |
|--|--|
| <input type="checkbox"/> Children and youth | <input type="checkbox"/> Parks and recreation |
| <input checked="" type="checkbox"/> Community engagement | <input type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Contracting equity | <input type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Utilities |
| <input checked="" type="checkbox"/> Economic development | <input checked="" type="checkbox"/> Workforce equity |
| <input type="checkbox"/> Education | <input type="checkbox"/> Other |
| <input type="checkbox"/> Environment | |
| <input type="checkbox"/> Food access and affordability | |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |
| <input type="checkbox"/> Jobs | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

The proposal aims to address geographical areas i.e. Supervisorial districts and neighborhoods within those districts where the supply of support and services is low or moderate at best and according to the Justice Equity Need Index, areas that are predominantly Black and Latinx and most negatively impacted by criminalization and detention –first policies.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

Population data characterizing the targeted communities where incarcerated individuals would be diverted/re-entered are compelling: i.e. South and East Los Angeles County.

Racial population:

- 95% Latinx and Black (68% & 27% respectively) in Supervisorial District 2.
- 87% Latinx and Black (73% & 14% respectively) in Supervisorial District 1.

These data are coupled with the Justice Equity Need index that indicates criminal justice involvement, behavioral health and social determinant risk indicators are among the highest in the County.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

There is a growing literature and research base supporting the effectiveness of culturally competent community-based strategies to either divert or prevent incarceration and/or substantially reduce the incarcerated population who are in need of mental health and substance use disorder services.

Literature on effective models suggest the importance of:

- broad community stakeholder involvement in the design and implementation of programs and services and,
- multi-disciplinary clinical and support services staffing that include individuals with lived experience and reflective of the ethnic diversity of the communities being served.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal?

If so, how can you obtain better data?

Beyond race, in designing and managing programs greater data specificity with regard to social and clinical subgroups of the target incarcerated and at-risk populations is needed including gender, age, sexual orientation, etc.

In addition, more robust clinical indicators of acuity and diagnosis in terms of mental health and substance use of incarcerated populations to be diverted, as well as populations at risk in the community

Given the vast number of diversion programs at all intercept levels currently implemented in the County, collect data and analyze program evaluation data from them to inform new initiatives.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

Individuals who are currently and formerly incarcerated with mental health and substance use disorder and their family members are the most affected community members. Individuals with lived experience, parent and family members, mental health needs and justice advocates have been represented in creating this proposal.

2. What has your engagement process told you about the burdens or benefits for different groups?

A broad and diverse engagement has compelled the ad hoc committee to adopt a more critical analysis and thoughtful approach especially given the involvement of individuals with lived experience. While there is a wide array of suggestions and recommendations contained in this proposal these are all bound by a unified goal statement.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

Racial inequity and the contributing social determinants of health disparities need to drive the discussion at the front end in designing, allocating resources, implementing and evaluating diversion and re-entry programs in the County of Los Angeles.

Goal 2B: Expand the Community-Based System of Care

Remove barriers that prevent not for profit community-based service providers from accessing County funding, contracting opportunities, technical assistance, and incubation opportunities.

Note: Racial equity analysis from Goal 3, A is relevant to Goal 4, B.

Goal 3: Coordinate Community-Based Services

Step #1: What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Create an Alternatives to Incarceration Coordination Initiative within the County governance structure to oversee program implementation and equitable distribution of resources. The Initiative would create policies and procedures to connect all County capacity building and services provision efforts. This Initiative would create linkages in service provision for county departments, non-profit community-based service

providers and the community at large so that mental health needs, substance use disorder, and poor social determinants of health are supported and treated through an integrated model.

We imply a budgetary impact through our statement describing the sub-topic goal or proposal since creating this initiative through a county governance structure will require a budget decision. Asking for a structure to be created to oversee the process will support implementation and will require some form of investment.

2. What are the intended results (in the community) and outcomes (within your own organization)?

The intended results in the community is to understand where the greatest impact service impact is through utilizing a tool to analyze delivery and equity. Through several of the strategies that connect to our sub-topic goal we hope to have a better understanding of what services are available and how to consistently support the sustainability of them. The outcome for the community and organizations is an equitable distribution of funds and resources based on race and geography. The initiative would seek to support communities in having access and awareness about programs that are existing while connecting people to services and decrease the amount of people going into the jail system.

3. What does this proposal have an ability to impact?

- | | |
|--|---|
| <input checked="" type="checkbox"/> Children and youth | <input type="checkbox"/> Parks and recreation |
| <input checked="" type="checkbox"/> Community engagement | <input type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Contracting equity | <input type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Economic development | <input type="checkbox"/> Workforce equity |
| <input checked="" type="checkbox"/> Education | <input type="checkbox"/> Other |
| <input checked="" type="checkbox"/> Environment | |
| <input type="checkbox"/> Food access and affordability | |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |
| <input checked="" type="checkbox"/> Jobs | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

Yes, it will have impacts on several geographies including communities that are impacted by incarceration. Through the utilization of Million Dollar Hoods data we are able to see that there are multiple communities that are impacted including Lancaster, Palmdale, Compton, South Central, East LA, and Long Beach. Through Advancement Project data we also see that the Pomona and Pacoima are neighborhoods that could be impacted by the equitable distribution of resources process we are seeking. We must adopt and administer the racial equity tool to all initiative strategies in order to learn more about the racial and geographic needs across LA County.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

Our strategies will allow us to answer these questions in a deeper way since we are recommending that we use the racial equity toolkit to understand the delivery of services across LA County through the creation of this initiative.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

This will be evaluated through the implementation of recommendations and the initiative moving forward.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal? If so, how can you obtain better data?

The data gaps include a need to understand the disparity among the sub-regions or different racial groups in accessing services. The toolkit will allow us to further analyze this and the community asset mapping through the Community Engagement Ad Hoc Committee will support us in understanding geographic needs. Through asset mapping workshops we hope to learn about what services people know exist. We seek to visualize community and County service information on a map to analyze the amount of resources in the prioritized areas, the inequity and need through geography and race, and what types of existing services are effective. The analysis of policies and practices of the current community-based solutions will help us figure out what the gaps in services are.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

The people that are most affected are individuals that have direct and indirect experience with incarceration such as formerly incarcerated people, currently incarcerated people, and their families. We have been able to involve people that are impacted by incarceration, people that utilize services, supportive service organizations, County departments, advocacy organizations, and academics through the current ad hoc committee and Work Group structure.

We need to expand this to engage additional directly impacted people with lived experience in the next phase of this process.

2. What has your engagement process told you about the burdens or benefits for different groups?

We have learned that there is a lack of service coordination which creates duplicative work, a disjointed process for people trying to get help, and limited awareness about all the services and supports that are available. There are effective programs available in most communities with a need for more collaboration and community connections to them.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

This is the first time that the Los Angeles community has embarked on this type of process of collaborating with County, community, and other stakeholders in developing a roadmap specifically for alternative, diversion, and reentry services.

a. Adequate resources to ensure on-going data collection, public reporting and community engagement?

There are not enough resources for this and it doesn't seem to be happening right now for people impacted by incarceration. Through the initiative, recommendations, and roadmap it is a good opportunity to create and sustain an on-going method to collect data, report publicly, and always engage the community.

If the answer to any of the above questions is no, what resources or actions are needed?

➤ County and community need to all buy into the process and utilize the racial equity tool across programs.

Case Processing

Goal 1: Improve Diversion Opportunities within the Court System

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a “proposal” in the remainder of these steps)

Formally implement recent legislative opportunities for earlier diversion away from the justice system for people with behavioral health needs, from the booking stage throughout the court process.

2. What are the intended results (in the community) and outcomes (within your own organization)?

Diversion as appropriate of people at intercept points post-arrest/citation through sentencing, with people being placed in the community with supports-treatment-services. Intended individual and community results will be preservation of or improvement in the people’s integration into community life, treatment in the least restrictive situation for each person, and avoidance of the harms associated with jail time such as job loss, family disruption, potential psychological harm. Departmental results will be a reshaping of various Departments’ resource use (e.g. reduction of the custody-related activities of LASD, DHS, DMH, Courts, with a shift towards assessment activity, and in some cases, to more work in the community.

3. What does this proposal have an ability to impact?

- Children and youth—Increase coherence of families
- Community engagement—Seek input on service needs and prevention strategies
- Contracting equity
- Criminal justice—Shift system emphasis, improved community relations

- Economic Development—More stability, more continuity of employment
- Education—Expectation that many diverted people will be in programs
- Environment
- Food access and affordability
- Government practices—Shift to a variety of rehabilitative and preventive services.
- Health—More local services which may also help non-justice people
- Housing—Supportive housing, reduced street living
- Human services—As with “health” above
- Jobs—Diversion and other community service-related jobs
- Parks and recreation
- Planning/Development
- Transportation
- Utilities
- Workforce equity—Many diverted people will be in the workforce
- other

Step #2:

What’s the data? What does the data tell us?

1. Will the proposal have impacts in the specific geographic areas (neighborhoods, areas, or regions)? What are the racial demographics of those living in the area?

Many areas will experience the impacts listed in Step 1 #3; the Data-Research ad hoc and other studies will help predict the areas experiencing most of the change. With carefully generated criteria and well-supported services available to compensate the shortfalls in high needs/low services areas, we can expect that the areas experiencing heavily jailing will experience the greatest change; this will reduce the system’s exacerbation of race/class inequality and have an advancing effect on equality.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

See the Data Research material, from which we may derive predictions.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies.

Current Office of Diversion and Reentry programs have initial statistics indicating successful services in terms of high levels of served people not being involved in offenses and remaining in programs and housing.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal? If so, how can you obtain better data?

See the work of the Data-Research group and data from current programs.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

Strategy 3. b. is to find professionals to do the forensic work; Strategy 4 is to seek public input and involvement in the court/justice system, essential for obtaining the best benefits of the proposed programs for individuals and communities, and likely to help reduce stigma.

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

Individuals with behavioral health needs who are charged with crimes and are involved in the court system, as well as the government agencies that work in that system, are most affected by this proposal. Participants in the group developing the proposal included a small number of people who have been directly impacted or have had family members or loved ones directly impacted by the system. The group also included representatives from agencies and advocates working in the system.

2. What has your engagement process told you about the burdens or benefits for different groups?

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

The group discussed several factors that perpetuate racial inequity related to this proposal, such as the fact that most defendants, if they are poor and persons of color, do not have the ability to influence the prosecution's decision, very early in the process, to determine whether and which charges to file, an opportunity sometimes available to people with the means to hire private counsel before any criminal charges are filed. There may also be disparities around the unequal distribution of diversion programming throughout the County court system, and who is able to take advantage of early diversion opportunities.

Pretrial / Bail Reform

Goal 2: Reduce Pretrial Detention and Increase Services

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Substantially and sustainably reduce pretrial incarceration of people with clinical behavioral health needs while strengthening public safety by instituting a presumption of release and using a public health approach that links accused persons to services and programs without additional justice system contact to reduce the financial burden on the accused by upholding the presumption of innocence. The broader intention is to reduce the entire pretrial population in comprehensive ways that recognize and address the disproportionate impacts of race, socioeconomic status, and other factors that contribute to pretrial detention.

2. What are the intended results (in the community) and outcomes (within your own organization)?

A substantial and long overdue reduction in the jail and supervised pretrial population along with quality,

efficient, non-punitive, and accessible services for families and community members dealing with both the linear, as well as the collateral consequences of law enforcement, court, and jail contact. Public safety and economic stability and prosperity will increase across LA County, as will generational impacts due to less family separation.

3. What does this proposal have an ability to impact?

- | | |
|---|---|
| <input checked="" type="checkbox"/> Children and youth | <input type="checkbox"/> Jobs |
| <input checked="" type="checkbox"/> Community engagement | <input type="checkbox"/> Parks and recreation |
| <input type="checkbox"/> Contracting equity | <input type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Economic development | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Education | <input type="checkbox"/> Workforce equity |
| <input checked="" type="checkbox"/> Environment | Other |
| <input checked="" type="checkbox"/> Food access and affordability | |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

Since areas with larger populations of people of color are more heavily policed, such persons in these neighborhoods when having justice system contact should experience improved linkage with needed clinical behavioral health services. In addition, with care made available within impacted communities, the opportunity for prevention and definitive treatment is realized. These areas are predominantly Black and Latinx, with the Million Dollar Hoods research indicating County Districts 2 and 3 spending the most on incarceration.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

With regard specifically to health care services, the definition of disparity, as employed by the Institute of Medicine (IOM), is a difference in health care quality not due to differences in health care needs or preferences of the patient. As such, disparities can be rooted in inequalities in access to good providers, differences in insurance coverage, as well as stemming from discrimination by professionals in the clinical encounter.

See <https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts> for factors affecting specific racial groups.

Some of the chief reasons why people of color aren't getting proper mental health care:

- A lack of availability
- Transportation issues, difficulty finding childcare/taking time off work
- The belief that mental health treatment “doesn’t work”
- The high level of mental health stigma in people of color populations
- A mental health system weighted heavily towards white values and culture norms
- Racism, bias, and discrimination in treatment settings
- Language barriers and an insufficient number of providers who speak languages other than English
- A lack of adequate health insurance coverage (and even for people with insurance, high deductibles and co-pays make it difficult to afford)

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

Since LA County has not had a pretrial services department coupled with its pattern of pretrial incarceration/plea bargaining, this proposal will require the independent entity to compile monthly statistics and perform regular, transparent analysis to direct its operation going forward. The San Francisco and Santa Clara pretrial services programs can serve as implementation models.

The current performance data of existing County and community services needs to be evaluated for strengths and weaknesses as the network of services and programs is improved and expanded.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal?

If so, how can you obtain better data?

Would need the breakdown of how many of the approximately 5300 currently incarcerated people with mental health needs are being held pretrial. Additionally, need to know how many of the 44% of pretrial people in jail are suffering from SUD or have been identified with other clinical behavioral health needs. Their zip codes should also be tracked. The LASD needs to supply and maintain this data.

These statistics will inform the programs and services provided by the local communities.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

The community members most affected by pretrial incarceration are currently and formerly incarcerated people, the family members and loved ones of currently and formerly incarcerated people, and the communities most targeted by the carceral system, including: people with mental health and behavioral health needs; Black and Latinx people; people of indigenous descent; queer, trans and gender non-conforming people; and indigent and individuals and families experiencing homelessness. The Justice Reform pretrial subcommittee includes a formerly incarcerated person, family members of formerly incarcerated people and members of the Latinx, Black and queer communities, as well as representatives of the following organizations and coalitions who advocate for a cross section of the most impacted communities: JusticeLA, Dignity and Power Now, Californians United for a Responsible Budget, The Bail Project, Just Leadership USA and the ACLU of Southern California. We hope to expand engagement to people who are currently incarcerated and recently released, people with behavioral health needs and individuals who are experiencing homelessness.

2. What has your engagement process told you about the burdens or benefits for different groups?

The stakeholders and advocates who are impacted by pretrial incarceration have the expertise of lived experience and offer direct knowledge on how the current system is affecting their families and communities. These stakeholders and advocates have limited access to funds to cover the expenses of participating in this Work Group, including parking and hours of labor. Currently incarcerated people, particularly those with mental health and substance use needs, are the most heavily impacted by the current system; however, there was not a system in place yet to directly engage these groups in the process of developing the recommendations.

The ATI engagement process thus far has informed us that people of color and people who are poor are affected most adversely by pretrial detention

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

It is essential to include those most impacted by the criminal justice system in the development of recommendations and implementation planning. A more effective engagement strategy that includes compensation and consideration of travel and work hours and other factors perpetuating racial inequity will allow us to include a broader group of stakeholders moving forward.

4. Adequate resources to ensure on-going data collection, public reporting and community engagement?

If the answer to any of the above questions is no, what resources or actions are needed?

Providing community stakeholders and advocates with resources, such as paid parking and compensation for hours spent on developing the recommendations, would help increase participation by those most impacted. Additionally, administering and collecting surveys from those currently incarcerated pretrial, recently released and those with mental health and behavioral health needs would provide more direct engagement. Up to date and comprehensive data on the composition of the County's pretrial population (i.e. the number of incarcerated pretrial individuals in need of mental health and behavioral health support) would help the Work Group develop more in-depth analysis. Lastly, stakeholder meetings hosted by community-based organizations in the communities most impacted would expand the breadth and scope of engagement.

Mental Health and Law Enforcement

Goal 3: Reduce and Improve Interactions between Law Enforcement and People with Mental Health Needs; Increase Diversion Opportunities and Improve Training for Law Enforcement

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Scale up mental health and community-based response to behavioral health crises to substantially reduce contact between people with behavioral health needs who are in crisis and law enforcement. When there is contact between people with behavioral health needs who are in crisis and law enforcement, ensure that law enforcement has the training and partnership with behavioral health personnel to respond appropriately to each situation and to divert many more people into community-based treatment and services.

2. What are the intended results (in the community) and outcomes (within your own organization)?

Community Results

- a. Linking those in Behavioral Health Crises with appropriate mental health services and interventions.
- b. Reduction of unnecessary interaction with Law Enforcement that may result in the arrest or incarceration of individuals with mental health disorders.
- c. Improving crisis response via quicker response times, less waiting on telephone lines, and collaborative teams consisting of mental health professionals and law enforcement as appropriate.
- d. Creating and increasing alternative clinical settings for those experiencing Behavioral Health Crises.

- e. Educating the Community regarding the availability of Behavioral Health Services in the Community,
- f. Improving the safety of those in Behavioral Health Crises and those responding by providing Crisis Intervention Training that includes educating first responders to respond appropriately to the symptomatic behavior of individuals with serious mental health needs who are in crisis, de-escalation techniques to reduce use of force and improve safety for both the community and law enforcement, and how to access community resources in order to link individuals to the effective level of treatment and/or services that is required.

Organization Outcomes

- a. Quicker response times
- b. Logistical improvements
- c. For law enforcement, more time to patrol and respond to situations that require a law enforcement response
- d. Greater utilization of mental health services
- e. Reduction in liability
- f. Reduction in number of currently incarcerated people and resources needed to care for them. What does this proposal have an ability to impact?

3. What does this proposal have an ability to impact?

- | | |
|--|--|
| <input checked="" type="checkbox"/> Children and youth | <input checked="" type="checkbox"/> Human services |
| <input checked="" type="checkbox"/> Community engagement | <input type="checkbox"/> Jobs |
| <input type="checkbox"/> Contracting equity | <input type="checkbox"/> Parks and recreation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Planning/development |
| <input type="checkbox"/> Economic development | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Education | <input type="checkbox"/> Utilities |
| <input checked="" type="checkbox"/> Environment | <input type="checkbox"/> Workforce equity |
| <input type="checkbox"/> Food access and affordability | <input type="checkbox"/> Other |
| <input checked="" type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

The above proposal will have impacts in all geographic areas in the County. The racial demographics of Los Angeles County as reported by www.racecounts.org are: White 27.2%; Latinx 48%; Black 8.0%; Native American .2%; Asian 13.8%; Pacific Islander .02%; Other .2; and 2+ races 2.2%. Source: American Community Survey Table DP05 (2014).

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

The Los Angeles County Sheriff's Department Custody Quarterly Report for the third quarter of 2018, indicates that the most populous groups of people in the jails during that time were Hispanic (52%); Black (29%) and White (15%), suggesting that a significantly higher percentage of Black people are justice-involved than exist in the general population. Data from www.racecounts.org, indicates that Black people are also significantly more likely to die from police encounters (Fatalities per 100,000: Black 1.37, Latinx .53; white .33, Asian Pacific Islander .29).

Other data suggests that certain racial groups are also exposed to inequities that increase stress and may also increase the need for behavioral crises intervention or contribute to circumstances that may lead to increased incarceration. Estimates place the number of currently incarcerated people suffering from mental health disorders at approximately 25-30. % According to The American Psychiatric Association, "people from racial/ethnic minority groups are less likely to receive mental health care. For example, in 2015, among adults with any mental health disorders, 48% of White people received mental health services, compared with 31% of Black people and Hispanics, and 22% of Asians." (www.psychiatry.org, "Mental Health Facts of Diverse Populations.") "Nearly a quarter of the County's African Americans (24.5 percent) and Latinos (23.7 percent) live below the poverty level—compared with about one in ten Whites (10.6 percent). Latinos are much more likely to be working poor compared with all other groups." (An Equity Profile of the Los Angeles Region, USC Program for Environment and Racial Equity). The working poverty rate for Latinos (12.5 percent) is almost three

times as high as for African Americans (4.3 percent). Id. Black people experience higher unemployment rates and lower income at all education levels than whites. Id. Low income Black and Latino people who are arrested are more likely to be unable to post bond and to remain in jail after arrest, even if they are never convicted. This can lead to disruption or loss of employment and health care, homelessness, and separation of families.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

LASD—The data provided by the LA County Sheriff’s Department (LASD) offers a wide perspective regarding recent trends observed Countywide in terms of police encounters with people who have mental health needs. Emphasis is placed upon those individuals who qualified under the law for a “hold” pursuant to WIC §§ 5150 or 5585, as a danger to themselves, danger to others in the community and/or gravely disabled due to mental health disorders.

WIC §§ 5150 or 5585 “Holds”	2018	2-yr Change	5-yr Change	MET Calls	MET Holds	% Holds by MET
Central Patrol Division	854	up 49%	up 89%	466	273	32.0%
Avalon	18	500%	800%	13	9	50.0%
Century	232	50%	176%	96	58	25.0%
Compton	238	38%	23%	96	60	25.2%
East LA	224	98%	207%	155	91	40.6%
Marina Del Rey	49	-8%	48%	37	16	32.7%
South LA	93	21%	21%	69	39	41.9%
South Patrol Division	1,624	up 71%	up 130%	1,221	790	48.6%
Carson	182	70%	27%	52	27	14.8%
Cerritos	80	8%	74%	89	47	58.8%
Norwalk	447	80%	224%	313	215	48.1%
Lakewood	631	96%	241%	506	337	53.4%
Lomita	114	24%	15%	67	40	35.1%
Pico Rivera	170	62%	81%	194	124	72.9%
East Patrol Division	1,520	up 92%	up 146%	1,094	723	47.6%
Altadena	135	150%	350%	55	40	29.6%
Crescenta Valley	59	31%	7%	31	16	27.1%
Industry	350	87%	127%	317	223	63.7%
San Dimas	176	66%	57%	67	30	17.0%
Temple	562	116%	219%	466	319	56.8%
Walnut	238	71%	164%	158	95	39.9%
North Patrol Division	2,757	up 72%	up 74%	2,356	1,392	50.5%
Lancaster	1,119	123%	155%	1,168	717	64.1%
Palmdale	585	34%	33%	549	325	55.6%
Santa Clarita	721	70%	49%	418	230	31.9%
Lost Hills/Malibu	148	-4%	0%	86	51	34.5%
West Hollywood	184	104%	159%	135	69	37.5%
All Patrol Divisions	6,755	up 72%	up 101%	5,137	3,178¹⁴¹	47.0%

While the provided data is not inclusive of every municipality in Los Angeles County, the data from the LASD offers a good cross section of all areas of the County as of calendar year 2018.

The Sheriff's Department and the County Board of Supervisors seek to have sufficient number of MET units Countywide to have MET responding to and/handling close to 90% of contacts with people with mental health needs to ensure the best possible outcomes and reduced uses of force by patrol deputies/officers. LASD reported in 2018, MET responded to and handled 47% of all "holds." The Civilian Oversight Commission and LASD MET have calculated 60 MET units as the minimum needed to meet this goal based upon numbers seen in 2018.

Data reveals a Countywide 2-year trend of 72% increased law enforcement encounters with people with mental health disorders who are experiencing crises. Over the past 5-years, the number of individuals placed on a "hold" by Sheriff's MET and patrol personnel has more than doubled in LA County.

The North County accounts for approximately 1/3 of law enforcement contacts with people with mental health needs in LA County, which has remained consistent for the past several years. However, the greatest increases in law enforcement encounters with people with mental health needs in 2018 was reported in the San Gabriel Valley (up 92%) followed by the South County (up 71%) with emphasis along the I-605 corridor in the First and Fourth Supervisorial Districts, which includes a significant number of individuals living in the San Gabriel Riverbed.

In addition to the obvious need for additional law enforcement/DMH collaborative "MET" or "SMART" team units, new or additional non-law enforcement community mobile and outreach resources are needed to keep up with the exponentially increasing demand for mental health crises and non-crisis services Countywide.

DMH

Per the consumers served in Outpatient Programs by ethnicity FY 16-17 data reported in the Los Angeles County Department of Mental Health Quality Improvement Work Plan Goals Evaluation report for CY 2017 (<http://psbqi.dmh.laCounty.gov/QUALITY%20IMPROVEMENT/QI%20Evaluation%20Report%202017.pdf>) , 57.2% (N=103,172) were Latinos, 21.6% (N=38,984) were African Americans , 16.6% (N=29,844) were White, 4% (N= 7,252) were Asian Pacific Islanders, and 0.55% (N=989) were Native American, These counts exclude the ethnicity unknown (N=13,786) and Other ethnicity (7,818). Based on the estimated prevalence rates for Serious Mental health disorders (SMI) and Serious Emotional Disorder (SED) from UCLA California Health

Interview Survey (CHIS), pooled estimates for CY 2015 and 2016 for population at or below 138% Federal Poverty level (FPL), penetration rates for FY 16-17 showed that of those estimated with SED and SMI percentage served for each of the ethnic groups was as follows: Latino at 59.7% (N=103,172/172,795), African American at 68.8% (N=38,984/56,701), White at 48.2% (N=29,844/61,956), API at 41% (N=7,242/17,709), and Native American at over 100% (N=989/851).

5. Are there data gaps? What additional data would be helpful in analyzing the proposal? If so, how can you obtain better data?

LASD

With 39 policing agency mental evaluation teams Countywide, in addition to DMH mobile response teams, there are multiple databases used to track various demographics associated with contacts with people who have mental health needs. In Los Angeles County, there is no single central collection point for such metrics associated with mobile outreach teams making contact with people who have mental health needs. Disparate database systems among police agencies are not linked to gather demographics data on the population of people who have mental health needs in LA County. A remedy for this is being investigated with a technical project ongoing and led by the Sheriff's Department (with CIO input) to eventually establish a central database in LA County to meet this need.

Today, the DMH likely has the best subset of information in this regard; however, the DMH dataset reflects just a fraction of all contacts with people who have mental health needs in LA County—only where a DMH clinician was present at the time of contact.

DMH

The data reported above for consumers served presents gaps as this does not include data related to other inequities related to other elements of culture per the National Culturally Linguistically Appropriate Services (CLAS) standards such as country of origin, degree of acculturation, linguistic characteristics, socioeconomic status, sexual orientation and gender identity, military affiliation and others.

Step #3:

How have communities been engaged?

Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

Among the most affected groups are those with mental health needs, who are experiencing mental health or other crises, who are or have been incarcerated, who lack access to a qualified mental health professional, or who are unable to obtain the services they need in a quick and timely manner, and their families. We understand that there is an ad hoc group tasked with identifying ways to increase community involvement in this project. In the meantime, persons who have experienced mental health needs, have had a loved one who has experienced mental health needs, who have been incarcerated or who have been active in community-based organizations have attended Work Group and ad hoc committee meetings and assisted in the preparation of our recommendations.

2. What has your engagement process told you about the burdens or benefits for different groups?

There are not enough resources to service those experiencing mental health crises and behavioral crises. Even where services are available, those in the community are not aware of them. Some individuals are reluctant to call law enforcement when they have a mental health need.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

We are continuing our investigation and exploration of possible causes. Please see response to Step 2, Question 2.

Adequate resources to ensure on-going data collection, public reporting and community engagement? Additional information is needed. We need additional time and also understand that there is an ad hoc committee assisting in gathering needed information. We need additional information regarding the events that trigger the need for crises intervention and potential responses and resources.

If the answer to any of the above questions is no, what resources or actions are needed?

Mental Health Court Programs

Goal 4: Increase and Improve Access to Treatment Services for Court-Involved Clients

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Expand and ensure easy access and timely linkage to treatment services for clients involved in the court process to a broader range of behavioral health programs and expand the diversity and capacity of those programs. Create a flexible and integrative service model across the Departments of Mental Health, Health Services and Public Health, in order to provide the most responsive system possible to client's service and housing needs. Streamline the referral process from arraignment to disposition, and avail Judges and Attorneys of the general menu of options available to qualifying clients requesting mental health, substance use disorder, or co-occurring treatment services.

2. What are the intended results (in the community) and outcomes (within your own organization)?

Results: Increase diversion and reduce incarceration of individuals with mental health needs by offering judicial officers easier access to outpatient, intensive outpatient, or residential treatment services and other supports in the community. Decreased need for hospitalization and law enforcement involvement.

Outcomes (for DMH): Better integration and coordination of care of diverted, justice-involved individuals. Better collaboration with other County departments and agencies. Better ability to provide effective services to clients/patients.

3. What does this proposal have an ability to impact? Criminal justice, health/mental health, government practices, children and youth (via impact on parents), housing, human services

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

This proposal should have a more robust impact on lower socioeconomic status areas with higher rates of people of color (e.g., African American, Latinx). Exact areas unknown, so racial demographics not known with certainty, either.

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

People of color are incarcerated at higher rates in Los Angeles County, both in the juvenile justice and adult criminal justice systems.

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies? TBD.

4. Are there data gaps? What additional data would be helpful in analyzing the proposal? If so, how can you obtain better data?

Yes. It would be helpful to know the race and ethnic makeup of individuals that may be eligible for diversion via court linkage programs.

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

Those who have mental health needs and criminal justice involvement, or family members of these individuals. Other individuals and society as a whole are also impacted, but less directly. We have solicited input from NAMI members and CBOs that represent individuals with criminal justice involvement.

2. What has your engagement process told you about the burdens or benefits for different groups?

Higher current burdens and likely more significant potential benefits for people and communities of color. People and communities of color tend to be arrested and incarcerated at higher rates.

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal? TBD

Adequate resources to ensure on-going data collection, public reporting and community engagement? No

If the answer to any of the above questions is no, what resources or actions are needed?

Integrated data tracking system for ODR, DMH (Court Linkage), Court, other partners. Ability to track, analyze, and report out on data/outcomes. May be accomplished via collaboration with academic partners (e.g., UCLA, USC, Rand).

Reentry

Goal 5: Improve Reentry Practices

Step #1:

What is your proposal and the desired results and outcomes?

1. Describe the policy, program, practice or budget decision (for the sake of brevity, we refer to this as a proposal in the remainder of the steps).

Improve pre-release and reentry practices to ensure that individuals with behavioral health needs can transition directly from jail into the appropriate community-based treatment and services

- A. Improve predictability of release dates and reduce after-hours releases of currently incarcerated people
 - > 1. Change release time policies for men leaving the jail to ensure they are not released overnight without the ability to link directly to programs or interim housing.
 - > 2. Fund community-based organizations to expand intake hours for interim housing programs and treatment programs to include overnight and weekend hours.
 - > 3. Fund a transition center within a few blocks of the downtown jails, operated by a community-based organization and providing a welcoming place to stay overnight, plus services
 - > 4. Implement more frequent LASD recalculation of release dates or provide data needed for release planners to better calculate the dates. Develop an automated mechanism to notify release planners of release date updates/changes.
 - > 5. Increase coordinated releases for people in jail exiting directly to programs, so that a specific time and date for release can be set and linkage facilitated.
- B. Improve treatment and linkage for individuals with co-occurring substance use disorder (SUD) and mental health needs:
 - > 1. Explore ways to incentivize community treatment facilities to accept patients from jail with co-occurring mental health disorders and SUD.
 - > 2. Expand access to START program SUD treatment services in County jails from the current 500 patients to at least 1,000 patients, with the goal of expanding to serve all those in need and an emphasis on patients with co-occurring mental health needs and SUD.

- > 3. Expand and enhance Medication Assisted Treatment (MAT) services in the jail, including methadone, buprenorphine, long-acting naltrexone, and specialty MAT clinics to allow patients to access patient-centered, harm reduction services on-site.

2. What are the intended results (in the community) and outcomes (within your own organization)?

- Effective connection between people released from jail to community services for improved recovery and vast reductions in recidivism
- Better case management and coordination between County agencies and CBO's
- Reduce relapse and overdose across LA County

3. What does this proposal have an ability to impact?

- | | |
|--|---|
| <input type="checkbox"/> Children and youth | <input type="checkbox"/> Parks and recreation |
| <input type="checkbox"/> Community engagement | <input type="checkbox"/> Planning/development |
| <input checked="" type="checkbox"/> Contracting equity | <input checked="" type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Criminal justice | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Economic development | <input type="checkbox"/> Workforce equity |
| <input type="checkbox"/> Education | <input checked="" type="checkbox"/> Other: Recidivism, public safety
& public health safety net programs |
| <input type="checkbox"/> Environment | |
| <input type="checkbox"/> Food access and affordability | |
| <input type="checkbox"/> Government practices | |
| <input checked="" type="checkbox"/> Health | |
| <input checked="" type="checkbox"/> Housing | |
| <input checked="" type="checkbox"/> Human services | |
| <input checked="" type="checkbox"/> Jobs | |

Step #2:

What's the data? What does the data tell us?

1. Will the proposal have impacts in specific geographic areas (neighborhood, areas, or regions)? What are the racial demographics of those living in the area?

Advancement Project JENI/JESI data (in development) showed which areas across LA County have higher need for services and transition centers

Need a mechanism to track racial demographic data

2. What does population level data, including quantitative and qualitative data, tell you about existing racial inequities? What does it tell you about root causes or factors influencing racial inequities?

Black people make up about 9% of the population in LA but 33% of the population in LA jails

Communities that are disinvested, poverty-stricken and overpoliced, like South LA, East LA and parts of the Antelope Valley, have higher rates of people with SUD's, homelessness, and incarceration rates.

DHS-CHS estimates that among approx. 5,000 currently incarcerated people with mental health needs in LA jails, 76% have a co-occurring SUD, for an estimated 3,600 currently incarcerated people with co-occurring disorders.

An estimated 2,500 LA County people in jail on any given day report issues with alcohol and opioid use

3. What performance level data do you have available for your proposal? This should include data associated with existing programs or policies?

DHS-CHS now operates the Substance Abuse Treatment and Reentry Transition (START) program, which provides in jail SUD treatment to approx. 500 people on any given day.

START uses evidence-based practices including cognitive behavioral therapy and motivational interviewing.

There are currently 95 COD treatment slots but approximately 1,800 are needed to meet the actual need

4. Are there data gaps? What additional data would be helpful in analyzing the proposal?

If so, how can you obtain better data?

Capture, and make accessible, disaggregated data to gauge how well LA County is diverting residents from incarceration by race, gender, and ethnicity

LASD data does not provide sufficient info to understand the direct links between individuals experiencing with mental health needs, substance use disorders, homelessness and their average length of stay and demographics

Better tracking of the costs of the incarceration system, including per-bed spending, to scale up non-incarceration alternatives that can potentially free up savings for reinvestment into community-based reentry programs

Environmental scan of effective community-based service providers to expand and stimulate capacity and growth

Identify key structural gaps in the continuum of care by engaging service providers and CBO's

Step #3:

How have communities been engaged? Are there opportunities to expand engagement?

1. Who are the most affected community members who are concerned with or have experience related to this proposal? How have you involved these community members in the development of this proposal?

The Justice Equity Alliance, made up of Community Coalition, LA Voice, and Advancement Project, has collected hundreds of surveys and conducted several focus groups across LA County with justice system impacted individuals and their family members of all races. The focus groups consisted of predominantly Black and Brown folks and was centered around community-based care, and there was overwhelming consensus on the need for more culturally competent reentry programs.

2. What has your engagement process told you about the burdens or benefits for different groups?

Some of the burdens that were lifted were the clear lack of resources and safety network services in the community's folks returned to

Another burden was relying on the Probation Department to assist with reintegrating back into society. Folks we polled and interviewed highlighted the benefit of having a community-based network of service providers, family, faith-based and CBO's

3. What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal?

Many people of color have been criminalized as threats to public safety, instead of marginalized individuals dealing with poverty, lack of access to quality jobs, education, housing, and food.

The opioid epidemic is now being looked at as a public health crisis with treatment and services but the crack cocaine epidemic affecting Black people was met with militarized, over policing and suppression, mandatory minimums, and sentencing disparities.

NOTES

- 1 David Cloud and Chelsea Davis, “First Do No Harm: Advancing Public Health in Policing Practices”, (New York: Vera Institute of Justice, 2015), https://storage.googleapis.com/vera-web-assets/downloads/Publications/first-do-no-harm/legacy_downloads/First-Do-No-Harm-FINAL-12032015.pdf
- 2 U.S. Department of Justice, letter to Anthony Peck, Esq. Deputy County Counsel and Stephanie Jo Reagan, Esq. Principal Deputy County Counsel for Los Angeles County, 04 Jun. 2014
- 3 Ryan A. Crowley, and Neil Kirschner. “The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper” *Health and Public Policy Committee of the American College of Physicians: Annals of Internal Medicine*. (2015) https://www.integration.samhsa.gov/Integration_of_BH_into_primary_care_Annals_of_Internal_Medicine.pdf
- 4 See Vera Institute of Justice, “Incarceration Trends”, <http://trends.vera.org/rates/los-angeles-county-ca>. (Hereinafter Vera, Incarceration Trends)
- 5 Bureau of Justices Statistics, “Annual Survey of Jails”, 2016 (ICPSR 37135). The 157,000 jail admissions include admissions to some city jails as well as LA County Jails. Annual jail admissions were reported by Los Angeles County Sheriff’s Department (112,852), Glendale Police Department (5,150), Long Beach Police Department (31,775), Monterey Park Police Department (740), Whittier Police Department (2,508), Alhambra City Jail (2,275) and the Montebello Police Department City Jail (1,885). In Chicago (Cook County) and New York City, there is just one jail system in each respective jurisdiction
- 6 Los Angeles County Sheriff’s Department, “Custody Division Quarterly Report: July – September 2018”, http://www.la-sheriff.org/s2/static_content/info/documents/Custody_Third_Quarter_Report_2018.pdf, (2018). (Hereinafter, LASD, Custody Report)
- 7 LASD, Custody Report
- 8 LASD, Custody Report
- 9 U.S. Census Bureau (2018). Quick Facts: Los Angeles County, California. Retrieved from: <https://www.census.gov/quickfacts/losangelesCountycalifornia>
- 10 U.S. Census Bureau (2018). Quick Facts: Los Angeles County, California. Retrieved from: <https://www.census.gov/quickfacts/losangelesCountycalifornia>
- 11 German Lopez, “How America’s criminal justice system became the country’s mental health system,” <https://www.vox.com/2016/3/1/11134908/criminal-justice-mental-health>, (October 18, 2016)
- 12 At least 20 percent of the jail mental health population self-reports being homeless. Los Angeles County Department of Health Services (LAC DHS), “Unpublished Administrative Data” (2017)
- 13 In addition to the substance use disorder numbers, 523 people needed medical housing (not ADA designated; an additional 447 people needed ADA designated housing). Los Angeles Sheriff’s Department, Custody Report
- 14 Looney A and Turner N. *Work and opportunity before and after incarceration*. (Washington, DC: The Brookings Institution, 2018), <https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/>
- 15 25% of jail inmates overall report being homeless. LASD, Custody Report
- 16 LASD, Custody Report
- 17 LASD, Custody Report
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