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SACHI A. HAMAI
Chief Executive Officer

August 7, 2019

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

From: Sachi A. Hamai
Chief Executive Officer

REPORT BACK ON DEVELOPING A CARE-FIRST TREATMENT MODEL FOR NEW MENTAL HEALTH TREATMENT CENTER (ITEM NO. 25, AGENDA OF FEBRUARY 12, 2019)

On February 12, 2019, the Board authorized the Department of Public Works (DPW) to finalize negotiations and execute the Design-Build contract with McCarthy Builders, Inc. (McCarthy) for the Mental Health Treatment Center (MHTC). At the same time, the Board directed the Departments of Health Services and Mental Health (Health Departments), in coordination with the Chief Executive Office (CEO) and in consultation with the Sheriff's Department, to work with the Design-Build team within the first 90-days of the 12-month validation period and develop a design for the MHTC that is informed by all of the leading research and information on mental health challenges experienced by those that come most in contact with law enforcement. The Board also directed that the design must support a "care-first" approach with the goal of diversion to community-based mental health treatment wherever possible. Moreover, the Board asked that the Health Departments and CEO include in the report-back options to "right size" the scale and scope of the MHTC.

Subsequently, DPW finalized and executed the Design-Build contract with McCarthy on March 28, 2019 and issued the Notice to Proceed to McCarthy on April 4, 2019, starting the one-year validation process. DPW, CEO, the Sheriff's Department, the Health Departments, and McCarthy then worked collaboratively during the beginning of the validation process to better refine the "care-first" elements of the project. Simultaneously, the Health Departments and the Office of Diversion and Reentry (ODR), in consultation with the CEO, developed options that respond to the Board's directives on the MHTC.

As described in the attached memo from the Health Departments (Attachment A), the Health Departments considered several factors in proposing their options to "right-size" the MHTC project, including demographics, trends in criminal justice, changes in treatment modalities, capacity limitations in the State Hospital system, and the impact of diversion programs. A recent preliminary report issued by ODR estimates that with an advancement of diversion programs and services, up to 56 percent of the approximately 5,134 mental health inmates currently in custody[1] could be successfully diverted to community-based housing if sufficient, appropriate resources were readily available in the community. The Health Departments note that any option for "right-sizing" the MHTC requires the investment in community-based treatment beds. They further acknowledge that developing community-based treatment beds will need to outpace and exceed the replacement of custody beds over time to maintain a steady flow of patients out of the custody system into community-based care.

The Health Departments' memo seeks to respond to the various questions in Supervisor Solis' June 22, 2019 letter (Attachment B) and provides three options to "right-size" the jail replacement by either eliminating the construction of new custody beds, constructing a mix of new treatment-based custody beds and community "care beds", and/or renovating existing facilities to accommodate individuals not potentially eligible for diversion. The options take into account the tremendous efforts currently underway by County departments and agencies to create a continuum of care that addresses the needs of individuals through a complement of health and mental health services, housing and services for the homeless, equitable distribution of resources throughout the community, and justice system reforms.

The three options outlined by the Health Departments are summarized as follows:

Option 1:

- Construct 2,400 non-custodial beds for "varying levels of clinical care" on the Vignes Campus[2] under the operational responsibility of the Health Departments;
- Renovate Twin Towers Correctional Facility (TTCF) to accommodate approximately 2,400 individuals with serious mental illness and/or complex medical conditions who are not able to be safely diverted from jail;
- Develop an unspecified number of additional community-based treatment capacity offsite; and
- Develop a plan for alternative custody space for housing inmates from Men's Central Jail on a temporary and/or permanent basis.

[1] ODR preliminary report references that the overall Jail Mental Health population on 2/14/2019 was 5,134
[2] Vignes Campus refers to the existing Men's Central Jail site

Option 2:

- Construct a new 2,400 custodial bed treatment-based facility on the Vignes Campus for those not potentially suitable for diversion; and
- Construct 2,400 non-custodial "care beds" under the operational responsibility of the Health Departments; including approximately 900 "higher acuity mental health beds" on the Vignes Campus and the remaining 1,500 community-based treatment beds at other locations.

Option 3:

- Construct 2,400 non-custodial "care beds" on the Vignes Campus under the operational responsibility of the Health Departments;
- Construct a 1,200-custodial bed treatment-based facility on the Vignes Campus for those not potentially suitable for diversion;
- Renovate TTCF to accommodate general population inmates transitioned from Men's Central Jail, and approximately 1,200 individuals with serious mental illness and/or complex medical conditions who are not able to be safely diverted from jail; and
- Develop an unspecified number of additional community-based treatment capacity offsite.

Sheriff's Department

The options were reviewed by the Sheriff's Department to determine the potential impacts within the custody system. The attached letter from the Sheriff's Department (Attachment C), describes a vision foreseeing the changing landscape of the County's continuum of care towards a "care-first" model while maintaining the necessary custodial based capacity to appropriately care for in-custody individuals. The Sheriff's Department indicates support for ODR's efforts on diversion but expresses concerns regarding the preliminary data presented from ODR and the ability to divert 56 percent of the current mental health inmates.

The Sheriff's Department recommends that the replacement facility maintain a minimum of 3,885 treatment-based custody beds to appropriately care for individuals who cannot be successfully diverted from custody. Statistics referenced by the Sheriff's Department reflect a 2.3 percent annual increase in the overall inmate population, with a significant increase in the mental health inmate population, which would increase the future need for capacity in the system.

The Sheriff's letter mentions that the County remains under a Department of Justice consent decree to provide a minimum level of medical and mental health care to all inmates in the Sheriff Department's custody. The existing facilities where the current

population is housed, such as TTCF, Century Regional Detention Facility, and Men's Central Jail, do not have the ability to adequately provide the necessary services and programming space as required by the Department of Justice.

Lastly, the Sheriff's Department notes that several prior studies[3] concluded that a new facility would require 4,600 or more beds to properly serve the medical and mental health inmate population.

Analysis of Options

The CEO and DPW have conducted an assessment of the likely impacts of the proposed programmatic changes of each of the three options including limitations inherent in the scope of the existing contract with McCarthy, change order restrictions, budgetary impacts, and operational impacts (Attachment D).

Proceeding with either Option 1 or Option 3 would likely require the cancellation of the current design-build contract, as the scope of work is significantly different than what was solicited in the Design-Build Request for Proposals, and any off-site construction will require the development of scope and cost and will require additional California Environmental Quality Act (CEQA) analysis. Additionally, the renovations proposed at TTCF will need to be studied further to determine the cost, scope, schedule, and operational impacts, which are likely to be significant.

Aspects of Option 2, such as the 1,500 off-site non-custodial beds would also exceed the scope of the approved construction contract and would likely require cancellation of the current design-build contract. Further, even without the off-site beds, the cost of the proposed 2,400 treatment-based custody beds and 900 non-custody "higher acuity mental health beds" will exceed both the current contract amount with McCarthy and the Board approved $2.18 billion project budget.

None of the three options presented is supported by the Sheriff's Department, as the number of custody beds developed is less than the projected need. Further, each option results in a significant loss of custody beds due to the demolition of Men's Central Jail that would increase the custodial capacity in remaining facilities, resulting in operational challenges. An analysis of operational impacts will be required to determine the extent of ongoing costs associated with each option. Additionally, the phasing constraints, escalation, and increased operational requirements will require a significant County investment beyond the $2.18 billion.

[3] Vanir Construction Management, Inc. Report (2014) and Health Management Associates Report (2015)

All options presented by the Health Departments will require the development of a system of treatment beds of various types. The exact numbers are not yet known, but at minimum would include acute, sub-acute, medical, and substance use treatment beds. The locations, cost, and funding are to be determined through collaborative meetings with the Health Departments and community stakeholders. The capital investment in building additional community-based capacity is significant and unknown.

In support of the projected County investment to build community-based capacity, on June 24, 2019, the Board directed the CEO to return to the Board during the Fiscal Year 2019-20, Supplemental Changes Budget in October with recommendations on creating a funding reserve to support the expansion of facilities that the County can use as alternatives to incarceration. In parallel, the Alternatives to Incarceration Work Group will return to the Board later this year with recommendations that will, among other things, identify diversion opportunities and produce a plan to expand the availability/use of County facilities that will serve as treatment facilities and alternatives to custody. Additionally, ODR will return early next year with the RAND report, which will contain recommendations related to diversion opportunities for the justice-involved mental health population.

Conclusion

Based on the Board's direction on February 12, 2019, to work with the Health Departments, Design-Builder, and other relevant stakeholders, the attached reports are provided for your consideration.

If you have any questions, please contact Brad Bolger of my staff at (213) 974-1360 or bbolger@ceo.lacounty.gov .

SAH:FAD:DPH
BMB:AMA:MJD:ns

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Sheriff
Health Agency
Health Services
Mental Health
Public Health
Public Works

Health Services
LOS ANGELES COUNTY

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

COUNTY OF LOS ANGELES
Public Health

August 5, 2019

TO: Sachi A Hamai
Chief Executive Officer

FROM: Christina R. Ghaly, M.D.
Director, Department of Health Services

Jonathan E. Sherin, M.D., Ph.D.
Director, Department of Mental Health

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director, Department of Public Health

SUBJECT: **DEVELOPMENT, DESIGN, RIGHT-SIZING, AND SCOPIING OF THE PROPOSED MENTAL HEALTH TREATMENT CENTER (RELATED TO ITEM #25 FROM THE FEBRUARY 12, 2019 BOARD MEETING)**

On February 12, 2019, the Board of Supervisors (Board) voted to award a design-build contract for construction of the planned Consolidated Correctional Treatment Facility (CCTF) and in doing so to rename the facility the Mental Health Treatment Center.

On the same date, the Board instructed the Directors of Mental Health (DMH), Public Health (DPH) and Health Services (DHS), in coordination with the Chief Executive Officer (CEO) to:

1. Report back to the Board within 180 days, and periodically thereafter, on how to staff and operate the Mental Health Treatment Center;

2. In consultation with the Sheriff, work with the design build team within the first 90 days of the 12-month validation period and develop a design for the Mental Health Treatment Center that is informed by all of the leading research and information on mental health challenges experienced by those that come most often into contact with law enforcement, the design must support a treatment-first approach, with appropriate security measure in place, with the ultimate goal of diversion to community-based mental health treatment wherever possible and the design process should also be done in coordination with other efforts moving in Los Angeles County (LA County) to understand the needs of those incarcerated and expanded diversion and alternatives to custody, particularly for those with clinical needs; and

3. With DPH and in consultation with community stakeholders, to include in the report back options to right-size the scale and scope of the project, including creating a continuum of clinical facilities operated by health personnel to ensure a decentralized, trauma-informed approach to achieve the goals of improved treatment and public safety in conjunction with diversion to community-based mental health treatment, whenever possible.

This report was developed by DMH, DHS, and DPH, in consultation with the above named entities, and also in consultation with the Department of Public Works (DPW), DHS' Office of Diversion and Re-entry (ODR) and Correctional Health Services, as well as with input from County justice partners including the Public Defender, the Alternative Public Defender, and the District Attorney. At the direction of the CEO, we are addressing this report back to you so that it may be sent together with additional reports to the Board as one single package.

The Health Departments wholeheartedly agree with the stated desire of the Board to implement a "care first, jail last" approach to providing for individuals involved in the criminal justice system and appreciate having an opportunity to offer our perspective on how to "right-size and scope" new facilities planned for the site of the current Men's Central Jail (MCJ) as a core part of the overall strategy. A truly "care first, jail last" system would operate according to several key tenets. Such a system would:

- **Deliver services along a comprehensive continuum of care:** Individuals would receive care from an integrated system of services and supports across a full continuum of health and behavioral health (mental health and substance use disorder (SUD)) services, from prevention and early intervention to treatment and healing. Although both acute and sub-acute locked hospital beds will always be important and necessary components of such a system of care, a massive and comprehensive array of treatment services must be available in unlocked settings, including both residential and non-residential sites, to ensure that individuals are only held in locked settings for their own safety, the safety of those around them, and the safety of the general public.
- **Be preferentially community-based**[1]**:** Wherever feasible, such a system would be community-based under the belief that individuals, wherever possible, have better

[1] While the term "jail" has an advantage of communicating clearly the type of facility being referenced (i.e., for occupancy by individuals who are incarcerated and under the supervision of law enforcement), its negative connotations have led to a desire for limiting its general use. Although understandable, in its absence, the lack of specificity of terms has led to confusion as to what type of facility is being proposed. For the purpose of clarity, this document uses the following terms in referring to different types of facilities in which individuals may reside for a period of time.

1) A "community-based" facility is any facility that is not operated or controlled by law enforcement. Community-based facilities can be classified as either health (e.g., those licensed and/or regulated through a Department within the California Health and Human Services Agency) or residential (e.g., licensed placements such as Board and Care, or unlicensed placements such as recuperative care or permanent supportive housing). In both types of community-based facilities, health and/or social service professionals are the primary operators and are responsible and accountable for making decisions as to admission/placement and discharge criteria. Individuals cannot be held against their will in a community-based facility, unless they are on a legal hold as the result of a health condition (e.g. disabling and/or life- threatening mental illness*) or as a court-implemented condition of release. It is noteworthy that the Joint Legislative Audit Committee is currently exploring the adequacy and applicability of current laws (defined for almost 50 years by California's LPS Act) that govern involuntary treatment of individuals suffering from behavioral health disorders. Among the many aspects of the law that will be studied, the state's focus on reducing incarceration and advancing justice reform will require that significant attention be paid to the need for compelling behavioral health treatment as a basic legal platform for realizing and optimizing the use of jail alternatives.
2) A "custody" facility is any facility that is operated or controlled by law enforcement personnel. Such facilities are licensed by the Board of State and Community Corrections (BSCC); admission and discharge decisions are made by the courts and implemented by law enforcement entities (e.g., Sheriff), rather than health or social service professionals. Custody facilities may have a range of embedded health services, but health professionals do not determine when an individual should be admitted or discharged; they only have discretion over what type of service is provided while an individual is incarcerated.

treatment and life outcomes when served in a community-based (care-oriented) and not custodial environments. Community-based facilities are inherently more therapeutic in nature and conducive to healing than are custodial ones. While a society's custodial infrastructure is critical to the safety and well-being of the greater community, it is not the optimal, ethical or appropriate placement for individuals whose health status or conditions are the root cause, and predominant driver, of their involvement with the criminal justice system. Indeed, were it not for the inadequate size and scope of the existing community-based system of care in LA County and beyond, many individuals would not have had involvement with the criminal justice system in the first place.

- **Place high value on quality and safety of care and care settings**: Wherever services are delivered, individuals should be cared for by staff and in facilities that uphold the fundamental dignity and value of human life. Regardless of whether the services are community-based or custody-based, they should be provided in such a manner and setting that reflects and upholds the value of each individual served. For this reason, we believe it is imperative that the County continue on a path toward demolishing MCJ, the conditions of which are deplorable, not conducive to providing high quality health or human services, and unsafe for both staff and detainees alike.
- **Provide adequate supply of housing and residential services:** It will be impossible for us to break the recurring cycle of incarcerating individuals suffering from mental illness and/or addictions without addressing homelessness as a key risk factor (and consequence) of both. Currently, there are insufficient funds dedicated to serving individuals who have become justice involved and diverting them to care in community-based settings. Even Measure H has limited funding dedicated to serving those individuals with patterns of homelessness that the County is attempting to divert into housing from the justice system.[2] Whether individuals can be diverted directly to permanent supportive housing or require time to stabilize in an acute or sub-acute facility prior to housing placement, flow through the system will always bottle neck and halt without adequate housing of all types and, as a result, individuals will either spend more time in jail or return to the streets.
- **Be geographically dispersed and decentralized**: Community is core to a person's overall health and well-being. Wherever possible, services are best provided through local, geographically dispersed facilities, allowing for individuals to remain close to their families, places of work and worship, activities of interest, and social networks, leaving them better able to fully integrate back in to their local community once intensive and/or long-term treatment is completed and they are clinically stable. Such an approach is more complicated in that it requires deeper engagement with communities and regulatory bodies across multiple geographies, but ultimately will achieve better outcomes for individuals, families and neighborhoods across LA County in addition to saving taxpayer dollars over the long term.

BACKGROUND

LA County operates several detention centers, each with the following capacity rating and approximate daily census counts:

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[2] Strategy B7 of the FY 19-20 Measure H funding plan includes funding for approximately 525 beds of interim housing (short-term, including recuperative care) for individuals exiting institutions, which includes hospitals as well as custody settings. ODR makes referrals into B7 funded beds but they are not sufficient in number to meet demand. In addition, as above, Measure H does not include any dedicated funding for permanent supportive housing or other residential housing (e.g. Board and Care) for individuals exiting custody settings through diversion.

Table I: Capacity, current census, and relevance to CCTF planning of County detention centers

	Board of State and Community Corrections Rated Capacity	Operating Capacity[3]	2019 Average Daily Inmate Population	Average population planned to move to future CCTF[4]
Pitchess Detention Center North	832	1,600	~7,000	320
Pitchess Detention Center South	844	1,516		0
North County Correctional Facility	2,214	4,344		0
Pitchess Detention Center East (Firecamp)	926	1,764		0
Century Regional Detention Facility	1,708	2,706	~2,100	674
Men's Central Jail	3,529	5,061	~4,400	480
Twin Towers Correctional Facility	2,484	4,374	~3,200	~3,200
Inmate Reception Center	n/a	n/a	~450	159
Total	**12,537**	**21,365**	**~17,150**	**4833**

LA County also has an additional currently vacant detention center: the Mira Loma Detention Center. This site is now being considered as a potential site for low-income housing.

CURRENT "CCTF" PLAN

Under the County's current CCTF design, inmates with serious mental illness, as well as a much smaller number of medically fragile inmates would transition to a 3,885-bed CCTF facility.

[3] LA County Sheriff's Department, as of 7/24/19.

[4] Mental health census counts based on "LASD Mental Health Count 5/21/19"; CTC and MOSH census based on ICHS recent average patient counts.

Currently these individuals with significant health conditions are being held primarily at TTCF, although an additional ~675 women with similar clinical needs are being held in High Observation Housing (HOH) and Moderate Observation Housing (MOH) at Century Regional Detention Center (CRDF); further, ~320 lower acuity men are held at Pitchess Detention Center North Campus, and ~480 male inmates who are medically fragile are held currently at MCJ. Individuals with mild to moderate mental illness, many of whom are taking psychotropic medications, are held in the General Population (GP) and are not planned to be transitioned to the CCTF; they will continue to be held in the County's other detention centers. A similar plan holds for individuals with SUD: single-diagnosed individuals (i.e., those who are not dually-diagnosed individuals with concomitant serious mental illness) are also housed in the GP and are outside of the counts planned for inclusion in the CCTF. Only individuals requiring medical detox, a service currently provided in very small numbers in a unit off the Inmate Reception Center, are planned to have a dedicated unit in the CCTF.

With respect to timing and general population movements, after completion of the CCTF, the County would plan to transfer inmates from the TTCF and other facilities noted above, leaving TTCF able to be transitioned into a facility serving the general population, rather than one dedicated to individuals with serious mental illness or complex medical conditions. Inmates housed currently in MCJ would be transitioned into the TTCF and other sites and, once vacated, would be demolished. Given the total loss of beds that closure of MCJ and opening of CCTF would bring about, displaced inmates could be housed in vacant or mostly vacant detention centers in the County, such as facilities on the Pitchess East Campus.

CONSIDERATIONS FOR RIGHT-SIZING AND SCOPING THE NEW PLANNED FACILITY/FACILITIES

The network of facilities that are needed to allow for the demolition of Men's Central Jail to move forward should be as large as needed to house the population that requires incarceration, taking into account relevant major demographic, clinical, and political factors, while creating sufficient capacity for those who can be safely cared for in the community. Identifying and correcting for the various factors is challenging but critical; incorrect assumptions carry a large societal cost. To underestimate the required facility size and build too small would place the general public at a safety risk and/or lead to persistent overcrowding in the LA County jail system with the associated human rights, health, and safety violations that come with it. To overestimate the size and build too large would risk a) wasting taxpayer funding on unneeded/unused custodial capacity[5] b) under-investing in community-based restoration and diversion programs that often result in better outcomes, and c) having individuals incarcerated more than necessary under an optimally functioning criminal justice system, an outcome with negative consequences on individuals, families and society.

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[5] Financial risk is due to a) Higher cost of construction of custody facilities as compared to the cost of constructing community-based placements, taking into account the full mix of types of placements that might be needed (e.g., while construction of OSHPD facilities is costly, a majority of community-based capacity can be provided in lower cost non-OSHPD care settings) and b) Lack of ability to enroll individuals in Medicaid when they are incarcerated, with resulting loss of associated Medicaid revenue for services that, if rendered in a community-based setting, would have been eligible for Medicaid reimbursement. Note this statement does not take into account custodial capacity outside of the Vignes campus; the County may choose to fill any unused capacity by relocating populations currently in other County jails.

A comprehensive jail sizing effort would take into account:

1. Demographic factors: This includes expected population growth, anticipated trends in crime and incarceration rates, mental health and substance use diagnosis and treatment rates[6] in the general vs. custodial population, etc. It is notable that the total jail population grew at less than 1% compound annual growth rate from 2010 to 2019, whereas the mental health population within the jail grew at an annual rate of 9% in the same period.
2. Changes in treatment modalities: The continued evolution and advancement of clinical behavioral medicine will, if implemented broadly, lead to improved recovery outcomes and could be expected to reduce frequency of arrests and demand for custody beds. One advance in particular, the expansion of Medications for Addiction Treatment (MAT) for SUDs, could have a large impact on patient flow.
3. Criminal justice trends: Examples include sentencing guidelines and practices, including those that influence the actual and targeted percent of sentence served by sub-population (e.g., by crime, among AB109 vs. non-AB109 population), and continued state prison (or state hospital) realignment.
4. Criminal justice reform initiatives: Examples include the impact and likelihood of implementing comprehensive bail reform, trends toward community-based restoration, etc. The potential impact of bail reform is most relevant, considering that 40-50% of individuals currently incarcerated are pre-trial, a number that is significantly higher than in other jurisdictions.[7]
5. Capacity limitations in the State Hospital system: California's State Hospital system has an inadequate number of beds to meet demand. Capacity limitations at the State level increase the demand for custodial beds above the level that would be required were sufficient State Hospital capacity available.
6. Anticipated impact of diversion programs: The impact of diversion is dependent on the hypothetical share of the population that is eligible for diversion and the County's level of commitment to reach that hypothetical maximum. The impact of diversion programs is also related to recidivism rates among diverted vs. non-diverted populations.

The supply-demand impact of factors 1-3 above will require a sophisticated evaluation that should be conducted by individuals with modeling expertise as related to demographic analytics, the influence of new behavioral health treatments on service delivery trends, and the overarching trajectory of our criminal justice policy. Though the bail reform aspect of criminal justice policy is touched on briefly below, the impact of current and future reform remains quite uncertain at this time, including implications for both custody and care beds. Expanded briefly below are considerations of factors 4-6.

Criminal justice reform initiatives (Bail reform)

If passed at either the local or state level, comprehensive bail reform has the potential to reduce the overall custodial population given the sizeable number of individuals who are in jail pre-trial. Further bail reform initiatives could also lead to a reduction in post-trial detainees if the community-based continuum of care is built up. If more individuals are released on their own recognizance

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[6] Rates of substance use disorders among individuals who are incarcerated are commonly considered to be as high as 65%, though treatment rates are substantially lower at less than 10% of those eligible. Rates of increase in treatment rates will depend on the availability of staff and funding needed to support such programs.

[7] Latest data available for pre-trial detainees is 44% accessed at

http://www.la-sheriff.org/s2/static_content/info/documents/Custody_Third_Quarter_Report_2018.pdf

and access community-based services while awaiting trial as a result of bail reform efforts, the impact of programming on the individual may help support disposition to the community rather than jail when they return for their day in court. Such reforms could reduce the overall jail population.

Capacity limitations in the State Hospital system

On any given day in LA County, there are approximately 300 individuals who have been charged with a felony, are deemed incompetent to stand trial (i.e., Felony Incompetent to Stand Trial or FISTs) and await transfer to a State Hospital, a problem the State is actively working to resolve.[8] ODR is already working with the State Hospitals to divert a portion of these individuals through its "Felony Incompetent to Stand Trial Community Based Restoration program (FIST-CBR)" program, work that could be expanded as the partnership deepens and additional funding sources are made available. That said, a portion of this population will not be eligible for diversion and will require placement in a State Hospital. As the County and State's interests are well aligned in seeking a solution to this problem it may be a fortuitous time to forge a partnership that could offer mutually beneficial solutions. One potential option to consider would be a partnership between County and State to construct State Hospital beds on either the current MCJ site or an alternative State Hospital property (e.g. Metropolitan State Hospital), allowing for a concomitant reduction in the total number of beds built for the new planned facility. This option has the added benefit that operational costs could be borne by the State, whereas the County currently bears 100% of the operational costs of care for individuals who are awaiting placement in State Hospitals.

Anticipated impact of diversion programs

The Board has given robust support for the creation of ODR and has reiterated on multiple occasions a shared desire to see ODR's scope, scale, and depth of work expand. To date, ODR's focus and resources have been dedicated to increasing diversion rates among individuals with serious mental illness (with or without comorbid SUDs). Consistent with these efforts and in response to an August 2018 Board motion, ODR commissioned a study of the jail mental health population to determine the share of current inmates who could be diverted from the jail and create a plan to scale up diversion efforts for individuals with serious clinical needs. This study, currently being conducted by the RAND Corporation, will analyze various data points to estimate the percentage of inmates that can be safely diverted to community-based treatment from current County custody settings, as determined by justice and clinical partners. Given that the full results of the RAND study will not be available until 2020, ODR performed, with statistical guidance provided by the RAND corporation and with the support of the District Attorney, Public Defender, and Alternate Public Defender, a preliminary analysis of current inmates to assess their potential appropriateness for release into community services, assuming sufficient community resources were broadly available to place individuals as ordered by the court.

In their review of 500 current jail mental health inmates, 56% were determined to be appropriate for diversion and an additional 7% were determined to be potentially appropriate.[9] While the

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[8] Data per Correctional Health Services. The Department of Mental Health also contracts with State Hospitals to care for County residents who are LPS conserved. Currently, DMH contracts for approximately 300 State Hospital beds and carries a waiting list of up to 50 additional individuals who require State Hospital level placement at any given time. These numbers are in addition to the FIST population referred to above.

[9] See full ODR study summary in Appendix I.

study did not separately measure diversion rates across jail housing sections for inmates with serious mental illness (i.e., Forensic Inpatient (FIP), High Observation Housing (HOH), Moderate Observation Housing (MOH)), it is assumed that diversion rates would not vary substantially between the FIP, moderate and high observation housing sub-populations. This number is higher than previous assumptions, which estimated that approximately 25% of the jail mental health population can be safely diverted to community-based resources.

While these preliminary findings are informative, the ODR study was focused only on the mental health population and is not able to provide data to support the share of the non-mental health population that is potentially divertible (i.e., SUD, medical CTC, and medical specialty custodial populations are not included). Once these non-mental health populations are appropriately studied, the number of total inmates in the county jail system who may be suitable for diversion to community-based placements would be expected to increase.

However, the above calculations are only the hypothetically divertible population. The ODR study assumed for its purposes that sufficient community-based placements are available to divert all those who are deemed suitable. This is not the reality that exists in LA County today. Today, approximately 5% of individuals with serious mental illness who are involved in the criminal justice system are diverted to community, far shy of the hypothetical 50%+ that is possible. The primary barrier to diverting a greater number of individuals from jail today is the lack of sufficient infrastructure to do so, particularly the lack of suitable community-based placements/resources, and flow between and among these various placements. Without sufficient capacity and flow through the system from one level of care to another, patients "build up" in the highest and/or most restrictive level of care; in this case, custodial environments. Unfortunately, an individuals' current access to a system of care consistent with the principles noted at the outset of this document is haphazard, limited by the available capacity rather than being based solely on an individual's clinical needs and suitability for diversion from the perspective of the criminal justice system.

Given this reality and our desire to be a "care first, jail last" county, it is critical that the County develop and commit to a plan to develop the infrastructure and resources that diversion programs require to complement construction of a "right-sized" replacement facility at the MCJ site. Building such a continuum will take a significant investment of time and resources. Additional financial resources would need to be provided to the health system (defined broadly) for the diversion facilities/programs needed to support this right-sized facility as current financing streams are not sufficient to fund the capital and County-responsible share of operating costs. This said, LA County has many assets to build upon. For example, there are a variety of vacant parcels and/or buildings that the county owns and could use for the purpose of creating community-based facilities.[10] In addition, there is existing structure within DHS' Housing for Health program and DMH's Full-Service Partnership program to help build up diversion focused programs; there is

[10] Such properties include the six County hospital campuses (LAC+USC Medical Center, Harbor-UCLA Medical Center, Olive View- UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center) as well as other properties such as the MLK Campus and the campus of the former High Desert Outpatient Center. Other County owned sites include the Mira Loma Detention Center, Antelope Valley Rehabilitation Center, and closed and/or underutilized Probation Camps. Finally, there is the potential to use and/or acquire other non-County-owned property such as Metropolitan State Hospital. Of note, these campuses are also sites to build up the 1,500+ beds needed to meet the needs of non-justice populations; such beds are largely additive with the needs for the justice-involved populations referred to here.

also existing funding in custodial health operations that, if used outside of custody, could leverage the Medicaid system and community mental health and/or Drug Medi-Cal networks.

However, to the extent limited funding is directed to custodial facilities without significant investment in community-based diversion and treatment, more people will require the custodial environment, for no other reason than that resources were not available to develop the alternative placements to which these same individuals may have benefited. If the care facilities are not simultaneously supported and built, it is impossible to arrive at a "care first, jail last" model.
One additional diversion-related factor that will affect a proper custodial sizing effort is the projected recidivism rate among diverted as compared to non-diverted populations. According to the Bureau of Justice Statistics, historical recidivism rates are 40% in the first year and 70% over three years in the overall prison population, with higher rates seen among those with mental health issues.[11] Data on jails is not readily available. If high-quality diversion programs can reduce this rate, then the overall capacity of the custodial component of a replacement facility will need to be smaller as subsequent crime and arrest rates will proportionately decline. Current projections included here do not take into account these potentially duplicate patient counts. In beginning to look at these numbers, ODR has contracted with RAND corporation, in a separate statement of work than the one noted above, to perform an initial study on housing and recidivism among ODR populations. Preliminary results are expected this summer; a more in-depth study looking at county service utilization and cost savings from ODR programs is anticipated to be available by the end of 2019.

APPROACHES TO RIGHT-SIZING A JAIL REPLACEMENT FACILITY/FACILITIES

One can consider two general approaches in sizing a potential Jail Replacement Facility (JRF) and the associated community-based treatment capacity needed to make sure a facility works. A first approach is to start with the cohort of individuals who were intended to be housed in the previously planned JRF (i.e., the CCTF), and then determine what portion of these individuals can be cared for in a community-based setting rather than a custodial setting, leaving the remainder to be housed in a smaller JRF. A second approach is to start with the available capacity in the LA County jail system, consider how LA County jail inmates could potentially be managed in the existing network of jails assuming the demolition of MCJ, determine if a bed deficit exists and, to the extent it does, deem this to be the optimal size of a newly designed JRF. This latter approach allows one to consider what conditions would need to exist if the County were to desire to not build a replacement jail. Both approaches, and associated construction options that could flow from each approach, are described below.

Approach 1: Size Jail Replacement Facility/Facilities (including community-based facilities) based on consideration of optimal placement for individuals intended to be incarcerated in the previously designed CCTF

Table II looks at the interrelationship between actual, assumed, and potential diversion rates among the population intended to be moved into the CCTF and the planned vs. projected jail and

[11] 2018 Update on Prisoner Recidivism: A 9-Year Follow-Up Period (2005-2014), Mariel Alper, Ph.D., Matthew R. Durose, BJS Statisticians, Joshua Markman, former BJS Statistician, May 23, 2018, NCJ 250975. Available at: http://www.bjs.gov/index.cfm?ty=pbdetail&iid=6266

community-based bed demand if the County chose to maximize diversion of the eligible population.

As can be seen in this table, the current proposed CCTF's 3,885 beds is much lower than the ~4,800 patients currently in TTCF, CRDF, and MCJ who are planned to transition to the new facility. The Board of Supervisors voted to reduce the size of the jail in 2015 to 3,885 based on an expectation that the County's creation of a new Diversion initiative for those with serious mental illness, would be able to sufficiently reduce the jail population to a level allowing it to fit in the planned CCTF. Without taking into account factors noted above that may cause the demand for beds in the new CCTF to rise (e.g., population growth, increases in the percent of sentence served, growth in the share of the custodial population that has mental illness) or fall (e.g., comprehensive bail reform, improved access to community SUD treatment (including MAT)), the County must reach a mental health diversion rate of 26%, to meet the footprint of the current plan, or else it will be required to take other action to fit in the new facility (e.g., shorten the percent of sentence served). This is a large increase in comparison to the estimated 5% of the mental health population that is currently diverted. In order for the County to be successful with a 3,885-bed facility for those with serious mental illness or complex medical conditions, a much more significant investment must be made by the County in diversion programming and community treatment than is currently planned. This is in addition to the new health staff that would be required to be added to the planned CCTF in order to transition the care from status quo to a "treatment-focused" custody environment.[12]

If one increases the assumed diversion rate to the currently believed hypothetical possible rate of 56% noted above and is able to place non-divertible FISTs in the optimal State Hospital environment, then the custodial facility bed demand falls to ~2,400, assuming again that there are no significant changes in other factors affecting the sizing equation. To reach this level of diversion, however, an additional ~2,400 community-based placements (including State Hospital capacity) are required to accommodate the *initial* custodial decompression upon the opening of the new facility. It is important to understand, however, that this number is not static, and will gradually increase over time in order to maintain steady state flow of patients out of the custodial system into community-based care. The rate of growth of needed placements is dependent on the projected length of stay in each care setting and is additive with the lower level of care or residential settings that patients must be moved to in order to achieve flow through the diversion system. At the "lowest" care setting, permanent supportive housing or other residential placements such as Board and Care will be required for extended periods of time for a large portion of individuals – similar to how permanent supportive housing is needed for many chronically homeless individuals.

Approach 2: Size jail replacement facility/facilities based on consideration of potential future capacity deficits in the LA County jail system

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[12] Given that there has not yet been a staffing model developed for the previously planned CCTF, estimates are not available as to the magnitude of these incremental staffing needed on the treatment or custody side, though the Health Departments are confident that new operating budget would be required in order to delivery the type of high-quality care envisioned for the facility.

As noted above, ~4,800 inmates among the total jail population are intended to be transitioned to the future JRF due to serious mental illness or complex medical conditions, a population that could be reduced to ~2,400 if the County were to maximize mental health diversion. This remaining 2,400 inmates who are anticipated to not be suitable for mental health diversion should be able to be housed in TTCF, a building with a BSCC capacity rating of 2,484. Under optimal conditions, it may be preferable to some renovations of TTCF in order to host the individual and group-based treatment space needed to deliver high-quality medical and mental health services for the population that would remain. Depending on the exact mix of patients diverted, additional FIP beds may also need to be created given the long-wait list for those beds currently (see Table II Column E), though depending on the disposition of the CTC-medical patients (and whether they are able to be transitioned to a community-based facility), it may be possible to convert additional CTC-medical beds to FIP or FIP step-down beds, as has been done in TTCF previously.

This leaves 12,300 individuals (approximately 1,400 women and 10,900 men) who do not have serious mental illness or complex medical conditions and would need to be housed in the County's remaining detention facilities, a problem the County will need to resolve in order to vacate and demolish MCJ in order to make room for the new planned facilities on the Vignes Campus.

While developing a plan for how the County manages the short-term and long-term relocation of these inmates is beyond the scope of this report, several factors could be considered. These include:

- Remodel and re-use of previously vacated or mostly vacant County detention facilities.
- Potential impact of bail reform: As noted above, approximately 47% of inmates are pre-trial; any bail reform effort that substantially reduces the share of inmates who are incarcerated pre-trial would help resolve the shortage of jail beds, while still recognizing that some share of these individuals will still be sentenced to jail time if convicted during trial.
- Expansion of diversion programs beyond the mental health population: As noted above, ODR's scope among the adult justice population is focused on individuals with serious mental illness; ODR does not currently divert individuals with SUD who do not have concomitant mental illness. Expansion of ODR's scope to include the SUD population, as well as medically fragile populations (e.g., individuals with dementia, individuals requiring CTC-medical level of care) would further reduce the number of individuals who require incarceration.
- Broader effort to enhance alternatives to custody for lower risk individuals.
- Partnership with the State to transition those currently awaiting State Hospital beds

MIX OF CAPACITY NEEDED IN THE COMMUNITY-BASED SYSTEMS OF CARE

Regardless of the approach taken, consideration must also be given to the scope or specific mix or type of services that should be provided in the new planned facility/facilities. Column A in Table II shows the corresponding community-based facility type(s) for each custodial housing type. Given that there are multiple levels of care listed for each custodial housing type, and multiple types of care within each general care level, additional work is needed to generate a more specific bed mix needed to accommodate the diversion population. This information is critical to determining the ultimate portfolio of community-based capacity that needs to be available in order to successfully divert all those who are deemed eligible. This work is being conducted by ODR with the support of DHS leadership and outside experts and in collaboration with DMH and DPH. The "Road Map" can then be combined with findings from a DMH and DPH-commissioned study

currently being conducted by Mercer Consulting to analyze existing facility-based capacity and the significant amount of unmet need for locked and unlocked mental health and SUD resources above and beyond that being deliberated in the CCTF context and inform our decisions about how to optimize the coordination, structure, configuration and capacity of the County's continuum of care, both within custodial settings and in community settings.

With regard to SUD, because of the exclusion of SUD-specific housing in the current jail and planned CCTF, and because ODR's scope of work does not currently extend to single-diagnosed individuals with SUD, there is not sufficient data available to inform right-sizing estimates regarding custody or community-based housing demand for justice-involved individuals with SUD. Additional analysis is needed, both to ensure that individuals in custody with SUD are able to access treatment within the CCTF as appropriate, and to adjust diversion projections to take into account those with SUDs.

OPTIONS

It goes without saying that the options presented below are focused on the health and wellbeing of individuals being cared for by the County and as such do not intend to make definitive statements about the safety of the public which requires primary input from our judicial and law enforcement experts. That said, taking into account the multiple analyses above, we respectfully suggest that the Board consider the options at the end of this section to frame its deliberations on a pathway forward. Each of the options that follow allows for the demolition of MCJ and relocation/diversion of the general inmate population currently housed there. In addition, each option allows for both the development of (or access to) facilities that are able to serve as high-quality treatment-oriented care settings for those individuals with mental illness who for various reasons are not expected to be divertible to the community-based systems of care.

The options being suggested are based on a number of premises and presumptions, including:

- That RAND corporation will validate ODR's preliminary study demonstrating that a large share of the current mental health population in the LA County jails is divertible to non-custody settings.
- That ODR and the justice partners across LA County will continue to develop practices and infrastructure that promote diversion when it can be done safely.
- That myriad efforts to address social determinant resource deficits (i.e. housing, employment) will be developed aggressively in tandem with any and all diversion efforts to absorb, support and empower the diverted population.
- That the County will escalate its investment of a robust system of health and human services embedded in communities across the entire county to ensure that individuals with mental illness and/or substance use disorders are not only able to access ongoing care following diversion, or re-entry, from the criminal justice system, but also screening, treatment and healing services to mitigate becoming involved with the criminal justice system in the first place. Doing so will require the development of a siting[13] and capital funding plan to build out community-based systems of care capacity needed to accommodate diverted population (without adversely impacting capacity needed for

[13] Siting plan would include construction on the Vignes Campus to leverage, if possible, the executed Design-Build contract by pivoting it to construction of a complex of non-custodial ("care") facilities.

County residents requiring mental health and substance use services who are not currently incarcerated).[14]

- That the County will stay committed to a strategy for building out a broad network of restorative care programs on our hospital campuses (i.e., BHC at MLK Campus; see Appendix II, "Restorative Care Network") and consider other County properties (i.e., Probation Camps and/or other dormant custody properties) as well where indicated and feasible.
- That the County will continue to work with the State Hospital system to devise and implement plans to create additional capacity needed to accommodate the FIST population as well as other populations for whom care at a State Hospital is indicated.

The options being presented below are related but different ways for the County to think about moving forward with alternatives to the currently designed CCTF. Though the logistics of the current CCTF contract are beyond the scope of this document as well as the Health Departments' expertise, options are being presented in the context of pivoting the plan to allow for a care-first, jail-last model, while at the same time, if at all possible, leveraging the existing contract to advance Vignes Campus development.

Regardless of the specific option preferred by the Board, in the interest of setting up strategies for each of the options below, it makes sense to aggressively ramp up the County's commitment to reducing the number of inmates with mental illness housed at TTCF in earnest by deploying staff and investing new funds accordingly. Two key early-win strategies for dropping the TTCF census are accessing untapped community-based IMD and State Hospital beds and, at the same time, redeploying homeless initiative investment toward housing that is dedicated to diversion; this is in addition to longer-term investments that are needed in scaling up the community-based systems of care across the County. Once the TTCF census starts to drop, the County can perform focused remodeling for an enhanced treatment environment (Option 1 and 3) for inmates with mental illness and/or transition in the MCJ population (Options 2 and 3).

As a last point that is inferred in the above analyses, should the County decide to move forward with the existing 3,885 bed CCTF as previously designed, it will be necessary for the County to construct and/or identify ~1,000 community-based care (including State Hospital) beds to account for the fact that, as it is currently planned, the CCTF is too small to accommodate its intended feeder populations. The County will also need to develop and identify funding for the higher annual operational costs expected to be required to staff and operate the treatment-oriented 3,885 bed, as compared to the staffing in place in current custodial facilities currently in use.

Option 1: Renovated TTCF and newly constructed 2,400 bed community-based Mental Health Treatment Center

[14] Information from the DMH and DPH-commissioned Mercer study and the ongoing work by DHS/ODR will help estimate the total service needs across levels of care, for both the justice-involved and non-justice-involved populations.

Option 1 Bed Summary:

Community-based care beds	
Vignes Campus	~2,400 bed community Mental Health Treatment Center(s) in one or more facilities[15]
Disseminated County-wide (off Vignes)	Additional beds as needed to support ongoing diversion and continuum of care for diverted population
Custody beds	
Newly constructed treatment-focused custody beds	None
TTCF usage	~2,400 treatment-focused custody beds
Total beds	
Total beds for currently incarcerated population planned to shift to CCTF	~4,800 beds

This option would prioritize construction of a new 2,400 bed "Mental Health Treatment Center" in one or more facilities, offering varying levels of clinical care (including triage services, acute, sub-acute, and residential levels of care) as needed to triage and care for the estimated number of individuals with serious mental illness who are able to be diverted from the jail. As with current CCTF plans, the newly constructed facilities would also include dedicated space required by County justice partners to evaluate and triage patients from a criminal justice lens, such as courtrooms, attorney-client consultation areas, etc.

This option also would include the continued use of TTCF for placement of ~2,400 individuals with serious mental illness and/or complex medical conditions who cannot be safely diverted to the community. If needed, renovations could create additional treatment space needed to provide group and individual therapy as well as dedication of additional space to accommodate psychiatric inpatients, many of whom are currently held in high observation housing. Significant attention would be placed on providing high quality and appropriate treatment options that are tailored to the specific needs of each patient. Thus with the demolition of MCJ, the Vignes Campus would transition fully into a health/treatment focused property for individuals who are both in custody and in the community. Additional community-based treatment capacity would be developed off the Vignes Campus to accommodate ongoing flow through the continuum of care for justice-related populations.[16] This would be done through a combination of leasing/contracted placement capacity, renovation of existing County buildings, and/or new construction.

Given that TTCF is currently planned to be used to house inmates currently held at MCJ after MCJ demolition, this plan would require identification of alternative custody space to which MCJ

[15] 2,400 beds noted here could alternatively be sited off Vignes campus if desired.

[16] This is in addition to the new capacity required for non-justice populations as detailed in the Mercer study commissioned by DMH and DPH

inmates could be housed so as not to delay demolition of MCJ. As noted above, a variety of factors (e.g., bail reform, greater use of alternatives to custody) may lead to a reduction in demand for jail beds among the general population. In addition, there are a number of county-owned facilities and properties that could potentially be renovated to serve, if needed, as custody space for incarcerated individuals. If Option 1 is selected as the preferred option by the Board, a detailed census model and transition plan would need to be developed.

In avoiding the construction of a new jail facility, at the Board's discretion, the funds currently earmarked for CCTF construction could be repurposed for other needs to support this option, including the development of the new 2,400 bed Mental Health Treatment Center facility or facilities. Such Mental Health Treatment Center beds could be built in such a manner as to maintain maximum flexibility so that, while built and licensed as community-beds, they could be used if needed for overflow of custody patients on an as needed basis. When used as custody beds, Sheriff personnel would be included in the treatment team staffing model. The number of mental health beds would depend upon the cost for construction, and the array of buildings would need to be organized to optimize safety and also encourage flow of patients (out of custody and into care when possible).

Option 2: Newly constructed 2,400 bed custody facility and 900 bed Mental Health Treatment Center

Option 2 Bed Summary:

Community-based care beds	
Vignes Campus	~900 bed Mental Health Treatment Center
Disseminated County-wide (off Vignes)	~1,500 beds plus additional beds as needed to support ongoing diversion and continuum of care for diverted population
Custody beds	
Newly constructed treatment-focused custody beds	~2,400 beds
TTCF usage	General population inmates transitioned from MCJ
Total beds	
Total beds for currently incarcerated population planned to shift to CCTF	~4,800 beds

This option would prioritize construction of a new 2,400-bed treatment-based custodial facility on the Vignes Campus able to house those not potentially suitable for diversion. In order to have capacity to house those who are eligible for diversion, ~2,400 additional beds would need to be built, using funding allocated for the CCTF project (with identification/allocation of new funding as needed) to develop the community-based systems of care required to house individuals diverted from jail. This community-based bed/slot capacity would be distributed between the Vignes Campus and other sites across the County, including but not limited to the current set of

health/hospital campuses. As a preliminary estimate, approximately 900 of the higher acuity mental health patients would be situated at the Vignes Campus[17], with the remaining 1,500 beds disseminated across other County properties and/or community sites. However, a more comprehensive bed mix and siting of these 2,400+ community-based beds would need to be based on an assessment by DPW, in partnership with CEO capital projects, County Counsel and Health Departments regarding constraints of the executed $1.4 billion Design-Build contract, CEQA considerations, anticipated costs of various alternative non-MCJ sites.

Option 3: Newly constructed 1,200 bed custody facility and 2,400 bed Mental Health Treatment Center

Option 3 Bed Summary:

Community-based care beds	
Vignes Campus	~2,400 bed Mental Health Treatment Center (flex-capacity for 1,200 of these to custody beds)
Disseminated County-wide (off Vignes)	Additional beds as needed to support ongoing diversion and continuum of care for diverted population
Custody beds	
Newly constructed treatment-focused custody beds	~1,200 beds (per above, 1,200 beds new Mental Health Treatment Center potentially able to be flexed to treatment-focused custody bed status)
TTCF usage	~1,200 treatment-focused custody beds; additional general population inmates transitioned from MCJ
Total beds	
Total beds for currently incarcerated population planned to shift to CCTF	~4,800 beds

Option three would include an initial footprint of 1,200 treatment-based custodial beds, with the remaining buildings on the Vignes Campus offering treatment options for approximately 2,400 non-custodial individuals who are diverted from jail settings. Twelve hundred (1,200) of these 2,400 care beds would be built to specifications that would allow for transition of some or all beds to custody beds to accommodate individuals who are incarcerated[18] if the County is not able to approach a diversion rate of 56% in the future. This option offers greater flexibility on the Vignes

[17] Bed allocation to be determined based in part on considerations of viable options under existing design-build contract.

[18] The feasibility of this approach requires further investigation by DPW

Campus, prioritizing construction of facilities that primarily support treatment for individuals who are not in custody, yet allowing for transition of a set number of beds from care to custodial if anticipated diversion rates are not achieved. If this option is selected, additional work would need to be done to determine the feasibility and associated costs of building a set of beds to flex between "care" and "custodial" bed types, including licensing considerations.

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Irrespective of the option preferred by the Board, additional work/investigations needed include the following:

- Development of a sizing and siting plan able to accommodate additional community-based care capacity, above the 2,400+ Community Based System of Care placements noted above, to ensure flow through continuum of care as diverted individuals step down to lower levels of care and housing. Estimates of the number of additional capacity required to maintain this flow is being performed by ODR and expert consultants in collaboration with the Health Departments. This sizing and siting plan should include an intensive landscape analysis of dormant and or under-utilized County properties to identify additional candidate sites for expanding mental health bed beyond the Vignes Campus.
- Jointly development, by the Health Departments and CEO, of recommendations for augmenting the current $2.2 billion to further build out CBSOC capacity, based on the number of placements needed to support care for individuals who are not currently incarcerated (e.g., ongoing Mercer study), as well as the ongoing care continuum for justice-based populations noted above.
- Identification of dedicated sources of ongoing funding needed to meet anticipated annual operating costs of a revised care and custodial plan that will bring new community-based services to both uninsured and Medi-Cal-eligible individuals, beyond that able to be earned through third-party reimbursement including federal Medicaid funds. Note that per current California Medi-Cal regulations, the County is responsible for funding the non-federal share of services provided.
- Potential options for enhancing the availability of housing for individuals diverted to the community to mitigate the likelihood that they will become homeless and re-arrested. To achieve an adequate stock of housing, it may be necessary to dedicate a portion of Measure H and HHH, as well as other housing funds, for example "No Place Like Home" from DMH, to develop residential placements for diverted individuals.
- Joint development, by the Public Defender, Alternate Public Defender, the Health Departments, ODR and CEO of recommendations on a robust pre-plea diversion plan principled on community-based services. In addition, identified entities would further, assess and report on existing leading practices of pre-plea supervised release, pre-plea diversion, and community-based treatment in California and across the nation. As part of this, entities would examine the potential to shift field supervision to the Health Departments for specified populations, providing a seamless single point of contact for the client base requiring community-based treatment services.

STAFFING AND OPERATING THE NEW PLANNED FACILITY OR FACILITIES

In the February 12th motion, the Board requested that the Health Departments make recommendations as to how and by whom the new facilities would be staffed. While a full staffing proposal has not been developed, in keeping with the Board's action in 2015 to create an Integrated Correctional Health Services unit within DHS which provides comprehensive physical health, mental health, and substance use services, health services delivered within a custodial

environment would be provided by DHS. However, as it is a custodial environment, the Sheriff's Department would be the primary owner and operator of the facility.

For community-based capacity, one Department would need to take primary responsibility for operating each facility (or unit of a facility), depending on the type of services offered, the level of acuity, and most importantly, the funding and licensure requirements of the facility. While the Departments will work collaboratively to offer integrated services between units, for a variety of operational, organizational, and regulatory reasons, each standalone unit would have one responsible Department providing staffing and leading operations. Once a final set of planned community-based facilities is determined, DHS, DMH, and DPH will work in partnership with the CEO to develop and submit a plan to the Board with proposed approaches to integration of services, staffing (including notably, the responsible Department), and funding needed to support these community-based services.

There are significant anticipated increases in overall operational costs for providing more people with high quality treatment services in both custodial and community settings. As noted above, this applies similarly to the previously planned CCTF for which there could be expected to be significant additional operating costs for new health/treatment staff, in addition to potentially additional custody staffing demands as well. While the County can draw down federal match dollars for most services provided in non-custodial settings (an additional benefit to diverting as many eligible people as possible to non-custodial treatment settings), it is important to note that additional local funding must be identified to access federal matching dollars for treatment services. Savings from reductions in the number of people in custody, where the County is responsible for 100% of costs, is one source of funding that must be accessible to offset increases associated with providing more people with care in non-custodial settings.

COMMUNITY ENGAGEMENT

In considering the options above, it is critically important that we continue to take into account the perspectives of the broader community and stakeholders, including those who reside in the areas surrounding the Vignes Campus (e.g., Chinatown), other communities that may be impacted by construction at the MCJ site and elsewhere, those who have been involved with the criminal justice system or been affected by incarceration and mental health advocates, among others. The Health Departments propose either:

1. Convening a series of community meetings in partnership with CEO, DPW and County Counsel to discuss plans for the Vignes Campus and related expansions of community-based treatment.
2. Leveraging and augmenting the community engagement efforts currently led by the ATI Workgroup to include a set of additional community workshops as indicated, and specifically in the East LA communities surrounding the Vignes Campus to offer an opportunity at all of the already planned workshops throughout the county for discussion of plans related to the Mental Health Treatment Center and the expansion of community-based treatment.

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Attachments

Table II: Interrelationship between actual, assumed, and potential diversion rates and planned vs. potential jail and community-based bed demand under full diversion

	Non-custodial equivalent levels of care[1]	Number of beds in currently proposed CCTF	Feeder sources for proposed CCTF beds[2]		Correction for current wait lists in TTCF[3]	Projected bed demand for new facility[4]	Current estimated diversion rate[5]	Required diversion rate[6]	Potential percent divertable[7]	Projected future bed demand by setting of care[8]		
			TTCF and IRC	Other Jails[9]						State Hospital Capacity[10]	Custodial Capacity	Community-based capacity
	A	B	C	D	E	F	H	I	J	K	L	M
Forensic Inpatient (CTC Psychiatric)	• Acute psych	240	46		+215 [+200 in HOH; +15 in CTC Medical]	261	5%	12%	56%	0	115	146
High Observation Housing	• Acute psych • Sub-acute psych	840	990	308 (CRDF)	-250 [200 to FIP; 50 to detox]	1048	5%	24%		66	395	587
Moderate Observation Housing	• Sub-acute psych • Residential	1800	2108	366 (CRDF) 320 (Pitches s)	-70 [to detox]	2724	5%	37%		66	1133	1525
Skilled Nursing Facility (CTC Medical)	• Medical Skilled Nursing Facility	120	165		-45 [15 to FIP; 10 to detox; 20 to Med spec]	120	0%	0%	25%	0	90	30
Medical Specialty	• Residential	480	0	480 (MCJ & CRDF)	0 [+20 in CTC medical; -20 to detox]	480	0%	0%	0%	0	480	0
Medical Detoxification	• Withdrawal mgmt	200	50[11]	0	+150 (+50 in HOH, +70 in MOH, +10 in CTC med, +20 in med spec)	200	0	0%	50%	0	200	0
High Security Housing	• n/a	205	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0
TOTAL		3885	4833		0	4833		26%[12]		132	2,413	2,288
										4833		

Notes:

1. Acute psych includes acute inpatient psychiatric units (FFS, Short-Doyle, and public) and psychiatric health facilities. Sub-acute psych includes State Hospital and community-based sub-acute mental health treatment (mostly IMD) facilities. Residential includes crisis residential, enriched residential services, short-term residential therapeutic programs, and permanent supportive housing.
2. Mental health census counts based on "LASD Mental Health Count 5/21/19"; CTC and MOSH census based on ICHS recent average patient counts.
3. Based on ICHS recent average patient counts
4. Estimates projected bed demand at most appropriate level of care; calculated as sum of column C, D and E. Holds diversion rate constant.
5. Estimated based on ODR experience.
6. The total diversion rate among the mental health population required to accommodate bed volumes in currently proposed CCTF, with other factors affecting ADC held constant (e.g., length of sentence served, incarceration rates, percent of total jail population with diagnosed mental health conditions). Calculated as the percent change between the bed count needed to accommodate the total pre-diversion population (Column F x (1+ Column H)) and projected future bed count planned in CCTF (column B).
7. ODR's current scope is individuals with mental illness with or without substance use disorders. Mental health numbers based on preliminary ODR Study; to be validated by ongoing RAND study results expected to be available in 2020. While future scope of activity could extend to diverting patients with serious physical health issues (including dementia) such as those requiring SNF-level of care, there is currently no experiential data that can be used to project the divertible share of the CTC or medical specialty populations. In the absence of available data and with the assumption that many patients in SNF level of care can be safely cared for in a non-custodial setting, it is assumed that 25% of CTC patients are divertible. In the absence of available data and with knowledge that diverting non-mentally or seriously ill populations would require broader criminal justice reform, it assumed for the purpose of this exercise that 0% of medical specialty patients are divertible. Because medical detoxification is a short, time-limited service for those who have recently entered jail, it is assumed the diversion rate for this care setting is 0% as well for the purposes of this document.
8. Represents new capacity required to accommodate transition at time of jail opening. Does not take into account compounded growth required to accommodate movement of patients efficiently through continuum of care. Community-based capacity calculated by multiplying Column F by (Column J – Column H); custodial capacity is remaining share minus the State Hospital component.
9. Under current proposed plan, women at CRDF requiring HOH and MOH level of care would be transitioned to new facility. Women requiring FIP and CTC/SNF level of care are already cared for at TTCF and would be included in the new facility. Women in other levels would remain at CRDF. Approximately 480 men and women from MCJ and CRDF who are medically complex would be transitioned to the new facility. Approximately 320 men with lower-acuity mental illness included in MOH counts are held at Pitchess North Campus.
10. Assumes there are approximately 150 patients in both HOH and MOH awaiting transfer to State Hospitals at any one time. Assumes diversion rate of State Hospital population is the same as the non-State Hospital population. Does not include patients awaiting transfer to State Hospitals from outside the custodial system (i.e., LPS-conserved individuals managed by DMH).
11. Dedication of ~50 beds located in pod off IRC to detox purposes.
12. With conversion of 205 High Security Housing beds to mental health beds, required overall diversion rate falls to 26% in order to "fit" into planned CCTF

Health Services
LOS ANGELES COUNTY

SPECIAL REPORT

April 17, 2019

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

OFFICE OF DIVERSION AND REENTRY

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Dustin Stephens, MD, PhD

Introduction

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

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

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

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

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

Methods

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

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

Results

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

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

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

Conclusions

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

May 11, 2019

Addendum

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

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

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

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

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

Restorative Care Network

At this time, Los Angeles County does not have any where near an adequate supply of truly comprehensive, community based programs that address the interrelated and complex needs of those struggling with access to intensive care for serious persistent mental illness and/or refractory substance use, too many of whom currently end up either homeless or "housed" in the jail. As such the BOS, with guidance from its Health Departments and key other health and human service partners, is looking to create a County-wide, health campus-based, network of integrated "Restorative Care" programs designed to address the broadest range of intensive behavioral healthcare needs through an enriched resource continuum.

The first such prototype, the Behavioral Health Center or "BHC", will be situated on the MLK Campus and is scheduled for completion in 2022. The MLK BHC will provide a wide range of services and supports through integrated programs that allow individuals with serious behavioral health needs to enter, and transition to, the appropriate level of care with the expectation of successful reintegration into the community as a goal. The continuum of clinical services to be delivered in the MLK BHC will include urgent care, crisis stabilization and sobering centers; acute and sub-acute psychiatric inpatient units; crisis and general mental health as well as substance use disorder residential beds; general and intensive outpatient mental health and substance use disorder treatment as well as ambulatory detox, rehabilitation and medical services; family, group and individual counseling as well as a gamut of "non-clinical" support resources that address the social determinants of health (e.g. on-site reintegration programming such as peer navigation/concierge services, education, vocational training, workforce development and employment, and housing, legal, benefits as well as Probation assistance, with childcare in a separate but adjacent facility).

The proximity and accessibility of these levels of care and supports on an enriched healthcare campus will facilitate long-term stabilization, minimize relapses and readmission into acute care including unnecessary visits to the emergency departments and long-term stays in inpatient facilities, and most importantly, will maximize diversion from the streets and the criminal justice system; "Care first, Jail last". Through access to an appropriate level of care to address illness and offer up a range of opportunities to facilitate healing, those in most need will be able to move along the continuum of care, escalating in intensity when indicated, and progressing to community re-integration as possible using a client-centered, strengths-based approach. Though this program will be community facing and accessible, it will also be accessible for reentry populations.

The following clinical and non-clinical components will comprise the MLK BHC, LA County's prototype Restorative Care Program:

- Peer Support
    - Concierge Services
    - Resource Center
- Urgent Care Services
    - Medical
    - Psychiatric
    - Recovery Intake (aka Sobering Center)

Restorative Care Network

- Mental Health, Ambulatory
  - Outpatient and Re-entry
  - Intensive Outpatient
- Mental Health, Residential
  - Open
    - General
    - Crisis
  - Secure
    - Sub-acute
    - Acute
- Substance Use Disorder
  - Outpatient Services
  - Withdrawal Management
  - Residential
- Primary Care Clinic
- Workforce Development
- Adult Protective Services
- Probation
  - Community Re-entry Center
  - Services and Support
  - Records
- Amenities and support services:
  - Conference Center
  - Grab 'n' Go Café
  - Kitchen
  - Security

Below is the locked and unlocked bed capacity of the BHC, which the Health Departments see as one set of programs on one campus but over time just one part of the larger, Restorative Care Network that is composed of the various care (not custody) facilities on the Vignes Campus (aka the future "MHTC"), as well as BHC-like facilities that are in the pipeline or in planning stages on other healthcare campuses (e.g. LAC+USC, Rancho, Harbor, Olive View, High Desert). It should be noted that the BHC bed capacity has been somewhat predetermined for the MLK Campus due in large part to the fact that is being developed in an existing building with a certain square footage that is amenable to restoration, and is not necessarily representative of the required, nor feasible, allotment of clinical resources on the other County healthcare campuses:

- 32 Acute Inpatient, locked
- 80 Sub-acute Inpatient, locked
- 130 Residential treatment
  - 16 Crisis
  - 16 Withdrawal Management
  - 66 Substance Use Disorder
  - 32 General

Restorative Care Network

Having these 242 beds accessible to, and embedded in, the community has numerous advantages over having all inventory concentrated on the Vignes Campus only, as articulated in the body of this report and we believe core to the County's commitment to a "Care first. Jail last." philosophy for managing many of our most vulnerable clients. Given that our model estimates the need for ~2,400 diversion beds to account for the current jail population, with additional capacity needed to ensure ongoing flow through a continuum of care, we must determine an overall strategy for building up the Restorative Care Network across the Vignes and County healthcare campuses.

As it will not be possible to accommodate all of this demand on the County properties, where we have site control and robust clinical footprints in place already, it is important to explore other facility-based treatment opportunities in various communities, an endeavor that is being actively explored by the Health Departments. As an example, DMH has identified and is working to contract with Las Encinas Hospital for an additional 16 sub-acute and 16 residential beds and DHS is exploring the potential acquisition of the St Vincent's campus. While it is important to recognize that this appendix as well as the main body of the document account for the general size and needs of the population that is currently justice-involved at any given time, we must ultimately consider the overall population of those with serious mental health and addiction problems across Los Angeles County who are not incarcerated but at great risk of ending up in jail and/or homeless due their illness and a lack of community-based care. All evidence indicates that these bed capacity deficits are sizeable. Preliminary results from the pending Mercer report suggest that more than 1,500 treatment beds (mostly sub-acute mental health) will be required to address the needs of those who are not currently justice-involved. Needless to say, the County's lack of adequate treatment beds is a massive challenge that can only be resolved with substantial further investment in both physical facilities and services.

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

856 KENNETH HAHN HALL OF ADMINISTRATION / LOS ANGELES, CALIFORNIA 90012 / (213) 974-4111

HILDA L. SOLIS
SUPERVISOR, FIRST DISTRICT

June 22, 2019

Ms. Sachi Hamai
Chief Executive Officer
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Kenneth Hahn Hall of Administration
Los Angeles, CA 90012

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Director of Mental Health
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Los Angeles, CA 90012

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313 North Figueroa Street, Room 806
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Mark Pestrella
Director of Public Works
900 South Freemont Avenue
Alhambra, CA 91803

Dear Ms. Hamai, Dr. Sherin, Dr. Ghaly, Dr. Ferrer, and Mr. Pestrella,

Subsequent to the Board Motions on February 12, 2019, and yesterday's briefing with you or your staff, I am pleased that the County is taking a new direction in being an innovative leader on criminal justice reform. I am proud of my colleagues for the bold position that we all took on February 12 to reject the Consolidated Correctional Treatment Facility concept as obsolete, in favor of a "care first, jail last" approach, based on evidence that demonstrates that punitive environments are not only inhumane for those who are suffering from mental illness, but that these environments also

exacerbate the illnesses faced by our most vulnerable residents, as well as greatly reduce their likelihood of recovery, upon release.

I am thankful for the tremendous work that the Alternatives to Incarceration (ATI) Workgroup has undertaken to detail what a "care first, jail last," model for the County will require. I am also appreciative of the collaborative effort that you all, as our department leaders, have undertaken to design a plan to bring this vision to life. It is a true accomplishment that in only a few months, this County has gone from one understanding of what treatment and justice look like, to a whole new model: a new model that is grounded in principles that prioritize decentralized services and care and based in what we know works best to support our residents and our communities so they can thrive. It is particularly heartening to see the synergistic alignment of these shared principles that is happening through the report-backs from both the ATI Workgroup to the 90-day presentation that you shared with me yesterday. These reports must form the basis from which we will collectively move forward.

As has been made clear throughout this process, the demolition of Men's Central Jail must remain at the core of whatever plan is advanced. For the last 60 years, this facility has notoriously defined the landscape of one of the entry points to Downtown LA, and the lives of far too many of our County's residents. I appreciate the historical moment we are in, one that will redefine how this site is used, and how it will shape the very landscape of the First District that I serve, for the decades that follow. To that end, I want to provide my feedback to this presentation and share what I hope to see in the coming weeks.

To state the somewhat obvious, the plan that has been put forth falls apart, and replicates the mistakes of the Reagan era's approach to deinstitutionalization, if we fail to properly invest in the proposal for off-site community-based treatment beds as a starting place. Though the current plan recommends 1,538 beds to begin with, this number will have to be greatly expanded to account for ongoing needs for care capacity. Despite the principles laid out in this "care first, jail last" plan, the only piece for which funding has been identified and a detailed plan to move forward has been developed, is the jail piece. Without a plan and strategy for how to provide the mental health care we know we must provide, I feel that yesterday I was presented with more of a "jail first, care…to be determined" plan.

Based on the abundance of evidence, including testimony from clinicians and other experts, national best practices, and shifts in the public's approaches to criminal justice, we know that people with mental illness need a comprehensive whole person treatment approach and that this treatment must be provided outside of a custody environment whenever possible. I have heard from psychiatrists who have worked in the jails who felt that they were unable to provide care in a way that was consistent with their medical ethics because of the very nature of the custodial setting. This does not change with a new custody facility.

This may be one of the most important decisions that we face as a county for decades

to come. The outcomes of the California Health Care Facility in Stockton provide important perspective. The facility was built six years ago to care for the most seriously ill inmates in California's prison system, increased medical and mental health care capacity for the state prison system, and was to provide a "healing atmosphere within a correctional environment."[1] However, just a few months ago, the state's inspector general reported a myriad of severe problems with the care provided, such that the facility received an "inadequate" rating and failing grades on eight of ten indicators. These outcomes add to my longstanding doubts about whether a custody environment, however improved, can adequately meet the needs of prisoners with clinical needs.

As currently designed, I fear that a plan for a jail will worsen health outcomes for those in the County's custody, increase the numbers of those facing homelessness, reinforce the generational cycle of incarceration and poverty, and fortify racial and income inequities for decades to come.

The preliminary study conducted by the Office of Diversion and Reentry of the population of those with serious mental illness who are divertible has provided us with an important starting point to begin to understand the real potential for reducing the population of those who are incarcerated in our County.

However, as yesterday's presentation made clear, while that study is an important starting point, there are still significant unknowns, such as: (a) the number of people who could be diverted based on addiction or medical care needs to a substance abuse treatment or medical care continuum; (b) the number of people we could reasonably expect to be released through properly implemented and bold pretrial reform mechanisms; and (c) the impact of state criminal justice reforms that are likely to continue in the direction that has been advanced in the last decade.

According to a recent study by UCLA, the median length of stay for people in our jails is ten to thirteen days – just long enough to disrupt a person's life, but not long enough to provide any treatment or services. However, despite concerns about the rates of early release, consistent with national trends, crime rates in LA County are the lowest that they have been in decades. Additionally, studies have shown that a person coming out of jail is six to ten times more likely to become homeless, and that people experiencing homelessness are up to seventeen times more likely to get arrested and begin the harmful cycle through the justice system.

All these data points beg the question: do these individuals need to be spending any time in jail at all? Are public safety goals and cost considerations not better served by instead, keeping them in their communities receiving the support and care they need and deserve?

We all know that the County currently lacks the volume of services that it would need to actually serve the mental health care, substance use disorder treatment, workforce

[1]Don Thompson, "Inspectors Slam Stockton Prison Medical Facility," April 25, 2019, (https://www.recordnet.com/news/20190425/inspectors-slam-stockton-prison-medical-facility)

development, housing, and education needs for many of the people who become involved with the criminal justice system. Instead, they go to jail, where they may receive some services, but most likely are not receiving the depth of services needed to ensure that they can succeed in their community once released.

Yesterday's presentation proposes a jail facility with a 2,400 bed capacity. I would like to understand what scenarios would have to be true with respect to the various factors identified as affecting the right-sizing of the jail replacement that would allow the Board to move forward with a plan that avoids jail construction altogether, and commits instead to only building facilities for services and care across LA County. As we discussed in the briefing yesterday, please provide a written response in the 90-day report back that

1) Considers options that would prioritize building up care and service capacity in the County, and that may avoid jail construction altogether. This might include for example, moving forward with the demolition of Men's Central Jail, building the approximately 900 on-site treatment beds suggested by yesterday's presentation while also building up the decentralized care infrastructure across the County, and reducing the jail population significantly such that renovating Twin Towers to provide for the treatment needs of those with clinical needs who are not diverted, could adequately address the treatment capacity needs that we currently face.
2) Considers a phased approach to the construction of the proposed 2,400-bed new jail facility. This may include a first phase of building 1,200 bed capacity, with the option to revisit the need for additional beds, up to 2,400 total, in four years, once community-based care capacity has received adequate investment and been built up.
3) Considers a plan for funding the off-site, community-based treatment capacity. The presentation includes a proposal for opportunities for increasing this capacity, in a phased approach over the next several years. Such a plan should lay out commitments of funding to the projects identified as having already been approved by the Board, such as the Restorative Care Village at LAC+USC.
4) Any plan must have a robust stake holder and community engagement process to receive input and allow impacted communities to provide feedback, especially those that are in the immediate vicinity of the Men's Central Jail site, such as the Chinatown community, and any other communities outside of Chinatown that may be impacted by construction at the Men's Central Jail site.

We have not given ourselves the opportunity to study how many people the courts might divert to services in the community instead of jail, if enough of those services existed. How many people could we prevent from even coming in contact with the criminal justice system if we comprehensively invested in building up the resources and services that people need to avoid falling through the cracks? I continue to want an opportunity to understand just what this investment would require.

For these reasons, I have deep questions about whether it is an appropriate use of the County's resources to build a jail to replace Men's Central Jail, or if continuing to invest major resources into the construction of a jail facility is actually counterproductive and

inconsistent with the stated vision for a decentralized, community-based, “care-first,” integrated system of care, that will lead to improved public safety and improved outcomes in all of our County’s communities.

I appreciate the opportunity to continue this important conversation.

Sincerely,

Hilda L. Solis

Supervisor Hilda L. Solis
Los Angeles County, First District

C: Board of Supervisors
Executive Officer of the Board
County Counsel
Director of the Office of Diversion and Reentry

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ALEX VILLANUEVA, SHERIFF

July 9, 2019

Ms. Sachi Hamai
Chief Executive Officer
County of Los Angeles
713 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Dear Ms. Hamai:

MENTAL HEALTH TREATMENT CENTER
MINIMUM CAPACITY

The Los Angeles County Sheriff's Department (Department) was recently briefed by the Department of Mental Health (DMH) and the Office of Diversion and Re-entry's (ODR) staff and their vision of a "Care First, Jail Last" continuum of care for individuals with complex behavioral health issues. The Department supports the ODRs efforts and is committed to collaborative effort by establishing partnerships with community based entities and other County departments. The Department appreciates the work the Department of Public Health and the ODR has produced; however, the data presented appears too ambiguous as an absolute resolution to our societies' medical and mental health concerns within and out of a custodial environment. The potential 56 percent diversion rate of current mental health inmates published in the "ODR 500 Study" might not have considered all related factors.

This briefing proposed a reduction from 3,885 in-custody beds to 2,400 in-custody beds. The Department recommends the new facility maintain a minimum of a 3,885 bed count. **Please see Attachment A - MHTC Proposed Scope - LASD.** One of the most dynamic and rapidly increasing populations within Custody Division is the mental health and medically acute afflicted

inmates. Often times this segment suffers from serious disorders which in turn presents the Department with varying challenges such as: inmate classifications, appropriate housing, treatment, and programming spaces to facilitate their rehabilitative needs.

The County jail system processes an average of 300 inmates per day or approximately 109,500 inmates per year. A recent snapshot in Q1 2019 reflected a daily inmate population of approximately 16,500 total male and female inmates. High Observation Housing (HOH) housed approximately 1,333 inmates, and Moderate Observation Housing (MOH) housed approximately 2,796 inmates, 1,160 additional inmates received mental health treatment in general population for a total of 5,289 mental health inmates. **Please see Attachment B - LASD Mental Health Count 02/26/2019.** Approximately 72 percent of the male and female inmates diagnosed with mental health needs were arrested for felony charges and only 15 percent were arrested for misdemeanors. **Please see Attachment C on page 3 - Custody Data 02/11/2019.** The remaining inmates had charges that could be deemed either a misdemeanor or a felony. The Department data indicates the mental health inmate population has increased from 14 percent in the year 2009 to 33 percent as of 2019. The existing facilities, which include the Pitchess Detention Center (PDC), Twin Towers Correctional facility (TTCF), Century Regional Detention Facility (CRDF), and Men's Central Jail (MCJ), where this population is currently housed, does not have the ability to adequately provide the necessary services and programming space, which is also required by the current Department of Justice (DOJ) lawsuit.

Unfortunately, current projections also reveal the mental health inmate population will continue to increase, requiring the need for even more appropriate and adequate housing. A recent study from the Bureau of Justice Statistics (2018) reviewed over 400,000 released from custody, 68 percent of the individuals were re-arrested within three years. **Please see Attachment D – 2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014).** Thus, pressures on the system will likely increase even with rehabilitative efforts.

The Department agrees the antiquated and deteriorating MCJ needs to be replaced with a new facility focused on providing more targeted medical and mental health care for those we have in our care. The proposed Mental Health Treatment Center (MHTC) would allow for those that cannot be diverted to receive appropriate treatment while in custody.

Several studies were conducted at the direction of the Board of Supervisors to estimate potential bed requirements for a new facility. One study by Health Management Associates noted that by the year 2025, the projected beds required for mental health inmates would be 6,773. However, the consultant recommended that the County proceed with a facility capacity of 4,600 to 5,060 while considering the Diversion program. Additionally, independent contractors, Vanir and AECOM, projected the need for approximately 4,800 beds, which is almost 1,000 beds more than the recommended 3,885 bed facility directed by the Board of Supervisors.

The current scoping document approved by the Board of Supervisors dated June 18, 2018, was the result of collaborative programming sessions with experts from PBA/HMA and Integrated Correctional Health Services, which is an umbrella organization over the Department of Mental Health, Department of Health Services, and Department of Public Health. The Department and this team of experts finalized a scoping document for the new 3,885 bed facility, identifying HOH and MOH modules, to include adequate living space and environment that will enhance successful rehabilitation results. **Please see Attachment E - PBA/HMA Los Angeles County Consolidated Correctional Treatment Facility Population Analysis and Community Health Care Continuum dated August 4, 2015.**

The Department is currently under a DOJ court order to provide a minimum level of medical and mental health care to inmates under the custody of the Department. The proposed MHTC of 3,885 bed facility will meet most of the minimum requirements outlined in the provisions of the DOJ lawsuit by increasing access to medical and mental health treatment for inmates incarcerated within the County jail system.

Reducing the bed count of the MHTC below 3,885 beds will negatively impact access to comprehensive care, once the facility is completed and for years to come. The current inmate population has seen a steady increase of 2.3 percent each year. At this rate, the Department's required bed space will exceed 23,000 by the year 2035. As a result, the Department will be forced to transfer some inmates diagnosed with medical/mental health issues to existing facilities away from MHTC that are not specifically designed to accommodate their related needs, which will impact the "Care First" approach.

The Department's current business model is focused on collaboration, being service oriented and transparent, with both County and community based

organizations. Custody Services Division has placed a great emphasis on providing constitutional care and the implementation of rehabilitative programs. It is our goal to foster greater trust with individuals currently incarcerated and the many organizations we partner with to provide services. However, the Department has a responsibility to provide the appropriate resources and infrastructure to address future inmate population needs. We need the MHTC to be relevant in regards to the capacity and designed specifically to provide future medical and clinical requirements. The MHTC needs to be built, anticipating the estimated future growth and needs by providing a "Care First" continuum of care treatment program within the Department's custody setting.

Should you have any questions, please contact Captain Hugo Macias, Custody Services Division, at (323) 526-5199.

Sincerely,

ALEX VILLANUEVA
SHERIFF

ATTACHMENT A

MHTC Proposed Scope - LASD

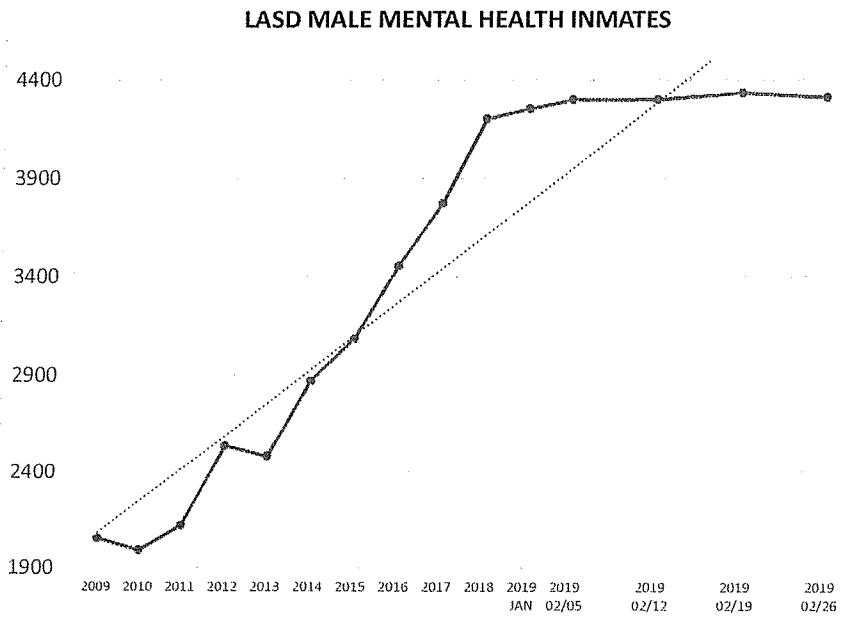
Mental Health Treatment Center (MHTC)	NUMBER
Medical CTC	120
Mental Health CTC	240
High Observation Housing	1045
Moderate Observation Housing	1,800
Medical Detoxification	200
Medical Outpatient Specialty Housing	480
BSCC RATED BED CAPACITY:	**3,885**
MENTAL HEALTH TREATMENT BED TOTAL:	3,885

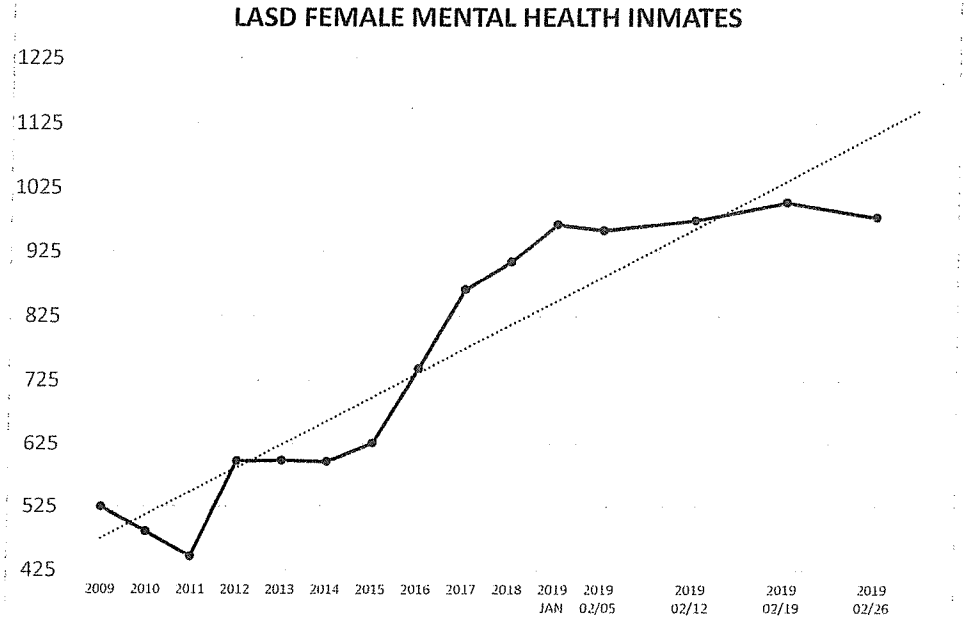
ATTACHMENT B

LASD Mental Health Count 02/26/19

		2009		2010		2011		2012		2013		2014		2015		2016		2017		2018		2019 JAN		2019 02/05		2019 02/12		2019 02/19		2019 02/26	
MALE	HOH - SM - FIP	21		17		18		25		25		24		26		28		26		24		25		26		24		25		26	
	HOH - SM	132	285	119	268	140	305	255	355	307	428	329	475	476	641	564	750	636	842	705	970	733	1019	741	1057	730	1048	729	1048	727	1029
	HOH - DM	132		132		147		75		96		122		139		158		180		241		261		290		294		294		276	
	MOH - SM - K10	N/A	1205	N/A	1196	N/A	1186	N/A	1301	25	1311	47	1582	84	1848	75	2057	59	2229	80	2416	86	2487	75	2485	83	2428	88	2442	86	2434
	MOH	1205		1196		1186		1301		1286		1535		1764		1982		2170		2336		2401		2410		2345		2354		2348	
	GPm - MCJ											358		506		615		661		753		698		715		778		792		786	
	GPm - TTCF		562		525		629		881		744	443	814	80	595	24	647	28	701	39	816	34	745	27	755	33	823	38	842	12	847
	GPm - PDC											13		9		8		12		24		13		13		12		12		49	
	Total	2052		1989		2120		2537		2483		2871		3084		3454		3772		4202		4251		4297		4299		4332		4310	
FEMALE	HOH - SM - FIP	8		14		13		8		8		9		11		10		9		8		9		9		9		6		7	
	HOH - SM	72	80	90	104	76	89	97	105	133	141	152	161	188	199	225	261	217	273	211	275	230	279	241	292	270	299	253	326	233	304
	HOH - DM	N/A		N/A		N/A		N/A		N/A		N/A		N/A		26		47		56		51		43		62		51		58	
	MOH		184		181		120		164		178		180		203		212		257		298		357		344		356		358		362
	GPm		260		201		237		329		280		256		224		270		336		336		331		322		319		318		313
	Total	524		486		446		598		599		597		626		743		866		909		967		958		974		1002		979	
Combined Mental Health total		2576		2475		2566		3135		3082		3468		3710		4197		4638		5110		5218		5255		5273		5334		5289	
ADIP		19080		16624		15013		18043		18687		18681		17050		16613		17024		16908		16284		16597		16561		16462		16580	
% of Mental Health Population		14%		15%		17%		17%		16%		19%		22%		25%		27%		30%		32%		32%		32%		32%		32%	

*Should be noted the numbers provided weekly are a snapshot of the day *





ATTACHMENT C

Custody data "Snapshot" of inmates in custody by charge on

02-11-2019

CHARGE	ALL	%
Assault, Aggravated	2,528	15.5%
Narcotics	1,592	9.7%
Robbery, Weapon	1,364	8.3%
Grand Theft Vehicle	1,332	8.1%
Burglary, Residential	1,148	7.0%
Felonies, Misc. -2	1,135	6.9%
Homicide	1,134	6.9%
Assault, Non-Aggravated	810	4.9%
Weapons Laws	790	4.8%
Under The Influence	752	4.6%
Misdemeanors, Misc.	588	3.6%
Sex Felonies	523	3.2%
Grand Theft	389	2.3%
Fraud	310	1.9%
Vandalism	308	1.8%
DUI	252	1.5%
Offenses Against Family	245	1.5%
Vehicle Laws	212	1.3%
Felonies, Misc. -1	152	0.9%
Rape	150	0.9%
Sex, Misdemeanors	99	0.6%
Forgery	95	0.58%
Arson	82	0.5%
Stolen Property	73	0.44%
Petty Theft	61	0.3%
Robbery, Strong Arm	50	0.3%
Drunk	41	0.25%
Warrants	36	0.22%
Disorderly Conduct	19	0.11%
Defrauding	6	0.03%
Liquor/Tobacco Laws	6	0.03%
Vagrancy	5	0.03%
Federal Offenses	5	0.03%
Burglary, Other	2	0.01%
Hate Crimes	1	0.006%
TOTAL	16295	

DATA BREAKDOWN

On 02-11-2019, LASD Jails housed 16,295 inmates.

12,271 were arrested for a Felony

75.3% of the jail population

1,681 were arrested for a Wobbler

10.3% of the jail population

2,343 were arrested for a Misdemeanor

14.4% of the jail population

DATA BREAKDOWN

On 02-11-2019, LASD Jails housed 2,016 female inmates.

1,605 females were arrested for a felony

79.7% of the female jail population

153 females were arrested for a Wobbler

7.6% of the female jail population

257 females were arrested for a Misdemeanor

12.7% of the female jail population

CHARGE	CRDF (Females)	%
Assault, Aggravated	287	14.2%
Grand Theft Vehicle	251	12.4%
Narcotics	211	10.46%
Robbery, Weapon	192	9.5%
Burglary, Residential	153	7.5%
Assault, Non-Aggravated	103	5.1%
Felonies, Misc. -2	102	5.0%
Fraud	100	4.9%
Grand Theft	92	4.5%
Homicide	88	4.3%
Under The Influence	79	3.9%
Misdemeanors, Misc.	47	2.3%
Offenses Against Family	42	2.08%
Vandalism	41	2.0%
Weapons Laws	37	1.8%
DUI	33	1.6%
Forgery	30	1.48%
Felonies, Misc. -1	21	1.04%
Vehicle Laws	19	0.94%
Sex, Misdemeanors	16	0.79%
Arson	16	0.79%
Stolen Property	11	0.54%
Petty Theft	10	0.49%
Robbery, Strong Arm	7	0.34%
Drunk	7	0.34%
Sex Felonies	6	0.29%
Disorderly Conduct	5	0.24%
Warrants	5	0.24%
Rape	2	0.09%
Defrauding	2	0.09%
Federal Offenses	1	0.04%
Burglary, Other	0	0%
Liquor/Tobacco Laws	0	0%
Vagrancy	0	0%
Hate Crimes	0	0%
TOTAL	2,016	

DATA BREAKDOWN

On 02-11-2019, LASD

1,254 inmates (Male & Female combined) were classified as HOH inmates.

909 HOH inmates (Male & Female) were arrested for a felony

72.5% of the HOH jail population

153 HOH inmates (Male & Female) were arrested for a Wobbler

12.2% of the HOH jail population

192 HOH inmates (Male & Female) were arrested for a Misdemeanor

15.3% of the HOH jail population

CHARGE	ALL	%
Assault, Aggravated	258	20.5%
Assault, Non-Aggravated	130	10.3%
Felonies, Misc. -2	122	9.7%
Robbery, Weapon	112	8.9%
Burglary, Residential	83	6.6%
Misdemeanors, Misc.	68	5.4%
Vandalism	67	5.3%
Court Ordered Returnee	62	4.9%
Narcotics	60	4.7%
Sex Felonies	43	3.4%
Homicide	37	2.9%
Offenses Against Family	35	2.7%
Grand Theft	25	1.9%
Grand Theft Vehicle	23	1.8%
Weapons Laws	19	1.5%
Sex, Misdemeanors	18	1.4%
Arson	13	1.0%
Rape	12	0.9%
Petty Theft	10	0.8%
Vehicle Laws	9	0.7%
DUI	8	0.6%
Drunk	8	0.6%
Fraud	7	0.5%
Felonies, Misc. -1	7	0.5%
Warrants	5	0.4%
Stolen Property	4	0.3%
Robbery, Strong Arm	3	0.2%
Forgery	2	0.1%
Disorderly Conduct	2	0.1%
Liquor/Tobacco Laws	1	0.07%
Vagrancy	1	0.07%
Defrauding	0	0
Federal Offenses	0	0
Burglary, Other	0	0
Hate Crimes	0	0
TOTAL	1,254	

Correctional Services Daily Briefing 2/22/2019				
Sentence Status I , All Cases Open (Pretrial)				
	Male	Female	Total	Percentage
Inmates with Open Charges	6,395	905	7,300	44.08%
Totals	6,395	905	7,300	44.08%
Sentence Status II, Sentenced on at least one case				
	Male	Female	Total	Percentage
Inmates Partially Sentenced	2,875	388	3,263	19.71%
N3 Partially Sentenced	62	19	81	0.49%
Totals	2,937	407	3,344	20.19%
Sentence Status III, No SPs, No 3056PC, No Open Charges				
	Male	Female	Total	Percentage
County Sentenced Inmates	1,177	191	1,368	8.26%
County Sentenced N3	2,129	412	2,541	15.35%
PRCS Revocation 3455	636	37	673	4.06%
Flash Incarceration 3454	8	0	8	0.05%
Totals	3,950	640	4,590	27.72%
State Prison Sentence (SP-SP4), No Open Charges, No 3056				
	Male	Female	Total	Percentage
SP - Sentenced to State Prison	442	27	469	2.83%
SP2 - Abstract Of Judgement received	14	1	15	0.09%
SP3 - All papers received	144	8	152	0.92%
SP4 - All paperwork processed	56	21	77	0.47%
Totals	656	57	713	4.31%
Parole Revocation				
	Male	Female	Total	Percentage
Parole Revocation 3000.08FPC	319	12	331	2.00%
Totals	319	12	331	2.00%
Case Suspended, Awaiting Placement to Mental Health Facility				
	Male	Female	Total	Percentage
Department of Mental Health	183	48	231	1.40%
Metropolitan State Hospital	1	1	2	0.01%
Patton State Hospital	39	7	46	0.28%
Jail-Based Competency Treatment Program	2	0	2	0.01%
Totals	225	56	281	1.70%
Custody Division Total	14,482	2,077	16,559	100%

DATA BREAKDOWN

On 02/22/2019

44% of all inmates in custody are pre-trial

20% have one case sentenced and one or more cases still open

4.3% are State Prisoners waiting for a bed in CDCR

2% are Parole holds

1.7% are waiting placement in a mental health facility

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

ATTACHMENT D

SPECIAL REPORT

MAY 2018

NCJ 250975

2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014)

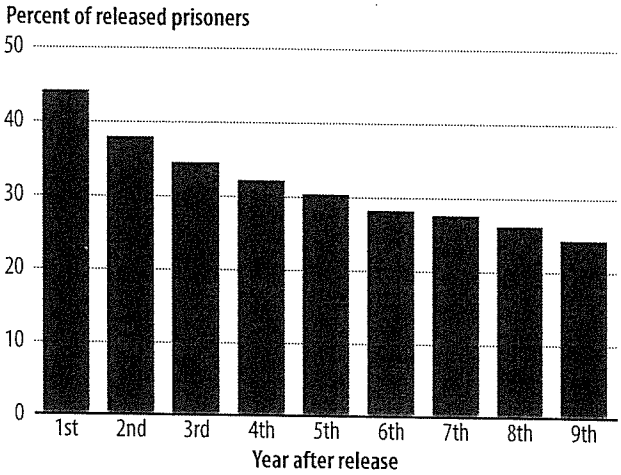
Mariel Alper, Ph.D., and Matthew R. Durose, *BJS Statisticians*
Joshua Markman, *former BJS Statistician*

Five in 6 (83%) state prisoners released in 2005 across 30 states were arrested at least once during the 9 years following their release. The remaining 17% were not arrested after release during the 9-year follow-up period.

About 4 in 9 (44%) prisoners released in 2005 were arrested at least once during their first year after release (**figure 1**). About 1 in 3 (34%) were arrested during their third year after release, and nearly 1 in 4 (24%) were arrested during their ninth year.

This report examines the post-release offending patterns of former prisoners and their involvement in criminal activity both within and outside of the state where they were imprisoned. The Bureau of Justice Statistics analyzed the offending patterns of 67,966 prisoners who were randomly sampled to represent the 401,288 state prisoners released in 2005 in 30 states. This sample is representative of the 30 states, both individually and collectively, included in the study (see *Methodology*). In 2005, these 30 states

FIGURE 1
Annual arrest percentage of prisoners released in 30 states in 2005



Note: The denominator for annual percent is 401,288 (total state prisoners released in 30 states in 2005). See table 5 for estimates and appendix table 7 standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

HIGHLIGHTS

- The 401,288 state prisoners released in 2005 had an estimated 1,994,000 arrests during the 9-year period, an average of 5 arrests per released prisoner. Sixty percent of these arrests occurred during years 4 through 9.
- An estimated 68% of released prisoners were arrested within 3 years, 79% within 6 years, and 83% within 9 years.
- Almost half (47%) of prisoners who did not have an arrest within 3 years of release were arrested during years 4 through 9.
- More than three-quarters (77%) of released drug offenders were arrested for a non-drug crime within 9 years.
- Forty-four percent of released prisoners were arrested during the first year following release, while 24% were arrested during year-9.
- Eighty-two percent of prisoners arrested during the 9-year period were arrested within the first 3 years.
- Five percent of prisoners were arrested during the first year after release and not arrested again during the 9-year follow-up period.
- During each year and cumulatively in the 9-year follow-up period, released property offenders were more likely to be arrested than released violent offenders.
- Eight percent of prisoners arrested during the first year after release were arrested outside the state that released them, compared to 14% of prisoners arrested during year-9.

BJS

were responsible for 77% of all persons released from state prisons nationwide. The findings are based on prisoner records obtained from the state departments of corrections through BJS's National Corrections Reporting Program and criminal history records obtained through requests to the FBI's Interstate Identification Index and state repositories via the International Justice and Public Safety Network (Nlets).

BJS first collected the criminal history records of this same sample of prisoners to analyze their recidivism patterns for 5 years following release.[1] In 2015, BJS re-collected the criminal history records on the same sample of prisoners to extend the original 5-year follow-up period to 9 years. This report presents the offending patterns for the full 9-year period. Both studies excluded prisoners who died during the respective follow-up periods. Because additional individuals in the sample died during the 9-year follow-up period, the overall universe of released prisoners declined from 404,638 during the 5-year follow-up study to 401,288 during the 9-year follow-up study. Since those 3,350 prisoners were not included in this longer study, recidivism estimates on the first 5 years following release in this report may differ slightly from previously published estimates on the 2005 release cohort.

About 1 in 4 state prisoners released in the 30 states in 2005 were in prison for a violent offense

Among the 401,288 prisoners released in 30 states in 2005, an estimated 9 in 10 (89%) were male (table 1). Eighteen percent were age 24 or younger at time of release, 51% were ages 25 to 39, and 31% were age 40 or older. The percentage of non-Hispanic black and non-Hispanic white prisoners were similar (40% each). Thirty-two percent of released prisoners were in prison for a drug offense, compared to 30% who were in prison for a property offense, 26% for a violent offense, and 13% for a public order offense.

[1]See *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010*, NCJ 244205, BJS web, April 2014.

TABLE 1
Characteristics of prisoners released in 30 states in 2005

Characteristic	Percent
All released prisoners	100%
Sex	
Male	89.3%
Female	10.7
Race/Hispanic origin[a]	
White	39.7%
Black/African American	40.1
Hispanic/Latino	17.7
Other[b]	2.4
America Indian or Alaska Native	1.2
Asian, Native Hawaiian, or Other Pacific Islander	0.8
Age at release	
24 or younger	17.7%
25–29	19.4
30–34	16.0
35–39	15.7
40 or older	31.2
Most serious commitment offense	
Violent	25.7%
Property	29.7
Drug	31.9
Public order[c]	12.7
Number of released prisoners	401,288

Note: Data on prisoners' sex and age at release were known for 100% of cases and race and Hispanic origin for nearly 100%. Detail may not sum to total due to rounding. See appendix table 2 for standard errors.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

[b]Includes persons of two or more races or other unspecified races.

[c]Includes 0.8% of cases in which the prisoner's most serious offense was unspecified.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Measuring recidivism

Recidivism measures require three characteristics:

1. a starting event, such as a release from prison
2. a measure of failure following the starting event, such as a subsequent arrest, conviction, or return to prison
3. an observation or follow-up period that generally extends from the date of the starting event to a predefined end date (e.g., 6 months, 1 year, 3 years, 5 years, or 9 years).

This study used four outcome measures to examine the recidivism patterns of former state prisoners. Arrest data were used because they provided the offense details needed to produce these four measures for prisoners from all 30 states in the study.

1. Cumulative arrest percentage is the percentage of prisoners who had been arrested at least once at various points in the follow-up period. For example, the cumulative arrest percentage for year-5 is the percentage of all released prisoners who had at least one arrest during the 5-year period. BJS previously examined the cumulative percentage of prisoners who had a subsequent conviction or returned to prison within 5 years following release.[2] The return-to-prison analysis for the 5-year follow-up study was limited to 23 of the study's 30 states with the data needed to identify returns to prison during the entire observation period.
2. Annual percentage of first arrests is the percentage of prisoners who had their first arrest following release during a specific year in the follow-up period. The denominator for each annual first-arrest percentage from years 1 through 9 is the total number of prisoners released in the 30 states during 2005. The numerators are the number of prisoners arrested for the first time during each of those years (i.e., they had not been arrested during a prior year in the follow-up period). The sum of the annual first-arrest percentages during a follow-up period equals the cumulative arrest percentage for the same period.
3. Annual arrest percentage of released prisoners includes those who were arrested at least once during a particular year within the follow-up period. The denominator for each percentage from years 1 through 9 is the total number of prisoners released in the 30 states during 2005. The numerators are the number of prisoners arrested during the particular year, regardless of whether they had been arrested during a prior year.
4. Annual volume of arrests is the total number of arrests of released prisoners during a particular year in the follow-up period. The total volume of arrests is the sum of each annual volume of arrests during the entire follow-up period. A prisoner may have had multiple arrests during a year or in the follow-up period, and a single arrest may have involved charges for more than one crime.

[2]See *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010*, NCJ 244205, BJS web, April 2014.

Measuring desistance

Desistance is measured as the percentage of prisoners who, after a particular year, had no subsequent arrests during the remainder of the 9-year follow-up period. For example, if a prisoner was arrested during year-3 but was not arrested during years 4 through 9, the prisoner would be classified as having desisted during year-3. While recidivism is a measure of arrest at any point during the follow-up period, desistance is a measure of the absence of arrest between a particular point within the follow-up period and the end of the follow-up period.

Importance of recidivism and desistance measures

Measures of recidivism and desistance provide information relevant to a deeper understanding of criminal behavior and the administration of justice in a wide range of policy areas. For example, law enforcement officials interested in the amount of crime committed by released prisoners can turn to statistics on the annual volume of arrests. Parole and probation agencies interested in the involvement of various types of former prisoners in criminal activities after release may focus on variations in cumulative arrest percentages. Treatment providers looking for measures of program effectiveness will be interested in desistance patterns. Additionally, task forces and policymakers examining the movement of criminals across state borders will be interested in the types of released prisoners most likely to commit new crimes (i.e., recidivate) in other states.

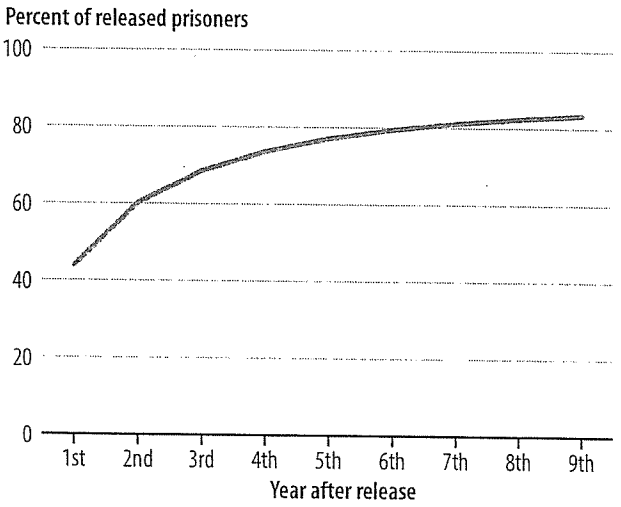
Extending the follow-up period from 3 to 9 years increased recidivism of prisoners by 15 percentage points

The cumulative arrest percentage among released prisoners increased 15 percentage points when the follow-up period was extended from 3 years to 9 years. Sixty-eight percent of prisoners had been arrested for a new crime 3 years after release, while 79% of prisoners were arrested after 6 years following release (table 2). At the end of the 9-year follow-up period, the percentage of prisoners arrested after release increased to 83% (figure 2).

The cumulative out-of-state arrest percentage among released prisoners doubled when the follow-up period was extended from 3 years to 9 years. Three years after release, 7.7% of prisoners had been arrested outside the state of release. At the end of the 9-year follow-up period, the percentage of prisoners arrested outside of the state of release increased to 15.4%.

FIGURE 2

Percent of prisoners released in 30 states in 2005 who were arrested since release, by year after release



Note: See table 2 for estimates and appendix table 3 for standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

TABLE 2

Cumulative percent of prisoners released in 30 states in 2005 who were arrested within or outside the state of release, by year after release

	Within or outside the state of release			Outside the state of release*		
Year after release	Total	Percent arrested	Percent not arrested	Total	Percent arrested	Percent not arrested
1	100%	43.9%	56.1%	100%	3.3%	96.7%
2	100%	60.1	39.9	100%	5.7	94.3
3	100%	68.4	31.6	100%	7.7	92.3
4	100%	73.5	26.5	100%	9.3	90.7
5	100%	77.0	23.0	100%	10.9	89.1
6	100%	79.4	20.6	100%	12.2	87.8
7	100%	81.1	18.9	100%	13.4	86.6
8	100%	82.4	17.6	100%	14.4	85.6
9	100%	83.4	16.6	100%	15.4	84.6

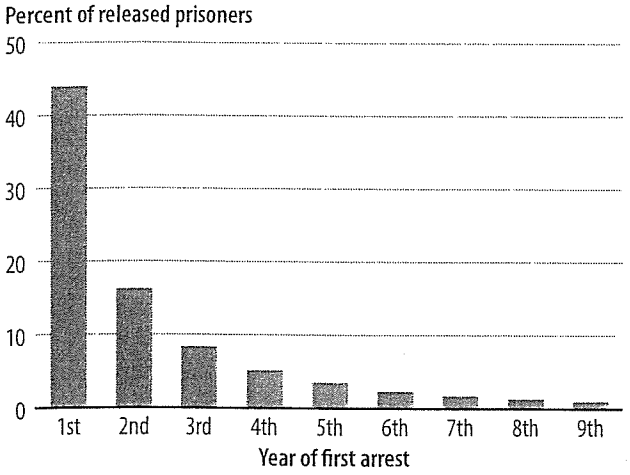
Note: Detail may not sum to total due to rounding. See appendix table 3 for standard errors.
*Prisoners arrested outside the state of release could have also been arrested within the state of release.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Forty-four percent of prisoners released in 2005 were arrested during the first year following release (figure 3). Sixteen percent of released prisoners were arrested for the first time during the second year after release, and 8% were arrested for the first time during the third year. Fifteen percent of released prisoners were arrested for the first time during years 4 through 9, including 11% arrested for the first time during years 4 through 6 and 4% arrested for the first time during years 7 through 9.

Of the released prisoners who were arrested for a new crime during the 9-year follow-up period, the majority of the prisoners' first post-release arrests occurred during the first 3 years of the follow-up period. More than half (53%) of all prisoners released in the 30 states in 2005 who were arrested during the 9-year follow-up period were arrested for the first time during the first year (not shown). Among all released prisoners arrested within 9 years, about 5 in 6 prisoners (82%) were arrested within the 3-year follow-up period (not shown).

FIGURE 3

Percent of prisoners released in 30 states in 2005 who were arrested after release, by year of first arrest



Note: The denominator for the annual percentage was 401,288 (total state prisoners released in 30 states in 2005). See appendix table 4 for estimates and standard errors.

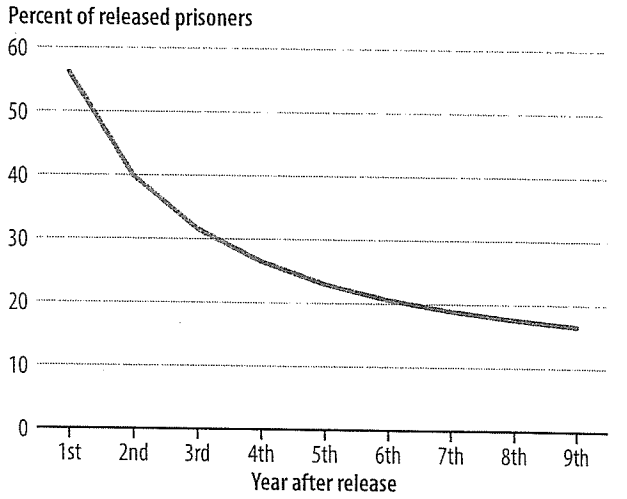
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Longer follow-up periods show substantial declines in apparent desistance

This study examined the extent to which released prisoners appeared to have desisted from criminal activity using various follow-up periods. Thirty-two percent of released prisoners had not been arrested within 3 years, compared to 21% within 6 years (figure 4). Within 9 years following release in 2005, the percentage of prisoners without a new arrest following release declined to 17%. That is, almost half (47%) of prisoners with no arrest within 3 years of release had an arrest during years 4 through 9.

FIGURE 4

Percent of prisoners released in 30 states in 2005 who were not arrested since release, by year following release



Note: See table 2 for estimates and appendix table 3 for standard errors.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

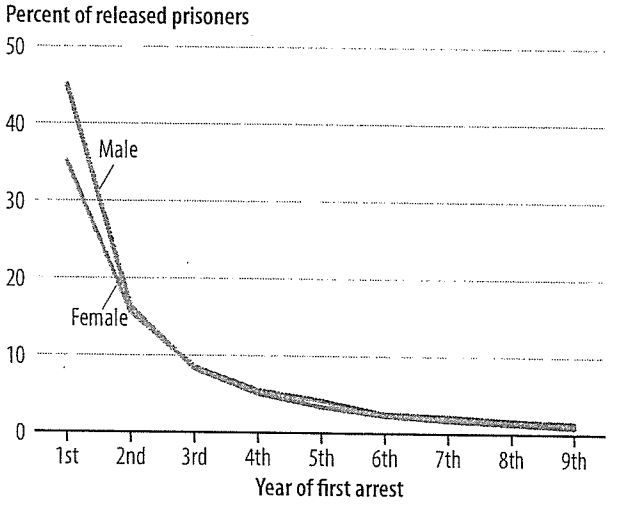
After year-1 the annual percentages of males and females arrested for the first time were similar

The difference in the percentage of male and female prisoners who were arrested for the first time each year following release narrowed after the first year. In the first year after release, 45% of male prisoners were arrested, compared to 35% of female prisoners (figure 5). However, during each of the following years, the percentages of males and females arrested for the first time following release were similar. During the 9-year follow-up period, 84% of male prisoners were arrested and 77% of female prisoners were arrested.

A smaller percentage of white prisoners than black or Hispanic prisoners recidivated during the first year after release. During the first year after release, 40% of white prisoners were arrested for the first time, compared to 47% of Hispanic and 46% of black prisoners (table 3). During year-2 after release, 16% of white prisoners were arrested for the first time, compared to 17% of black and 14% of Hispanic prisoners. During the ninth year after release, about 1% of each sex, race, Hispanic origin, and age group were arrested for the first time. During the 9-year follow-up period, 87% of black prisoners and 81% of white and Hispanic prisoners were arrested.

FIGURE 5

Percent of prisoners released in 30 states in 2005 who were arrested following release, by sex of prisoner and year of first arrest



Note: See table 3 for estimates and appendix table 5 for standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

TABLE 3

Percent of prisoners released in 30 states in 2005 who were arrested after release, by prisoner characteristics and year of first arrest

Characteristic	Total arrested within 9 years	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
All released prisoners	83.4%	43.9%	16.2%	8.3%	5.1%	3.5%	2.3%	1.7%	1.3%	1.0%
Sex										
Male	84.2%	44.9%	16.3%	8.3%	5.1%	3.4%	2.3%	1.7%	1.3%	0.9%
Female	76.8	35.1	15.7	8.5	5.5	4.2	2.5	2.2	1.7	1.4
Age at release										
24 or younger	90.1%	51.8%	17.0%	7.7%	4.8%	3.4%	2.0%	1.7%	1.0%	0.7%
25–39	85.3	44.9	16.7	8.6	5.2	3.6	2.3	1.7	1.4	0.9
25–29	87.0	45.9	16.8	8.8	5.5	3.8	2.5	1.5	1.3	0.9
30–34	84.3	43.9	16.5	8.2	5.3	3.5	2.3	1.9	1.7	1.0
35–39	84.3	44.6	16.8	8.7	4.9	3.4	2.2	1.7	1.2	0.9
40 or older	76.5	37.8	15.1	8.1	5.1	3.5	2.5	1.9	1.4	1.2
Race/Hispanic origin[a]										
White	80.9%	40.2%	15.8%	8.4%	5.2%	3.8%	2.6%	2.2%	1.5%	1.2%
Black/African American	86.9	46.0	17.4	8.6	5.5	3.4	2.3	1.6	1.2	0.9
Hispanic/Latino	81.3	47.3	14.3	7.2	4.2	3.1	2.2	0.9	1.3	0.7
Other[b]	82.4	44.1	16.4	8.8	4.5	3.0	1.3	2.1	1.3	1.1
American Indian or Alaska Native	85.0	43.5	16.3	9.5	4.8	3.6	1.6	2.7	1.6	1.4
Asian, Native Hawaiian, or Other Pacific Islander	79.4	45.0	16.0	8.3	4.0	1.3	1.3	1.3	1.2	1.0

Note: Data on prisoners' sex and age at release were known for 100% of cases and race and Hispanic origin for nearly 100%. Detail may not sum to total due to rounding. See appendix table 5 for standard errors.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

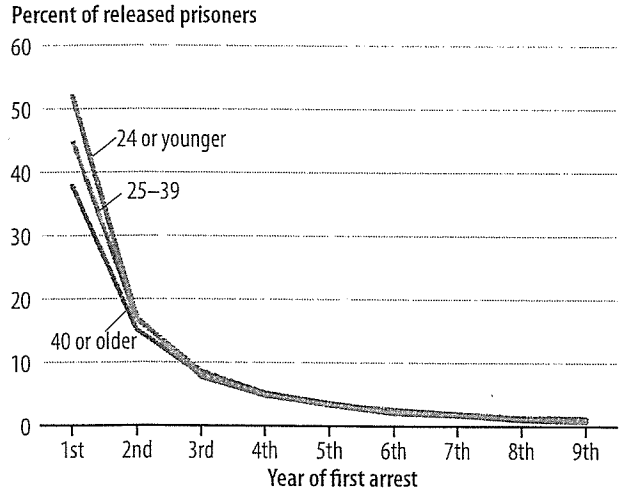
[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

The difference in the percentage of prisoners in each age group who were arrested for the first time each year following release narrowed after the first year. During the first year after release, 52% of prisoners age 24 or younger at time of release were arrested, compared to 38% of prisoners age 40 or older (figure 6). During the second year, an estimated 17% of prisoners age 24 or younger were arrested for the first time following release, compared to 15% of prisoners age 40 or older. During the 9-year follow-up period, 90% of prisoners age 24 or younger at release were arrested, 77% of prisoners age 40 or older at release were arrested, and 43% (not shown) of prisoners age 60 or older were arrested.

FIGURE 6

Percent of prisoners released in 30 states in 2005 who were arrested after release, by age at release and year of first arrest



Note: See table 3 for estimates and appendix table 5 for standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Prisoners released in 30 states in 2005 were arrested nearly 2 million times during the 9 years following release.

The 401,288 state prisoners released in 2005 had an estimated 1,994,000 arrests during the 9-year period, an average of 5 arrests per released prisoner (table 4). Extending the follow-up period to 9 years captured more than double the number of post-release arrests observed in a 3-year follow-up period and increased the number of arrests observed during a 5-year follow-up period by 38%. Six in 10 (60%) of the 1,994,000 arrests during the 9-year period occurred from years 4 through 9.

An estimated 23% of released prisoners were responsible for half of the nearly 1,994,000 arrests that occurred during the 9-year follow-up period (not shown). A similar percentage of prisoners were responsible for half of the arrests during the 3-year follow-up period (also 23%) (not shown).

TABLE 4

Post-release arrests of prisoners released in 30 states in 2005, by year after arrest

Year after arrest	Number of arrests during year/period	Percent of arrests during year/period	Cumulative number of all arrests since release	Cumulative percent of all arrests since release
Total	1,994,000	100%	~	~
Years 1–3	804,000	40.3%	~	~
1	306,000	15.4	306,000	15.4
2	260,000	13.0	567,000	28.4
3	238,000	11.9	804,000	40.3
Years 4–6	620,000	31.1%	~	~
4	219,000	11.0	1,024,000	51.3
5	210,000	10.6	1,234,000	61.9
6	190,000	9.6	1,425,000	71.4
Years 7–9	570,000	28.6%	~	~
7	196,000	9.8	1,620,000	81.2
8	194,000	9.7	1,814,000	91.0
9	180,000	9.0	1,994,000	100

Note: Number of post-release arrests was rounded to the nearest 1,000. Detail may not sum to total due to rounding. See appendix table 6 for standard errors.
~Not applicable.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

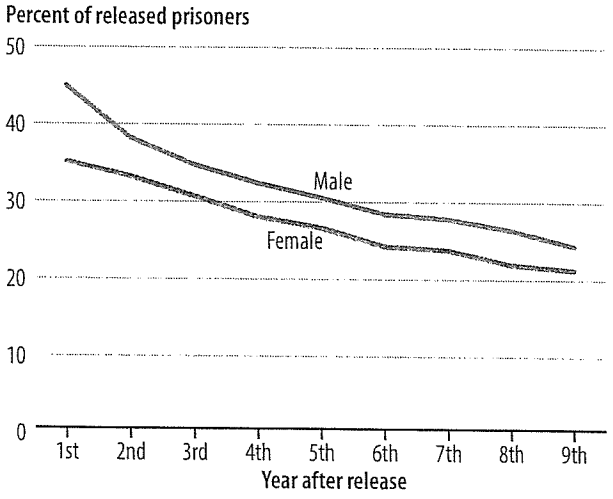
Male and younger prisoners were more likely to be arrested each year than female and older prisoners

Patterns of the annual arrest percentages differ from patterns of the year of first arrest. Thirty-four percent of all released prisoners were arrested during their third year after release, compared to 24% during their ninth year (table 5). Nearly a quarter (24%) of the released prisoners who were arrested during year-3 had not previously been arrested following release (not shown). Four percent of the released prisoners who were arrested during year-9 had not previously been arrested following release (not shown).

Forty-five percent of male prisoners were arrested during the first year after release, compared to 35% of female prisoners (figure 7). During year-9, the difference between males and females narrowed with 24% of male prisoners arrested compared to 21% of female prisoners. While the difference in percentage

FIGURE 7

Annual arrest percentage of prisoners released in 30 states in 2005, by sex of prisoner



Note: See table 5 for estimates and appendix table 7 for standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

TABLE 5

Annual arrest percentage of prisoners released in 30 states in 2005, by prisoner characteristics

Characteristic	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
All released prisoners	43.9%	37.7%	34.3%	31.9%	30.1%	28.0%	27.4%	25.9%	24.0%
Sex									
Male	44.9%	38.2%	34.7%	32.3%	30.5%	28.4%	27.8%	26.4%	24.3%
Female	35.1	33.2	30.7	28.0	26.6	24.3	23.8	21.9	21.3
Age at release									
24 or younger	51.8%	42.3%	36.7%	34.4%	34.3%	31.3%	31.9%	30.3%	27.6%
25–39	44.9	38.9	35.7	33.4	31.1	29.3	28.9	27.5	25.6
25–29	45.9	39.2	36.3	33.2	31.7	30.3	29.3	28.3	26.4
30–34	43.9	38.1	34.4	32.8	30.3	28.2	28.1	27.2	24.1
35–39	44.6	39.3	36.3	34.1	31.3	29.3	29.4	27.1	26.1
40 or older	37.8	33.1	30.5	28.1	25.9	23.8	22.2	20.7	19.4
Race/Hispanic origin[a]									
White	40.2%	35.0%	32.2%	29.9%	28.7%	26.8%	26.2%	25.0%	22.9%
Black/African American	46.0	40.6	36.5	34.1	31.9	29.5	29.1	27.3	25.3
Hispanic/Latino	47.3	36.9	33.6	31.4	29.3	26.8	25.7	24.0	23.4
Other[b]	44.1	37.8	35.3	32.0	27.8	28.7	29.9	29.2	24.6
American Indian or Alaska Native	43.5	37.8	38.8	32.3	29.9	31.3	34.7	31.0	26.0
Asian, Native Hawaiian, or Other Pacific Islander	45.0	39.1	29.7	31.3	25.2	25.4	26.2	27.5	21.2

Note: Data on prisoners' sex and age at release were known for 100% of cases, and race and Hispanic origin were known for nearly 100% of cases. See appendix table 7 for standard errors.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

[b]Includes persons of two or more races or other specified races.

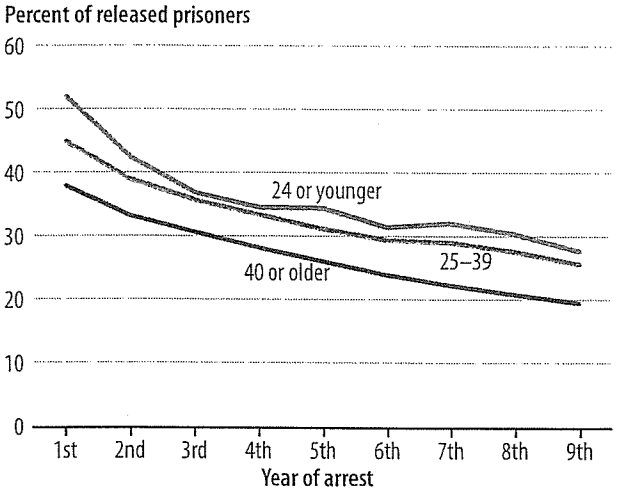
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

points narrowed from 10% during year-1 to 3% during year-9, the difference between male and female prisoners decreased proportionally. During year-1, the percentage of female prisoners who were arrested following release was 78% of that for male prisoners, while during year-9 the percentage of female prisoners was 87% of that for male prisoners (not shown).

Younger prisoners (those age 24 or younger) were more likely to be arrested than older prisoners (those age 40 or older) during each year following release. For example, 28% of prisoners released at age 24 or younger were arrested during year-9, compared to 19% of those age 40 or older (figure 8).

FIGURE 8

Annual arrest percentage of prisoners released in 30 states in 2005, by age of prisoner at release



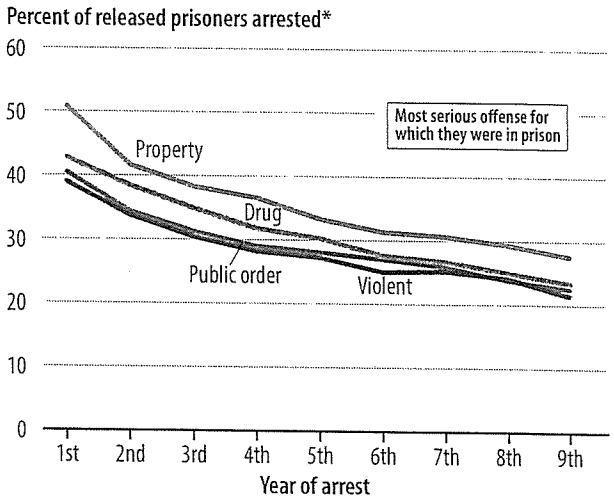
Note: See table 5 for estimates and appendix table 7 for standard errors.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

During the 9 years after release, prisoners released for a property offense were most likely to be arrested

During the first year following release, the percentage of prisoners released for a property offense who were arrested for any type of offense (including violent, property, drug, or public order offenses) was higher than the percentage of prisoners released for a drug or violent offense. This general pattern was maintained across the 9-year follow-up period. It should be noted that persons could have been serving time in prison for more than one offense and were categorized for this report by the most serious offense for which they were imprisoned: a violent, property, drug, or public order crime.

FIGURE 9

Annual percentage of prisoners released in 30 states in 2005 who were arrested for any type of offense, by most serious commitment offense



Note: Public order includes 0.8% of cases in which prisoners' most serious offense was unspecified. See table 6 for estimates and appendix table 8 for standard errors.
*Persons could have been in prison for more than one offense; the most serious one is reported in this figure.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Thirty-nine percent of prisoners released in 2005 who were serving time for a violent offense were arrested for any type of offense during the first year following release, compared to 51% of those released after serving time for a property offense (table 6, figure 9). By year-9 these percentages fell to 21% for those released for a violent offense and 28% for those released for a property offense. However, similar to year-1, the percentage of prisoners released for a violent offense who were arrested following release was about three-quarters of the percentage for those released for a property offense.

TABLE 6

Annual arrest percentage of prisoners released in 30 states in 2005, by most serious commitment offense and type of post-release arrest offense

Most serious commitment offense	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Any arrest after release									
All released prisoners	43.9%	37.7%	34.3%	31.9%	30.1%	28.0%	27.4%	25.9%	24.0%
Violent*	38.9	33.7	30.4	28.1	27.2	25.0	25.2	24.1	21.4
Property	50.8 †	41.6 †	38.3 †	36.5 †	33.2 †	31.3 †	30.6 †	29.3 †	27.6 †
Drug	42.8 †	38.5 †	34.9 †	31.8 †	30.2 †	27.6 †	26.7 †	25.0	23.4 †
Public order	40.5	34.3	31.2	28.9	28.0	27.0 †	25.8	23.8	22.5
Violent arrest after release									
All released prisoners	9.0%	8.3%	7.6%	7.6%	7.2%	6.5%	6.6%	6.0%	5.2%
Violent*	11.0	10.2	8.4	8.8	8.9	6.8	6.9	6.5	5.8
Property	9.3 †	7.8 †	7.7	7.8 †	6.9 †	7.1	7.2	6.2	5.7
Drug	6.8 †	7.2 †	6.7 †	6.2 †	6.2 †	5.3 †	5.7 †	5.4 †	4.4 †
Public order	9.7	8.6 †	8.3	8.1	7.3 †	7.2	6.6	6.4	5.3
Arrest after release for same type as most serious commitment offense[a]									
All released prisoners	21.0%	18.0%	15.6%	14.5%	13.7%	12.2%	11.8%	11.5%	10.6%
Violent	11.0	10.2	8.4	8.8	8.9	6.8	6.9	6.5	5.8
Property	25.0	20.6	17.6	16.9	15.6	14.2	14.1	13.9	12.6
Drug	22.0	19.6	17.2	15.0	13.8	12.2	11.5	11.4	11.0
Public order	29.2	23.8	21.1	19.2	18.4	18.2	17.0	16.0	14.5
Arrested after release for different type of offense than most serious commitment offense[b]									
All released prisoners	36.1%	30.9%	28.0%	26.3%	24.6%	23.1%	22.8%	21.5%	20.0%
Violent	35.2	30.4	27.6	25.1	23.9	22.7	22.8	22.0	19.5
Property	42.4	34.4	31.6	30.6	27.6	26.0	25.6	24.1	23.0
Drug	34.8	31.3	27.9	26.0	24.6	22.7	22.2	20.7	19.1
Public order	26.3	22.6	20.7	19.8	18.7	17.9	18.0	16.6	16.0

Note: Persons could have been in prison for more than one offense; the most serious one is reported in this table. Each arrest may include more than one type of offense. 'Type of offense' refers to the categories of violent, property, drug, and public order. Public order includes 0.8% of cases in which prisoners' most serious offense was unspecified. See appendix table 8 for standard errors.

*Comparison group.

†Difference with comparison group is significant at the 95% confidence level.

[a,b]Percentages in these two categories do not sum to the 'any arrest after release' category because categories overlap.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

At the end of the 9-year follow-up period, 79% of prisoners released for a violent offense had been arrested for any type of crime (table 7). Prisoners released for a violent offense were less likely to have been arrested for any type of crime than prisoners released for a property (88%) or drug (84%) offense but were more likely to have been arrested for a violent offense.

TABLE 7

Cumulative percent of prisoners released in 30 states in 2005 who were arrested following release, by most serious commitment offense and type of post-release arrest offense

Most serious commitment offense	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Any arrest after release									
All released prisoners	43.9%	60.1%	68.4%	73.5%	77.0%	79.4%	81.1%	82.4%	83.4%
Violent*	38.9	54.2	62.2	67.6	71.6	74.2	76.1	77.7	78.7
Property	50.8 †	67.1 †	75.0 †	79.6 †	82.4 †	84.4 †	85.8 †	86.9 †	87.8 †
Drug	42.8 †	59.9 †	68.6 †	73.9 †	77.5 †	79.8 †	81.5 †	82.7 †	83.8 †
Public order	40.5	55.9	65.0 †	70.2 †	74.1 †	76.9 †	79.2 †	80.6 †	81.9 †
Violent arrest after release									
All released prisoners	9.0%	15.8%	20.9%	25.4%	29.3%	32.3%	35.0%	37.3%	39.1%
Violent*	11.0	19.1	24.5	29.6	34.0	36.9	39.5	41.7	43.4
Property	9.3 †	15.8 †	20.9 †	25.7 †	29.3 †	32.9 †	36.0 †	38.5 †	40.4 †
Drug	6.8 †	12.7 †	17.5 †	21.3 †	25.1 †	27.7 †	30.1 †	32.1 †	34.0 †
Public order	9.7	16.4 †	21.8 †	26.6 †	30.0 †	32.9 †	35.7 †	38.1 †	39.8 †
Arrest after release for same type as most serious commitment offense[a]									
All released prisoners	21.0%	32.5%	39.6%	45.0%	49.1%	52.1%	54.5%	56.5%	58.2%
Violent	11.0	19.1	24.5	29.6	34.0	36.9	39.5	41.7	43.4
Property	25.0	37.5	45.0	50.4	54.6	57.6	60.0	61.9	63.5
Drug	22.0	34.7	42.5	47.9	51.8	54.4	56.7	58.6	60.4
Public order	29.2	42.4	50.4	56.1	60.3	63.8	66.6	68.6	70.3
Arrested after release for different type of offense than most serious commitment offense[b]									
All released prisoners	36.1%	51.0%	59.4%	65.0%	68.9%	71.7%	73.9%	75.6%	76.9%
Violent	35.2	49.6	57.5	63.0	67.1	69.9	72.1	73.7	74.8
Property	42.4	58.0	66.4	71.8	75.3	77.9	79.8	81.4	82.6
Drug	34.8	50.2	58.8	64.6	68.6	71.4	73.6	75.3	76.7
Public order	26.3	39.7	48.2	54.3	58.4	61.6	64.6	66.5	68.2

Note: Persons could have been in prison for more than one offense; the most serious one is reported in this table. Each arrest may include more than one type of offense. 'Type of offense' refers to the categories of violent, property, drug, and public order. Public order includes 0.8% of cases in which prisoners' most serious offense was unspecified. See appendix table 9 for standard errors.

*Comparison group.

†Difference with comparison group is significant at the 95% confidence level.

[a,b]Percentages in these two categories do not sum to the 'any arrest after release' category because categories overlap.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

By the sixth year after release, prisoners released for a violent or property crime were similarly likely to be arrested for a violent crime

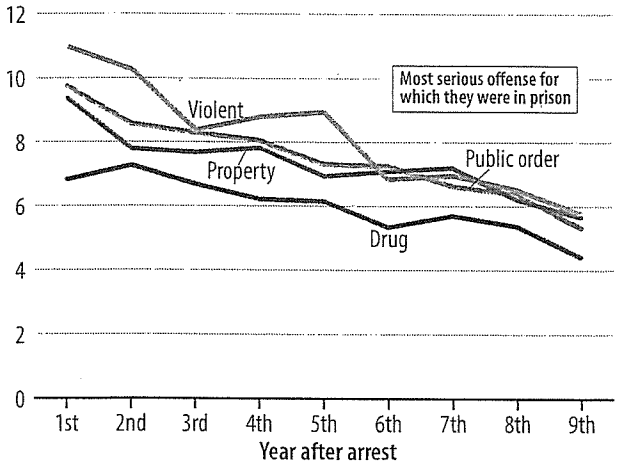
During the first year of the follow-up period, a larger percentage of prisoners released for a violent offense were arrested for a violent crime than those released for a property or drug offense. Eleven percent of prisoners released for a violent offense were arrested during year-1 for a violent offense, compared to 9% of those released for a property offense and 7% of prisoners released for a drug offense (figure 10). However, beginning in year-6, prisoners released for a violent offense were similarly likely to be arrested for a violent crime as those released for a property or public order offense. Throughout the 9-year follow-up period, prisoners released for a drug offense were less likely to be arrested for a violent crime than prisoners released for a violent offense.

Among prisoners arrested following release, the percentage of arrests in another state increased each year after release

The likelihood of former prisoners being arrested outside the state where they were released increased with a longer follow-up period. During each of the 9 years following release, fewer than 4% of prisoners were arrested outside the state (table 8). However, among prisoners arrested within a given year following release, the percentage of prisoners arrested in another state increased as the length of time from release in 2005 increased. Eight percent of prisoners arrested during year-1 were arrested outside of the state from which they were released. Fourteen percent of prisoners who were arrested during year-9 were arrested outside of the state of release.

FIGURE 10

Annual percentage of prisoners released in 30 states in 2005 who were arrested for a violent crime, by most serious commitment offense



Note: Public order includes 0.8% of cases in which prisoners' most serious offense was unspecified. See table 6 for estimates and appendix table 8 for standard errors.

*Persons could have been in prison for more than one offense; the most serious one is reported in this figure.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

TABLE 8

Annual arrest percentage of prisoners released in 30 states in 2005, by whether arrested within or outside the state of release

Year after arrest	All released prisoners: Outside state of release	All released prisoners: Within or outside state of release	Among released prisoners arrested during the year, percent arrested outside state of release
1	3.3%	43.9%	7.5%
2	3.4	37.7	9.0
3	3.4	34.3	10.0
4	3.5	31.9	10.9
5	3.6	30.1	12.0
6	3.5	28.0	12.6
7	3.6	27.4	13.3
8	3.5	25.9	13.6
9	3.4	24.0	14.2
Arrested anytime in follow-up period	15.4%	83.4%	~

Note: Detail may not sum to total due to rounding. See appendix table 10 for standard errors.

~Not applicable.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Five percent of prisoners were arrested during year-1 following release and not arrested again during years 2 through 9

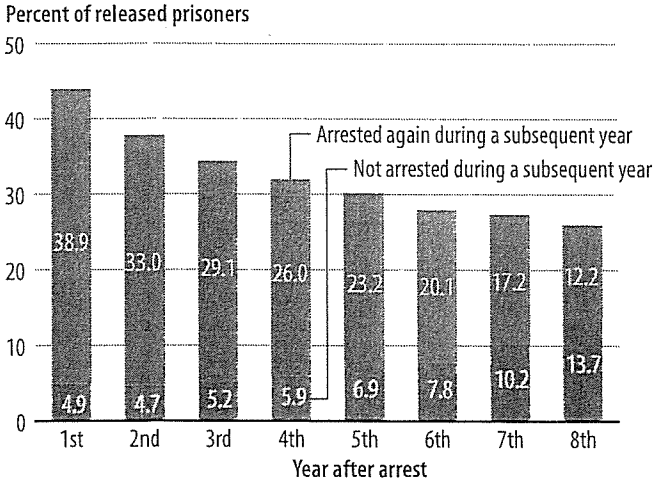
Thirty-nine percent of all released prisoners were arrested during the first year after release and were also subsequently arrested at least once during years 2 through 9 (figure 11). Five percent of prisoners were arrested during the first year after release and were not arrested again during years 2 though 9. Among prisoners arrested during the first year following release, nearly 9 in 10 (89%) were arrested again during the next 8 years (not shown).

During the second year after release, 38% of prisoners were arrested. A third (33%) of all released prisoners were arrested during the second year and also arrested again at least once during years 3 through 9. The remaining 5% were not arrested again during the follow-up period.

The percentage who were not arrested during a subsequent year increased during the later years of the follow-up period. However, there are fewer observable years in which to capture a subsequent arrest during later years of the follow-up period. (For example, in year-8 there is only one subsequent year.)

FIGURE 11

Percent of prisoners released in 30 states in 2005 who were arrested after release, by year after arrest and whether arrested during subsequent years



Note: The denominator for the annual percentage was 401,288 (total state prisoners released in 30 states in 2005). See appendix table 11 for estimates and standard errors.

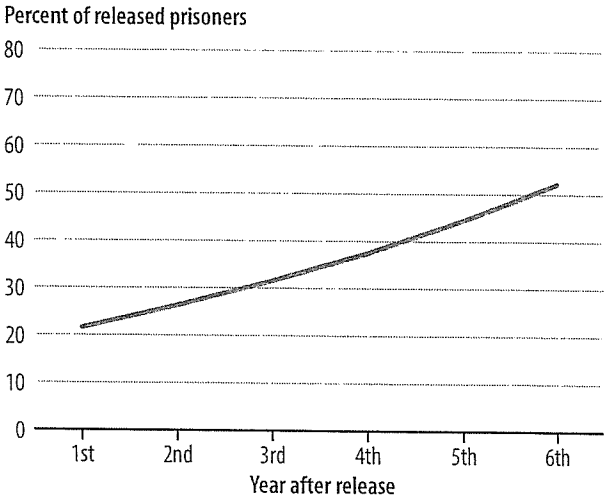
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Forty-four percent of released prisoners were not arrested after year-5

Twenty-two percent of released prisoners were not arrested after year-1 of the follow-up period (figure 12). In other words, when measured by a new arrest, 22% of prisoners appeared to desist by year-1 because they were not arrested during years 2 through 9. Some released prisoners may not have been arrested because they were incarcerated at certain times during the follow-up period. Thirty-one percent of prisoners appeared to have desisted by year-3 and 44% by year-5. This percentage eclipsed 52% in year-6, at which point two-thirds of the observable years had elapsed.

FIGURE 12

Prisoners released in 30 states in 2005 who were not arrested in the remainder of the follow-up period, by year after release



Note: Estimates after year-6 are not presented as 3 years of subsequent arrests could not be measured. See appendix table 12 for estimates and standard errors.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

Longer follow-up periods provide additional data on the nature of criminal careers, but take time

Research on the criminal activities of persons released from prison has employed different follow-up periods. A 3-year follow-up period has been common, but other time periods (e.g., 1-year, 5-year, and 9-year, as in this report) have been used. Which follow-up period is employed is often driven by the availability of data or the need to study a specific cohort (e.g., those released 3 years ago). Independent of these constraints, deciding which follow-up period to use is closely linked to the competing concerns of accuracy and immediacy.

This study provides empirical evidence that may be used to inform which follow-up period is preferred for various research efforts and policy applications. For example, comparing the 3-year and 9-year follow-up periods showed that the basic recidivism percentage (defined as the cumulative arrest percentage following release) was underestimated by an average of 15 percentage points using the 3-year window. Similarly, the 9-year follow-up period showed that the percentage of released prisoners arrested in states outside the state that released them was twice as high as that observed in a study with a 3-year follow-up period.

With a follow-up period of 3 years, researchers and policymakers would not have observed more than half of the arrests of prisoners after their release. This study's 9-year follow-up period showed that 60% of all arrests of released prisoners occurred more than 3 years after their release.

A longer follow-up period enables researchers and policymakers to better explore the attributes of desistance. This study found that 32% of released prisoners had no arrests following release during the 3-year follow-up period (and appeared to have desisted from criminal activity), but almost half of those (15%) were arrested during the subsequent 6 years, leaving 17% who had no arrests during the 9-year follow-up period (see table 2). In addition, the study found that 24% of released prisoners were still actively involved in criminal activity and were arrested during year-9, which could be viewed as inviting an even longer period of review. The longer period also enables researchers to understand more complex patterns of desistance. For example, of the 44% of released prisoners who were arrested during their first year after release, 1 in 9 (5% of all released prisoners) had no additional arrests during the 9-year follow-up period.

Counterbalancing the value of a longer follow-up period is the need for up-to-date information. Offending patterns may change with time and the offending patterns of prisoners released 10 years ago may be different than those of prisoners released in recent years. In addition, policymakers and practitioners have a need for timely information and may not have time for a recidivism study with a long observation period to be completed to assess the value of a rehabilitation program for released prisoners or a policy change affecting sentencing.

There is no standard length for follow-up periods used in studies of the criminal careers of released prisoners or any other cohort of offenders. This study shows how recidivism and desistance measures change when longer or shorter follow-up periods are used. With these additional data, designers and users of recidivism and desistance studies have more information to determine which follow-up period is best for their needs.

Methodology

Sampling

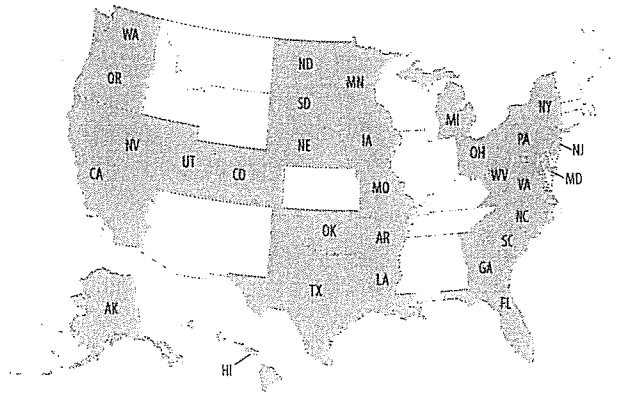
This study estimates the recidivism patterns of persons released in 2005 from state prisons in 30 states. States were included in this study if the state departments of corrections could provide the prisoner records and the FBI or state identification numbers on persons released from prison during 2005. The fingerprint-based identification numbers were required to obtain the criminal history records on released prisoners. The prisoner records—obtained from the state departments of corrections through the Bureau of Justice Statistics' (BJS) National Corrections Reporting Program (NCRP)—also included each prisoner's sex, race, Hispanic origin, date of birth, confinement offenses, sentence length, type of prison release, and date of release. The 30 states whose departments of corrections submitted the NCRP data on prisoners released in 2005 included Alaska, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Iowa, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, and West Virginia (map 1).

Across the 30 states in 2005, a total of 412,731 prisoners were released and were eligible for this study (see appendix table 1). That number excludes 131,997 prisoners (for a total of 544,728) who were sentenced to less than one year, transferred to the custody of another authority, died in prison, were released on bond, were released to seek or participate in an appeal of a case, or escaped from prison or were absent without official leave. The first release during 2005 was used for those prisoners released multiple times during the year.

From the universe of persons released from prison in the 30 states in 2005 in this study, all males and females who were in prison for homicide were selected with certainty into the study. Analyses were done to determine the number of non-homicide prisoners that would be needed from each state's universe of released prisoners to yield a statistically sound estimate of that state's recidivism and desistance rates. As a result, states contributed different numbers of records to the final sample. To achieve the desired state-level samples, lists of all males and females imprisoned for a non-homicide offense were sorted separately by the county in which the sentence was imposed, race, Hispanic origin, age, and most serious

MAP 1

States included in the BJS recidivism study of prisoners released in 2005



Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

commitment offense. The within-state sampling rate for female prisoners was double that of males to improve the precision of female recidivism and desistance estimates. The combined number of persons in the 30 state samples totaled 70,878 individuals who were representative of all state prisoners released in those states during 2005. (This number dropped to 67,966 after accounting for those who died during the subsequent 9 years, lacked criminal history records, or had invalid release records.) Each prisoner in the sample was assigned a weight based on the probability of selection within the state.

Collecting and processing criminal records for recidivism research

In 2008, BJS entered into a data-sharing agreement with the FBI's Criminal Justice Information Services Division and the International Justice and Public Safety Network (Nlets) to allow BJS access to criminal history records through the FBI's Interstate Identification Index (III). Additionally, a data security agreement was executed between BJS, the FBI, and Nlets to define the operational and technical practices used to protect the confidentiality and integrity of the criminal history data during data exchange, processing, and storage.

The FBI's III is an automated pointer system that allows authorized agencies to determine whether any state repository has criminal history records on an individual. Nlets is a computer-based network that is responsible for interstate transmissions of federal and state criminal history records. It allows authorized users to query III and send requests to states holding criminal history records on an individual. The FBI also

maintains criminal history records for which it has sole responsibility for disseminating, such as information on federal arrests. The identification bureaus that operate the central repositories in each state respond automatically to requests over the Nlets network with an individual's criminal history record. Put together, these requests represent the individual's national criminal history record.

Once BJS received approval from the FBI's Institutional Review Board to conduct this recidivism study on prisoners released in 2005, Nlets transmitted the state and FBI identification numbers on the sampled prisoners to the FBI's III system to collect the criminal history records on behalf of BJS. The criminal history records include information from the state of release and all other states in which the sampled prisoners had been arrested both prior to the release in 2005 and afterwards.

Nlets parsed the fields from individual criminal history records into a relational database consisting of state- and federal-specific numeric codes and text descriptions (e.g., criminal statutes and case outcome information) into a uniform record layout. NORC at the University of Chicago assisted BJS with standardizing the content of the relational database into a uniform coding structure to support national-level recidivism research.

BJS conducted a series of data-quality checks on the criminal history records to assess the accuracy and completeness of the information, including an examination of the response messages and the identification numbers that failed to match a record in III. To ensure that the correct records were received on the released prisoners using their fingerprint-based identification numbers, BJS compared other individual identifiers in the NCRP data to those reported in the criminal history records. For 98% of cases, a released prisoner's date of birth in the NCRP data exactly matched the prisoner's birthdate in the criminal history records. Nearly 100% (99.9%) of the NCRP and criminal history records matched prisoner sex, race, and Hispanic origin.

BJS reviewed the criminal history records for differences and inconsistencies in reporting practices and noticed some variations across states. During data processing and analysis, steps were taken to standardize the information and to minimize the impact these variations had on the overall recidivism and desistance estimates. For example, administrative (e.g., a criminal registration or the issuance of a warrant) and procedural (e.g., transferring a suspect to another jurisdiction) records embedded in the criminal history data that did not refer to an actual arrest were identified and removed. Traffic offenses (except for vehicular manslaughter, driving while intoxicated, and hit-and-run) were also excluded because the reporting of these events in the criminal history records varied widely by state.

Deaths during the follow-up period

BJS documented that 2,173 of the 70,878 sampled prisoners died during the 9-year follow-up period, and BJS removed these cases from the recidivism and desistance analysis along with four additional cases that were determined to be invalid release records. The fingerprint-verified death notices obtained through the FBI's III system were used to identify some of the sampled prisoners who died within the 9 years following release in 2005. Additional deaths were identified through the Social Security Administration's (SSA) public Death Master File (DMF). While the public DMF provided a more complete source of death information than the FBI's III system, the public DMF provided death information only for the years 2005 to 2011. Therefore, the identification of those who died between 2012 and 2014 was limited to the FBI's III data, which included only fingerprint-verified deaths.

The number of released prisoners who were identified as dead between 2005 and 2011 in the public DMF is an undercount of the actual number of deaths within the sample. Due to state disclosure laws, the public DMF does not include information on certain protected state death records received via SSA's contracts with the states. Beginning in 2011, the SSA removed more than 4 million state-reported death records from the public DMF and began adding fewer records to the public DMF. As a result, the public DMF contains an undercount of annual deaths.

The extent to which the public DMF undercounts the annual number of deaths is not exactly known. Analyses of deaths in the public DMF compared to those reported by the Centers for Disease Control and Prevention's (CDC) mortality counts suggest that the public DMF undercounted the overall number of deaths in the United States by about 10% in 2005. The undercount increased during succeeding years, and as of 2010, the public DMF contained less than half (45%) of the deaths reported by the CDC. If the number of released prisoners who died during the follow-up

period and were removed from the recidivism and desistance analysis were adjusted to account for this undercount, the estimated cumulative recidivism rate would likely increase by about one percentage point.

Missing criminal history records

Among the 68,701 sampled prisoners not identified as deceased during the follow-up period, BJS did not receive criminal history records on 735 prisoners, either because the state departments of correction were unable to provide their FBI or state identification number or because the prisoner had an identification number that did not link to a criminal history record either in the FBI or state record repositories. To account for the missing criminal history records and to ensure the recidivism and desistance statistics were representative of all 68,701 prisoners in the analysis, BJS developed weighting class adjustments to account for those prisoners without criminal history information to reduce nonresponse bias.

To create the statistical adjustments, the 68,701 sampled prisoners were stratified into groups by crossing the two categories of sex (male or female), five categories of age at release (24 or younger, 25 to 29, 30 to 34, 35 to 39, or 40 or older), four categories of race/Hispanic origin (non-Hispanic white, non-Hispanic black, Hispanic, or other race), and four categories of the most serious commitment offense (violent, property, drug, or public order). Within each of the subgroups, statistical weights were applied to the data of the 67,966 prisoners with criminal history information to allow their data to represent the 735 prisoners without criminal history information.

Conducting tests of statistical significance

This study was based on a sample, not a complete enumeration, so the estimates are subject to sampling error. One measure of the sampling error associated with an estimate is the standard error. The standard error can vary from one estimate to the next. In general, an estimate with a smaller standard error provides a more reliable approximation of the true value than an estimate with a larger standard error. Estimates with relatively large standard errors should be interpreted with caution. BJS conducted tests to determine whether differences in the estimates were statistically significant once sampling error was taken into account.

All differences discussed in this report are statistically significant at the 95% confidence interval level. Standard errors were generated using Stata, a statistical software package that calculates sampling errors for data from complex sample surveys.

Offense definitions

Violent offenses include homicide, rape or sexual assault, robbery, assault, and other miscellaneous or unspecified violent offenses.

Property offenses include burglary, fraud or forgery, larceny, motor vehicle theft, and other miscellaneous or unspecified property offenses.

Drug offenses include possession, trafficking, and other miscellaneous or unspecified drug offenses.

Public order offenses include violations of the peace or order of the community or threats to the public health or safety through unacceptable conduct, interference with a governmental authority, or the violation of civil rights or liberties. This category includes weapons offenses, driving under the influence, probation and parole violation, obstruction of justice, commercialized vice, disorderly conduct, and other miscellaneous or unspecified offenses.

Arrests for probation and parole violations

In this report, arrests for probation and parole violations were included as public order offenses. Excluding arrests for probation and parole violations from the analysis would have had only a small impact on the recidivism rates. Excluding probation and parole violations from the annual arrest percentages, 39.5% of prisoners released in 30 states in 2005 were arrested in year-1, 34.3% were arrested in year-2, 31.5% in year-3, 29.7% in year-4, 28.2% in year-5, 25.9% in year-6, 25.9% in year-7, 24.6% in year-8, and 23.0% in year-9. Overall, excluding probation and parole violations, 82.4% of prisoners released in 30 states in 2005 were arrested within 9 years. In other words, 99% of prisoners who were arrested during the 9-year follow-up period were arrested for an offense other than a probation or parole violation.

APPENDIX TABLE 1
Number of prisoners released in 30 states in 2005

State	Number of released prisoners[a]	Number of sample cases	Released prisoners included in the study[b]		Criminal history record collected	
			Weighted total	Sample size	Number	Percent
All released prisoners	412,731	70,878	401,288	68,701	67,966	98.9%
Alaska	1,827	1,158	1,707	1,082	1,062	98.2
Arkansas	10,844	2,785	10,426	2,675	2,618	97.9
California	107,633	4,604	105,392	4,511	4,510	100
Colorado	8,277	2,351	7,942	2,254	2,247	99.7
Florida	31,537	3,350	30,636	3,253	3,240	99.6
Georgia	12,321	2,763	12,011	2,687	2,592	96.5
Hawaii	1,041	793	1,016	774	767	99.1
Iowa	4,607	1,897	4,406	1,816	1,810	99.7
Louisiana	12,876	2,806	12,422	2,712	2,697	99.4
Maryland	10,200	2,597	9,769	2,488	2,468	99.2
Michigan	12,177	2,603	11,633	2,490	2,471	99.2
Minnesota	4,619	1,897	4,570	1,877	1,873	99.8
Missouri	15,997	2,919	15,404	2,810	2,805	99.8
Nebraska	1,386	966	1,364	951	951	100
Nevada	5,022	1,973	4,930	1,935	1,787	92.4
New Jersey	13,097	2,697	12,964	2,666	2,622	98.3
New York	23,963	3,532	23,226	3,433	3,433	100
North Carolina	11,743	2,748	11,229	2,626	2,616	99.6
North Dakota	884	686	865	671	663	98.8
Ohio	15,832	3,070	15,555	3,015	2,927	97.1
Oklahoma	7,768	2,345	7,424	2,240	2,169	96.8
Oregon	4,731	1,955	4,595	1,900	1,898	99.9
Pennsylvania	12,452	2,840	11,884	2,712	2,685	99.0
South Carolina	10,046	2,537	9,971	2,516	2,500	99.4
South Dakota	2,159	1,285	2,142	1,275	1,268	99.5
Texas	43,532	3,779	42,770	3,713	3,713	100
Utah	3,000	1,569	2,951	1,543	1,534	99.4
Virginia	12,776	2,719	12,148	2,585	2,574	99.6
Washington	8,439	2,443	8,093	2,343	2,341	99.9
West Virginia	1,945	1,211	1,842	1,148	1,125	98.0

[a]Excludes released prisoners whose sentence was less than one year; releases to custody, detainer, or warrant; releases due to death; escapes or absent without leave; transfers; administrative releases; and releases on appeal. The first release was selected for persons released multiple times during 2005.

[b]Excludes 2,173 sampled prisoners (when weighted representing 11,443 individuals) who died during the follow-up period and four cases determined to be invalid release records.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 2

Standard errors for table 1: Characteristics of prisoners released in 30 states in 2005

Characteristic	Standard error
Sex	
Male	0.003%
Female	0.003
Race/Hispanic origin	
White	0.28%
Black/African American	0.27
Hispanic/Latino	0.27
Other	0.09
American Indian or Alaska Native	0.05
Asian, Native Hawaiian, or Other Pacific Islander	0.06
Age at release	
24 or younger	0.22%
25–29	0.24
30–34	0.22
35–39	0.22
40 or older	0.28
Most serious commitment offense	
Violent	0.26%
Property	0.28
Drug	0.28
Public order	0.18

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 4

Standard errors for figure 3: Percent of prisoners released in 30 states in 2005 who were arrested after release, by year after release

Year of first arrest	Estimate	Standard error
1	43.9%	0.29%
2	16.2	0.21
3	8.3	0.15
4	5.1	0.11
5	3.5	0.09
6	2.3	0.07
7	1.7	0.06
8	1.3	0.05
9	1.0	0.05

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 3

Standard errors for table 2, figure 2, and figure 4: Cumulative percent of prisoners released in 30 states in 2005 who were arrested within or outside the state of release, by year after release

	Within or outside the state of release		Outside the state of release	
Year after release	Percent arrested	Percent not arrested	Percent arrested	Percent not arrested
1	0.29%	0.29%	0.09%	0.11%
2	0.27	0.21	0.11	0.09
3	0.25	0.15	0.13	0.09
4	0.23	0.11	0.15	0.08
5	0.22	0.09	0.16	0.08
6	0.21	0.07	0.17	0.08
7	0.21	0.06	0.18	0.07
8	0.20	0.05	0.19	0.07
9	0.20	0.05	0.19	0.07

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 5

Standard errors for table 3, figure 5, and figure 6: Percent of prisoners released in 30 states in 2005 who were arrested after release, by prisoner characteristics and year of first arrest

Characteristic	Total arrested within 9 years	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
All released prisoners	0.20%	0.29%	0.21%	0.15%	0.11%	0.09%	0.07%	0.06%	0.05%	0.05%
Sex										
Male	0.22%	0.32%	0.23%	0.16%	0.12%	0.10%	0.08%	0.07%	0.06%	0.05%
Female	0.39	0.49	0.37	0.26	0.22	0.19	0.14	0.13	0.11	0.12
Age at release										
24 or younger	0.36%	0.68%	0.50%	0.32%	0.26%	0.23%	0.14%	0.15%	0.10%	0.07%
25–39	0.27	0.41	0.30	0.22	0.16	0.13	0.10	0.08	0.08	0.06
25–29	0.40	0.68	0.48	0.36	0.26	0.20	0.16	0.12	0.14	0.10
30–34	0.52	0.76	0.53	0.35	0.30	0.23	0.19	0.15	0.18	0.12
35–39	0.51	0.77	0.54	0.41	0.28	0.24	0.17	0.15	0.12	0.11
40 or older	0.42	0.54	0.38	0.27	0.21	0.18	0.15	0.11	0.09	0.12
Race/Hispanic origin										
White	0.31%	0.44%	0.31%	0.23%	0.17%	0.14%	0.10%	0.11%	0.08%	0.08%
Black/African American	0.25	0.42	0.31	0.21	0.18	0.14	0.11	0.09	0.07	0.07
Hispanic/Latino	0.67	0.93	0.64	0.45	0.33	0.29	0.24	0.12	0.19	0.14
Other	1.37	1.98	1.55	1.00	0.55	0.48	0.16	0.33	0.20	0.20
American Indian or Alaska Native	1.49	2.21	1.65	0.79	0.46	0.41	0.22	0.41	0.26	0.28
Asian, Native Hawaiian, or Other Pacific Islander	2.58	3.77	2.99	2.09	0.70	0.22	0.34	0.54	0.33	0.39

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 6

Standard errors for table 4: Post-release arrests of prisoners released in 30 states in 2005, by year after arrest

Year after arrest	Number of arrests during year/period	Percent of arrests during year/period	Cumulative number of all arrests since release	Cumulative percent of all arrests since release
Total	15,295	~	~	~
Years 1–3	6,173	0.22%	~	~
1	2,941	0.13	2,941	0.13
2	2,910	0.13	4,675	0.19
3	2,819	0.12	6,173	0.22
Years 4–6	6,223	0.19%	~	~
4	2,838	0.11	7,704	0.24
5	3,009	0.12	9,317	0.24
6	2,613	0.11	10,530	0.23
Years 7–9	7,295	0.23%	~	~
7	2,982	0.12	12,006	0.20
8	3,212	0.13	13,570	0.14
9	3,333	0.14	15,295	~

~Not applicable.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 7

Standard errors for table 5, figure 1, figure 7, and figure 8: Annual arrest percentage of prisoners released in 30 states in 2005, by prisoner characteristics

Characteristic	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
All released prisoners	0.29%	0.29%	0.29%	0.29%	0.28%	0.28%	0.28%	0.27%	0.27%
Sex									
Male	0.32%	0.32%	0.32%	0.32%	0.31%	0.31%	0.31%	0.30%	0.30%
Female	0.49	0.50	0.49	0.48	0.47	0.46	0.45	0.44	0.44
Age at release									
24 or younger	0.68%	0.69%	0.68%	0.67%	0.68%	0.66%	0.67%	0.65%	0.64%
25–39	0.41	0.42	0.41	0.41	0.40	0.40	0.40	0.39	0.39
25–29	0.68	0.68	0.68	0.67	0.65	0.65	0.65	0.64	0.63
30–34	0.76	0.75	0.73	0.73	0.72	0.71	0.70	0.70	0.67
35–39	0.77	0.76	0.76	0.75	0.74	0.73	0.74	0.71	0.72
40 or older	0.54	0.53	0.52	0.52	0.51	0.49	0.48	0.47	0.47
Race/Hispanic origin									
White	0.44%	0.44%	0.43%	0.43%	0.42%	0.41%	0.41%	0.40%	0.40%
Black/African American	0.42	0.43	0.42	0.42	0.41	0.40	0.41	0.40	0.39
Hispanic/Latino	0.93	0.92	0.91	0.90	0.88	0.86	0.85	0.83	0.83
Other	1.98	1.99	1.94	1.87	1.83	1.90	1.86	1.90	1.70
American Indian or Alaska Native	2.21	2.22	2.22	2.01	2.06	2.18	2.21	2.13	1.83
Asian, Native Hawaiian, or Other Pacific Islander	3.77	3.86	3.50	3.64	3.49	3.58	3.50	3.66	3.14

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 8

Standard errors for table 6, figure 9, and figure 10: Annual arrest percentage of prisoners released in 30 states in 2005, by most serious commitment offense and type of post-release offense

Most serious commitment offense	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Any arrest after release									
All released prisoners	0.29%	0.29%	0.29%	0.29%	0.28%	0.28%	0.28%	0.27%	0.27%
Violent	0.60	0.59	0.58	0.56	0.56	0.54	0.55	0.55	0.53
Property	0.55	0.56	0.56	0.56	0.55	0.54	0.54	0.53	0.52
Drug	0.53	0.53	0.53	0.51	0.51	0.49	0.49	0.48	0.47
Public order	0.78	0.77	0.74	0.73	0.73	0.72	0.71	0.69	0.69
Violent arrest after release									
All released prisoners	0.18%	0.17%	0.17%	0.17%	0.16%	0.15%	0.16%	0.15%	0.14%
Violent	0.39	0.37	0.34	0.36	0.37	0.30	0.31	0.31	0.29
Property	0.34	0.29	0.30	0.32	0.30	0.31	0.32	0.28	0.28
Drug	0.27	0.29	0.28	0.27	0.27	0.23	0.25	0.25	0.22
Public order	0.49	0.45	0.44	0.46	0.43	0.42	0.40	0.40	0.36
Arrest after release for same type as most serious commitment offense									
All released prisoners	0.26%	0.24%	0.23%	0.22%	0.22%	0.21%	0.20%	0.20%	0.20%
Violent	0.39	0.37	0.34	0.36	0.37	0.30	0.31	0.31	0.29
Property	0.51	0.45	0.43	0.44	0.42	0.40	0.39	0.40	0.39
Drug	0.48	0.45	0.43	0.41	0.39	0.38	0.36	0.36	0.37
Public order	0.77	0.73	0.70	0.67	0.66	0.66	0.63	0.63	0.60
Arrested after release for different type of offense than most serious commitment offense									
All released prisoners	0.29%	0.29%	0.28%	0.28%	0.27%	0.27%	0.27%	0.26%	0.26%
Violent	0.60	0.58	0.57	0.55	0.54	0.53	0.54	0.54	0.52
Property	0.56	0.55	0.55	0.55	0.53	0.52	0.52	0.51	0.51
Drug	0.53	0.52	0.51	0.50	0.49	0.47	0.47	0.45	0.44
Public order	0.72	0.67	0.64	0.64	0.65	0.62	0.63	0.61	0.62

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 9

Standard errors for table 7: Cumulative percent of prisoners released in 30 states in 2005 who were arrested following release, by most serious commitment offense and type of post-release arrest offense

Most serious commitment offense	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Any arrest after release									
All released prisoners	0.29%	0.27%	0.25%	0.23%	0.22%	0.21%	0.21%	0.20%	0.20%
Violent	0.60	0.57	0.54	0.52	0.49	0.47	0.46	0.45	0.45
Property	0.55	0.49	0.44	0.40	0.38	0.36	0.35	0.34	0.33
Drug	0.53	0.49	0.45	0.42	0.40	0.38	0.37	0.36	0.35
Public order	0.78	0.75	0.70	0.66	0.63	0.61	0.58	0.57	0.56
Violent arrest after release									
All released prisoners	0.18%	0.22%	0.25%	0.27%	0.28%	0.28%	0.29%	0.29%	0.29%
Violent	0.39	0.49	0.53	0.56	0.58	0.59	0.59	0.59	0.59
Property	0.34	0.41	0.46	0.49	0.52	0.53	0.55	0.55	0.56
Drug	0.27	0.36	0.42	0.45	0.47	0.48	0.49	0.50	0.51
Public order	0.49	0.60	0.66	0.71	0.73	0.74	0.75	0.76	0.76
Arrest after release for same type as most serious commitment offense									
All released prisoners	0.26%	0.29%	0.30%	0.30%	0.30%	0.30%	0.29%	0.29%	0.29%
Violent	0.39	0.49	0.53	0.56	0.58	0.59	0.59	0.59	0.59
Property	0.50	0.55	0.56	0.56	0.56	0.55	0.55	0.54	0.54
Drug	0.48	0.52	0.53	0.53	0.53	0.52	0.52	0.51	0.51
Public order	0.77	0.78	0.76	0.74	0.72	0.70	0.68	0.67	0.65
Arrested after release for different type of offense than most serious commitment offense									
All released prisoners	0.29%	0.28%	0.26%	0.25%	0.25%	0.24%	0.23%	0.23%	0.22%
Violent	0.60	0.59	0.56	0.54	0.52	0.50	0.49	0.48	0.47
Property	0.56	0.52	0.48	0.45	0.43	0.41	0.40	0.39	0.38
Drug	0.53	0.52	0.49	0.46	0.45	0.43	0.42	0.41	0.41
Public order	0.72	0.77	0.77	0.76	0.75	0.74	0.72	0.71	0.70

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 10

Standard errors for table 8: Annual arrest percentage of prisoners released in 30 states in 2005, by whether arrested within or outside the state of release

	All released prisoners		Among released prisoners arrested during the year, percent arrested outside of state of release
Year after release	Outside state of release	Within or outside state of release	
1	0.09%	0.29%	0.20%
2	0.09	0.29	0.23
3	0.09	0.29	0.27
4	0.09	0.29	0.29
5	0.09	0.28	0.31
6	0.10	0.28	0.33
7	0.10	0.28	0.35
8	0.09	0.27	0.36
9	0.10	0.27	0.40
Arrested anytime in follow-up period	0.19%	0.20%	~

~Not applicable.

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 11

Estimates and standard errors for figure 11: Percent of prisoners released in 30 states in 2005 who were arrested after release, by year of arrest and whether arrested during subsequent years

	Total		Arrested again during a subsequent year		Not arrested during a subsequent year	
Year after release	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
1	43.9%	0.29%	38.9%	0.29%	4.9%	0.14%
2	37.7	0.29	33.0	0.29	4.7	0.12
3	34.3	0.29	29.1	0.28	5.2	0.13
4	31.9	0.29	26.0	0.28	5.9	0.14
5	30.1	0.28	23.2	0.27	6.9	0.15
6	28.0	0.28	20.1	0.26	7.8	0.16
7	27.4	0.28	17.2	0.25	10.2	0.18
8	25.9	0.27	12.2	0.22	13.7	0.20

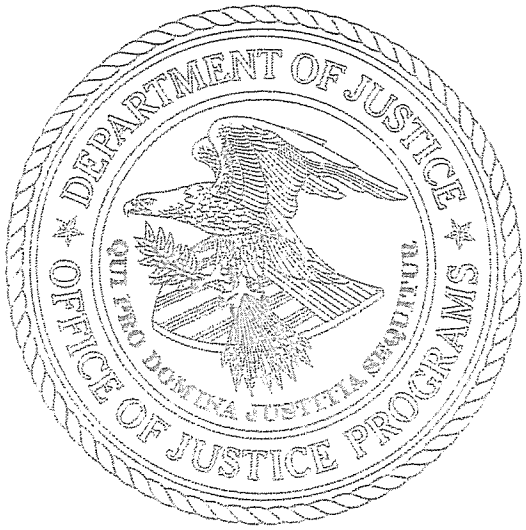
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.

APPENDIX TABLE 12

Estimates and standard errors for figure 12: Prisoners released in 30 states in 2005 who were not arrested in the remainder of the follow-up period, by year after release

	Number		Percent	
Year after release	Estimate	Standard error	Estimate	Standard error
1	86,000	927	21.5%	0.23%
2	105,000	1,000	26.2	0.25
3	126,000	1,069	31.4	0.27
4	150,000	1,129	37.3	0.28
5	178,000	1,173	44.3	0.29
6	209,000	1,193	52.1	0.30

Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2005 data collection, 2005–2014.



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This report was written by Mariel Alper, Joshua Markman, and Matthew R. Durose. Stephanie Mueller and Matthew R. Durose verified the report.

Brigitte Coulton and Jill Thomas edited the report. Steven Grudziecki produced the report.

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Table of Contents

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.

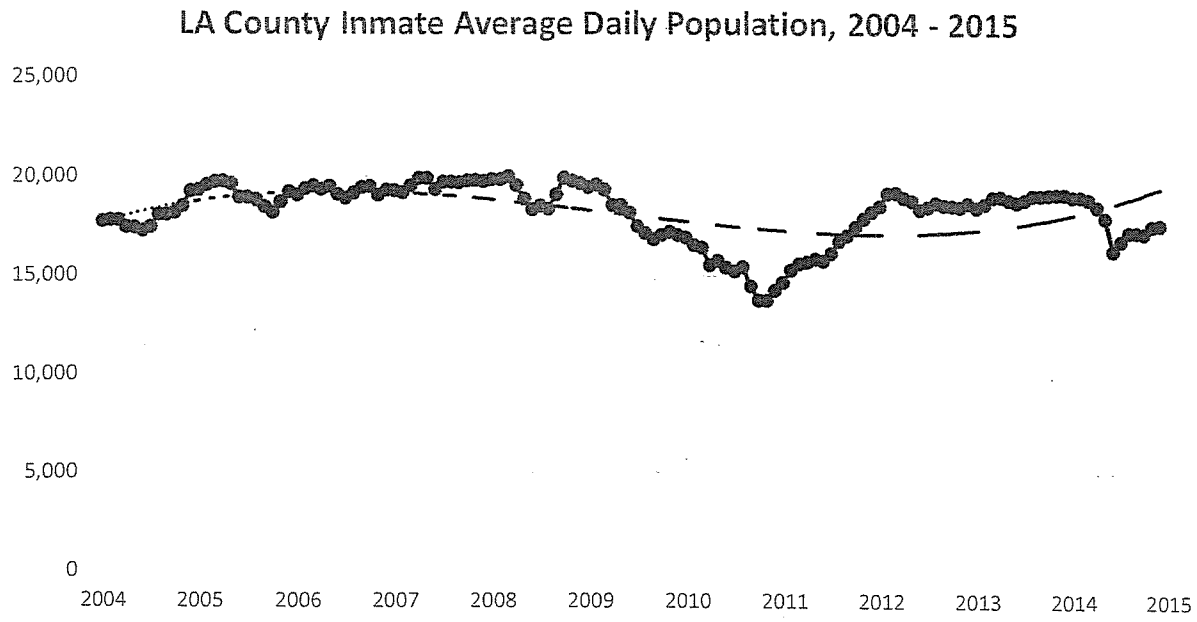
In order to evaluate the impact of the various legislative initiatives, the consultant team needed to develop an independent patient-inmate population projection that extends twenty years, to 2035. While patient-inmate population forecast accuracy becomes limited beyond five years, there is a need for 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.

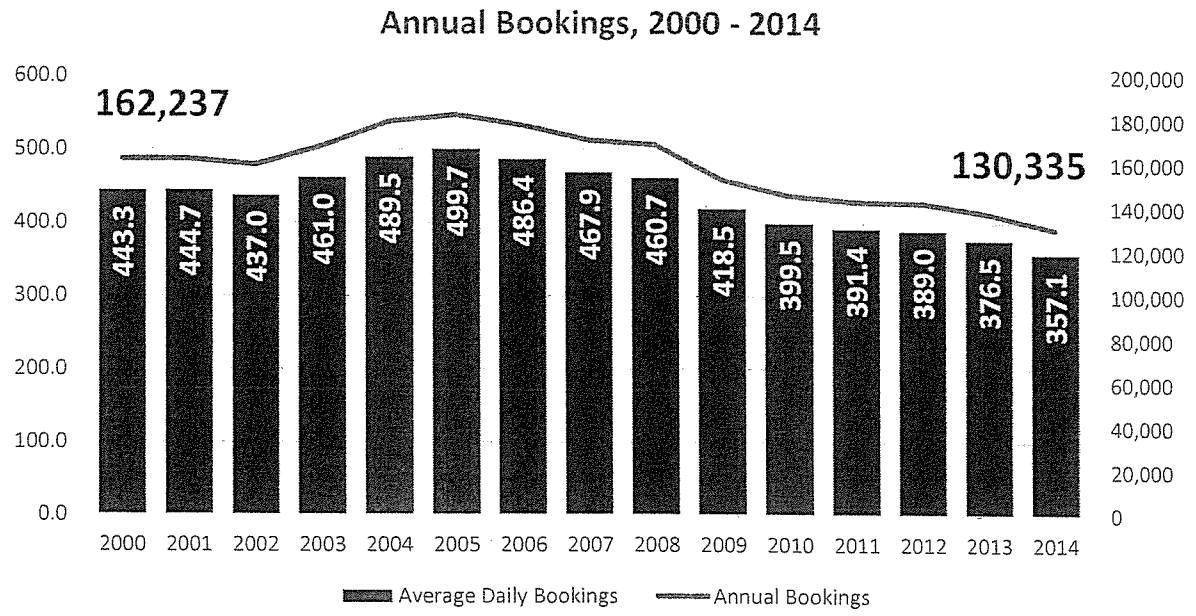
Figure 1. LA County Inmate Average Daily Population, 2004-2015



[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.

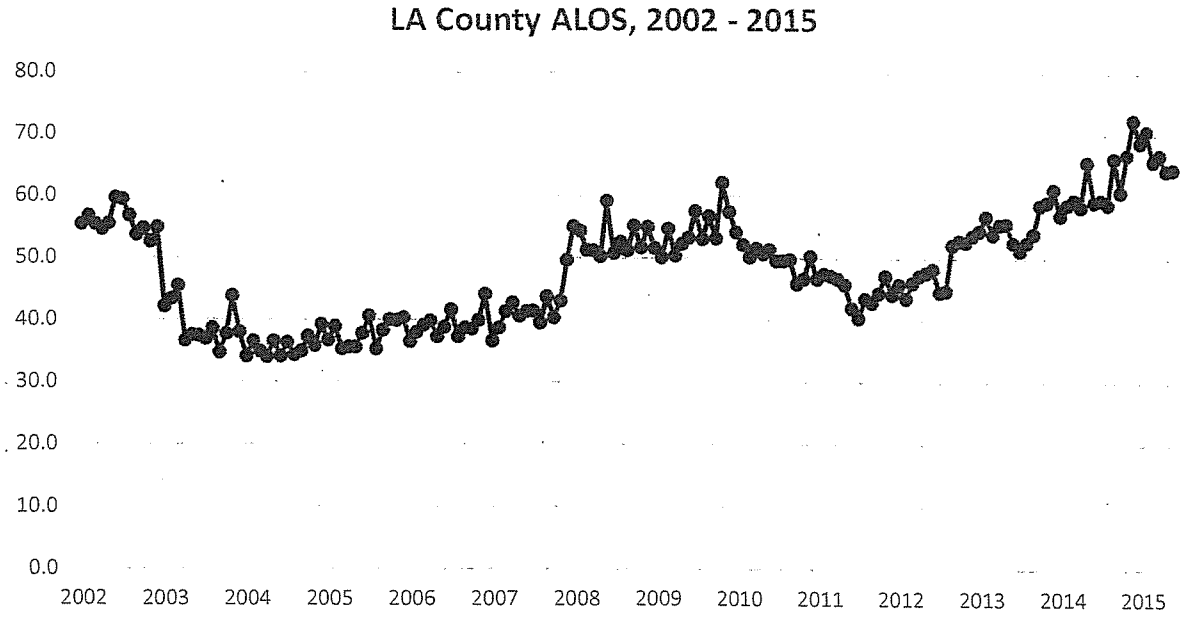
Figure 2. Annual Bookings, 2000-2014



[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.

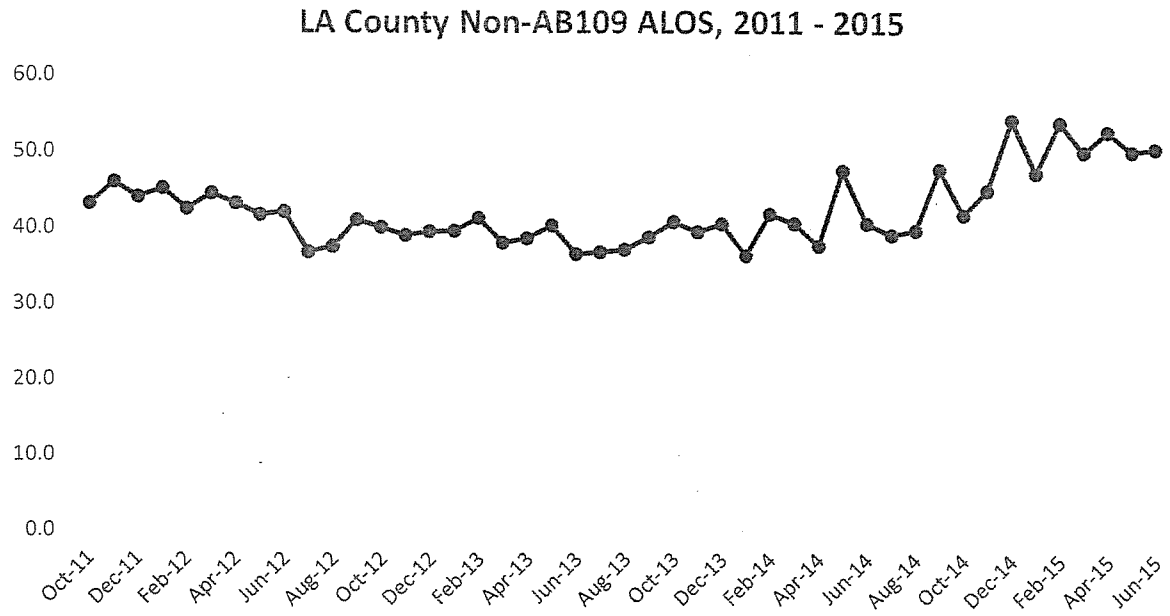
Figure 3. LA County ALOS, 2002-2015



[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.

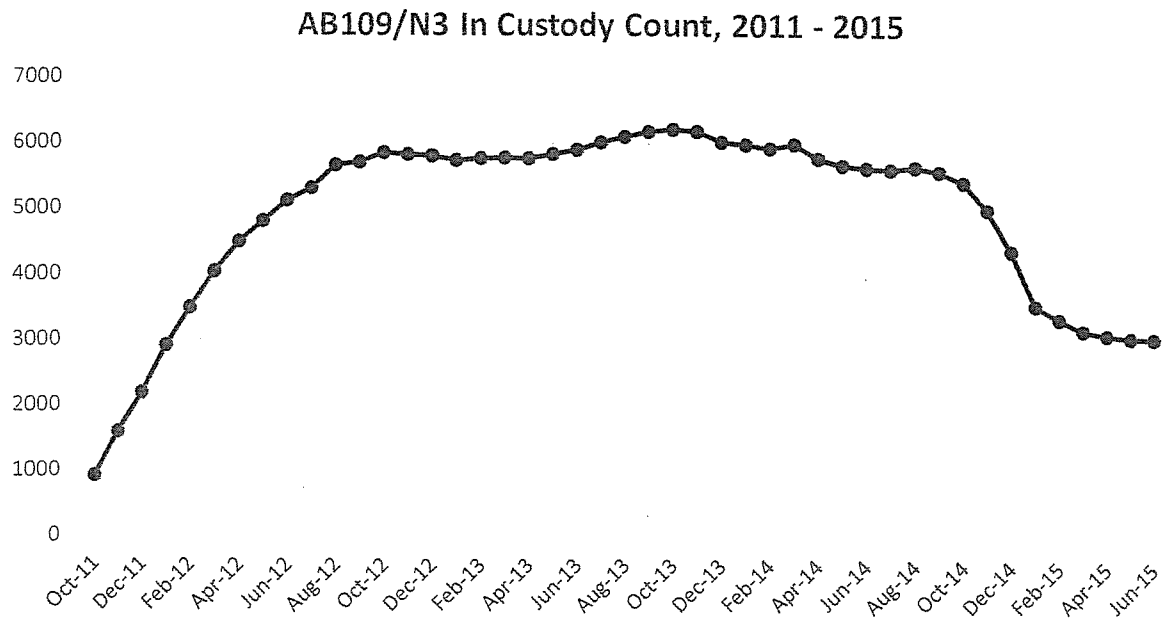
Figure 4. LA County Non-AB109 ALOS, 2011-2015



[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.

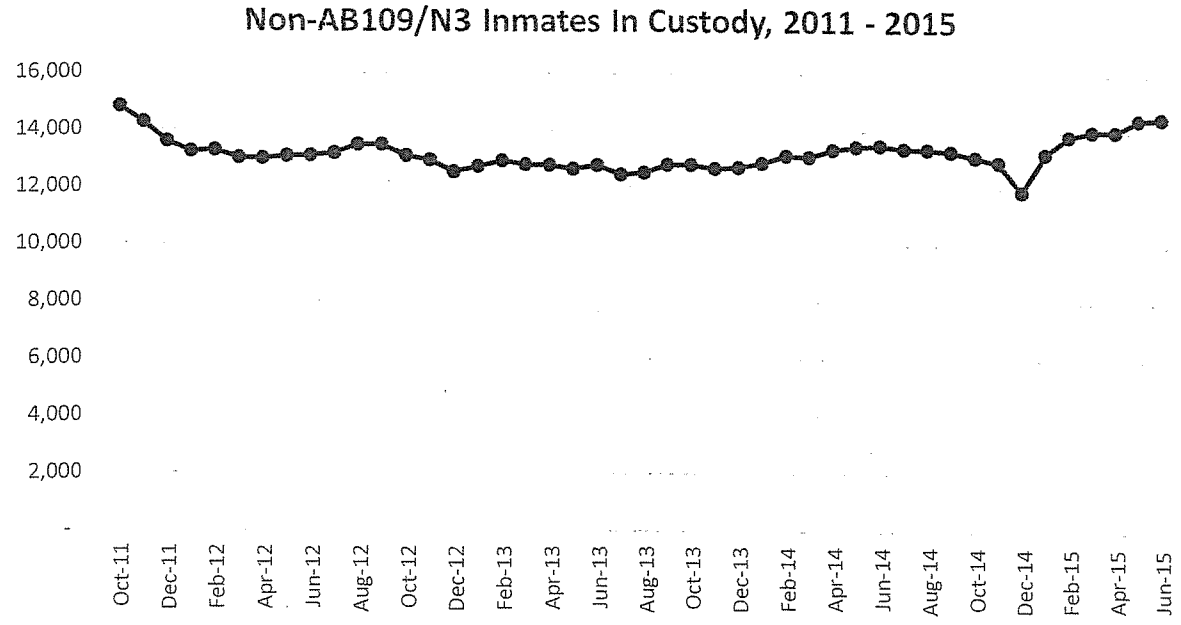
Figure 5. AB109/N3 in Custody Count, 2011-2015



[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.

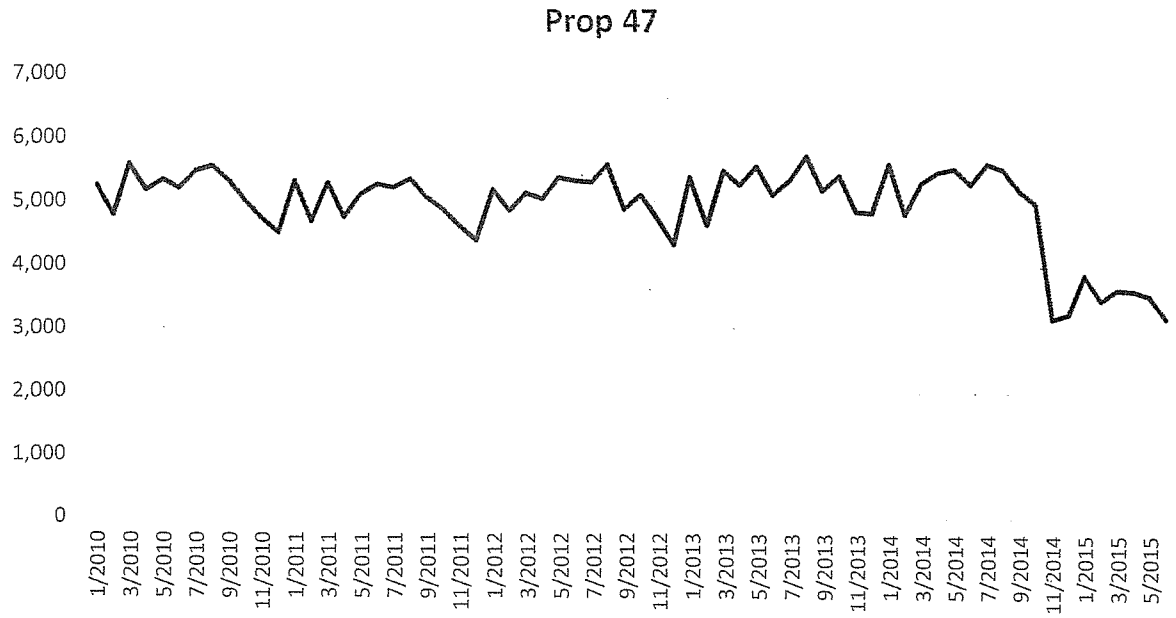
Figure 6. Non-AB109/N3 Patient-inmates in Custody, 2011-2015



[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.

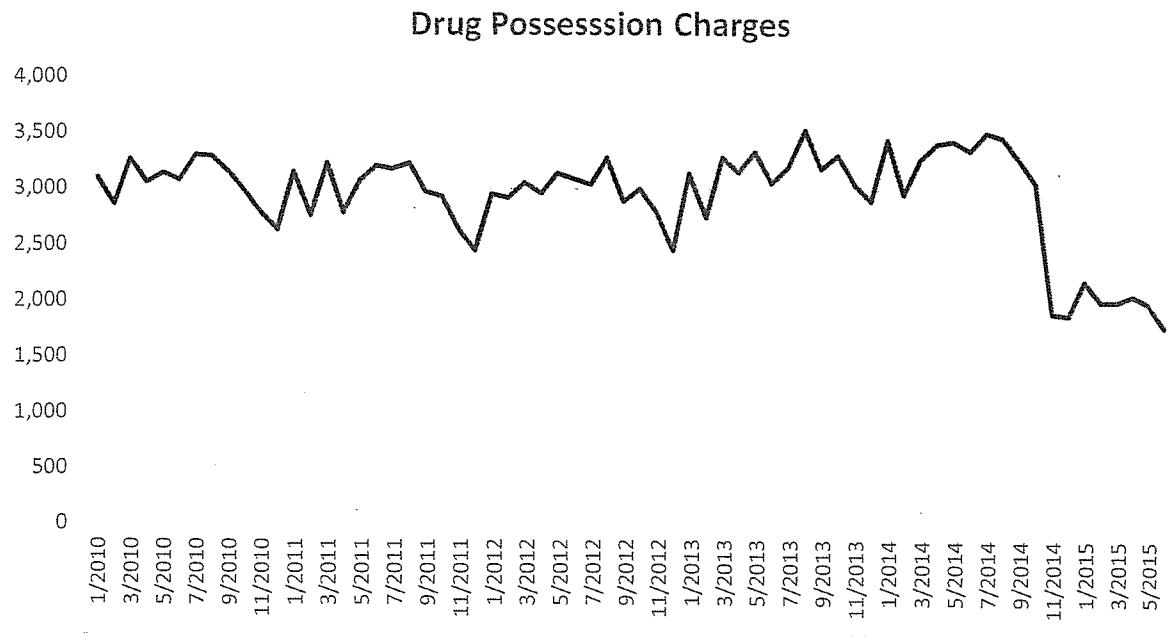
Figure 7. Prop 47



[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



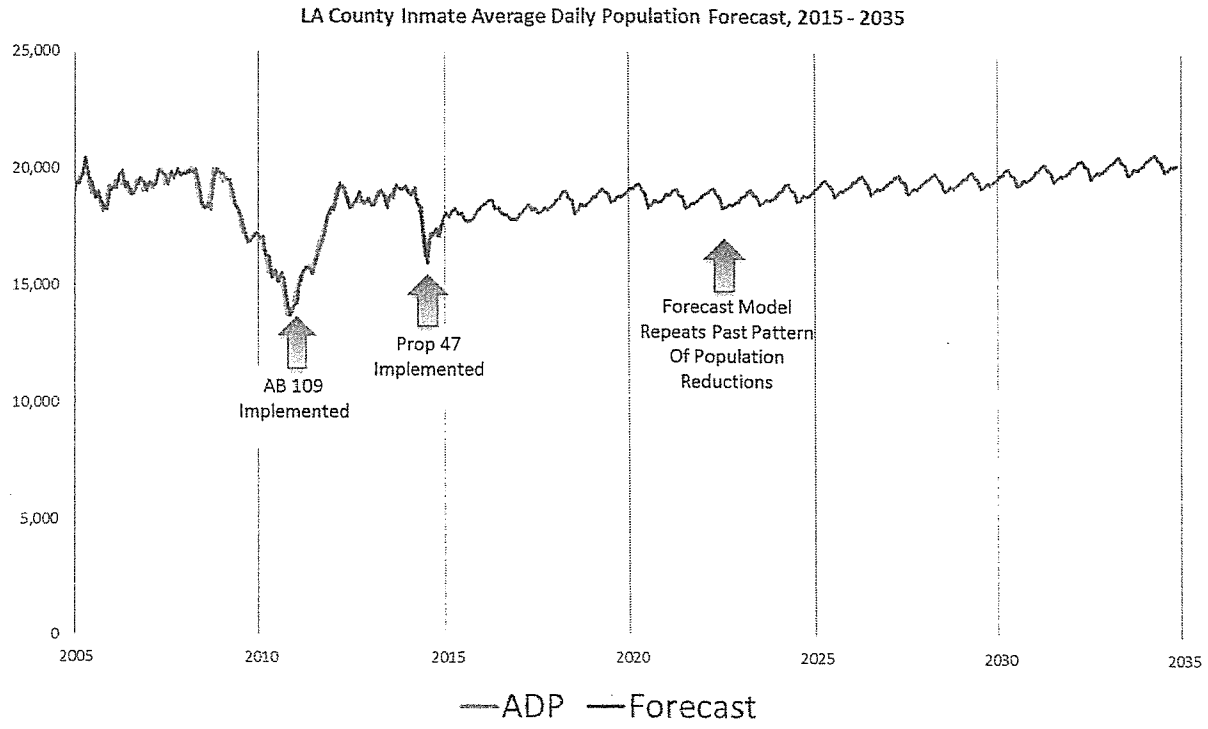
[Data Source: LASD]

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.

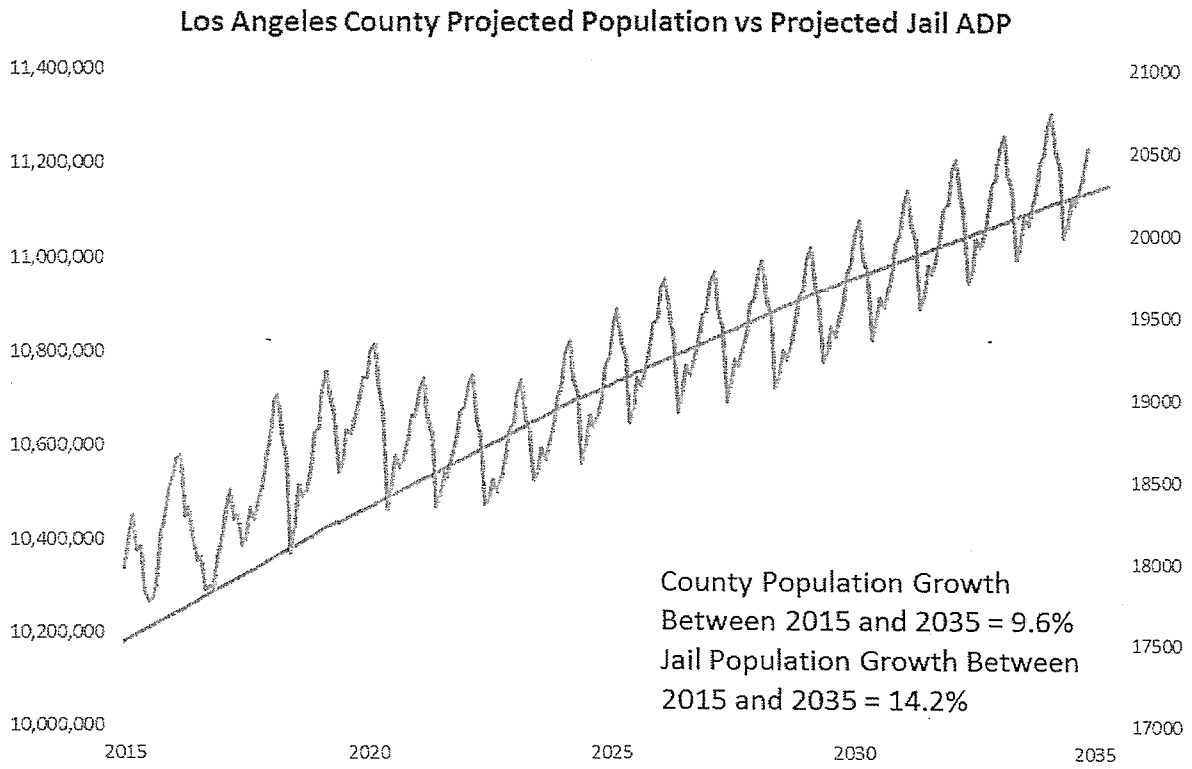
Overall, several factors will ultimately combine to drive the county jail's population numbers. In terms of what determines the jail's population, the roughly 35% decline in bookings in the last 10 years competes with the 70% increase in ALOS during that time. A series of ARIMA time series models were 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.

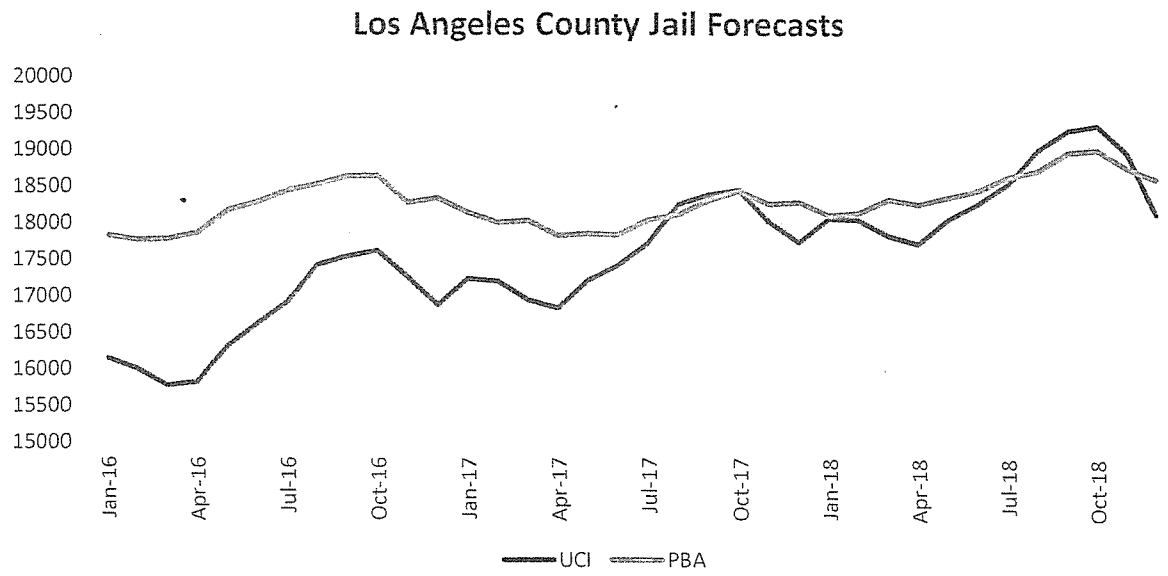
Figure 10. Los Angeles County Projected Population vs. Projected Jail ADP



[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.

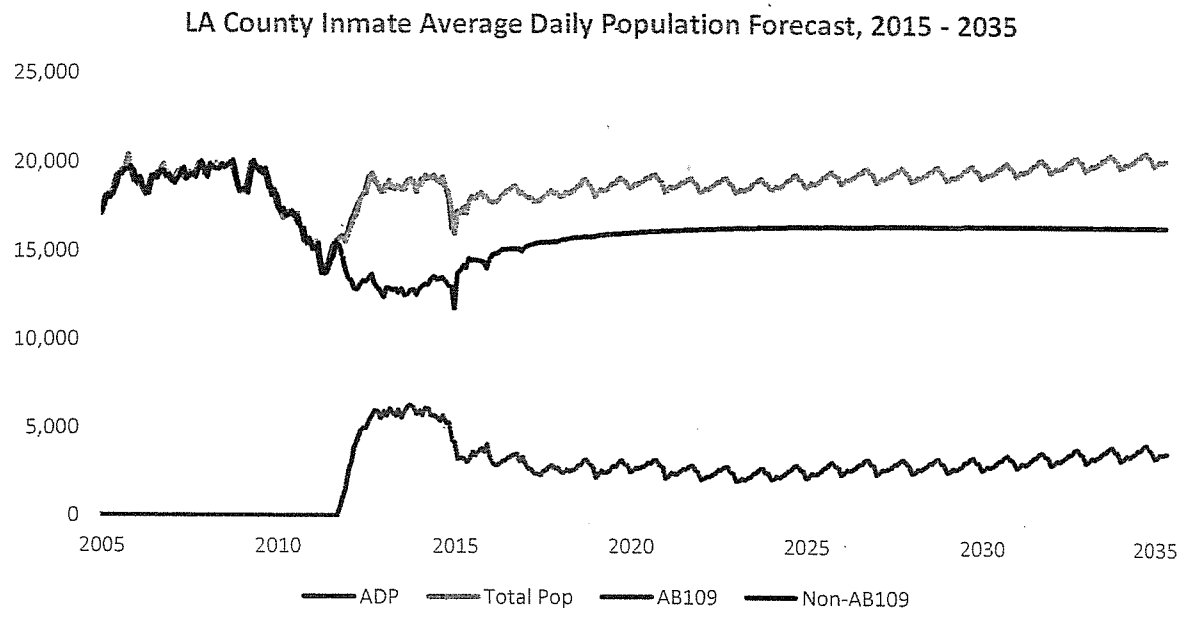
Table 1.

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

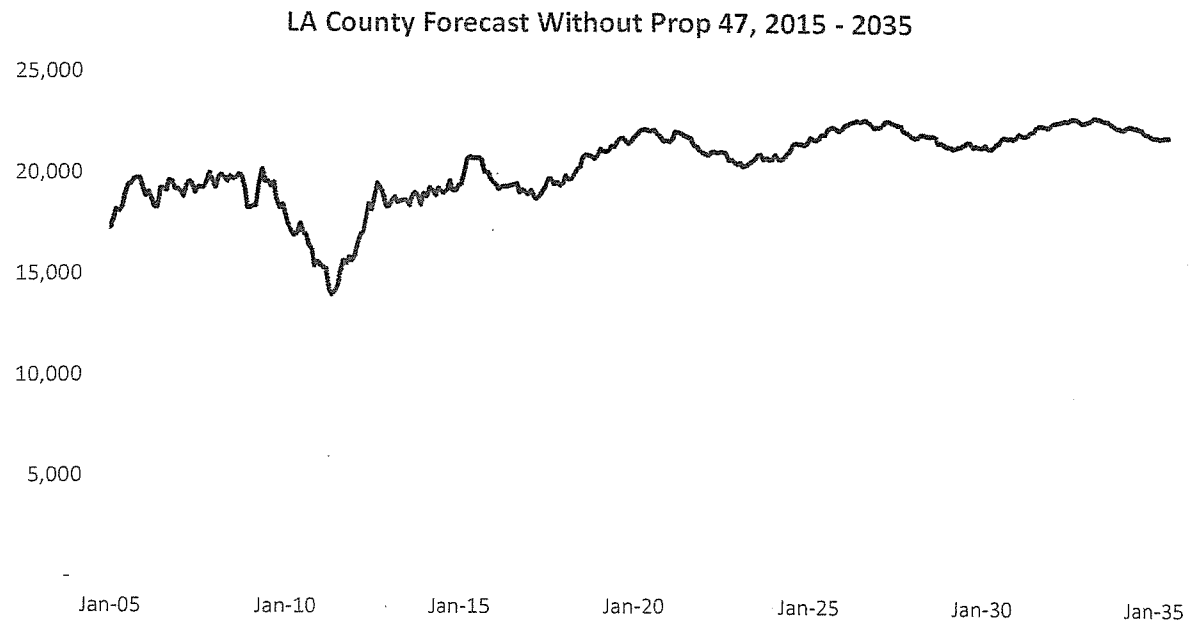
Figure 12. LA County Inmate Average Daily Population Forecast, 2015-2035



[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

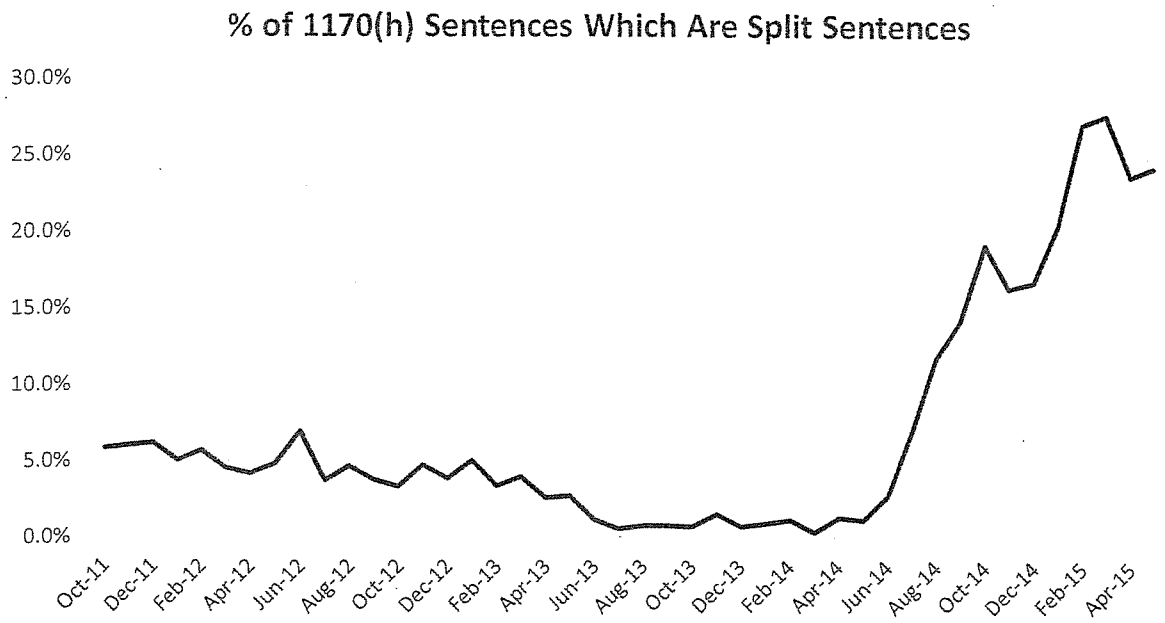


[Data Source: LASD]

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.

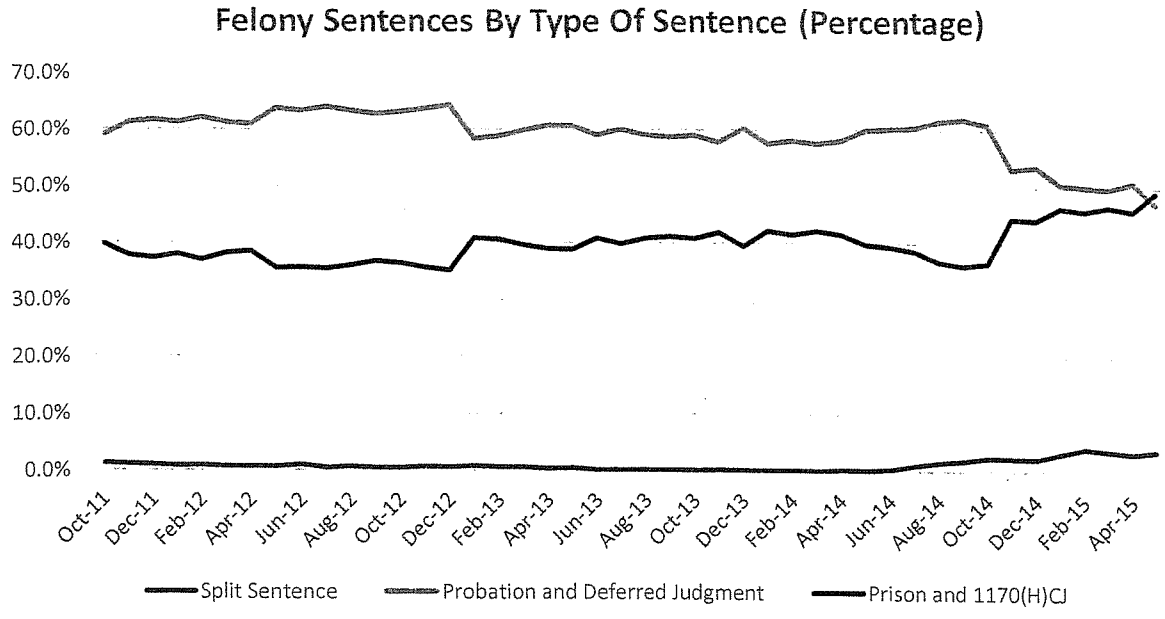
Figure 14. Percentage of 1170(h) Sentences which are Split Sentences



[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)

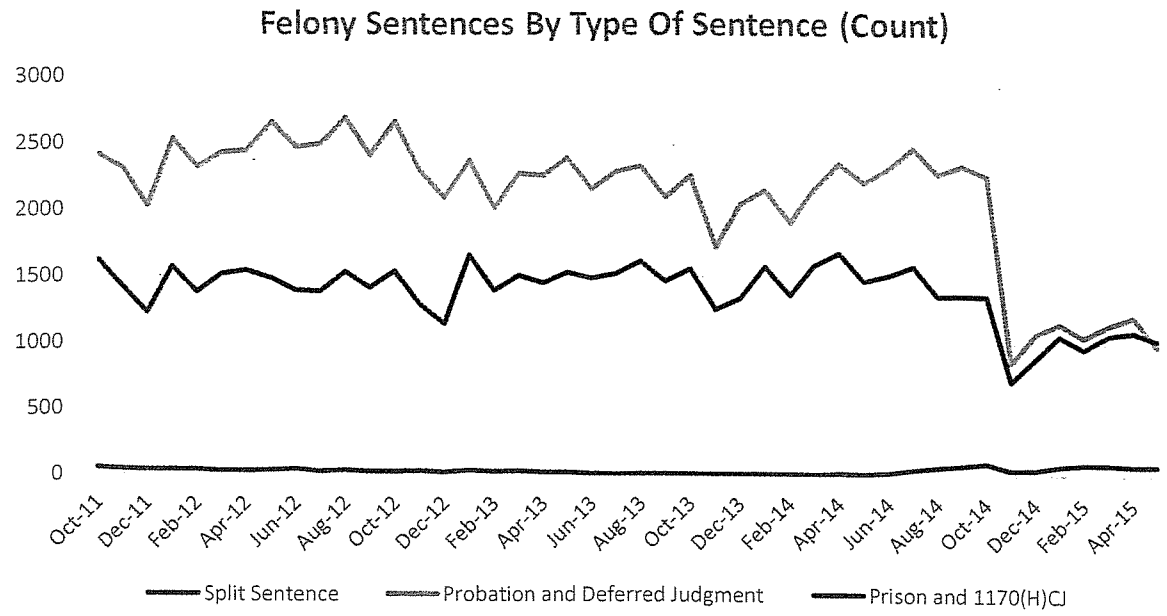


[Data Source: LASD]

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			

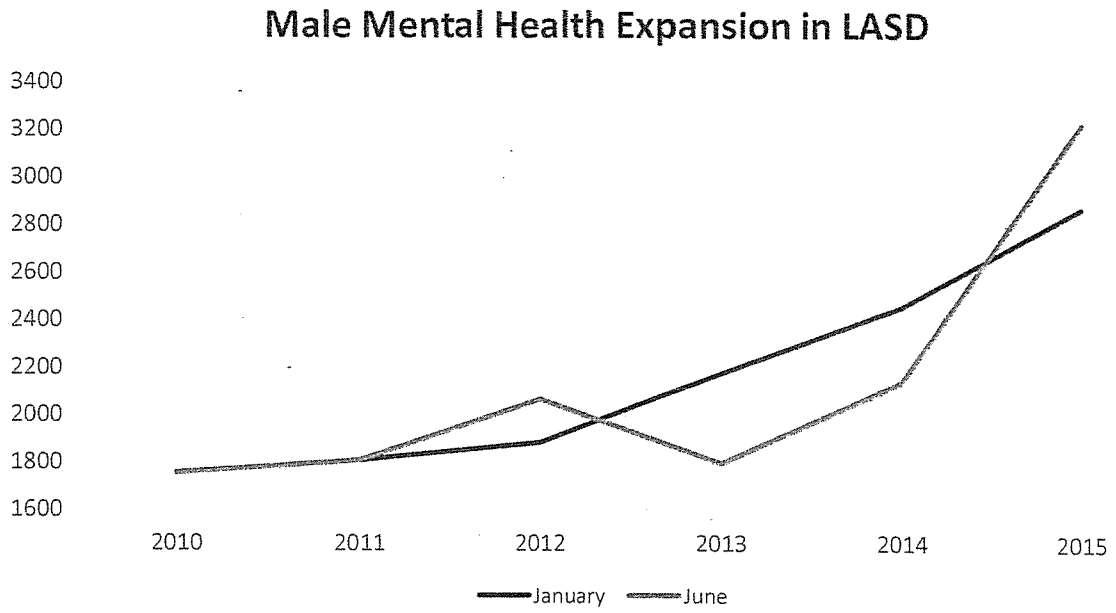
[Data Source: LASD]

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

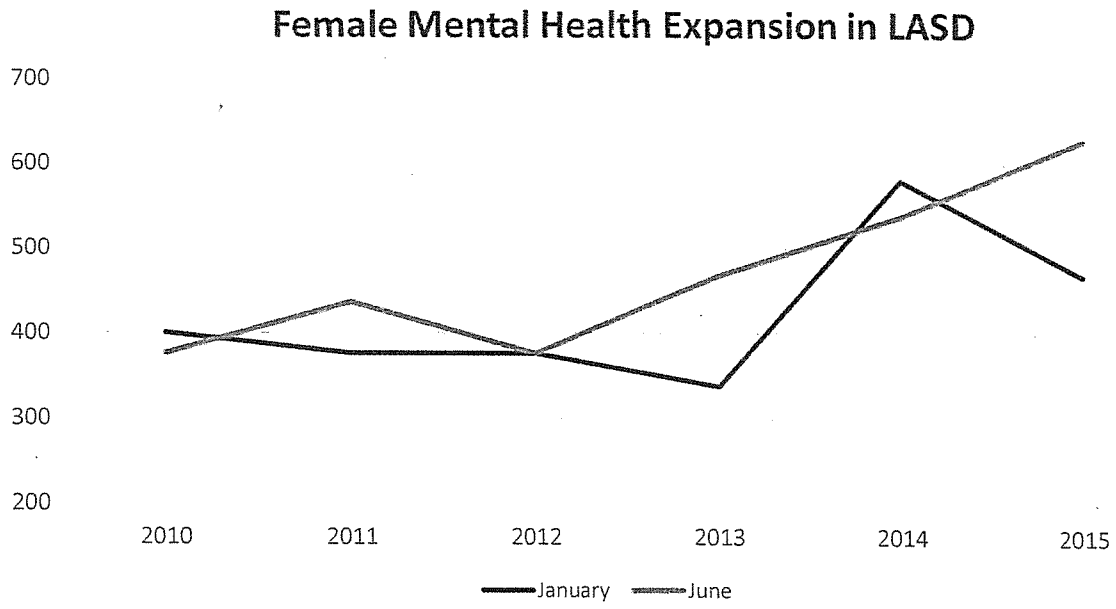
The population of men and women who have mental illnesses housed in LASD facilities constitutes the largest group of individuals projected to be housed in the CCTF. As demonstrated in the graphs below, there has been a steady and dramatic increase in the numbers of males and females with mental health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



[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.

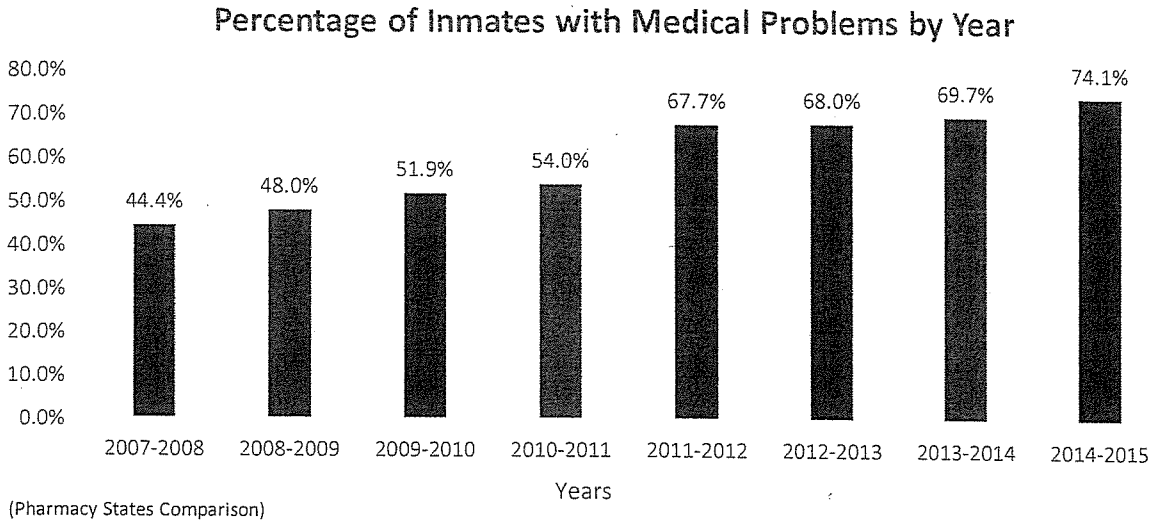
The **General Population** units house 762 mentally ill individuals in Central Men's Jail and Century Regional Detention Facility were not fully evaluated, mental health providers and officer communicated that a not insignificant number of these patient-inmates do not adapt well in GP housing and shuttle 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



(Pharmacy States Comparison)

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:

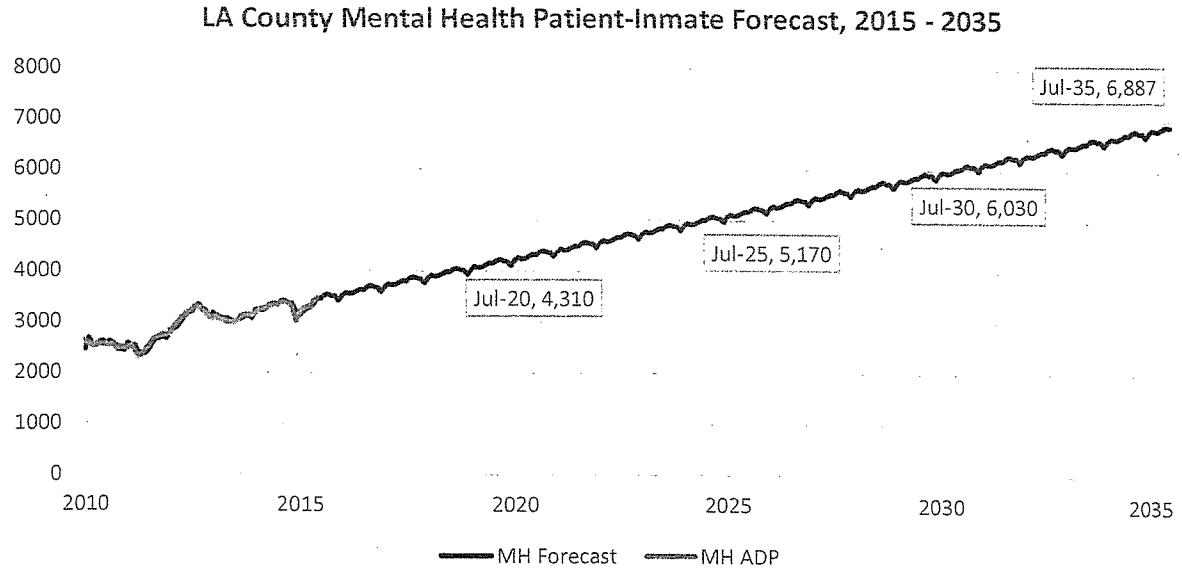
Table 11. Mental Health Client Census

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	
Cumulative Total			519			1967			568		3055

[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.

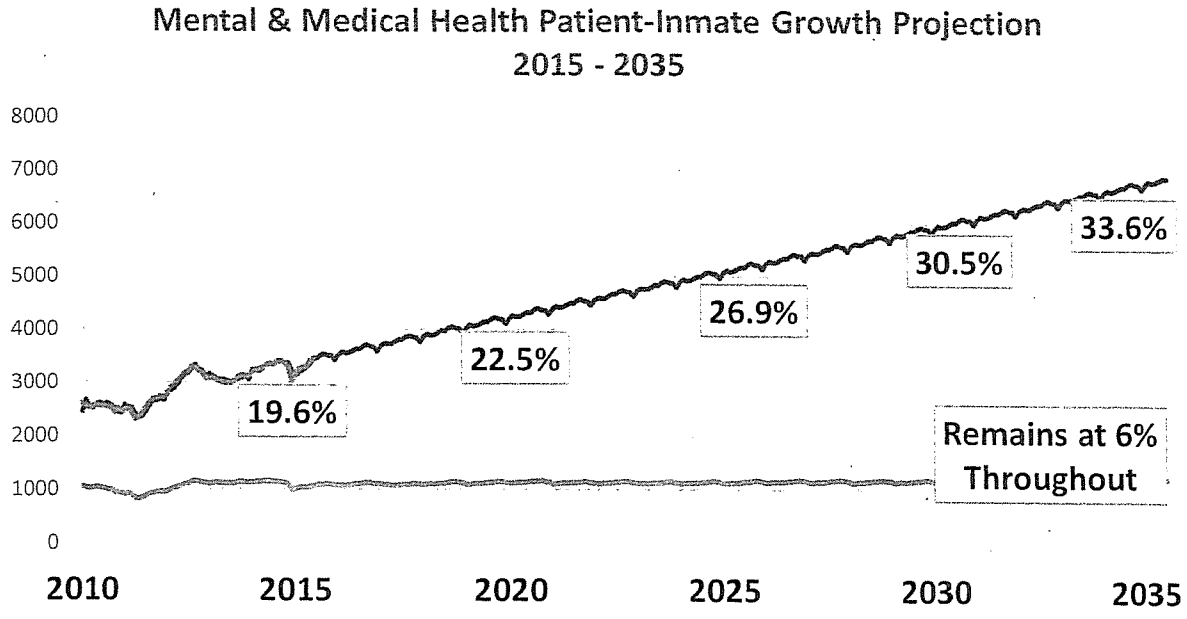
Medical Forecast

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

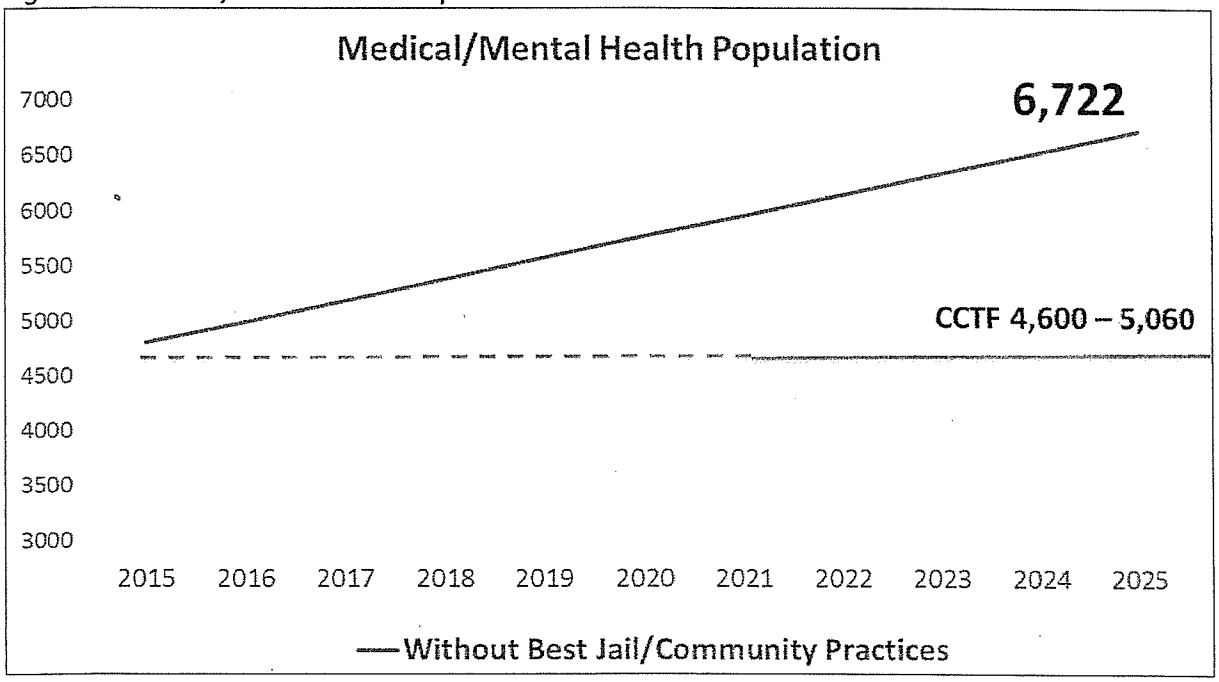
PROJECTED CCTF BED NEED 2025				
Beds	Current Need	Projected Need	Scenario 1 Ilustration	Scenario 2 Illustration
CCTF MOSH	600 - 700	916	147	92
CTC Medical	160 - 180	236	35	24
Detox	200-220	250	38	25
MH in Medical Beds	**960-1100**	**1403**	**211**	140
CCTF FIP Licensed	60	96	0	0
CCTF MH Licensable	180 - 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	
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	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CHOADA	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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 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; HelpTeam; 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

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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*

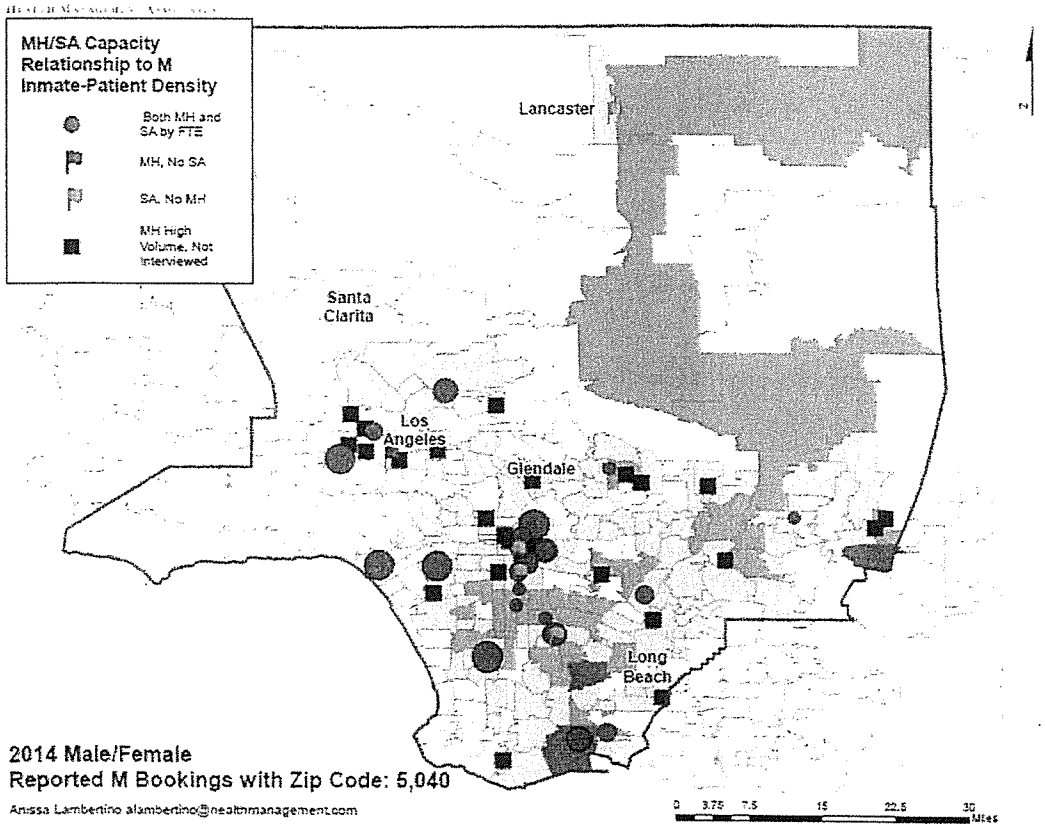
^Men Only

Appendix C. Geographic Information System Mapping

MH/SA Capacity Relationship to M Patient-inmate Density

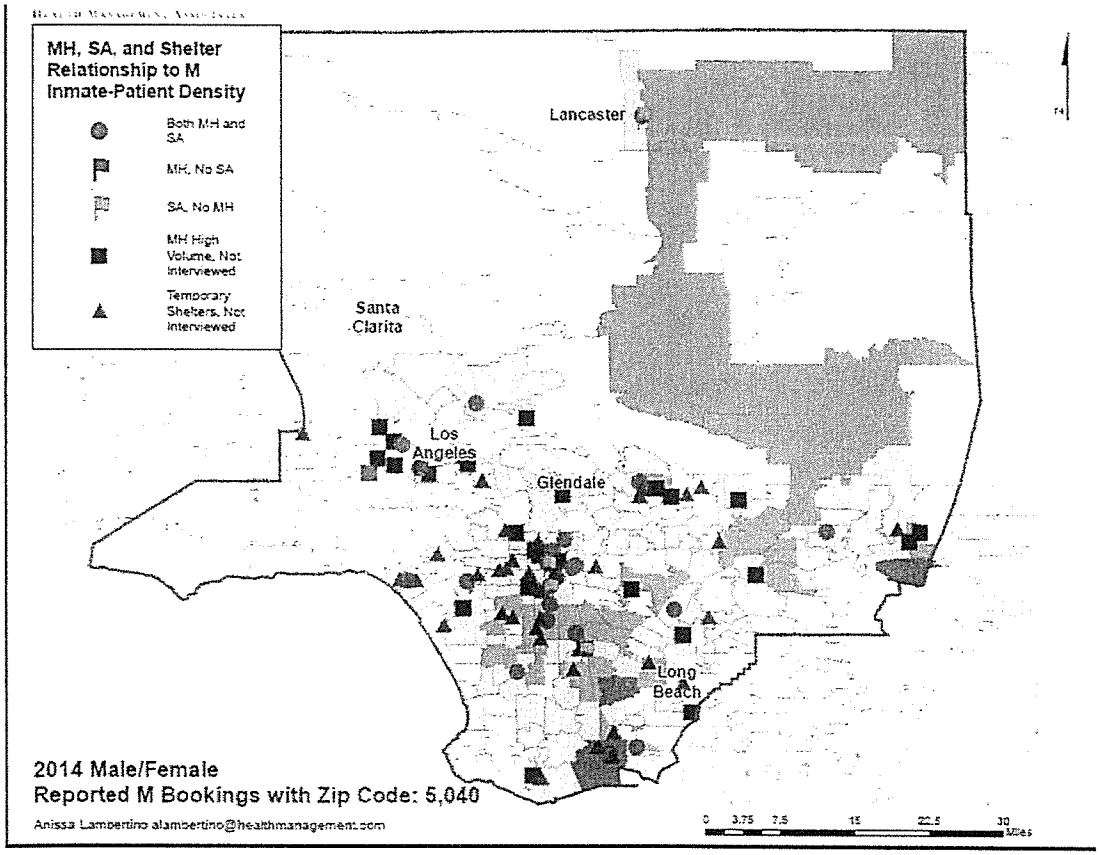
There were 14,893 bookings reported as "M" in 2014. The map below examines the geographic density distribution by zip code in a subgroup of 5,040 males and females with reported zip codes (9,547 had a zip code of 0). Patient-inmate density was defined as zip code counts of 1-10, 11-34, 35-77, and 78-159,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

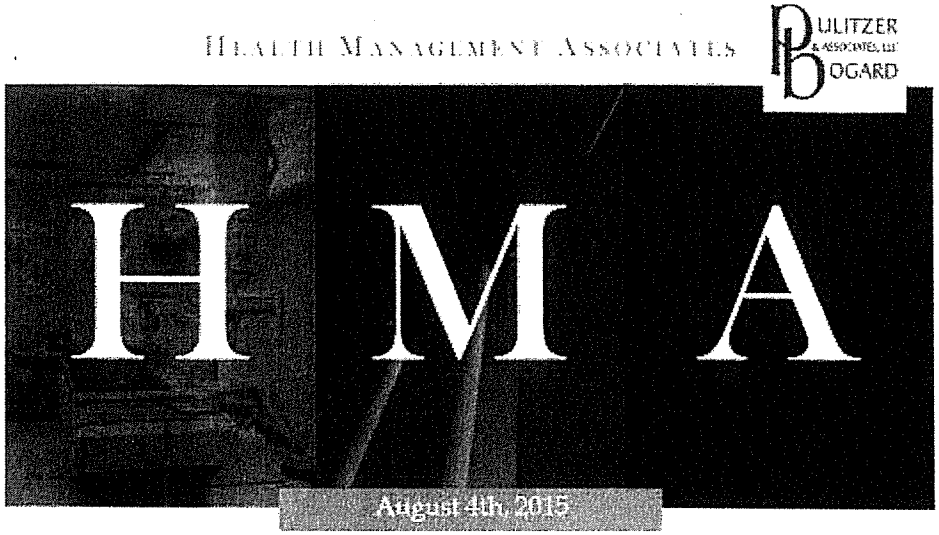


MH, SA, and Shelter Relationship to M Patient-inmate Density

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.


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

Appendix D. LA County Correctional Treatment Facility Presentation



LA County Consolidated Correctional Treatment Facility

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

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Deliverables

Legislative Impact on Population

The likely impacts to the Los Angeles County jail population of Proposition 47, AB 109 (split sentencing), AB 624 (community corrections system) and inmate population projections over the next several years, including projections on 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 on Mental Health/Substance Abuse Treatment.

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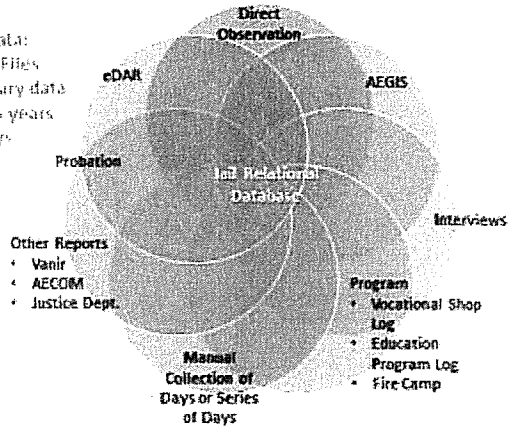
L.A. County Relational Database

6 Million Rows of Data:
Reviewed 296 Data Files
10.5 years of summary data
Every inmate for 5.5 years
755,897 inmate stays



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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

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LEGISLATIVE IMPACT ON POPULATION

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Legislative Impact on LASD

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

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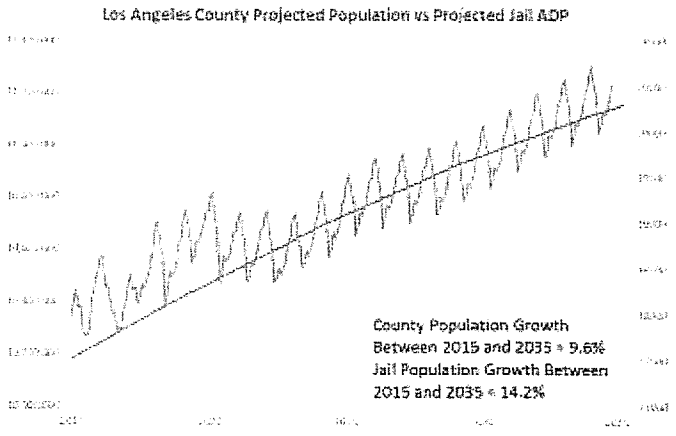

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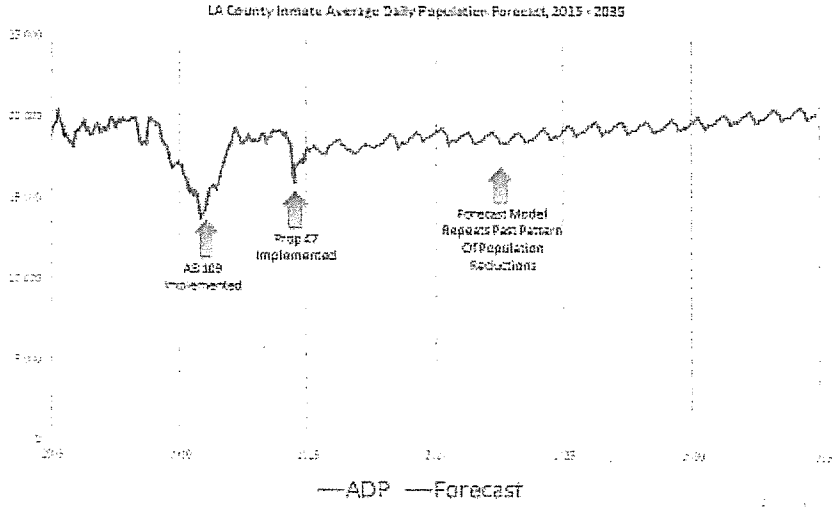
LA County Jail Population Forecast



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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**

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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.

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CCTF POPULATION ANALYSIS AND FINDINGS

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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

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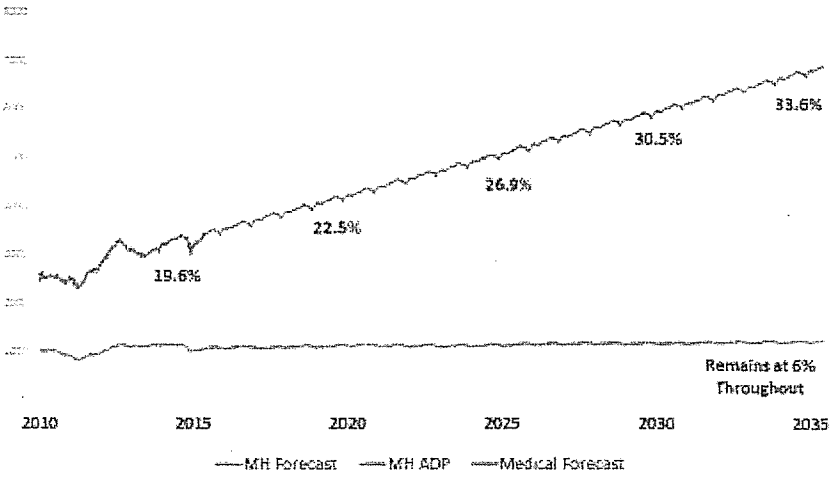
LA County Mental Health & Medical Special Housing Forecasts, 2015 - 2035



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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)

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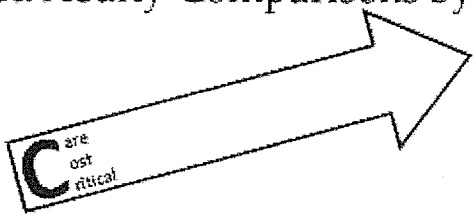
Simplified Acuity Comparisons by Bed Type



Hospital	Outpatient	General Floor	Telemetry	ICU
Forensic	GP on Meds	MOH	HOH	FIP
MH	Outpatient	Stepdown Urgent Care	IMD	State Hospital High Acuity
SUD	Outpatient			Medical Detox

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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 (TTP)
  - Observation Units: High and Moderate Mental Health and Special Population
  - ADA housing

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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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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 case 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 Adjudication Diversion and Transition into the Community

COMMUNITY CAPACITY AND DIVERSION

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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 PIP 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	
Special Management	200	200	0	0
Total beds	4400-5060	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

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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)

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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

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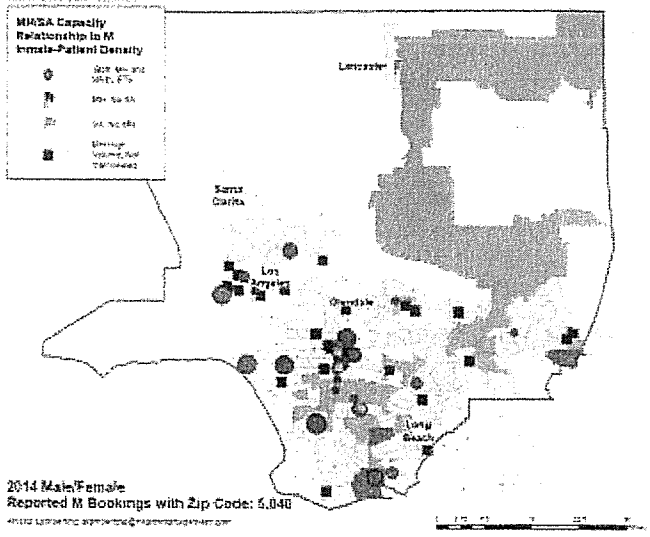

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Summary Recommendations

- 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

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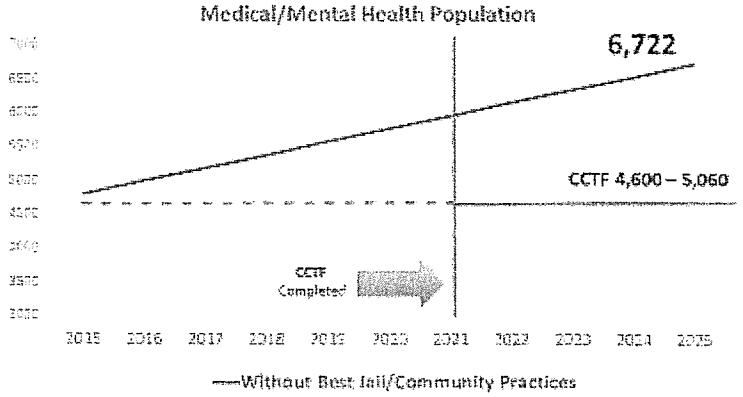
Without implementation of best practices bed needs will rise to 6,722 by 2025



Analysis of Health Departments' Options

Attachment D

	Potential Contract Implications	Potential CEQA Implications	Potential Budgetary Implications	Potential Operational Implications
Option #1	-The option differs fundamentally from what was solicited in the request for proposals (RFP), and is likely outside the scope of the solicitation and constitutes a different project. Change-order limitations could also prove insurmountable. -To deliver Option 1, termination of the current contract and issuance of a new procurement are advisable. This would require new scoping documents, user group meetings, and consultant services to develop cost and schedule estimates.	-Would require additional CEQA analysis (either an Addendum or a Supplement to the Board approved Environmental Impact Report (EIR), or a new EIR) due to the addition of the licensed medical, non-custody beds and the extensive renovations to Twin Towers Correctional Facility. -Proposed offsite non-custody beds would require a separate new CEQA analysis.	-Cost to develop 2,400 licensed medical non-custody beds and renovate Twin Towers Correctional Facility for 2,400 mental health inmates is likely to cost significantly more than the current $1.45B DB contract. -Unknown capital/operating cost implications for developing community-based capacity – additional funding would be required.	-Would reduce number of custody beds in the system by approximately 7,000. -Would replace the loss of approximately 7,000 custody beds with 2,400 non-custody beds at the Vignes Campus, and an unspecified number of offsite non-custody beds. -Relies on a presumed reduction in demand for custody beds based on diversion projections. -Would likely disperse inmates throughout the correctional system potentially exceeding capacity at other facilities.
Option #2	-Delivering all of Option #2 under the current Design Build (DB) contract is likely not feasible (but delivering only a portion of Option #2 would be): The 2,400 custodial-bed portion is likely within solicitation-scope and change-order limitations; however, the 900-bed medical, non-custodial portion is likely outside solicitation-scope and change-order limitations. -To deliver Option #2 in its entirety, termination of the current contract and issuance of a new solicitation are advisable. To deliver only the 2,400 custodial-bed component, a Board-approved change order would be required. -Savings from reduction in custody beds likely to only cover costs for some of the 900 community-based beds. -Proposed 1,500 offsite non-custody beds cannot be delivered under the current design-build contract.	-Generally, stays within the confines of the Board approved EIR for on-site work, but some additional CEQA analysis would likely be required. -Proposed offsite non-custody beds would require a separate new CEQA analysis.	-On-site phasing plan may result in higher escalation/construction costs. -Development of 900 licensed medical beds on site, in addition to custody beds, would likely exceed the $1.45B DB Contract. -Unknown capital/operating cost implications for developing supplementary community-based capacity – additional funding would be required.	-Would reduce the number of custody beds in the system by approximately 2,600. -Would replace the loss of approximately 2,600 custody beds with 900 non-custody beds at the Vignes Campus, and 1,500 offsite non-custody beds. -Relies on a presumed reduction in demand for custody beds based on diversion projections. -Would likely disperse inmates throughout the correctional system potentially exceeding capacity at other facilities.
Option #3	-Functionally, the same analysis as for Option #1 above. -To deliver Option 3, termination of the current contract and issuance of a new procurement are advisable. -Would require new scoping documents, user group meetings, and consultant services to develop cost and schedule estimates.	-Functionally, the same analysis as for Option #1 above. -Would require additional CEQA analysis (either an Addendum or a Supplement to the Board approved EIR, or a new EIR) due to the addition of the licensed medical, non-custody beds and the extensive renovations to Twin Towers Correctional Facility. -Proposed offsite non-custody beds would require a separate new CEQA analysis.	-Development of 2,400 licensed medical beds on site, in addition to custody beds, would likely exceed the $1.45B DB Contract. -Unknown capital/operating cost implications for developing community-based capacity – additional funding would be required.	-Would reduce the number of custody beds in the system by approximately 3,800. -Would replace the loss of approximately 3,800 custody beds with 2,400 non-custody beds at the Vignes Campus, and an unspecified number of offsite non-custody beds. -Relies on a presumed reduction in demand for custody beds based on diversion projections. -Would likely disperse inmates throughout the correctional system potentially exceeding capacity at other facilities.