Sybil Brand Commission
For Institutional Inspections

Annual Report
2016 and 2017

Sybil Brand Commission for Institutional Inspections
Kenneth Hahn Hall of Administration
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Los Angeles, CA 90012
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SYBIL BRAND COMMISSIONERS

First District

Johanna Arias-Bhatia
(2016/2017)

Percy Duran III
(2016/2017)

Second District

Susan Burton
(2016/2017)

Cheryl Grills Ph.D.
(2016/2017)

Third District

Keren Goldberg
5/26/15 – 2/1/16

Fourth District

Donald S. Andrews
2016

Eleanor R. Montaño
(2016/2017)

Fifth District

Barbara Bigby
(2016/2017)

Anne Hill
2016

The Sybil Brand Commission for Institutional Inspections, formerly called the Institutional Inspection Commission, was founded in 1959 by Sybil Brand who saw the need to improve the overcrowded conditions of incarcerated juveniles, men, and women. The name change to Sybil Brand Commission for Institutional Inspections, was in honor of her 90th birthday and her 50th Year of dedicated service to the County of Los Angeles.

MISSION STATEMENT

The Mission of the Sybil Brand Commission for Institutional Inspections is to ensure that conditions and treatment of adults and children under the supervision of County custody and care facilities reflect safe, humane, and best practice.

In recent history, the Sybil Brand Commission ("SBC" or "the Commission") is responsible for conducting inspections of jails, lockups, and probation and correctional facilities in the County of Los Angeles. These inspections involve a complete evaluation of the effective and economical administration of each facility's cleanliness, discipline practices, and conditions of confinement of its prisoners. Additionally, the Commission may inspect the permit and registration of such jail and lockup, whether the institution is located within or outside of the corporate limits of any incorporated city. The Commission also inspects Department of Children and Family Services and Probation Department group home facilities to determine their conditions.

AUTHORITY

The Sybil Brand Commission is authorized by Chapter 2.82 of the Los Angeles County Code and consists of ten members; two from each Supervisorial District, with the Sheriff and the Chief Probation Officer serving as ex-officio members. The Commission meets the 1st and 3rd Wednesday at 10:00 a.m., in Room 372 of the Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles, CA 90012.

DUTIES

The duties of the Commission are generally defined by Sections 2.82.070, 2.82.080, and 2.82.090 of the Los Angeles County Code.

2.82.070 General Duties

The Commission shall conduct inspections as provided in this chapter and shall advise on industrial and educational programs for both juvenile and adult detention inmates in County jail facilities and probation camps.

2.82.080 Inspection of Jails, Probation and Correctional Facilities
At least once each year or more often as the Commission may deem necessary or proper or as directed by a judge of the Superior Court, the members of the Commission or of a committee of the Commission shall visit and inspect each jail or lockup in the County, and County probation and correctional facilities.

2.82.090 Inspections
The members of the Commission, in visiting and inspecting jails and lockups as provided in this chapter, shall examine every department of each institution visited and shall determine its condition in terms of effective and economical administration, the cleanliness, discipline and comfort of its inmates, and in any other respects, whether such institution is located within or without the corporate limits of any incorporated city.

COMMISSION OPERATIONS

2016 Goals

The Commission's 2016 goals remained the same as those established and approved in 2015. They were to:

1. Visit one Los Angeles County Probation camp or Juvenile Hall per month to ensure equitable inspections across all juvenile lockup facilities and to ensure compliance with policies and practices related to the management of Probation Camps and Juvenile Halls.
2. Visit and inspect all Los Angeles County group homes, jails and lockup facilities at least once per year to ensure compliance with policies and practices related to the management of group homes, jails and lockup facilities.
3. Collaborate with Los Angeles County Departments of Children and Family Services (DCFS), Probation, Sheriff, Auditor-Controller, Mental Health and Internal Services to ensure the safety and proper care of youth in group homes, probation camps and inmates in the jail/lockup facilities.
4. Collaborate and coordinate with relevant Los Angeles County Commissions to share information and support efforts of mutual interest related to group homes and jail facilities.
5. Identify issues, trends and efforts related to Child Trafficking to determine how the Commission can assist current County efforts.
6. Obtain the floor plans of each Los Angeles County jail and increase inspection coverage of all sections of each jail.

In January 2017, the Commission established and approved a new set of streamlined goals. They were to:

1. Assess access to and effectiveness of education and alternative programming in the jails and juvenile camps
2. Review quality and access of medical services in Los Angeles County jails
3. Monitor the transition of group homes to Short Term Residential Treatment Centers (STRTC) and its impact across supervisory districts

Commission Officers
The SBC held its fifth election in December 2016 electing Commissioner Johanna Arias-Bhatia as Chair and Commissioner Cheryl Grills as Vice Chair to serve in the 2017 term. In December, 2017 the Commission elected Commissioner Cheryl Grills to serve as Chair for the 2018 term and Commissioner Percy Duran III to serve as the Vice Chair.

Commission Vacancies
The Commission did not operate with a full complement of ten Commissioners for neither the 2016 nor 2017 calendar years. During the 2016 term the Commission had three vacancies (in Districts 3 and 4). During the 2017 term the Commission had six active Commissioners with two vacancies from District 3, one vacancy from District 4, and one vacancy from District 5.

Commission Ordinance
In 2016 the Commission amended its County Ordinance to read as follows:

> 2.82.060 - Duties generally.
>
> The commission shall conduct inspections as provided in this chapter and shall advise and ensure on matters pertinent to constitutional and state rights; reentry, vocational, and educational programs for both juvenile and adult detention inmates in County Jail facilities and probation camps as well as programs and independent living for youth in DCFS and Probation Short Term Residential Treatment Centers.
>
> (Ord. 10086 § 1 (part), 1970: Ord. 9564 § 1 (part), 1968: Ord. 4099 Art. 54§ 1347, 1942.)
>
> 2.82.070- Inspection of jails, probation and correctional facilities, and short term residential treatment centers.
>
> At least once each year and as more often as the commission may deem necessary or proper or as directed by a judge of the Superior Court, the members of the commission or of a committee of the commission shall visit and inspect each jail or lockup in the county, county probation and correctional facilities, and short term residential treatment centers.
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> (Ord. 10164 § 1, 1970: Ord. 9992 § 2, 1970: Ord. 9673 § 3 (part), 1968: Ord. 9564 § 1 (part), 1968:

Ord. 4099 Art. 54§ 1348, 1942.)

2.82.080- Inspections-Matters to be examined.

The members of the commission, in visiting and inspecting jails, lockups, probation and correctional facilities, and short term residential treatment centers, as provided in this chapter, shall examine every department of each institution visited, and shall ascertain its condition as to effective and economical administration of reentry, vocational, and educational programming therein, as well as the cleanliness, discipline and comfort of its inmates, and in any other respects, whether such institution is located within or without the corporate limits of any incorporated city.

(Ord. 9673 § 3 (part), 1968: Ord. 9564 § 1 (part), 1968: Ord. 4099 Art. 54§ 1349, 1942.)

2.82.100- Inspections-Authority to inspect register and visit all persons.

Every member of the commission, while visiting and inspecting a jail or lockup, probation and correctional facilities and short term residential treatment centers as provided in this chapter, may call for and inspect the permit and register of such jail and lockup, probation and correctional facilities and short term residential treatment centers and may see and visit all persons kept in such jail and lockup, probation and correctional facilities and short term residential treatment centers.

(Ord. 9673 § 3 (part), 1968: Ord. 9564 § 1 (part), 1968: Ord. 4099 Art. 54§ 1349, 1942.)

2.82.090 - Sunset review date.

The sunset review date for the commission shall be October 1, 2017.

Commission By-Laws

In 2016 the Commission amended its By-Laws to address concerns related to viability, scope, and procedures. These changes included reducing the number of meetings to two times per month rather than weekly to allow the Commissioners more time to conduct inspections and to increase the pool of professional candidates who might be interested in serving on the Commission but who would be unable to make a weekly meeting time commitment.

SYBIL BRAND COMMISSION INSPECTIONS AND FINDINGS

2016 INSPECTIONS SUMMARY

In 2016 and 2017, the Commission inspected DCFS group homes; Probation Department group homes across the five supervisorial districts; Probation Department juvenile camps;

Probation Department juvenile halls; County courthouses across the five supervisorial districts, and each of the County jails. In several instances, facilities were inspected multiple times within the year prompted by concerns or the need to conduct follow-up inspections related to unsatisfactory findings.

A total of 535 inspections were conducted in 2016 and 2017. The number of inspections by category included:

Juvenile Camps:	N=20
Juvenile Hall:	N=10
County Courthouses:	N=58
Group Homes:	N=343
Jail/Lock Ups:	N=54
Sheriff Stations:	N=49
Transitional Youth:	N=1

Because of the nature of SBC inspections (unannounced with collection of diverse and detailed data via Commission inspection protocols) Commissioners are very familiar with the County institutions and their staff; able to monitor the issues identified on an ongoing basis; and able to coordinate findings with relevant County departments at monthly Commission business meetings to bring resolution to issues in a timely fashion, the Commission stands uniquely poised to efficiently bring attention to issues and problems in County group homes, jails, and juvenile detention facilities. In 2016 and 2017 the commission identified a cross section of issues within group homes, jails, and juvenile lock up facilities and continued to collaborate with County departments, entities, and stakeholders.

2016 Unsatisfactory Findings

In 2016, the Commission made **30** unsatisfactory findings determinations. These findings were specific to the following facilities:

Jails

- Century Regional Detention Facility
- Men's Central Jail
- Van Nuys Courthouse - West
- Twin Towers Correctional Facility

Courthouses

- Van Nuys Courthouse
- Inglewood Courthouse

Sheriff Stations

- Altadena Sheriff Station

Group Homes

- Community Youth Sports and Arts
- Human Services Network
- Murrell West (Pillsbury)
- Garces Residential (Claremont)
- Phoenix House of Los Angeles
- McKinley Boys Children Center
- Rosemary Children Service
- Casa Editha Foundation

2017 Unsatisfactory Findings

In 2017, the Commission made **17** unsatisfactory findings determinations. These findings were specific to the following facilities:

Juvenile Detentions

- Barry J. Nidorf Juvenile Hall

Jails

- Century Regional Detention Facility
- Men's Central Jail

Group Homes

- Penny Lane #7
- Penny Lance #4
- Humanistic Foundation
- Rosemary Children's Services (Bonnie, Green Street, Freemont, 500 House, & HR)
- San Gabriel Children Center
- Human Service Network
- Bourne, Inc. (Santa Anita & Monterosa)
- Eggleston Youth Center
- Bourne, Inc. (Santa Anita & Monterosa)
- Eggleston Youth Center

Unsatisfactory Findings: Major Themes & Concerns

Group Homes

Many of the concerns in the DCFS and Probation Department group homes were related to the quality of facilities and maintenance, the appropriate completion of Needs and Service Plans, understanding AWOL trends overall and by demographic characteristics (e.g., age, gender, ethnicity, Service Planning Area), and use of psychotropic medications.

- The Commission expressed concerns about the high incidence of AWOLS, particularly from group homes and probation camps and made repeated requests to DCFS and the Probation Department to conduct their own analysis of AWOLs by ethnicity, gender, Supervisorial District, and type of group home to determine potential issues and possible insights about how best to address this problem.
- The Commission noted that many group homes were not prepared for emergencies. For example, emergency supplies are scattered throughout the home i.e. water in the garage, canned food in the pantry and emergency supplies locked in storage areas with no clear shift staff access to or knowledge of the location of keys. In the event of an emergency, proper protocol is to gather emergency supplies and do any required evacuation of the premises. Group homes were uneven in their readiness for emergencies.
- Weekend and holiday group home staff are not informed about or familiar with the youth's Needs & Services Plan (NSP) thereby allowing for gaps in appropriate services and oversight. In general, group home staff did not seem to be aware of or intentionally using the information contained within the NSPs to guide their understanding and interaction with youth, the activities planned for youth, or to gauge declines in or improvements in behavioral and emotional functioning.
- In general, youth did not seem to be included in the creation of or revisions to their NSP.
- Some concerns were noted regarding the inappropriate storage of medication. In one particular group home, medication was found in an unlocked, empty refrigerator. In other instances, secure storage of medications, labeling of medications, and tracking the dispensing of medications were noted.
- Several group homes were in the process of moving to the Short Term Residential Therapeutic Program (STRTP) model. The Department of Mental Health assisted with this transition. However, concerns were noted by the Commission regarding the difficulty in meeting requirements for this transition by smaller groups homes (e.g., including licensing, in-home specialty mental health services, and other requirements). Additional details related to STRTP are provided later in this report.

Jails

In the County jails, a number of the concerns were related to facilities and maintenance, staffing, medical and mental health care, and a variety of jail practices (e.g., visitor wait times, vending machine prices, correct accounting of time served for those serving as trustees, etc.).

- Medical care was a frequent concern. Common issues included insufficient number of medical staffing, space for mental health staff, long wait times to see medical personnel, inadequate access to special dietary needs (including diabetics)/physical accommodations, rapid spread of germs and viruses, lack of sufficient numbers of mental health services and staff, failure to receive medication (including psychotropic medication), and inadequate access to dental services, and questionable levels of respectful communication by nursing staff with inmates.
- Facilities issues included a variety of plumbing, ventilation, air quality, air temperature, water temperature, mold and sanitation maintenance issues across Men's Central Jail, Twin Towers, and CRDF.

- Access to educational programming was noted across facilities. Education Based Incarceration (EBI) programming was desired by more people than the facility could serve. Problems were encountered by some community organizations/institutions willing to provide services (including pro bono) but administrative red tape within the jail often thwarted attempts to offer them. Security clearances were unduly delayed and cumbersome in some instances presenting yet another obstacle.
- In several instances, inmates found it difficult to access educational resources (books, law library). Women at CRDF do not have access to the legal library.
- Gender disparities and violations of privacy were noted, particularly in Twin Towers. These included decreased access to educational opportunities for female inmates at Twin Towers—especially those assigned to trustee duties; strip searches in which female inmates private parts were exposed to male inmates; inadequate access to feminine hygiene products; the release of women at 3:00 am without access to transportation or support—particularly at CRDF; and limited access to parent-child bonding opportunities for inmates with infant(s) and/or young children.
- Voting and voter registration was a huge problem throughout the jails. Inmates were unaware of and/or failed to receive voter registration information and forms in a timely manner, often despite requests. Staff and inmate services were unaware of or not equipped to handle voter registration. Voter registration information signs were found in several instances to be posted in obscure locations or to not be posted at all. Furthermore, many inmates falsely believed that they were unable to vote in the June 2016 elections with no attempt to provide accurate information to counter the misperceptions. This was despite the Sheriff Department's reassurance that voter registration forms were issued to all eligible inmates in March 2016.
- Reentry services lacking visibility and accessibility were noted on numerous occasions during inspections. This was especially true for women. Women released from CRDF, for example, do not have easy access to the reentry services located downtown at Twin Towers. Pre-release access to reentry services is problematic even for those held at Twin Towers and Men's Central Jail.

CRDF Specific Concerns

A series of concerns related to CRDF are summarized separately. Three categories represent the issues observed and documented by the Commission:

A. Environment that Creates and Exacerbates Mental Health Problems
B. Deteriorating Physical Conditions
C. Inadequate Medical, Dental, and Vision Care

A. *Environment that Creates and Exacerbates Mental Health Issues*

The mental health dorms (2100-2400; 3100-3200; 3400; 1300-1400) were inspected several times. All mental health dorms are single-cell dorms where women are placed in solitary confinement. In addition to serving as a mental health dorm, some of the cells operate as High Observation Housing overflow.

Upon entry into CRDF, women are assessed/diagnosed by the initial point of contact personnel (typically a police officer). Mental health status may be determined by non-mental health personnel. When a woman has been deemed to be mentally unfit to join the general population by this police officer, she awaits a mental health evaluation by a professional mental health specialist. She is brought into the jail and put in isolation—lock-down and is a condition of total segregation. The evaluation is not to exceed 40 hours of solitary confinement in the mental health dorm. However, the Commission discovered that there are women who have been locked in their rooms for 2 weeks uninterrupted—allowed out for an hour here or there to shower or eat at the common area table. Unsanitary and unhealthy conditions and circumstances may prevail. In moments of emotional crisis or physical pain, a woman may be left unattended. A few examples illustrate the concerns registered by the Commission. One woman reported immense physical pain but stated she did not receive assistance for hours. One woman had feces on her wall and it is unclear for what period of time. She had not been given the opportunity to shower and was prohibited from movement outside of cell time. In addition, no one had assessed her suicide status. Another woman was sent to the mental health dorm as a form of discipline –not because she had an acute mental health episode (the violation—she had talked back to a nurse). She was in solitary confinement for 15 days.

Commissioners routinely interview women in the dorms during their inspections. One woman was in the mental health area for 57 days without receiving medication. One woman had a bare mattress on floor (no sheet) and one thin blanket. When asked why she was on the floor, she replied that the floor was the warmest place in the cell. In addition, the vent, full of dust and particles, blew right on her if she slept in her bed.

This type of confinement has the capacity to retraumatize people and promote or exacerbate a mental health crisis and deterioration in mood, behavior, and cognitive functioning. This is particularly for women who, psychologically, have high relational needs which are frustrated under these conditions.

In terms of assessments to make determinations about placement in these high observation conditions, it is not clear that an officer in a crisis situation can accurately make this assessment. It is also unclear that there is an adequate level of training at CRDF to equip an officer with the tools to make such complex determinations which can be complicated by the stress inherent in the situation and by the forces of implicit bias. The Commission attempted to gather information from the Sherriff's Department to determine if there were a disproportionate number of African American women who received placement in this level of confinement but the Commission was unable to receive data that could answer the question with any accuracy. Once placed in the mental health dorm, a person can go for weeks without being properly assessed. We are concerned that in time, the impact of the solitary confinement and isolation can produce severe and irreversible damage to a person's psyche.

B. *Physical Conditions*

The Commissioners observed and recorded multiple instances of noticeable deterioration in CRDF's building and infrastructure. This is most evident in the plumbing, the vents, and mold in the showers. Commissioners spoke with inmates who shared that the drinking water comes out brown from some faucets. In that vein, representatives from the Sheriff's Department have informed the Commission of recurring plumbing issues in the facility, oftentimes leading to water outages and temporary shut-down of select bathrooms and showers. In addition, the Commissioners saw gnats or fruit flies coming out of multiple sink holes. There was also notable green mold build-up and mildew in certain showers. Lastly, the air vents in multiple modules were caked with dust, lint, and other particles. One vent had some brown substance dripping from it. (It was reported to the Commission that one deputy got a respiratory infection.) It appears that the vents are creating a public health hazard as all parties – deputies, inmates, medical providers, and staff – are vulnerable to inhaling those particles.

Another physical infrastructure concern has to do with overcrowding and the resulting organization of beds in certain modules within the facility. In some instances the women are triple bunked and the top bunk is very close to vents (increasing draft and cold temperatures) and close to the ceiling and light fixtures with the risk of bumping one's head if you sit up without taking conscious precautions. The deputies have not taken precautions to protect from head injury for those women who sleep on the top bunk.

C. *Medical, Dental, and Vision Care*

The Commission shared concerns with the Sheriff's Department during monthly business meetings about the medical services and mental health services provided in the jails. The Commissioners spoke with multiple women who complained of not receiving adequate mental, dental and physical services at CRDF. In interviews, multiple women shared that they had not received their medications despite having been incarcerated for at least 10 weeks. They shared that dental services were not very accessible. Long waits are a common occurrence, even in instances where there were abscesses and considerable pain. They also noted that when seen, most dentists will just pull teeth instead of giving an individualized assessment of comprehensive dental needs or alternatives to extraction. Finally, some women had been without their eyeglasses for several weeks post incarceration.

Camps and Juvenile Halls

- Concerns related to the juvenile halls and camps were associated with facilities and maintenance, staffing, staff-youth interactions, and programming.
- Privacy concerns were noted. Youth can be seen by officers of another gender while using the bathroom. This results from the way the bathrooms are configured and the staffing plan that has male and female staff supervising male and female youth on any

given shift and in any given unit. Youth will use the toilet and shower facilities in full view of all staff, of both genders, and even within view of Sybil Brand Commissioners. Youth can also be seen changing clothing out in the open dorm areas in full view of everyone.

- Inspection reports raised concerns that educational standards are not upheld.
    - It was not uncommon on some visits to see youth in different age groups, grade levels, and locations in a facility completing the exact same school assignments.
    - In some facilities, higher youth incident reports were noted in the education areas, begging the questions "why?" and "with what effect on instructional time?"
- The practice of isolation was replaced with "hope centers." The Commission raised concerns that these centers do not always seem to be much different from the isolation practiced in the special handling units. There still appear to be varying degrees of isolation.
    - For example, two youth were observed in the "hope centers" during an inspection. Staff indicated that one had been there at least four to six weeks because he has the status of "green lite" by a rival gang. (Meaning he was placed there for his safety.) The other individual had been the focus of an altercation in the yard, which allegedly caused him concern for his safety. There were no other options made available to these two individuals besides the "hope center."

Concerns Related to Continuum of Care Reform (CCR) Implementation

The Commission shared several concerns related to the implementation of the Short-Term Residential Therapeutic Program (STRTP) in Los Angeles County, particularly related to potential unintended consequences for the number and type of placements for children in the 2nd District.

The Commission's concerns were informed, in part, from observations of closures of smaller group homes, by discussions with representatives from group homes in the County who attended a Commission meeting, and by DCFS, the Probation Department, and LADMH responses to Commission queries. The most salient issues include the following summarized by representatives from small DCFS group homes and shared with the Commission.

1. Small community-based residential homes provide a valuable resource for youth who cannot be successfully placed with family, foster homes, or adopted. It is a viable and preferable alternative to large residential treatment facilities for those youth who would benefit from remaining connected to the community and yet require the structure, mental health and behavioral interventions provided by trained professional staff. It is an important link in the continuum of care to ensure successful permanency.

2. Small community based residential homes uniquely meet the mental health needs of attachment-disordered, traumatized youth who may not want or cannot tolerate

the dynamics of parental or family relationships, and who are more comfortable forming meaningful relationships with trained staff without the challenges inherent in familial bonding. Additionally, mental health, social and behavioral needs can be effectively met without the stigmatizing effects of being isolated from the community and thereby avoiding the long term, negative effects of the institutional experience. This would be a return to an antiquated model of child care which placed all children and youth requiring out-of-home care into large institutional facilities?

3. The STRTP model, as it stands now, with each provider having its own mental health contract, will erode the normalizing, home-like environment small community-based homes now provide. Requiring licensed mental health and medical professionals to be present in the home 40 hours per week will force each facility to operate as a "mini mental health" facility and undermine the positive effects of milieu treatment in a normalizing setting.

4. Due to structural, financial, and treatment unviability of applying the STRTP model to small community-based treatment facilities, many or all of these will either close or transform to such a degree that this treatment model will no longer be available to youth. Therefore, if youth are not successfully stabilized with family, in foster homes, or adopted, the only remaining placement option will be large institutional residential care facilities. While there are many youth who may at some time require the isolation from the community, and the structure and intensive mental health and behavioral interventions of an institutional setting, there are many others who would be better served in the small, community-based congregate setting of a 6-bed home. Additionally, the small facility serves as an effective "step down" placement so youth can transition from institutional care back to their families, into foster care, or adoption. If small community based homes are not recognized and supported as an effective and important treatment mode, that option will no longer be available in the continuum of care.

5. The small community-based facility with contracted mental health services effectively serves families and youth via on-site or in-home scheduled therapy sessions and as needed for crisis intervention. Having licensed mental health and medical providers present full-time in the facility is appropriate for in-patient or hospital like settings, but not appropriate for small treatment homes. It would likely impede client "buy-in" for therapy provided by professional staff who are present in their home for extended periods of time (what therapist remains in a client home 5 days a week?) As clients always have a "right to refuse" service, this creates a situation where the agencies are funding full time positions for which they might not be able to bill. Small agencies, without significant private dollar funding streams, would not be able to absorb that loss, nor would they be able to weather the unavoidable delays in DMH payment. Lastly, this is an extremely

ineffective use of DMH resources when it is already experiencing significant challenges in recruiting and retaining qualified DMH providers.

6. DCFS projects that children placed in STRTPS will be reduced by 80%, contingent on successful placement of children with family, foster home, relatives, or adoption. Yet, there is no data to show that these alternative placements will actually succeed, in the long term, for the majority of children and youth, nor result in a "recycling" of youth through various placements. Placement decisions should *always* be made in the best interests of the child ("first placement, best placement"), *not* to serve a theoretical goal of reducing numbers. Already, providers are seeing children and youth cycling back to group home care after failing family placement and foster care. Each time this happens, children and youth are re-traumatized, disrupted and further damaged by the system they find themselves in. Continuity of effective services is further disrupted by systemic challenges at all levels of care. *Ensuring that a range of placement options exist for each child, which are systemically and fiscally supported to deliver high quality services for the optimal, appropriate treatment model and initial placement, would be more likely to ensure the effective continuum of care these children need and deserve.*

7. DCFS needs to be more transparent and engage all providers as to the direction and means of achieving continuum of care reform. If out-of-home placement is to be reduced by 80 %, why require existing group home providers to convert to an STRTP if there won't be a need for those beds? Why contract with new STRTPs, when there are already more available beds than needed? Is there an alternative placement model in consideration to meet the needs of children and youth who would be better served in small community-based homes that link their youth to mental health services from a contracted provider? DCFS needs to recognize the value of both large and small providers and engage them more fully in the process of determining how the goals of continuum of care reform should best be reached. Without that transparency and engagement at all levels of the system of care, and responsiveness to the real, immediate needs of children and youth, this reform will result in failure to effectively protect and serve our children as they need and deserve.

COLLABORATION WITH LOS ANGELES COUNTY COMMISSIONS AND DEPARTMENTS

The Commission did outreach and engaged with representatives from eight County departments, commissions, or community organizations in 2016. Representatives were invited to Commission meetings to discuss specific issues of common concern and to further the Commission's ability to fulfill its mandate.

In 2016 these included:

- Community Care Licensing- Alan Henry (2/17/16)
- Fiscal Administration Bureau, Director- Donald C. Joe (3/2/16)
- Mental Health in Jails
    - Jail Mental Health, Program Director- Dr. Timothy Belavich, PhD (3/9/16)
    - Mental Health Program Manager- Susan Ruehl, LCSW (3/9/16)
    - Mental Health Professional- Keith M. Markley, MD (3/9/16)
- City Counsel (2) - Alexandra Zuiderweg (3/9/16) and (9/28/16)
- Report on Electronic Monitoring Devices
    - Probation Department, Pretrial Services Division, Director- Edwin Monteagudo (3/16/16)
    - Probation Department, Pretrial Services Division, Electronic Monitoring (EM), Senior Investigator - Claudia Quinonez (3/16/16)
- The Probation Commission (6/21/ 16)
- District Attorney- Jackie Lacey (8/10/16)
- League of Women Voters- Jean Thompson and Marilu Guevara (9/7/16)

In 2017 the Commission engaged with representatives from the following County departments, commissions, or community organizations.

- Office of Child Protection
    - Office of Child Protection, Executive Director – Judge Michael Nash (2/8/17)
    - Office of Child Protection, Assistant Executive Director- Carrie Miller (2/8/17)
- DCFS, Out of Home Investigation Section, Children's Service Administrator III- Nancy A. Bilin, MA (4/12/17)
- Group Homes of the Second Supervisorial District- Group Home Representatives Continuum of Care Reform (CCR) (5/3/17)
- Sheriff Civilian Oversight Commission (SCOC)- Brian Williams (7/5/17)

SYBIL BRAND COMMISSION SCHOLARSHIPS

The Commission, desiring to encourage and assist youth placed in group homes to further their educational goals, awarded three individual $500 scholarships to exemplary youth in 2016 and two individual $500 scholarships in 2017. The scholarships were available to youth in either Department of Probation group homes or DCFS group homes.

Seven scholarships were awarded in 2016. Two scholarships were awarded in 2017. The 2016 and 2017 recipients were awarded their scholarships at the SBC Scholarship Presentation Breakfast and then were personally recognized by the Board of Supervisors (BOS) at the BOS meeting.

ANNUAL WORK PLAN

SYBIL BRAND COMMISSION 2018 GOALS

The Commission voted on and approved the following 2018 goals and associated strategic actions and timeline.

Goal 1: Evaluate services available to juveniles and adults detained in County jails, juvenile halls and youth camps. What is their contribution to reduced recidivism, effective reentry, and skills development? To what extent are there unmet, underserved or inappropriately served needs among youth and adult detainees?

Strategic Actions: Develop a secondary assessment and interview protocol to accompany the Commission's existing inspection tool.

a. Determine current education services, access, utilization, quality, and outcomes
b. Review current available medical and mental health services, access, appropriateness, and outcomes
c. Consider accessing pro bono evaluations from local universities
d. Seek regular Commission access to internal audits, quality assurance, program evaluation and other reports

Goal 2: The Sybil Brand Commission shall continue with inspections of DCFS and Probation Department Group Homes

Strategic Actions: Continue inspections with current inspection protocol

a. Monitor implementation of STRTP with special attention to potential unintended consequences for specific County districts, family reunification, and education needs.

Timeline:

a. Weekly inspections of group homes, juvenile halls and camps, and County jails
b. Monthly business meeting with representatives from Departments of Children and Family Services, Mental Health, Probation, Office of the Inspector General, Auditor-Controller, Internal Services, and the Sheriffs.
c. Commission reports to the Board of Supervisors as needed.
d. Commission Annual Report – January 30, 2019.