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Mental Health Commission
MHC Finance and Justice Systems Committee
Joint Committee Meeting
Tuesday, January 19th, 2023, 1:30-3:00 PM
Via: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481

Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from the October 20th, 2022 MHC Finance Committee Meeting**

VI. **APPROVE minutes from the October 25th, 2022 Justice Systems Committee meeting**

VII. **DISCUSS meeting of MHC Chair Barbara Serwin; Director of Behavioral Health Services, Dr. Suzanne Tavano; Assistant County Counsel, Rebecca Hooley; MHC Chair, Barbara Serwin, to discuss the reasons why BHS and County Counsel are opposed to providing data regarding the diagnosis(es) of mentally ill persons detained at the Martinez Detention Facility (MDF), including potential next steps forward, MHC Chair, Barbara Serwin**

(Agenda Continued on Page Two)

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers. The Commission is pleased to make special accommodations, if needed, please call ahead at (925) 313-9553 to arrange.

VIII. DISCUSS with Dr. Marie, Scannell, Director, Forensic Mental Health (FMH) Dept. of Contra Costa Behavioral Health Services (CCBHS), the Dept. of State Hospitals (DSH) 2022-2023 and onward funding for Contra Costa's Incompetent to Stand Trial (IST) population

IX. Adjourn

ATTACHMENTS:

A. 2022-2023 DSH Funding Legislation to help counties care for their Incompetent to Stand Trial (IST) population

B. Summary Analysis of the 2022-2023 DSH Funding Legislation

C. Progress Report on Scaling up Diversion and Reentry Efforts for People with Serious Clinical Needs, Los Angeles County Health Services (9/9/2019)

D. 2020 RAND Research Report

E. Juvenile Justice Commission Position Statement, October 24, 2022

Department of State Hospitals
Incompetent to Stand Trial Solutions Proposal

The 2021 Budget Act included $75 million in fiscal year (FY) 2021-22 and $175 million in FY 2022-23 and ongoing to support the immediate implementation of actionable solutions, based on recommendations identified by the Incompetent to Stand Trial Workgroup, to provide timely access to treatment for individuals with serious mental illnesses who are found incompetent to stand trial (IST) on felony charges. The Administration proposes a total of $571 million ongoing beginning in FY 2022-23 to support implementation of solutions to provide timely treatment and support the ongoing efforts to decriminalize mental illness in California.

This document provides background regarding California's IST crisis, describes the elements in the Administration's proposal and serves as the basis for further discussions with stakeholders and the Legislature regarding the proposed solutions to be implemented.

Background

Like most states in the country, California is home to thousands of vulnerable and sick individuals who, as a result of not being engaged in early, upstream treatment and support interventions, decompensate to a point where engagement and treatment is difficult. The lives of many of these Californians are lives of illness, vulnerability, and homelessness, and they often cycle in and out of incarceration. Criminal defendants who are unable to understand criminal proceedings or assist counsel in their defense are determined by a court to be Incompetent to Stand Trial (IST). If these individuals are charged with a felony, they can be committed to the Department of State Hospitals (DSH) to provide clinical and medical services with the goal of restoring their competency and enabling them to return to court to resume their criminal proceedings.

Although the 2022-23 Governor's Budget and recent prior budget acts make significant investments that will expand community based behavioral health infrastructure and services, there is still an increasing number of individuals with under or untreated mental health conditions who are being found IST and referred to DSH. Despite recent efforts including increased bed capacity, decreases to the average length of stay, and the implementation of county-based treatment programs, the increasing number of county IST referrals has resulted in a large waitlist and long wait times for defendants pending placement to DSH. Furthermore, the impacts of the COVID-19 Pandemic and necessary infection control measures put in place at DSH facilities resulted in slower admissions and reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union sued DSH (*Stiavetti v. Clendenin*) alleging that the amount of time IST defendants were waiting for admission into a DSH treatment program violated individuals' due process rights. The Alameda Superior Court ultimately ruled that DSH must commence substantive treatment services within 28 days from receipt of commitment for felony IST patients, with a specified timeline for meeting that standard over the next three years.

In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed IST on felony charges. The legislation also includes triggers that will authorize DSH to stop admission of Lanterman-Petris-Short (LPS) patients and impose LPS census reduction targets if satisfactory progress towards implementing Workgroup solutions is not made within the outlined timeframes.

The IST Workgroup convened between August 2021 and November 2021 with several representatives and stakeholders from multiple state agencies, the Judicial Council, local government, and justice system partners, as well as representatives from patients' rights and family member organizations. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH restoration of competency programs. The Workgroup report released on November 30, 2021 summarizes identified strategies and solutions and can be reviewed at: https://www.chhs.ca.gov/wp-content/uploads/2021/12/IST_Solutions_Report_Final_v2.pdf.

DSH IST Solutions Proposal Summary

DSH proposes to implement the following solutions informed by the recommendations developed by the IST Solutions Workgroup. Utilizing a combination of existing funding for IST programs, the $75 million in FY 2021-22 and $175 million ongoing that was set aside to support IST solutions implementation, the Governor's Budget proposes a total of $571 million in ongoing funding beginning in 2022-23. The components of the proposal below will provide early stabilization, care coordination, expand community-based treatment and diversion options for felony ISTs that will help end the cycle of criminalization and increase community transitions for state hospital patients. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in *Stiavetti v. Clendenin*. These proposals also have corresponding proposed trailer bill language, which will be made publicly available in the near future.

Early Stabilization and Community Care Coordination

The goal of Early Stabilization and Community Care Coordination is to provide timely access to treatment and to promote stabilization of IST defendants to increase community-based treatment placements.

1. Stabilization and Early Access Treatment

   $24.9 million from the $75 million current year set-aside and $66.8 million ongoing will be dedicated to providing essential treatment services to individuals on DSH's IST waitlist. This robust program will provide access to treatment at the earliest point possible upon IST commitment when individuals are arrested and booked into jail. Treatment will be facilitated in partnership with county jail mental health providers for individuals found to be IST on felony charges and will include administration of medications, increased clinical engagement, and competency education. Existing Jail-Based Competency Treatment (JBCT) program infrastructure and resources will be leveraged to offer early access to treatment services for additional felony IST defendants waiting in jails.

   In addition, resources are included to support the cost of psychotropic medications including long-acting injectable (LAI) medications. The goal is to facilitate the stabilization and medication compliance of IST patients, both of which will promote increased eligibility and placement in a diversion or other community-based treatment programs.

2. Care Coordination and Waitlist Management

   As DSH continues to add community-based programs to the menu of patient placement options to mitigate the IST crisis, DSH's Patient Management Unit's (PMU) role as the hub of patient information and coordination continues to grow more complex. $1.7 million from the current year set-aside and $4.9 million in budget year is included to further enhance the tracking and management of all felony IST patients committed to the department. Teams will screen all felony IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment-to-admission case management to coordinate appropriate placements and maximize bed usage for ISTs. Resources are included to enhance existing technology systems and to develop a statewide transportation contract to transport patients between facilities within the DSH continuum of care to better facilitate inpatient admissions and transfers. Also included are resources to assist with gathering and maintaining high data quality and meeting data reporting requirements under *Stiavetti*.

Expanding Felony IST Community Programing via Community Based Restoration and Diversion

The goal of expanding Community Based Restoration (CBR) and Diversion programs is to provide care in the most appropriate community-based setting as an alternative to a placement in a DSH bed. The DSH-Diversion program is designed to serve eligible felony IST defendants in intensive community-based services and, if defendants are successful in the program, to have the current charges dropped. DSH's CBR program is also community-based treatment, but with the focus of restoring competency so a defendant's criminal proceedings can resume. Once an individual is restored to competency and their charges are resolved or an individual completes diversion and the charges are dropped, the goal is to transition them to long-term community treatment and support to ultimately reduce the cycle of criminalization. DSH estimates that 60-70% of IST commitments will be eligible for services each year in a community-based program, for a total of approximately 3,000 felony ISTs based on the current (first quarter of 2021-22) monthly average referral rate of 455 ISTs.

The expansion of existing CBR and Diversion programs are made alongside an investment in infrastructure funding to support a dedicated inventory of community placements, most notably housing, to serve felony ISTs in these programs. The following program enhancements were developed in response to the recommendations of the IST Solutions Workgroup.

1. Housing Augmentation for Current Diversion Contracts

   $42 million of the $75 million IST Solutions current year set-aside is dedicated to a one-time interim housing investment for felony IST clients participating in the DSH Diversion program. An additional $18 million in funds from the existing Diversion program will also be leveraged. $75,000 per client will support the cost of appropriate housing to facilitate increased placements into county Diversion programs. This funding will be limited to new clients who have been found felony IST and may not be used to support likely-to-be IST defendants. Counties can utilize this funding to provide housing to diversion clients in the most appropriate level-of-care including, but not limited to short-term treatment facilities such as Institute for Mental Disease (IMD) and Mental Health Rehabilitation Centers, residential housing with clinically enhanced services, board and care homes, or other appropriate residential facilities.

   These resources are designed as a short-term solution to increase the number of felony ISTs served in county diversion programs. Limited placements and housing inventory in the community, as well as the stigma associated with this population, creates barriers for counties that current

Diversion funding levels cannot overcome. This additional funding will support county efforts to secure appropriate placements and housing for Diversion clients until DSH is able to partner with counties to establish long-term residential housing infrastructure (see next section).

2. Felony IST Residential Housing Infrastructure Investments – 5,000 CBR or Diversion Beds

   $6.4 million from the current year set-aside and $233 million one-time funds are dedicated to infrastructure to develop residential housing settings to support felony IST individuals who are participating in either community - based restoration or diversion programs. DSH estimates that approximately 3,000 of the individuals found IST annually are eligible for participation in community-based treatment programs. Average lengths of stay of 18-20 months results in a housing deficit of approximately 5,000 beds. The proposed funding level assumes these beds will be spread across approximately 700 housing units of 8-10 beds each and approximately $350,000 in start-up funds will be provided for each unit to cover the down payment, necessary retrofitting, and furnishings for staff and patients. The ongoing cost of operating the homes will be provided through a per-patient rate (described below), paid to counties or to service providers, who are responsible for securing client housing and providing wrap-around treatment services.

   This residential housing program will complement the IMD, and Sub-Acute infrastructure program funded in the 2021 Budget Act. IMD and sub-acute beds are a key component for treating felony ISTs in the community. DSH is currently developing new IMD and Sub-Acute capacity across the state, and these beds will be available as a step-down stabilization option for ISTs transitioning from jail to the community and can also be utilized when IST clients in the community need a higher-level of care. Together, these programs will create a complete continuum of community placement and housing options for ISTs across the state.

3. Felony IST Community Program Funding for CBR or Diversion Clients

   In combination with current budget authority to support existing CBR and Diversion programs, DSH will invest $136.5 million from the $175 million set-aside in the budget year for IST solutions and an additional $130 million ongoing to the creation or expansion of permanent community-based treatment programs for felony IST patients. These resources will support a robust per-patient rate, non-treatment costs of managing community-based programs, transitional housing support for IST defendants released

directly from custody, and substantial technical assistance resources for participating counties.

Counties will receive $125,000 per felony IST client treated in either a CBR or Diversion program. This rate is intended to support an intensive community treatment model with increased frequency of clinical contacts and access to psychiatry services, as well as all wrap-around services, and housing costs for an average 18-month length of stay. In addition, this rate is intended to support the use of both forensic peer specialists and partnerships with county probation departments to increase treatment engagement and success in community programs.

DSH acknowledges that County costs for establishing and maintaining this programming goes beyond the direct costs of care for the clients. Ongoing new funding is also included to assist counties with the additional costs incurred by the county implementers and stakeholders involved in planning and running these programs. Funds will be allocated based on the county's baseline number of actual IST referrals, and can be used by counties to pay for expenses such as a community care coordinator to facilitate client placement, a forensic evaluator, additional positions for the District Attorney and Public Defender offices, pre-trial probation services, additional Public Guardian services, and data collection activities. In addition to this allocation, every participating county will receive $100,000 per year to support local behavioral health and justice stakeholder collaborative efforts to identify solutions that target the overall reduction of felony IST commitments in their county.

DSH also proposes to work with counties to explore opportunities for transitional placement services to support client housing needs if an IST is restored in jail and released back to the community. The goal is to facilitate a smooth community transition and allow time for the county's coordination of benefits and qualified services.

Finally, $6 million ongoing is included for robust technical assistance for counties, an external program evaluation of the community programs established, and resources for DSH to provide administrative and clinical support to the community programs. These components are intended to fully support counties in effectively managing the treatment of felony ISTs in their communities through workforce development initiatives, clinical and psychopharmacological support and training, and data-driven decision-making.

Increased Placements to CONREP and Transitions to County Services

$433,000 ($1.2 million ongoing) is included to pilot a new independent placement determination panel to increase the number of individuals served in the community via Conditional Release Program (CONREP). This new panel will revise the Community Program Director (CPD) role as part of CONREP and improve the assessment process for patients who are committed to DSH as Not Guilty by Reason of Insanity (NGI) or as an Offender with Mental Health Disorder (OMD). The overall increased utilization of CONREP will free beds in the state hospitals. While CONREP CPDs will continue to be responsible for placement determinations of ISTs prior to DSH commitment, future consideration will be made to revise this responsibility and pilot an independent evaluation model for IST placement determinations.

Felony IST Growth and County Share of Costs

These investments support the goal of providing care in the least restrictive, community-based settings while maintaining public safety. The growing number of county IST referrals is largely driven by insufficient appropriate community treatment services which leads to under or untreated individuals with serious mental illnesses being increasingly involved in the justice system. To ensure that the expansion of DSH funded community-based care does not create unintended incentives that drive additional IST referrals, the state will implement a growth cap that will include a county cost sharing methodology if the growth cap is exceeded.

DSH proposes to set each county's referral cap at the total number of felony ISTs committed to DSH in the current fiscal year (FY 2021-22). If counties exceed their baseline referral rate, they will be responsible for a portion of treatment costs for IST patients that are referred above their baseline. The total share of cost of care will be based on the treatment location for each IST patient (DSH in-patient or community-based programs) and will apply to all counties, regardless of whether they contract with the department for community-based programming.

Proposal Funding Summary

Program Costs	CY	BY Ongoing
	(Dollars in Thousands)	
Early Stabilization and Community Care Coordination		
Stabilization and Early Access Treatment	$ 24,900	$ 66,800
Care Coordination and Waitlist Management	$ 1,700	$ 4,900
Subtotal, Stabilization and Community Care Coordination	**$ 26,600**	**$ 71,700**
Funding - IST Solutions $75M & $175M	*$ 26,600*	*$ 38,500*
Additional Funding Needed	$ -	$ 33,200
Expanding Felony IST Community Programming via Diversion and Community Based Restoration		
Housing Augmentation for Current Diversion Contracts	$ 60,000	$ -
Felony IST Residential Housing Infrastructure Investments - 5,000 CBR or Diversion Beds	$ 6,400	$ 233,000
Felony IST Community Program Funding for CBR or Diversion Clients	$ -	$ 266,500
Subtotal, Expand Community Capacity	**$ 66,400**	**$ 499,500**
Existing Diversion and CBR Authority	*$ 18,000*	*$ 46,000*
Funding - IST Solutions $75M & $175M	*$ 48,400*	*$ 136,500*
Additional Funding Needed	$ -	$ 317,000
Increased Placements to CONREP and Transitions to County Services		
Increased CONREP Placements	$ -	$ 433
Subtotal, Increased CONREP Placements and Transition Services	**$ -**	**$ 433**
Funding - IST Solutions $75M & $175M	$ -	$ -
Additional Funding Needed	$ -	$ 433
Total, DSH IST Solutions Proposal	**$ 93,000**	**$ 571,000**
Existing Diversion and CBR Authority	$ 18,000	$ 46,000
Funding - IST Solutions $75M & $175M	$ 75,000	$ 175,000
Total Additional Funding	$ -	$ 350,000

DSH IST 2022-2023 Funding Analysis by Douglas Dunn

Dept. of State Hospitals (DSH) 2022-2023 IST funding help for the counties: 8 pages. Funding Summary is on Page 8 of the DSH document. Important Points:

$571M/year increased to $625M/year in 2025-2026 ongoing help proposal divided between:

- **Early Stabilization & Community Care Coordination**—page 3
  1. Stabilization and Early Access to Treatment
     A. $25.9M in 2021-2022 dedicated to providing essential treatment services for persons on the DSH waitlist. $66M annually ongoing within existing counties Jail-Based Competency Restoration (JBCT) programs.
     B. Resources included to provide Long-Acting Injectable (LAI) medications to persons on the waitlist.
  2. Care and Coordination Waitlist Management--$.1.7M in 2021-2022 and $.4.9M ongoing to establish and maintain tracking of all Incompetent to Stand Trial (IST) persons in the DSH system.
- **Expanding Felony Incompetent to Stand Trial (FIST) Community Programing vis Community Based Restoration (CBR) and Diversion**—Pages 4-6.
- 60-70% of IST commitments yearly eligible each year for CBR & Diversion. This means 3K annually and 455 referrals monthly are eligible for CBR & Diversion.
  1. Housing Augmentation for Current Housing Contracts—Pages 4-5
     A. $42M from 2021-2022 one time set aside and an existing $18M can be sued for clients participating in a Community Diversion program.
     B. $75K/client will be used to support clients in appropriate levels of housing, including shorter-term treatment facilities such as Institute of Mental Diseases (IMD) Mental Health Rehabilitation Centers (MHRCs).
  2. (FIST) Residential Housing Infrastructure Investments – 5,000 CBR or Diversion Beds--Page 5
     A. $6.4M from current set aside and $233M in one-time funds dedicated to rehabilitate or build housing to support FIST clients in CBR & Diversion programs.
     B. Assumes per client Avg. Length of Stay (ALOS) of 18-20 months, need for 5K beds in 700 units of 8-10 persons each and approximated $350K/unit in provided start-up funds.
  3. Felony IST (FIST) Community Program Funding for CBR or Diversion Clients--Pages 5-6
     A. $136.5M from 2021-2022 budget & $130M ongoing to provide permanent , community based treatment programs for the FIST population
     B. $125K/FIST client , including complementing the IMD and Sub-acute infrastructure program step-down programing for FIST clients transitioning from jail or clients in the community needing a higher level of care. Assumes an 18 month Length of Stay (LOS)/client.
     C. Baseline # of county FIST referrals will be used to pay for non-direct cost of care and services such as additional District Attorney, Public Defender, pre-trial probation services and Public Guardian personnel.
     D. Every participating county will receive $100K/year to support stakeholder efforts to identify solutions that will reduce IST commitments in their county.
     E. $6M/year ongoing Technical Assistance to participating counties.

- **Increased Placements to CONREP and Transitions to County Services**—Page 7
  NOTE: $33K (2021-2022) and then $1.2M ongoing proposed) for persons committed to DSH as either Not Guilty by Reason of Insanity (NGI) or Offender with a Mental Health Disorder (OMD)..

- **Felony IST Growth & County Share of Costs**—Page 7.
- **NOTE:** DSH is implementing a referral cap based on each counties FIST's committed to DSH in 2021-2022. It they exceed their referral cap, they will be responsible for the portion of treatment costs for IST patients referred above the 2021-2022 baseline. Total share of cost of care t/b based on each IST patient's treatment location (DSH inpatient or in-community).

Health Services
LOS ANGELES COUNTY

September 9, 2019

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

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Fourth District

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Fifth District

Christina R. Ghaly, M.D.
Director

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TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **PROGRESS REPORT ON SCALING UP DIVERSION AND REENTRY EFFORTS FOR PEOPLE WITH SERIOUS CLINICAL NEEDS (ITEM #17 FROM THE AUGUST 14, 2018 BOARD MEETING)**

On August 14, 2018, the Board of Supervisors (Board) approved a motion titled "Scaling up Diversion and Reentry Efforts for People with Serious Clinical Needs." This motion directed the Director of the Department of Health Services (DHS) to analyze three major categories addressing "how the County can continue to build and scale the appropriately sized and qualified network of community services to divert, treat and support inmates with serious clinical needs, as well as prevent their entry into the criminal justice system." The progress on each directive is reported here.

DIRECTIVE 1: STUDY OF EXISTING COUNTY JAIL POPULATION TO IDENTIFY WHO WOULD LIKELY BE ELIGIBLE FOR DIVERSION.

The Office of Diversion and Reentry (ODR) contracted with RAND Corporation, Groundswell Services, Inc., UCLA School of Law, and UC Irvine to conduct a scientific study of the current jail population in order to identify the proportion of the mental health population that could be diverted from the jail into community settings of care. Additional study is needed to identify those in the existing jail population with substance use disorder and those in the general population who may be eligible for diversion based on their clinical conditions and current criminal charges. Results from this additional study, along with the final report from RAND, would be used to finalize the Los Angeles County's strategy for creating and scaling community-based diversion and re-entry.

While waiting for results from the final RAND study, slated for release in 2020, ODR conducted a preliminary analysis with statistical guidance from RAND that focused on the jail population with mental health conditions.

Using a data set of the jail mental health population on February 14, 2019 (n=5134) provided by the Los Angeles County Sheriff's Department, ODR randomly selected 500 individuals and examined both their clinical and legal status in order to assess their likelihood for diversion. Measures were taken to ensure inter-rater reliability and a representative sample. Midway through

data collection, ODR also met with the Office of the District Attorney (DA), the Public Defender (PD), and the Alternate Public Defender (APD) to validate their assessment using randomly selected cases from the data set. Of the 500 cases examined, 56% (95% confidence interval: 52-61%) were found to be appropriate for potential release to community-based services and 7% (95% confidence interval: 5-9%) were found to be potentially appropriate. This study found that a substantial portion of the jail mental health population could be effectively supported in community-based care, and the findings informed our estimates regarding the size and scope of scaling up diversion efforts for this segment of the jail population. See the special report attached (*An estimate of persons in the jail mental health population likely to be appropriate for safe release into community services*, April 17, 2019).

DIRECTIVE 2: ASSESSMENT OF RETURN ON INVESTMENT AND OUTCOMES OF THE EXISTING ODR HOUSING PROGRAM.

ODR contracted with RAND Corporation, in a separate statement of work than the one noted above, to perform an initial study on housing retention and rearrests in ODR's Supportive Housing Program. See the special report attached (*Los Angeles County Office of Diversion and Reentry's Supportive Housing Program, A Study of Participants' Housing Stability and New Felony Convictions*, June 28, 2019). This report presents early findings indicating 6- and 12-month housing stability rates of 91% and 74%, respectively. ODR Housing retention rates are lower than that seen among the population that DHS' Housing for Health unit has placed in permanent supportive housing; these are typically in the 90% range. This difference is believed to be due to the disproportionately high acuity of behavioral health conditions among ODR clients. Many of those served by ODR are individuals who are difficult to engage in treatment and not those who may otherwise come into contact with the County's non justice-related homelessness or housing systems.

The above study also assessed rearrest rates among clients in ODR's Supportive Housing Program. For the first cohort that was placed in permanent supportive housing more than one year ago, 14% had a new felony conviction. While there is limited literature on recidivism rates for the jail population, especially for those with serious mental health disorder and histories of chronic homelessness, among the limited studies that do exist, the ODR Housing outcomes are very promising. One such study cites a 53% recidivism in the first year for persons with serious mental disorders, and another study finds 68% recidivism in the first year for persons with co-occurring mental disorder and substance use disorder (Hirschtritt, 2017, Blank 2012).

A separate in-depth study looking at County service utilization and cost savings from ODR programs is currently underway and is anticipated to be available by Summer 2020. We will provide a report of this study's findings to the Board once it is available.

DIRECTIVE 3: CREATION OF A ROAD MAP FOR THOSE WITH SERIOUS CLINICAL NEEDS WHICH INCLUDES A DESCRIPTION OF THE TYPES OF COMMUNITY PROGRAMS AND FACILITIES REQUIRED TO SERVE THE DIVERTABLE POPULATION, AND THE STAFF, FUNDING SOURCES, LEGISLATIVE AND/OR POLICY CHANGES, INFORMATION TECHNOLOGY NEEDS AND DEPARTMENTAL AND JUSTICE PARTNER CULTURE-BASED TRANSFORMATIONS NEEDED TO IMPLEMENT THOSE PROGRAMS.

The Road Map to diversion into community services is preliminary at this point and includes primarily an analysis of community-based capacity needed for persons with serious mental health conditions in the Los Angeles County jail system. Included is some consideration for

other populations (e.g., those in need of detox beds or skilled nursing beds) but given that ODR has less experience in diversion in these (or other medically complex) populations, we were more limited in the conclusions that could be drawn about divertability and quantity of community-based capacity needed. Some aspects of this preliminary Road Map are unique and tailored to the legal and clinical environment in Los Angeles County; other aspects are innovations found to be successful in other jurisdictions.

The attached table (Table 1) shows the projected community capacity need by level of care based upon jail demand, divertability, and length of stay for a segment of the jail population. These data primarily take into account those in the jail specialty mental health population as well as individuals who are medically complex and estimates their ongoing community care need (over a three-year period) based upon presumed divertability. Inmate/patients included in the Los Angeles County Sheriff's Department mental health counts who reside in the jail's general population were not included in Table 1 (however, their divertability could be estimated in a future study using existing data). Quantifying community services for persons with primary substance use disorders was not included in this preliminary report since there has not been any large-scale targeted diversion efforts focused on this population and thus their divertability at this time is difficult to measure. Footnotes in Table 1 describe how calculations and estimates were obtained.

Table 1 focuses on community resources needed based upon jail demand. It does not include pre-booking interventions, which are an important part of diversion. It is difficult to estimate the need for pre-booking diversion, though existing data provided by Exodus Recovery Services, Inc. shows that the Los Angeles County's mental health urgent care and sobering centers are caring for approximately 10,000 persons per year, 82% of whom are homeless, and less than one percent of whom are discharged with housing resources. The majority (87%) are brought in on Welfare and Institutions Code (WIC) 5150 involuntary holds. In order to create meaningful pre-booking diversion services, connection to housing must be assured (as it is in ODR's pre-booking LEAD program) and "crisis diversion" must be more broadly available, not just through WIC 5150 holds. Models for these crisis diversion centers connected to dedicated housing are described below and are key elements of the Alternatives to Incarceration (ATI) Work Group recommendations due to the Board by the end of the year.

Sequential Intercept Mapping: In order for diversion to work, interventions and programming must occur well before any contact with the criminal justice system, and at each point of contact along the way. The ATI is engaged in a detailed mapping of proposed and existing community-based interventions and services at each intercept zero through six as well as numerous recommendations on the infrastructure that would need to exist to support those interventions and services, from prevention through reentry. The ATI Work Group has engaged hundreds of County and community stakeholders, as well as intensive community engagement sessions including those who have personal experience with the criminal justice system, to reach consensus on these recommendations and map. The work describes a decentralized, community-based system of care and vastly expanded diversion opportunities and alternatives to jail custody for people with clinical behavioral health disorders and some other vulnerable groups in jail custody. The final ATI map and implementation plan will be included in their December 2019 report to the Board.

The Importance of Including Resources for Persons with Substance Use Disorders: Persons with substance use disorders make up the majority of the jail population on any given day. The majority of persons in the mental health population of the jail also have a co-occurring substance use disorder, which in many cases becomes the pivotal aspect of their health and

behavior, which leads them to jail. Treating those with substance use disorders as part of any diversion plan is essential. This report includes recommendations on the need to build out residential substance use treatment for those who are divertable. However, we were unable to estimate the divertable population of those with substance use disorders alone (i.e., without co-occurring mental illness) via the studies completed for this report due to a lack of experience with these populations. As noted earlier in the report, an additional study is needed to inform this assessment. At the Board's guidance, talks are underway with the Superior Court leadership in order to consider how substance use disorder diversion might be expanded in the future in our County. This subject is also a component of the ATI work.

A description of the kind of programs needed and the type of facilities needed to site them

ODR currently operates several diversion programs, both pre-booking and post-booking. These programs, focused on medically complex populations and those with serious mental illness, could inform the expansion of new diversion programs for other medically fragile populations as well as those with a primary diagnosis of substance use disorder. A portfolio of flexible, community-based programming offering a broad continuum of services must be available to successfully divert the wide variety of individuals who might be eligible. The types of placements that might commonly be used are listed and briefly described below.

- Acute psychiatric inpatient care – Acute psychiatric inpatient care is the most intensive level of psychiatric care. Treatment is provided in a secure locked facility that is medically staffed with a multimodal approach. Daily evaluations by a psychiatrist, 24-hour skilled psychiatric nursing care, medical evaluations, and a structured milieu are required. The goal of an inpatient psychiatric hospitalization is to stabilize the individual who is experiencing acute psychiatric symptoms with a relatively onset or marked decompensation of a more chronic condition. To be suitable for acute psychiatric hospitalization, the individual must meet criteria for a WIC 5150 hold; meaning, the person must be a danger to themselves, a danger to others, and/or gravely disabled due to a serious mental disorder. ODR currently has access to 18 beds of acute psychiatric inpatient care on a dedicated ward at Olive View-UCLA Medical Center. Inpatient services can be reimbursed by an individual's insurance and the ODR team is working with DHS Finance as well as with the Department of Mental Health (DMH) and other entities to ensure that we maximize state and federal funding sources for reimbursable inpatient services. OSHPD regulates the design and construction of inpatient psychiatric facilities.

- Sub-acute psychiatric inpatient care (also referred to commonly as a locked IMD[1]) – Sub-acute psychiatric inpatient care is a step down from an acute psychiatric hospitalization and a step up in acuity from a conventional skilled nursing facility. This setting includes comprehensive inpatient care designed for someone who is medically fragile and/or has an acute illness, injury, or exacerbation of a disease process. Treatment is generally rendered immediately after, or instead of, acute hospitalization. Typically, treatment addresses one or more complex medical conditions in the context of a person's underlying chronic illnesses. Services can be reimbursed by an individual's

[1] An Institution for Mental Diseases (IMD) is a facility of more than 16 beds that is primarily engaged in providing care for individuals with behavioral health disorders. Though the term is commonly (though imprecisely) used with an intention to refer to sub-acute facilities, an inpatient or other psychiatric facility can also be an IMD (depending on bed counts and other services on the facility's license).

insurance. ODR currently has no access to sub-acute psychiatric inpatient beds. OSHPD regulates the design and construction of sub-acute psychiatric facilities.

- Specialty Interim Housing – Interim housing provides persons being diverted from jail with temporary housing in a safe and supportive short- to medium- term environment. While in interim housing, participants' clinical needs are addressed and stabilized. Additionally, this setting connects participants to permanent supportive housing opportunities in their communities. Interim housing is R2 (multifamily residential) zoned housing. ODR has generally found that smaller (20-30 bed) settings that feel like a home are more conducive to clients' success. Sites are staffed 24-hours and include resident aides, case manager(s), and LVNs. Currently services in interim housing are rendered by ODR contracted Community-Based Organizations (CBOs), and beds are "leased" by ODR in order to ensure access for ODR clients.

- Skilled nursing care – A skilled nursing facility provides medically necessary professional services such as nursing care and/or rehabilitation services. Skilled nursing facilities provide round-the-clock assistance with healthcare and activities of daily living. Services can be reimbursed by an individual's insurance. ODR currently contracts for access to skilled nursing facility beds within the community on an individual case basis. OSHPD regulates the design and construction of skilled nursing facilities.

- Medical recuperative care – Medical recuperative care provides temporary housing and medical care for persons who do not require hospitalization but are too ill or frail to recover from a physical illness or injury in a lower level of care. The goal is to facilitate a process of healthy recovery that homelessness, or less supportive environments, might impede or prevent. Additionally, medical recuperative care is provided at lower cost than hospital care. Recuperative care facilities are R2 (multifamily residential) zoned residential housing or buildings with commercial zoning. Services are rendered by ODR contracted CBO providers, and beds are "leased" by ODR in order to ensure access for ODR clients.

- Psychiatric recuperative care – Psychiatric recuperative care provides temporary housing and psychiatric care for persons who do not require inpatient psychiatric hospitalization but have psychiatric needs that require a high level of support. On-site services include medication education and monitoring, observation, case management, and therapeutic support. Like medical recuperative care, psychiatric recuperative care facilities are R2 (multifamily residential) zoned residential housing or building with commercial zoning. Currently, services are rendered by ODR-contracted CBO providers and beds are "leased" by ODR in order to ensure access for ODR clients.

- Residential substance use disorder treatment – Residential substance use disorder treatment is a commonly used intervention for individuals with substance use or co-occurring mental and substance use disorders that need structured 24-hour care. Treatment occurs in licensed residential facilities. ODR partners with the Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) to refer clients to residential substance use treatment and is working with SAPC to identify beds that could be dedicated to diversion clients. Residential substance use treatment requires Department of Health Care Services (DHCS) licensed facilities. For this setting, ODR can access community-based residential substance use disorder treatment beds funded

by Drug Medi-Cal, but access has been limited to date due to a limited supply of beds within Los Angeles County.

- Permanent supportive housing – Permanent supportive housing pairs long-term rental assistance/subsidies with long-term intensive case management services. Permanent supportive housing can be either a scattered site (e.g., units within community-based multifamily apartments with landlords willing to accept rental assistance and work with ODR's population) or project-based (e.g., ODR secures housing through partnerships with affordable housing developers). Project-based sites have space for case management offices and community activities. Rental subsidies are provided through Housing for Health's Flexible Housing Subsidy pool (FHSP), Intensive Case Management Services (ICMS) is provided through ODR. There is an effort underway to secure federally funded Housing Choice Vouchers (Section 8) in addition to the locally funded FHSP. The FHSP is also used to support placement of ODR clients in licensed Adult Residential Facilities, also known as Board and Cares. These facilities may serve as long-term residences for those who need support with their activities of daily living.

- Social rehabilitation-based acute diversion units – Social rehabilitation-based acute diversion units offer clinical interventions for individuals experiencing an escalating psychiatric crisis, and provide rapid engagement, assessment, and intervention in order to prevent further deterioration. Based on the principles of social rehabilitation[2], it is a voluntary alternative to Psychiatric Emergency Services. The Dore Clinic, located in San Francisco, funded primarily with Medi-Cal dollars, accepts patients from law enforcement in lieu of booking and connects them to their associated crisis residential housing program, which is often located in community urgent care centers.

- Intensive crisis residential treatment programs – Intensive crisis residential treatment programs provide housing for up to two weeks for people experiencing mental health crises who also have medical needs. These crisis residential programs can be linked directly to social rehabilitation-based acute diversion units and offer ICMS and a path to longer-term interim and permanent housing. These potential pre-booking diversion settings would consist of transitional housing settings with commercial zoning or R2 zoned residential housing that could be connected to the urgent care centers described above. The Dore House (which is connected to the Dore Clinic noted above) in San Francisco, is an example of this model and is funded via Medicaid dollars.

- Intensive outpatient substance use services – Intensive outpatient (ASAM level 2.1) services are outpatient substance use disorder treatment services that are appropriate for patients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Such services are provided to clients for a minimum of nine hours and a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical

[2] Social rehabilitation proposes that treatment for serious mental illness and associated psychosocial challenges is most successful in a planned social-relational situation. This social approach to rehabilitation draws on the therapeutic value of everyday normalized experiences, such as meals and chores, to help clients build skills and healthy relationships with each other and with staff.

exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services, alcohol/drug testing, discharge services, and case management. Services are provided by a licensed professional or a registered/certified counselor.

- Recovery housing – Recovery Bridge Housing (RBH) is defined as a type of abstinence-focused, peer-supported housing that provides a safe interim living environment that is supportive of recovery for patients (age 18+) who are homeless or unstably housed. Clients in RBH must be concurrently in substance use disorder treatment in outpatient, intensive outpatient, opioid treatment program, or outpatient withdrawal management settings. The services provided in RBH vary, and include peer support, group and house meetings, self-help, and life skills development, among other recovery-oriented services. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

- Withdrawal management – Withdrawal management, also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal symptoms from alcohol, sedatives, opioids, and other substances. The goal of withdrawal management is to facilitate safe withdrawal from substances and to provide the appropriate level of support during the withdrawal period, which then allows the client and treatment team to work together to determine an optimal ongoing substance use disorder treatment approach. Withdrawal management services can be provided in outpatient, intensive outpatient, residential, or inpatient settings, when determined to be medically necessary and in accordance with an individualized treatment plan. Withdrawal management services include intake and assessment, observation (to evaluate health status and response to prescribed medication), medication services, and discharge planning.

Additional Staffing Capacity Required to Expand Diversion Opportunities

In order to support the growth of diversion, additional court intervention staff, provider support/supervisory staff, and administrative staff are needed, along with additional resources to expand community-based service capacity. These additional staff are needed to support coordination across the clinical and social services delivery systems and ensure the flow of clients through the justice system. Investments are also needed to ensure increased capacity of provider networks, responsive program design and implementation, appropriate and effective referral systems, and necessary compliance infrastructure.

ODR met with County justice partners in the preparation of this report and they voiced that in order to keep pace with diversion, additional staffing of lawyers and paralegals was needed for the DA, PD, and APD. It has been particularly helpful to ODR to work specifically with defense and prosecution appointed liaisons who understand and can help effectuate diversions and other interventions, especially in complex cases. Additionally, as programs for those charged with and convicted of felonies grow, there will be an increased need for both pre-trial and formal probation and associated probation staffing costs.

The mix of community-based staff needed to scale diversion efforts varies by level of care. For the most common diversion settings, interim housing and permanent supportive housing, staffing including residential support staff, case managers, social workers, psychiatrics, and administrative staff. Additional resources are needed connect clients to supports that facilitate

the prompt release and stabilization of clients leaving jail and those requiring permanent supportive housing. A focus on smaller, highly supportive sites has allowed ODR to quickly scale interim housing beds to meet capacity needs, while ensuring quality services and appropriate levels of supervision/oversight.

Workforce development is an essential tool to meet the current staffing needs of the community-based care continuum. If diversion programs expand and are scaled, workforce development will become even more important. In order to keep pace with staffing needs, we will need to consider recruitment and incentives for students in the healthcare, social work and case management professions.

Future reports will provide more detailed ratios of staff needed by classification per number of patients served to support further expansion of Los Angeles County diversion efforts.

The sources of funds that could support the programs

While continuing to access and maximize funding through AB109, SB678, and Department of State Hospitals (DSH) contracts, further exploration of non-county public and private funding is appropriate, along with the option of repurposing potential cost savings that result from a reduction of jail beds if diversion opportunities are expanded.

- Mental Health Services Act (MHSA): California's MHSA permits expenditures in the following areas: 1) Community Services and Supports (CSS), 2) Capital Facilities and Technological Needs (CF/TN), 3) Workforce Education and Training (WET), 4) Prevention and Early Intervention (PEI), and 5) Innovation (INN). ODR's current efforts most closely align with areas 1 and 5.

    - Area 1: MHSA funding is currently used to support DMH Full-Service Partnership (FSP) teams that serve ODR clients, though funding is not sufficient to meet the demand for such services. Area 1 also includes outreach and engagement with underserved populations and the MHSA Housing Program includes development of permanent supportive housing.

    - Area 5: 5% of MHSA funding is distributed to counties for the Innovation (INN) component. Counties use these funds to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of INN is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. The purpose of an INN project is to increase access to underserved groups, increase the quality of services including measurable outcomes, promote interagency and community collaboration, and increase access to mental health services including but not limited to permanent supportive housing.

  A majority of the services for mental health diversion clients, including "bridge" psychiatric care, targeted case management, interim housing, and rental subsidies, are currently funded through ODR's budget, despite the fact that some of these services fall within the scope of services eligible to be reimbursed through MHSA (and Medicaid specialty mental health), thus raising the potential for additional MHSA funds to be allocated to diversion populations. ODR is in discussion with DMH on the possibility of

additional annual allocation of MHSA funds, subject to MHSA stakeholder and Board approval.

- Medicaid (Medi-Cal): DHS is exploring opportunities to draw down Medicaid funding to support the case management costs associated with interim and permanent supportive housing. However, Medicaid already funds other levels of care referred to in this report (e.g., acute and sub-acute psychiatric care, substance use disorder treatment and skilled nursing care). DHS, DMH, and DPH will work together to be sure we are maximizing available opportunities to leverage Medicaid reimbursement to pay for eligible services and placements to which individuals are entitled.

- Federal Housing Vouchers: ODR has historically relied on ODR funding sources for rental subsidies but is currently seeking to secure federal rental subsidies to augment the number of clients and populations that can be diverted. A similar locally based strategy would be to consider amending the Los Angeles County Development Authority's administrative plan to request an additional preference under the Housing Choice Voucher Program (Section 8) to prioritize a specified number of diversion client applicants. This is a strategy that has been successfully employed to provide greater access to rental assistance subsidies for persons experiencing homelessness via the Coordinated Entry System. The strategy would need to include sufficient client services and administrative resources to maximize the likelihood of a successful, long-term housing placement.

- Measure H: Measure H is a quarter cent sales tax in Los Angeles County that was designed to address homelessness and provide services and housing. A portion of Measure H funding is allocated for interim housing for individuals exiting institutions (inclusive of hospitals) and it is reasonable to explore opportunities to designate set asides in Measure H funded beds for diversion clients.

The legislative and/or policy changes needed

The overriding understanding driving the support for community services to divert, treat and support inmates with serious mental illness and substance use disorders is that the current policy of providing treatment through incarceration does not work. The failure to actually treat the needs of this vulnerable population not only hurts the individual but also the community. The Los Angeles County's efforts to scale up diversion and reentry services recognizes this. Changes in policy and legislation are needed to support these efforts. To this end, below are proposed and still needed federal and state legislation.

Proposed Federal Legislation

The passage of the Affordable Care Act (ACA) extended eligibility for public health insurance to all adults with incomes up to 138% of the federal poverty line, creating the opportunity to expand coverage for many among the uninsured jail population. California further expanded on this with the enactment of AB 720, which allows jails to be sites of health insurance enrollment. These laws reflect the understanding that incarcerated people have disproportionately high medical, mental health and substance use disorder needs and recognize the importance of providing mental health and substance use disorder treatment to prevent re-incarceration.

Fundamentally, the mental health and substance use disorder service needs of clients exist before incarceration, during incarceration, and after incarceration. Currently, under Federal and

State law, an individual's benefits are suspended once incarcerated. While efforts have been made to quickly reinstate benefits at release, the reality is that this generally does not happen. As such, clients with high needs are often released without linkages to services and face significant challenges in obtaining treatment once released. The proposed legislation described below addresses this systematic failure and could help fund further diversion in Los Angeles County.

- HR 1329: HR 1329 is bipartisan legislation that empowers states to expand access to Medicaid services for incarcerated individuals up to 30 days before release from jail or prison. When putting forward this legislation, the sponsor stated, "Empowering states to deliver needed treatment to individuals as they transition out of the criminal justice system not only helps the individuals address their [medical and mental health] needs, but also makes our communities safer, saves money over the long term, and delivers vital services to a truly vulnerable group of people."

- HR 1345: The U.S. Supreme Court's interpretation of the Eighth Amendment requires government entities to provide medical care to all inmates, but people who are incarcerated in a county jail or juvenile detention facility typically lose their Medicare, Medicaid, Children's Health Insurance Program (CHIP) or Supplementary Security Income (SSI) benefits, even if they have not been convicted of a crime. As a result, local governments are burdened with the expense of providing health care to thousands of men, women, and children awaiting trial. Indeed, requiring county governments to cover health care costs for inmates who have not been convicted places an unnecessary burden on local governments, which have already been negatively impacted by widespread budget deficits and cuts to safety net programs and other essential services. Terminating benefits to inmates who are awaiting trial also taints the presumption of innocence and disproportionately affects low-income and minority populations who do not have the means to post bail, which paradoxically would enable them to continue receiving benefits.

  HR 1345 requires that individuals who receive Medicare, Medicaid, CHIP, and/or SSI, and are subsequently incarcerated pending disposition of their charges, maintain those benefits until they are convicted of a crime. Furthermore, the bill eliminates the current mandatory 30-day delay in reinstating Medicaid mental health care benefits for those released from custody. Finally, this bill preserves the partnership between federal and local governments, ensuring that local governments are not burdened with an unfair share of meeting the mandate to guarantee medical coverage.

Federal Legislation Needed

- IMD Exclusion Waiver: The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid matching payments for care provided to most adult patients in mental health and substance use disorder residential treatment facilities larger than 16 beds whose roster has more than 51% of its patients being treated for serious mental disorders or substance use disorders. Continued pursuit of an IMD Exclusion Waiver is essential. Through this waiver, freestanding psychiatric acute and sub-acute facilities would receive funding for those who meet medical necessity criteria for inpatient treatment. Diversion opportunities would increase in proportion to an increased capacity and availability of IMD beds.

Proposed State Legislation

- SB 282: This bill requires the California Department of Corrections and Rehabilitation (CDCR) to transfer all funds from the Integrated Services for Mentally Ill Parolees (ISMIP) program to the California Department of Housing and Community Development (HCD) for the newly created Supportive Housing Program for Persons on Parole, to provide permanent supportive housing and wraparound services to mentally ill parolees who are homeless or at risk of homelessness. This bill recognizes that individuals on parole are seven times more likely to recidivate when homeless than when housed. Evidence shows that supportive housing, or housing that is affordable to people on parole living in extreme poverty that does not limit the length of stay and offers tenants services promoting housing stability, reduces recidivism and improves the tenant's ability to recover from mental illness. After a 2017 UCLA study showed that the ISMIP program did not significantly reduce recidivism, this bill was proposed with the goal of strengthening programs for our most vulnerable people on parole to promote evidence-based, wraparound services, including rental subsidies, in an amount adequate to allow mentally ill parolees experiencing homelessness, or at risk of experiencing homelessness upon release from prison, to obtain and maintain housing stability during and after the term of parole, thereby reducing recidivism among those with a history of homelessness.

- SB 665: SB 665 would use MHSA funds to provide services to individuals in county jail or who are under mandatory supervision. This would not apply to those in state prisons or those in jail that are convicted of a felony. The use of these funds would go through the same public process required for all MHSA programing. Regarding this Senate Bill, Senator Umberg stated, "With the number of incarcerated who are suffering from mental health issues and limited funding sources for treatment, it is critical to explore the flexibility of existing mental health funding sources and that is what this bill would do."

State Legislation Needed

In 2018, the California State Legislature passed AB 1810 and SB 215 which amended Penal Code Sections 1001.35-1001.36 to create a way for courts to authorize pre-trial diversion for individuals with serious mental disorders who are charged with certain felony or misdemeanor crimes. Pre-trial and pre-plea diversion under AB 1810 is an opportunity for justice-involved individuals to avoid a criminal conviction and receive treatment. AB 1810 established WIC 4361, which allowed a funding opportunity for DSH to contract with counties to support a specific target population of individuals with serious mental illnesses who have the potential to be or are deemed Incompetent to Stand Trial (IST) on felony charges (known as the DSH Diversion Funding Program). The DSH Diversion Funding Program only authorized one-time funds of $100 million available over a three-year period. ODR has contracted with DSH to implement the program in Los Angeles County through the DSH Diversion with the goal of serving 200 clients over the three-year term of the contract. DSH Diversion launched March 2019 and only operates out of Clara Shortridge Foltz Criminal Justice Center (CCB)--one of the 24 courthouses in Los Angeles County hearing criminal cases. Thus, only clients with cases in CCB can be served at this time. Notwithstanding this limitation, to date, DSH Diversion has served 40 clients, which would put it on track to meet the target goal of the contract in little over two years. The need for this program is clear. An amendment to WIC 4361 to increase the available funding thereby increasing the scope of this program is also important.

IT resources needed

Access to electronic information systems where court and clinical information are held is critical to the work of diversion. In order to understand who can be a candidate for diversion, both legal and clinical status must be known and accessible to the teams tasked with carrying out diversions. Ongoing access to the clinical chart for the Jail Health Information System (JHIS), DHS Online Real-time Centralized Health Information Database (ORCHID), DPH and DMH Integrated Behavioral Health Information System (IBHIS) has been essential to staff coordinating services and care. Access to court orders via the Los Angeles Superior Courts Data and Document Exchange Service (DDES) and the Justice Partner Portal (JPP) is also critical.

Practice and/or cultural transformations needed in individual departments

DHS, DMH, and DPH are working to better align resources to maximize the number of individuals who can be diverted. A collaborative approach has allowed "packages" to be assembled and offered in courtrooms in order to effectuate jail diversion (e.g., pairing ODR Housing with ICMS and FSP), and this approach will be necessary in order to continue to maximize and leverage resources across the health departments to serve the divertable population. In the past, judges and prosecutors have often determined level of care (e.g., settling a case for one year of locked placement), however, justice partners have an increasing understanding of how clinical need must determine level of care, both in terms of responsible use of limited resources, but also in terms of ability to leverage funding resources such as Medicaid.

NEXT STEPS

1) **Provide this report to the ATI:** The ATI final report will be presented in December of 2019. We hope this preliminary report will provide important information for the group to consider as it develops implementation plans for their recommendations, which include but go beyond the scope of this report.

2) **Develop plans to better understand the diversion potential among the jail population struggling with addictions as well as other medically complex populations:** DHS and DPH will partner together to consider potential options and pathways in support of substance use diversion efforts, including ultimately a formal study of the divertability among substance use disorder populations. ODR will also continue to work to expand and study diversion of medically fragile individuals.

3) **Support development of a siting plan for needed community-based capacity:** This report presents estimates of the numbers of resources needed, particularly for those with serious mental illness who are thought to be appropriate for diversion. Next, the County should determine how these resources could be developed and built and how to start the capital and real estate process to create them. As requested in the August 13, 2019 Board motion, "Exploring a Decentralized Continuum of Community-Based Services and Care for Los Angeles County," the CEO and Department of Public Works with input from DMH, DPH and DHS will report back on a specific siting plan, including the number of beds that are required and the estimated cost for construction or renovation.

4) **Engage in continued partnership and advocacy with the State regarding support for diversion efforts:** The Board could consider sending a letter to the Governor asking

to partner broadly on diversion efforts in Los Angeles County. This could include, for example, funding for expansion of services for the IST population, as well as partnering on the purchase and/or rehabilitation of buildings, including those on the grounds of Metropolitan State Hospital.

5) **Promote legislative agenda:** County stakeholders and representatives from the Los Angeles County Departments will provide support for the CEO's efforts in working to get the bills described herein passed, including visiting and speaking with policy makers in Sacramento.

6) **Explore modifying Measure H Plan:** Efforts could be made to investigate whether the Measure H Plan could be modified and explore opportunities to designate set asides in Measure H funded beds for diversion efforts.

7) **Maximize MHSA dollars:** The Los Angeles County's current efforts in diversion most closely align with MHSA's expenditures in CSS and INN areas; the potential applicability to diversion of other MHSA funding categories is unclear. Further exploration of the feasibility of dedicating MHSA funds, across all categories, to support diversion efforts would be informative and provide the Board with valuable information on potential ongoing sources of funds for diversion programs.

8) **Calculate staffing needs:** Future reports will provide information on additional staff needed to ramp up and support diversion at scale, providing detailed ratios of staff by classification per patients served, including consideration of the need for additional staffing among County justice partners.

If you have any questions or concerns, please do not hesitate to contact me. Alternatively, you or your staff may also contact Judge Peter Espinoza, Director of ODR at (213) 288-8644 or by e-mail at pespinoza2@dhs.lacounty.gov.

CRG:ko

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Alternate Public Defender
Children and Family Services
District Attorney
Mental Health
Probation
Public Defender
Public Health
Public Social Services
Public Works
Sheriff
Superior Court

Health Services
LOS ANGELES COUNTY

SPECIAL REPORT

April 17, 2019

An estimate of persons in the jail mental health population likely to be appropriate for safe release into community services

OFFICE OF DIVERSION AND REENTRY

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Cases were randomly selected from the study sample and reviewed with...leadership from the Los Angeles Public Defender, Alternate Public Defender and the District Attorney. Justice partners reached consensus and agreed in all selected cases with ODR's assessment.

Introduction

On 8/14/2018, The Los Angeles County Board of Supervisors passed a motion, Scaling up Diversion and Reentry Efforts for People with Serious Clinical Needs, which directed the Department of Health Services to work with appropriate partners to conduct a study of the existing County jail population to identify who would likely be eligible for diversion and reentry programs based on their clinical conditions and current criminal charges. The study's intent is to inform plans and discussions regarding the amount of community-based service capacity that would need to be built to adequately serve this population. That study is currently being conducted by a team of researchers from the RAND Corporation, Groundswell Services, Inc., UCLA School of Law, and UC Irvine. In advance of that study, and to inform accelerated efforts underway in Los Angeles County to address the needs of persons with mental disorders inside the jail, the Office of Diversion and Reentry (ODR) conducted this preliminary study to estimate the proportion of the jail mental health population that could be safely removed from the jail into community-based services, without consideration of the current supply of such services. Determinations were made after clinical and legal review of each individual case, and were based upon ODR's experience with over 3000 cases successfully settled in court for release since ODR's inception in 2016.The study team consisted of the same ODR reviewers, with clinical and legal training, who evaluate actual cases put forward in ODR hearings. The sources of clinical and legal information (jail medical chart and court data service) were also the same sources consulted when evaluating actual cases put forward in ODR hearings. This project was approved by the Los Angeles County Department of Public Health Institutional Review Board.

Table 1. Demographic characteristics of study sample (*n*=500) and overall Jail Mental Health population (N=5134) on 2/14/2019

Characteristic	Study Sample (*n*=500) n (%)	All JMH (*N*=5134) N (%)	*p*-value*
Age (years)			0.98*
Mean (SD)	37.1 (11.7)	37.2 (11.8)	
Median (IQR)	36 (28–44)	35 (28–45)	
Sex			0.19
Female	65 (13%)	779 (15%)	
Male	435 (87%)	4355 (85%)	
Race			0.48
Black	201 (40%)	2117 (41%)	
Hispanic	187 (37%)	1775 (35%)	
White	94 (19%)	1001 (19%)	
All other races	18 (4%)	241 (5%)	

* Chi-square test for categorical measures and Wilcoxon Rank-Sum test for nonparametric age data

Methods

Data from the overall Jail Mental Health (JMH) population on 2/14/2019 (N=5134) were collected from L.A. Sheriff's Department records. The total jail population on 2/14/2019 was 16621. A priori power analysis conducted in consultation with RAND indicated a sample size of 500 inmates was required to reliably assess potential for diversion in the overall population, therefore, 500 inmate records were selected using a random number generator. Demographic factors (age, sex, race) were assessed to ensure proportionate distribution in the random sample. Three ODR staff members reviewed JMH and legal records of 150 inmates each to determine potential appropriateness for release into community services based upon overall psychiatric and legal impression, and with the assumption that there was an available, suitable placement for each case. The first 50 charts were reviewed as a group; thereafter charts were reviewed by only one reviewer with the exception of every 25th chart and all uncertain cases which were reviewed together to maintain interrater reliability. On 3/22/2019, at the data collection halfway point, 10 cases were randomly selected from the study sample and reviewed in a meeting with justice partner leadership from the Los Angeles Public Defender, Alternate Public Defender and the District Attorney. Justice partners reached consensus and agreed in all selected cases with ODR's assessment. Potential for safe release to community-based services was recorded as either: yes (appropriate), maybe (potentially appropriate), or no (not appropriate).

> ***More than half of the jail mental health population is estimated to be appropriate for safe release into community-based services, if sufficient numbers of those services were available.***

Results

The demographic characteristics of the study population were similar to the overall JMH population as noted in Table 1 below. 297 inmates in the sample were charged with a felony (59%), 72 with a misdemeanor (14%) and 131 with both a felony and a misdemeanor (26%). Median age of the sample was 36 years, and overall JMH population median was 35 years. Men constituted 87% of the sample and 85% of the overall JMH population. 40% of the sample was Black, 37% Hispanic, 19% White, and 4% all other races; overall JMH population proportions were 41%, 35%, 19%, and 5%, respectively. There were no statistically significant demographic differences between the study sample and the overall JMH population (see Table 1). 281 inmates from the sample were determined to be potentially appropriate for safe release to community-based services (56%; 95% confidence interval: 52–61%), while an additional 34 inmates (7%) were potentially appropriate (see Table 2).

Table 2. Appropriateness for safe release to community-based services in a random sample of jail inmates receiving Jail Mental Health services (*n*=500)

Potential for Safe Release to Community-Based Services	**n (%)**	**Margin of Error** (95% confidence interval)
Appropriate (*yes*)	**281 (56%)**	52–61%
Potentially appropriate (*maybe*)	**34 (7%)**	5–9%
Not appropriate (*no*)	**185 (37%)**	33–41%

Conclusions

More than half of the jail mental health population (56%; 95% confidence interval: 52–61%) is estimated to be appropriate for safe release into community-based services, if sufficient numbers of those services were available. Extrapolated to the entire jail mental health population in custody on 2/14/2019, this represents 2875 persons that would be expected to be appropriate for release. Findings are limited to estimates based upon cases already successfully settled in ODR. While ODR is eager for the results of the larger RAND study to be completed in the Fall of 2019, it is our hope that the findings of this study will help guide the County's strategy for creating and scaling community-based diversion and reentry program capacity for those with serious clinical conditions.

May 11, 2019

Addendum

We examined whether appropriateness for release into community-based services was related to race in the study sample and found no statistical differences as to whether a person was appropriate, potentially appropriate or not appropriate according to their race (Table 3).

Table 3. Proportions by race of overall Jail Mental Health (JMH) population (*N*=5134) compared to diversion study sample (n=500) subgroups sampled on 2/14/2019

Inmate Group	**Race**				***p*-value**
	Black	Hispanic	White	All Other	
Overall JMH (*N*=5134)	2117 (41%)	1775 (35%)	1001 (19%)	241 (5%)	0.14[1]
Diversion Sample (n=500)					
Yes (*n*=281)	106 (38%)	102 (36%)	59 (21%)	14 (5%)	0.71[2]
No (*n*=185)	75 (41%)	76 (41%)	30 (16%)	4 (2%)	0.14[2]
Maybe (*n*=34)	20 (59%)	9 (26%)	5 (15%)	0 (0%)	0.23[2]

[1] Overall JMH population (N=5134) compared to combined diversion study sample (n=500) using Fisher's exact test

[2] Pairwise comparisons of diversion study subgroups to overall JMH population with significance level of $p<0.017$ with Bonferroni correction factor for multiple hypothesis testing (Fisher's exact test used for cell counts <5)

Attachment

Research Report

SARAH B. HUNTER, ADAM SCHERLING

Los Angeles County Office of Diversion and Reentry's Supportive Housing Program

A Study of Participants' Housing Stability and New Felony Convictions

KEY FINDINGS

- From April 2016 through April 2019, 311 participants were enrolled.
- The majority were male and African American.
- Seventy-eight percent of the population suffered from at least one mental health disorder and nearly 40 percent had both a mental health and substance use disorder.
- Individuals without a behavioral health diagnosis (less than 3 percent) qualified because of a serious physical health issue or pregnancy.
- Housing stability rates were calculated for two groups: people who had received housing for at least six months or for at least 12 months. The six-month housing stability rate was 91 percent; the 12-month housing stability rate was 74 percent.
- Of a total of 96 individuals, 13 had been convicted of a new felony during the 12 months after being housed, for a 14-percent qualifying return rate. Three other individuals had pending felony charges.

Los Angeles (LA) County is home to the largest jail system in the world, operated by the LA County Sheriff's Department (LASD). The county is also the center of one of the most acute homelessness problems in the United States. According to the 2019 Point-in-Time Count (Los Angeles Homeless Services Authority, 2019), there are nearly 59,000 people experiencing homelessness within LA County. On any given night, the LA County jail houses more than 16,000 inmates, and recent estimates suggest that nearly one-half of all inmates have at least one chronic disease, about two-thirds have a substance use disorder, and about one-fourth have serious mental illness (Gorman, 2018; Hamai, 2015). Because of the lack of affordable housing and social services in the community, LA County jail has seen an increase in the number of individuals with complex clinical needs.

A recent initiative designed to tackle these issues is the LA County Department of Health Services' Office of Diversion and Reentry's (ODR's) supportive housing program, which provides housing coupled with case management. Evidence suggests that this type of program has helped individuals experiencing homelessness and suffering from co-occurring mental health and substance use conditions by increasing housing stability and reducing dependence on publicly funded crisis care (Larimer et al., 2009). However, less is known about the use of supportive housing to address the needs of individuals under criminal court supervision. A recent pilot in New York City suggested potential cost offsets, such as reduction in incarceration costs (Aidala et al., 2014). However, as outlined in a recent systematic review conducted by the National Academy of Sciences (2018), the effectiveness of permanent supportive housing remains inconclusive.

Therefore, it is important to understand whether supportive housing is achieving its goals. The LA County program's goals are to improve housing stability and reduce criminal justice involvement among individuals enrolled into the program.

Methods

We used ODR data that represented participants enrolled in the supportive housing program between April 2016 and April 2019. The data set provided participant demographic information and clinical diagnosis as determined by ODR personnel. We summarized this information to help describe who is being served by the program.

ODR also gave us data from the housing provider (i.e., Brilliant Corners) that provided information about each participant's housing status, such as move-in and move-out dates, reason for exit, and destination at exit. We used the destination classification definitions specified by the U.S. Department of Housing and Urban Development (2016) to classify individuals' housing status as stable, neutral, or unstable. We calculated housing stability rates for two groups: people who had received housing for at least six months or for at least 12 months.

Finally, ODR submitted to us data maintained by the LASD on arrests among program participants. ODR reviewed these cases against criminal court records and classified them as to whether the arrest (1) led to a new felony case or (2) was a probation violation, dismissed by court, or rejected by the District Attorney's Office. We examined rates of new felonies among participants that received supportive housing at least 12 months ago.

The LA County program's goals are to improve housing stability and reduce criminal justice involvement among individuals enrolled into the program.

Findings

Program Participants

In Table 1, we present descriptive information about the full sample and of individuals who were featured in the outcome analyses. Of the 311 participants enrolled from April 2016 through April 2019, the average age was 39 years old (range between 20 and 69), and the majority were male and African-American. Approximately 7 percent of the population was classified as being in the top 5 percent of LA County social service utilizers, according to reports produced by the County Executive Office (Hamai, 2018), which maintains an aggregated data set of service use across several service sectors (e.g., health care, mental health care, substance use treatment, and law enforcement). The primary clinical diagnoses were substance use disorders, psychotic disorders, and bipolar disorders. Seventy-eight percent of the population suffered from at least one mental health

LA County ODR's supportive housing program improved housing stability and reduced criminal justice involvement

91% had stable housing after 6 months

74% had stable housing after 12 months

86% had no new felony convictions after 12 months

DATA USED IN THIS STUDY are from the Office of Diversion and Reentry (ODR) and represent participants enrolled in ODR's supportive housing program in LA County between April 2016 and April 2019.

STUDY ANALYSIS INDICATES that out of 187 study participants, 169 had stable housing after six months. *Note:* One person was not counted in the housing-stability calculation rate because the individual moved to a higher level of care.

OUT OF 96 STUDY PARTICIPANTS, 69 had stable housing after 12 months. *Note:* Three people were not counted in this rate because two had moved to a higher level of care and one was deceased.

THE AVERAGE AGE OF THE 311 PARTICIPANTS was 39 years old. Sixty-six percent were male; 34 percent were female.

Program participants had mental health, substance use, and/or health related issues

78% mental health disorder (psychotic and bipolar disorders most prevalent)
51% psychotic disorder
58% substance use disorder
39% co-occurring mental health and substance abuse disorders
19% substance abuse disorder (only)
3% serious physical health issue or pregnant

disorder and nearly 40 percent had both a mental health and substance use disorder. Individuals without a behavioral health diagnosis (less than 3 percent) qualified because of a serious physical health issue or pregnancy.

The study samples featured in our outcome analyses (n = 187 and n = 96; i.e., those who were housed at least six and 12 months prior to the end of the study period) were similar to the total population in terms of demographic, service utilization and clinical diagnoses.

Housing Stability

The six-month housing stability rate was 91 percent; the 12-month housing stability rate was 74 percent.

TABLE 1

ODR Supportive Housing Participant Characteristics

		All clients (n = 311)	Housed Before October 1, 2018 (n = 187)	Housed Before April 1, 2018 (n = 96)
Mean age		39.1	39.6	40.3
Sex or gender	Female	30.9%	27.3%	22.9%
	Male	66.2%	70.6%	76.0%
	Transgender female, trans woman, male-to-female, transfeminine	2.9%	2.1%	1.0%
Race	American Indian or Alaska Native	2.3%	1.6%	1.0%
	Asian	2.3%	2.1%	3.1%
	Black or African American	46.3%	49.7%	44.8%
	Multiracial	7.4%	8.0%	6.2%
	Native Hawaiian or other Pacific Islander	0.3%	0.5%	1.0%
	White	27.3%	21.9%	21.9%
	Client doesn't know	9.0%	9.6%	14.6%
	Client refused	2.3%	2.7%	4.2%
	Data not collected	2.9%	3.7%	3.1%
Ethnicity	Non-Hispanic/Latino	70.1%	71.1%	70.8%
	Hispanic/Latino	28.6%	27.3%	28.1%
	Client doesn't know	1.0%	1.1%	1.0%
	Data not collected	0.3%	0.5%	0.0%
High service utilizers		7.4%	7.0%	7.3%
Clinical diagnoses	Anxiety, depression, adjustment disorder	12.5%	17.1%	16.7%
	Bipolar disorder	22.5%	21.9%	17.7%
	Posttraumatic stress disorder	2.9%	3.2%	2.1%
	Psychotic disorder	50.5%	44.4%	52.1%
	Substance use disorder	58.2%	59.9%	53.1%
	Other diagnosis	0.6%	1.0%	2.0%
	Any mental health diagnosis	78.1%	76.5%	81.2%
	Both mental health and substance use disorders	39.2%	39.0%	34.4%
	No behavioral health diagnoses	2.9%	2.7%	0.0%

NOTE: Percentages might not sum to 100 because of rounding.

Six Months

Of the full group of 187 individuals, 169 people were in a permanent housing situation at six months. One individual had moved to a higher level of care and therefore was not considered in the calculation. The remaining 17 people were documented as living in temporary or unstable living conditions: jail or prison (n = 8), returning to interim housing or the street (n = 3), residing in a substance use disorder treatment program (n = 1), or in an "other/unknown" status at exit (n = 5).

Twelve Months

Of the full group of 96 individuals, 69 people were in a permanent housing situation at 12 months. Three were considered neutral and therefore not used in

the calculation (two had moved to a higher level of care and one was deceased). The remaining 24 were documented as living in temporary or unstable living situations: jail or prison (n = 14), returning to interim housing or the street (n = 3), residing in a substance use disorder treatment program (n = 1), or in an "other/unknown" status at exit (n = 6).

Felony Rates

Among those individuals who had been placed in housing at least 12 months before the end of the study period (i.e., April 2019), we examined whether participants had a new felony charge during the 12-month period after housing. Of a total of 96, 13 individuals had been convicted of a new felony during the 12 months after being housed, for a 14-percent qualifying return rate. Three other individuals had pending felony charges.

Conclusions

This report presents early interim findings about ODR's supportive housing program. We found six-month and 12-month housing stability rates of 91 percent and 74 percent, respectively. Of the cohort that had been placed in housing more than a year ago, 14 percent had new felony convictions. Our next analysis will examine county service use and associated costs for this population prior to and after housing placement to better understand how the program might influence changes to service access and use of different publicly funded resources.

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About This Report

This is the first of two reports planned to provide information about the individuals served by the Los Angeles County Department of Health Services' Office of Diversion and Reentry's supportive housing program and is part of an evaluation effort by the RAND Corporation in collaboration with the Los Angeles County Department of Health Services' Office of Diversion and Reentry; the Los Angeles County Sheriff's Department; and Brilliant Corners, a nonprofit supportive housing provider. This report should be of interest to corrections agencies, supportive housing providers, and policymakers in the criminal justice and supportive housing field. It was funded through a contract with Brilliant Corners.

RAND Justice Policy Program

RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Justice Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as access to justice, policing, corrections, drug policy, and court system reform, as well as other policy concerns pertaining to public safety and criminal and civil justice. For more information, email justicepolicy@rand.org.

Questions or comments about this report should be sent to the project leader, Sarah B. Hunter, at Sarah_Hunter@rand.org.

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Table 1: Projected community capacity need by level of care based upon jail demand, divertability, and length of stay among specialty mental health and medically fragile population in the LA County jail

Community LOC	Correctional LOC	Number in Custody Now[1]	Estimated Proportion Needing LOC (%)[2]	Estimated Number in Custody Needing LOC[3]	Potential % Divertible[4]	Projected Number of Persons in Custody Needing Community Services (on any given day)[5]	ALOS Jail (days)[6]	Jail Bed turnover (times per year)[7]	Projected Number of Persons from Custody Needing Community Services (per year)[8]	ALOS Community (days)[9]	Community Bed turnover (times per year)[10]	Projected Community Bed Capacity Need by LOC[11] Year 1	Year 2	Year 3
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Acute Inpatient	FIP + HOH	46 (FIP) 1298 (HOH)	100% (FIP) 17% (HOH)	267	56%	150	115	3.17	476	40	9.13	52	52	52
Subacute Inpatient	HOH + MOH	1298 (HOH) 2794 (MOH)	83% (HOH) 20% (MOH)	1636	56%	916	177	2.06	1887	274	1.33	1418	1418	1418
Specialty Interim Housing	MOH	2794	80%	2235	56%	1252	177	2.06	2579	365	1	2579[12]	2579	2579
Skilled Nursing Facility (SNF)	CTC	150	100%	150	50%	75	177	2.06	155	274	1.33	117	117	117
Medical Recuperative Care	MOSH	400	100%	400	5%[13]	20	177	2.06	41	274	1.33	31	31	31
Permanent Supportive Housing (PSH)	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	1000[14]	2684[15]	3947[16]
											Total Capacity Needed	5197	6881	8144
											Total New Capacity Needed (with current supply subtracted)	3197	4881	6144

Abbreviations:
LOC: Level of Care
ALOS: Average Length of Stay
FIP: Forensic Inpatient Unit
HOH: High Observation Housing
MOH: Moderate Observation Housing
SUD: Substance Use Disorder

[1] Based upon the Los Angeles Sheriff's Department Mental Health Count

[2] Based upon "P level" clinical distinctions within housing levels

[3] C x D = E

[4] Based upon "An Estimate of persons in the jail mental health population likely to be appropriate for safe release into community services" 4/22/19

[5] E x F = G

[6] Provided by Los Angeles Sheriff's Department (as average length of stay since arrest, given as HOH 115 days, Jail Overall 177 days), exception is SUD treatment within the jail which is temporary and typically not longer than 90 days

[7] 365 days per year ÷ H

[8] G x I = J

[9] Acute inpatient based upon 6C unit at OVMC, other settings based upon Housing for Health average LOS, Detox and Substance Use settings based upon SAPC average LOS

[10] 365 days per year ÷ K

[11] J ÷ L = M

[12] 1000 ODR interim housing placements are already in supply, thus 1,579 are needed.

[13] This 5% figure is from "Table II: Interrelationship between actual, assumed, and potential diversion rates and planned vs. potential jail and community-based bed demand under full diversion" in the 8/5/19 Report Back from the LA County Health Directors, "Development, Design, Right-sizing, and Scoping of the Proposed Mental Health Treatment Center." This 5% figure is an estimate given that no study has examined the divertability of the population of persons with serious physical disorders inside the jail. The actual figure is likely to be higher.

[14] Year 1 begins with current number of persons already in ODR PSH, 1000 units are already in current supply

[15,16] Accounts for movement of all persons in Specialty Interim Residential to PSH once per year, and is additive for those already in PSH in previous years, with 25% attrition

RAND CORPORATION

Research Report

STEPHANIE BROOKS HOLLIDAY, NICHOLAS M. PACE, NEIL GOWENSMITH, IRA PACKER, DANIEL MURRIE, ALICIA VIRANI, BING HAN, SARAH B. HUNTER

Estimating the Size of the Los Angeles County Jail Mental Health Population Appropriate for Release into Community Services

The largest mental health facilities in the United States are now county jails.[1] About 15 percent of men and 31 percent of women incarcerated in jails have a serious and persistent mental disorder.[2] Conservative estimates suggest that 900,000 persons with serious mental illness are admitted annually to U.S. jails, usually as pretrial detainees.[3] Los Angeles County is no exception to this trend. On average, in 2018, 30 percent of individuals incarcerated in the county jail system on any given day were in mental health housing units and/or prescribed psychotropic medications (5,111 of 17,024 individuals in the average daily inmate population for that year).[4] This reflected a substantial increase since 2009, when just 14 percent of those in the county jail were in the jail mental health population. Moreover, between 2010 and 2015, there was a 350-percent increase in the number of incompetent-to-stand-trial cases referred to Department 95, Los Angeles County's mental health court program.[5]

KEY FINDINGS

- In June 2019, 5,544 individuals were in the Los Angeles County jail mental health population, which includes individuals in mental health housing units and/or taking psychotropic medications.
- Researchers developed a set of structured legal and clinical criteria to reflect the factors that contribute to the Office of Diversion and Reentry's (ODR's) decisionmaking when determining whether an individual may be put forward as a candidate for *diversion*—that is, redirection of eligible individuals with serious mental illness from traditional criminal justice processing into community-based services.
- Based on a consideration of these legal and clinical factors, an estimated 61 percent of the jail mental health population (about 3,368 individuals) were determined to be *appropriate* candidates for diversion; 7 percent *potentially appropriate* (414 individuals); and 32 percent (1,762 individuals) *not appropriate* candidates for diversion.
- In conducting our review, we were not bound to existing diversion programs in Los Angeles County (or the current capacity of existing programs). Because of this, these findings will help the county determine the full size of the population that would be appropriate for diversion and how it would need to scale community-based treatment programs to accommodate those individuals.

Abbreviations

BOS	Los Angeles County Board of Supervisors
CBR	community-based restoration
CSG	Council of State Governments
DHS	Los Angeles County Department of Health Services
DMH	Los Angeles County Department of Mental Health
DSH	California Department of State Hospitals
FIST	felony incompetent to stand trial
LASD	Los Angeles County Sheriff Department
MIST	misdemeanor incompetent to stand trial
ODR	Office of Diversion and Reentry
SMI	serious mental illness

This increase in the mental health population in county jails is coupled with an increasing emphasis on establishing programs designed to redirect eligible individuals with mental health disorders from traditional criminal justice processing and provide them with community-based clinical services. Such redirection is often characterized as *diversion*. Diversion programs have many potential advantages: They connect individuals with needed treatment services, reduce the burden on correctional systems to provide these services, and may save costs without compromising public safety.[6] Moreover, providing treatment in the least-restrictive environment is a core principle of patient-centered care. The movement toward diversion is taking place on a national level. For example, in 2015, the Stepping Up Initiative was launched by the National Association of Counties, the American Psychiatric Association Foundation, and the Council of State Governments (CSG) Justice Center with the explicit goal of connecting counties with "the tools they need to develop cross-systems, data-driven strategies that can lead to measurable reductions in the number of people with mental illnesses and co-occurring disorders in jails."[7]

Recognizing the local need in Los Angeles County for alternative approaches for dealing with mental health challenges in the criminal justice system, the ODR was established within the Los Angeles County Department of Health Services (DHS) in 2015. At the same time, DHS became primarily responsible for provision of care in the county jail.[8] Although several small diversion options were available in Los Angeles County at the time (e.g., specialty courts), most individuals with mental health concerns in county jails received jail-based services.[9] In contrast, ODR aims to support individuals with serious mental illness (SMI) who are involved in the criminal justice system by allowing them to access community-based services.[10]

ODR currently supports several courtroom interventions along the continuum described in the Sequential Intercept Model,[11] which result in release into community services (referred to as *diversion* for the purposes of this report, but it should be noted that this term is distinct from "the California Department of State Hospitals [DSH] Diversion," which is a specific program offered by ODR). Current ODR programs that remove individuals with SMI from custody are described in Box 1.[12] As of November 2019, ODR had removed 4,305 individuals from custody and placed them in community-based

Diversion programs have many potential advantages: They connect individuals with needed treatment services, reduce the burden on correctional systems to provide these services, and may save costs without compromising public safety.

Box 1. Current ODR Diversion Programs

- **Supportive housing program for individuals experiencing homelessness (i.e., ODR Housing program):** Initiated in August 2016, this program is designed to serve individuals with a felony charge who are experiencing SMI and homelessness. Those who enroll in the program plead guilty or no contest and are sentenced to ODR Housing with a term of probation of three to five years. A key condition of probation is to comply with the terms of ODR Housing. Individuals who enroll are then eligible to remain in ODR Housing after probation termination, as it reverts to permanent supportive housing with continued case management services for life.
- **Misdemeanor Incompetent to Stand Trial–Community-Based Restoration program (MIST-CBR):** Started in October 2015, this program serves individuals who are charged with misdemeanors and found incompetent to stand trial. For these individuals, ODR submits a conditional release request, and diversion to community-based treatment settings takes place under the supervision of mental health judges.
- **Felony Incompetent to Stand Trial–Community-Based Restoration program (FIST-CBR):** Started in July 2018, this program is a collaboration with DSH. DSH provides funding to support community-based restoration for individuals who would otherwise be waiting for state hospital slots. Individuals are committed to housing in the community and receive community-based restoration. Additionally, ODR identifies individuals in jail who have become competent while waiting for DSH placement and typically recommends entry into another ODR program (e.g., ODR Housing) or a jail-based program (a pathway referred to as the "Off-Ramp").
- **DSH Diversion program (under California Penal Code § 1001.36):** This new program (also known as "DSH Diversion"), effective January 1, 2019, was established by California Penal Code §§ 1001.35–1001.36 ("Diversion of Individuals with Mental Disorders"). The new laws allow for diversion of individuals charged with felonies or misdemeanors *if* a qualified mental health expert can identify a nexus between the offense and a mental health concern. ODR receives funding from DSH to provide services to those who meet the statutory criteria and who have the potential to be deemed incompetent to stand trial. DSH narrowed the eligibility criteria to serve those diagnosed with schizophrenia, schizoaffective disorder, and bipolar I disorder and charged with a felony offense.

services through its programs.[13] This included 2,316 through ODR Housing, 1,577 through MIST-CBR, 230 through FIST-CBR/Off-Ramp, and 64 through DSH Diversion.

Current Policy Landscape in Los Angeles

In the last two years, the Los Angeles County Board of Supervisors (BOS) has made significant efforts to encourage the study of alternatives to incarceration, with a particular focus on the population with mental illness. In August 2018, the BOS directed a study of the existing jail mental health population to determine who may be eligible for diversion programs (which resulted in this report) and required the development of a "diversion road map" that would explore how the county could increase the availability of community-based treatment options.[14] This includes a focus on the types of programs, staffing, and funding that would be needed to support additional diversion efforts. Furthermore, the BOS acknowledged the lack of both state and local mental health beds in California and directed the Los Angeles County Department of Mental Health (DMH) to "assess current and future need for Mental Health Hospital beds that support the jail population."[15] In February 2019, the BOS then established the Alternatives to Incarceration Workgroup, which was tasked with bringing stakeholders together to build a "more effective justice system."[16] In their interim report, the workgroup encouraged the expansion of a system of care that is accessible to individuals experiencing mental illness before they end up involved in the criminal legal system.

In addition to studying the needs of those with mental illnesses and the best practices needed to

To ensure that an appropriately sized system of care exists in Los Angeles County, it is critical to know the size of the potentially divertible population.

support them, the county also has taken steps to fund and expand available services. The BOS authorized ODR to expand its current ODR Housing program to eligible individuals in the entire county by the end of 2019; previously, its services were only available to cases heard at the downtown central courthouse.[17] Moreover, the passage of Assembly Bill No. 1810, which allows for pretrial diversion of individuals charged with certain crimes who are experiencing mental health issues, expanded ODR's capacity to address the needs of this population as well as the capacity of the courts and public defender's offices to divert individuals more quickly into community-based alternatives.[18] Furthermore, as a new measure, the county is investing in a campus-based project designed as an alternative to arresting and incarcerating individuals experiencing mental health issues and homelessness,[19] which highlights additional efforts to augment existing systems of care.

Another key shift happened in August 2019. The Men's Central Jail, located in downtown Los Angeles, was slated to be replaced with the Consolidated Correctional Treatment Facility, often described as a "mental health jail" that would provide treatment to more than 3,800 incarcerated individuals with mental health concerns in a secure setting. In February 2019, the BOS modified this plan to build at least one mental health facility, which would be run by health providers. On August 5, 2019, DHS, DMH, and the Department of Public Health delivered a report to the County Chief Executive Office outlining the need for services to be developed along a continuum of care, with significant options for unlocked community-based facilities for individuals with mental health issues.[20] On August 13, 2019, the BOS voted to cancel the contract to replace the Men's Central Jail,[21] citing the importance of understanding what percentage of individuals in the jail could be safely diverted to community-based treatment as critical to determining what type (and size) of treatment center would be needed.[22] Together, these recent policy actions highlight the need to understand the current size of the population appropriate for diversion.

About This Research

To ensure that an appropriately sized system of care exists in Los Angeles County, it is critical to know the size of the potentially divertible population. The RAND Corporation was contracted by ODR, in collaboration with Groundswell Services, Inc.; the University of California, Los Angeles, School of Law Criminal Justice Program; and the University of California, Irvine, to estimate the size of the current population of individuals incarcerated in county jails who would likely be legally suitable (i.e., appropriate for diversion from a legal perspective) and clinically eligible (i.e., appropriate for diversion from a clinical perspective) for community-based treatment programs. ODR as an agency is responsible for identifying individuals to put forward as a candidate for diversion. Our goal was to understand the factors that contribute to ODR's decisionmaking when determining whether they will put someone forward as a candidate and then to apply the factors to a representative sample from the jail mental health population. In conducting this research, we were not bound to existing diversion programs (or current capacity within existing programs) in Los Angeles County; rather, we were interested in determining what percentage of individuals incarcerated at the

county jail could be diverted assuming that there were no limits on the types of programs or number of treatment slots available in the community. The research was designed to help determine how the county would need to scale community-based treatment programs to accommodate the full divertible population.

Methods

There were two phases to our methods: First, we developed a set of structured clinical and legal review criteria to ensure the reliability and replicability of our decisions regarding appropriateness for diversion. Second, we applied these criteria to a stratified random sample of individuals from the jail mental health population to identify an estimate of divertible individuals.

Phase 1: Developing Legal and Clinical Criteria

We began by developing criteria used to determine legal suitability and clinical eligibility for diversion. We started this phase by holding discussions with ODR clinicians to better understand ODR programs and processes, including the factors they consider when determining if they will put someone forward as a candidate for diversion. We also held discussions with a number of other important stakeholders—including district attorneys, public defenders and alternate public defenders, LASD representatives, and program clinicians—to better understand the context in which the ODR programs operate. Because diversion is a decision that ultimately involves multiple stakeholders—including defense attorneys, prosecutors, and judges—ODR staff work closely with these individuals to determine who may be appropriate candidates for diversion. In practice, ODR staff apply this knowledge when conducting their initial screening of an individual's suitability. Based on our discussions, and dependent on the particular program, it appears that ODR considers whether the case has at least some potential for a successful review when the question of legal suitability is reviewed by a judge. This should be kept in mind in the context of our criteria development work.

Our goal was to develop criteria that reflect ODR's decisionmaking for identifying potential candidates for diversion.

Our goal was to develop criteria that reflect ODR's decisionmaking for identifying potential candidates for diversion. These were then formally tested against a sample of cases that ODR reviewed as part of a preliminary study,[23] which enabled us to examine the reliability of our criteria before they were applied to a larger sample in the second phase of our study (see Appendix A for a discussion of our reliability testing). Our legal criteria were developed to identify current and past charges that might render someone not appropriate for diversion, based on ODR's experience in its interactions with criminal justice stakeholders (for legal review criteria, see Appendix B). Our clinical criteria were developed to identify individuals with SMI, which are the target population for ODR services.[24] This was based on diagnosis but also other specific indicators that might capture someone with SMI who did not have a diagnosis in the jail medical records. These indicators included descriptions in the records of observable behaviors that demonstrated SMI as well as prescriptions for antipsychotic medications (for clinical review criteria, see Appendix C). Together, the legal and clinical assessment would allow us to classify individuals as *appropriate* (i.e., no obvious bars to diversion are apparent), *potentially appropriate* (e.g., some factors may be viewed with disfavor by a judge or district attorney, but no complete bar was identified), or *not appropriate* for diversion.

Phase 2: Review of Sampled Cases

After establishing the legal and clinical criteria, we conducted a chart review of a stratified random sample of individuals from the jail mental health population to identify an estimate of the number of individuals that are potentially divertible. LASD provided a data set that included all individuals in its jail mental health population on June 6, 2019. This was made up of individuals in LASD custody facilities who were in mental health housing units (including moderate observation housing, high observation housing, or the forensic inpatient unit), taking psychotropic medications, or both. The data sets included all individuals incarcerated at the jail regardless of custody status (pre- versus posttrial) because our focus was determining whether individuals would be suitable given their clinical characteristics and current and previous criminal charges rather than their current stage of processing.[25] The jail mental health population at the time the data were pulled was 5,544 people. Based on an initial power analysis, we selected a sample of 500 individuals (details regarding the sampling strategy are provided below).

To conduct the chart review, we began with examining an individual's legal status. At our request, ODR provided select legal-related information for each individual in the sample, including the statutory citation (e.g., California Penal Code § 594[a]) and level (e.g., misdemeanor) for each charge pending against the individual as well as the citation and charge level for each felony conviction within the previous five years. Based on our discussions with ODR, we flagged common California criminal statute citations as to whether they involved alleged or adjudged actions that were likely to result in the individual being viewed as not appropriate or only potentially appropriate for diversion, which were generally based on charge severity. A pending charge of California Penal Code § 261(a)(2) (rape by force or fear of bodily injury) or California Penal Code § 664/187(a) (attempted murder), for example, would characterize the individual as not appropriate for diversion based on our prior research. All cases that were determined to be appropriate or potentially appropriate then underwent the clinical review.

The clinical review was then conducted by a subset of clinicians on the project team. Clinical reviewers did not have access to the individual's legal information when conducting their assessments. Initially, three cases each were reviewed by pairs of clinicians to ensure interrater reliability.[26] Then, each individual in the sample was reviewed by one of two team members and was designated as either appropriate or not appropriate for diversion based on the clinical criteria. We randomly selected 20 charts to be independently reviewed by two team members and then assessed interrater reliability by determining whether both team members came to the same determination independently. As the clinicians coded the charts, they flagged any charts that were especially challenging or inconclusive. All flagged charts were reviewed by another clinician to make a final determination.[27]

After completion of the clinical review, the legal and clinical decisions were synthesized using the rules articulated in the flow chart depicted in Figure 1.

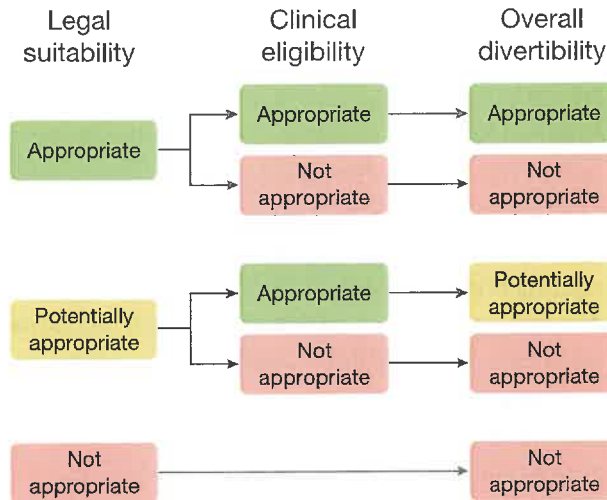
Sampling Strategy and Statistical Analysis

We applied the self-weighting stratified sampling method to draw a representative study sample from the jail mental health population (i.e., the sampling frame for this study). Self-weighted stratified sampling aims to produce a representative study sample by using demographic information to create strata (i.e., subgroups of the study population) and minimizing the design effect of survey sampling. The sampling frame contained 5,544 individuals with their sex, age, and race/ethnicity information. Given our target sample size, our sampling rate was roughly 9 percent.[28]

We performed standard statistical analysis for contingency tables adjusting for survey designs including sampling strata, survey weights, and finite population corrections.[29] The survey weights did not introduce a notable impact to the final estimates because of the self-weighting design. The stratification design and finite population correction

FIGURE 1

Path to Legal and Clinical Decisions to Determine Diversion Appropriateness



mostly reduced the standard errors in all analysis slightly. All analyses were performed by the survey package in Stata 14.2.

Results

In Table 1, we describe the demographic characteristics of the jail mental health population at the time our data were drawn. The majority of individuals were men; regarding race/ethnicity, the largest percentage of individuals were non-Latino black (about 41 percent), followed by Latino (about 35 percent).

Based on our analyses, we found that about 60.8 percent of the jail mental health population were appropriate for diversion (about 3,368 individuals, based on the current population); 7.5 percent were potentially appropriate (about 414 individuals); and 31.8 percent were not appropriate (about 1,762) (see Table 2).

Table 3 reports the decisions regarding appropriateness for diversion by gender. A larger percentage of women were determined to be appropriate candidates for diversion than men.

Additional analyses by race/ethnicity are reported in Appendix D.

TABLE 1

Demographic Characteristics of the Jail Mental Health Population

Demographic Characteristics	Percentage (*n*)
Sex	
Male	85.10% (4,718)
Female	14.90% (826)
Age (years old)	
< 28	22.75% (1,261)
28–34 years old	26.15% (1,450)
35–44 years old	25.20% (1,397)
45+ years old	25.90% (1,436)
Race/ethnicity	
Non-Latino white	19.25% (1,067)
Non-Latino black	40.69% (2,256)
Latino	35.35% (1,960)
Other	4.71% (261)

TABLE 2

Appropriateness for Diversion of the Jail Mental Health Population

Final Decision	Percentage	95% Confidence Interval	Standard Error	Design Effect
Appropriate	60.75%	56.63–64.73%	2.06%	0.981
Potentially appropriate	7.47%	5.55–9.99%	1.12%	0.994
Not appropriate	31.78%	28.07–35.74%	1.95%	0.966

NOTE: Design effect refers to the ratio in the variance of an estimate between the current sample and a simple random sample without any survey design.

Discussion

This study provided an estimate of the percentage of individuals in the jail mental health population who may be appropriate for community-based diversion. Applying our criteria, which were designed to reflect the factors that ODR generally considers when deciding whether to put someone forward as a potential candidate for diversion, we found that an estimated 60.8 percent of the jail mental health population would be appropriate candidates for diversion, and 7.5 percent would be potentially

TABLE 3

Appropriateness for Diversion, by Gender

Final Decision	Percentage	95% Confidence Interval	Standard Error	Design Effect
Men				
Appropriate	58.51%	53.97–62.91%	2.28%	0.993
Potentially appropriate	8.31%	6.12–11.18%	1.28%	0.991
Not appropriate	33.18%	29.09–37.55%	2.15%	0.970
Women				
Appropriate	73.55%	63.13–81.88%	4.73%	0.962
Potentially appropriate	2.69%	0.69–9.93%	1.81%	1.053
Not appropriate	23.76%	15.9–33.93%	4.53%	0.950

NOTE: Design effect refers to the ratio in the variance of an estimate between the current sample and a simple random sample without any survey design.

appropriate candidates for diversion. This is similar to estimates found by ODR during its preliminary study, which was conducted with a simple random sample drawn about four months earlier than our sample. Specifically, ODR found that an estimated 56 percent (95 percent CI [confidence interval]: 52–62 percent) of individuals were appropriate for diversion, and 7 percent (95 percent CI: 5–9 percent) were potentially appropriate for diversion (Ochoa et al., 2019) (for more on this study, see Appendix A). Additionally, we found that more women than men were determined to be appropriate for diversion. Understanding the size and characteristics of the population appropriate for release to community-based treatment is important for the county, as one of the main constraints to serving this population is the existing capacity to serve these individuals. Specifically, knowing how many individuals could be appropriate for diversion is the first step toward understanding the types of programs, staff, and funding that would be needed to treat those individuals in the community, as well as the impact on the overall jail mental health population.

It is important to note that we did not consider specific ODR programs when determining whether an individual was appropriate for diversion. Rather, our approach reflected an "ideal world" scenario in which there was a sufficient number of community-based treatment slots to serve the divertible individuals, regardless of the precise details of any particular program. To build on these results, there are several next steps that would be informative. First, it would be helpful to determine how many of those considered divertible would be eligible for each of the existing diversion programs. That would provide a more nuanced basis for determining the need for expansion of capacity in each of those existing programs. Second, it would be useful to determine the level of care needed by each individual, given their current clinical condition (e.g., acuity of symptoms, level of psychosocial functioning). Our clinical criteria included a mix of historical or static factors (e.g., history of conservatorship) as well as current clinical factors (e.g., presence of observed behaviors consistent with SMI). This means that individuals identified as clinically eligible for diversion could have a variety of current treatment needs. This type of follow-up analysis could provide data regarding the kinds of additional programming that may be needed (e.g., additional community inpatient psychiatric beds), which would allow Los Angeles County to determine what the current community-based capacity is for those levels of care and identify what gaps exist.

In addition, in our review, we did not consider whether individuals were pre-sentence or post-sentence. This is because we operated under the assumption that if an individual was serving a sentence at the time the sample was drawn but had been identified sooner as appropriate for diversion, he or she could have been diverted at some point during pretrial proceedings or at the time the court's judgment was rendered. That said, it is also worthwhile to consider effective community-based treatment options that can be provided along the entire continuum of the Sequential Intercept Model. Although ODR has created interventions across intercepts, most are at intercept 3 (jails/courts). However, early diversion efforts can drastically reduce the demand for competency-related services. Most competency-to-stand-trial evaluations are now conducted pursuant to misdemeanor charges.[30] Many of these evaluations could likely be avoided

with the presence of strong, robust diversion and preventive programs. Fortunately, even without an expanded scope, ODR seems to be consistent with (if not advancing) nationwide trends in this regard; however, other examples could be illustrative for the county to consider. Miami-Dade County uses detention, diversion, and holding facilities that prioritize mental health and psychosocial needs over competency services.[31] Bexar County in Texas provides police officers with a dedicated short-term treatment facility for individuals with mental illness who have minor charges; outcomes are promising in that numbers of diversions have increased annually.[32] Maricopa County in Arizona fields a similar program with comparable results, offering law enforcement workers a drop-in crisis center for individuals they encounter that prioritizes mental health care over minor criminal prosecution.[33] Eugene, Oregon, intervenes at the point of arrest, often sending a CAHOOTS (Crisis Assistance Helping Out on the Streets team), which includes a medic and a crisis worker to respond in cases of urgent mental health crises.[34] These services are critical in decreasing the criminalization of persons with mental illness.

Even with increased diversion, however, there will continue to be a large number of individuals with mental health needs who remain in jail—whether because of limited community-based capacity, concerns about legal suitability for diversion, or issues related to public safety. Some of these individuals may be waiting placement in a state hospital (e.g., for restoration to competence to stand trial), and some of these individuals will be serving sentences. In addition, the process of obtaining a judicial determination of whether diversion is an appropriate pathway for an individual—and for finding a suitable facility to accept that person—is neither automatic nor swift. Thus, LASD and DHS will continue to have a major role in housing and supervising individuals with mental illness in the jail system. This is important for two reasons. First, it will be critical to ensure that the mental health needs of individuals who remain incarcerated are met in a timely and effective manner. Second, this creates groups of individuals who will require services following discharge. Although ODR is currently focusing on providing clinical-legal interventions through the court system, there are other efforts underway that provide discharge planning and reentry services. For example, Los Angeles County has piloted certain programs such as the Mentally Ill Offender Crime Reduction grant, although there were challenges to retaining individuals in this program.[35] These reentry efforts have been continued through the Whole Person Care initiative, in which evaluation efforts are currently underway.[36] The county might also consider ways to integrate other evidence-based reentry programs or approaches into reentry services, such as forensic assertive community treatment or intensive case management models given the continued need for discharge and reentry service planning.[37]

Finally, with expansion comes constraints on the courtrooms hearing these cases. In our discussions with legal stakeholders, the issue of overload in cases was raised. Because all cases should receive individualized consideration, the number of cases in any given "mental health" courtroom should be

Even with increased diversion, however, there will continue to be a large number of individuals with mental health needs who remain in jail—whether because of limitations to community-based capacity, concerns about legal suitability for diversion, or issues related to public safety.

of concern. For example, based on our stakeholder discussions, Department 44 in the Clara Shortridge Foltz Criminal Justice Center of Los Angeles—where cases for ODR Housing are heard—has 400–500 cases on calendar every month. This is not to say that there are 400–500 new cases each month, as the vast majority of these are progress reports that come back to court repeatedly; however, this number is quite large. Expanding the number of individuals being diverted may also require an increase in the number of days per month that diversion cases are heard by the court. If ODR begins working with all clients who are appropriate for diversion, it is clear that an expansion of the number of courtrooms within each courthouse will be required.

Limitations

There are certain limitations to this study that should be considered when interpreting the findings. First, although we were able to use ODR's preliminary study to assess the consistency of our review criteria with ODR's decisionmaking process, we were unable to validate our criteria against true "successful" diversion—that is, whether an individual who was recommended for diversion was actually diverted. In addition, although we conducted informational interviews with several key legal stakeholders in the early stages of this project, we had limited success obtaining input from judges, who are the ultimate legal decisionmakers, given the individualized nature of their decisions and lack of systematic data regarding rates with which diversion is granted. Therefore, our understanding of the legal factors that shape diversion come from our discussion with ODR and its experience. That said, as described above, ODR validated its decisions regarding appropriateness for diversion for a small number of cases in its preliminary review with legal stakeholders, and we used ODR's review as the foundation for our own criteria.

Second, ODR staff are routinely present in the courtrooms of the small number of judges within the Los Angeles Superior Court system who currently consider ODR diversion cases, and our sense is that they are intimately familiar with the dynamics of how prosecutors, defense counsel, and judges in those courts interact at such hearings and how these stakeholders perceive the benefits and drawbacks of diverting individuals. But significant expansion of diversion resources and the associated use of such programs will similarly expand the venues across the county in which cases will be heard far beyond the small number of courtrooms that are currently in play. Legal stakeholders in other courts may have differing views regarding the factors that shape legal suitability and clinical eligibility. If it is assumed that the judges assigned to courtrooms currently handling mental health matters represent a group who are relatively receptive to diversion, then our estimates should be considered as an upper bound of the population that would ultimately be diverted even if treatment resources were available without limitation.

Third, judges do not have unlimited discretion when deciding whether release into community services is an appropriate pathway for the people facing criminal charges in their courtroom. For example, admission to ODR Housing requires that an individual plead guilty or no contest in exchange for probation in which adherence to the rules of that program is a condition of the sentence. California law sets forth a number of situations in which individuals facing criminal charges are statutorily deemed to be ineligible for probation (e.g., California Penal Codes §1203, §667, §667.61), which would

[O]ur estimates should be considered as an upper bound of the population that would ultimately be diverted even if treatment resources were available without limitation.

presumably apply as well to any diversion program using the ODR Housing admission model. In addition, DSH Diversion includes certain statutory restrictions related to both legal and clinical status (e.g., the program is available to individuals with schizophrenia, schizoaffective disorder, and bipolar I disorder). These factors may affect the specific programs for which a given individual would be eligible.

Fourth, any clinical review of mental health among individuals being held in county jails must grapple with the implications of substance abuse. Individuals with a diagnosis of a substance use disorder alone are not eligible for diversion through ODR's programs. Most individuals in our sample had some substance abuse history, and many even demonstrated the effects of substance intoxication upon admission. Although our review tried to identify only symptoms resulting from SMI, there may be instances in which the jail clinicians (whose notes we reviewed) mistook the effects of substances for symptoms of psychiatric illness. Conversely, there may be instances in which they failed to recognize genuine symptoms that were overshadowed by (or mistakenly attributed to) the effects of substances, especially for individuals who were admitted to jail shortly before our review took place. Because most individuals in our sample remained in jail far longer than most effects of substances persist, we believe this dilemma was mitigated by reviewing clinical information over as much as a yearlong period, although this span varied depending on when individuals were first jailed (and when released, if relevant) during our review period. But we acknowledge that any review of this sort—just like any clinical diagnosis in jail—cannot infallibly distinguish all symptoms of mental illness from all effects of substances.

Fifth, it is important to note that our review focused on the jail mental health population at a single point in time. Individuals with SMI often cycle through the justice system, so it is possible that diverting these individuals could prevent those future cycles through the system and help alleviate the overall jail mental health population in a meaningful way. However, we cannot formally extrapolate what effect diverting 60.8 percent of the jail mental health population at a point in time would have on the jail mental health population in a given year. As a next step, it would be valuable to refine our estimates using additional contextual information, such as the average length of stay of individuals in the jail mental health population, their level of care throughout their jail stay or stays, and the number of repeat admissions in a given period (e.g., one year). This information would be important to gain a more-granular understanding of both the community- and jail-based resources needed to serve this population.

Finally, we were limited in the types of clinical and legal data we could access for this study and were limited only to those individuals with an established mental health concern (i.e., they were part of the jail mental health population). When ODR is determining whether an individual may be appropriate for diversion, it has access to information beyond what was available to the project team. This includes information about the use of publicly funded mental health services and additional detail about the circumstances surrounding current criminal charges. Even with our limited data source, we were able to reliably replicate ODR's decisionmaking on a small number of cases (as described in Appendix A); however, it is possible that access to more complete sources of data would have yielded information relevant to appropriateness for diversion.

Next Steps

As Los Angeles County continues to augment the availability of diversion programs in the community, we offer the following recommendations. First, we recommend considering ways to increase ODR's capacity for ongoing data collection. This could include leveraging existing data-collection efforts in Los Angeles, such as the Chief Information Office's Information Hub, which aims to integrate data from various public agencies, including DHS, DMH, Los Angeles Homeless Services Authority, Probation Department, and LASD. These types of cross-system data sets are also consistent with the recommendations of the Stepping Up Initiative.[38] However, criminal justice information is not currently available in the Information Hub, and there are challenges to using the data as a real-time

way to track outcomes.[39] Therefore, this might also include new data-collection infrastructure or efforts. An increased capacity for ongoing data collection is particularly important because there are numerous systemic changes and evolvement of the systems in place. As there is expansion to other courts, it will be important to track the rates of release to community-based treatment in these different courts, identify differences, and work toward a consistent approach across courts.

Second, it is also critical to closely track the demand, process, and outcomes of diversion. This includes the number of individuals who are at least potential candidates (such as the mental health population in county jails); how many are brought to ODR's attention by attorneys, judges, and jail staff for consideration; how many are selected as candidates for diversion by ODR (and the reasons why others were not); how many of those who are recommended by ODR for diversion are ultimately diverted (and what reasons appear to be controlling for judicial decisions to reject diversion); how many diverted individuals remain stably housed; how many are reincarcerated; and how many are reconvicted. A recent study of ODR Housing is an excellent start to evaluating outcomes,[40] but it was limited to one program at one point in time. If ODR were given adequate resources to augment its current data-collection capabilities and policies and maintain them consistently going forward, it would be possible to continuously track progress and identify factors that are associated with successful versus unsuccessful diversion.

In addition, although our findings suggest that a substantial number of individuals could be eligible for ODR's programs, there are some legal procedural issues at play that might prevent ODR from achieving diversion for all who are eligible. For example, as described, ODR Housing requires a guilty or no contest plea, and the program is much more intensive than the plea bargains that are often offered in early disposition courts throughout the county. One of our discussions with a legal stakeholder suggested that public defenders are sometimes less likely to encourage their clients to take advantage of the program for that reason. In contrast, California Penal Code § 1001.36 allows for pre-plea diversion, ultimately resulting in the dismissal of charges at the conclusion of the period of diversion—a key benefit of the program. If ODR shifted more of its programming to be available to individuals pre-plea through this program articulated in the penal code, this could greatly alleviate the issue. Finally, it is important to note that these diversion programs are voluntary, and not every individual who is offered diversion will accept diversion. Therefore, although our estimates reflect those who might be appropriate for diversion, it is likely that some subset would decline to participate in a diversion program.

Finally, although ODR is responsible for developing diversionary programming, there are other local and state agencies that have a stake and a role in providing solutions. Therefore, future work to address the needs of justice-involved individuals with mental illness will continue to require the input and resources of a variety of stakeholders. Similarly, the landscape of diversion is shaped not only by local innovations but also by state-level initiatives and statutes, such as California Penal Code § 1001.36. It will be valuable to understand how to best leverage these opportunities to create additional diversion opportunities in Los Angeles County. Ultimately,

[A]lthough our findings suggest that a substantial number of individuals could be eligible for ODR's programs, there are some legal procedural issues at play that might prevent ODR from achieving diversion for all who are eligible.

policymakers can more effectively address this growing issue without compromising public safety by better understanding who can be successfully diverted, the services that they need, and the opportunities to develop innovative and effective programs.

Appendix A. Developing and Testing the Reliability of the Legal and Clinical Criteria

Given our aim to create reliable criteria to use in the second phase of our study, we first needed to test whether our criteria reliably reflected the factors that ODR takes into consideration when determining whether to put someone forward as a candidate for diversion. To do this, we used a preliminary study conducted by ODR for testing purposes, which enabled us to apply our criteria to a set of cases reviewed by ODR and refine the criteria as necessary.

ODR Preliminary Study

In an effort to provide the BOS with a preliminary estimate of the divertible population, ODR conducted an initial chart review to yield an estimate of divertible cases in February 2019.[41] For this effort, ODR staff reviewed 500 cases, randomly selected from the jail mental health population (i.e., individuals in mental health housing units, taking psychotropic medications, or both). They then conducted a review of each individual, using the same sources of information that they consult when evaluating a potential client's legal and clinical status to determine whether they will ask the court to place the individual into an ODR diversion program. This process began with a review of each individual's criminal history, including current charges (made up of the details surrounding the nature and circumstances of the charges) and past convictions. Next, they made a determination of whether there were any factors present that were very likely to render an individual legally unsuitable for diversion by the court. If no such factors were present, they then reviewed an individual's clinical background, including information from the jail medical record as well as information regarding use of public mental health services in Los Angeles County. Based on both the legal and clinical review, they then made a determination about each person's overall potential for safe release to community-based treatment, with each person categorized as *appropriate*, *potentially appropriate*, or *not appropriate* for diversion. As part of this work, ODR reviewed a small subset of the cases in its sample with relevant stakeholders to validate the decisions. ODR's research found that an estimated 56 percent of individuals were appropriate for diversion, 7 percent were potentially appropriate, and 37 percent were not appropriate.

RAND Reliability Check

In developing the legal criteria, we had an ongoing series of discussions with ODR, which provided insight into the nature of decisions made for existing programs and the nature of decisions made as part of its preliminary study. We also considered the views of legal stakeholders who were interviewed in the beginning of our study. Based on these sources, we developed several versions of the eligibility criteria. Regarding legal criteria, we began with about 50 different "formulas" for examining case charge information collected by ODR and rating each case. We also had a preliminary version of clinical criteria, which we applied over varying time frames (e.g., six months versus one year before the date of the chart review).

To ensure that our criteria reliably reflected ODR's decisionmaking, we randomly selected 50 cases used in the ODR preliminary study to test our criteria. Our aim was to achieve at least 80 percent agreement with ODR's decisions to calibrate our criteria. To conduct this reliability check, we divided the 50 randomly selected cases into two groups. Based on this review, we identified the combination of legal and clinical criteria that best matched the ODR decisions. Although some versions of these criteria reached 80-percent agreement, we used the results as an opportunity to refine the criteria and maximize agreement. We discussed each of the 25 cases with ODR to understand its decisionmaking process and adjust the criteria accordingly.

We then applied the revised criteria to the second set of 25 cases. We tested two versions of the criteria we developed and again assessed the percentage of agreement with ODR decisions. We discussed the cases in which there was disagreement with ODR, which informed final updates to the criteria to maximize agreement. Our final set of criteria resulted in 92-percent agreement across the 50 test cases. Legal criteria are presented in Appendix B, and clinical criteria are presented in Appendix C.

Appendix B. Legal Criteria

Legal Criteria

Cases that are considered appropriate candidates to put forward for diversion include those that are considered to have no obvious legal issue; those considered potentially appropriate are those in which there are certain charges or statuses that raise some question of suitability but the issue is not one that appears to be an obvious bar for diversion. All cases categorized as appropriate or potentially appropriate were reviewed for clinical eligibility (see Appendix C).

Individuals were classified as not appropriate if there was a current felony charge or a prior felony conviction within five years for murder, voluntary or involuntary manslaughter, rape or sexual insertion, sex crimes involving minors, carjacking, the use of firearms (such as possession during the commission of a crime, discharging, or brandishing), or kidnapping for the purpose of sexual offenses or robbery.

Potentially appropriate candidates were those who had current felony charges for arson involving residential settings or injuries, certain types of firearm possession crimes (such as possession of a firearm by a convicted felon), and certain types of kidnapping or stalking crimes. Cases included in the potentially appropriate categories involved instances for which additional detail about the nature of the charges or circumstances surrounding the charges would need to be reviewed more closely prior to making a final decision regarding appropriateness for diversion. Individuals who were in the jail population for only parole violations were rated as potentially appropriate unless another aspect of their legal status rated them as not appropriate.

It is important to note that, in large part, these charges generally reflect those that are considered to be more serious threats to public safety. Individuals with these charges are likely to be perceived as a greater ongoing threat to public safety, and, based on our key informant discussions, these charges are considered by legal stakeholders when determining whether an individual may be appropriate for diversion. However, it is important to note that this is not a proxy for a formal risk assessment, which would provide more data about actual risk to public safety.

Individuals in our sample were classified as legally appropriate if they did not fit one of the preceding criteria. The specific citations that were used to identify individuals who were not appropriate or potentially appropriate for diversion appear in Table B.1 (this table contains only penal code citations; for a version with details about the specific charges, see Appendix E). Table B.1 does not contain an exhaustive list of charges but rather reflects only those current charges and prior convictions that were identified as relevant in our discussions with ODR, particularly those represented within the review sample.

Data Source

The information source we used to apply the legal suitability criteria was criminal history data found in the Los Angeles Superior Court's Data and Document Exchange Service (DDES) online system, which was one of several sources used in the ODR preliminary study. Because we were not granted access to DDES, we relied on ODR to use the system on our behalf and to provide us with current charge and recent conviction information. ODR staff indicated that pending legal status and criminal history are the factors they most frequently consider when making assessments regarding potential legal suitability.

TABLE B.1

Legal Review Criteria

Appropriateness for Diversion	Cites/Charges Included			
Not appropriate	PC 32	PC 262	PC 288.5	PC 664/215(a)
	PC 182.5	PC 262(a)(1)	PC 288.7(a)	PC 664/261(a)(2)
	PC 186.28	PC 264.1(a)	PC 288.7(b)	PC 667.1
	PC 187	PC 264.1	PC 289(a)	PC 667.15(a)
	PC 187(a)	PC 266	PC 289(a)(1)	PC 667.15(b)
	PC 187(a)(1)	PC 266h	PC 289(a)(1)(a)	PC 667.51
	PC 189	PC 266h(b)(1)	PC 289(a)(1)(b)	PC 667.61
	PC 190.05	PC 266i(b)(1)	PC 289(a)(1)(c)	PC 667.71
	PC 192(a)	PC 266i(b)(2)	PC 289(b)	PC 667.8(a)
	PC 192(b)	PC 266j	PC 289(c)	PC 667.8(b)
	PC 207(b)	PC 267	PC 289(d)	PC 11418(a)(1)
	PC 209(b)	PC 269	PC 289(e)	PC 11418(a)1
	PC 209(b)(1)	PC 272	PC 289(f)	PC 11418(b)1
	PC 209.5	PC 272(a)(1)	PC 289(g)	PC 11418(b)2
	PC 209.5(a)	PC 286(a)(1)	PC 289(h)	PC 11418(b)3
	PC 215	PC 286(b)(1)	PC 289(i)	PC 11418(c)
	PC 215(a)	PC 286(b)(2)	PC 289(j)	PC 11418.5
	PC 217.1(b)	PC 286(c)(1)	PC 311.1	PC 12021.5
	PC 220(a)(2)	PC 287(b)(1)	PC 311.11(a)	PC 12022(a)(1)
	PC 236.1(c)	PC 287(b)(2)	PC 311.11(b)	PC 12022(a)(2)
	PC 236.1(c)(1)	PC 287(c)(1)	PC 311.11(c)	PC 12022(b)(2)
	PC 236.1(c)(2)	PC 288(a)	PC 311.11	PC 12022(c)
	PC 245(a)(2)	PC 288(b)	PC 311.4(b)	PC 12022.3(a)
	PC 245(a)(3)	PC 288(b)(1)	PC 311.4(c)	PC 12022.3(b)
	PC 245(b)	PC 288(b)(2)	PC 417(a)(2)	PC 12022.4
	PC 245(d)(1)	PC 288(b)2	PC 417(b)	PC 12022.5(a)
	PC 245(d)(2)	PC 288(c)(1)	PC 417(c)	PC 12022.5(b)
	PC 245(d)(3)	PC 288(c)(2)	PC 417.3	PC 12022.53(b)
	PC 245.5(b)	PC 288a(b)(1)	PC 417.4	PC 12022.53(c)
	PC 246.3	PC 288a(b)(2)	PC 647.6(a)(1)	PC 12022.53(d)
	PC 246.3(a)	PC 288a(c)(1)	PC 647.6	PC 12022.55
	PC 261	PC 288.2	PC 653f(b)	PC 18745
	PC 261(a)(2)	PC 288.3	PC 664/187(a)	PC 25800
	PC 261(a)(3)	PC 288.4(a)	PC 664/187(a)(1)	PC 26100(b)
	PC 261(a)(4)	PC 288.4(b)	PC 664/187	PC 26100(c)
	PC 261.5(c)	PC 288.5(a)	PC 664/192(a)	PC 26100(d)
	PC 261.5(d)			
Potentially appropriate	HS 11370.1(a)	PC 646.9(c)	PC 25850(a)	PC 29805
	HS 11370.1	PC 664/207(a)	PC 25850(c)(1)	PC 29875
	HS 11550(e)	PC 667.85	PC 25850(c)(2)	PC 29900(a)
	PC 166(d)(1)	PC 12022.2(a)	PC 25850(c)(3)	PC 29900(a)(1)
	PC 207(a)	PC 24310	PC 25850(c)(4)	PC 29900
	PC 207	PC 24510	PC 25850(c)(5)	PC 29905
	PC 209(a)	PC 24610	PC 25850(c)(6)	PC 30305(b)
	PC 451(a)	PC 25100(a)	PC 25850(c)(7)	PC 30305(b)(1)
	PC 451(b)	PC 25100(b)	PC 25850	PC 30315
	PC 451.1	PC 25100	PC 27500	PC 30320
	PC 451.5	PC 25110(a)	PC 27590	PC 32310
	PC 452(a)	PC 25300	PC 28250	PC 33215
	PC 452(b)	PC 25400(a)(1)	PC 29800(a)(1)	Current charges (parole violation only[a])
	PC 646.9(b)	PC 25400(c)(4)	PC 29800	

NOTES: All other cases were considered appropriate for purposes of our review. PC = California Penal Code; HS = California Health and Safety Code.

[a] There is no specific penal code associated with this criterion.

Appendix C. Clinical Criteria

Clinical Criteria

Our clinical criteria were developed to detect individuals who might have SMI, whether formally diagnosed or not. We developed four indicators of SMI. If any of these indicators were present, then an individual was considered *appropriate* for diversion. If no indicators were present, then an individual was considered *not appropriate* for diversion.

The four indicators include the following:

1. Incompetence to stand trial or conservatorship (past or present)
   - If an individual has been determined to be incompetent to stand trial or has been placed on conservatorship, he or she was considered to be divertible.
2. Qualifying diagnosis of serious mental illness
   - We determined whether an individual had a qualifying diagnosis. This could include a qualifying diagnosis made at least once at the jail or a qualifying diagnosis given at least twice historically in the community. Qualifying diagnoses are summarized in Table C.1.
3. Prescribed an antipsychotic or mood stabilizer
   - It appeared that diagnoses were not always reliably documented in the jail medical record. Therefore, being prescribed an antipsychotic or mood stabilizer was considered an indicator of SMI. Relevant psychotropic medications are summarized in Table C.2.
4. Presence of observed behaviors consistent with SMI
   - We wanted to account for the possibility that some individuals with SMI had not yet been formally diagnosed. Therefore, we also determined whether there was evidence of observed behaviors consistent with the qualifying diagnoses (e.g., hallucinations, delusions, mania, persistent positive symptoms after multiple weeks of incarceration so that they do not appear to be due to effect of substance).

Data Sources

We used two data sources to assess the clinical criteria. First, data regarding incompetence to stand trial and conservatorship were provided along with the legal information provided by ODR. Second, data regarding clinical diagnoses, medications, and observed behaviors were obtained from the jail medical record. We obtained this information through a review of relevant mental health notes in the 12 months prior to the date of the data pull (June 6, 2019).

TABLE C.1

Qualifying Diagnoses

Category	Diagnosis		ICD-10	
Psychotic	Schizophrenia		F20.9	
	Schizoaffective disorder			
	Bipolar type		F25.0	
	Depressive type		F25.1	
	Delusional disorder		F22	
	Brief psychotic disorder		F23	
	Schizophreniform disorder		F20.81	
	Psychotic disorder due to another medical condition			
	With delusions		F06.2	
	With hallucinations		F06.0	
	Other specified spectrum and other psychotic disorder		F28	
	Unspecified schizophrenia spectrum and other psychotic disorder		F29	
Mood	Bipolar I disorder	Current/most recent episode manic	Current/most recent episode hypomanic	Current/most recent episode depressed
	Mild	F31.11		F31.31
	Moderate	F31.12		F31.32
	Severe	F31.13		F31.4
	With psychotic features	F31.2		F31.5
	In partial remission	F31.73	F31.71	F31.75
	In full remission	F31.74	F31.72	F31.76
	Unspecified		F31.9	
	Major depressive disorder with psychotic features	F32.3	F33.3	
Intellectual disability	Intellectual disability (Intellectual developmental disorder)		F70–79	

NOTE: ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th revision.

TABLE C.2

Antipsychotics and Mood Stabilizers

Medication Class	Medications
Antipsychotic medications	Atypical/second generation Aripiprazole (Abilify) Asenapine (Saphris) Clozapine (Clorzaril) Iloperidone (Fanapt) Lurasidone (Latuda) Olanzapine (Zyprexa, Zypexa, Zydis, Relprevv) Paliperidone (Invega) Quetiapine (Seroquel) Risperidone (Risperdal) Ziprasidone (Zeldox) Typical/first generation Chlorpromazine (Thorazine, Promapar) Droperidol (Inapsine) Fluphenazine (Permitil, Prolixin) Haloperidol (Haldol) Loxapine (Loxitane) Perphenazine (Trilafon) Pimozide (Orap) Prochlorperazine (Compazine, Compro, Procomp) Thioridazine (Mellaril) Thiothixene (Navane) Trifluoperazine (Stelazine)
Mood stabilizers	Carbamazepine (Carbatrol, Epitol, Equetro, Tegratol) Divalproex sodium (Depakote) Lamotrigine (Lamictal) Lithium Topiramate (Topamax) Valproic acid (Depakene)

Appendix D. Results for Subgroups by Gender and Race/Ethnicity

Table D.1 reports our decisions regarding appropriateness for diversion by race/ethnicity.

TABLE D.1

Appropriateness for Diversion, by Race/Ethnicity

Final Decision	Percentage	95% Confidence Interval	Standard Error	Design Effect
Non-Latino white				
Appropriate	64.45%	55.06–72.85%	4.52%	0.965
Potentially appropriate	8.2%	4.28–15.13%	2.62%	0.985
Not appropriate	27.35%	19.85–36.39%	4.19%	0.954
Non-Latino black				
Appropriate	57.16%	50.5–63.58%	3.34%	0.997
Potentially appropriate	9.49%	6.27–14.12%	1.96%	0.982
Not appropriate	33.35%	27.51–39.74%	3.11%	0.958
Latino				
Appropriate	61.94%	54.91–68.5%	3.46%	0.966
Potentially appropriate	5.16%	2.76–9.44%	1.61%	1.007
Not appropriate	32.9%	26.68–39.78%	3.33%	0.956
Other				
Appropriate	67.72%	48.07–82.62%	4.08%	0.939
Potentially appropriate	4.28%	0.56–26.21%	4.08%	1.130
Not appropriate	28.0%	13.57–49.06%	8.79%	1.064

NOTE: Design effect refers to the ratio in the variance of an estimate between the current sample and a simple random sample without any survey design.

Appendix E. Legal Review Criteria Tables with Citations and Descriptions

The legal review criteria used in this study (including citations plus descriptions) appear in Table E.1 for cases that would be rated as not appropriate for diversion and in Table E.2 for those rated as only potentially appropriate.

TABLE E.1
Current Non-Misdemeanor Charges and Recent Felony Convictions Rated as Not Appropriate for Diversion

Cite	Description
PC 32	Accessories to murder
PC 182.5	Conspiracy: Gang participation with knowledge of and benefit from felonies
PC 186.28	Supplying or selling firearm used in street gang activity
PC 187	Murder, first degree
PC 187(a)	Murder and attempted murder
PC 187(a)(1)	Murder and attempted murder
PC 189	Murder, first degree
PC 190.05	Second-degree murder with prior 187
PC 192(a)	Voluntary manslaughter
PC 192(b)	Involuntary manslaughter
PC 207(b)	Kidnapping a victim under 14 for sexual assault
PC 209(b)	Kidnapping for robbery, sexual assault
PC 209(b)(1)	Kidnapping for sex offense or robbery
PC 209.5	Kidnapping during the commission of a carjacking
PC 209.5(a)	Kidnapping during a carjacking
PC 215	Carjacking
PC 215(a)	Carjacking
PC 217.1(b)	Attempt to kill public official
PC 220(a)(2)	Assault with intent to commit sex crime on a minor
PC 236.1(c)	Human trafficking for purpose of inducing minor for sex act
PC 236.1(c)(1)	Human trafficking for purpose of inducing minor for sex act
PC 236.1(c)(2)	Human trafficking for purpose of inducing minor for sex act
PC 245(a)(2)	Assault with a firearm
PC 245(a)(3)	Assault with a machine gun
PC 245(b)	Assault with a semiautomatic rifle
PC 245(d)(1)	Assault with a firearm upon a peace officer or firefighter
PC 245(d)(2)	Assault with a semiautomatic rifle upon a peace officer or firefighter
PC 245(d)(3)	Assault with a machine gun or assault weapon upon a peace officer or firefighter

Cite	Description
PC 245.5(b)	Assault with a firearm upon a school employee
PC 246.3	Discharging firearm in grossly negligent manner
PC 246.3(a)	Discharge a firearm with gross neglect
PC 261	Rape
PC 261(a)(2)	Rape by force or fear of bodily injury
PC 261(a)(3)	Rape by intoxicant ("date rape")
PC 261(a)(4)	Rape of unconscious person
PC 261.5(c)	Unlawful sexual intercourse—minor over 3 years younger
PC 261.5(d)	Unlawful sexual intercourse—21 years or older, minor under 16 years
PC 262	Rape of spouse
PC 262(a)(1)	Spousal rape by force or fear of injury
PC 264.1(a)	Rape in concert by multiple defendants
PC 264.1	Rape in concert with force or violence
PC 266	Seduction of minor for prostitution
PC 266h	Pimping—under age 16
PC 266h(b)(1)	Pimping a minor over 15 years old
PC 266i(b)(1)	Pandering—minor 16 years or older
PC 266i(b)(2)	Pandering—minor under 16
PC 266j	Procurement of child under 16 for lewd and lascivious acts
PC 267	Abduction of person under 18 for purposes of prostitution
PC 269	Rape—child under 14 and 10 or more years younger than defendant (PC 261(a)(2 or 6), 264.1, 286, 288(a), or 289(a))
PC 272	Contributing to delinquency of a minor
PC 272(a)(1)	Contributing to a minor's delinquency
PC 286(a)(1)	Sodomy of minor under eighteen
PC 286(b)(1)	Sodomy—victim under 18
PC 286(b)(2)	Sodomy—victim under 16, defendant over 21
PC 286(c)(1)	Sodomy—victim under 14, defendant 10 years older
PC 287(b)(1)	Oral copulation—victim under 18
PC 287(b)(2)	Oral copulation—victim under 16
PC 287(c)(1)	Oral copulation—victim under 14
PC 288(a)	Lewd act on child—victim under 14
PC 288(b)	Lewd act on child—by use of force or fear
PC 288(b)(1)	Lewd act by force on a child under 14
PC 288(b)(2)	Lewd act on child—by caretaker upon dependent adult by use of force or fear
PC 288(b)2	Lewd act on child—by caretaker upon dependent adult by use of force or fear

Cite	Description
PC 288(c)(1)	Lewd act on child—victim 14 or 15, defendant 10 years older
PC 288(c)(2)	Lewd act on child—by caretaker upon dependent adult by use of force or fear
PC 288a(b)(1)	Oral copulation—victim under 18
PC 288a(b)(2)	Oral copulation—victim under 16
PC 288a(c)(1)	Oral copulation - victim under 14
PC 288.2	Distribution or exhibition of lewd material to minor (as defined in PC 313)
PC 288.3	Contacting or attempted contact with a minor or person believed to be a minor with intent to commit specified kidnapping, child pornography, or other sex crimes involving a minor
PC 288.4(a)	Arranging meeting with a minor or person believed to be a minor for purpose of exposing genitalia or engaging in lewd and lascivious behavior
PC 288.4(b)	Going to place arranged under 288.4(a)
PC 288.5(a)	Continuous sexual abuse of a child
PC 288.5	Engaging in 3 or more acts of substantial sexual conduct with child under age 14
PC 288.7(a)	Engaging in specified sexual conduct with a child age 10 or under
PC 288.7(b)	Engaging in specified sexual conduct with a child age 10 or under
PC 289(a)	Sexual penetration by foreign object
PC 289(a)(1)	Sexual penetration by object by force
PC 289(a)(1)(a)	Sexual penetration by object by force
PC 289(a)(1)(b)	Sexual penetration by object by force on child less than 14 years old
PC 289(a)(1)(c)	Sexual penetration by object by force on minor 14 years old or older
PC 289(b)	Sexual penetration by foreign object
PC 289(c)	Sexual penetration by foreign object
PC 289(d)	Sexual penetration by foreign object
PC 289(e)	Sexual penetration by foreign object while victim intoxicated or anesthetized
PC 289(f)	Sexual penetration by foreign object
PC 289(g)	Sexual penetration by foreign object
PC 289(h)	Sexual penetration by foreign object—victim under 18
PC 289(i)	Sexual penetration by foreign object—victim under 16
PC 289(j)	Sexual penetration by foreign object—victim under 14
PC 311.1	Bringing into state matter depicting child in sexual conduct
PC 311.11(a)	Possess child pornography
PC 311.11(b)	Possess/control any matter relating to sexual conduct of a minor with a prior
PC 311.11(c)	Possess child pornography images
PC 311.11	Possess/control any matter relating to sexual conduct of a minor
PC 311.4(b)	Using minor to assist in distribution of obscene matter; posing or modeling involving sexual conduct
PC 311.4(c)	Using minor to assist in distribution of obscene matter; posing or modeling involving sexual conduct
PC 417(a)(2)	Brandishing a firearm

Cite	Description
PC 417(b)	Exhibiting loaded firearm at day care center
PC 417(c)	Exhibiting firearm in presence of peace officer
PC 417.3	Exhibiting firearm at occupant of vehicle
PC 417.4	Brandishing imitation firearm with threat
PC 647.6(a)(1)	Annoy or molest a child
PC 647.6	Molesting a child
PC 653f(b)	Solicitation to commit murder
PC 664/187(a)	Attempted murder
PC 664/187(a)(1)	Attempted murder
PC 664/187	Attempted murder
PC 664/192(a)	Attempted voluntary manslaughter
PC 664/215(a)	Attempted carjacking
PC 664/261(a)(2)	Attempted rape by force or fear of bodily injury
PC 667.1	Anal/genital penetration (289), victim disabled, over 65 or under 14, and prior 289
PC 667.15(a)	Exhibiting to minor matter depicting minor engaging in sexual conduct (288)
PC 667.15(b)	Exhibiting to minor matter depicting minor engaging in sexual conduct (3 or more acts of 288.5)
PC 667.51	Prior sex offense, minor victim
PC 667.61	Aggravated sex offenses—life sentence
PC 667.71	Sex crimes: 261(a)2, 262(a)1, 264.1, 288a, 288b, 289a, 288.5, 286c, 286d, 289
PC 667.8(a)	Kidnapping to commit sex offense (261, 262, 264.1, 286, 288a, 289)
PC 667.8(b)	Kidnapping victim under 14 to commit sex offense 286c, 288, 288a(c)
PC 11418(a)(1)	Possess weapon of mass destruction
PC 11418(a)1	Possession, manufacture, or use of weapon of mass destruction
PC 11418(b)1	Use of weapon of mass destruction against a person
PC 11418(b)2	Use of weapon of mass destruction in water or food
PC 11418(b)3	Use of weapon of mass destruction against animals or crops
PC 11418(c)	Use of weapon of mass destruction against natural resources
PC 11418.5	Credible threat to use weapon of mass destruction
PC 12021.5	Possession of firearm, detachable magazine, or belt-feeding device during street gang crime
PC 12022(a)(1)	Principal armed with firearm
PC 12022(a)(2)	Principal armed with assault weapon or machine gun
PC 12022(b)(2)	Personal use of deadly/dangerous weapon and carjacking
PC 12022(c)	Personally armed with firearm during specified drug offense
PC 12022.3(a)	Sexual offenses—use of firearm or deadly weapon in commission (261, 262, 264.1, 286,288, 288a, 289)
PC 12022.3(b)	Sexual offenses—armed with firearm or deadly weapon (261, 262, 264.1, 286, 288, 288a, 289)
PC 12022.4	Furnishing firearm for felony

Cite	Description
PC 12022.5(a)	Personal use of firearm
PC 12022.5(b)	Personal use of assault weapon or machine gun
PC 12022.53(b)	Personal use of firearm in specified crimes (see Appendix A)
PC 12022.53(c)	Personal discharge of firearm in specified crimes (see Appendix A)
PC 12022.53(d)	Personal discharge of firearm causing GBI or death in specified crimes (see Appendix A) or 12034 from vehicle or 246 at inhabited dwelling, vehicle, or aircraft
PC 12022.55	Discharging firearm from vehicle with GBI or death
PC 18745	Explosion or attempt to explode destructive device with intent to murder
PC 25800	Carrying a loaded firearm with intent to commit felony
PC 26100(b)	Allowing another to discharge firearm from vehicle
PC 26100(c)	Discharge of firearm from vehicle at a person
PC 26100(d)	Malicious discharge of firearm from vehicle

NOTE: GBI = great bodily injury.

TABLE E.2

Current Non-Misdemeanor Charges Rated as Potentially Appropriate for Diversion

Cite	Description
N/A	Instances in which the only current charges involve parole violations
HS 11370.1(a)	Possess loaded firearm and controlled substance
HS 11370.1	Possession of controlled substance while armed with firearm
HS 11550(e)	Under the influence while in possession of firearm
PC 166(d)(1)	Possession of firearm by prohibited person based on issuance of TRO/CPO
PC 207(a)	Kidnapping
PC 207	Kidnapping
PC 209(a)	Kidnapping for ransom or extortion
PC 451(a)	Arson—with GBI
PC 451(b)	Arson—inhabited structure or property
PC 451.1	Arson with prior; GBI to emergency personnel; GBI to more than one victim; multiple structures or special device used
PC 451.5	Aggravated arson—willful, malicious intent to cause injury to one or more persons, damage to property, etc.
PC 452(a)	Unlawfully causing a fire—with GBI
PC 452(b)	Unlawfully causing a fire—inhabited structure or property
PC 646.9(b)	Stalking violation of TRO
PC 646.9(c)	Stalking with prior specified felony conviction
PC 664/207(a)	Kidnapping
PC 667.85	Kidnapping victim under 14 to permanently deprive parent
PC 12022.2(a)	Armed with firearm with armor/metal piercing ammunition
PC 24310	Manufacture, import, sell, or possess any firearm camouflaging container
PC 24510	Manufacture, import, sell, or possess any firearm not immediately recognizable as a firearm
PC 24610	Manufacture, import, sell, or possess any undetectable firearm
PC 25100(a)	Criminal storage of firearm—1st degree
PC 25100(b)	Criminal storage of firearm—2nd degree
PC 25100	Criminal storage of firearm—1st degree
PC 25110(a)	Criminal storage of firearm—1st degree
PC 25300	Carrying a firearm in public place or on public street while masking one's identity
PC 25400(a)(1)	Carry concealed firearm in vehicle
PC 25400(c)(4)	Carrying a concealed firearm by felon
PC 25850(a)	Carrying a loaded firearm
PC 25850(c)(1)	Carrying a loaded firearm
PC 25850(c)(2)	Carrying a loaded firearm
PC 25850(c)(3)	Carrying a loaded firearm

Cite	Description
PC 25850(c)(4)	Carrying a loaded firearm
PC 25850(c)(5)	Carrying a loaded firearm
PC 25850(c)(6)	Carrying a loaded firearm
PC 25850(c)(7)	Carrying a loaded firearm
PC 25850	Carrying loaded firearm in vehicle, or on person in a public place with prior felony conviction, stolen firearm or by gang member
PC 27500	Delivering concealable firearm to person within any of the classes prohibited by California Penal Code 12021 or 12021.1
PC 27590	Delivering concealable firearm to person within any of the classes prohibited by California Penal Code 12021 or 12021.1
PC 28250	Knowingly provide false information on firearm application by felon or other prohibited person
PC 29800(a)(1)	Possession of firearm by felon
PC 29800	Persons prohibited from possessing firearms
PC 29805	Possession of firearm by persons with certain priors
PC 29875	Persons prohibited from possessing firearms
PC 29900(a)	Person previously convicted of violent offense prohibited from possessing firearms
PC 29900(a)(1)	Person previously convicted of violent offense prohibited from possessing firearms
PC 29900	Person previously convicted of violent offense prohibited from possessing firearms
PC 29905	Person previously convicted of violent offense prohibited from possessing firearms
PC 30305(b)	Possession of ammunition by person with street gang injunction
PC 30305(b)(1)	Possession of ammunition by person with street gang injunction
PC 30315	Possession of armor-piercing ammunition
PC 30320	Sale or transport of armor-piercing ammunition
PC 32310	Manufacturing, importing, keeping for sale, offering or exposing for sale, giving or lending large-capacity magazine
PC 33215	Manufacturer, transportation, sale, or possession of short-barreled shotgun

NOTES: TRO/CPO = temporary restraining order/criminal protective order.

Notes

[1] Torrey et al., 2010.

[2] Steadman et al., 2009.

[3] Steadman et al., 2005.

[4] LASD, 2019.

[5] Katz, 2019.

[6] Heilbrun et al., 2012.

[7] National Association of Counties, American Psychiatric Association Foundation, Justice Center/the Council of State Governments, Bureau of Justice Assistance/U.S. Department of Justice, 2018, p. 1.

[8] *Motion by Supervisors Mark Ridley-Thomas and Sheila Kuehl: Expanding Effective Diversion Efforts in Los Angeles County*, 2015.

[9] Lacey, 2014.

[10] DHS, 2018.

[11] Munetz and Griffin, 2006.

[12] DHS, Office of Diversion and Reentry, undated. ODR also operates a Maternal Health diversion program, which began in April 2018 and is open to any women who are pregnant during their jail stay. Women who agree to participate plead guilty to their charge and are placed on probation. Women do not necessarily have to have mental illnesses or be experiencing homelessness to participate.

[13] Health Services, Office of Diversion and Reentry, Los Angeles County, 2019.

[14] *Motion by Supervisors Mark Ridley-Thomas and Kathryn Barger: Scaling Up Diversion and Reentry Efforts for People with Serious Clinical Needs*, 2018.

[15] *Motion by Supervisors Kathryn Barger and Hilda Solis: Addressing the Shortage of Mental Health Hospital Beds*, 2019, p. 2.

[16] *Revised Motion by Supervisors Sheila Kuehl and Mark Ridley-Thomas: Developing the Los Angeles County Roadmap for Expanding Alternatives to Custody and Diversion*, 2019, p. 2.

[17] *Motion by Supervisors Mark Ridley-Thomas and Sheila Kuehl: Expanding ODR's Housing Program Countywide to Safely Divert More Individuals with Serious Clinical Needs*, 2019.

[18] *Motion by Supervisors Sheila Kuehl and Mark Ridley-Thomas: Expanding Countywide Diversion for Justice Involved Adults*, 2019; Garcia, 2019.

[19] *LAC + USC Restorative Village Concept Paper*, undated.

[20] County of Los Angeles Chief Executive Office, 2019.

[21] *Motion by Supervisors Hilda L. Solis and Sheila Kuehl: Cancellation of Design-Build Contract with McCarthy Building Companies, Inc.*, 2019.

[22] *Motion by Supervisors Hilda L. Solis and Sheila Kuehl: Cancellation of Design-Build Contract with McCarthy Building Companies, Inc.*, 2019.

[23] ODR's preliminary study was conducted in advance of the current effort to provide the county with initial information to "guide the County's strategy for creating and scaling . . . program capacity" (Ochoa et al., 2019).

[24] ODR also diverts individuals diagnosed with intellectual disability, which was included as a clinically eligible diagnosis. However, because these cases tend to be infrequent, we did not construct criteria to detect undiagnosed cases of intellectual disability in the same way that we did for SMI.

[25] This decision reflects our assumption that both pre- and posttrial diversion options could be available, and that if posttrial individuals had been identified as appropriate for diversion earlier, they could have been diverted through a pretrial option. That said, in our data set, posttrial individuals may have had different legal or clinical characteristics than pretrial individuals, which we were unable to quantify. In the jail mental health population at the time the data were pulled, 2,665 people had all open charges, 1,163 had at least one case for which they had been sentenced, and 1,716 had been sentenced on all cases.

[26] The legal review did not require multiple raters, as a given charge was either present or not for each individual. However, the clinical data involved review of progress notes in the jail medical record, and certain criteria (i.e., presence of observed behaviors consistent with SMI) involved some clinical judgment. For this reason, we included a formal process for testing interrater reliability.

[27] One of the 20 charts included in the interrater reliability sample was flagged as a "challenging case" for review by a third clinician. Cohen's kappa for the remaining 19 charts was 0.86 (considered strong interrater reliability; McHugh, 2012).

[28] We defined *age categories* by the quartiles in the sampling frame: younger than 28 years old, 28 or older, and younger than 35, 35 or older and younger than 45, and 45 or older. We grouped race/ethnicity into four groups: Latinos of all races, non-Latino white, non-Latino black, and others. Sampling strata were defined by age categories, race/ethnicity groups, and sex. There was a total of 32 strata theoretically (four age categories by four race/ethnicity groups by two sex levels). However, this study's sampling frame contained 29 strata because the remaining three strata had no individuals. In each stratum, a simple random sample was drawn where the sample size was proportional to the size of the stratum (i.e., the number of individuals in the stratum). The sample size in all strata was truncated to be no smaller than four so that we could have a minimal number of sampled individuals for any subpopulation. This strategy yielded a roughly self-weighted sample (i.e., the sample weights of all sampled individuals were roughly equal).

[29] The finite population correction accounts for the fact that the target population is finite (i.e., 5,544 in this study), and the uncertainty or variance in any sample-based estimate is reduced when the sample size is relatively large compared with the finite population size. Our sampling rate of 9 percent gave a modest amount of reduction by adjusting the finite population correction.

[30] Cochrane, Grisso, and Frederick, 2001; Gowensmith, 2010; Warren et al., 2006.

[31] Qureshi et al., 2015.

[32] Cowell et al., 2008.

[33] Gowensmith and Murrie, 2019.

[34] White Bird Clinic, undated.

[35] Hunter et al., 2018.

[36] UCLA Clinical and Translational Science Institute, undated.

[37] DeMatteo et al., 2013.

[38] National Association of Counties, American Psychiatric Association Foundation, Justice Center/the Council of State Governments, Bureau of Justice Assistance/U.S. Department of Justice, 2018.

[39] Hunter et al., 2017.

[40] Hunter and Scherling, 2019.

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About This Report

In 2015, the Office of Diversion and Reentry Division (ODR), an internal department of the Los Angeles County Department of Health Services, was created to redirect individuals with serious mental illness from the criminal justice system. Part of ODR's mission is to identify individuals currently incarcerated in a Los Angeles County jail who are experiencing a serious mental health disorder and, to the extent practical, provide them with appropriate community-based levels of care with the goals of reducing recidivism and improving health outcomes. Such redirection from the traditional criminal justice process is often characterized as *diversion*. To better build and scale efforts to support this work, in 2018, the Los Angeles County's Board of Supervisors asked for a study of the existing county jail mental health population to identify those who would likely be eligible for diversion based on their legal suitability and clinical eligibility. ODR selected the RAND Corporation, in collaboration with Groundswell Services, Inc.; the University of California, Los Angeles, School of Law Criminal Justice Program; and the University of California, Irvine, to help it address this question through joint funding from Los Angeles County and the Conrad N. Hilton Foundation. This report includes the results from a legal and clinical review of recently incarcerated individuals identified with a serious mental health condition. The authors also provide recommendations for future programming and research. This report will be of interest to state and county governments as well as other organizations serving criminal justice–involved populations with serious mental illness.

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Juvenile Justice Commission
Contra Costa County

Juvenile Probation Facilities & Program Updates

2022

Position Statement

10/24/2022

Executive Summary

The Contra Costa Juvenile Justice Commission met individually with key agency stakeholders, including the Probation Department, the District Attorney's Office, the Public Defender's Office, the County Office of Education, and Behavioral Health Services. In addition, the Commission held a public meeting on 10/17/2022 wherein stakeholders provided information about proposed changes to the Juvenile Probation Facilities and Programs.

There are 2 primary changes that the Probation Department is proposing making to the system. The first change is creating a new Community Pathways program, which will serve both as a step-down from their in-custody secure track program *and* as a separate disposition option for Courts to avoid placing youth in custody. The second change is the simultaneous closure of the Orin Allen Youth Rehabilitation Facility (OAYRF).

The Commission unequivocally endorses the first change. The creation of a new program model that allows youth to be served in the community is directly in line with

the recommendations that this Commission made in 2020, the last time we issued public recommendations on this matter.

The second change, the closure of OAYRF, is more complicated. The Probation Department has stated that the only way that they can meet their staffing needs at the Juvenile Hall and operate the new Community Pathway program is to reallocate staff currently assigned to OAYRF to these programs. The Commission has also heard statements from many stakeholders and the community, and strongly itself believes, that ideally the Community Pathway program would be up and running prior to closing OAYRF. This would allow the new program to develop a track record of trust with other stakeholders, particularly the District Attorney, Public Defender, and the Courts.

The Commission therefore recommends that the Board of Supervisors delay their decision-making regarding the closure of OAYRF for a short period of time to provide more time for stakeholders to have further discussions about the closure of OAYRF and get buy-in from key institutional stakeholders.

More detailed recommendations are contained with this Position Statement.

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Background

Orin Allen Ranch Youth Rehabilitation Facility

The Orin Allen Youth Rehabilitation Facility ("OAYRF") is a minimum security ranch-style detention facility established in 1960. With the addition of a second dormitory in 1999, OAYRF can theoretically house a maximum of 100 youth. OAYRF is located in the southeastern portion of Contra Costa, occupying 50 acres in Byron, CA. The commonly used portion of the facility is approximately 2-4 acres and includes a cluster of buildings - two dormitories, classrooms, an indoor recreation area, a cafeteria, and an administration building. There are also significant areas dedicated to outdoor recreation - there is an outdoor visitation area, with a pond, as well as a pool and an outdoor basketball court. Access to and from the different buildings is open, without fencing or walls.

Probation provides cognitive behavioral programming that has been developed over a number of years at the facility to the youth. In addition, the Mt. McKinley school operates classrooms out of the facility, providing on-site educational services to the youth. Further, Contra Costa Health Services has one clinician onsite who is able to provide behavioral health services. Nursing care is available during the week to treat routine medical needs of the youth.

OAYRF is not considered a "locked" facility, as youth are housed in a single "dormitory" style room at night (no individual cells) and the property is not enclosed with full fencing. The facility currently serves as the "least restrictive" custodial disposition option for youth to Contra Costa Juvenile Court when evaluating where to place youth who have a sustained petition in Contra Costa County, and thereby

occupies a key position in the continuum of dispositional choices available to Superior Court judges.

As incarceration rates in the County have dropped over the last several years, the population at OAYRF has declined from an average of 30-40 youth, to currently housing between 10 and 20 during the COVID pandemic. The facility population has generally been on the low end of this range during 2022. As of October 21, 2022, the Probation Department is currently reporting 12 youth are housed at the facility.

The current program design and structure is limited to only allow male (identifying) youth to be housed at the Facility. Female (identifying) youth cannot be placed there. Because medical services are not available 7-days per week, youth who need regular access to controlled substances[1] cannot be placed at the facility.

Portions of OAYRF are aging and in need of upgrades to bring it into compliance with the Americans with Disabilities Act, as well as Titles 15 and 24 of the California Code of Regulations. In 2019, the County Administrator's Office commissioned a facility study by Vanir Construction Management, Inc. This report called for between 3.5 and 12 million dollars in upgrades and new construction.

John A. Davis Juvenile Hall

The John A. Davis Juvenile Hall ("Hall") opened in 2005 and is a significantly newer piece of construction. The Hall is operated as a secure detention facility. The Hall currently has 10 individual housing units, and is capable of housing 290 youth. Facility design in the late 90s and 00s were heavily influenced by an era that focused on a high bed count to serve a large population.

[1] such as controlled psychotropic medication (for example, benzodiazepines)

The Hall currently serves four populations of youth. The first two are described below - youth in either the “Commitment Track” or “Secure Track” of the Briones Youth Academy. The third population served at the Hall are youth who are detained prior to adjudication or final disposition (which makes up approximately half the population at the Hall). The fourth population of youth are female-identifying individuals who are on a placement term similar to the Briones Youth Academy “Commitment Track” but are placed in a separate program called the “Girls in Motion” program.

The current population of the Juvenile Hall as of October 21, 2022 was 62. The average population at the Juvenile Hall has been approximately in this range for the last 6-12 months. This marks a significant uptick in the population over 2020-2021, where the average population was around 40. We have seen an increase in the number of filings against youth in the last 6-12 months as the effects of the pandemic have receded. While we have not seen population levels reach the highs prior to the pandemic, there is reason for concern and monitoring of the population size as changes of this magnitude are enacted.

The Commission believes there is broad stakeholder ambition that the County never return to incarceration levels approaching pre-pandemic levels.

Modern Practices in Juvenile Justice Facility Design

Research and evolving best practices in criminal and youth justice reform in the intervening 2 decades have indicated that the number of youth who are best served in a secure setting following their disposition should be reduced from practices in previous decades. This would focus incarceration on youth who have the very highest levels of risk (generally the youth who have committed the most serious offenses). We have seen a corresponding, and significant, decline in the number of youth at both

OAYRF and the Hall over the last ten years, with a significant decline in the number of youth at the beginning of the COVID pandemic, when the County worked with the Courts to order the early release of many youth at the facility.

The Juvenile Hall's Adaptation to Modern Juvenile Justice Best Practices

However, this does not change the fact that the Hall was designed with the goals and best practices of a different era of youth justice. The facility has a distinctly institutional feel due to the architectural limitations of the facility. While the Probation department has made concerted efforts to soften the feel of the facility in order to create a more rehabilitative milieu, these efforts are limited by the underlying facility design.

It is also critical to note that the facility was never designed to house and accommodate youth for the sheer length of time that youth could now spend in the facility. As the County now begins planning for the fact that some youth could be spending multiple years living in the facility, this is a consideration that must be given serious thought.

The Hall has outdoor recreation areas, including a moderately large astro-turf field where youth can play sports, as well as a horticultural program (currently on hiatus due to the COVID-19 pandemic).

Briones Youth Academy

The Briones Youth Academy ("BYA") is an umbrella term used to describe three similar programs that serve youth with different needs. The programs are described below in ascending order of restriction and intensity needs for the youth.

Community Track

The first and least restrictive program, which will be discussed more fully later in this statement, is the "Community Track" or "Community Pathway" program. This program is generally between 6 and 12 months. The key difference in this program from the others is that the youth are served **at home** in the community. This is a new program that Probation intends to launch in 2023. One youth is currently being served as a pilot case on the Community Pathways program; however, the Probation Department cannot currently offer all of the services and supports that it intends once the program is fully up and running.

Commitment Track

The second program is the "Commitment Track." This track is effectively an updated version of what was previously known as the Youthful Offender Treatment Program. This is a program that serves relatively high risk youth whom the Court has determined must be removed from the home. The duration of the program lasts between 9 and 12 months, with the average program completion time around 10 months.

Secure Track

The third and most restrictive program is the "Secure Track." This track was developed in response to state legislation which called for the eventual closure of the Division of Juvenile Justice ("DJJ"). Youth who have been determined to have committed very serious 707(b) and would have previously been referred to the DJJ for placement are now placed on the "Secure Track" of the Briones Youth Academy. Program durations on the "Secure Track" range in a period of years - the Commission's best information is that the youth in the "Secure Track" are generally placed there for between 18 months

and 3 years, with the possibility of significantly longer placement durations in the future.

Briones Youth Academy Program Similarities

While each of the programs that make up the Briones Youth Academy serve different categories of youth with different needs, the programs have significantly overlapping similarities. The Probation Department has built cognitive behavioral programming which is broadly shared between the programs. In addition educational and vocational programming is offered to both “Commitment Track” and “Secure Track” youth.

Commitment Track and Secure Track Housing

In both the “Commitment Track” and the “Secure Track” programs, youth are housed at the John Davis Juvenile Hall (described below). Currently youth in both programs are housed on the same housing unit at the Hall. As the population and needs of the “Secure Track” youth evolve over time, it will likely be necessary to separate these youth on to separate units. Because of the program duration differences for “Commitment Track” and “Secure Track,” we may see the average population age in the programs diverge over time. In addition, “Secure Track” youth will likely complete their cognitive behavioral programming significantly before their program ends, which could create programming challenges for Probation to manage while the youth are comingled on the same housing unit.

Step Down Needs for Secure Track

Given the significant duration of placement durations for “Secure Track” youth, the County envisions offering youth who are demonstrating success on completing their in-custody programming with “step-down” options. Step Down options are court

ordered changes in placements. Every 6 months, a youth will have a review hearing before a Judge of the Superior Court of Contra Costa who will determine if the youth is eligible for a step down, informed by the recommendations of the Probation Department, the District Attorney, and the youth's defense counsel.

It's important to note that the Juvenile Hall was not designed for youth placement durations for the full duration contemplated by the law. The space available to the youth is confined, access to the outdoors is tightly controlled, there is limited privacy, and connections with the youth's family and community outside the facility are limited. Step Downs are a critical mechanism to ensure rehabilitative outcomes are maximized for the youth.

The "Community Track" is the first Step Down program that the Probation Department has designed in response to the state's legislative closure of the Division of Juvenile Justice. It will serve **both** as an *original* disposition option[2] for the youth **and** as a *step-down*.[3]

The Probation Department also plans to open up the Tamalpais housing unit, commonly known as the "Tam" unit, as an *informal* step down option for "Secure Track" youth. Once youth on the "Secure Track" have progressed significantly enough through their programming, they would be transferred within the Juvenile Hall to this unit. The unit has a somewhat softer feel. The Department currently has two youth who are eligible for this informal step-down option, but has insufficient staffing to open the

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[2] meaning that the youth is never placed into an in-custody placement. Youth may have been held at the Juvenile Hall prior to their disposition placement by the Court.
[3] meaning that at a six-month review, the Court can order the transfer of the youth from their in-custody placement on the "Secure Track" to the "Community Track"

unit 24/7 under the requirements of Title 15. The Department's staff will, when able, take the youth to the "Tam" unit as a reward for periods of time during the day.

Ideally the County will explore developing additional, intermediary step down options between the "Secure Track" program at the Juvenile Hall and the "Community Track" program. It would be ideal to explore options regarding residential, staffed programs that are operated in the community. This would allow youth to step down to a more home-like facility operated by a community based organization that would be able to provide residential and support services to youth as they re-enter the community prior to sending them fully home.

Closure of the Division of Juvenile Justice & Transition of the Youth Back to Contra Costa

In the Fall of 2020, the Legislature passed SB 823 and it was subsequently signed by the Governor and became law. Among several things, this bill created a phase-out of the statewide youth prison called the Division of Juvenile Justice.[4] As part of the closure plan, each county was required to create a subcommittee of its Juvenile Justice Coordinating Council[5] to discuss and plan for the closure. The Contra Costa DJJ Realignment subcommittee met very regularly - as frequently as twice per month - during 2020 and much of 2021 in order to plan.

[4] The Division of Juvenile Justice was previously known as the California Youth Authority (1943-2004) and was known as the Youth Corrections Authority (1941-1943).

[5] The Juvenile Justice Coordinating Council ("JJCC") is a separate body from the Juvenile Justice Commission ("JJC"). Though the names are similar, they have different functions. The JJCC is an advisory body to the County. The JJCC has both required statutory participants from key county stakeholders, as well as additional members who are added pursuant to ordinances passed by the Board of Supervisors. The Chair of the JJC sits as an ex-officio member of the JJCC, according to an order of the Board of Supervisors in 2020.

On June 30, 2021 the Division of Juvenile Justice (DJJ) stopped accepting new youth. Judges in juvenile courts around the State had, prior to this date, the ability to place youth at the DJJ rather than to place them in a county facility or program. Historically, Contra Costa has placed a significant number of the youth committing the most serious offenses at the DJJ. In particular, the DJJ had more effective programming designed to provide support and services to youth who had committed serious sexual offenses.

On June 30, 2023 (in approximately 8 months), the DJJ will completely close. All of the youth who were placed there prior to June 30, 2021 will need to be returned to their home county. This is a major logistical challenge for Contra Costa County.

Currently there are 18 youth at the DJJ who are from Contra Costa. Of those 18 youth, the Probation Department currently believes 11 will need to transition from the DJJ to the “Secure Track” of the Briones Youth Academy.

These youth will need to be housed at the Juvenile Hall. This population of youth will have significantly different needs from the youth currently on the “Secure Track” of the Briones Youth Academy. Their time at the DJJ will have created a significantly different experience, which will require separate programming needs. All of the youth will have spent a *minimum* of two years in custody, meaning that they will have experienced much of the cognitive behavioral programming that is available to “Secure Track” youth during their time at DJJ. In addition, this population of youth will have a significantly different age and sophistication mix compared to existing “Secure Track” youth.

The Probation Department currently believes that this population of youth will need to be housed separately from the “Secure Track” and “Commitment Track” youth. The Commission concurs in this determination. However, this means that the Probation

Department will need to open a new housing unit at the Juvenile Hall, increasing their staffing needs.

Proposed Closure of the Orin Allen Youth Rehabilitation Facility

2020 Closure Proposal

The Commission received notice in the early summer of 2020 that the Board of Supervisors was considering a proposal to close the Orin Allen Youth Rehabilitation Facility and relocate the youth housed there to the John A. Davis Juvenile Hall ("the Hall").

At the time of this proposal, the Probation Department planned to relocate the youth at OAYRF to a housing unit at the Hall, called the Tamalpais Unit (or the "Tam" unit). This unit has the least institutional feel, and the Probation Department invested significant time and attention in attempting to soften the feel of the unit as much as possible.

This Commission opposed this plan at the time. In the statement we issued on August 2, 2020, the Commission determined that the closure should be delayed until such time as the Probation Department could develop a plan to serve the population of the OAYRF in the community.

Current Closure & Program Update Proposal

The Probation Department brought forward a new plan to close OAYRF. On September 20th, Chief of Probation Esa Ehmen-Krause provided preliminary details to the Board of Supervisors and has provided follow up details to the Commission via individual meetings as well as in the public Commission meeting on October 17th, 2022.

The Department plans to close OAYRF *around* January 2023.[6] The Probation Department will, prior to the closure date, work with existing staff at OAYRF to transfer them into placements either at the Juvenile Hall, expanding staff support there, or to positions that support the Community Track program.

Standing up the Community Track program is also key to the Probation Department's plan. While there is one youth currently as a pilot case on that program, allowing the program to scale to support the anticipated population and enable all of the services that the Probation Department envisions is key to the County's plan.

Considerations

The Commission has given considerable time and attention to this matter, and it is important to recognize that there are no clear answers. There are a number of intersecting concerns and serious logistical challenges that the County needs to overcome.

Continuum of Options for Serving Youth

Under the current placement continuum, the County has essentially three categories of options available to most youth who become justice involved.

Pre-Filing Options are diversion programs which usually, if successfully completed, result in the dismissal of the petition against the youth. These programs are served out in the community. Generally these arrangements fall under the concept of "prosecutorial discretion" or "law enforcement discretion" to not bring a case. This

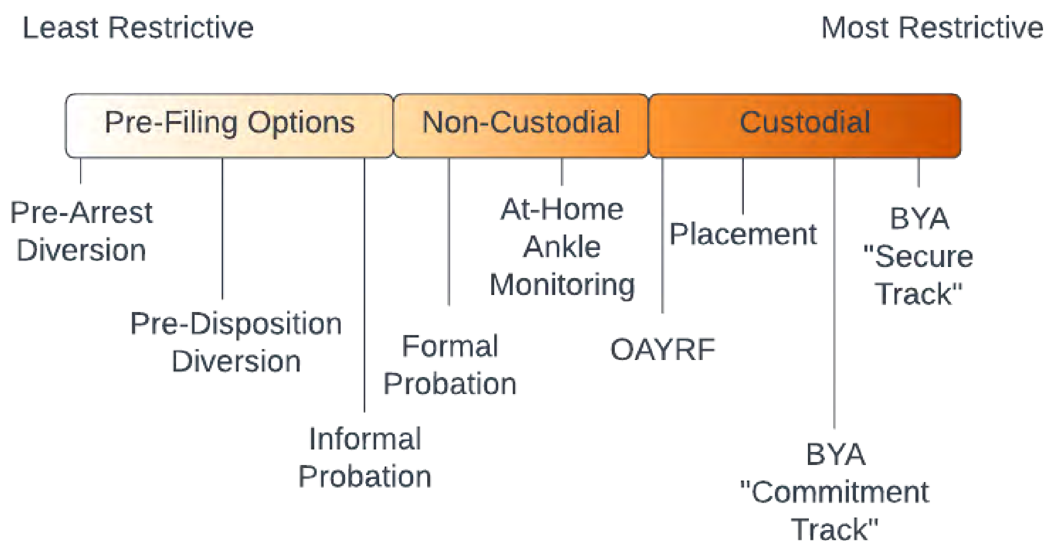
[6] The Department cannot provide a firm closure date until the Board of Supervisors provides direction to proceed with OAYRF closure. Further, the Department believes timeline flexibility may be necessary to ensure that the youth currently at the Ranch experience minimal disruption in services and outcomes. The Commission interpretes this to mean that OAYRF may close anywhere between December 2022 and April of 2023.

means that these are not ordered by the Court, and often are done prior to a petition being filed against the youth.

Non-Custodial disposition options are ordered by the Court after a petition against a youth has been sustained[7] but do not require the youth to be incarcerated at a County or State facility.

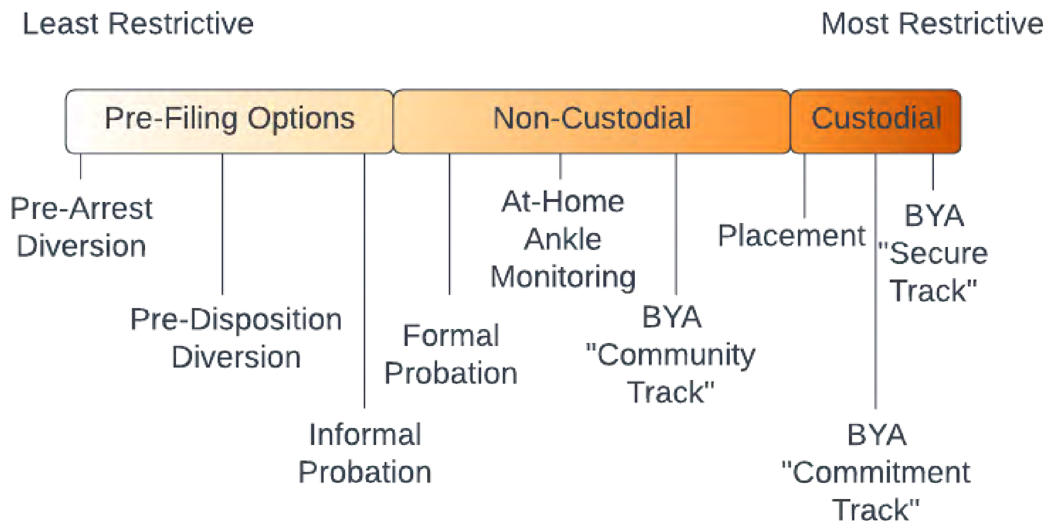
Custodial disposition options are also ordered by the Court, but are the options where youth are incarcerated - they are held in a County run facility operated by the Probation department.

Figure 1. Current State of Continuum of Disposition Options for Youth



[7] In California, juvenile law is *not* criminal law, but is actually civil in nature. This leads to the language around juvenile law being different from adult criminal law. While an adult is "charged" with a crime, a youth has a "petition filed" by the District Attorney's office. In addition, a youth is not "convicted" but has their "petition sustained." The linguistic differences are important to minimize the stigmatization and focus on the rehabilitative outcomes of the youth.

Figure 2. Proposed Future State of Continuum of Disposition Options for Youth



In order to illustrate the proposal changes to the status quo, the Commission has prepared a very high level overview of ways cases can be resolved when a youth becomes justice involved on a continuum of "least restrictive" to "most restrictive." Figures 1 and 2 compare the "status quo" or current state of programs and facilities to the proposed future state under the Probation Department's plan.[8] [9]

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[8] The physical distance between disposition options on the visuals here are **not** meant to indicate any sense of "degree" between the level of restrictiveness of the programs. The visuals are not "to scale" in terms of restrictiveness and may condense or exaggerate the differences. The order in which items appear on the continuum is relevant, e.g. BYA "Commitment Track" is less restrictive than BYA "Secure Track" but the *degree* of restrictiveness cannot be measured scientifically.

[9] Placement options include placement at Short Term Residential Treatment Programs (often referred to as "STRTP"s and sometimes pronounced as "Strips") as well as placement with Resource families. Their placement on these visuals can range from Custodial to non-custodial and vary. The visual placement here is meant to represent placement with a STRTP. STRTPs used to be known colloquially as "group homes." These facilities are run by independent service providers - they are not run by the Probation Department and are licensed by the Community Care Licensing division of the Department of Social

Under California law, youth are to be served in the “least restrictive appropriate environment” available. This means that the Court must determine, on a case-by-case basis, which disposition options are appropriate, and then place the youth in the least restrictive of these options.

Comparing Figure 1, the Current State, against Figure 2, the Future State, shows that the “Non-Custodial” options are expanded by adding the Community Track. The Custodial options are limited by removing OAYRF.

Generally speaking, the Commission believes expanding Non-Custodial options is the correct direction for new program development in Contra Costa County.

There is significant concern that making both of these changes simultaneously provides insufficient time for the County and the Court to adapt to the changing landscape of options available to youth and county agencies to provide the best possible care and rehabilitative outcomes to youth while balancing public safety.

Community Track Program

The proposed Community Pathways program, while a major step forward in best practices, is not yet fully implemented. While the Probation Department expresses confidence that they will be ready to immediately transition from OAYRF to the “Community Track” program, it would be reasonable to expect “bumps” in that process.

The Commission believes standing up any program will have both foreseen and unforeseen challenges. The challenges should not inhibit the development of more

Services of the State of California. The Probation Department contracts with specific STRTPs in order to provide options for youth who are best served in an STRTP setting.

modern, best practice conformed programming. It is a reason to, where possible, be cautious in the rollout and implementation.

Staffing Shortfalls in the Probation Department

One of the key factors involved in the Probation Department's planning process is providing adequate staff for all of the significant needs facing the Department. Despite consistent attempts to recruit and retain, the Probation Department is deeply concerned about their ability to maintain staffing sufficient to comply with their Title XV staffing requirements.

It's important to note that this does not appear to be a *funding* concern. While improving general compensation for probation staff might, over the next 1-3 years, increase the number of applicants applying for positions at the Probation Department, there are key staffing needs that must be addressed *no later* than June 30, 2023.

There is a significant risk that if OAYRF remains open, the Department may not be able to recruit sufficient staff to operate a new housing unit prior to the return of the youth from the DJJ. This would be a significant safety concern, and potentially an overcrowding concern. There is no stakeholder who believes it would be acceptable practice for the Probation Department to house these populations of youth together.

Institutional Stakeholder Buy-In

The specific timing of the renewed call to close OAYRF caught many stakeholders off-guard. While Probation has The Commission believes that the Probation Department has done significant planning and due diligence on the logistics and program design around both OAYRF closure and the creation of the Community Track program.

The Commission met with many *other* stakeholders prior to its meeting on October 17th and heard from many at the meeting on the 17th. Some of the stakeholders, such as the Community Office of Education appear to have varying levels of awareness and planning in place - Lynn Mackey, the Superintendent of the County Office of Education, has come out in support of the plan. While CCOE has expanded transition education staffing, there would be advantages for more robust discussion about what the community expects and what "good" looks like in regards to providing education support for youth on the Community Track program.

The Behavioral Health team that provides services to both the Hall and OAYRF have expressed confidence in their ability to continue to support youth on the Community Track.

However, the District Attorney and the Public Defender's office both express significant concern about moving forward with the plan at this time. Both believe that more time to build awareness of the nuances and details of the plan would be important.

The Commission concurs. Buy-in from the District Attorney's office is critical to ensure success. The District Attorney has a duty to balance the needs of the youth, and the requirement to serve those needs in the least restrictive appropriate environment, with public safety as they make filing decisions and disposition recommendations to the Court. They need to have confidence in the program design and the ability of the Probation Department to meet their concerns around public safety in order for the program to be successful.

While we understand further conversations between the District Attorney, Public Defender, and Chief of Probation have occurred since October 17th, the Commission is unaware of the outcomes of those conversations and if they have changed the position

of either office. This highlights the compressed timeline in which these conversations are being held.

Ideal Case

The ideal case in front of the County is clear. The County **should** stand up and fully implement the Community Pathways program for 12-24 months prior to authorizing the closure of OAYRF. This will allow stakeholders to ensure the same target group of youth is able to be served by the Community Track program as at OAYRF.

A very real concern of the closure of OAYRF is the potential for net widening given the removal of an out of home placement option for lower risk youth. Stakeholders have explicitly stated that these youth would not be recommended for placement in the Hall due to their lower risk. However, because the changes proposed by the Probation Department at this time represent a significant change to the continuum of disposition options available to the Courts, this may be an unintended consequence.

In order to effectively monitor the changes, it would be preferable to have both programs operating in parallel. Once OAYRF is closed, it is not coming back. The County is openly contemplating selling the facility. Further, closing the facility will require significant work, as would re-opening the facility if it were still available. It also would be unfair to staff to transfer them back and forth, creating disruption and whiplash in their lives.

The key challenge here is the timeline in which the Legislature has mandated the closure of the DJJ. If that constraint were lifted, there would be significantly more flexibility in the way that the County could address this change. Key stakeholders

worked hard in 2020, in particular, to build a DJJ Realignment plan, particularly the values around that plan.

Recommendations

The Commission recommends the following:

1. The Board of Supervisors should table the current proposal to close the OAYRF for a limited period of time. Given the pressure of DJJ closure on June 30, 2023, revisiting the issue should not be tabled longer than 2-3 months.
2. The Probation Department should plan to delay closure of OAYRF until March of 2023.
3. The Probation Department should continue alignment conversations with the District Attorney's office between now and revisiting the matter in 2-3 months to ensure that the District Attorney can express confidence in the Community Track plan and express a commitment to embrace it.
4. The Probation Department should share its staffing projections and analysis with the Juvenile Justice Commission, the Board of Supervisors, interested institutional stakeholders, and the community.[10]
    a. In the event that an analysis demonstrates that a funding increase to the Probation Department could impact their ability to recruit sufficient staff to implement the Community Track program, operate OAYRF, and open a new housing unit at the Juvenile Hall to accommodate returning DJJ youth, the Board of Supervisors should consider approving additional funds.

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[10] The Commission wishes to note that a request was made on October 17th at a meeting of the Juvenile Justice Commission to the Probation Department for these staffing projections and the Department did not express opposition to sharing that in November. We wish to ensure there's adequate time and transparency for everyone to validate the internal thinking of the Probation Department.

5. In the event that there is any feasible path forward that allows the Community Track program to be piloted for a significant duration of time, 12-24 months, without compromising the safety of the youth or violating existing state or federal law, the County should move forward with all speed towards that objective.
    a. *In the event that it's not possible to operate the Community Track program while simultaneously operating OAYRF, the goal should be to serve youth in their homes. All of the recommendations in this section should be read in that spirit.*
6. The Probation Department should begin preliminary plans for the development of additional step down options for Secure Track youth in the next 6-12 months, with discussions about those options occurring at both the DJJ Realignment Subcommittee and the Juvenile Justice Commission.[11]
7. The Board of Supervisors identify a county agency responsible with collecting and publishing a dataset designed to improve public confidence that the changes contemplated by the County do not result in net widening and provide insight about how to remediate any unintentional net widening that does occur. This Agency will need to work with the Court in order to ensure data is released appropriately.
    a. Background:
        i. As this is a key time of change for disposition options available to youth in the County, it would benefit the community to have clearer data around disposition recommendations in order to monitor and manage concerns around net widening. Three or four key

[11] The Commission wishes to recognize that the planning efforts for DJJ Realignment have been significant for the Probation Department. The Department's juvenile facilities team has worked very hard to build this plan, while continuing to operate their existing programs. The Commission wishes to express its appreciation for the Probation Department's efforts.

stakeholders make recommendations to the Court regarding disposition options: the Probation Department, Children & Family Services (in some cases), the District Attorney and defense counsel for the youth (in almost all cases the Public Defender). It is in the best interests of the community to periodically share population level data about recommendations and disposition outcomes to monitor the progress being made in the County towards its stated goals.

ii. The Commission believes it is best to start collecting this data immediately as the new program comes online, and should be done in a lightweight way. Data should be published in an aggregated manner, most likely on a quarterly or twice-yearly basis.

b. Data that the Commission recommends should be captured includes the following:

i. Charges filed against youth, including an indication when the charge is a reduced or lesser offense (for example, when a new underlying crime has been filed, but the petition filed is a probation violation - the raw charging data would indicate a probation violation but that information alone fails to capture the dynamic involved),

ii. The disposition recommendations made by each stakeholder involved in the cases,

iii. If an out of home placement is requested by any agency,

iv. The disposition actually ordered by the Court,