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HEALTH MANAGEMENT ASSOCIATES

Los Angeles County Consolidated Correctional Treatment Facility Population Analysis and Community Heath Care Continuum

PRESENTED TO THE
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AUGUST 4, 2015

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Introduction

On June 9, 2015 the Board of Supervisors passed a resolution requesting that the following analyses be performed prior to proceeding with the next phases of the CCTF project.

The requested analysis had three primary tasks:

Task One: CCTF Population Analysis and Findings
The actual number of treatment beds required at the proposed Consolidated Correctional Treatment Facility that will replace Men's Central Jail.

Task Two: Community Capacity and Diversion
A capacity assessment of all community based alternative options for treatment, including but not limited to Mental Health and Substance Abuse Treatment. An assessment on the number of inmates that can be successfully placed into an outside facility (community based) for Mental Health/Substance Abuse Treatment;

Task Three: Legislative Impact on Population
The likely impacts to the Los Angeles County jail population of Proposition 47, AB 1468 (split sentencing), AB 624 (enhanced credit system) and inmate population projections over the next several years, including projections for those with Mental Health disorders.

Subsequent to the resolution being enacted the CEO's office sought credentials and qualifications from national consulting firms with expertise in correctional health care, community diversion and population data analysis. The firms Health Management Associates (HMA) from Chicago and Pulitzer/Bogard & Associates (P/BA) from New York were selected to collaborate in performing these tasks. The contract to perform the work commenced on June 23, 2015.

The following week the consultant team was in Los Angeles for a kick-off meeting with key stakeholders and soliciting data and other materials to support the work effort. Data was requested from the Los Angeles Sheriff's Department, the Department of Mental Health, and the Department of Public Health. Over the next two weeks, the consultant team toured the Twin Towers Correctional Facility, Men's Central Jail, the Century Regional Correctional Facility, the Intake Reception and Classification areas, the Forensic Inpatient Psychiatric unit, High Observation Housing, Moderate Observation Housing, Correctional Treatment Centers, and Medical Observation Specialty Housing. We also conducted interviews with correctional leadership and officers, clinical leadership, and physicians and nurse managers on the specialized housing and treatment units.

Over the course of the next few weeks the consultant team received and analyzed six million rows of data extracted from 298 files, reports and other materials; 10.5 years of summary jail data; and every inmate admission for 5.5 years which translated into 755,897 inmate stays. The consultant team also made contacts with 26 MH and/or SA community providers who were interviewed to assess capacity for community based alternative options for treatment. Additional numerous interviews occurred with Probation, Parole, District Attorney's Office, Department of Health, Department of Mental Health, Department of Public Health, BOS representatives and other stakeholders.

This report represents the culmination of the consultant team's analysis, conclusions and recommendations. The report's organization differs from the order of the resolution tasks in that the Legislative Impact Analysis which was expanded to include a more comprehensive population analysis appears first as it supports the analysis of the CCTF Population Analysis. The Community Capacity and Diversion analysis is the final section of the report.

The project could not have been accomplished in such a short timeline without the assistance and cooperation of the Los Angeles Sheriff's Department, the Department of Health Services, the Department of Mental Health, the Department of Public Health, the Department of Public Works, CEOs office and the involvement of a large number of community-based service providers.

Section I. Los Angeles County Patient-Inmate Base Forecast Analysis

Introduction

The Board of Supervisors asked the consultant team to study the likely impacts to the Los Angeles County jail population of Proposition 47, AB 1468 (split sentencing), AB 624 (enhanced credit system) and patient-inmate population projections over the next several years, including projections for those with Mental Health disorders.

While AB 109 which passed in 2011 to alleviate prison overcrowding, was not the focus of the analysis, the metrics relating to that population were included in the projections analysis. Simply stated, AB 109 calls for defendants convicted of relatively minor felonies to be sent to county jails instead of state prison, a policy shift known as realignment. Under realignment, counties such as Los Angeles have been required to handle large numbers of patient-inmates diverted from the state system.

The Prop 47 Referendum was passed by California voters on November 4, 2014. The initiative redefined some nonviolent offenses as misdemeanors, rather than felonies, as they had previously been categorized. The key provisions of Prop 47 include that offenders whose sentence currently includes a jail term would stay in jail for a shorter time period and some offenders currently serving sentences in jail for certain felonies could be eligible for release.

AB 1468, split sentencing, is a judicial practice that began statewide in January 2015 but was already implemented in some counties. In Los Angeles, the District Attorney adopted the provisions of the law in June of 2014. The law applies to only non-serious, non-violent, and non-sexual felonies. The split sentence is part served in the county jail and part spent in intense supervision by probation in the community. The second portion of the split sentence, referred to as the "tail," might include mandatory drug/alcohol classes and/or mental health services. Another aspect of the law is the ability for probation to place offenders in jail on a technical violation for up to 10 days.

AB 624 is a county jail rehabilitation program that went into effect in September 2013. It allows the Sheriff to expand the rehabilitation credit program from one to six weeks for patient-inmates who successfully complete specific program performance objectives. Examples of programming include classes to improve employability, literacy, or social skills. In LA County, the Sherriff's department initiative is referred to as EBI or the Education Based Initiatives program.

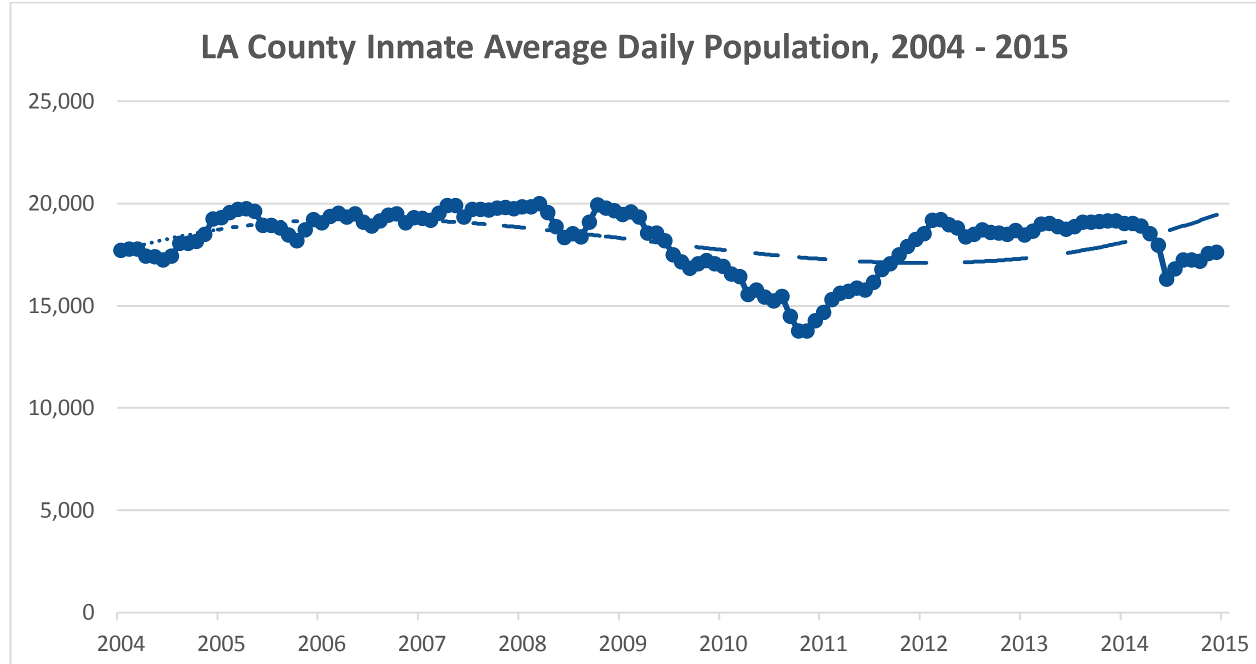
In order to evaluate the impact of the various legislative initiatives, the consultant team needed to develop an independent patient-inmate population projection that extends twenty years, to 2035. While patient-inmate population forecast accuracy becomes limited beyond five years, there is a need for policy makers to look to the future for planning purposes. Best practices calls for forecasts to be monitored carefully and updated to account for changes in legislation, new policy initiatives and fluctuations in the jail population.

Population Dynamics Overview

A comprehensive series of Autoregressive Integrated Moving Average (ARIMA) time series forecasts were constructed based on a variety of datasets provided by jail staff. The forecast was conducted on data as of the end of June 2015. As the chart below indicates, there are 2 major 'shocks' to the patient-inmate population trend. The largest shock begins in advance of realignment in 2011 as the population

hits its lowest level in the months immediately before realignment takes effect. The population trend returns to roughly 'normal' levels during 2012 (however, the mix of the population changes substantially with the influx of AB109 patient-inmates). The second shock follows in late Fall 2014 in response to Proposition 47---the Average Daily Population (ADP) for December 2014 drops to 16,301. At the end of June 2015, it appears that the population is possibly beginning to rebound a bit from the impact of Prop 47. The ADP increases during both May and June.

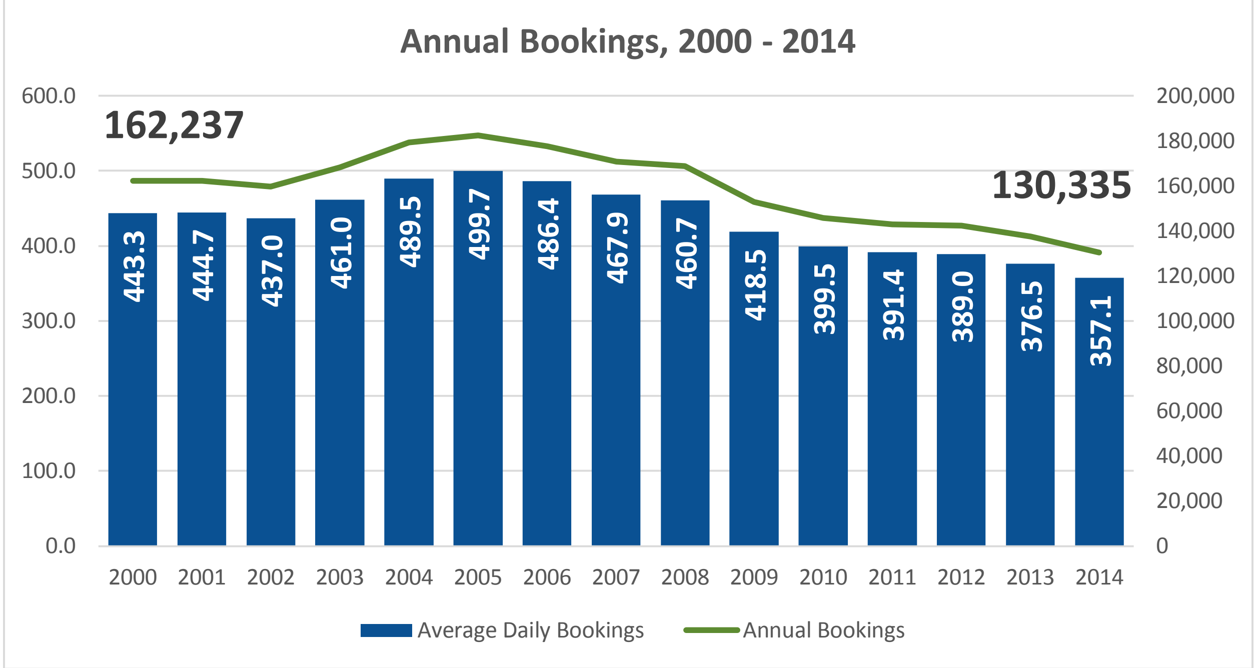
Figure 1. LA County Inmate Average Daily Population, 2004-2015



[Data Source: LASD]

Meanwhile, we see different trends for the two drivers of jail population, bookings and Average Length of Stay (ALOS). As the chart below indicates, bookings have declined steadily over time with the most prominent reduction coming at the time Prop 47 is implemented.

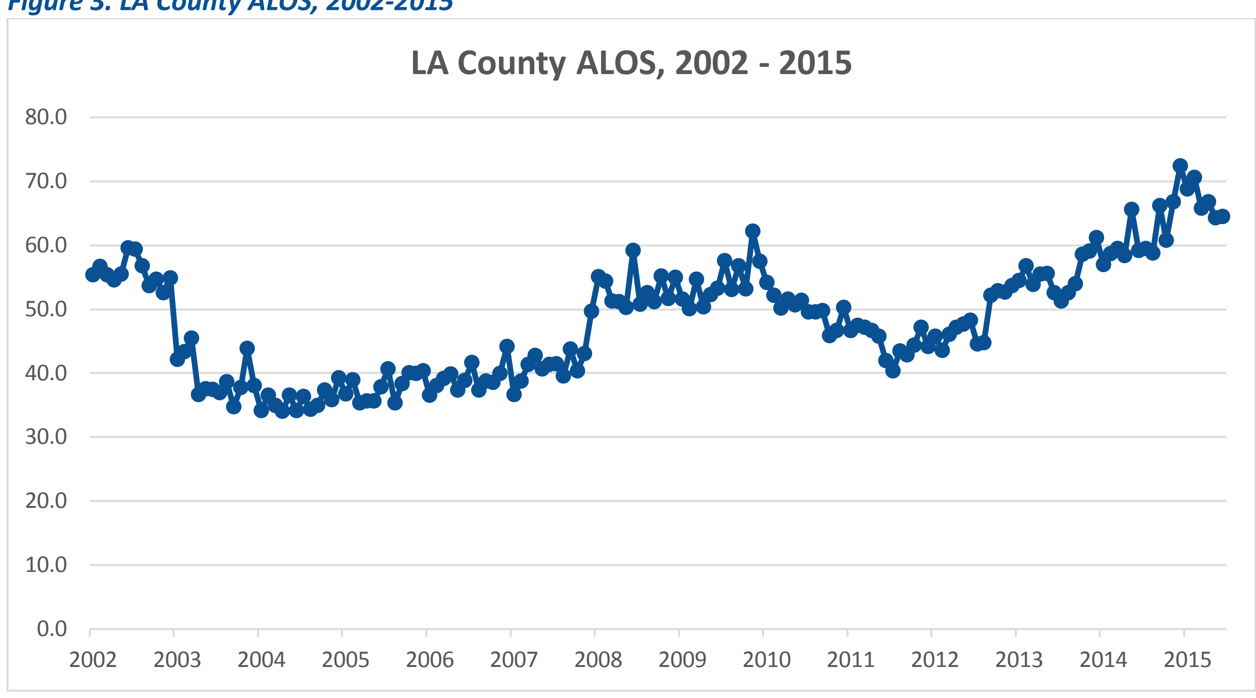
Figure 2. Annual Bookings, 2000-2014



[Data Source: LASD]

Average Length of Stay is more variable but the trend shows a gradual increase due to the impact of AB109 causing more individuals to serve their sentences in the jail rather than at state prison. The longer sentences simply translate into longer average lengths of stay.

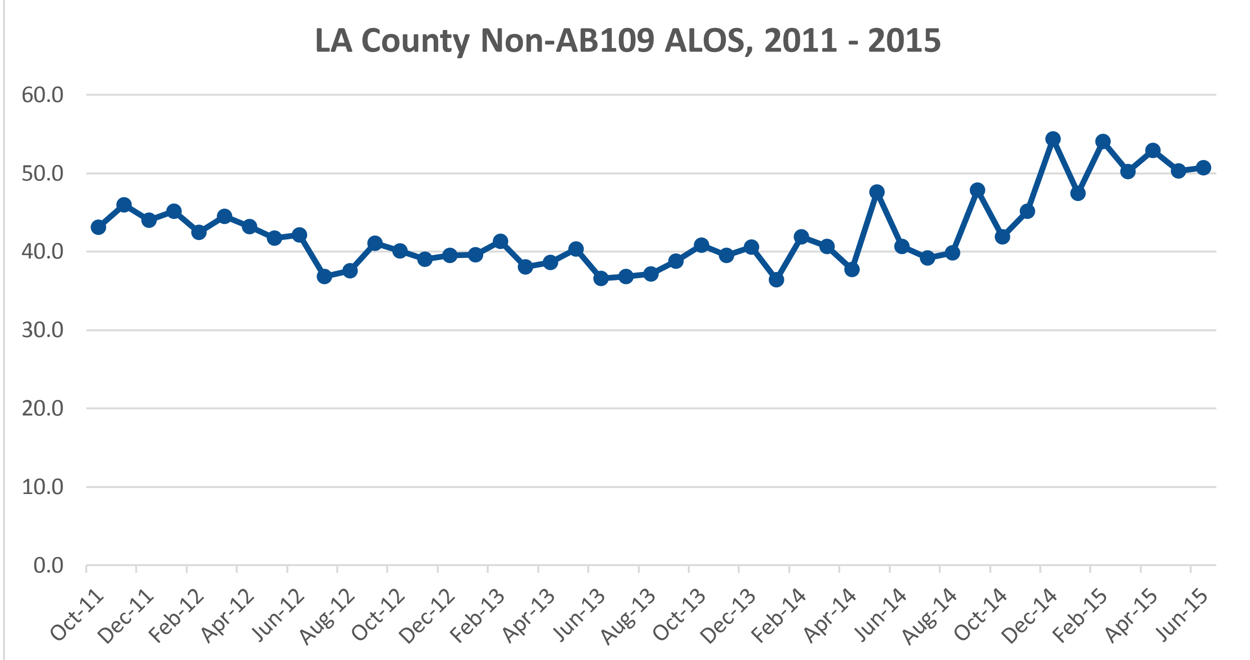
Figure 3. LA County ALOS, 2002-2015



[Data Source: LASD]

The chart below shows the population of non-AB109 patient-inmates. Note that the ALOS increases as the jail's overall population declines due to Prop 47. It is arguable that more patient-inmates may be serving more of their sentence time due to having more jail space. As a result of Prop 47, the Sheriff's Department has confirmed that over the past eighteen months it has gradually reversed its prior practice of shortening time served and as of Feb 2nd 2015, nonviolent patient-inmates are now serving 90% of sentenced time.

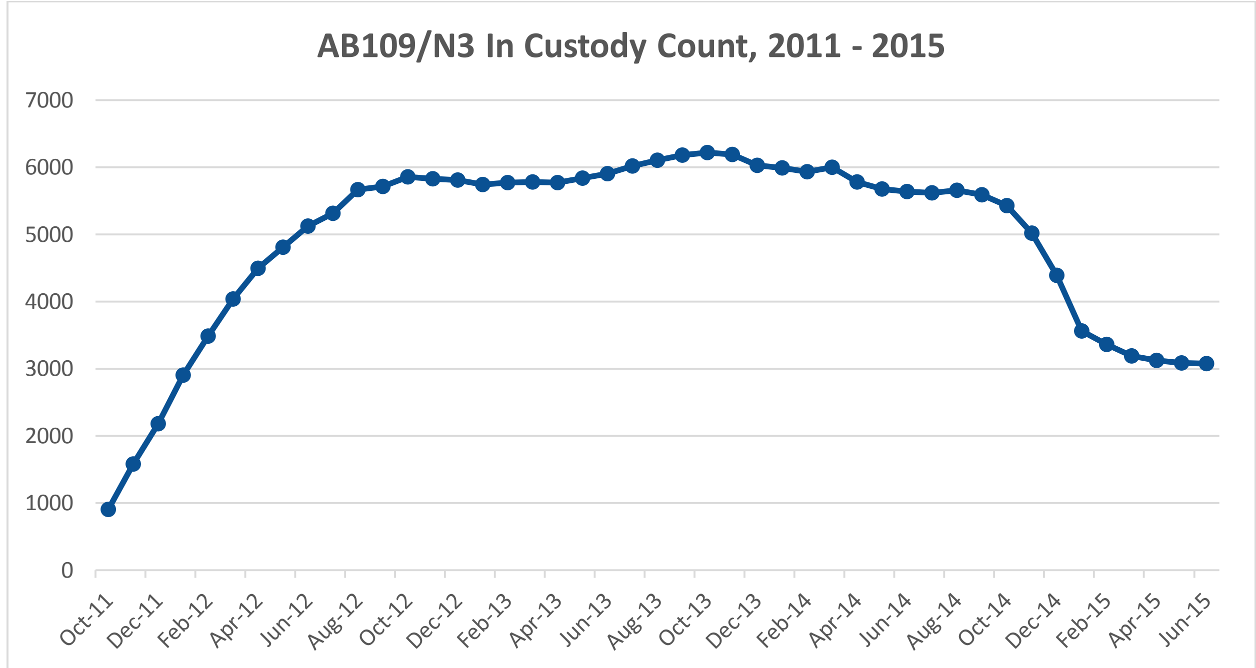
Figure 4. LA County Non-AB109 ALOS, 2011-2015



[Data Source: LASD]

The number of AB 109 patient-inmates is clearly impacted by Prop 47. The chart below provides the 'in custody' count of so-called N3 patient-inmates (convictions which are non-violent, non-serious, and non-sexual). As the chart attests, the population builds up in the first year and then stabilizes somewhat at about 6,000 patient-inmates. The number drops significantly after Prop 47 such that there were just over 3,000 N3 patient-inmates in custody by the end of June 2015.

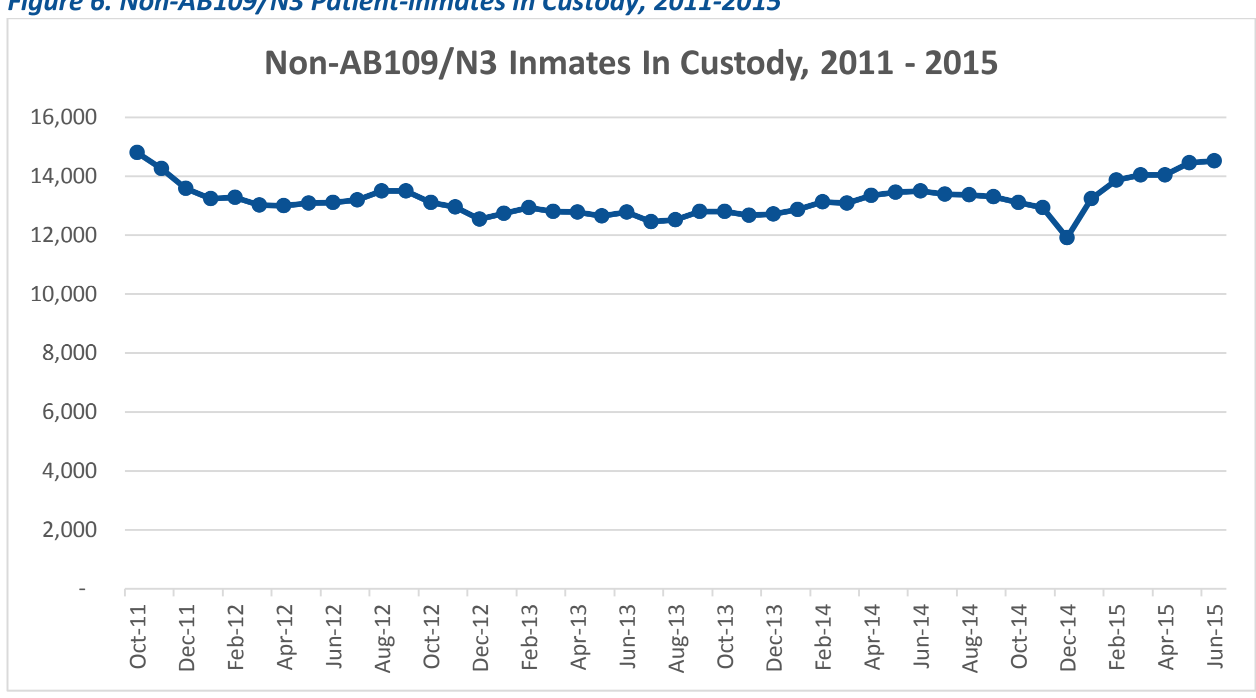
Figure 5. AB109/N3 in Custody Count, 2011-2015



[Data Source: LASD]

The number of non-N3 patient-inmates in custody, however, appears to be slightly increasing. The chart below shows the 'shock' pattern of Prop 47's implementation, but it also shows a gradually increasing trend through the end of June 2015.

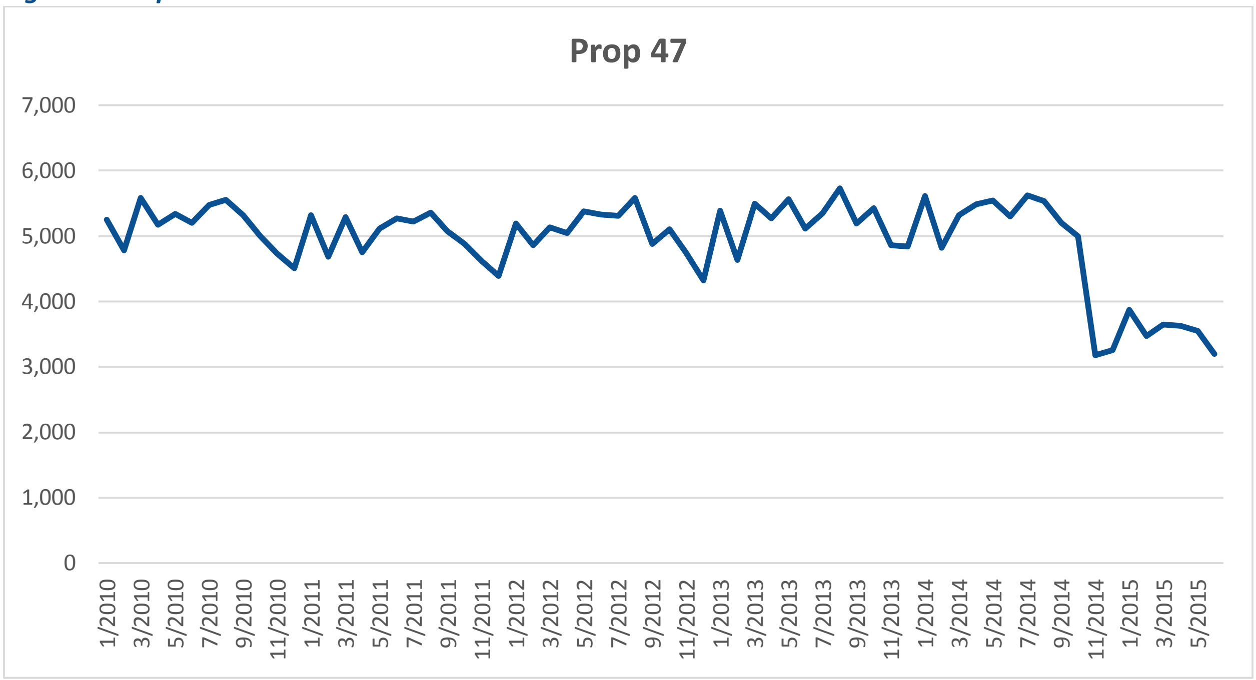
Figure 6. Non-AB109/N3 Patient-inmates in Custody, 2011-2015



[Data Source: LASD]

It is also possible to evaluate the impact of Prop 47 by analyzing the charges of the patient-inmates in jail before and after the law's implementation in November 2014. Because the jail's data system does not identify which of a patient-inmate's charges is the most serious, and given the time constraints of this project, the charts below represent a count of patient-inmates having a certain charge. The first chart below details the number of patient-inmates having at least one charge covered by Prop 47. Notice the decrease after November 2014.

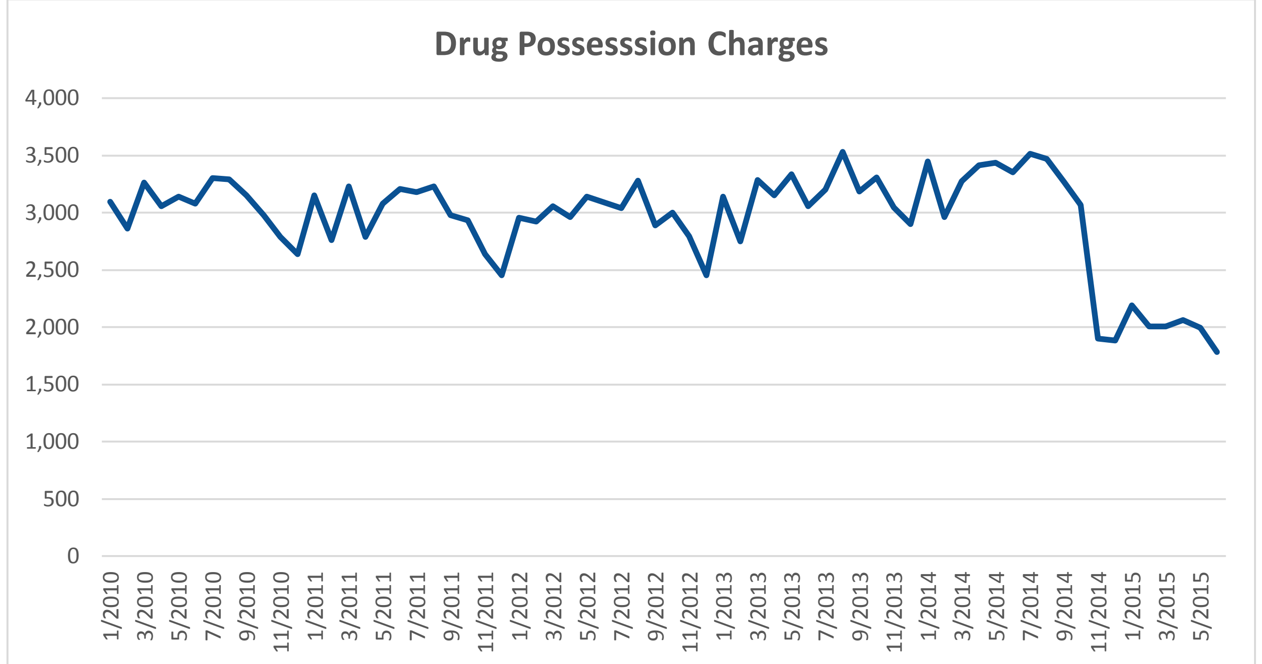
Figure 7. Prop 47



[Data Source: LASD]

Meanwhile, the chart below depicts the counts of patient-inmates having at least one drug possession charge. Note that these patient-inmates may also have additional other charges.

Figure 8. Drug Possession Charges



[Data Source: LASD]

Population Forecast

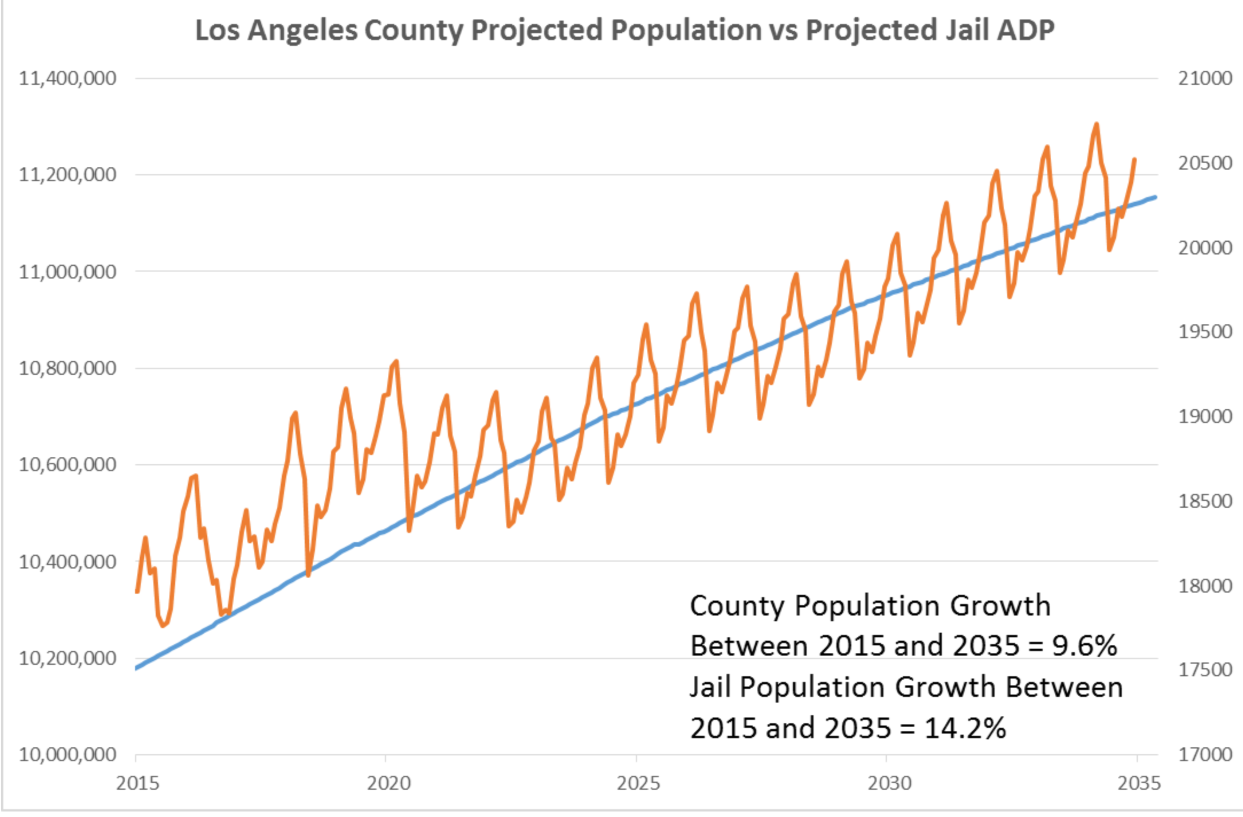
In general, the best predictor of any trend's future is that trend's past. However, because of the connection between past behavior of a trend and expected future behavior, it should be noted that all forecasts are less accurate the further into the future one calculates. Thus, any jail population forecast using accepted time series analytical approaches could be expected to be highly accurate in the near term and less precise as time passes. Perhaps the biggest reason why is the fact that unforeseen population and public policy changes very often intervene into a given situation after the forecast is produced. Forecasts of any type are only as good as what is known when the forecast was produced and a relative absence of major events after production. Any forecast assumes that what was known about the status quo at the time the forecast is produced remains in place for the duration of the forecast.

Overall, several factors will ultimately combine to drive the county jail's population numbers. In terms of what determines the jail's population, the roughly 35% decline in bookings in the last 10 years competes with the 70% increase in ALOS during that time. A series of ARIMA time series models were built to statistically resolve the patient-inmate population trend. The chart below shows the base forecast for the jail. This forecast model used the jail's bookings and average length of stay as leading indicators, as well as county population growth and the incarceration patterns for the past ten years. The forecast indicates that the jail's population will continue to rebound somewhat from Prop 47 in the short term, followed by a gradual increase over time such that the jail's population eclipses 20,000 inmates by the end of the forecast period in 2035.

Figure 9. LA County Inmate Average Daily Population Forecast, 2015-2035

The chart below illustrates the growth of the jail population in comparison to that of Los Angeles County. While county population growth is only one marker in developing the population projections, the visualization shows how the two projections track, with the jail population projected to grow by 14.2% and the county population by 9.6% over the next twenty years.

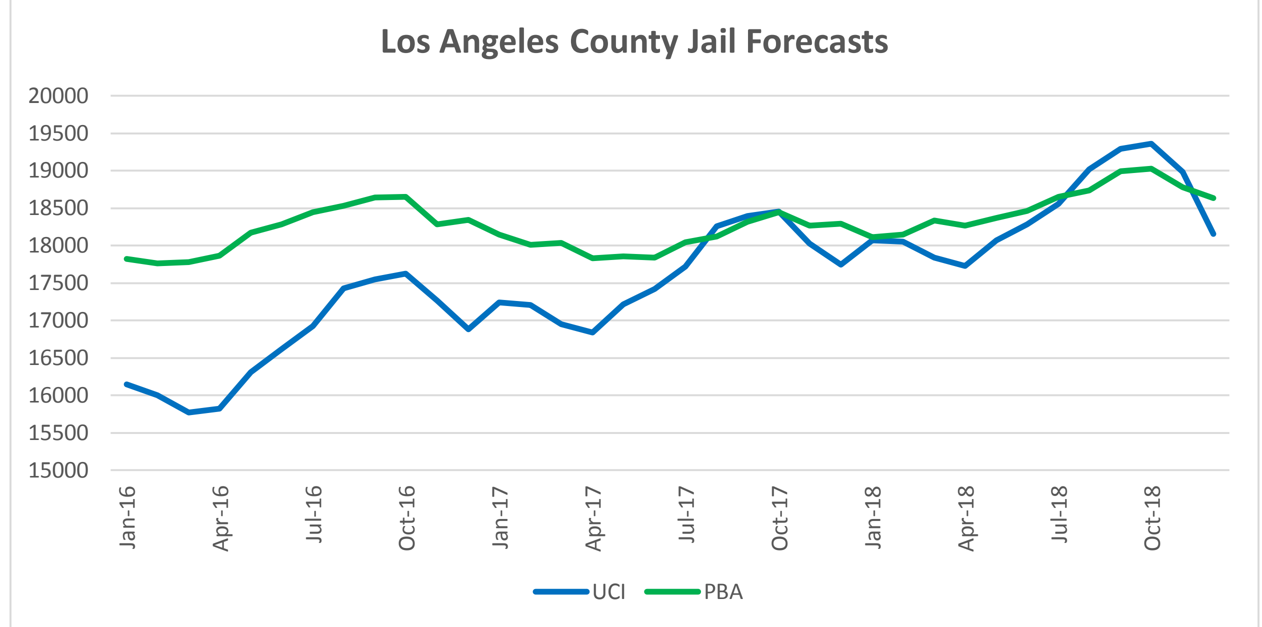
Figure 10. Los Angeles County Projected Population vs. Projected Jail ADP



[Data Source: California Department of Finance]

Experts at the University of California-Irvine built a population projection tool for the California Department of Corrections and Rehabilitation (CDCR), which was validated and customized for the California prison population. This model was then applied and adapted to the Los Angeles County Jail population. The recently completed UCI forecast of the future jail population in Los Angeles County is based on data ending March 31, 2015 indicates an overall increase through 2018 (the end of their forecast outlook) with a mean average daily population in 2018 of 18,451 inmates and a December 2018 population of 18,152. The forecast presented in this report is based on data ending June 30, 2015 shows a similar pattern and a mean average daily population in 2018 of 18,541 inmates and a December 2018 population of 18,634.

Figure 11. Los Angeles County Jail Forecasts



[Data Source: UCI and LASD]

A pair of follow-up forecast analyses broke the above base twenty year forecast into 2 components: AB 109 patient-inmates and non-AB 109 patient-inmates. The chart below the table indicates that the ARIMA process expects that the impact of Prop 47 has not quite stabilized (note also that the forecast model trends lines fit the ADP data well enough to hide the ADP trend). The AB109 count drops as a proportion of the population. The non-AB 109 patient-inmates are staying longer and continue to increase in number.

The table below summarizes the projections in five year increments through 2035. It also adds in two key variables that take the base projections, which represent average daily populations, and translates them into a bed need forecast. The two variables are peaking and classification. Peaking accounts for the daily fluctuations in the jail population which were calculated, based on historical data, to be an average of 6.1%. Classification is the process used by the LASD to internally place patient-inmates in appropriate housing units based on the COMPAS[1] system. The 6.4% figure represents the historically calculated average of additional beds needed to properly safely and appropriately house patient-inmates on a daily basis. These two variables when applied to the base projections results in a true bed need forecast.

Table 1.

Month	Base Projection	Non AB109	AB 109	Peaking (6.1%)	Classification (6.4%)	Bed Need
Jul-15	17,965	14,965	3,000	1,096	1,150	20,211
Jul-20	19,128	16,112	3,016	1,167	1,224	21,519
Jul-25	19,199	16,432	2,768	1,171	1,229	21,599

[1] COMPAS, developed by Northpointe Inc., is a nationally accepted decision tree classification system that follows accepted principles and guidelines for objective inmate classification.

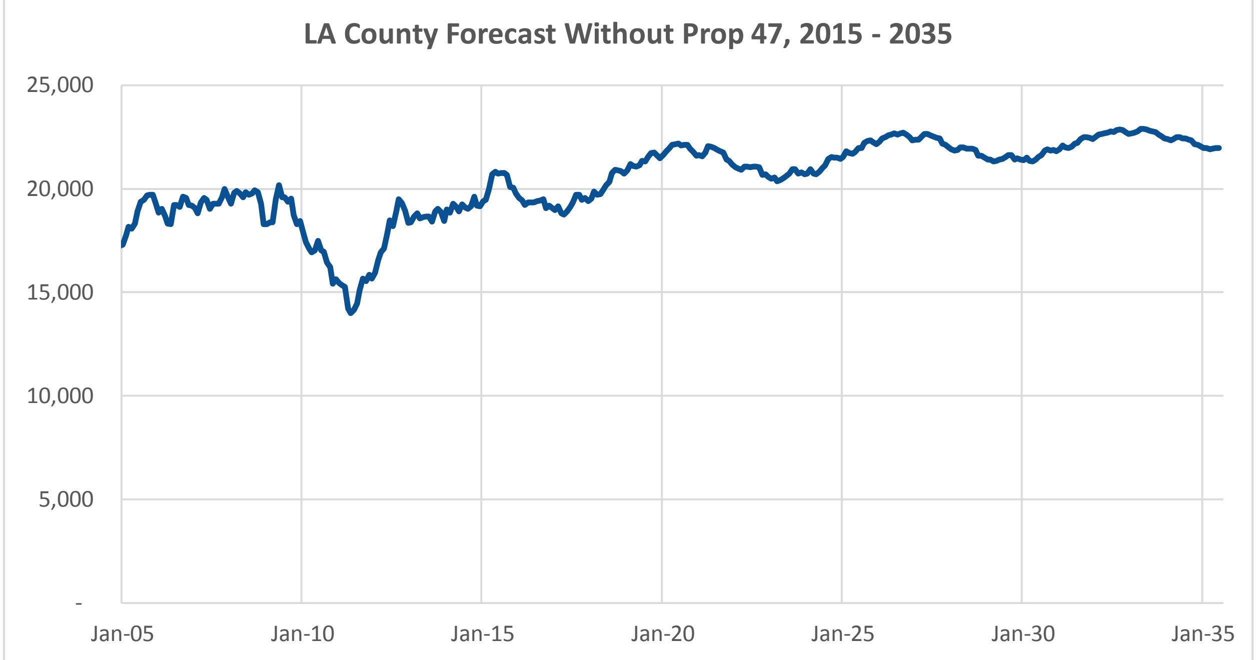
Month	Base Projection	Non AB109	AB 109	Peaking (6.1%)	Classification (6.4%)	Bed Need
Jul-30	19,768	16,509	3,259	1,206	1,265	22,239
Jul-35	20,519	16,664	3,855	1,252	1,313	23,084

Figure 12. LA County Inmate Average Daily Population Forecast, 2015-2035

[Date Source: LASD]

A completely separate forecast was also constructed to examine the impact of Prop 47 on the jail's population. This ARIMA forecast analyzed the data prior to late Fall 2014 and utilized bookings and ALOS as leading indicators. One particularly interesting feature about this forecast is that this model is actually showing multiple regular future 'shocks' to the system, which is something none of the base forecasts that were analyzed indicated. The most important aspect of this forecast is that the jail's population trends much higher than the base forecast such that the jail's population eclipsed 22,000 inmates before the end of the forecast period, a clear indication of the impact of Prop 47.

Figure 13. LA County Forecast Without Prop 47, 2015-2035

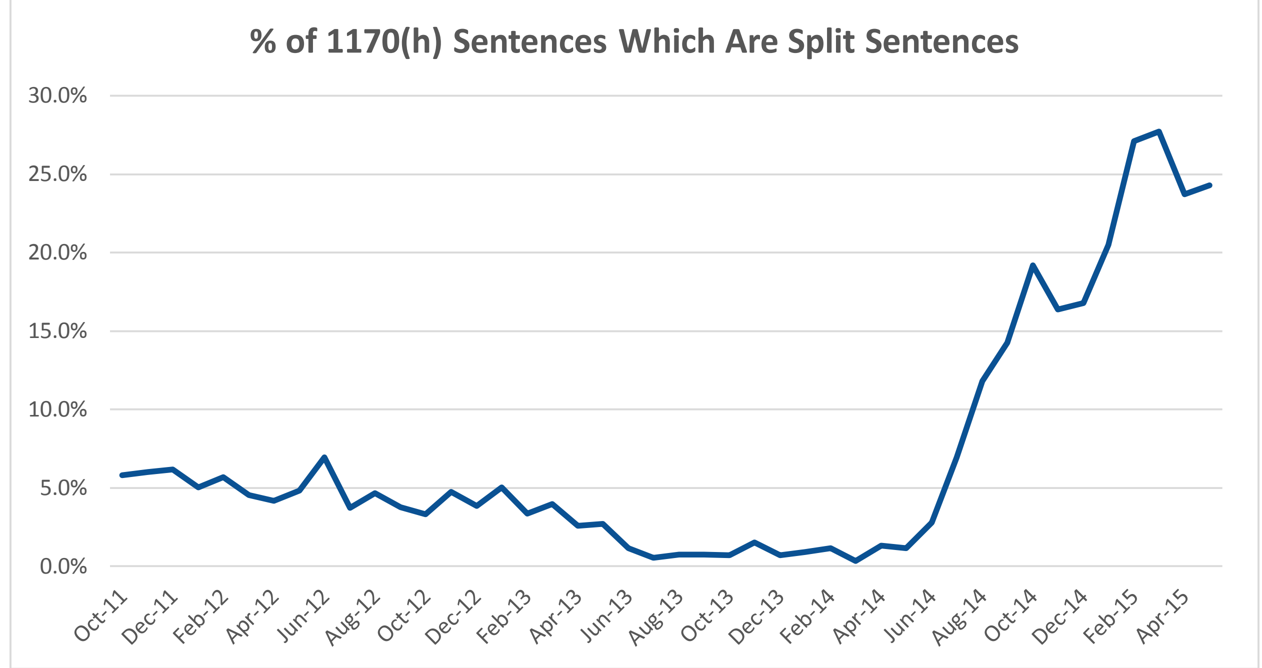


[Data Source: LASD]

Evaluation of Impact of AB1468 (Split Sentencing)

AB1468 went into effect January 2015. The law mandates that unless a judge finds otherwise, a defendant sentenced to county jail under realignment will receive a split sentence. A split sentence is simply a sentence where the conclusion of the sentence time is spent on community supervision rather than in custody. In advance of this law, the Los Angeles District Attorney issued a directive on June 30, 2014 encouraging prosecutors to recommend/pursue split sentences. The chart below shows the increase in the percentage of split sentences for patient-inmates who received county sentences, since the directive was released and AB1468 went into effect. This increase is positive but not as impactful as the effect of Prop 47 which has decreased overall numbers including those who would have been eligible for split sentencing.

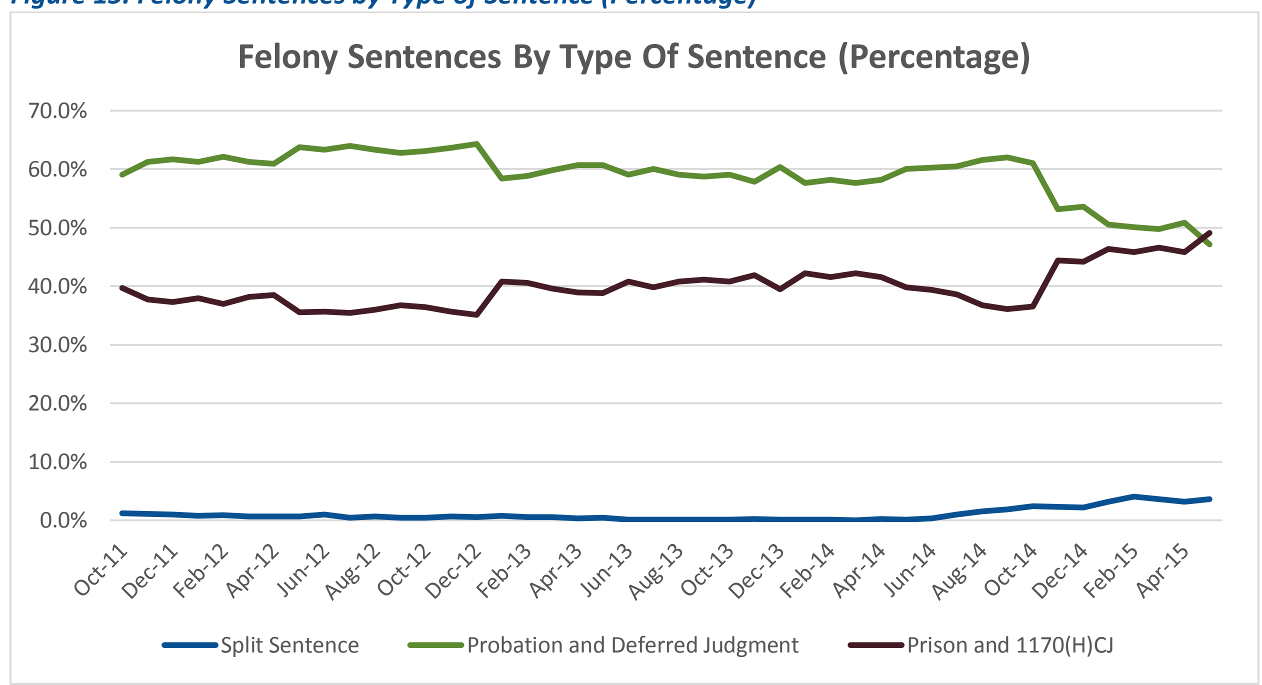
Figure 14. Percentage of 1170(h) Sentences which are Split Sentences



[Data Source: LASD]

In terms of the overall criminal justice picture, however, this is a relatively small percentage of cases sentenced by the Court. The figure below shows the proportions of sentences since realignment.

Figure 15. Felony Sentences by Type of Sentence (Percentage)

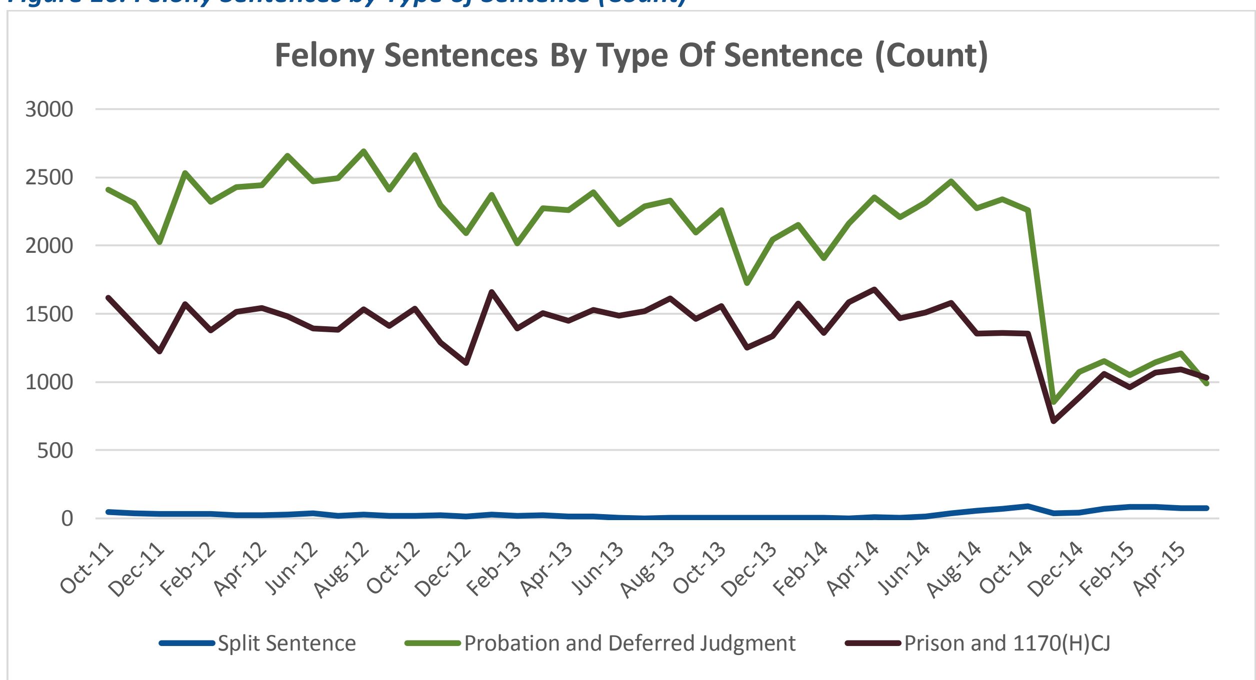


[Data Source: LASD]

While split sentences are a small proportion of the sentences, the chart above also demonstrates that the majority of felony sentences are probation/deferred judgement. At first glance, it would seem that

the increase in the percentage of offenders heading to custody would be cause for alarm. However, in light of the shrinking number of sentences due to the combination of Prop 47 and an overall reduction in arrests, the actual impact in terms of the jail's population is significantly lower than before Prop 47 went into effect. The chart below shows the felony sentence count rather than the percentage.

Figure 16. Felony Sentences by Type of Sentence (Count)



[Data Source: LASD]

In terms of the impact of AB1468 on the jail's population, the increase in split sentences in one sense is difficult to judge. The jail's data do not identify which patient-inmates have a split sentence, making it difficult at present to evaluate an actual impact on jail length of stay. In addition, the District Attorney's directive on split sentences is only a year old and the law itself has only been in effect for just over half a year. This relative scarcity of data makes it difficult to develop an accurate forecast model of split sentencing as a predictor of the jail's population. Indeed, only a couple time series models of split sentence numbers passed muster statistically and those were highly suspect given the 'shock' of having split sentences suddenly increase toward the end of the data. When split sentencing data were added to the base forecast as a predictor, there was no real impact on the numbers involved. More important to remember is that the statistical approach used to produce the base forecast is actually factoring in split sentencing because the forecast itself is mostly based on the jail's population trend. Given that the number of split sentences is statistically correlated with the reduction in the jail's population, the law is having a positive impact. However, given that there were 2,100 felony sentences in May and 77 (3.7%) were split sentences, the impact on the jail's population is significantly less pronounced than Prop 47.

Evaluation of Impact of AB624 (Enhanced Credit System)

AB624 went into effect in September 2013. AB624 provides up to 6 weeks program credit for patient-inmates who successfully complete rehabilitative programming. The law allows patient-inmates affected by realignment to receive the same proportion of program credits they would have received had they

been incarcerated in state prison facilities. At the outset, it is critical that the jail find a way to integrate all of its program statistics into the jail's computer system to enable easy and accurate reporting. Program credit data was not available covering dates prior to the implementation of AB624, making it difficult at best to evaluate changes in the jail's population wrought by the legislation. In terms of the jail's population, the ARIMA forecast approach, being based on the past history of the population trend and given the fact that AB624 has been in effect for nearly 2 years, the impact of the legislation is actually already accounted for in the population projection.

Data regarding the jail's Education Based Initiatives (EBI) appear to indicate a decrease in program utilization for 2015. In 2014, 1,901 patient-inmates received credit in a total of 5,093 courses. Annualizing the 2015 data indicates that the number (as well as proportion) of patient-inmates expected to receive credit will decrease in 2015. This follows a decrease in 2013.

The data detailing the Vocational Shop credits is a bit more detailed but again does not go back historically long enough to allow for statistical modeling. The nearly 3 years' worth of data detailed credits earned as well as the impact on actual release dates of the program. Taking this information for released patient-inmates only, it is possible to examine the impact on the jail's population. It should be noted how this analysis treated patient-inmates with multiple sentences. Specifically, some patient-inmates serving multiple sentences had multiple release dates. Although the patient-inmate earns credit toward all sentences, it was assumed that the patient-inmate would in reality be released on the latest release date. In other words, if patient-inmate A had 3 sentence release dates of January 1, February 1, and March 1, it is assumed that the patient-inmate would stay until March 1. This is important to note because the vocational program generates a significant amount of time credit, but with multiple sentences involved, the patient-inmate may time out on one or more sentences, but cannot be released because time remains on other sentences. Overall, in terms of analyzing when an individual would actually leave jail, what matters the most is the comparison of when the individual actually left jail vs. when the individual originally would have left jail.

For the data provided, 3,182 patient-inmates were actually released from jail with a total amount of 118,762 jail days saved (keep in mind that the 3,182 patient-inmates had more time credits than those jail days given the above discussion of multiple sentence release dates). The bottom-line impact on the jail's average daily population from the vocational programs data was 186 patient-inmates overall. Comparing the portion of the data which cover the time prior to the enactment of AB624, it appears that this impact has increased by roughly 49 patient-inmates on an average daily basis.

In addition to education and vocational programs, patient-inmates can be sent to the fire camp program for training. The table below details statistics since the program began in March 2012, as of May 8, 2015.

Table 2.

Total Patient-Inmates Transferred to Fire Camp Training Since March 2012:	985
Inmates in Fire Training Class	815
Graduated Fire Training	673

[Data Source: LASD]

Overall, as with split sentencing, given the numbers of patient-inmates in vocational, education, and fire camp programs, which are all worthwhile, the impact on the jail's population, although positive, is somewhat small in comparison to initiatives such as Prop 47. The best conclusions which can be drawn about the full scope of the impact of AB624 is that it helps control the jail's average daily population and that this impact is accounted for in the jail's population forecast presented earlier.

The table below illustrates what the jail forecasts would have been had Prop 47 not passed and the smaller impact that AB 624 is expected to have. As can be seen in the table the 2025 year forecast would be over 3000 beds higher without Prop 47.

Table 3.

Month	Projected Bed Need	Projected Bed Need with No Prop 47	Estimated Bed Need with No AB624
July 2015	20,211	23,364	20,379
July 2020	21,519	24,836	21,687
July 2025	21,599	24,730	21,767
July 2030	22,239	24,341	22,407
July 2035	23,084	24,719	23,252

Section II. Correctional Treatment Facility Population Analysis and Findings

LA County Jail Consolidated Correctional Treatment Facility

Introduction

As with many jails located in large metropolitan areas, Los Angeles County Sheriff's Department houses detainees and patient-inmates in facilities that were designed and built a number of years ago. The eight correctional facilities in the LADOC currently housing detainees and patient-inmates were constructed between 18 and 52 years ago.

Expertise in the design of recently constructed correctional facilities have advanced by incorporating a better understanding of internal flow, patient-inmate observation, safety of patient-inmate and staff, and construction materials and techniques. These advances, in turn, have accommodated the changing health needs of the incarcerated population. Examples include the 1) dramatic increase in the admission of individuals with mental illness and/or chronic medical diseases, 2) design modifications of the physical plant to maximize the prevention of suicide, 3) improved accessibility for the physically impaired, and 4) services and supports required by longer lengths of stay of the detained population. Conversely, older correctional facilities have become notably outdated, inefficient, unsafe, and unhealthy.

In the early 2000's, the Los Angeles Sheriff's Department (LASD) and Los Angeles County began developing plans to replace its aging Men's Central Jail (MCJ). The MCJ facility built in 1963 and expanded in 1970 has a physical plant that was designed for a different era and different approach to housing detainees, the majority of whom were initially short stay pre-adjudication men.

The stated goal of the Men's Central Jail replacement facility was to build a state-of-the -art correctional treatment facility incorporating elements of flexibility that would allow modifications if and when the population and the approach to corrections and treatment changed. The planned replacement facility was named the Consolidated Correctional Treatment Facility (CCTF); its name indicating the intent to use this structure to house and treat detainees and patient-inmates who have mental illnesses and serious chronic medical conditions in the custody of the LASD. This new facility would have "sufficient space designed to address the rehabilitation needs of individuals with mental health problems and co-occurring disorders. (Expanding) space for those in an acute mental health crisis to address the level of actual treatment need with flexibility as those needs change. Treatment spaces should facilitate integrated care for health, mental health, and substance abuse interventions." (June 9, 2015 "County of Los Angeles Consolidated Correctional Treatment Facility" presentation to Board of Supervisors).

The patient-inmate population currently designated for the CCTF includes those with acute and chronical mental illness, as well as those with acute but mostly chronical medical conditions that require increased access to nursing and medical services. A number of individuals projected to be housed in the CCTF would benefit from a facility designed to incorporate standards of the Americans with Disabilities Act (ADA).

Number of Treatment Bed Required at the CCTF to Replace the Men's Central Jail le

Supporting Evidence for a Consolidated Correctional Treatment Facility

Three LASD correctional facilities -- Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), and Century Regional Detention Facility (CRDF) -- house the vast majority of men and women who have serious mental illness and complicated acute and chronic medical conditions who would be considered for transfer to the new CCTF.

The Men's Central Jail's physical plant and structure is now 52 years old and its expansion 45 years old. Both the initial and expanded sections are outdated and not designed to address the security and medical complexity of the populations housed in the facility. MCJ's census consistently approximately 4,100. The average daily census exceeds the functional (but not the rated) capacity of this aging facility.

The clinical treatment areas are restricted in size and require constant focused effort by the staff to assure access and sight and sound privacy. The MCJ houses a number of different groupings of at-risk patient-inmates including a unit with the highest security level individuals. The movement of high security individuals for even minor health concerns is complicated utilizing significant correctional and medical resources. The male Medical Observation Specialty Housing (MOSH) unit is situated in the MCJ. The MOSH houses men with complicated and/or chronic medical illnesses including patient-inmates requiring complex wound care and men on Insulin, anti-coagulation treatment, active cancer treatment, sleep apnea treatment (CPAP), dialysis treatment, and other complex regimens. An Impaired Mobility area houses a number of individuals using canes, crutches, wheel chairs, and other assistive devices. MCJ also has transgender and gay housing units – individuals housed on this unit require increased levels of ongoing medical and mental health services. MCJ also houses approximately 500-600 men who are prescribed psychotropic medication or who remain on the mental health case load but who are deemed clinically suitable for housing in General Population.

The **Twin Towers Correctional Facility** (TTCF) is adjacent to and interconnected with the Central Men's Jail. The facility was built in 1997. Its average daily census is approximately 3500 and consistently exceeds the facility's BSCC rated capacity of 2244. Located within the Twin Towers is the male and female Forensic Inpatient Psychiatric (FIP) unit, the male and female medical Correctional Treatment Center (CTC), the male mental health High Observation Housing (HOH) and the Moderate Observation Housing (MOH) units, the Mental Health Intake Housing units, the ADA housing unit, the Intake and Reception Center (IRC), the IRC Overflow area, the Urgent Care Center, multiple specialty clinics, and diagnostic testing areas.

General medical clinics, specialty clinic areas, treatment rooms, urgent care, IRC provider assessment areas at the Twin Towers are limited in size and, as in MCJ, require diligent effort on behalf of the medical and correctional staff to maximize both access and sight and sound privacy as required by HIPAA regulations and best correctional health practices. Additionally, privacy during medical and mental health evaluations and interviews increase the personal safety of patient-inmates whose may be vulnerable within general population is this information becomes general knowledge within the patient-inmate population.

TTCF houses the most severe mental health population in the LASD facilities. Space in each of the mental health treatment and housing areas is at a premium. Program space on mental health housing units is available but limited. The number of HOH and MOH housing units has increased to

accommodate the steady rise in volume of mentally ill patient-inmates that has most notably occurred over the past five years. The mental health population has increased from 14.9% to 19.6% of the jail population at LASD from 2010 to thus far in 2015.

Issues with inadequate lines of sight needed to appropriately observe patient-inmates are evident throughout all the medical and mental treatment and housing units in TTCF including the FIP, CTC, IRC, HOH, and MOH. TTCF utilizes additional staffing resources and has retrofitted some areas with supplemental monitoring devices to address this ongoing concern.

Beds in the Forensic Inpatient Psychiatric (FIP) and the Medical Correctional Treatment Centers (CTC) are in great demand with daily backlog of referrals waiting for admission. The mental health and medical staff prioritize referrals for admission to assure that the sickest have ready access to these units. Patient-inmates awaiting admission to the FIP or CTC require redirection of staff resources to assure that these men and women are adequately monitored and provided required treatment while awaiting admission. The inability to readily move individuals to the level of care required by their acuity places the individual and the institution at risk and utilizes additional correctional and health staff resources.

The male Intake & Reception Center (IRC) for the LASD is located at the Twin Towers facility. The IRC serves an extremely high volume of daily admissions with daily bookings averaging 300-350. The flow of new admissions is subject to backlogs and slowdowns due to a variety of logistical and structural reasons. The sight lines into a number of the holding cells are restricted requiring assignment of additional staff to assure adequate monitoring.

Contemporary intake processing areas subscribe to an “open waiting” concept where majority of admissions are waiting for processing in an open environment similar to an emergency room of a hospital. This allows for all personnel to clearly observe patient-inmates and maintain proper visual supervision, especially of new admissions who have medical or mental health flags or obvious health care issues.

The provider assessment room affords limited sight and sound privacy.

Admissions at risk for withdrawal from drugs or alcohol are screened with Clinical Institute Withdrawal Assessment (CIWA) testing and if asymptomatic can be ordered to have a repeat CIWA screening in 72 hours. New admissions at risk for withdrawal are not referred to a dedicated housing unit where they can be observed and monitored. The high volume of admissions has resulted in the creation of an IRC Overflow area on a different floor that enables some decompression of the crowded environment in the IRC but delays the completion of intake screening and the assignment of new admissions to the needed level of housing.

The Century Regional Detention Facility (CRDF) was built in 1994 as a male correctional facility but was subsequently converted to the LASD’s main housing facility for female detainees and patient-inmates. CRDF currently houses approximately 2000-2100 women. CRDF has High Observation Housing (HOH) and Moderate Observation Housing (MOH) units for females with significant mental illnesses. Lines of sight in the upper tier cells are limited or not optimal for high and moderate observation units. Females with chronic medical conditions are housed in non-cohorted General Population housing units. Women who mentally or medically decompensate and require a higher level of health care have to be

transported to the Twin Towers which requires a 30-60 minute crosstown trip. Decompensated females frequently have to be held at CRDF awaiting a bed at the Twin Towers Correctional Facility Forensic Inpatient Psychiatry (FIP) or Correctional Treatment Center (CTC) medical unit. CRDF was not initially designed to be an Intake & Reception Center resulting in intake screening being provided in the dayroom of a housing unit. The IRC's location creates ongoing issues with addressing sight and sound privacy and gathering reliable clinical information.

Admissions to CRDF at risk for withdrawal from alcohol or drugs are screened with CIWA testing. Females at risk for withdrawal are not housed in a cohorted unit. Follow-up CIWA testing is not universally performed. Clinical Opiate Withdrawal Score (COWS) assessment is not currently utilized in the LADOC.

Men's Central Jail, Twin Towers Correctional Facility, and Century Regional Detention Facility house the sickest and most complicated mental health and medical patient-inmates housed in the LASD. All three of these facilities have structural designs that complicate the ability of correctional staff to provide a safe and secure environment, interfere with the staffs' ability to clinically monitor the status of the patient-inmate population, and create barriers that complicate the ability to meet the health care service needs of the individuals housed in these facilities. The TTCF and CRDF Intake and Reception areas where patient-inmates enter the LASD are inadequate for comprehensive screening and determination of acuity by clinical staff.

The distributed housing of **patient-inmates with** serious mental ill and medical illnesses across three facilities stretches the ability of both the correctional and health care staffs to monitor and treat this complicated patient-inmate population. Creating cohorts of acute and chronic mentally and medically ill detainees and patient-inmates and individuals at risk for alcohol or drug withdrawal would allow valuable clinical and correctional staff resources to be concentrated in a single facility and enable programs and treatment to be focused on the highest risk individuals. The concentration of these high risk mental health and medical patient-inmates would also facilitate movement to other levels of mental health care within the projected CCTF when the individuals' clinical status improves or deteriorates.

Current Volume of Patient-Inmates with Serious Mental and Medical Illnesses Housed in Twin Towers

Collecting the average daily population data of patient-inmates who have mental illness and medical conditions was challenged by the lack of an integrated database that includes jail population management data , mental health data, medical data, and relational data (such as housing location, length of stay data in each level of care, diagnoses, and acuity level). A relational database had to be built using the data that was available in order to provide population projection data. For some projections a number of sources provided individual pieces of data that enabled the development of a "snapshot" of the population and treatment need trends.

Mental Health and Medical Population Snapshot

A one week snapshot (June 24 – June 30, 2015) of data was collected to determine the average capacity in each type of housing, how many beds were occupied and any restrictions on housing use and other comments (Table 4). This one week snapshot was analyzed for all facilities that reported either medical or mental health beds.

Table 4: LASD Facility Average Capacity and Occupancy, 6/24/15 – 6/30/15

Facility	Rated Capacity	Avg. Cap	Avg Occ	Range	Restricted	Comments
MCJ Medical						
6000	N/R	12	4.71	3 - 7	0	
7000	N/R	55	51.43	49-50	4-Mar	
7100	N/R	46	41.57	40-44	0	
7200	N/R	50	48.43	46-50	0	
7202	N/R	18	15.71	14-18	0	
8000	N/R	154	113.86	112-120	5 SPH 3 Dialysis	
8100	N/R	80	53.14	50 -56	0	
8200	N/R	60	30.29	29 - 33	0	
MCJ MOSH		**475**	359.14	343 - 378		
LA/USC Male*	N/R	40	20.14	14 -28	5 SPH	
LA/USC Fem*	N/R		7.14	5 -10	0	
LA/USC Med Center		**40**	27.29	19 - 38		
TTCF-MED						
MOSH 232	N/R	218	174.86	110 - 179	0	59 of these beds used for workers
CTC 322 Fem*	N/R	30	21.14	20 - 22	0	
CTC 322 Male*	N/R		3.00	3	0	
CTC 331 Male	N/R	60	40.71	38 - 42	0	
CTC 332 Male	N/R	60	36.71	35-39	0	ADA, W/C, Deaf and Blind; housing upper level ADA bunks used to house I/M workers
TTCF Medical		**408**	303.71	206 - 246		
* denotes combined count; Beds available for either gender						
TTCF-MH						
FIP Males*	N/R	46	29.29	26 - 30	0	
FIP Females*	N/R		7.71	6 - 9	2 K-10	
HOH SMC	600	418.43	404.00	388-442	0	Capacity Range 392-457
HOH DMC	120	216.29	155.14	142-170	0	Capacity Range 180-223
Step Down S/A	1122	1821.00	1715.86	1695-1733	0	
K-10 M	192	93.43	81.71	80-84	0	
TTCF Mental Health		**2595.14**	2393.71	2337-2468		Averaged Based on Fluctuating Capacity
* denotes combined count; Beds available for either gender						
CRDF-Medical						
HOH SMC Fem	240	198.29	189.71	180-197	0	Capacity Range 188-219
HOH DMC Fem	0	0.00	0.00	0	0	Included with HOH SMC
Step Down S/A Fem	160	190.00	186.86	184-189	0	

Facility	Rated Capacity	Avg. Cap	Avg Occ	Range	Restricted	Comments
CRDF -MH		**388.29**	376.57	364 - 386		Averaged Based on Fluctuating Capacity
MOSH Pregnant	80	124.00	121.86	115-124	0	
MOSH Diabetic	80	124.00	112.86	107-122	0	
MOSH MRSA	N/R	10.00	3.00	3 - 4	0	
CRDF Medical		**258.00**	237.71	225 -250		
NCCF						
514 MOSH	32	60	48.71	45-50	0	
911 Ad Seg Med	32	1	0.29	0 - 1	0	
NCCF Medical		61	49	45 - 51		
N/R= Not Rated Designated Medical Beds not Rated by BSCC						
Current System		4183	3720			

[Data Source: LASD]

Although this table is created from a limited snapshot of data, of significance is the significant range of occupancy for each bed. These change even within one week at each of the jails that have designated health care beds which demonstrates the frequency of admissions to these units and implies the daily population management required in attempting to move those in need of a designated bed into an appropriate level of care. Patient-inmates are often placed at a lower level of care than is required due to the sheer overcrowding at many levels of care. The snapshot also demonstrates that although there appears to be more capacity than is being used, the current facility design does not provide enough single cell housing to be able to safely meet the housing need of all of the patient-inmates. It is not unusual for one patient-inmate to occupy a double cell or even a four bed dorm in order to accommodate their safety and security needs. It should also be noted that BSCC does not rate the capacity of designated health care beds.

Mental Health Population

The population of men and women who have mental illnesses housed in LASD facilities constitutes the largest group of individuals projected to be housed in the CCTF. As demonstrated in the graphs below, there has been a steady and dramatic increase in the numbers of males and females with mental health illnesses housed in the LASD. The mental health population in LASD has increased overall from 14.9% to 19.6% of the jail population since 2010.

Figure 17. Male Mental Health Expansion in LASD

Male Mental Health Expansion in LASD

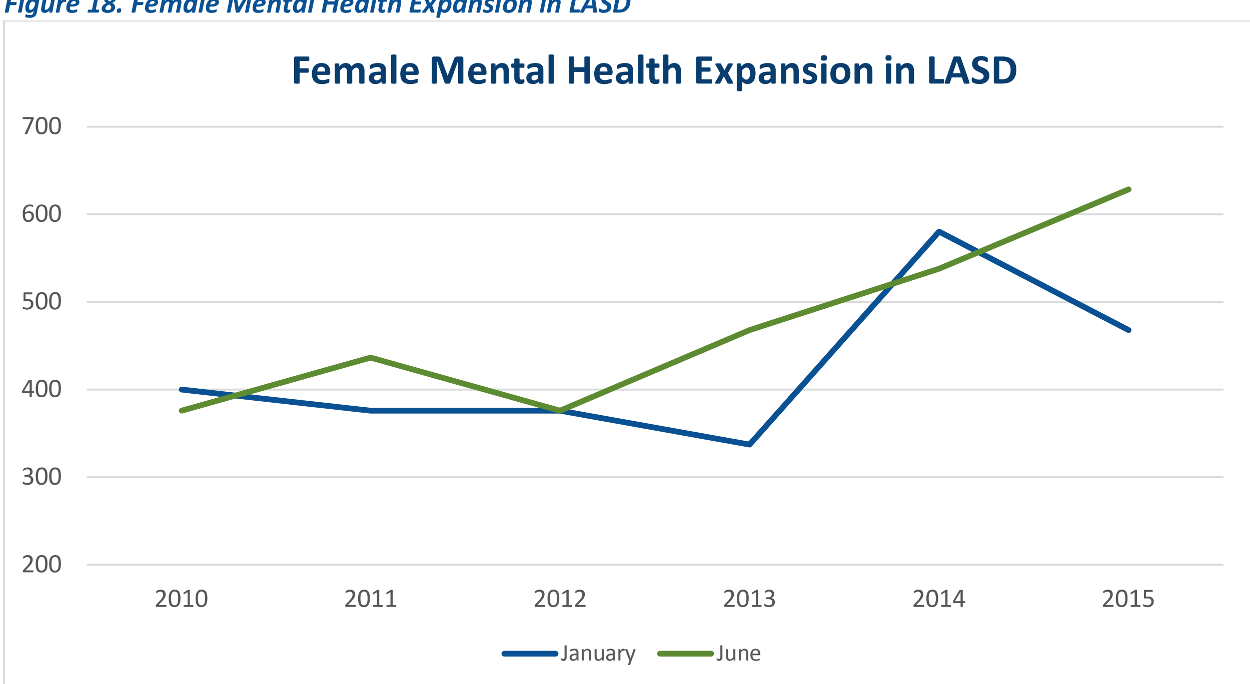
3400
3200
3000
2800
2600
2400
2200
2000
1800
1600

2010 2011 2012 2013 2014 2015

January June

[Data Source: DMH]

Figure 18. Female Mental Health Expansion in LASD



[Data Source: DMH]

In the first five months of 2015, the mental health population using LASD mental health code designations of flags identified an average daily combined male and female mental health population of 3459.

One Week Data Snapshot of Mental Health Beds in TTCF and CRDF:

The following table shows the mental health male and female beds and a one week data snapshot of the population at and CRDF. HOH and MOH beds have rated capacities; in total there were 2434 mental health beds with an average capacity of 2,983 and average occupancy of 2,770. An additional 700 to 800 mentally ill patient-inmates are housed in General Population.

Table 5.

6/24-6/30/15 Snapshot Study Analysis						
Facility	**Rated Capacity**	**Avg. Cap**	**Avg Occ**	**Range**	**Restricted**	**Comments**
TTCF-MH						
FIP Males*	N/R*	46	29.29	26 - 30	0	
FIP Females*	N/R*		7.71	6 - 9	2 K-10	
HOH SMC	600	418.43	404.00	388-442	0	Capacity Range 392-457
HOH DMC	120	216.29	155.14	142-170	0	Capacity Range 180-223
MOH	1122	1821.00	1715.86	1695-1733	0	
K-10 M	192	93.43	81.71	80-84	0	
TTCF MH TOTALS	**2034**	**2595.14**	**2393.71**			
* denotes combined						
CRDF						
HOH SMC Fem	240	198.29	189.71	180-197	0	Capacity Range 188-219
HOH DMC Fem	0	0.00	0.00	0	0	Included with HOH SMC
MOH	160	190.00	186.86	184-189	0	
CRDF -MH TOTALS	**400**	**388.29**	**376.57**	364 - 386		Averaged Based on Fluctuating Capacity
N/R* Medical Beds not Rated						

[Data Source: LASD]

As you will note in the capacities and occupancy rates vary greatly based on the data sets or snapshots that were used. It is noted that mental health data is difficult to extrapolate from the eDAR database since it is primarily based on patient-inmate encounters.

In a separate snapshot on May 12, 2015 the Population Management Bureau of the LASD reported that there were 3,678 mentally ill men and women housed in the LASD. (5/12/15 LASD Population Management Bureau Presentation)

Additional data was obtained during on-site visits during the second week of July, 2015, 3,452 patient patient-inmates who have mentally illness were reported to be housed in special housing within the LASD jail facilities (see Table 6 below) (July 11, 2015 Statistics produced by LASD and confirmed by interviews with Department of Mental Health leadership and providers). A total of 2,301 males with mental illness were housed in TTCF (26 men in the Mental Health FIP unit, 584 men in High Observation Housing (HOH), and 1691 men in Moderate Observation Housing (MOH)). A total of 382 females were housed in mental health housing (7 females in the TTCF FIP unit, 196 women at CRDF HOH, and 186 females at CDRF MOH.) An additional 762 patient-inmates with mental illness were housed in General Population (GP) housing (556 men at CMJ. and 206 females at CRDF). The cumulative volume of identified patient-inmates with mental illness housed in LASD facilities was 3,452 including 2,690 in either FIP, HOH, and MOH housing units and 762 in General Population housing.

The incarcerated population on July 11, 2015 consisted of 2,857 (83%) males and 595 (17%) females who had mental illnesses. The rate of mental illness in the LASD was significantly higher in the female population (27% 1 per 3.7 females) than in the male population (19%, 1 per 5.2 males). 60% of the population who had mental illnesses on this single day was housed in designated mental health units and 40% in GP housing.

Table 6. Mental Health Population by Housing Area, Single Day Snapshot Data (July 11, 2015 LASD Data)

	Male	Female	Total
FIP	26 (TTCF)	7 (TTCF)	33
HOH	584 (TTCF)	196 (CRDF)	780
MOH	1691 (TTCF)	186 (CRDF)	1877
GP	556 (CMJ)	206 (CRDF)	762
Total	2857	595	3,452
Total Male and Female	3,452		

The Los Angeles Sheriff Department reported that on any given day of the month, 3,382 patient-inmates in March 2015, and 3,369 patient-inmates in May 2015, were receiving psychotropic medications (LASD Medical Services Bureau Summary Report, 2015).

LASD Pharmacy reported that in June, 2015, 2,860 patient-inmates had active psychotropic medication orders on the Mental Health Medication Administration Record (MAR). (7/4/15 Communication with LADOC pharmacy administration) This medication audit may underestimate the actual number of patient-inmates on prescribed psychotropic medications due to patient-inmate refusals, modest delays in initiating psychotropic medications on new admissions who are still under evaluation, and the presence of currently undiagnosed or minimally symptomatic mentally ill who did not give a history of mental illness at the time of admission.

LASD reported that there have been over 50,000 annual mental health admissions to the LASD from 2011-2014; this approaches 35-38% of all admissions (Data Source: IS Admissions Report [IS290]). A one day audit in May, 2015 of admissions performed by Intake & Reception Center mental health staff and reported that 38% of all new admissions were referred for mental health evaluation and 53% of this referral group were admitted to mental health housing (5/6/15, Audit by IRC mental health team).

Although there will be variations in this data, it is evident that there are a large number of mentally ill men and women admitted to the LASD and well over 3,000 men and women with mental illness housed in the LASD on any given day. A significant percentage of this population would benefit from placement in mental health housing designed specifically for the needs and risks of the mentally ill and staffed appropriately by mental health providers and trained correctional health officers.

The **Mental Health Forensic Inpatient Psychiatric Unit (FIP)** in TTCF has 46 single and small dorm beds to treat both male and female patient-inmates who require inpatient psychiatric care.. All 46 beds are regularly not available due to the ongoing shortage of single bed rooms resulting in the housing of single patient-inmates in 4 bed dorms. From 2010 through 2014 there was an average of 586 annual admissions to the FIP. Annualized statistics project there will be 596 FIP admissions in 2015. The average

daily census (ADC) in the FIP from 2010-2014 was 35. To date the ADC is 38 (82.6% occupancy rate) in 2015. Acute mental health FIP admissions have an average length of stay of 15 days but there are a number of chronic long term admissions with LOS greater than 140 days. On July 7, 2015 15 of the 38 FIP patients (40%) were long term chronic patients; the FIP psychiatrist stated that this number would likely increase with time.

Some chronic patients are in the FIP for over 12 months. Some of the acute and chronic residents in the FIP are men and women who have been found by the court to be Misdemeanor or Felony Incompetent to Stand Trial (MIST or FIST); these individuals have predictably longer length of stays as they are being restored to competence or while they await transfer to a community or state mental health institution for restoration.

On July 21, 2015 there were 113 mental health patient-inmates sentenced to a state hospital for felony Incompetent to Stand Trial findings as well as NGRI court findings. These include 87 males and 26 females. The average LOS in the facility is 170 days with a range from 22 to 840 days. The average LOS after sentencing was 38 days with a range from one to 148 days waiting for transfer to a state hospital. As demonstrated by the following table the security level of these patient-inmates ranged from level 4 through level 9. None of these patient-inmates were at security levels 1 through 3.

Table 7. Number of Patients by Security Level in State Mental Hospital, July 21, 2015

	4	5	6	7	8	9	Total
Female	4	0	4	15	3	0	26
Male	15	10	18	29	14	2	87

[Data Source: Department of Mental Health]

FIP beds are in significant demand; referrals approved for admission are kept in male and female High Observation Housing (HOH) units including the IRC Intake Housing overflow area. Neither of these units are optimally suited for the housing and treatment of the seriously decompensated patient-inmates with mental illness. Department of Mental Health providers estimate that a high percentage of HOH individuals would be admitted to community inpatient psychiatric hospitals if they were not incarcerated and that a minimum of 200-250 patient-inmates could easily be identified for transfer to the FIP if beds were available. LASD reported that 425 (55%) of the 780 men and women housed in HOH during the second week of July 2015 would require psychiatric hospitalization or IMD placement if discharged to the community from the LASD (LASD JMHS Tier Rating Predictive Data, July 2015). An expansion of FIP beds or equivalent intensive mental health beds is needed.

The **High Observation Housing (HOH) units** at Twin Towers Correctional Facility (TTCF) and Century Regional Detention Facility (CRDF) house 750-800 seriously mentally ill (SMI) men and women. Most are housed in bi-level PODS with single or double bed cells; the upper level has been fitted with metal mesh screens to prevent suicidal patient-inmates from jumping/attempting suicide from the upper level. Even though these patients require high observation, the cells on the upper level have limited lines of sight for both the correctional and mental health staff. Program space is available but it is not fully optimal. Mental health providers in separate interviews stated that the HOH units were not structurally designed to provide optimal mental health interventions. There is limited access to natural light or opportunities for recreation/exercise for large muscle exercise. As noted in the previous paragraph, the mental health

staff estimates that, based on the level of mental health severity, a high percentage (40-55%) of the individuals housed in the HOH's warrant admission to the Forensic Inpatient Psychiatry (FIP) unit.

A high number of HOH patient-inmates at both TTCF and CRDF are already on waiting lists awaiting transfer to the FIP. Individuals deemed incompetent to stand trial are housed on HOH units. A cursory walk-through of the HOH's by the consultant team accompanied by correctional and mental health leadership readily identified a number of agitated, decompensated, and disconnected, or active suicidal (smocked and chained to a table in the dayroom) individuals on virtually every tier with readily identifiable clinical indications for transfer to the FIP. HOH housing is not physically suitable to address the clinical needs of this level of mental health acuity.

Mental health leadership communicated that a more therapeutic mental health environment in the HOH would allow more expedited transfers from the FIP decompressing the high census on the FIP. It is also estimated that a number of men housed in Moderate Observation Housing (MOH) would optimally be treated in the High Observation Housing (HOH) unit or the FIP.

The **Moderate Observation Housing** (MOH) units at Twin Towers Correctional Facility (TTCF) and Century Regional Detention Facility (CRDF) housed 1,877 patient-inmates (1691 males and 186 females) during the second week of July 2015. As in the HOH's, the MOH living units are two level PODS with protective metal mesh screens on the railings of the upper levels. The cells are single and double beds. Overcrowding has resulted in the placement of bunk beds in the many of the male MOH day rooms. As in the FIP and HOH, individuals deemed incompetent to stand trial are also housed on MOH units. Lines of sight, especially for the upper level cells, and program space is limited. A tour of the male MOH units at TTCF also readily identified individuals who required transfer to a higher level of care in the HOH's or the FIP. Conversely at CRDF the females housed on the MOH visited appeared relatively stable, engaged in their environment, and properly housed at this level of care.

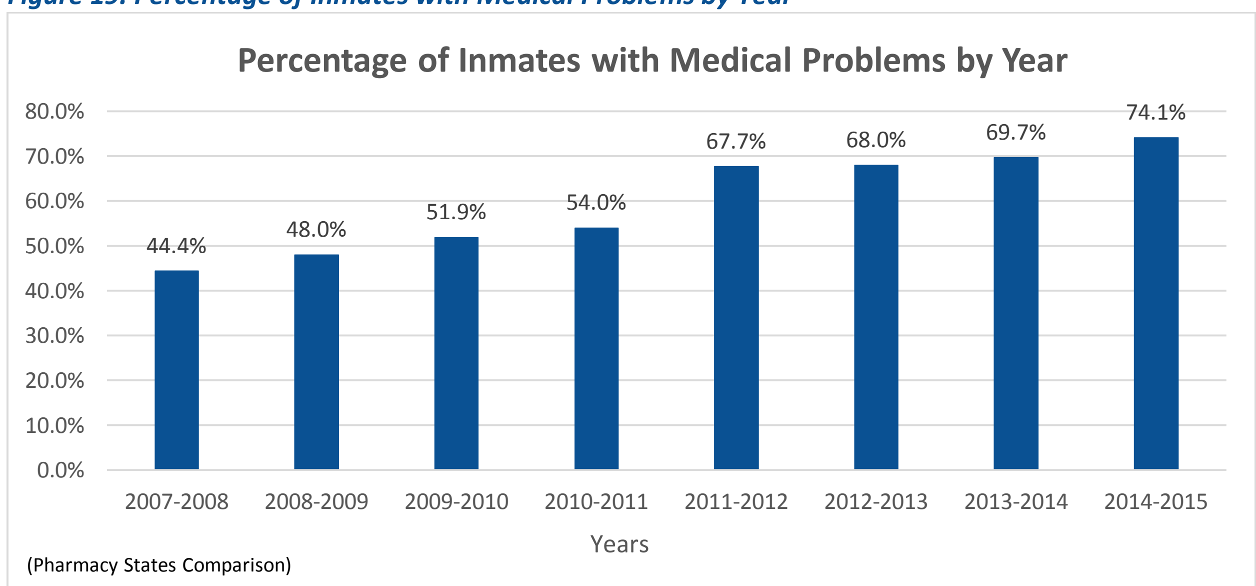
The **General Population** units house 762 mentally ill individuals in Central Men's Jail and Century Regional Detention Facility were not fully evaluated, mental health providers and officer communicated that a not insignificant number of these patient-inmates do not adapt well in GP housing and shuttle in and out of higher level of mental health care units. Although a number of stabilized patient-inmates with mental illness can function in the General Population, a subgroup of stabilized patient-inmates would be optimally housed and maintained in Moderate Observation Housing.

Medical Population

The **Medical Correctional Treatment Center** (CTC) located in the Twin Towers Correctional Facility (TTCF) has 150 licensed beds. The CTC serves both males and females with acute and chronic medical conditions. Approximately 23-30% of the CTC beds are occupied by patient-inmates with medical and mental health co-morbidities (7/7/15 interview with FIP psychiatrist). The CTC operates at a lower functional capacity due to a shortage of single bed rooms resulting in admissions who require a single room for medical reasons or security classification to be housed in a multi-bed dorm. Facilities with daily waiting lists for transfer to the CTC include but are not limited to TTCF, CRDF, IRC Intake, LAC-USC (LCMC) locked inpatient unit, and community hospitals with patients in the LASD custody. Poor lines of sight from nursing stations and correctional posts have been attempted to be addressed by the installation of cameras in some CTC rooms; however, these cameras do not take the place of human

observation and interaction and can only be considered as supplemental. With the increasing age of the LASD population and the increasing volume of admissions with significant medical problems, the medical Correctional Treatment Center needs more beds on units designed to treat and monitor this increasingly complex patient population.

Figure 19. Percentage of Inmates with Medical Problems by Year



During the one week snapshot (see table below), although the capacity is 150 beds, the occupancy was far less than that for the very reasons explained above. Not only does the level of treatment need to be considered when placing patient-inmates into an appropriate bed, but the safety and security needs must also be considered and addressed. Double rooms and small dorms may frequently house only one high security level or required special handling patient-inmate.

Table 8. Medical Capacity Snapshot Data Analysis June 24-June 30, 2015

TTCF-MED	Rated Capacity	Avg. Cap	Avg Occ	Range	Restricted	Comments
CTC 322 Fem*	N/R*	30	21.14	20 - 22	0	
CTC 322 Male*	N/R*		3.00	3	0	
CTC 331 Male	N/R*	60	40.71	38 - 42	0	
CTC 332 Male	N/R*	60	36.71	35-39	0	ADA, W/C, Deaf and Blind; houing upper level ADA bunks used to house I/M workers
TTCF Medical Total		**150**	**101.5714**			

[Data Source: LASD]

It is noted that CTC 322 has 30 beds that are used for both males and females. Gender is another consideration in the population how special needs designated beds are managed within the CTC.

The **Medical Observation Specialty Housing** (MOSH) for men is located in the Men's Central Jail housing patient-inmates requiring insulin treatment, anti-coagulation therapy, sleep apnea devices (CPAP), dialysis, uncomplicated wound care, outpatient oxygen therapy, chronic disease monitoring, utilization of catheters and ostomies, mild-moderate substance abuse withdrawal treatment, limb monitoring for

orthopedic devices (casts, pins, rods), liquid diets for fractured jaws, chemotherapy, use of assistive devices to ambulate, temporary isolation for communicable illnesses, and other acute and chronic therapy or monitoring. On May 12, 2015 the MOSH housed 369 patient-inmates (LASD Population Management Power Point) including 130 insulin-requiring diabetes. An additional 44 individuals with impaired mobility were housed on the ADA modified unit Twin Towers Correctional Facility (TTCF) 232 POD.

There is not a designated Medical Observation unit at the Century Regional Detention Facility although there are two small dorms in the facility's OB-GYN specialty clinic area in the medical clinic wing. These mini-MOSH dorms house women with non-complicated wounds and pregnancies that need close monitoring. On May 15, 2015 four women (LASD Population Management Power Point) were housed in these dorms and a similar number during a site visit on June 30, 2015. On June 30, 2015, CRDF housed 54 insulin-requiring diabetes, 1 patient-inmate on anti-coagulation medication, and 30 women using wheel chairs (many of whom have some capability to ambulate).

As noted in the above one week snapshot table, although the LASD facilities reported 1012 MOSH beds the need for a single bed results in the utilization of only 821 beds due to the previously stated challenges of placing patient-inmates into single beds when required. There also seems to be a range of what is considered MOSH beds. In some instances, there are GP units that based on population management practices house medically vulnerable patient-inmates although they are not designated MOSH beds.

Table 9. Housing Occupancy by Housing Unit

	6/24-6/30/15 Snapshot Study Analysis							
Facility	**Rated Capacity**	**Avg. Cap**	**Avg Occ**	**Range**	**Restricted**	**Comments**		
MCJ								
6000	N/R*	12	4.71	3 - 7	0			
7000	N/R*	55	51.43	49-50	4-Mar			
7100	N/R*	46	41.57	40-44	0			
7200	N/R*	50	48.43	46-50	0			
7202	N/R*	18	15.71	14-18	0			
8000	N/R*	154	113.86	112-120	5 SPH 3 Dialysis			
8100	N/R*	80	53.14	50 -56	0			
8200	N/R*	60	30.29	29 - 33	0			
MCJ MOSH		**475**	**359.14**	343 - 378				
TTCF-MOSH								
MOSH 232	N/R*	218	174.86	110 - 179	0	59 of these beds used for workers		
TTCF Medical		**218**	**175.00**	110-179				
CRDF								
MOSH Pregnant	80	124.00	121.86	115-124	0			
MOSH Diabetic	80	124.00	112.86	107-122	0			
MOSH MRSA	N/R*	10.00	3.00	3 - 4	0			
CRDF Medical		**258.00**	**237.71**	225 -250				
NCCF								
514 MOSH	32	60	48.71	45-50	0			
911 Ad Seg Med	32	1	0.29	0 - 1	0			
NCCF Medical		**61**	**49**	45 - 51				
TOTAL MOSH BEDS		**1012.00**	**820.86**					

[Data Source: LASD Facilities]

As noted in the section on medical Correctional Treatment Center, there is increasing age of the LASD population and the increasing volume of admissions with significant medical problems. The Medical Observation Specialty Housing unit will likely need more beds designed to treat and monitor the needs of this patient-inmate population. An additional increase in MOSH beds will be required if all new admissions at risk for substance withdrawal are housed in the CCTF and if it is determined that a number of females with acute and chronic medical conditions housed at CRDF are better treated and monitored in the CCTF facility.

Detoxification Screening and Services in the LADOC are currently provided in Twin Towers Correctional Facility (TTCF) and the Century Regional Detention Facility (CRDF). All new admissions with an active level of substance abuse that puts them at risk for withdrawal are screened using the Clinical Institute Withdrawal Assessment (CIWA) tool during the intake medical screening process. CIWA is nationally used as scoring tool for signs and symptoms of alcohol withdrawal. Those with a high CIWA score and/or signs of withdrawal are either hospitalized, assigned to special housing, or started on outpatient

detoxification treatment. Asymptomatic patient-inmates may have a repeat CIWA screening evaluation ordered in 72 hours. Pharmacy medication statistics indicated that there was an average of 135 orders for chlordiazepoxide (Librium) during three non-consecutive weeks in April, May, and June 2015. With the exception of this incomplete surrogate marker for substance abuse treatment, no additional data were provided about the incidence of substance abuse withdrawal in the LASD. The Department of Public Health estimates that 80% of all admissions to the LASD have a history of substance abuse.

Statistics from Cook County Jail (average daily census of 8,500) reported that each day approximately 30 asymptomatic or mildly symptomatic (low CIWA-A (alcohol) or Clinical Opiate Withdrawal Scale (COWS) scores) men and women are admitted to its detoxification dormitories utilizing 110 beds per day. Approximately 20 percent of the new admissions requiring detox treatment are already admitted to mental health or medical housing. Dallas County Jail (average daily census 6,000) has 76 patient-inmates receiving substance abuse detox treatment on a daily basis. It would not be unreasonable to predict that LASD with an average daily census (ADC) over 17,000 would require 200-220 beds to run a comprehensive detoxification program.

Table 10. Detoxification Beds by Inmate Population for three County Jails

	Average Daily Census	Detox Beds Per 1000 Inmates	Detox Beds
Cook County Jail (CCDOC)	8,500	13.5	110
Dallas County Jail	6,000	12.7	76
Los Angeles County Jail	17,000	*13.1	**200-220

** Average of CCDOC and Dallas rates*

***Estimated*

Section III. Understanding Our Mental Health and Medical Forecast Data

Mental Health Forecasts

Our forecast data are derived from single point in time snapshot census data for each year 2010 – 2015. The table we were sent is pasted below:

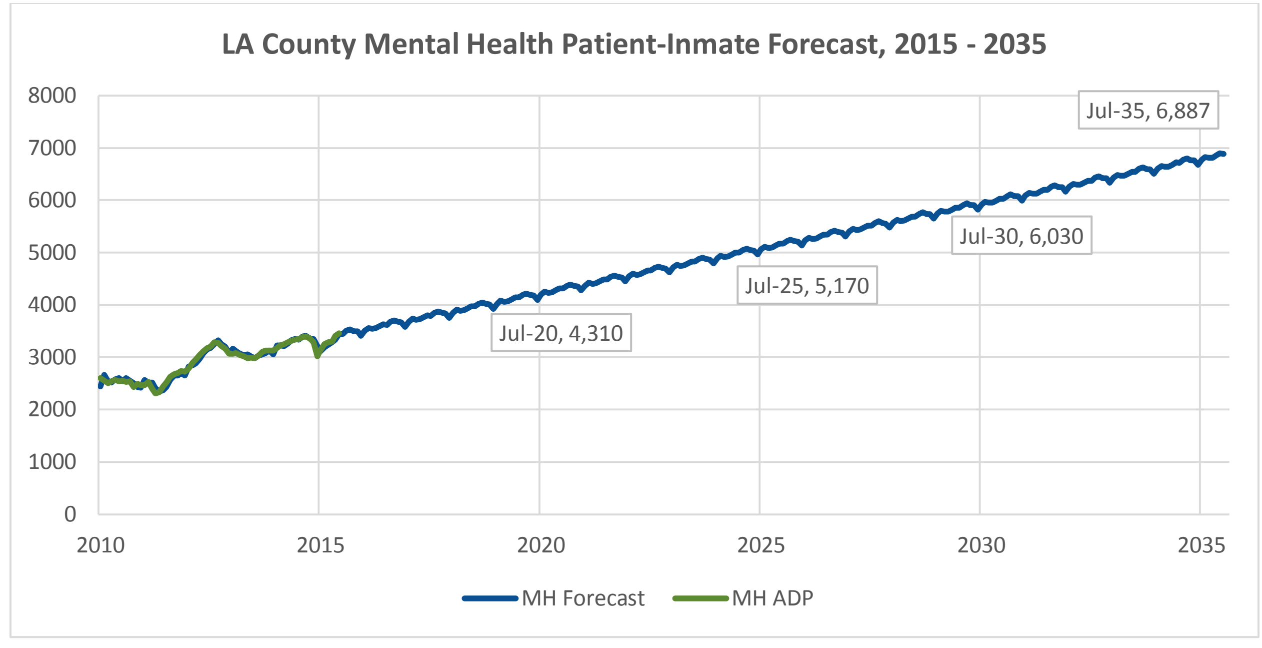
Table 11. Mental Health Client Census

Mental Health Client Census Snapshot Data						
Location	2010	2011	2012	2013	2014	June 2015
Men's MOH	1,196	1,186	1,301	1,232	1,528	1,691
Men's HOH	251	287	330	393	440	584
Men's GP	525	629	881	744	655	556
MHUCTC (Men)	17	18	25	24	26	27
Total	**1,989**	**2,120**	**2,537**	**2,393**	**2,649**	**2,858**
Women's MOH	181	120	164	183	183	186
Women's HOH	90	76	97	122	166	196
Women's GP	201	237	329	280	248	206
MHUCTC (Women)	14	13	8	10	8	6
Total	**486**	**446**	**598**	**595**	**605**	**594**
Overall Total	**2,475**	**2,566**	**3,135**	**2,988**	**3,254**	**3,452**

[Data Source: DMH}

The consultant team used these numbers and by calculating the percentage they constituted of the actual jail ADP, 'filled in the blanks' for each month by smoothing over the differences between the annual percentages. In the end, this provided us an estimate of the monthly mental health population in the housing areas above. This set of monthly time points was then used in an exponential smoothing forecast of the mental health population (figure below). This predicts an almost doubling of the current mental health population by 2035.

Figure 20. LA County Mental health Patient-Inmate Forecast, 2015-2035



[Data Source: LASD + DMH]

Mental Health by Security Level Analysis

LASD Population Management Bureau uploaded a series of files that provided the historical housing for patient-inmates who were housed in mental health housing areas. The housing units in question appear in the table below. This set of data was used to construct the numbers that yielded a full analysis contained data from years 2010 to 2015. However, to determine how many patient-inmates were housed in each designated unit required that the housing unit numbers be hand cross-matched with each facility's (CCTF, CRDF) bi-annual five year housing charts that designated the special mental health units that other FIP are designated from the GP housing modules. The several thousand cross matches was undertaken initially, but resulted in confusion since although there are specifically designated HOH and MOH housing units, they change due to the expanding and contracting admissions and other environmental and staffing issues. Those changes, however, are not noted on the Facility Housing Charts.

It is also important to consider the security level of the patient-inmate who are in specialized housing. The following table shows the security levels of those patients who are in designated medical or mental health housing by security level. This table demonstrates the potential number of patient-inmate who could be diverted from specialized beds if they were stable for transportation or change in housing. It is unlikely that anyone in high security would be diverted until their case has been resolved by the court. There are potential candidates within medium security levels that with careful risk assessment and evaluation may meet diversion criteria. Security level assignment is a function of the jail's classification and is not a complete risk assessment for the determining success in community. It is important to remember that 90% of patient-inmates will return to the community from jail or prison settings.

Figure 21.

	Low Security				Medium Security			High Security			
Security Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Unk**	Total
Totals	8	49	74	388	108	681	1178	527	41	1	**3055**
Cumulative Total	**519**				**1967**			**568**			

[Data Source: LASD]

It is important to note that these numbers were not used for the forecast data. Moreover, there is a very good chance that the housing locations do not match the housing locations listed in the Projected Bed Distribution Table. It is much more likely that these numbers in the table above match up with the snapshot data upon which the forecast is based. However, the classification data are limited by containing only the housing locations listed in the facility housing charts. In short, to compare the numbers across tables is faulty since they are not equivalent data or data sources.

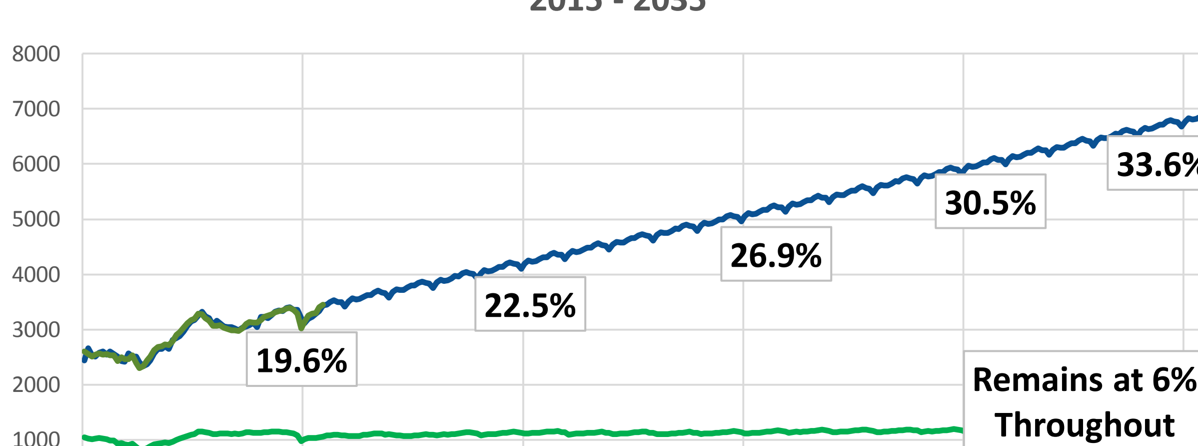
Medical Forecast

The medical data were challenging to model. Available data covered 3 months for each year in 2010 – 2015 for: MCJ MOSH, TTCF CTC, CRDF; however we were unable to obtain historical data for: NCCF MOSH, and TTCF MOSH.

Using the methods above, we were able to statistically estimate data where it was unobtainable back to 2010. For NCCF and TTCF MOSH, however, we took the population from a snapshot in June 2015 and estimated each month based on the capacity for those two locations. This means we are making the assumption that those areas were filled to capacity in 2010. We extrapolated each month between 2010 and June 2015 based on occupancy percentage. We summed the estimates of the five areas to produce an overall area estimate of the medical population. Unfortunately, the medical population numbers, calculated in this manner[2], represented a steadily declining trend such that we were unable to produce a forecast model in a meaningful way. Therefore, we produced a medical forecast by making the assumption that the population of interest constituted 6%[3] of the overall ADP. This 6% was then calculated against the overall jail population forecast to produce the forecast charted below.

The graph below tracks the projected growth for the medical and mental health as a percentage of the total population.

Figure 22. Mental and Medical Health Patient-Inmate Growth Rate



Data Source: LASD

[2] See 'Medical Data Worksheet' tab of LA Master Data v5 file
[3] This was based on an overall calculation for the population

Principles to inform number of Actual Beds in the Consolidated Correctional Treatment Facility

What is the patient-inmate population that should be housed in CCTF?

The Consolidated Correctional Treatment Facility (CCTF) is projected to be a "treatment" facility housing incarcerated individuals with mental health and medical conditions that require services that cannot be readily provided in General Population housing facilities. Individuals who would be best housed in the CCTF include patient-inmates who:

- Have Unstable Mental Illness who could be safely and adequately treated in a FIP, HOH).
- Have Moderately Stable Mental Illness who is at risk for decompensation who could be safely and adequately treated and monitored in a MOH.
- Have Acute and Chronical Mental Illness[4] (current Forensic Inpatient Psychiatric Unit (FIP), High Observation Housing (HOH), Moderate Observation Housing (MOH) populations and select General Population (GP) inmates on psychotropic medications).
- Have Stable Mental Illness who is at risk for decompensation.
- Have mental health and medical conditions which require higher (non-CTC) level of nursing care, monitoring, treatment.
- Are at medical risk for deterioration, decompensation, or complications due to their underlying condition. Examples include: heightened risk for substance abuse withdrawal, diabetes receiving insulin, complex medication regimens, not fully controlled seizures, etc.
- Have Chronic Medical Illness which requires increased access to medical and nursing care, frequent monitoring, and/or frequent dressing changes.
- Have Acute and Chronic Medical Illnesses[5] (current Correctional Treatment Center (CTC) and Medical Observation Specialty Housing (MOSH) populations.)
- Individuals with impaired mobility[6] who can safely function in a non-CTC environment.
- Individuals who require respiratory, droplet, contact isolation.

Why should Patient-Inmates be in CCTF and what services will they need?

The housing of a large number of acutely and chronically ill individuals in a single facility will require the concomitant availability of an increased number of health care staff, increased access to monitoring, treatment, therapeutic, and diagnostic services, and adequate clinical space to accommodate the

[4] Mental illness: CTC/HOH/MOH level of care population (some Traumatic Brain Injury, Dementia, Organic Brain Syndrome or dementia with behavior disorders)

[5] Medical Illness: Post-op, Insulin Requiring Diabetics, anti-coagulation treatment, COPD, CHF, CAD, pacemakers/defibrillators, Chronic Oxygen, Difficult to control seizure disorders, complex medical conditions, physically debilitated, complicated wound care, hemodialysis/peritoneal dialysis, complex treatment regimens, IV antibiotics or IV infusions, hemophilia, wired jaw fractures, feeding tubes, catheters, ostomies, CPAP devices, Detox treatment, cancer on active treatment, fragile elderly, post CVA, Dementia, TBI, OBS, etc.)

[6] Impaired Mobility: Wheel chair dependent, paraplegia, leg/arm casts, crutches, walkers, individuals at risk for fall

heightened volume of staff and services. The concentration of services in a single facility or on a single campus will enhance access and streamline movement. The projected population housed in the Consolidated Correctional Treatment Facility will require:

- Higher levels of nursing care.
- More frequent monitoring that cannot be safely performed in General Population housing.
- Ongoing treatment not able to be provided in a General Population setting.
- Increased observation due to heightened risk for deterioration or decompensation of mental or medical health conditions.
- Ongoing injectable treatment.
- Enhanced access to specialized mental or medical care.
- Enhanced access to urgent care.
- Increased frequency of dressing changes for complicated and non-complicated wounds.
- Specialized housing for airborne, droplet, contact isolation.
- Increased access to care that can only be provided in a facility staffed with mental and medical health staff for 24 hours per day and 7 days per week.

What are the benefits of Consolidated Correctional Treatment Facility (CCTF) housing?

The consolidated housing of individuals with mental and medical illnesses and conditions in a facility that provides enhanced access to monitoring, treatment, individual and group therapy, diagnostic testing, and urgent care and facilitated movement to and from housing with different levels of care will result in benefits to the therapeutic and work environment and to the health and safety of both inmates and staff. These benefits include:

- Increased concentration of clinical staff including nurses, medical providers, and mental health providers required to provide care to this high risk population in the CCTF.
- Increased concentration of high risk individuals and needed clinical staff in a single facility will avoid the need to duplicate clinical staffing and services in other facilities housing only inmates of lower acuity; this will enable other facilities to safely decrease their clinical staffing and/or hours of onsite clinical coverage.
- Increased concentration and access to onsite clinical staff and services including specialty clinics, pharmacy, urgent care, diagnostic testing, and physical and occupational therapy will facilitate access and minimize movement.
- Increased concentration of high cost and complex diagnostic and treatment equipment. This would minimize duplication of costly equipment and services in other facilities.
- Closer proximity to higher levels of care (Forensic Inpatient Psychiatry Unit, Correctional Treatment Center medical beds, High Observation Housing , Moderate Observation Housing, Medical Observation Specialty Housing, Detox services along with specialty consultations,

specialized therapy, urgent care, and diagnostic testing will enhance access and decrease transfer and movement time for correctional staff.

- Increased capability to monitor at-risk patients due to higher staffing levels and improved lines of sight and observation capability.
- Enhanced sight and sound privacy without compromising security monitoring and in compliance with HIPAA confidentiality requirements related to health care needs and treatment.
- Increased program space for individual, group, and recreational therapy. These programs are essential to accelerate and maintain stabilization of patient-inmates with mental and medical conditions allowing them to be housed at the most appropriate, least costly level of care.
- Decreased incidents of suicide due to enhancements of physical plant and better observation of at-risk patients.
- Increased compliance with Americans with Disabilities Act and other regulatory guidelines.
- Creation of a more optimal mental health and medical therapeutic environment.
- Facilitated transport from Intake Reception and Classification (IRC) of high risk patient-inmates with mental and physical illnesses to appropriate clinical housing or treatment area.
- Enhanced capacity to house patient-inmates who have mental illnesses in the appropriate level of care housing
- Enhanced capacity to house patient-inmates who have acute and chronic medical conditions and disease processes in the appropriate level of care housing.
- Expedited discharge of inpatients from Los Angeles County –USC Medical Center (LCMC), Harbor-UCLA Medical Center, Olive View Medical Center, and community hospitals to beds in the Correctional Treatment Center; this will have positive implications for the care of the involved inpatients, the availability of valuable bed space in these hospitals, and utilization of correctional staff resources.
- Prevention of costly hospitalizations and complications. The increased monitoring and access to treatment modalities, consultations, and services will facilitate the stabilization of acute and chronic mental health and medical conditions and decrease the risk of complications for this very high risk patient-inmate population.
- Enhanced compliance with best practice standards of care.
- Provision of health care that is consistent with community practices.

What space would optimally support this population?

The Consolidated Correctional Treatment Facility (CCTF) will require a mix of single cell, double cell, and small to medium sized dormitory housing. The high volume of mentally and medically ill inmates will require substantial clinical interview and examination rooms, diagnostic testing capability, and individual, group, and recreation program space along with supportive office spaces.

- Single cells should be utilized primarily for those individuals whose mental health or medical conditions clinically warrants single cell housing.
- Double cells are best used for persons who are medically and mentally stable and not vulnerable to Prisoners Rape Elimination Act (PREA) issues.
- Dormitories are less costly to construct and permit enhanced observation of the individuals housed in this type of unit. Dormitory housing allows more streamlined correctional officer staffing. The rate of successful suicides and incidence of complications of suicide attempts is decreased in dormitory settings; however, they must be designed to address any vulnerabilities toward PREA violations and/or issues.
- The CCTF should be designed so that out-of-cell time is optimized, individual and group therapy, program space, and exercise area are readily accessible without the need for extensive movement.
- Clinical space should be adequate to meet the needs of the patient population, located proximate to housing units to maximize access and minimize movement, assure appropriate level of sight and sound privacy, and allow security monitoring.
- Clinical space should also be accessible and proximal, if not adjacent, to the housing units

Trends in the Population of Patient-inmates with Mental and Medical Illnesses in the LASD.

- The population of Los Angeles County is likely to steadily increase.
- The number of admissions of patient-inmates to LADOC is likely to steadily increase.
- The number of admissions of patient-inmates with serious mental illnesses and serious chronic medical problems and longer LOS in specialized medical housing is likely to increase. As these populations increase, there will be a need to address the percentage of patient-inmates who have mental and medical issues needing specialized medical housing.
- Ongoing activities in Los Angeles County to increase diversion, develop linkages with community services, shorten lengths of stay, and legislate new initiatives will need to be closely monitored to evaluate the impact on the admission of mentally ill and medically ill to the LASD.
- A combination of diversion programs and additional appropriate health care spaces are needed to address both front end diversion and back end reentry as well as the ability for patient-inmates to receive community-based, high quality health care while incarcerated.
- To provide the necessary services to Los Angeles County residents who become patient-inmates requires an integrated health care continuum from the community (when necessary) into the jail and back into the community upon release.

LADOC Populations and Services that should be placed in the Consolidated Correctional Facility (CCTF)

Populations

a. Forensic Inpatient Psychiatry (FIP) unit for patient-inmates with Seriously Mentally Ill (SMI) in crisis.

b. Intensive Mental Health Care unit for the SMI not in acute crisis.

c. High Observation Housing (HOH) and Moderate Observation Housing (MOH) for continued stabilization of SMI.

d. Correctional Treatment Center (CTC) for acute or chronic medical conditions requiring high levels of nursing care, monitoring , complex treatment regimens, and assistance with activities of daily living.

e. Medical Observation Specialty Housing (MOSH) for acute and chronic medical conditions that require increased (non-CTC) levels of nursing care, monitoring, complex treatment, and medical isolation.

f. Detoxification Services for new admissions at risk for Withdrawal from Substance Use (alcohol, opiates, benzodiazepines)

Services

a. Intake Reception and Classification Centers for new admissions to the LADOC.

b. Specialty Consultation Clinics that allow enhanced access to specialty consultation for the high risk individuals housed in the CCTF and the other LADOC facilities

c. Urgent Care Center that will provide enhanced access to urgent care services for the CCTF and other facilities on the campus.

d. Advanced diagnostic testing that would allow increased access for the high risk population in the CCTF and for other LADOC facilities.

e. Dialysis Unit to provide onsite treatment for end stage renal failure

Recommendations

The following recommendations were formulated utilizing the data provided by the Los Angeles Sheriff Department, the Department of Mental Health, and the Department of Public Health, tours of Twin Towers Correctional Facility, Men's Central Jail, and Century Regional Correctional Facility including Intake Reception and Classification areas, Forensic Inpatient Psychiatric unit, High Observation Housing, Moderate Observation Housing, Correctional Treatment Center, and Medical Observation Specialty Housing, and interviews with correctional leadership and officers, clinical leadership, and physicians and nurse managers on the specialized housing and treatment units.

The recommendations concerning the actual beds required in the Consolidated Correctional Treatment Facility were developed with an understanding that the average daily census in the Los Angeles Department of Corrections is likely to increase over the next 10-20 years (see data graphs in Population

Projection section). Projections of estimated future jail populations are not reliable for more than 2-3 years out and the actual rate of increase or even decrease will be determined by Los Angeles County population changes, the economy, legislative and judicial reforms, diversion programs, and the capability and willingness of the community health care providers to accept referrals of individuals from the jail.

1. The Consolidated Correctional Treatment Facility will be a “treatment” facility.
2. The Consolidated Correctional Treatment Facility should house all mentally and medically ill individuals in the custody of the Los Angeles Sheriff’s Department who require higher levels of care, monitoring, treatment, therapy, and access to care that cannot be provided in General Population facilities or units.
3. The Consolidated Correctional Treatment Facility should house all individuals with impaired mobility who cannot safely and securely function in a General Population facility. A notable percentage of the housing units should be designed to achieve compliance with the Americans with Disabilities Act (ADA).
4. Between 240-260 licensed or licensable mental health crisis (Forensic Inpatient Psychiatry) and intensive care mental health beds are needed to meet the mental health needs of the male and female jail population.
5. Between 800-900 High Observation Housing beds are needed to continue a high level of mental health treatment for the male and female jail population who do not require intensive mental health treatment services.
6. Between 2,400-2,600 Moderate Observation Housing beds are needed to house and continue outpatient mental health treatment for the male and female jail populations. These beds will house individuals currently primarily housed in Moderate Observation Housing with the addition of select individuals currently housed in General Population on psychotropic medications.
7. Males and females whose mental health illness has been deemed sufficiently stable and whose risk of decompensation is sufficiently low as determined by mental health staff may be housed in General Population with ongoing mental health visits and treatment.
8. The total number estimated mental health beds in the Consolidated Correctional Treatment Facility will be approximately 3,640 to3,960. This estimate is essentially the current volume of patient-inmates with mental illness in the LASD. In addition to these beds, there will continue to be a number of stable patient-inmates with mental illness who have been clinically approved for housing in General Population housing.
9. The medical Correctional Treatment Center should be relocated into the Consolidated Correctional Treatment Facility. Between 160-180 Correctional Treatment Center beds are needed to provide the highest level of medical care to the male and female jail populations.
10. Approximately 600-700 Medical Observation Specialty Housing beds are needed to house male and females with acute and chronic medical conditions, mobility impairments, medical isolation, and complex medication or treatment regimens.

11. Approximately 200-220 Detoxification beds are needed to address the treatment and monitoring of new admissions at risk for withdrawal from alcohol, opiates, and benzodiazepines but who are asymptomatic or mildly symptomatic. This population will be cohorted in a dormitory setting to maximize observation of this high risk population.
12. Substance abuse treatment will be provided to individuals admitted to the Consolidated Correctional Treatment Facility for mental health or medical housing. There will be no beds designated solely for the treatment of substance abuse. However, substance abuse treatment should be available for all inmates with substance abuse and addictions throughout the LASD facilities.
13. New male and female Intake Reception and Classification Centers (IRC) should be incorporated into the Consolidated Correctional Treatment Facility. The screening, evaluation and classification performed at the time of admission is vital to delivery of health services in the LASD and early initiation of planning for transition of higher acuity individuals back into the community. IRCs with optimized flow and design should be located in close proximity to urgent care and high risk mental health and medical housing units.
14. The Urgent Care Center should be placed in the Consolidated Correctional Treatment Facility. The Urgent Care Center will have the scope of services and space to evaluate and treat the inmate population in the Consolidated Correctional Treatment Facility and in other facilities on the campus.
15. Specialty Consultation Services, a dialysis unit, and advanced diagnostic testing will be provided in the Consolidated Correctional Treatment Facility that will serve the facilities on the Downtown campus and referrals from other facilities.
16. There may be opportunity for cost savings if the mental health and medical, licensed and licensable Correctional Treatment Center beds are constructed in a single separate structure with ready access to IRC and the CCTF specialized mental health and medical housing.
17. The Consolidated Correctional Treatment Facility should be planned and designed to meet the current and immediate future medical and mental health needs of the LASD population yet have the flexibility in design and structure to allow modification if there are future significant changes in the volume of mentally and medically ill individuals admitted to the LASD.
18. The recommended number of beds in the CCTF is projected to address the immediate and near term needs of the LASD. These bed recommendations must be accompanied by a concomitant sustained effort by Los Angeles County to expand alternatives to incarceration and develop opportunities to provide services in the community for individuals who do not need to be incarcerated. (See comments and table below).

Projected Bed Distribution

The following table is a comparison of proposed bed distributions since 2013. While it is understood that projections are best kept to the short term for accuracy, for planning purposes it is useful to project into the future to plan for future growth. The projections developed for Section One of this report also projected growth for medical and mental health beds for the CCTF.

Table 12. Projected Bed Distribution

Beds	Vanir	AECOM CCTF	LASD 6/9/15 CCTF	2015 Current Need	2025 Projected Need
CCTF MOSH	500	512	512	600-700	916
CTC Medical				160-180	236
Detox				200-220	251
Total Medical Beds	**500**	**512**	**512**	**960-1100**	**1403****
CCTF FIP Licensed	60	60	60	60	96
CCTF MH Licensable	200	180	180	180-200	290
CCTF HOH SMC	600	576	864	800-900*	926
CCTF HOH DMC	200	192	0	0	308
CCTF MOH	2200	2208	2112	2400-2600	3550
Total MH Beds	**3260**	**3216**	**3216**	**3440-3760**	**5170**
CCTF SUD Level 1, 2	400	512	0	0	0
CCTF SUD Level 3	100	0	0	0	0
Total SUD Beds	**500**	**512**	**0**	**0**	**0**
Total Special Mgmt.	**600**	**600**	**200**	**200**	**200**
CCTF Capacity	**4860**	**4840**	**3928**	**4600-5060**	**6773**

**include all cells*

***Projected Need of 1152 + 251 Detox*

The projections to year 2025 found that there will be a need for 1155 medical beds about 5,132, mental health beds for a total projection of 6,487 beds. The additional medical detoxification and special management beds result in a projected need for 6,773 beds by the year 2025.

Table 13. Projected CCTF Bed Need 2025

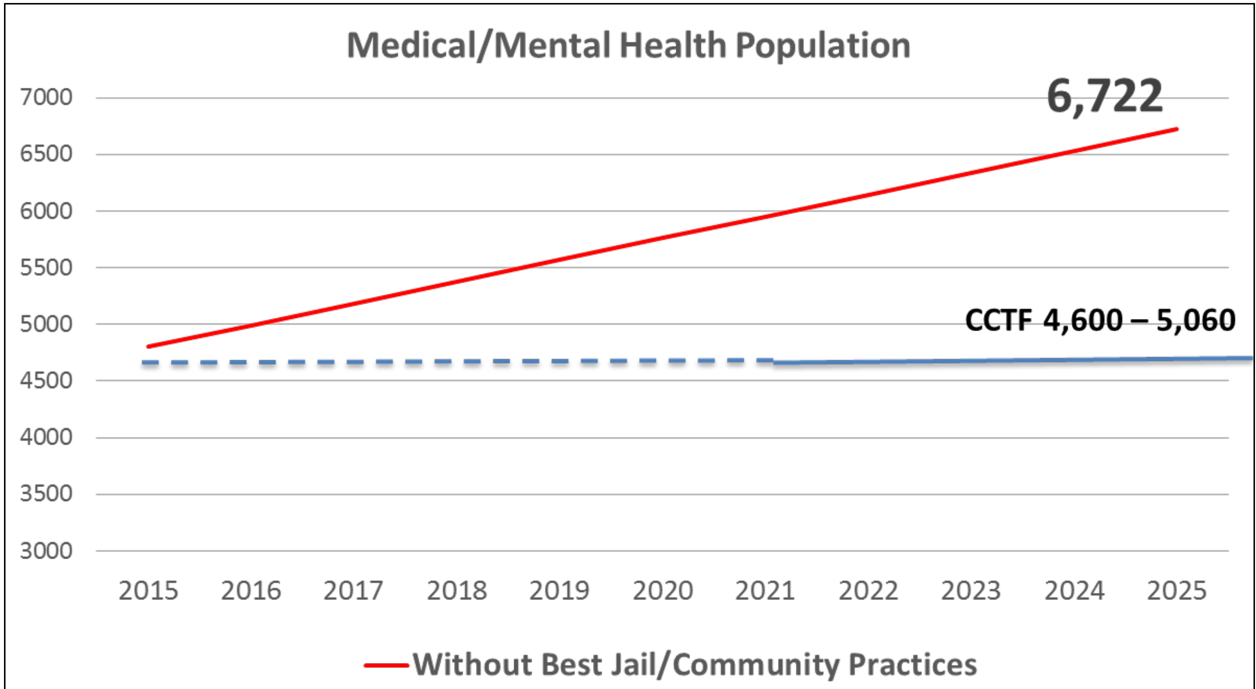
PROJECTED CCTF BED NEED 2025				
Beds	**Current Need**	**Projected Need**	**Scenario 1 Illustration**	**Scenario 2 Illustration**
CCTF MOSH	600 - 700	916	147	92
CTC Medical	160 - 180	236	35	24
Detox	200-220	250	38	25
MH in Medical Beds	**960-1100**	**1403**	**211**	140
CCTF FIP Licensed	60	96	0	0
CCTF MH Licensable	180 - 200	290	44	29
CCTF HOH	800 - 900	1234	185	123
CCTF MOH	2400 - 2600	3550	532	355
Total MH Beds	**3440 - 3760**	**5170**	**775**	507
Other (IRC,Disc, Transit)	0	0	0	0
High Security DC	**200**	**200**	0	0
Total per Security Level	**4600-5060**	**6772**	**986**	**647**
Glimpse into the Future if More Community Capacity Exists for Diversion at all Intercept Points in the CJ System				
3 Convergent Best Practice Opportunities Toward Jail Bed Need Reduction				
MH to GP greater stabilization of the population			300	300
Diverting more MI from of the jails in the beginning			300	450
Successful community reintegration/transition I/Ms who do not return to jail system			200	400
			1786	**1797**

The CCTF capacity bed need is the 2025 projected need unless there will be a robust concomitant development and implementation of best practices in the correctional facilities (correctional, medical, and mental health) and in the community. It is anticipated that by building robust capacity across the diversion and reentry continuum of health care in the community, the projected current bed need of 4600 – 5060 beds should meet the level of need for designated health care treatment beds at the CCTF. It is vital that the continuum of health care in the community and the jail employ best practices to ensure the health and well-being of the LA County communities.

As demonstrated in the above table, there are two illustrations of diversion opportunities that involve diversion from the jail at the front end, diversion from CCTF to General Population following stabilization, and diversion into the community either during incarceration or at the point of release. There are numerous more possibilities that need to be explored by LA County in order to build the robust community capacity that is needed individuals who are involved in the criminal justice system and those who have successfully avoided the criminal justice system through the clinical and housing supports within the community. If the community is unable to develop more capacity, 6722 beds will be

required at the CCTF to treat the increasing populations of inmates who require medical and mental health treatment while incarcerated.

Figure 23. Medical/Mental Health Population



Section IV. Community Capacity and Diversion

Scope and Focus of Community Capacity Assessment

The consulting team was engaged by LA County to provide an assessment of the existing and potential community capacity to serve the population targeted for the CCTF. This information would then inform final recommendations regarding the size and capacity needs of the new facility, as well as the potential need to allocate funds for expansion of community-based capacity to address some of these needs. Within the scope of this assessment was a broad inventory of existing community-based programs, services, and providers to offer context for the existing capacity and from which to estimate the potential for expansion of those programs and services if appropriate for the target population. The scope of this assessment was relevant services for the adult population in LA County. Therefore the information below is not intended to serve as a complete inventory of providers or services available through Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health, and the Department of Substance Abuse Prevention and Control (SAPC). Information gathered for this review and assessment was garnered from data provided by LA County staff and various stakeholders, an environmental scan of publically available information, and key informant interviews identified and recommended by County Supervisors and County staff. Due to the aggressive timeline identified to complete this scope of work, the information that follows provides a high level environmental scan and inventory of system services and general capacity. We specifically focus on the potential for existing or expanded community service system capacity to provide behavioral health and other medical services to medically fragile individuals.

Environmental Factors Potentially Impacting Community Capacity and the CCTF

Diversion Program Development including Sequential Intercept Mapping

Los Angeles County has committed significant time and resources to understand the potential benefits of diverting individuals, both pre and post arrest, from incarceration. It is important to understand these efforts due to the potential impact on where individuals needing behavioral health treatment would be served and the impact of these population shifts between the jail and community. Specifically, the creation or continued expansion of diversion programs and community based services could divert individuals now counted within CCTF bed needs. In addition, the acuity of illness of those who do not meet diversion criteria could remain high. That along with the seriousness of the crime (felony) would indicate a group of individuals not amenable to treatment outside a correctional setting due to security and public safety with beds in CCTF still needed to serve these individuals.

The Los Angeles County District Attorney's Office contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA.[7] As part of the assessment and planning process, approximately 100 participants attended a county-wide summit/kickoff meeting in May of 2014. PRA reported that there were 46 cross-systems partners from mental health, substance abuse treatment, health care, human services,

[7] Policy Research Associates, Inc. *Sequential Intercept Mapping Report – LA County, CA.* 2014

corrections, advocates, consumers, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts that participated in the Los Angeles County Sequential Intercept Mapping and priority planning on July 8, 2014. This cross-agency participation is essential to diversion program planning and implementation success. In their report, *Sequential Intercept Mapping Report – LA County, CA*, PRA summarized the recommendations which included formalizing a county wide planning body to address the needs of justice involved persons with co-occurring mental health and substance use disorders. This recommendation has been realized with the creation of the Countywide Criminal Justice Coordinating Committee (CCJCC). The report went on to recognize several on-going initiatives that currently address identified gaps or can increase access to care for justice involved individuals with behavioral health disorders. Rather than taking a heavy focus on the development of new initiatives and resources, PRA recommends an "adapt and expand" approach to the priorities and recommendations identified during the Sequential Intercept Mapping workshop. Because this expansion is not yet fully implemented, it is difficult to predict the impact. However expansion of diversion programs certainly has the potential to reduce the number of mental health beds at the CCTF over the longer term. In order to estimate this impact, a more detailed analysis of the potentially impact of the current jail population, through application of diversion program criteria and available program slots created, would be required.

New Medi-Cal Eligibility for Justice-Involved Population through the Affordable Care Act

Californian's expansion of Medi-Cal eligibility under the provisions of the Affordable Care Act extends eligibility to childless adults with incomes up to 138% of the Federal Poverty Level. Most low-income adult males were ineligible in the past. Many - if not most – incarcerated males and females are now eligible for Medi-Cal and therefore eligible for a full scope of mental health and substance use disorder (SUD) diagnostic and treatment services provided in the community.

CA 1115 Medi-Call Waiver Addressing SUD Treatment

On November 21, 2014, DHCS submitted a waiver amendment of CA's current 1115 Demonstration waiver to CMS to expand Medi-Cal's Substance Use Disorder (SUD) program, known as Drug Medi-Cal (DMC), to the entire Medi-Cal population. Through the Waiver renewal, California is seeking to cover an *expanded* range of drug and alcohol disorders for new and existing Medi-Cal enrollees. The pending waiver envisions an organized delivery system for SUD treatment and an expansion of medication-assisted treatment and residential care, among other treatment services. The waiver amendment will allow the State to extend the DMC Residential Treatment Service, as an integral aspect of the continuum of care, to additional beneficiaries. Historically, the Residential Treatment service was only available to pregnant/postpartum beneficiaries in facilities with a capacity of 16 or fewer beds. This waiver amendment will create a Residential Treatment service operable in facilities with no bed capacity limits. A series of incentive programs are also planned to strengthen partnerships and collaboration between Medi-Cal managed health care plans, county specialty mental health plans, substance use disorder treatment services, and contracted providers. While this expansion of access to SUD treatment is still pending approval by CMS and will require significant time to implement, it stands to provide more community capacity for services and, if utilized, the potential to divert individuals from incarceration.

Scrutiny from the Department of Justice

The Civil Rights Division of the Department of Justice, created in 1957 by the enactment of the Civil Rights Act of 1957, is charged to ensure that the civil and constitutional rights of all American citizens, particularly some of the most vulnerable populations, are upheld. The Division enforces federal statutes prohibiting discrimination on the basis of race, color, sex, disability, religion, familial status and national origin. Since its establishment, the Division has grown dramatically in both size and scope. The Special Litigation Section works to protect the rights of people who are in prisons and jails run by state or local governments and is currently active in more than half of the states, including California. The Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a, allows the Attorney General to review conditions and practices within these institutions. As part of a CRIPA investigation, the DOJ can act if a systemic pattern or practice that causes harm is identified. In these cases the DOJ works with state or local agencies to fix the identified problems. In some cases the Attorney General may file a lawsuit in federal court. Los Angeles County has had previous contact with the DOJ specific to mental health treatment within the jail. Existing or previous recommendations or agreements must be considered when designing and finalizing facility, staffing, and programming for the CTCF.

Overview of Community-Based Systems of Care

Program descriptions were taken from publically available documents and information provided by the Department of Public Health-Substance Abuse Prevention and Control and the Department of Health Service's Department of Mental Health. This overview is not intended to be a complete listing of programs and services in the county, but instead provides summaries of existing services that may currently provide or develop capacity to serve the target population in this report, i.e. adults currently within the LA County Jail and targeted for services in the proposed CTCF.

Department of Mental Health

The Los Angeles County Department of Mental Health is the largest county-operated mental health department in the United States, directly operating programs in more than 85 sites, and providing services via contract program and DMH staff at approximately 300 sites co-located with other County departments, schools, courts and other organizations. Each year, the County contracts with more than 1,000 organizations and individual practitioners to provide a variety of mental health-related services to provide services for eligible individuals across the lifespan. What follows is an overview of programs that may be leveraged to expand community capacity to serve court and jail connected individuals. This is not meant to be an exhaustive list

Emergency Outreach Bureau - Field Response Operations

ACCESS Psychiatric Mobile Response Team: ACCESS operates 24 hours/day, 7 days/week as the entry point for mental health services in Los Angeles County. Services include deployment of crisis evaluation teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport.

Alternative Crisis Services: Alternate Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration

and linkage to community-based programs, e.g. Full Service Partnerships (FSP) and Assertive Community Treatment Programs (ACT), housing alternatives and treatment for co-occurring substance abuse. ACS programs include:

1. **Urgent Care Centers (UCC)/Crisis Resolution Services (CRS):** UCCs are geographically located throughout the County. They provide intensive crisis services to individuals who otherwise would be brought to emergency rooms, including up to 23 hours of immediate care and linkage to community-based solutions; provide crisis intervention services, including integrated services for co-occurring substance abuse disorders, focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment. UCC/CRS do not currently serve individuals with a primary substance use disorder.
2. **Countywide Resource Management:** Provide overall administrative, clinical, integrative, and fiscal management functions for the Department's indigent acute inpatient, long-term institutional, and crisis, intensive, and supportive residential resources, with a daily capacity for approximately 2000 persons; provide coordination, linkage, and integration of inpatient and residential services throughout the system to reduce rates of re-hospitalization, incarceration, and the need for long-term institutional care, while increasing the potential for community living and recovery. The office also assumed responsibility for placement of individuals served under AB109 funding. The office has approximately 300 slots for community-based treatment through the Full Service Partnerships and 60 beds allocated in Institutions for Mental Disease (IMD).
3. **Residential and Bridging Services:** DMH program liaisons and peer advocates provide assistance in the coordination of psychiatric services and supports for individuals being discharged from County Hospital Psychiatric Emergency Services, UCCs, IMDs, and crisis residential, supportive residential, substance abuse, and other specialized programs. This step-down program supports successfully reintegration in the community upon discharge, encouraging collaboration amongst all of an individual's providers. Mental Health Peer Advocates facilitate self-help and substance abuse groups in IMD and IMD Step-Down Programs. In addition, Advocates provide education and information about recovery and wellness to clients, families, and providers.
4. **Supportive Residential Programs (Enriched Residential and IMD Step-Down):** These residential programs provide supportive on-site mental health services at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing, or other independent living situations. These settings are primarily focused on serving persons being discharged from IMDs, acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care. In addition, the program targets individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living. The services are designed to break the cycle of costly emergency and inpatient care and promote successful community reintegration.

Assisted Outpatient Treatment for Los Angeles (AOT-LA): Assisted Outpatient Treatment, also known as Laura's Law, was initiated following the 2001 killing of Laura Wilcox by an individual suffering from severe mental illness. Allows LAC DMH to serve seriously mentally ill persons at substantial risk of deterioration and/or detention under WIC5150 as a direct result from poor psychiatric treatment compliance. AOT eligible individuals are outreached in an effort to voluntarily engage them in Full Service Partnership (FSP) services. If individuals in the program refuse services, AOT-LA may petition the court to order the individual into psychiatric outpatient treatment, namely FSP. Eligibility criteria for AOT services in LA County includes:

- 18 years of age or older
- Seriously mentally ill
- Unlikely to survive safely in the community without supervision
- Have a history of non-compliance with treatment that has either
- Two or more hospitalizations or incarcerations within the last 36 months; or
- Within the last 48 months, one or more acts and/or attempts to cause serious physical harm to self and/or others
- Is substantially deteriorating
- Likely to result in grave disability or serious harm to self or others without treatment
- Has failed to engage in available treatment
- Likely to benefit from AOT LA which is the least restrictive placement necessary to ensure the person's recovery and stability.

Services include extensive outreach and engagement for a minimum of 30 days, screening and assessment, linkage to Full Service Partnership providers, and participation in court hearings and follow-up on court mandates.[8]

Law Enforcement Teams: This co-response model pairs a DMH clinician with a law enforcement officer to provide field response to situations involving mentally ill, violent or high risk individuals. Primary mission is to provide 911 response to community requests or patrol officer requests for services. Teams also assist PMRT as resources permit. Current programs:

- Santa Monica Police Department Homeless Liaison Program (HLP)
- Burbank Police Department Mental Health Evaluation Team (BMHET)
- Los Angeles County Sheriff's Department Mental Evaluation Team (MET)
- Long Beach Police Department Mental Evaluation Team (Long Beach MET)
- Los Angeles County Metropolitan Transit Authority Crisis Response Unit (CRU)
- Pasadena Police Department Homeless Outreach Psychiatric Evaluations (HOPE)
- Los Angeles Police Department System-wide Mental Assessment Response Team (SMART)

School Threat Assessment and Response Team (START): START provides training, early screening and identification, assessment, intervention, case management and monitoring services in collaboration

[8] Information from AOT-LA Power Point presentation accessed 7/9/2015. http://file.lacounty.gov/dmh/cms1_227734.pdf

with school districts, colleges, universities and technical school, and in partnership with local and federal law enforcement agencies. The program's services are designed to prevent targeted school violence.

Homeless Outreach Mobile Engagement (HOME): HOME provides countywide field-based outreach and engagement services to homeless persons and the mentally ill who live in encampments or other locations where outreach is not provided in a concentrated manner.

Case Assessment and Management Program (CAMP): CAMP collaborates with the Los Angeles Police Department (LAPD) in addressing persons of concern including 911 high utilizers, chronic callers to public figures and, suicide-by-cop issues.

Specialized Prevention Unit (SPU): SPU collaborates with law enforcement agencies and private security firms regarding persons of concern and provides consultation focusing on violence threat risk assessment.

Mental Health Alert Team (MHAT): MHAT provides the mental health response to local and federal law enforcement agencies in facilitating a negotiated solution to barricade and hostage situations.

Homeless Outreach Teams: Homeless Outreach Teams (HOT) are comprised of Psychiatric Mobile Response Teams (PMRT) staff that provide outreach, engagement, and field response to homeless persons with mental illness. HOT targets services to individuals that are at risk of involuntary hospitalization.

Psychiatric Mobile Response Teams: Psychiatric Mobile Response Teams consists of DMH licensed clinical staff assigned to a specific Service Area in Los Angeles County. Teams have legal authority per Welfare and Institutions Code 5150 and 5585 to initiate applications for evaluation of involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder.

Service Area Navigators: The DMH Stakeholder group unanimously supported the creation of Service Area Navigator Teams that would, across age groups, assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Specific Navigation tasks include:

- Engaging with people and families to quickly identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity if those seeking them;
- Recruiting community-based organizations and professional service providers to become part of an active locally-based support network for people in the Service Area, including those most challenged by mental health issues; and
- Following-up with people with whom they have engaged to ensure that they have received the help they need.

Navigators are using information technology and other means to map and keep up to date about the current availability of services and supports in their Service Area and engage in joint planning efforts

with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to clients in the mental health system.

Adult System of Care (ASOC)

Los Angeles County Department of Mental Health provides an array of mental health and supportive services for clients, between the ages of 26 and 59, who live with serious mental illness and co-occurring substance use disorders. Mental health services are available through a reported equal combination of directly operated by the county and contract agencies throughout the County. Contracted services provided in these agencies include assessment, therapy, medication, case management, crisis intervention, and other supportive services related to housing, prevocational and employment. These services are consistent with a recovery model of care intended to reduce psychiatric symptoms, increase independent living.

As a result of Mental Health Services Act (MHSA), additional services were made available to the existing continuum of care. Current Adult MHSA programs include Prevention and Early Intervention (PEI) services, intensive services such as Full Service Partnerships (FSP) and Field Capable Clinical Services (FCCS), recovery focused Wellness Centers, Path and Client Run Services that are designed to support clients who are in later stages of recovery. Through MHSA, ASOC also provides specialty services to our Veterans through the Veterans and Loved Ones Recovery (VALOR) program. Finally, ASOC provides specialty mental health services to families and individuals returning to work through the Cal Works and GROW programs

Substance Abuse Prevention and Control (SAPC)

The Substance Abuse Prevention and Control (SAPC) program leads and facilitates the delivery of a full spectrum of prevention, treatment, and recovery support services proven to reduce the impact of substance use, abuse, and addiction in Los Angeles County. Services are provided through contracts with over 150 community-based organizations to County residents, particularly the uninsured and/or underinsured. SAPC staff serve as technical experts and consultants to meet the needs of the public and contracted organizations in the field of alcohol and other drug (AOD) use and abuse.

AB109 Responsibilities

The local Community Corrections Partnership (CCP) recommendations to the Board of Supervisors that individuals under post-release community supervision (PCS) utilize the Department of Public Health – Substance Abuse Prevention and Control (DPH-SAPC) to assist in accessing substance use disorder (SUD) treatment services. The role of the DPH-SAPC is to provide the programmatic oversight and funding for residential, outpatient counseling, and alcohol and drug-free-living centers services to be made available to post-release persons (PSP) released under AB 109. Once the PSP is released from state prison they must report to a designated county Probation HUB for a risk assessment that includes a behavioral screening for SUD, mental health, or co-occurring disorders. If an AB 109 PSP is determined to need SUD only treatment services, he/she will be referred to a designated Community Assessment Services Center for full clinical assessment and connected with appropriate treatment, with a certified and/or licensed AB 109 Post-Release Community Supervision Treatment Program.

Community Assessment Service Centers (CASC)

The Community Assessment Service Centers (CASC) system is composed of eight lead contracted community-based organizations located throughout the County's eight Service Planning Areas (SPA). There are currently 19 Service Center sites located throughout Los Angeles County. Each of the service centers acts as the entry point for any County residents seeking alcohol and other drug treatment and recovery services. The CASC work closely with a network of Substance Abuse Prevention and Control contracted alcohol and other drug treatment agencies, mental health providers, domestic violence agencies, and other community-based organizations providing information and referrals on a wide variety of supportive services. Ancillary service referrals may include: literacy training, temporary housing, and referrals to food banks, health care clinics, mental health, and other needed services.

The CASCs currently provide services to the public, along with categorically funded clients such as General Relief and CalWORKs recipients for the Department of Public Social Services, the Department of Family and Children Services, and to criminal justice clients funded through the Substance Abuse and Crime Prevention Act of 2000 (Offender Treatment Program/Proposition 36). The CASC only refer to County contracted treatment agencies. Each CASC site *provides:*

- Screening, clinical assessment, and referral services for the general public and persons referred to treatment by various programs or agencies.
- Receiving and managing calls from the Los Angeles County 1-800 toll-free alcohol and other drug referral line (1-800-564-6600).
- Face-to-face comprehensive clinical alcohol and other drug assessments, employing a computerized/automated assessment instrument utilizing the Addiction Severity Index.
- Assessing participant's eligibility for specifically funded County contracted alcohol and other drug programs.
- Ancillary service referrals which include, but are not limited to, vocational rehabilitation, education, transportation, other public social services, housing, health, legal, and mental health services.
- An HIV/AIDS Specialist on site who interfaces with persons needing specialized services and assists in providing the bridge to treatment for needle exchange participants.
- The provision of limited medical screenings for infectious disease, at some sites.
- The coordination and scheduling of on-site provider orientations to participants at Department of Public Social Services (DPSS) GAIN Regional Offices, located within the CASC SPA.

Court Related Programs

Co-Occurring Disorders Court Program: The Co-Occurring Disorders Court (CODC) is a pilot court program created to supervise criminal defendants diagnosed with both a mental illness and a substance abuse disorder. The project involves an 18-month program that integrates mental health and substance abuse treatment services. The Los Angeles County CODC program was implemented in 2007 and is funded by the County of Los Angeles Homeless Prevention Initiative and Mental Health Services Act. In 2008, SAPC received an enhancement grant for the CODC program from the federal Substance Abuse

and Mental Health Services Administration that provides CODC clients with short-term residential services at the Antelope Valley Rehabilitation Center in Acton.

Family Dependency Drug Court Program: The Dependency Drug Court Program is a collaboration between the Los Angeles County Board of Supervisors, Superior Court, DCFS, County Counsel, SAPC, and attorneys for both parents and children. The program addresses the needs of substance abusing parents while efforts are being made to support family reunification. The program requires a minimum of twelve months of treatment and aims to 1) decrease time to reunification, 2) reduce the number of substantiated allegations of abuse or neglect following reunification, 3) lower the rate of subsequent removal after reunification, and 4) track re-entry rates and the time that elapses before the termination of parent rights.

Drug Court Program and Probation Department: The Los Angeles County Board of Supervisors, Superior Court, District Attorney, Public Defender, Sheriff, Probation Department, and SAPC worked together to develop a probation program for drug-using offenders. While on probation and subject to the rules of the Probation Department, drug-using offenders participate in intensive judicial supervision, case management, mandatory substance abuse treatment, drug testing, graduated sanctions, and rewards. Upon successful completion of the program, offenders' guilty pleas are vacated and their cases dismissed. There are 12 Adult Drug Courts located throughout Los Angeles County, each of which is headed by a judge or commissioner, with an assigned community-based treatment provider that works closely with the entire drug court team. Each drug court features strong collaboration among the judicial officer, prosecution, defense counsel, law enforcement, probation and a community-based treatment provider.

Parolee Services Network: The Parolee Services Network (PSN) program, a collaborative between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Alcohol and Drug Programs (ADP), provides community-based alcohol and drug abuse treatment for eligible parolees in 17 counties statewide. The purpose of the PSN project is to provide prison parolees with a full array of treatment and recovery services to promote long-term sobriety, support community reentry, and reduce criminal recidivism. Funded by the CDCR, the Los Angeles County PSN project was implemented in 1991. SAPC oversees local community treatment providers that provide PSN services throughout the County.

Sentenced Offender Drug Court (SODC) Program: SODC, initiated in August 1998 under the leadership of Judge Michael Tynan is an intensive program for convicted, non-violent felony offenders who face state prison due to their criminal records and history of drug addiction. These higher risk offenders have medium to high levels of drug addiction and are offered the SODC program with formal probation as an alternative to state prison. SODC integrates in-custody and post-release treatment components.

Substance Abuse Offender Treatment Program (previously known as Proposition 36): Proposition 36, also known as the Substance Abuse and Crime Prevention Act (SACPA), is an initiative measure passed by California voters on November 7, 2000, which made significant changes in California's judicial processes and substance abuse treatment systems for handling certain non-violent drug offenders. The program was implemented July 1, 2001, and requires probation and drug treatment (instead of incarceration) for probationers and parolees with drug-related probation or parole violations and for

persons convicted of possession, use, transportation for personal use, or being under the influence of a controlled substance; applies to non-violent drug possession/use offenses by individuals with no prior violent felony convictions only; and provides up to six months of community-based substance abuse treatment for eligible participants.

In FY 2009-10, funding for Proposition 36 under SACPA was eliminated, but the mandate for the provision of Proposition 36 drug treatment services continues indefinitely. Instead of funding the Proposition 36 program, the State Legislature approved $18 million under the Offender Treatment Program and a one-time allocation of $45 million under the Recovery Act Justice Assistance Grant – Substance Abuse Offender Treatment Program, authorized by the American Recovery Act and Reinvestment Act of 2009, for a total statewide allocation of $63 million for FY 2009-10.

Second Chance Women's Re-entry Court Program: The Los Angeles County Board of Supervisors, Superior Court, Sheriff, District Attorney, Public Defender, Probation Department, Countywide Criminal Justice Coordination Committee, UCLA Integrated Substance Abuse Programs, and SAPC joined together to establish the Second Chance Women's Re-Entry Court Program to provide services for 25 female offenders who are legal residents of Los Angeles County and are 1) paroled from a CDCR institution under jurisdiction of the Los Angeles Superior Court and facing a new, non-violent, non-serious felony charge; 2) concurrently on parole and probation; or 3) on felony probation with a high risk of being sentenced to State prison. Eligible clients are required to complete a treatment plan with incentives and sanctions that includes stabilization, orientation, assessment, intensive treatment, transition, and enhancement services.

General Relief - Mandatory Substance Use Disorder Recovery Program

On June 3, 1997, the Los Angeles County Board of Supervisors adopted an ordinance requiring adult (18 and older) General Relief (GR) applicants/participants to undergo screening for Substance Use Disorder (SUD), if there is reasonable suspicion that the individual may have an alcohol or other drug (AOD) problem. The Board further required that anyone screened, professionally evaluated, and determined to be in need of treatment services must participate in a program as a condition of receiving GR. Based on the Board's action, the DPSS and the Department of *SAPC* developed the Mandatory Substance Abuse Recovery Program (MSARP) designed to assist GR applicants/participants with SUD problems recover from their chemical dependency. MSARP was implemented on November 1, 1997.

Office of Prevention and Youth Treatment

The Office of Prevention and Youth Treatment Programs and Policy is responsible for program planning, development, implementation, and evaluation for Substance Abuse Prevention and Control's contracted substance abuse prevention and select youth services contracts. SAPC's Prevention System of Services is comprised of a network of community-based organizations implementing evidence-based community- and individual-level services to address SAPC's Goals and Objectives. Prevention contractors determine which of the County's Goals and Objectives are of greatest priority in their target city and/or communities based on data gathered during a local needs assessment and by implementing the Strategic Prevention Framework (SPF) Steps: Assessment, Capacity, Planning, Implementation, and Evaluation. The Prevention System of Services includes eight Environmental Prevention Services (EPS)

contracts, 34 Comprehensive Prevention Services (CPS) contracts, and one Friday Night Live (FNL) contract (youth program).

The Parolee Services Network program

The Parolee Services Network (PSN) program, a collaborative between the California Department of Corrections and Rehabilitation (CDCR) and the California Department of Alcohol and Drug Programs (ADP), provides community-based alcohol and drug abuse treatment for eligible parolees in 17 counties statewide. The purpose of the PSN project is to provide prison parolees with a full array of treatment and recovery services to promote long-term sobriety, support community reentry, and reduce criminal recidivism. Funded by the CDCR, the Los Angeles County PSN project was implemented in 1991. SAPC oversees local community treatment providers that provide PSN services throughout the County.

Substance Use Disorder Outpatient and Residential Treatment

The Antelope Valley Rehabilitation Centers (AVRCs) residential program, located on 135 acres in the mountain setting of the Acton Rehabilitation Center, provides services to adult men and women. Acton Rehabilitation Center can accommodate over 300 individuals in care. High Desert Recovery Services (HDRS), the outpatient branch of the AVRC, located in Lancaster, provides county operated low-cost, comprehensive, adult outpatient substance use disorder treatment program. Substance use disorder (SUD) outpatient and residential programs provide treatment services that include mental health and physical health assessment, treatment and referral; gender separate and specific residential treatment programs and facilities with trauma-informed treatment for women and men; medication assisted treatment (MAT); evidence based practice educational curriculum; individual and group counseling; discharge coordination and continuum of care planning; wellness programs within residential programs, including smoking cessation program, 12-step recovery groups and recreational activities.

Effort Toward a Capacity Analysis

Methodology

We interviewed key informants from several community agencies (33 interviews completed) to provide information on service capacity and service lines. The list of agencies participating in key informant interviews is contained in Appendix A. The interviews were conducted either in person or by phone to meet the availability of the interviewee. Tables including both qualitative and quantitative information on community mental health services provided is detailed in Appendix B. In addition, data was obtained from the Los Angeles County Departments of Mental and Public Health/Substance Abuse Prevention and Control; this includes information linked to contractual obligations and measurable outcomes for a subset of the contracted agencies.

Limitations

There are several limitations in our ability to quantify current community-based mental health capacity. A comprehensive capacity analysis is not possible with the data we were able to obtain and in the timeframe provided for the study. The interview findings and the data obtained are broad indicators of capacity but should not be understood to comprehensively capture the true potential capacity for the community system of care for the justice involved population. Other challenges to conducting a

capacity analysis include patient utilization of multiple service providers, and a lack of structured communication between agencies that would identify these patterns of utilization. Agencies rely primarily on self-report by the patient.

Service Capacity for High Acuity Mental Health and SUD Needs

Data from the DMH Countywide Resource Management Office indicate bed capacity by levels of care for Los Angeles County. These community inpatient and high acuity beds with skilled nursing care do not meet the current need. As indicated in the table below, these beds are limited and there are waiting lists.

Table 14. Intensive Mental Health Service Capacity in LA County

Facility Type	Bed capacity June 2015	Patient Waiting List July 2015	Average Length of Stay
State Hospitals High Acuity Beds	248	13	4.5 Years
Institution of Mental Disease (IMD) Facilities and Sub-Acute Facilities	1074	205	1.6 Years
IMD Step Down Programs	613	65	10 Months
Crisis Residential Facilities	34	0	30 Days
Acute Adult/Older Adult Inpatient and Psychiatric Health Facilities	2096	Unavailable	Unavailable

Source: DMH Countywide Resource Management Office

While plans are currently underway for construction of at least 3 new Psychiatric Urgent Care Centers in LA County; they would only provide an additional 54 beds which is insufficient to meet the demand. Other factors which directly impact the number of available inpatient high acuity mental health beds include:

- Individuals deemed gravely disabled must complete the Conservatorship paperwork process which can take several weeks.
- State Hospital census numbers are growing due to increasing numbers of individuals incompetent to stand trial on felony charges. State hospitals are charged with serving violent individuals and are now experiencing high census numbers and rising levels of violence that are increasingly difficult to manage. Their high census causes back-ups in sub-acute and Institution for Mental Diseases (IMD) beds.
- IMD housing priority goes to jail and county hospital needs. This is an important priority but serves to reduce access to necessary IMD services for community residents. Also, overcrowded jail conditions and back-ups in IMD access leads to some jailed individuals transferred to the county hospital where they then enter the DMH system.
- Outlying counties compete with Los Angeles County for available beds.

Service Capacity for Outpatient Mental Health and Substance Abuse Providers

Full Service Partnership Services

The 2004 Mental Health Services Act established county-based Full Service Partnerships to serve those with the most serious needs. Adult Full Service Partnership (FSP) programs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive service program. The foundation of Full Service Partnerships is doing “whatever it takes” to help individuals on their path to recovery and wellness. Full Service Partnerships embrace client driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers.

Adult FSP programs also assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have a co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community and other locations. Peer and caregiver support groups are available. Embedded in Full Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically competent and appropriate. Adult Full Service Partnership programs in Los Angeles County will provide services to 2,611 individuals this fiscal year.

Array of Services and Staffing Offered

The majority of agencies interviewed serve adult justice involved men and women with both serious mental illness and SUD and significant needs for social services including housing. A lengthy list of services are offered and outlined below. Of the 33 agencies interviewed, the following percent of those agencies offer the service listed. For example, 43 percent of the agencies identified that provide mental health services, provide inpatient services. For mental health disorders, agencies identified provide the following services:

- Inpatient (43%)
- Intensive Community Support (90%)
- Outpatient MH (90%)
- Counseling (90%)
- Medication Management (71%)
- Crisis Intervention (90%)
- Group Therapy (81%)
- Support Groups (81%)
- Day Treatment (48%)
- Case Management (90%)
- Supported Housing (100%)
- Employment Support (85%)
- Onsite Primary Care Services (46%)

For substance use disorders, agencies identified provide the following services:

- Intensive Outpatient (64%)
- Outpatient (84%)

- Case Management (92%)
- Detoxification (24%)
- Medication Assisted Treatment (52%)
- Residential Recovery (88%)
- 12 Step Programs (96%)
- Harm Reduction (80%)
- Group Therapy (88%)
- Other SUD Treatments (52%)
- Abstinence Only Treatment (36%)
- Housing Case Management (88%)
- Employment Case Management (85%)
- Diversion Programs (69%)
- Court Funded Services (69%)
- Special Population Focus Programs (e.g. women's recovery groups or rehabilitation housing)

Table 15 indicates that individuals either directly referred from jail or those living in the community with a history of incarcerations in the previous six months represent 15% of the total FSP treatment slots in the County. To some degree, the system requires some empty beds at all times to maintain efficiency in responding to priority bed need crises.

Table 15. Full Service Partnership Program Statistics June 2015

Service Area	Total Slots	Authorized Slots	Available Slots	% Target Met	Jail Referrals
1	155	166	-11	107.1	13
2	586	487	99	83.1	92
3	503	439	64	87.3	99
4	608	550	58	90.5	89
5	232	211	21	90.9	47
6	735	693	42	94.3	123
7	390	343	47	87.9	63
8	1069	939	130	87.8	110
C	207	157	50	75.8	58
Total	4485	985	500	88.9	694

Capacity of Substance Use Disorder Services

The Substance Abuse Prevention and Control Division of the Department of Public Health furnished the following data regarding substance abuse treatment services. A total of 129 AB109 beds have been funded for 2015-2016, with the twelve selected clinical delivery agencies distributed around Los Angeles County. (These twelve were selected from among 31 agencies who submitted proposals for the AB109 Work Order Solicitation)

The 129 bed total is an increase of 23 treatment slots over the 106 beds that were funded for FY 2013-2014. That year saw 3317 referrals to Community Assessment Service Centers (CASCs) and 1,585 admission episodes. The increase in bed availability this year, however, does not sufficiently address the

approximately 1,661 AB109 clients not being served (or 50% of the approximately 7669 AB109 substance use disorder referrals).

It is worth noting that homeless rates decreased, emergency room visits decreased and employment rates increased from admission to discharge from treatment for the AB109 population. Additionally, 2014 data showed that AB109 clients who were positively compliant with their substance use disorder treatment had a 44% new arrest rate, while 58% of those who were negatively compliant were newly arrested.

Table 16. County of Los Angeles Department of Public Health Substance Abuse and Control AB109 Treatment Data 2014-2015

	Number of Cases	% At Admission	% At Discharge
Employment	589	23.7	31.1
Homelessness	1,385	32.4	23.4
Emergency Room Visits	1,385	5.3	3.2
Physical Health Problems	1,385	9.4	5.5

Capacity for Clinical Services

This sample of interviewed agencies reported a total of 81,117 unduplicated clients seen in the past year, of which 36% (29,202) were estimated to have a criminal history. Interviewees observed how justice-involved individuals often have co-occurring SUD and mental illness, and at any point in time either or both may be mild, moderate, or severe and chronic or acute. Their criminal histories and other complex social factors present additional treatment challenges. A number of agencies quoted statistics about shorter lifespan for homeless and mentally ill populations, and agency intentions to access health, oral health, pharmacy, and recreational services for their clients as much as possible.

Managing Client Complexity

Co-occurring SUD and SMI are common within the patient-inmate population of the jail creating a more complex clinical picture for management when these individuals are moved in to the community for care. Interviewed agencies were asked about their ability to manage complex clients, on a scale of 1 – 5, with 1 being the least complex and 5 being the most, the average agency response was 4.8. This indicates high tolerance in the community for the complex co-occurring conditions and social and economic challenges posed by this population. Common themes arising in the interview discussions around their challenges included the high emotional demands of this challenging population and a commitment to providing treatment excellence and housing services to this very vulnerable justice involved population.

Security Concerns

The majority of surveyed agencies (75%) expressed minimal to no security concerns in taking care of this challenging population, often highlighting their answers with comments such as, “We offer a respectful environment and have only had one or two incidents in 25 years.” Another, though, reported “Security is a top priority issue, and we count knives after meals.” Agencies with security concerns often worried more about the dangerous neighborhood where they were located than about threats from clients. A common complaint from smaller agencies is that costs for hiring security personnel are not typically

reimbursed as part of any of their contracts, placing undue financial pressure and forcing difficult choices about safety priorities. One interviewee stated "the AB109 clients are "more sick" with increasing violent outbursts in the contracted treatment agencies. It is time to step back and rethink our treatment orientation for this population."

Additional Findings

Agencies that are not sufficiently resourced to provide any number of these services reported attempting to make referrals to other resources. Many agencies provide services for which they are not reimbursed in response to patient needs, such as hiring a therapist to work with psychological issues in the SUD population. Many are on constant lookout for new funding opportunities to move toward whole-person integrated care. Regularly the response to the apparently straightforward question of 'what clinical services do you provide' was met with a reply that service provision depends on the current stream of services funding, grants and/or donations, which may be in flux. For these agencies, changes in funding impacts staff hiring which impacts patient care priorities. In general terms, community-based agencies provide the services they are funded for and their funding comes from a variety of sources and changes regularly. Day-to-day management in this fluid environment poses enormous administrative challenges and contributes to frequent staff turn-over and burnout. All the interviewed agencies expressed strong interest in expanding capacity if resources were consistently available.

Nearly all agencies interviewed serve both men and women, though few provide gender-specific services. While some agencies readily accept clients with serious crimes, sexual and violent histories and electronic monitoring, a number of programs situated near schools are restricted from accepting clients who have committed sexual crimes. Several programs also reported refusing services to individuals with arson histories. Client Referrals come from more than 20 different sources which are listed in Appendix A. (Interviewed Agencies Client Information). All agencies interviewed reported working with law enforcement agencies and/or courts.

Agencies reported some additional resource challenges that seemed to be more difficult for smaller agencies that did not have the economies of scale that some of their larger sister agencies benefit from. Opportunity for system support of some of these practices would add the additional benefit of standardizing approach and decreasing variability in practices with contracted providers. Several of these challenges are listed below.

- Physical plant needs and repairs
- Staffing changes related to volume instability. Agencies would like to increases staff and hire back staff that have been laid off
- Expenses for staff training and the implementation of evidence-based interventions such as "Seeking Safety" for trauma and addiction
- Costs of layering services such as licensed therapists to work with psychological issues in the SUD population. Many are on constant lookout for new funding opportunities to move toward whole-person integrated care.

- Workforce development including cross training staff of skills and abilities for both mental health and addictions
- Practice transformation costs: Move toward a whole person integrated care model including physical health, nursing, and oral health care.
- Increase programs for diverse and special populations such as young adults, women and GLBT persons
- Need for books, classes, and computer resources for to assist clients with education and job placement.

Some agencies would like to increase their own housing capacity; all see accessible and affordable housing in the community as a foundational element of treatment success and recovery.

A number of key interviewees spoke of enhancing in-reach programs that accelerate treatment interventions and bridges to post-release treatment communities. In reach allows community partners to begin engagement with the client prior to their release. Creating this early connection with the client assists in improving their overall engagement in the programming and facilitates a smoother transition back into the community.

Some agencies would like to expand ongoing and successful diversion projects, such as the innovative Custody to Community Transitional Residential Program in cooperation with the Department of Corrections. Others noted that in considering expansion, they would like to change current contracts that keep empty beds or patent slots empty by holding them in reserve for a referral source/payor.

Finally, agencies noted the need for funding to improve data collection, electronic health records, monthly report preparation, and grant development as integral to increasing capacity.

Applying Findings to Bed Projections

The study of community capacity for mental health and SUD services aligns with the consulting team's assessment of CCTF beds. LA County clearly lacks the capacity to serve more jail clients with high-acuity mental health services such as state hospital forensic care and IMD services. Access to substance use disorder services is acutely limited. A continuum of care is impeded by a fragmented system of substance use programming, mental health services, social services/case management and housing. Recruitment and retention of practitioners and clinicians with specialized training to effectively work with the justice involved population is also severely limited.

Community detox beds are at a high premium, as are agencies that provide an array of coordinated services along the continuum of care. As noted above, the majority of agencies interviewed articulated their optimism that as funding becomes available, so will more community based agencies and program offerings.

It appears that the jail could and should make use of additional Full Service Partnership slots, but even if the jail used all 500 slots open today, and if the expected 54 new psychiatric Urgent Care slots were to open tomorrow, there are more detainees in HOH and waiting for HOH than the community capacity

can accommodate. The proposed HOH and MOH beds in the CCTF remain advisable. Should community capacity grow, HOH and MOH beds can readily and inexpensively be converted for other purposes.

Detainees who could currently be appropriate for community mental health and/or SUD services cannot be sufficiently served by the existing community treatment network, because the current network is sized to serve the population currently funded and is insufficient for the actual need in the community. A concerted effort to "grow" the desired community capacity is a wise investment but will take time and will require some new community services tailored to the justice involved population. More AB109 SUD providers need to be established, more capacity in the community to apply evidence-based SUD treatment that addresses behavior needs to be developed, and community agencies need to grow and stabilize under consistent funding in order to reliably serve as an alternative to the jail.

LA County Report: Conclusions and Recommendations

Conclusions

The CCTF should be considered within the context of a full continuum of health care delivery of services to the disenfranchised population of LA County and in particular your most vulnerable populations who are mentally ill, physically ill, substance abusing and in many cases homeless.

The County and the Sheriff's Department need a facility that consolidates all higher level health care services within a best practice environment. The mission of the CCTF will provide skilled nursing care, more intensive health care monitoring and observation of patient-inmates' mental and/or medical health conditions. The CCTF will provide enhanced access to specialized mental health and medical care in a facility that is staffed with the appropriate number of medical and mental health professionals. It will also increase the concentration of high cost and complex patient care and treatment minimizing duplication of costly services in other facilities.

The CCTF will align the jail system with the continuum of health care services within Los Angeles County enhancing compliance with best practice standards of care by providing health care that is consistent with community practices.

Recommendations

The recommendations concerning the actual beds required in the Consolidated Correctional Treatment Facility were developed with an understanding that the average daily census in the Los Angeles jail system is likely to increase over the next 10-20 years. While it is understood that projections are best kept to the short term for accuracy, for planning purposes it is useful to project into the future to plan for future growth. The projections developed in this report formed the foundation for projected growth for medical and mental health beds for the system. Calculations were applied to determine the current and projected number of each type of bed that will be needed. The current and near term CCTF recommended bed need ranges from 4600 to 5060 beds. While the projected 2025 bed need is 6,773 beds if current practices were to continue, the consultant team recommendation is to plan for the current and near term bed need with the assumption that a range of community and systemic initiatives will comprise the approximate 1700 bed differential.

It is anticipated that the County will support and fund a robust capacity across the diversion and reentry continuum of health care in the community. It is vital that the continuum of health care in the community and within the jail system employ best practices to ensure the health and well-being of the LA County disenfranchised populations.

To avoid this, it is recommended that LA County:

- Move forward with the CCTF project to build a treatment facility capacity of 4600-5060 beds
- Align health care services to best practices across the continuum of health care services in the county
- Build a cross-agency county wide integrated IT and health information system
- Require a continuum of care culture that recognizes that jail health care is a significant part of the county health system
- Consistent with best practices, integrate physical and mental health services
- Direct additional concurrent analysis and reporting to enhance the development of the CCTF, the continuum of health care across the system and develop integrated IT and health information systems.

Appendices

Appendix A. List of Agencies that Participated in Key Informant Interviews

Agency/Key Informant Interviews	Complete
CSH	Not Available
Prototypes	Not Available
Alcoholism Center for Women	X
Behavioral Health Services	X
LARPP	X
Grandview Foundation	X
Homeless Health Care LA	X
LA Center for Alcohol and Drug Abuse	X
Nat Council on Alcoholism	X
Phoenix Houses	X
Project Impact	X
Shields for Families	Not Available
Tarzana Treatment Centers	X
Skid Row Housing Trust	X
Paving the Way	X
Watts Health Foundation/House of Uhuru	X
HealthRight 360	X
Ocean Park Community Center/LAMP	X
ST Joseph Center	Not Available
Amity	X

Agency/Key Informant Interviews	Complete
Weingart	X
Special Services for Groups /HOPICS	X
Special Services for Groups/ Alliance	x
Drug Policy Alliance	X
Just Us	X
Special Services for Groups Project	X
In2 Rekovery	X
CLARE Foundation	Not Available
Safe Refuge	X
California Hispanic Commission on Alcohol and Drug Abuse, Inc.	X
Canon House	X
US Veterans Association	Not Available
Telecare	Not Available
Didi Hirsch Mental Health Services	Not Available
SFVCMHC	X
Gateways Hospital and MHC	X
Pacific Asian Counseling Services 310) 337-1550	X
ACLU 213-977-7500	X
Exodus	X
Mental Health America	X

Appendix B. Mental Health Services Provided by Agency or Partner Agency

Interviewed Mental Health Providers and Services Provided Directly or through partners

Agency Name	Mental Health Services	Inpatient	Intensive Community Support	Outpatient	Counseling	Medication Management	Case Management	Crisis	Group Therapy	Support Groups	Day Treatment	Housing	Other Mental Health Services
LACADA	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Watts Health Foundation	✓						✓					✓	
Weingart Foundation	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Exodus	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Safe Refuge	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Mental Health America	✓		✓	✓	✓			✓	✓	✓		✓	✓
OPCC/LAMP	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Special Services for Groups/Homeless Outreach	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CHCADA	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alcoholism Center for Women*													
Canon House	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	
Behavioral Health Services	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	
Homeless Health Care Los Angeles	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
SSG Alliance/ Pacific Asian Counseling Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Phoenix House	✓		✓	✓	✓	✓	✓	✓				✓	
Project Impact													
Project 180	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
In2ReKovery	✓											✓	
SFVCMHC	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Tarzana Treatment Center	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Grandview Foundation^	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
HealthRight 360	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Paving the Way													
NCADD of East San Gabriel and Pomona Valleys	✓									✓			
Amity													
Gateways Hospital and Mental Health Center	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Table notes:

- **Women Only*
- *^Men Only*

Interviewed Substance Abuse Providers and Services Provided (directly or through partners)

Agency	Substance Abuse Treatment	Intensive Outpatient (IOP)	Outpatient	Case Management	Recovery Support	Detoxification	Medication Assisted Treatment	Recovery Housing	12 Step Program	Harm Reduction	Group Therapy	Other Substance Use Treatment	Abstinence Only Program for SUD
LACADA	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓
Watts Health Foundation	✓		✓	✓	✓			✓	✓		✓	✓	✓
Weingart Foundation	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Exodus	✓			✓			✓		✓	✓			
Safe Refuge	✓		✓	✓	✓			✓	✓	✓	✓	✓	✓
Mental Health America	✓								✓	✓	✓		
OPCC/LAMP	✓		✓	✓	✓		✓	✓	✓	✓	✓		
Special Services for Groups/Homeless Outreach	✓		✓	✓	✓			✓	✓	✓	✓		
CHCADA	✓		✓	✓					✓	✓	✓		
Alcoholism Center for Women*	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓
Canon House	✓	✓	✓	✓	✓			✓	✓		✓		✓
Behavioral Health Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Homeless Health Care Los Angeles	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
SSG Alliance/ Pacific Asian Counseling Services	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	
Phoenix House	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Project Impact	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Project 180	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
In2ReKovery													
SFVCMHC	✓	✓	✓	✓	✓			✓	✓	✓	✓		
Tarzana Treatment Center	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Grandview Foundation^	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
HealthRight 360	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Paving the Way	✓	✓						✓	✓				✓
NCADD of East San Gabriel and Pomona Valleys	✓		✓	✓	✓			✓	✓		✓	✓	
Amity	✓	✓		✓	✓				✓	✓		✓	
Gateways Hospital and Mental Health Center	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		

**Women Only*

^Men Only

Interviewed Agencies Employee Snapshot

Agency	FTE Staff	Primarily Sustance Abuse FTE Staff	Primarily Mental Health FTE	Equally Substance Abuse and Mental Health FTE	Clinical FTE	Clinical FTE Staff with Specific Training in Trauma	Clinical FTE Staff with Specific Training in Culturally
LACADA	110			66	66	46	46
Watts Health Foundation	19	15	2		17	1	17
Weingart Foundation							
Exodus	439	0	263	0	263	85	263
Safe Refuge	55	54	1		33	33	33
Mental Health America	250			150	150	150	150
OPCC/LAMP	270	55	99	66	220	100	100
Special Services for Groups/Homeless Outreach	30	0	0	15	15	7	15
CHCADA	58			58	58	58	58
Alcoholism Center for Women*	10	8	0	0	8	8	8
Canon House	7	5	2		7	7	7
Behavioral Health Services	300	72	6		80		80
Homeless Health Care Los Angeles	50			30	30		
SSG Alliance/ Pacific Asian Counseling Services	52	0	0	47	47	20	47
Phoenix House	110	90	0	0	90		90
Project Impact	90	75	0	0	75		
Project 180	60	6	6	36	48		48
In2ReKovery	0						
SFVCMHC	35				10		
Tarzana Treatment Center	650	315	105	0	420		420
Grandview Foundation^	20	3.5	1.5	5	5	5	5
HealthRight 360	95	52	13	0	65	Provide TIC	95
Paving the Way							
NCADD of East San Gabriel and Pomona Valleys	15	15	0	0	15	1	15
Amity	35	0	0	35	20	20	20
Gateways Hospital and Mental Health Center	360	90	250	0	125	10	100%

**Women Only*

^Men Only

Interviewed Agencies Clinician Information

Agency	Psychiatrist	Psychiatrist Board Certified in Addiction	Nurse Practitioner	Licensed SW/MFT/MH	Nursing	Case managers	Addiction Certified Peer Counselors	Mental Health Peers	Other (Please Specify)
LACADA		✓		✓		✓	✓		
Watts Health Foundation				✓		✓	✓		
Weingart Foundation	✓			✓		✓	✓		
Exodus	✓		✓	✓	✓	✓		✓	Psych Techs
Safe Refuge	✓		✓	✓	✓	✓	✓	✓	
Mental Health America	✓		✓		✓	✓			
OPCC/LAMP	✓	✓	✓	✓	✓	✓	✓	✓	Psychologist
Special Services for Groups/Homeless Outreach	✓				✓	✓	✓		
CHCADA	✓		✓	✓	✓	✓	✓	✓	
Alcoholism Center for Women*							✓		
Canon House				✓		✓	✓		Psychologist
Behavioral Health Services	✓	✓	✓	✓	✓	✓	✓	✓	Medical Director
Homeless Health Care Los Angeles	✓		✓	✓	✓	✓	✓	✓	
SSG Alliance/ Pacific Asian Counseling Services	✓					✓		✓	
Phoenix House	✓	✓		✓	✓	✓	✓	✓	
Project Impact				✓		✓	✓		MD, Psychologist
Project 180	✓			✓		✓	✓	✓	
In2ReKovery									
SFVCMHC	✓			✓	✓	✓	✓		
Tarzana Treatment Center	✓	✓	✓	✓	✓	✓		✓	
Grandview Foundation^				✓		✓	✓		MD Board Certified Addiction
HealthRight 360	✓			✓		✓	✓		
Paving the Way									
NCADD of East San Gabriel and Pomona Valleys							✓		
Amity		✓				✓	✓		15 Peer Counselors with Lived Experience
Gateways Hospital and Mental Health Center	✓	✓	✓	✓	✓	✓	✓	✓	

**Women Only*

^Men Only

Client Estimates

Agency	What is the estimated number of unduplicated clients served annually through your agency?	What is the estimated number of agency clients with court or correctional involvement served annually through your agency?	How are clients referred?
LACADA	5000	3500	Probation or Parole
Watts Health Foundation	300	240	CASC is central referral hub. Cold Call from Internet; Word of Mouth; Transfer from Another Facility; Partnership with Sheriff Probation/Women on Ankle Monitoring; Direct Referral; HIV Aids Program for 8-10 Beds Reserved Straight from Jails
Weingart Foundation	70		Probation; Parole,Walk-in; AB109
Exodus	18200		Walk-in; Primary Care Doctors; Psychiatry Referrals; hospitals, ERs, law enforcement, PET Teams
Safe Refuge	800	216	Jail Inreach, AB109
Mental Health America	1325	149	Program Completely Voluntary (As such don't accept probation or parole)
OPCC/LAMP	3000	2100	Self; Access Centers; Providers; DHS; Help Team; SMPD; Street Outreach; Sheriff; AB109; Housing for Health DHS program
Special Services for Groups/Homeless Outreach	175	100	Walk-in; Probation; AB109; CASC
CHCADA	175	160	AB109; CASC; Drug Court; Self Referral; Probation; Police and Word of Mouth
Alcoholism Center for Women*	175	165	Had HR360 Collaborative Grant from Inreach; Collaborate from Phoenix House for 4 months of Treatment; Court Referred (Pre- or Post- Sentencing)
Canon House	800	750	AB109; Courts; CASC
Behavioral Health Services	13120	4500	AB109; Probation; SASCA-now STOP via Community Education Centers
Homeless Health Care Los Angeles	10500	5250	AB109; CASC; Coordinated Entry Program; Community Referrals from Shelters and Partner Organizations; Client Word of Mouth; Hospitals, FQHCs, and Hospitals
SSG Alliance/ Pacific Asian Counseling Services	600	300	DMH; Many on Probation (Come Directly from Jail)
Phoenix House	2000	2000	STOP Centers; Prison; Probation; Pre-trial
Project Impact	900	540	CASC; Word of Mouth; Managed Care; Kaiser
Project 180	300	300	Probation; DMH
In2ReKovery			Hospitals; Word of Mouth
SFVCMHC	300	120	AB109 Hub; DMH FSP Service Area Navigators
Tarzana Treatment Center	16000	1600	STOP Case Management; Drug Court; Case Manager at Jail; AB109 CASCS; US Federal Probation
Grandview Foundation^	225	225	HR360; SASCA contract; Parole Community Education Center
HealthRight 360	2000	2000	Department of Corrections; County Transition Unit
Paving the Way	362	362	AB109; Parole; Prison In Reach; Prison Pastor
NCADD of East San Gabriel and Pomona Valleys	1440	936	Courts; DMV; Probation; Parole; DCFS; CASC
Amity	750	750	Parole; Prison; No DMH Contract; No SAPC contract
Gateways Hospital and Mental Health Center	2600	2600	Jail; Countywide Resource Mangagement; Outreach
*Women Only			
^Men Only			

Other Wrap Around Services (Directly provided or through partners)

Agency	Supportive Housing	Supportive Employment	Integrated Primary Care	Diversion Related Programs (Mobile Crisis, FACT, Re-Entry	Court Funded Services	Program for Specialty Populations
LACADA	✓	✓	✓	✓	✓	✓
Watts Health Foundation	✓	✓	✓	✓	✓	✓
Weingart Foundation	✓	✓		✓	✓	✓
Exodus						
Safe Refuge	✓	✓	✓	✓	✓	✓
Mental Health America	✓	✓				
OPCC/LAMP	✓	✓	✓	✓	✓	✓
Special Services for Groups/Homeless Outreach						
CHCADA	✓	✓		✓	✓	✓
Alcoholism Center for Women*	✓	✓		✓	✓	
Canon House	✓	✓		✓	✓	✓
Behavioral Health Services	✓	✓				
Homeless Health Care Los Angeles	✓	✓		✓	✓	✓
SSG Alliance/ Pacific Asian Counseling Services	✓	✓	✓	✓	✓	✓
Phoenix House	✓	✓	✓	✓	✓	
Project Impact	✓	✓	✓	✓	✓	✓
Project 180	✓	✓		✓	✓	✓
In2ReKovery	✓					
SFVCMHC	✓	✓	✓	✓	✓	✓
Tarzana Treatment Center	✓	✓	✓	✓	✓	✓
Grandview Foundation^	✓	✓	✓		✓	✓
HealthRight 360	✓	✓		✓		
Paving the Way	✓	✓	✓			
NCADD of East San Gabriel and Pomona Valleys						
Amity	✓	✓		✓	✓	
Gateways Hospital and Mental Health Center	✓	✓	✓	✓	✓	✓

**Women Only*

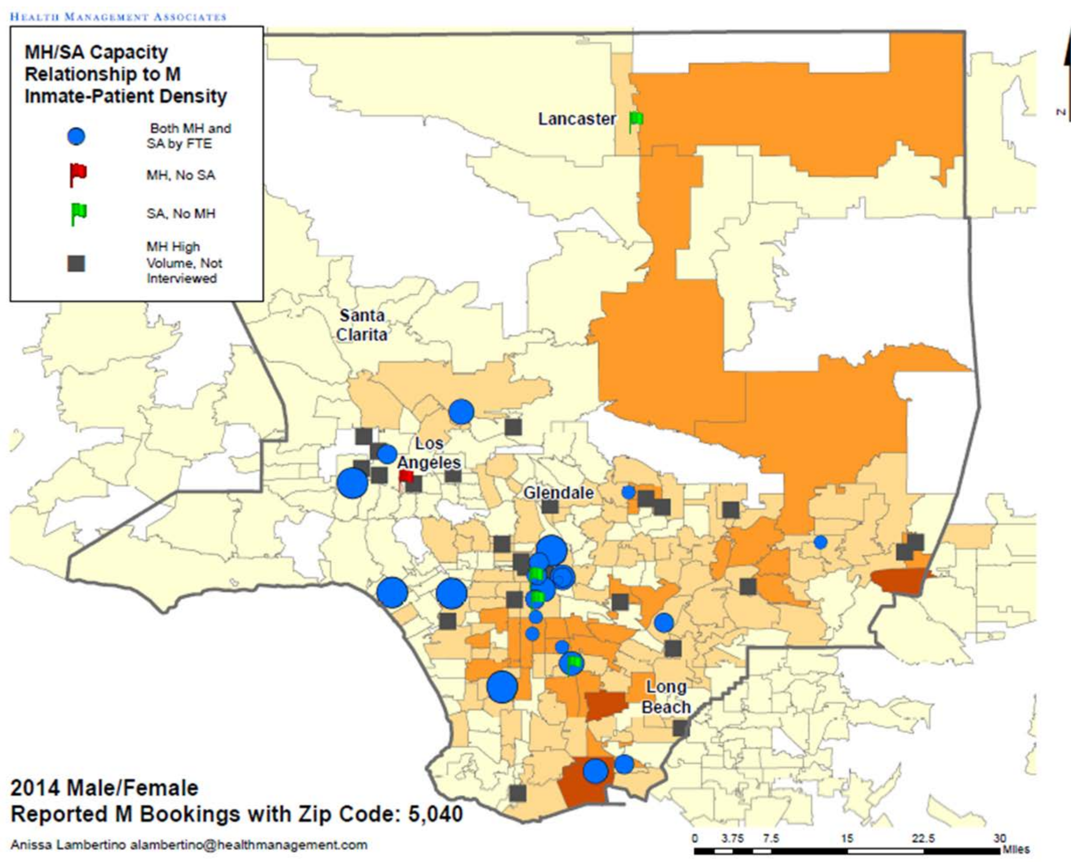
^Men Only

Appendix C. Geographic Information System Mapping

MH/SA Capacity Relationship to M Patient-inmate Density

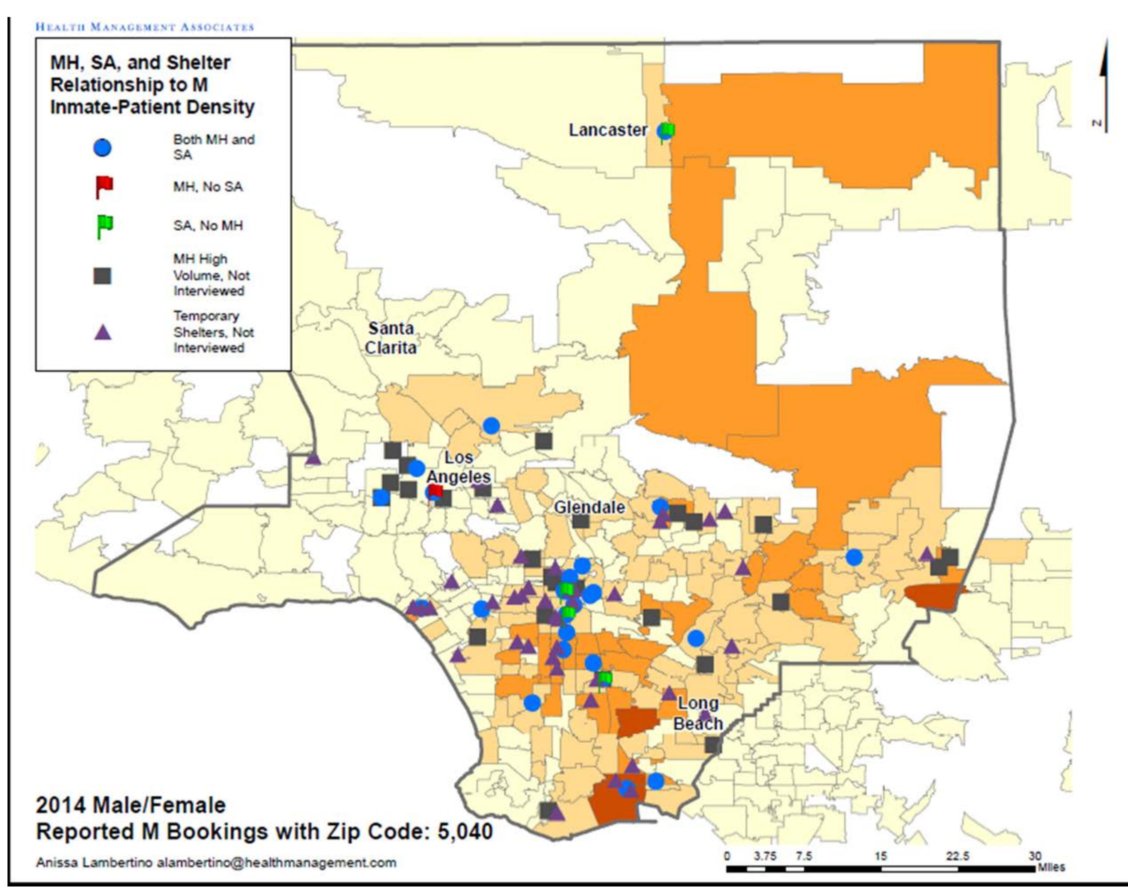
There were 14,893 bookings reported as "M" in 2014. The map below examines the geographic density distribution by zip code in a subgroup of 5,040 males and females with reported zip codes (9,547 had a zip code of 0). Patient-inmate density was defined as zip code counts of 1-10, 11-34, 35-77, and 78-159, cutoffs defined by natural breaks in the data (Jenks).

The locations of providers we interviewed are also identified on the map. The providers were defined by full-time equivalent (FTE) staff divided into quartiles (7-30, 31-60, 61-250, and 251-650). These are presented on the maps as graduated symbols The larger the symbol, the greater number the FTEs currently employed by the provider agency; the smaller the symbol, the fewer FTEs. The smallest symbol represents providers with missing FTE data (n=3). We also obtained an additional list of high volume outpatient mental health clinic locations using Esri Community Analyst's Business and Facilities Search function; we plotted these locations on the map as well. .



MH, SA, and Shelter Relationship to M Patient-inmate Density

Temporary shelter, community housing services, emergency shelters, and settlement house locations obtained from Esri Community Analyst's Business and Facilities Search function are presented in addition to the map above. MH and SA providers are identified by location.


Health Management Associates
MH, SA, and Shelter Relationship to M Inmate-Patient Density
Both MH and SA
MH, No SA
SA, No MH
MH High Volume, Not Interviewed
Temporary Shelters, Not Interviewed
Lancaster
Santa Clarita
Los Angeles
Glendale
Long Beach
2014 Male/Female
Reported M Bookings with Zip Code: 5,040
Anissa Lambertino alambertino@healthmanagement.com
0 3.75 7.5 15 22.5 30 Miles
N

Appendix D. LA County Correctional Treatment Facility Presentation

LA County Consolidated Correctional Treatment Facility

HealthManagement.com

The Team

- Health Management Associates
  - Linda Follenweider MS, CNP
  - Jack Raba MD
  - Gina Eckart MS LMHC
  - Jeff Ring PhD
  - Donna Strugar-Fritsch RN
  - Anissa Lambertino PhD
- Pulitzer Bogard Associates
  - Curtiss Pulitzer RA
  - Judith Regina-Whiteley MS, CNP
  - Patrick Jablonski PhD

HMA | 2

Deliverables

Legislative Impact on Population

The likely impacts to the Los Angeles County jail population of Proposition 47, AB 1468 (split sentencing), AB 624 (enhanced credit system) and inmate population projections over the next several years, including projections for those with Mental Health disorders.

CCTF Population Analysis and findings

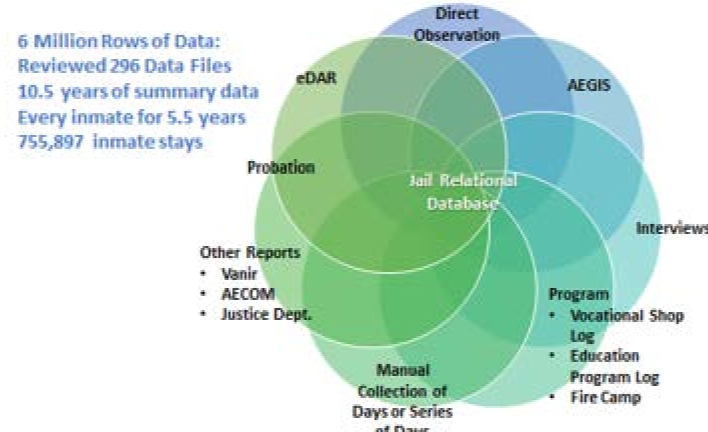
The actual number of treatment beds required at the proposed Consolidated Correctional Treatment Facility that will replace Men's Central Jail.

Community Capacity and Diversion

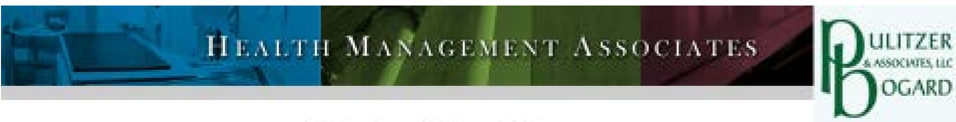
A capacity assessment of all community based alternative options for treatment, including but not limited to Mental Health and Substance Abuse Treatment. An assessment on the number of inmates that can be successfully placed into an outside facility (community based) for Mental Health/Substance Abuse Treatment;

HMA | 3

L.A. County Relational Database



HMA | 4



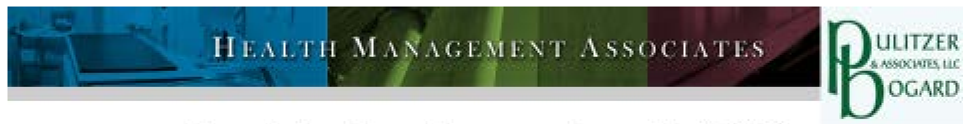
Data Challenges

- All data sources are not equal for analysis so assumptions had to be made
- Mental and/or physical health acuity markers are not available in data sets
- Snapshots of data were used to make some assumptions for trends which impacts generalizability
- Some data not available so data inferences were applied (detox)
- We had to create a database where one did not exist in an expedited timeline
- Substance abuse data was very limited

HMA | 5

LEGISLATIVE IMPACT ON POPULATION

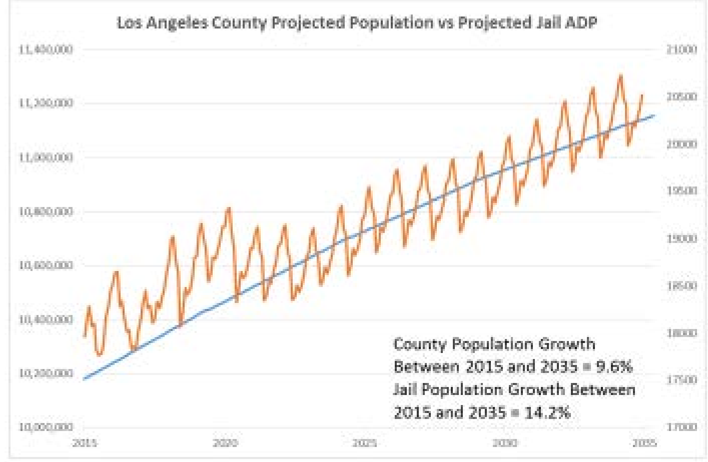
HMA | 6



Legislative Impact on LASD

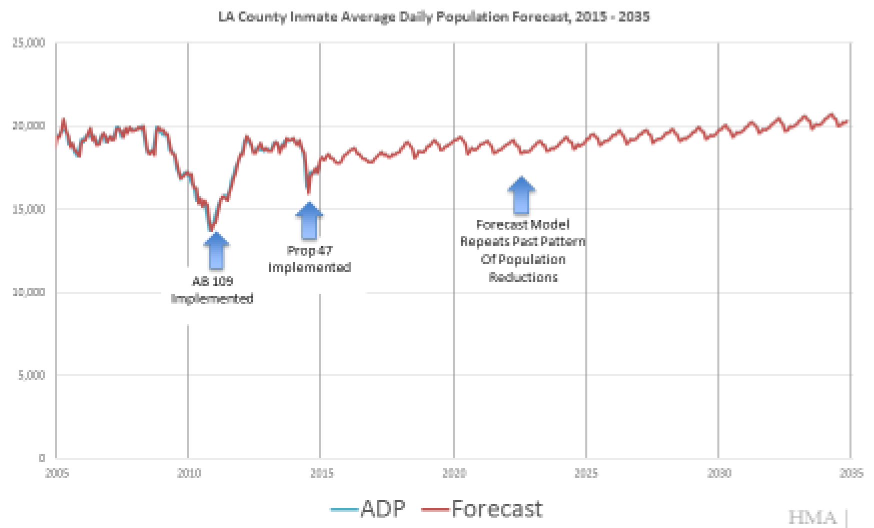
- Inmate Population Forecast
- Prop 47
- Split sentence AB1468
- Earned Credit AB624
- AB 109

HMA | 7



HMA | 8

LA County Jail Population Forecast



HMA |

LA County Jail Population Forecast

Month	Non AB109	AB 109	Base Projection	Peaking (6.1%)	Classification (6.4%)	Bed Need
July 2015	14,965	3,000	**17,965**	1,096	1,150	**20,211**
July 2020	16,112	3,016	**19,128**	1,167	1,224	**21,519**
July 2025	16,432	2,768	**19,199**	1,171	1,229	**21,599**
July 2030	16,509	3,259	**19,768**	1,206	1,265	**22,239**
July 2035	16,664	3,855	**20,519**	1,252	1,313	**23,084**

HMA |

Bed Need Projections by Initiative

Month	Projected Bed Need	Projected Bed Need With No Prop 47	Estimated Bed Need With No AB624
July 2015	20,211	23,364	20,379
July 2020	21,519	24,836	21,687
July 2025	21,599	24,730	21,767
July 2030	22,239	24,341	22,407
July 2035	23,084	24,719	23,252

- The impact of AB1468, although positive, is limited due to the relatively small percentage of all felony sentences that are split sentences.
- The actual impact on the jail population could not be calculated with available data.

HMA | 11

CCTF POPULATION ANALYSIS AND FINDINGS

HMA | 12

Why is healthcare important in a jail?

- 90% of people incarcerated will return to their community
- People enter jail sick and at risk
- Continuum of care includes jail services
- "No wrong door"
- Stable return to community
  - Healthier communities
  - Positive impact on recidivism

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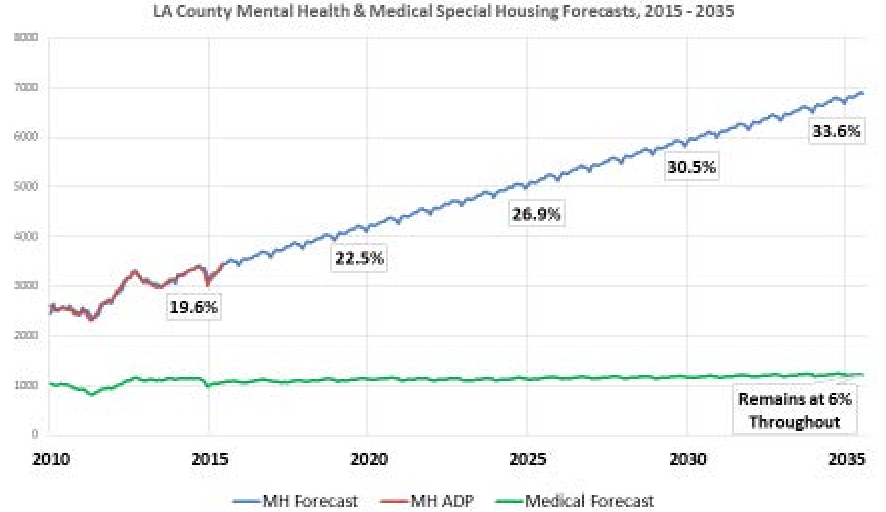
Some Key Initial Findings

- Jail observation units house acute and severely mentally ill inmates that should be in a high acuity inpatient level bed. (Insufficient beds)
- Receiving areas where inmates enter the facility are inadequate for screening by clinical staff and do not support expanded services and assessments
- Current correctional and medical IT systems do not share information or inform each other
- There is insufficient ADA accessible housing

HMA | 14



HMA | 15

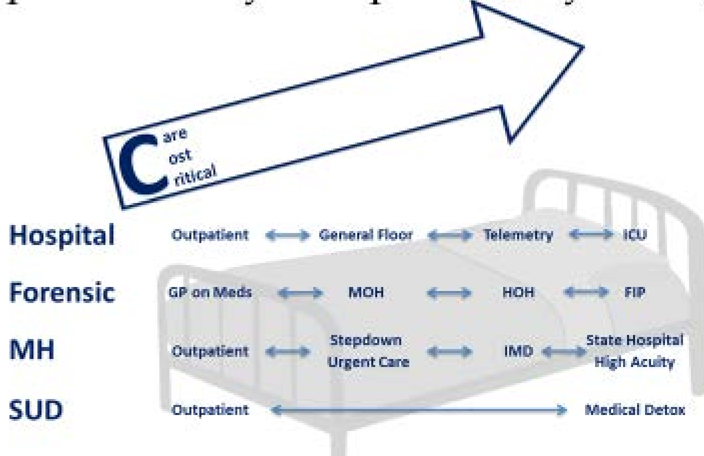
Mental Health Population by COMPAS Classification Level

	Low Security				Medium Security			High Security			
Security Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Unk**	Total
Totals	8	49	74	388	108	681	1178	527	41	1	
Cumulative Total	**519**				**1967**			**568**			**3055**

- COMPAS is a validated classification tool to assist in assigning safe housing and programing within the jail.
- It is not a Comprehensive Health Risk Assessment Tool (Physical /Mental Health)

HMA |

Simplified Acuity Comparisons by Bed Type



HMA | 17

Building to Best Practice

- **Total 4600-5060**
  - Dedicated Detox Unit
  - Male Intake and Screening (point of entry) IRC
  - Female Intake and Screening (point of entry) IRC
  - High Acuity Medical Beds (CTC)
  - Urgent Care
  - High Acuity Mental Health (FIP)
  - Observation Units: High and Moderate Mental Health and Special Population
  - ADA housing

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HEALTH MANAGEMENT ASSOCIATES

PULITZER & ASSOCIATES, LLC BOGARD

Bed Distribution Comparison

Beds	Vanir	AECOM CCTF	LASD 6/9/15 CCTF	2015 Current Recommendations	2025 Projections
CCTF MOSH	500	512	512	600 - 700	916
CTC Medical				160 - 180	236
Detox				200 - 220	251
Total Medical Beds	**500**	**512**	**512**	**960 - 1100**	**1403**
CCTF FIP Licensed	60	60	60	60	96
CCTF MH Licensable	200	180	180	180 - 200	290
CCTF HOH Single Man Cells	600	576	864	800 - 900	926
CCTF HOH Double Man Cells	200	192	0		308
CCTF MOH	2200	2208	2112	2400 - 2600	3550
Total MH Beds	**3260**	**3216**	**3216**	**3440 - 3760**	**5170**
CCTF SUD Level 1, 2	400	512	0	0	0
CCTF SUD Level 3	100	0	0	0	0
Total SUD Beds	**500**	**512**	**0**	**0**	**0**
Total Special Mgmt.	**600**	**600**	**200**	**200**	**200**
CCTF Capacity	**4860**	**4840**	**3928**	**4600-5060**	**6773**

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PULITZER & ASSOCIATES, LLC BOGARD

CCTF Framework Recommendations

- Jail is a part of the LA County Health Care System
- Best Practice Services and CCTF are parallel activities for implementation
  - Pre and Post Custody Diversion
  - Transition into the community
  - Continuum of care with complex care management
  - Increase capacity for community services
  - Robust IT
- Need early risk assessment for total service needs
  - Evaluation tools- build and standardize
  - Evaluation process-build and standardize
- Eliminate variability across service providers
  - Assign accurate, standardized acuity descriptors for mental health
  - Exchange information
  - Outcome reporting
- Full Integration and Co-location of Medical and Physical Health

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Pre –Post Admission Diversion and Transition into the Community

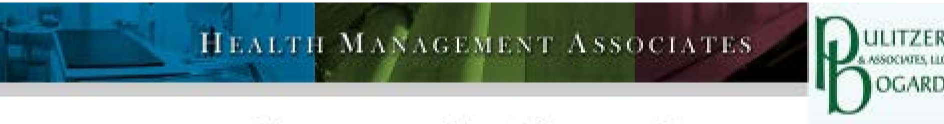
COMMUNITY CAPACITY AND DIVERSION

HMA | 21

PROJECTED CCTF BED NEED 2025 Diversion Illustrations

Beds	Current Need	Projected Need	Diversion opportunity (15%)	Diversion opportunity (10%)
CCTF MOSH	600 - 700	916	147	92
CTC Medical	160 - 180	236	35	24
Detox	200-220	251	38	25
MH in Medical Beds	960-1100	1403	211	140
CCTF FIP Licensed	60	96	0	0
CCTF MH Licensable	180 - 200	290	44	29
CCTF HOH	800 - 900	1234	185	123
CCTF MOH	2400 - 2600	3550	532	355
Total MH Beds	3440 - 3760	5170	775	507
Other (IRC,Disc, Transit)	0	0	0	0
Special Management	200	200	0	0
Total beds	4600-5060	6773	986	647
Community Capacity Exists for Diversion at all Intercept Points in the CJ System				
Additional Diversion Opportunities toward Jail Bed Need Reduction				
MOH to GP greater stabilization of the population			300	300
Diverting more Mentally Ill from the jails in the beginning			300	450
Successful community transition inmates and no recidivism			200	400
Total Number of inmates to meet delta			**1786**	**1797**

22



Community Capacity

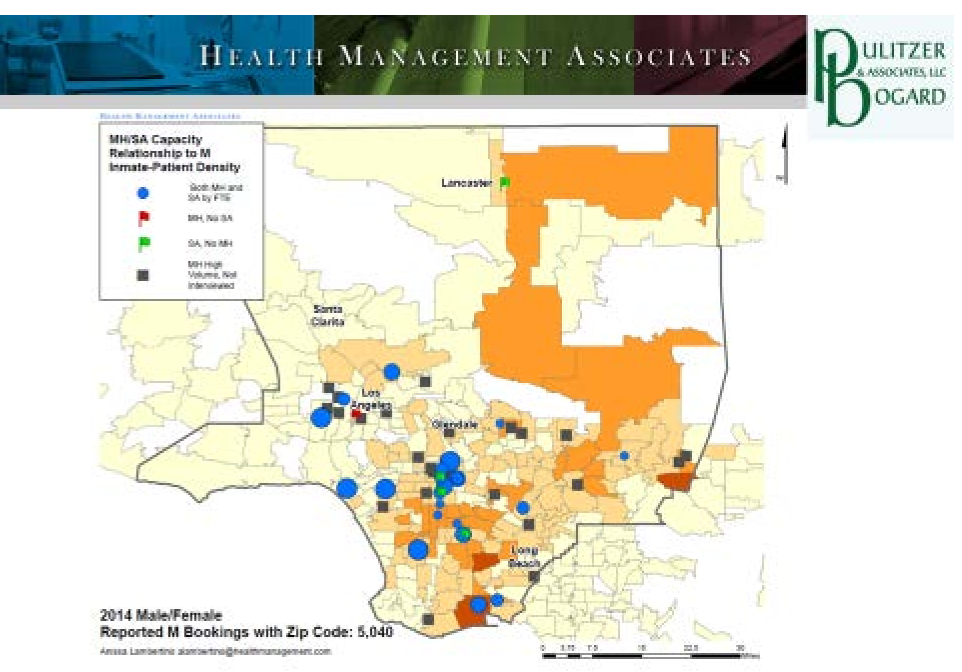
- 26 MH and/or SA Providers interviewed
- Majority SA **and** MH services
- Current community provider capacity is limited or met
- Competition for beds
- No immediate capacity in the jail or community for acute SMI
  - 295 acute SMI on waiting list (7/15/2015)

HMA | 23

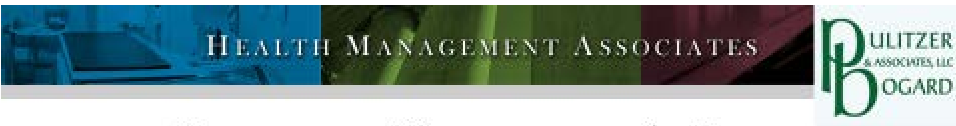
Community Provider Observations

- Community Partners report:
  - Willingness to expand services
  - Ability to manage complex patients
  - Need for stable funding for service expansion
- Balanced approach needs to occur that does not "push out" community patients
- Currently higher levels of care beds are full or near full

HMA | 24



HMA | 25

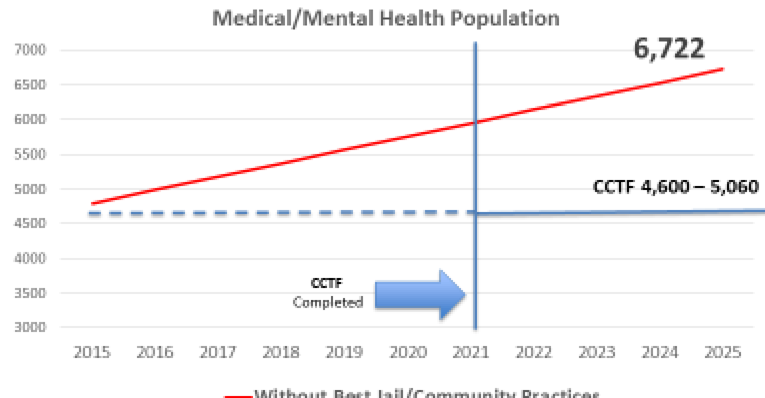


Summary Recommendations

- Move forward with the CCTF project
- Align health services to best practices throughout system
- Build an integrated IT and health information system
- Require a Continuum of Care Culture
- Integrate Physical and Mental Health Services
- Direct Additional **Concurrent** Analysis and Reporting

HMA | 26

Without implementation of best practices bed needs will rise to 6,722 by 2025



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