Alternatives to Incarceration Work Group
Infrastructure Preliminary Implementation Plan

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
Public Communication and Accountability *84. Increase, ensure, and fund public collaboration in all phases of Alternatives to Incarceration planning, implementation, evaluation, and system oversight and across relevant County, Court, justice, health and social service systems. This collaboration can be piloted via the ATI Community Engagement Workshops and the Ad Hoc Committee structure, which includes work on gender, sexual orientation, and racial equity, by instituting quarterly stakeholder meetings to communicate updated ATI progress, discuss service and communication gaps, and highlight best practices. Fund and staff post-ATI final report, i.e., the initiative should host recurring implementation meetings across the County and with relevant County departments to discuss policy impacts, resolve policy conflicts, monitor fiscal impacts, assess eligibility barriers, and*	Year 1 1a. Create an Alternatives to Incarceration (ATI) Initiative under the Strategic Integration section of the CEO's office. 1b. Use County supplementary budget's funding reserve to start the ATI Initiative. Host regular Budget Summits, including invitations to community, in order to distinguish ATI budget allocation. Ensure ATI Initiative budget is sufficiently distinct from larger CEO budget and available to the public. Create comprehensive funding strategy including public and private funding resources to fully fund all ATI activities across all departments and partnerships. 1c. Maintain existing voting member structure that includes representatives from 15 County Departments, 10 community stakeholders, and 7-10 community members from the Advisory Collaborative of Impacted People (see recommendation 55). Voting members will support decision making and provide feedback on planning, implementation, evaluation, and system oversight of ATI recommendations across relevant County court, justice, health and social service systems.	Lead: ATI becomes a unit housed under the CEO's office and explore a public and private and explore a braided funding model. Center for Strategic Partnerships Inherit ATI voting members from existing structure. Partner: Explore philanthropic partnerships, community based stakeholders.	Existing Funding Source(s): Currently leveraging staff from other county departments (eg. ODR, WPC), board offices, philanthropy, ATI community-based organizations, and voting membership department staff. Existing Staffing: Currently leveraging 2 leads to coordinate the work group and 24 supporting county staffers and consultants. Additional Funding Source(s) to Expand: Use County supplementary budget's funding reserve to sufficiently to address the first-year goals and implement the ATI Initiative recommendations. Establish adequate dedicated resources within County Counsel, Center for Strategic Partnerships to provide necessary support in year one.	Proposed Change: Board motion to establish an ATI Coordination Initiative including formalizing the ATI Collaborative. Utilize existing processes to authorize legislative advocacy for recommendations that may require this for implementation. Role of ATI collaborative is to identify policy, funding, and resource goals that require state or federal legislative action in collaboration with CEO-Legislative Affairs and community advocates. Board action to add ATI as a Board Priority.	The ATI Racial Equity Manager works with ATI leadership, staff, and collaborative to develop, implement, monitor, evaluate, and revise program policies and procedures that fulfill racial equity criteria. Anticipate needed funding resources for materials and on-going staff development and training. Ensure community representation is as diverse, culturally competent and represent the populations they are trained to serve. Criteria and/or guidelines are adopted into the county contracting and hiring process. The ATI Racial Equity Manager coordinates cross-department policies, procedures, staff development and training, and other necessary implementation strategies and tactics to ensure racial equity processes are well aligned across key departments.	Year 1 Metrics: 1a. Hire fifty percent of executive leadership and administrative support staff who have been a part of the process. 1b. Number (33-35) of members maintained in structure through voting members (county and community) and appointments to the Advisory Collaborative. 1c. Number (13-26) of recommendations being implemented in first phase. 1d. Number of implementation plans developed for new recommendations that do not have plans. 1e. Complete (Y/N) evaluation of county system to determine resource distribution and gaps for contracting needs. Year 2 Metrics:	Potential Impact: Countywide departments, community based organizations, and community members Unintended Consequences: Does not incorporate the voices of currently incarcerated people. Oversight mechanisms need to ensure strong accountability. Interventions: Staff member creates an open line of communication so currently incarcerated people can provide feedback. Full range of budgetary oversight over County departments that work on services for justice involved people to improve program implementation and assess the functionality of success countywide.

develop evaluation metrics of success. **New Program**	They may also support decisions regarding equitable distribution of resources and policy actions. 1d. Create a term limit structure for voting members, ensuring ongoing parity between members from the County Departments and community. The terms should be between 2-4 years and staggered. Current voting members will continue to serve for the purpose of continuity in initial implementation. Board members will revisit community stakeholder appointments at the 2-year mark in February 2021. • Voting members from County Departments continue to partner with designated liaisons within their offices to work with ATI Co-Directors on an ongoing basis. • Continue ad hoc committee structure – coordinated by ATI supervisors – to ensure the development of complete implementation plans and any new recommendations needed to achieve the goals of the ATI Road Map. 1e. Create a leadership structure including someone who has led the ATI Work Group process so that there is institutional knowledge and continuity for the launch of the ATI Initiative.		Clarify fund development processes in collaboration with the CEO, county department chiefs, and the ATI division (including Finance & Operations). <u>Additional Staffing Needed to Expand:</u> Current staff and voting members must be leveraged to continue the work beyond February 2020. Between 20-26 staff need to be hired to support the ongoing work of the ATI Initiative, but this must be assessed based on initiative growth.			2a. Hire the other fifty percent of the ATI workforce. 2b. Number (33-35) of members maintained in structure through voting members (county and community) and appointments to the Advisory Collaborative. 2c. Number of new recommendations being implemented in second phase. 2d. Number of ATI meetings that involve voting members, ad hoc committees, relevant county departments and the larger community to coordinate ATI recommendations. 2e. Complete (Y/N) creation of auditing process. 2f. Complete report (Y/N) on racial equity matrix. <u>Year 3 Metrics:</u> 3a. Number (33-35) of new members maintained in structure through voting members (county and community) and	

	• Hire an Implementation & Coordination Manager; a Racial Equity Manager; and a Finance & Operations Manager to be supervised by the Director or Co-Directors. The managers coordinate supervision of the various Division Directors within the ATI Initiative. • Hire Directors to oversee the following Divisions: Community Engagement; Data & Research; Program Development; Policy Implementation; and Communications. Each Division will be accountable for implementing specific recommendations in the ATI Roadmap but will work collaboratively across Divisions to do so. • Ensure the hiring of people who have been personally experienced or been impacted by incarceration. 1f. Use ATI Work Group roadmap and existing implementation plans to begin work immediately upon the creation of the ATI Initiative. Where implementation plans do not exist for existing recommendations, continue ad hoc committee structure to create the plans and retrieve feedback					appointments to the Advisory Collaborative. 3b. Number of new recommendations being implemented in thirds phase. 3c. Complete (Y/N) development of county contracting model. 3d. Complete (Y/N) evaluation of ATI strategies and implementation work.	

	from voting members within 12 months. 1g. Evaluate County systems in concert with Organizational Capacity Building and Contracting ATI recommendations to establish accurate picture of the current state of County contracting and develop the ideal County contracting model 1h. Present to the voting membership and the larger community on a quarterly basis to continue the community engagement effort that has been created the first year of the ATI inception. Provide regular updates to the Board. 1i. Coordinate all existing efforts towards adult justice system reform under the ATI initiative in collaboration with the executive working group from board agenda of August 13, 2019, Item 23. Initiative should also work in close partnership with youth justice work group to leverage resources and share best practices. <u>Year 2</u> 2a. Develop proposal for ideal Count y contracting model with auditing piece 2b. Create an auditing process within the ATI Initiative, leveraging the work of the Los Angeles County Auditor Controller, that can, in Year 2,						

	begin to perform financial and program oversight and ensure equitable distribution of services and impact in coordination with all county departments serving justice involved populations. 2c. Compile and report racial equity metrics and on-going thereafter. <u>Year 3</u> 3a. Implement ideal County contracting model. 3b. Evaluate ATI Initiative effectiveness and assess improvements and best practices of current model.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
110. Expand and coordinate data tracking/collection across all relevant County justice and health/social service entities to retrieve data necessary for services, programming, preventative measures, and alternatives to incarceration. Align this data collection with existing County data tools/portals such as One Degree, CHAMP, LANES, CES, etc. to inform a uniform client database. **Expand and/or Scale Program**	<u>Year 1:</u> 1a. Assess the current state of data tracking and collection across justice, health, and social services entities, for the purposes identified in this recommendation. 1b. Identify gaps in data tracking and collection for services, programming, preventative measures, and alternatives to incarceration.	<u>Lead:</u> CEO/CIO <u>Partners:</u> ISAB, PD, APD, DA Probation, Sheriff, LA City Attorney, DHS, DMH, DPH, DCFS DPSS, WDACS, LAHSA, LANES	<u>Existing Funding Source(s) and Staffing:</u> Data collection and tracking across entities is currently supported by a variety of funding mechanisms too numerous to describe here. <u>Additional Funding/Staffing Needed to Expand:</u> The need for additional funding and/or staffing will be determined during the development of the Year 2 roadmap.	A legal analysis is needed to determine whether there are any barriers to incorporating the necessary data into the County's Information Hub or in any other uniform client database.	All entities should collect data on the race/ethnicity of their clients	Completion of assessment of current state of data tracking and collection. Completion of gaps assessment. Completion of legal analysis. Completion of roadmap development. Completion of roadmap implementation.	Expanding data collection and tracking could improve service delivery and our understanding of outcomes for different populations and programs. A potential unintended consequence would be the use of data against clients. To minimize the risk of unintended harm, appropriate safety and privacy protections should be in place.
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111. Develop a uniform client database across all relevant County services and justice entities to follow and support the justice-involved individual (longitudinally & latitudinally) regardless of system access point, with the following database features: (a) interface capabilities linking services providers as well as tracking service availability among LA County's considerable resources; (b) alignment with existing tools such as One Degree, CHAMP, LANES, CES, etc. to improve patient referral processes as well as to assist in performance tracking and accountability as individuals move between systems and services; (c) capacity for family and service provider feedback to track problems and response progress; and (d) protection of privacy rights and interests of justice-involved individuals. **New Program**	Year 1: Assess the feasibility and appropriateness of (a) incorporating these features into the County's Information Hub or other County systems or platforms; and (b) what interfaces and alignments should be prioritized. Year 2: Develop a roadmap to incorporate the features listed in this recommendation into the systems identified in the Year 1 feasibility assessment. Year 3: Begin implementation of the roadmap developed in Year 2.	Lead: CEO/CIO Partners: DHS DMH DPH DCFS DPSS WDACS LAHSA LANES PD APD Probation	Existing Funding Source(s) and Staffing: There is currently no funding or staffing to support the features described in this recommendation. Additional Funding Source(s) and Staffing to Expand: The need for additional funding and/or staffing will be determined during the development of the Year 2 roadmap.	A legal analysis is needed to determine if there are any legal barriers to implementing the features described in this recommendation into the systems identified in the Year 1 feasibility assessment.	Performance and accountability metrics, as well as outcomes for services and programs, should be reported by clients' race/ethnicity.	Completion of feasibility assessment. Completion of legal analysis. Completion of roadmap development. Completion of roadmap implementation.	Developing the features described in this recommendation could reduce inefficiencies in service delivery, thus improving outcomes for different justice-involved populations and County programs. A potential unintended consequence would be the use of data against clients. To minimize the risk of unintended harm, appropriate safety and privacy protections should be in place.
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Public Communication and Accountability *86. Create, staff, and fund an Advisory Collaborative of Impacted People to ensure there is continuous feedback and accountability*	Year 1: 1a. Recruit, Select and Seat the Countywide Reentry Health Advisory Collaborative. 1b. hold monthly advisory collaborative meetings focused on	Lead: ATI Initiative, DHS Partners: ODR	Existing Funding Source(s): Philanthropy. Grant from Robert Wood Johnson Foundation will provide funding through 2020.		Commitment from leadership on racial equity practices to select membership. Seating/selecting membership of the body	Year 1 Metrics: 1a. Number (7-10 people) of representatives from impacted communities in decision making spaces throughout ATI	Potential Impact: Formerly incarcerated peoples will be impacted by this recommendation and given a seat at the table to support in

to the prioritized communities and LA County at large in the implementation of the comprehensive roadmap. Ensure consistent representation of people who identify as cisgender women, LGBQ+, and TGI, including the most marginalized racial, ethnic and cultural groups in the geographic areas most impacted by incarceration, on the Advisory Collaborative. **Expand and/or Scale Program**	informing, monitoring and implementing the ATI roadmap. 1c. Identify ongoing staff/departmental support and funding for the Advisory Collaborative beyond Whole Person Care. <u>Year 2:</u> 2a. Review Advisory Collaborative membership to fill any key vacancies or expansion opportunities. 2b. Continue monthly meetings, including increased training and technical assistance to members of the body focused on improving facilitation and other professional development skills. 2c. Confirm commitment to the advisory body through continued staffing and funding from county departments and philanthropic partners. <u>Year 3:</u> 3a. Review Advisory Collaborative membership to fill any key vacancies or expansion opportunities. 3b. Continue monthly advisory collaborative meetings focused on informing, monitoring and implementing the ATI roadmap. 3c. Confirm commitment to the advisory body through continued staffing and funding from county departments and philanthropic partners.		<u>Existing Staffing:</u> DHS Whole Person Care Collaboration Team will provide staffing through 2020 tentatively. <u>Additional Funding Source(s) to Expand:</u> All. Total costs for the advisory collaborative (about $25k/year need to be covered beyond 2020. <u>Additional Staffing Needed to Expand:</u> All. Total staffing needs, about 50% FTE, need to be covered beyond 2020.		based on a race equity approach. Collaborative recruitment and outreach should include statement about commitment to racial equity. Provide racial equity and cultural humility training and on-going boosters to collaborative participants. Training should include education on the history of racism and racial inequities in LA County mental health, substance use and justice systems.	implementation and development. 1b. Number of monthly meetings to engage representatives. <u>Year 2 Metrics:</u> 2a. Number of month meetings to engage representatives. <u>Year 3 Metrics:</u> 3a. Complete (Y/N) evaluation of the experiences of people who participated in the collaborative.	decision making about their communities. <u>Unintended Consequence:</u> Due to the small size of the advisory body, 7-10 members, there will definitely be a lack of representation across every group that is impacted by incarceration. <u>Interventions:</u> We will work to reduce the negative impacts of this recommendation by inclusion of and proximity to the larger ATI Initiative The work done through this recommendation will not be in a vacuum but rather supported by and surrounded by a larger more broadly diverse group of stakeholders.

	3d. Assess the experiences of the members of the collaborative to learn their individual and collective impact as a part of the collaborative.						
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Equitable Resource Distribution *87. Utilize data-driven tools (e.g., Race Forward's Community Benefits Agreement and Racial Impact Tool, or Advancement Project's JENI/JESI, etc.) to create processes for equitable resource and contract distribution with program offices across health and social service departments. These processes should prioritize remedying racial and geographic disparities while also taking into account cultural, gender, sexual orientation and special populations' needs. Involve County and impacted communities in equitably distributing and leveraging resources to sustain community health.* **Practice Change**	Year 1: 1a. Investigate and identify potential equity-based tools to be used in propelling this goal. in coordination/consultation with staff at Office of Diversion & Reentry, the Center for Health Equity, and/or ATI voting members with relevant experience. 1b. Develop criteria by which to evaluate and select the equity-based tool/s to be used. The ATI entity should solicit input from CBOs, advocates, and other community members with direct, relevant experience creating and/or utilizing such tools. 1c. Assess existing master agreement, contracting, and sub-contracting constraints to using said tool/s. 1d. In consultation with impacted departments and agencies (such as Health Services, Mental Health, Public Health, Probation, etc.) and their respective contracting units. 1e. Should also consult with relevant service providers – as articulated in Recommendation	Lead: ATI Initiative, CEO/CIO ATI Initiative housed under the CEO's office would lead the effort. Primary decision-making comes from Director/s and Equity Manager. Partners: Relevant County Departments (such as Mental Health, Probation, Public Health, Health Services, etc.) and their respective contracting units. Participating (and potential) service providers.	Existing Funding Source(s): There is no funding currently supporting this. Existing Staffing: There are some staff members within current departments attempting to move these practices forward. Additional Funding Source(s) to Expand: Funding for the equity-based tool would be minimal in year one, other than reliance upon staff expertise and the option of employing outside consultants in evaluating/designing a satisfactory equity tool. Additional Staffing Needed to Expand: Staffing would come primarily from within the ATI unit but would also rely upon expertise from outside sources such as relevant County departments' contracting and data divisions.	Current Policy: Locally LA County has committed to a Just Culture Model. Proposed Change: Locally and statewide an incorporation of Racial Equity Tools and Community Benefits Agreements in policy development will support equitable policy implementation.	The ATI Racial Equity Manager coordinates cross-department policies, procedures, staff development and training, and other necessary implementation strategies and tactics to ensure racial equity processes are well aligned across key departments. As work progresses, Manager shifts focus from tool creation, implementation, and dissemination and moves toward monitoring and evaluating progress as captured in this tool. During the rollout of these efforts, the county should establish a data team to develop baseline race equity data by synthesizing current race equity data and analysis from relevant sources. This should be done in advance of establishing streamlined data platforms that have been recommended. Sources can include the CEO's Office, DMH, DPH, Million Dollar Hoods, Prison Policy Initiative, etc.	Year 1 Metrics: 1a. Number of system actors, organizations and individuals surveyed to improve contracting processes and service delivery in collaboration with other ATI recommendations 1b. Number of meeting held to discuss contracting barriers and improvements with key partners. 1c. Complete (Y/N) identification and/or development of equity based tool and strategies to improve contracting decisions. Year 2 Metrics: 2a. Number of revised contracting policies and procedures in collaboration with other ATI recommendations 2b. Complete (Y/N) a countywide plan for	Potential Impact: Countywide impact across relevant departments, community based organizations, and people receiving services. Unintended Consequence: Takes into account multiple identities that communities might hold to shift disparities that exist which could be expanded to include sexual orientation, disability, etc. Interventions: Work towards developing a tool that takes into account multiple identities that intersect with race, geography, etc.

	66 – to solicit their feedback on how to best tailor tool to contracting practices. 1f. Develop and refine strategies/means by which to ease utilization of data-driven tool/s in contracting decisions across all relevant departments and agencies – as well as any philanthropies that may carry out ATI programmatic priorities utilizing systems created by the ATI Initiative and other ATI recommendations. 1g. Establish timelines for when tool adoption should be initiated across all relevant entities. 1h. By conclusion of Year One, selected tool employed to begin analyzing existing level of racial and geographical equity in Los Angeles County services in order to establish baseline by which to measure longitudinal change as broader ATI recommendations are implemented. 1i. Will rely upon available contracting and resource data across relevant departments and agencies but not confine its future analyses/goals to what data is available in Year One. <u>Year 2:</u> 2a. Enact necessary contracting revisions (in association with Recommendation #67) to pave the way for using the tool.		The initial stages of tool evaluation / construction would require specialized staff that would need to be employed as either regular/temp ATI staff or as outside consultants. Maintenance of said tool should likely be accomplished by in-house staff. This can be accomplished by 1-3 FTEs. Rewriting contracting and master agreement protocols and procedures would necessarily require staffing from each of the relevant departments as well as lead direction from ATI unit staff.		Criteria and/or guidelines are adopted into the county contracting and allocation process to ensure both racial and geographic equity targets are being met.	tool utilization and compliance 2c. Number of trainings given to county departments on the use of the equity based tool 2d. Number of information sessions and/or resources developed to share equity based framework with community based organizations and the broader public 2e. Number of meetings to discuss utilization of the tool 2f. Launch (Y/N) of new contracting process in collaboration with other ATI recommendations <u>Year 3 Metrics:</u> 3a. Complete (Y/N) evaluation of tool and contracting changes in collaboration with other ATI recommendations	

	2b. Ensure that each impacted County department and outside programmatic contracting/subcontracting entity, as well as the centralized, newly-developed ATI contracting unit, is in compliance. 2c. Develop county-wide plan for tool utilization in contracting. 2d. Distribute tool to County departments and train on how to use it in contracting. 2e. Develop an external facing and community-vetted resource guide for existing and prospective service providers that explains equity principles to be employed in ATI contracting and programming. 2f. Should outline the range of impacted funding, steps to take, requirements based on either the contract amount or some other criteria, and timeline for expected shift. 2g. Establish partnership with CBOs and service providers that work with system-impacted communities to spread the word about new equity-based contracting goals and process. 2h. Work with advisory collaborative and working group composed of relevant, community-minded service providers, impacted (those using the tool) County departmental staff, system-impacted residents,						

	and relevant CBOs to track and monitor equity tool implementation. 2i. Initiate RFPs for first round of equity-based contracts and data-tracking mechanisms to follow their progress.' By conclusion of Year Two, should use selected tool to have a first cut analysis of existing level of racial and geographical equity in Los Angeles County services in order to establish baseline by which to measure longitudinal change. 2j. Should identify which unavailable contracting and resource data across relevant departments and agencies would improve equity assessment and – in conjunction with Recommendations #53 and #59 – move to ensure such data is made readily available in the next year. <u>Year 2</u>: 3a. First year of tool implementation to evaluate changes in contracting dollars. 3b. Establish a publicly-accessible dashboard to demonstrate equity and change over time. 3c. Begin dedicating time within community and ATI workgroup feedback sessions to review and assess the equity analysis. 3d. Through the development of new contracting models work with relevant County-generated						

	contract departments to use a new equity-aligned contracting mechanisms. 3e. Begin second tranche of equity-based RFPs/contracts in alignment with approved ATI priorities. 3f. After evaluating equity implementation challenges in previous year, begin to identify and enact solutions to most pressing obstacles.						
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Public Awareness & Education *89. Develop a public education and communications campaign to build awareness of a treatment-first model, not incarceration and punishment. This campaign should stress use of the DMH ACCESS line, CBO network, SASH helpline, suicide prevention hotline (rather than 911) for behavioral crises, available non-law enforcement resources, and different types of community-based solutions.* **New Program**	Year 1: 1a. Designate or hire a dedicated County person to be the communications center for the ATI. 1b. Continue the communications work generated through the ATI report development and develop a detailed plan to bring ATI work to the broader public's awareness to educate and gain public support. Plan may include identifying an ATI spokesperson or champion who can be the voice of this effort and reach out to local media to share updates on this work. 1c. Explore hiring a communication consultant work with County staff to help develop a comprehensive and broad-reaching strategy for this public awareness effort. The consultant must have the capacity to work with advisory collaborative	Lead: ATI Initiative Partners: DMH, DPH, BOS offices, CEO, CEO-Countywide Communication	Existing Funding Source(s): Unknown DHS and CEO funding Existing Staffing: CEO and BOS communications offices may be able to offer support. Additional Funding Source(s) to Expand: Philanthropy partnering and/or leveraging county dollars to support communications work. Additional Staffing Needed to Expand: This would be a function filled by ATI staff; additional support from communications consultant.	Current Policy: N/A Proposed Change:	Commitment from leadership on racial equity. Ensure any and all materials developed are culturally appropriate and language accessible. Campaign strategy and content will be developed in collaboration with community and individuals with lived experience.	Metrics: Year 1 Metrics: 1a. Number of external media hits regarding ATI final report and foundational recommendations. 1b. Number of individuals aware of ATI effort from the broader community including people impacted by the justice system. 1c. Number of meetings generated to support internal ATI communications coordination for first phase of implementation with key county departments.	Potential Impact: Individuals County-wide would be impacted by this. Raising public awareness will increase support for this effort and raise awareness about services available in the community. This may also lead to additional community resources/ partnerships. Unintended Consequence: There is no mention of developing education and communications campaigns for a wide variety of languages so that all Los Angeles community members

	including ATI workgroup voting members and individuals with lived experience. 1d. Develop internal County communication channels to break down silos between departments and agencies. <u>Year 2:</u> 2a. Provide training and technical assistance to County staff so that communication and language on ATI is streamlined and consistent. 2b. Create a system of public accountability to ensure the community receives information about the County's progress and ability to implement the ATI recommendations/work. This would be a feedback loop allowing services to be tweaked and adjusted. 2c. Launch broader marketing campaign related to ATI building off the messaging developed in Year 1. <u>Year 3:</u> 3a. Evaluate success of public awareness efforts; explore how to fine-tune messaging to ensure public understanding and support.					<u>Year 2 Metrics:</u> 2a. Hiring of communications consultant. 2b. Number of trainings generated to support county staff and community in sharing information about the ATI. 2c. Explore metrics as suggested by communication consultant. 2d. Complete (Y/N) the creation of an accountability communications mechanism as a part of the ATI Initiative. 2e. Launch (Y/N) broad ATI marketing campaign. <u>Year 3 Metrics:</u> 3a. Complete (Y/N) evaluation of the success of public awareness efforts; explore how to fine-tune messaging to ensure public understanding and support.	will be aware of the services. <u>Interventions:</u> Incorporate the evaluation of language needs across communities that are utilizing the service and accommodate this need by developing tailored communications campaigns.
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Organizational Capacity Building and Contracting *92. Utilize County capacity-building programs, in conjunction with equity analysis, to expand the community-based system of care by: (a) finding and supporting smaller organizations in different SPAs to qualify for and access funds while providing seed funding (i.e. philanthropic partnerships, business loans, flexible government funding, pay for success models, and/or zone area investments, etc.); including those organizations with a history of serving system-involved people who identify as cisgender women, LGBQ+ and/or TGI; b) promoting existing providers as potential incubators; and (c) supporting training and TA to become service providers accessing Medi-Cal Fee Waiver, County and State funding, and organizational coaching as well as training in evidence-informed practice in serving TGI / LGBQ+ people.* **Expand and/or Scale Program**	Year 1: 1a. Convene departments and organizations working on countywide organizational capacity building efforts with a strong focus on incubation of new organizations and supporting existing county contractors. 1b. Hold quarterly meetings with departments and organizations to coordinate capacity building efforts. 1c. Leverage and publicize resources that meet the organizational needs of small to large non-profits to ensure organizational sustainability and an effective delivery of services for people that are impacted by the justice system. 1d. Use an equity analysis tool as presented in other infrastructure recommendations and plans to ensure that organizational capacity building resources are being distributed to communities impacted by incarceration. Year 2: 2a. Explore flexible funding options to support organizational infrastructure development for incubated organizations and current contractors. 2b. Evaluate the effectiveness of current capacity building projects that deliver operational support, coaching/consulting support, and incubation academies in collaboration with leads and	Lead: ATI Initiative, DPH Partners: CEO-Center for Strategic Partnerships, DHS-WPC, DPH-SAPC, LAHSA, United Way, Liberty Hill Foundation	Existing Funding Source(s): County, State and Federal Funding Sources through each department and partner. Existing Staffing: At least 7 staff comprised of at least one representative from each of the lead and key partners distinguished. Additional Funding Source(s) to Expand: Continued funding will be needed to support the projects past 2020-2021 through federal/state funding source, as well as county dollars. Additional Staffing Needed to Expand: Each lead and department will need to ensure they have staff to carry out the project and coordinate a countywide approach together.	Current Policy: County is supportive of capacity building efforts. Proposed Change: Develop policy to distinguish funding that can support capital costs and operational needs. Work with the state and federal government to provide additional resources for capacity building efforts that ensure an effective delivery of services and supports the strengthening of organizational health for all county partners.	Establishing Metrics and/or Processes: Commitment from lead and partners on the incorporation of racial equity decision making practices in selecting participating agencies that receive organizational capacity building support. Ensure there are contracting options available to organizations that are led by people of color that have been impacted by the justice system. Commitment from county program departments to incorporate and use a racial equity tool as a component of contract decision making. Collect data on race and neighborhood of leadership within contracted agencies. Ensure RFPs and contracts include a statement about racial equity and ask contractors to include a description of how they will maintain a commitment to racial equity in proposals.	Year 1 Metrics: 1a. Number (15) of organizations receiving incubation support that are from directly impacted communities and represent equitable distribution of resources. 1b. Number (30) of current contractors receiving organizational capacity building support that are from directly impacted communities and represent equitable distribution of resources. 1c. Number of meetings a year held to coordinate and refine organizational capacity building work Year 2 Metrics: 2a. Percentage (50%) of the agencies above will be eligible for capital infrastructure support with a focus on directly impacted communities that represent and equitable distribution of resources 2b. Number of meetings a year held to coordinate and refine	Potential Impact: Organizations that currently contract or would like to contract with the county. Unintended Consequence: Lack of support for organizations that are not currently registered as a non-profit. Interventions: Create an additional incubation program that could be focused on supporting individuals who have been impacted by incarceration in starting their own non-profits.

	organizational participants through an equity lens (race, geography, gender, sexual orientation, etc.). 2c. Continue quarterly meetings to coordinate and assess capacity building efforts. 2d. Report on organizational capacity building best practices to ensure resources sustain these efforts past 2021. <u>Year 3</u>**:** 3a: Revise organizational capacity building projects to incorporate the evaluation shared in year 2 with a strong emphasis on equity at all levels across the county. 3b. Refine organizational capacity building projects to meet the continuous needs of organizations that have participated and/or will participate in future activities. 3c. Confirm commitment to ongoing capacity building support to build up and sustain the continuum of care.					organizational capacity building work 2c. Complete (Y/N) evaluation of current capacity building efforts that includes best practices. <u>Year 3 Metrics:</u> 3a. Number of improvements to organizational capacity building coordination and implementation recognized by year 2 evaluation.	
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
Organizational Capacity Building and Contracting *95. Standardize a simplified, more accessible contracting process across agencies and departments and outreach to service providers who might benefit from such reforms.*	<u>Year 1:</u> 1a. Develop tools, processes, and metrics to evaluate contracting policies and procedures across agencies and departments. 1b. Actively gather anonymous feedback from service providers contracted and not contracted with the County to ensure	<u>Lead</u>: CEO and ATI Initiative (clarify distinct roles) <u>Partners</u>: County Contracts and Grants (C&G)	<u>Existing Funding Source(s):</u> Funding is leveraged in coordination with County Contracts and Grants divisions. <u>Existing Staffing:</u>	<u>Current Policy:</u> Each department has separate contracts and grants process. <u>Proposed Change:</u> Analysis of current source (e.g. state and federal) funding requirements,	<u>Establishing Metrics and/or Processes:</u> Adopt criteria and/or guidelines that are integrated into the county contracting and hiring process, per ATI Unit lead. Active engagement to	<u>Year 1 Metrics:</u> 1a. Number of system actors, organizations and individuals surveyed to improve contracting processes and service delivery. 1b. Number of revised contracting	<u>Potential Impact:</u> The direct service delivery system is expanded: smaller yet impactful service providers are receiving contracts which enable greater stability, continuity, in their program

Expand and/or Scale Program	transparency in understanding hurdles to participation; and to identify innovations that create greater access to county contracts. Action is connected to Capacity Building and Contracting recommendations. 1c. Work with advisory collaborative and working group to incorporate the voices of existing community-minded service providers, county staff, system-impacted men and women, and small-scale culturally responsive CBOs to engage them in reviewing existing contracting systems and barriers, learning about data tools, best practices from other County departments or other jurisdictions, and understanding and defining need. 1d. Develop implementation plan based on key actions 1 - 3. <u>Year 2:</u> 2a. Based on input from #3 and 4, and asset/deficit mapping, develop outreach and technical assistance plan that addresses the array of assets and disparities, especially in under-resourced regions. 2b. Launch revised contracting process. Determine if this should initially be through pilot programs, or if ready for across county department implementation. <u>Year 3:</u>	divisions, County Counsel, Probation, ODR, DHS, DMH, SAPC, LAHSA, DCFS, Community Based Organizations, etc.	Staffing exists in each C&G division within the county. <u>Additional Funding Source(s) to Expand:</u> Additional funding will need to be used to facilitate partnership building between leads and partners. <u>Additional Staffing Needed to Expand:</u> It is likely that current staff can be leveraged to implement this recommendation	restrictions, and criteria that might hinder the implementation of this recommendation.	cross-department policies, procedures, staff development and training, and other necessary implementation strategies and tactics to ensure racial equity processes are well aligned across key departments. Develop an agency feedback mechanism to evaluate and implement practice changes to county contracting processes.	policies and procedures. 1c. Number of meeting held to discuss contracting barriers and improvements with key partners. <u>Year 2 Metrics:</u> 2a. Number of contracting barriers identified. 2b. Number of corrective actions and TA implemented to improve contracting through an equity lens. 2d. Mapping (Y/N) of service delivery landscape to distinguish how to closely reflect equitable distribution of resources, based on needs, services index, and race. 2e. Launch (Y/N) of new contracting process. <u>Year 3 Metrics:</u> 3a. Number of contracts with providers who demonstrate impact and efficacy toward meeting ATI goals, but were previously unable to secure county contracts due	delivery, while strengthening overall regional impact as they become woven into the continuum of services. <u>Unintended Consequence:</u> Certain types of services (e.g. street outreach) might be shifted to the smaller more grassroots organizations that some larger organizations currently have, but may not be as impactful. <u>Interventions:</u> Ensure that organizations are incentivized to work together and collaborate to ensure that improved contracting processes supports equitable service distribution.

	3a. Assess revised contracting process, identify corrective actions, and begin implementation of those corrective actions. 3b. Continue providing tailored technical assistance to non-county contractors.					to the complex process. 3b. Number of TA strategies offered to organizations to educate individuals on contracting possibilities.	
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
Workforce Hiring and Training *108. Increase employment and retention of Community Health Workers (CHWs) to expand service capacity, cultural competency, and client/provider trust, by: (a) hiring, training and professionally advancing CHWs with lived experience of the justice system and/or who identify as LGBQ+, TGI, and/or cisgender women; (b) creating pathways for CHWs to move up to full-time, salaried County jobs with benefits; and (c) including continual evaluation and improvements made to ensure the CHW program is effective in building this innovative workforce.* **Expand and/or Scale Program** **Practice Change**	Year 1: 1a. Using program and evaluation data (including data fr om CHWs interviews) identify the capacity of current CHW teams to meet the needs of the community, by Service Planning Areas (SPA). 1b. Using data, determine which SPAs are in need of CHWs to serve which communities and determine need of lived experiences. 1c. Hold listening sessions, across all SPAs, to identify barriers of applying for CHW jobs both county jobs and jobs through contracted service providers. Year 2: 2a. Create a steering committee comprised of multiple departments to create and come to consensus on CHW role, job description and hiring best practices including recruitment process, and interview process (core interview questions	Lead: DHS, LA County Department of Human Resources (DHR), DMH, DPH Partners: Community organizatio ns who serve and hire individuals with lived experience of the justice system and/or who identify as LGBQ+, TGI, and/or cisgender women, CEO, WERC	Existing Funding Source(s): Varies by department, including but not limited to Medi-Cal, SB 678, and other types of county funding. Existing Staffing: ~25 Program managers and supervisors, ~70 CHWs. Additional Funding Sources to Expand: Need to continue using existing funding sources. Additional Staffing Needed to Expand: CHWs to meet community needs, additional 2-3 PMs and program assistants to lead recruitment, and hiring projects.	Current Policy: Fair Chance Initiative for Hiring Ordinance.	Establishing Metrics and/or Processes: Commitment from leadership on racial equity. Mandatory racial equity presentations and bias training for all staff including staff involved in the recruitment and hiring committees. Encouragement of all recruitment and hiring staff to complete a Do I have bias? Self-assessment. For example, the Harvard implicit bias test. Create job descriptions that include clear qualifications and name cultural elements that are relevant. Must be written in a manner that does not appear to be a forced disclosure of a protected class. Development of bias checklist in hiring process.	Year 1 Metrics: 1a. Number of new CHWs with the county and contracted agencies, compared to the assessed need, and self-reported demographics. 1b. Percent of new or expanded contracted CBOs with full-time CHWs in communities most impacted. 1c. Number of preparation sessions across the SPAs and number of attendees. Year 2 Metrics: 2a. Number of meetings to discuss CHW job description, hiring practices, retention practices, and career pathways with multiple departments. 2b. Complete (Y/N) the creation of	Potential Impact: Increase employment opportuni ties for individuals with lived experience of the justice system and/or who identify as LGBQ+, TGI, and/or cisgender women. Individuals and/or communities who do not feel comfortable or want to self-disclose lived experien ces or identities during hiring process. Unintended Consequence: Individuals and/or communities with specific language needs from service providers. Interventions: In preparation sessions and community sessions explain why

	and composition of interview panel) that should always include current CHWs. Should include retention of CHWs and career pathways. 2b. Conduct preparation sessions to understand the necessary qualities and primary roles of a CHW; be able to search for county jobs and sign up for county job notifications; Understand the process of applying for a county job; Be able to create a county profile; Be able to use the county profile to apply for a job; Understand the importance of the supplemental questions; and Know who to contact for help. Similar preparation sessions for application systems used by contracted service providers. 2c. Hire new cohort of CHWs. 2d. Monitor hiring of CHWs for other career pathways such as management, counseling, etc. <u>Year 3:</u> 3a. With previous steering committee debrief year 2 hiring and identify opportunities for improvement, document improvements in the process. 3b. Following improvements Hire new cohort of CHWs following improvements.				Development and implementation of an employee satisfaction survey to evaluate and take action to address staff concerns relating to racial equity and hiring practices.	information that focuses on a job description, hiring and retention practices, and the establishment of multiple career pathways. 2c. Number of preparation sessions across the SPAs and number of attendees. 2d. Number of additional CHWs hired from directly impacted and identified communities. 2e. Number of CHWs moving into a broad array of career pathways such as management and director positions in directly impacted and identified communities. <u>Year 3 Metrics:</u> 3a. Number of improvements identified to support CHW employment and other career pathways. 3b. Number of additional CHWs hired from directly impacted and identified communities.	there is a focus and need to hire individuals with lived experiences and with specific identities. Collect language profi ciency data (in addition to English) to ensure employers know language needs across the SPAs and can hire based on language needs.

						3c. Number of CHWs moving into a broad array of career pathways such as management and director positions in directly impacted and identified communities.	

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1. Decentralize and develop cross-functional teams to coordinate behavioral health needs before booking, with an emphasis on warm handoffs when connecting clients to optimal services. **New Program**	Year 1 1a. Identify, assess, and evaluate existing county and community based multidisciplinary teams (MDT, PMRT, etc.) of behavioral health and mental health professionals to: act as first responders at initial contact, in crisis and non-crisis conditions to assess individual(s) needs and make appropriate service recommendations. Determine how best to expand and if there are ways to make minor modifications to minimize cost and increase capacity. 1b. Offer alternative support at all points by educating caseworkers to utilize previously existing databases to determine whether detained individuals are already connected to services and facilitate communication between multidisciplinary teams and previous providers to connect individuals with services to address their needs. 1c. Develop and utilize effective and thorough integrated system of available resources including wrap around housing, mental health providers, SUD providers, etc. 1d.Expand the number of MDTs (estimate of 36 and may need	Lead: DHS Key Partners: ODR, DPH, DMH, PMRT (Psychiatric Mobile Response Team), Dept. of Social Services, 211 LA, LA Health Care Agency Community Outreach, Reentry Intensive Case Management, Services, Whole Person Care	Existing Funding Sources: Funding from Department of Mental Health to support PMRT and Psychiatric Hospitalization Services, Homeless Initiative to support MDT or HOME, and WPC/ODR support of R-ICMS and other services Existing Staff: Unknown Additional Funding Sources: Cost is approx. $500,000 per team. If at least 36 teams were added that would be roughly $18 million. Additional Staffing Needed to Expand: An array of staff to support Multidisciplinary Teams such as outreach workers, administration, and community-based support response teams like staff with SUD expertise	Allow for the flexible use of funding to expand reach of cross-functional teams	Ensure workforce and trained clinicians are as diverse, culturally competent and represent the populations they are trained to serve. Ensure that staff is also able to provide in-language services to the population they serve that is consistent with Federal Title 6 and the Dymally-Allatorre Bilingual Services Act.	Year 1 Metrics: 1a.Identify frequency of use for MRT and PMRT requests involving some if not all these factors (a) formerly incarcerated people, (b) identification of gender and sexual orientation, (c) age (adult or minor), (d) ethnicity, and (e) resulting diagnosis/action 1b. Compare frequency of use for MRT to the numbers of people in jail with SUD/mental illness 1c. Add at least 18 MDT teams across the county. 1d. Elevate monthly regional homeless meetings to support cross functional team communication. Year 2 Metrics: 2a. Track alternative support referrals through the cross- functional team approach and effectiveness of MDTs. 2b. Add at least 18	Potential Impact: Impact on individuals that are unhoused and impacted by multiple behavioral health needs Unintended Consequences: Responding teams may not have been trained to address the needs of individuals that have experienced severe trauma, and/or violence in order to prevent incarceration Interventions: Train responding teams to effectively address cases of trauma and violence with alternative approaches. Enhance the ATI Restorative Justice and Trauma Prevention recommendations by creating specialized teams that address these issues and coordinate with current MDTs.

	respond in real time, expand the populations served, and enhance referral connections. Increase is based on homeless count numbers and include mental health, homeless services, substance use disorder, peer, and generalist outreach workers. 1e. Ensure that teams work with other cross-functional teams mentioned in the implementation plan for recommendation #36. <u>Year 2:</u> 2a. Ensure that the ATI coordination initiative, and relative departments (DMH, LASD, LAPD) are tracking, analyzing, and/or collecting data to (a) determine the results of MDT and PMRT response, and the follow-up; (b) reasoning behind result; (c) when hospitalization, length of time of hospitalization; (d) condition of release; and (e) outcome or prognosis at time of release. <u>Year 3:</u> 3a. Improve databases on probable preventions that were successfully used in year 1 as well as continue to support the sustainability of MRT and PMRT response.		<u>Facilities:</u> Identify existing locations, across LA County in high-need areas that can be utilized as comprehensive health centers with wrap around services similar to MLK Hospital.			additional MDT teams across the county. <u>Year 3 Metrics:</u> 3a. Track and assess outcomes of MDTs and identify at least 10 probable preventions, interventions, and/or improvements. 3b. Assess the need to increase the number of MDTs across the county.	

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2. Create and expand decentralized, coordinated service hubs (ex: MLK Behavioral Health Center) in strategic locations across the 8 Service Planning Areas (especially SPA 1, 3, and 7) where people their families, and support network can seek referral and/or immediate admission 24 hours a day to a spectrum of trauma-informed services that include but are not limited to mental health including Psychiatric Urgent Care Centers; supportive housing via a coordinated entry system; and substance use disorder services such as withdrawal management, medication assisted treatment (MAT) and recovery intake centers (i.e., sobering centers). **Expand / Scale Program**	Year 1: 1a. Follow up on the status of the motion "Expanding capacity to better serve the health, well-being, and socio- economic needs of Los Angeles County's vulnerable residents" which assessed countywide opportunities to establish facilities that support integrated direct care services to develop restorative care village facilities across the county.[1] 1b. Distinguish which additional county health and public health buildings while identifying additional community based buildings/locations are suitable for building out service centers including, but not limited to SPAs 1, 3, and 7. Spaces will provide more community- oriented spaces like Community Health and Trauma Prevention Centers, recuperative care, bridge housing, permanent supportive housing, respite/recovery centers, psychiatric services, and other social service opportunities.	Lead: DHS, DMH, DPH. A primary partner may also be the LA County Development Authority (LACDA). Key players: Board of Supervisors, MLK Community Hospital, LAC+USC, LAHSA, Recuperative Care Contractors (JWCH, etc.), Behavioral Health Placement Facilities (BHS, etc.), Reentry-ICMS and Housing Services Organizations (PATH, St. Joseph's Center, Drug Policy Alliance (DPA), Harbor Interfaith, Whittier First Day, LACADA, SSG etc.), DPH and WPC Regional Centers, legal service providers (Public Defenders, APD,	Existing Funding Sources: DMC could be used for treatment related services. DPH-SAPC also funds the Client Engagement and Navigation Services (CENS) which could be co-located depending on available funding from other sources. All distinguished leads and key players are supporting a similar model at the MLK Community Hospital and Behavioral Health Center). Existing Staffing: Evaluate current staff capacity in lead departments and key partners/ Additional Funding Sources to Expand: At least $335 million to build the infrastructure at an existing county hospital based on the cost of the	State level Need state action to reduce the time restriction to become DMC certified AB 362 (Eggman) would allow certain jurisdictions to pilot overdose prevention programs. Ensure that the bill is amended to include county of LA as a potential jurisdiction to pilot these programs. County level Ensure that providers educate patients on different treatment options available particularly for patients who are in pre-contemplation Advocate for additional funding sources to continue the implementation of coordinated service hub models that support integrated service delivery.	Develop a long-term plan to fund specific social service needs for demographic and regional communities through program evaluation and a survey of system-involved individuals and community members. Develop plan for programs to publish accurate information/datasets on racial impact to Los Angeles County Open Data and have data available in multiple languages.	1- yr metrics: 1a. Number of county and community health centers slated for renovation and/or expansion as service hubs. Target: At least 4 of county and community health centers that have been slated for renovation and/or expansion as service hubs 1b. Number of individuals admitted and served in different systems of care (key partners column). Target: Increase in the number of individuals served in different systems of care (key partners column) with a special focus on those who are unhoused and/or impacted by incarceration. Year 2 Metrics: 2a. Number of individuals admitted and served in different systems of care	Potential Impact: Develop an integrated and collaborative system of care for all people impacted by the social determinants of health and incarceration. Unintended Consequences: If policies do not change; people with justice involvement, serious offenses, arson cases, immigration status, or people who are not insured will continue to be denied access to community based services in the decentralized community based system of care we intend to build and develop. For instance, elderly people on parole could potentially be left out considering they are being released from state prisons. They

[1] http://file.lacounty.gov/SDSInter/bos/supdocs/117805.pdf

	1c. Collect feedback on regional models such as MLK Community Hospital, HIV Health District, 1 and WPC Regional Coordinating Centers to improve and develop service delivery hub model in several Service Planning Areas (SPA). Evaluate the number of staff needed to support a regional service delivery model. 1d. Assess behavioral health needs and incarceration impact by neighborhood utilizing data from DMH, DHS, psychiatric UCCs, medical UCCs, Million Dollar Hoods, and other community-based healthcare resources to decide where coordinated service hubs should be located. 1e. Develop a plan to improve service hubs to ensure that they incorporate wraparound services that accommodate families, individuals, service, companion pets, services for individuals in all stages of the SUD process (pre- contemplation, contemplation, preparation, action, and/or maintenance). 1f. Implement overdose prevention programs to address the needs of individuals who are in the active state of using drugs and that could offer a spectrum of services and consider	Medical Legal Partnership), Syringe Exchange Programs, and other organizations not currently contracted with the county providing specialized services (TransLatin@ Coalition).	MLK Behavioral Health Center. Additional funds will need to be used to staff the facilities and provide capacity building support to non-profit partners.[2] <u>Additional Staffing Needed to Expand:</u> All stated research needs. Improving quality of an integrated online tool Expanding programs and creating new programs – street medicine programs, coordinated service hubs, overdose prevention programs, etc. <u>Facilities:</u> Clinics - both fixed brick and mortar clinics and mobile clinics			(key partners column). Target: Increase in the number of individuals served in different systems of care (key partners column) with a special focus on those who are unhoused and/or impacted by incarceration. <u>Year 3 Metrics:</u> 3a. Completion of assessment of whether the county is still in need of service hub capacity with a fiscal viability component. The assessment must provide recommendations and guidelines to sustain the coordination of service hubs. Assessment completed in Year 3. 3b. Number of individuals admitted and served in different systems of care (key partners column). Target: Increase in the number of individuals served in different systems of care (key partners column) with a special focus on those who are unhoused and/or impacted by incarceration.	will need services and might have serious offenses which is a barrier to accessing LA County services. <u>Interventions:</u> Remove policies that prevent people with justice involvement, serious offenses, arson cases, immigration status, or people who are not insured from accessing services, housing, and resources. Allocate funding for services specifically for patients who are unhoused, have serious offenses, arson cases, elderly people on parole, non-citizens who might not be enrolled in a health insurance or program to cover medical expenses. Support flexible funding sources for recommendation 21 to support additional services for clients. Ensure coverage for behavioral health and medical health needs for people who do not have insurance and supplemental funding for people who do

	partnering with existing syringe exchange programs to expand capacity as well. 1g. Identify community-based programs currently facilitating 24 hour admissions (inpatient, outpatient, rehabilitation centers, sober livings, co- occurring programs) and immediately increase funding to expand capacity 1h. Identify current existing programs that could expand to do 24 hour admissions and conduct needs assessment to identify barriers to do 24 hour admissions. Develop plan to route funding to these programs to expand. 1i. Increase collaboration between housing services and identify barriers to do 24-hour admissions. Develop plan to route funding to These programs to expand. 1i. Increase collaboration between Housing services and outpatient Programs. Conduct needs assess-ment for Service and Bed Availability Tool (SBAT) and the Coordinated Entry System (CES). 1j. Develop a plan to implement						have insurance that does not cover the full scope of needed treatment. Miscellaneous client and provider needs include but not limited to: housing, clothing, food, transportation, education and training.

	an effective and thorough integrated system or expand SBAT to create a system that provides information about bed availability in Psychiatric Urgent Care Centers; supportive housing via a coordinated entry system; and non -coercive substance use disorder services such as withdrawal management, medication assisted treatment (MAT) and recovery intake centers (i.e., sobering centers), and inpatient psychiatric hospitals. Services needed in addition to those listed in recommendation include but are not limited to: beds in inpatient psychiatric hospitals, co-occurring disorder residential treatment, crisis residential programs, co- occurring disorder residential treatment for people with severe persistent mental illness and medical needs. Services need to be available to people across the age spectrum and for families. 1k. Research policy barriers that limit the ability of people requiring inpatient psychiatric treatment to access services between private and county hospitals when a 5150 hold has been written (ex. someone who has a hold written at a private						

	hospital cannot be moved to a county psychiatric unit even if private hospital does not have a psychiatric unit). Begin developing streamlined referral process that allows people to access the appropriate level of care despite the type of hospital they are in at the time of referral. 1l. Develop plan for parents to be able to access inpatient services without DCFS involvement that includes family services within an inpatient setting where children remain safe while non-DCFS care teams provide childcare and coordinate family/neighbor/community care for children as quickly as possible. Develop interdisciplinary teams that include childcare provider, clinician, nurse, psychiatrist to be available to serve families when primary caregiver is in inpatient treatment. 1m. Provide directly impacted peer advocate with shared intersectional identities to people seeking services to assist in guiding thorough process of inpatient treatment. Expand services to be available to people without documentation 1n. Ensure that services are available to people who are						

	conserved by the Los Angeles Public Guardian across the spectrum of care. <u>Year 2</u> 2a. Expand resources to previously existing coordinated service hubs within the county and community as indicated by needs assessment in SPAs with special focus on 1, 3, and 7 to promote the services created and implemented in year 1. 2b. Expand street medicine programs and continue supporting the operation of overdose prevention programs 2c. Assess the integrated system that provides bed availability (SBAT, CES, or other) and connect to 211, 1Degree, etc. 2d. Evaluate regional service hub model and distinguish best practices and improvements. 2e. Recommend the reallocation of resources from the criminal legal system to community-based supportive services based on findings from mandated program evaluation. <u>Year 3</u> 3a. The Board of Supervisors will establish						

	permanent local funding streams, including identifying and securing additional funding from State and local budgets, to support the expansion of community- based services and databases based on findings from mandated program evaluations.						

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3. Expand family reunification models and connect families to low- cost or no-cost parenting groups. Family reunification models and parenting groups should be evidence-informed and have demonstrated they are correlated with better outcomes for participants and their children. These resources should be provided by community organizations and there should be ready availability of resources tailored to the unique needs of cisgender women who identify as mothers as well as LGBQ+ and TGI parents. **Expand / Scale Program** **New Program**	Year 1: 1a. Research models in place today and assess their usefulness going forward and make recommendations for improvement and adaptation to meet the needs of ATI recommendation, including informing mothers/parents of the court proceedings around their child's custody and providing low to no cost legal services to regain custody 1b. Evaluate if there are other opportunities with other departments such as DPSS and DCFS to do more prevention-oriented work, for individuals regardless of whether a program participant will connect with DPSS and DCFS 1c. Employ mechanisms to facilitate communication between families and caseworker. 1d. Select and expand a variety of programs that meet parenting group needs such as including a mediator between children/family to help with the transitions and programs that provide resources tailored to the unique needs of cisgender women who identify as mothers as well as LGBQ+ and TGI parents.	Lead Departments: DCFS, DMH, DPH DPSS, Probation - for referrals of parents to groups. Key Partners New Way of Life, National Alliance on Mental Illness, Department of Social Services, Miriam's House, Operation Boot Strap, and other organizations providing family reunification programs and parenting groups	Existing Funding Source(s): Family Reunification (FR) assistance available through Assembly Bill (AB) 429 Existing Staffing: Look at staff handling the Family Reunification Program at DPSS and DCFS Additional Funding Source(s) to Expand: Venue spaces to provide training, counseling sessions, cell phones/internet access to all participants, marketing, outreach, printed materials, stipends for participation, wages for trainers and HR structure, transportation (tap cards, Lyft vouchers) program management. Partnerships and contracts with community based organizations reunifying families and implementing parenting groups. Additional Staffing Needed to Expand: Counseling services and outreach to inform	Proposed change: Create contract opportunities through the county to expand family reunification and parenting group programs, which will require revising the county's contract process to allow for smaller organizations to participate and provide services.	Train and hire individuals who look, talk and identify with the people in their support groups (a) lived experience counselors/staff to evaluate, access, and provide support/resources. Monitor the impact of these practices and community education on communities of color that are highly impacted by incarceration according to data from the Million Dollar Hoods.	Year 1 Metrics: 1a. Number of existing or new programs going under expansion. Year 2 Metrics: 2a. Number of families served through parenting groups and reunification programs 2b. Percent of mother/parents/relative s able to regain custody of their children within 1 year (or other appropriate time interval). Year 3 Metrics 3a. Number or percent of families able to regain custody within 1 year (or other appropriate time interval) based on preliminary evaluation of the first three years of implementation.	Potential Impact: People who need access to family reunification programs and parenting groups Unintended Consequences: People with justice involvement, serious offenses, immigration status can be left out of family reunification programs, especially, if some programs do not support the reunification of multi status families, adult children, elderly parents, etc. Also, given that DPSS oversees the reunification programs, families might be required to have an open case with DCFS or the courts to participate in the programs, adding a burden for families to access these services Interventions: Ensure that the implementation and expansion of these programs support the

	1e. Expand community partnerships for agencies that are doing family reunification 1f. Survey what incentives would help community members participate in meetings: child care, transportation, stipends? 1g. Market/outreach and create referral structure with county agencies with identified parenting groups 1h. Need to develop or support existing parenting groups that provide support to families in cases of domestic violence, mental illness, and substance use <u>Year 2:</u> 2a. Include multidisciplinary teams and facilitate the move and ensure that health care workers participating in these teams receive training on available family reunification programs and parenting groups.		community members of available services.				reunification of families and loved ones willing to participate in the program that were traditionally barred due to justice involvement, serious offenses, or immigration status Ensure that these programs help remove barriers to house family members together in all housing. Including public housing. Ensure that family reunification and parenting programs are widely accessible across departments and other agencies Make sure individuals are informed that participation is voluntary and won't result in any action from DCFS or DPSS, especially families without documentation or have been impacted by the incarceration of a loved one

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Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
4. Train families of people with clinical behavioral health disorders on how to support their loved ones, assess service needs, provide assistance through various stages of treatment, and follow prevention/treatment plans while incentivizing family/client involvement with compensation and certificates, etc. **Expand / Scale Program** **New Program**	Year 1: 1a. Research models in place today and assess their usefulness in training families on how to support their loved ones with clinical behavioral needs, evaluate capacity and provide steps for expansion. 1b. Ensure that trainings provide evidence based information and are given by health care professionals and people with lived experience and also include training groups for children, youth to help them understand the behavioral needs of their family member. 1c. Compensating or incentivizing parents, family members, and clients and organizations to provide and be part of training services. 1d. Develop a standard for what qualifies for program completion and receiving a certificate of participation Consider creating a program whereby the certificate of completion means something/counts towards something. 1e. Evaluate ability to do a media campaign similar to the "We Rise" effort by DMH media	Lead Departments: DMH, DPH, DCFS Key Partners: County CEO's office Public Guardian's Office Probation - for referrals of parents to groups. National Alliance on Mental Illness, Beit Shuvah, and other community organizations providing treatment services	Existing Funding Source(s): Evaluate the funding sources as well as the available staff within lead departments. Existing staff Assess current staff capacity within lead. departments and key partners. Additional Funding Source(s) to Expand: outreach, printed materials, stipends for participation, wages for trainers, financial assistance for under resourced family's transportation and program management, a county agency or develop an agency to provide resources to family members and caregivers to enroll in trainings. Additional Staffing Needed to Expand: Training services and provide support based on the needs of the families.	Create a mechanism where compensation is provided for completing the training program, especially for under resourced families and individuals	Provide racial equity and health equity in general training to all contractors and providers Ensure that trainee sessions also involve service providers with lived experience Create interventions targeting social stigma on clinical behavioral health disorders, consider developing culturally appropriate resources that are in- language, (i.e, media, messages, factsheets, health prevention programs) to reach communities of color Advance training support for diverse family populations, including: linguistic and cultural minorities, people identifying as lesbian, gay, bisexual, and transgender (LGBT), and individuals involved in the justice system.	Year 1 Metrics: 1a. % of families and caregivers participating in trainings and compared that % to the % of people enrolled in treatment services to better inform service delivery and support needed for individuals to complete treatment. Year 2 Metrics: 2a. Conduct a focus group with families participating in trainings to inform improvements and expansion of training programs. Year 3 Metrics: 3a. Evaluate the implementation of this recommendation through surveys to continue the support and stabilization of training programs	Potential Impact: Families of people in need or enrolled in behavioral health clinical treatment. Unintended Consequences: Excludes caregivers or other individuals who are not part of the family system of departments and have a general understanding of the needs of families and individuals they collectively serve. In the absence of a support system, connect patients with a mentor with whom they can talk about their recovery process and access trauma support. In some cases, allows people who need services to voluntarily identify the staff to train them and support them. Ensure no one is denied training based on prior justice involvement.

	campaign to make people aware of the services (ex: this is where you want to call to get information, develop 2 to 3 hotlines). <u>Year 2</u> 2a. Ensure county contracts with organizations already doing the work to expand family training services in various communities, especially in areas highly impacted by incarceration. 2b.Provide ongoing financial/staff support for the implementation of family support programs. <u>Year 3:</u> 3a.Ensure that training information is easily accessible (i.e location, requirements, compensation, etc.) and that training is offered to families at every stage of treatment. 3b. Secure funding streams to continue compensating families for participating in training programs and to make training services permanently available.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**

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5. Support meaningful exchange of information and clarity between provider, patient, and family/caregiver to improve patient care and health outcomes, including but not limited to modifying DMH's HIPAA policy for contractors. **Practice / Policy Change**	Year 1: 1a. Identify the best practices that clinics and community providers are utilizing to engage families and caregivers in patient treatment plans. 1b. Define an approach to HIPAA countywide – for issues of mental health and substance use disorders to ensure that provider, patient, and family/caregiver are communicating about care planning needs. 1c. Place notice in offices, clinics, hospitals to help all parties understand their rights. 1d. Create a central hub for receiving and provide information on HIPAA violations or questions and training. Year 2: 2a. Properly train providers and caregivers on the requirements, responsibilities, limits and possibilities of HIPAA. Year 3: 3a. Assess effectiveness of newly defined HIPPA approaches and generate improvements based on need. 3b. Assess use and effectiveness of public notice strategy and central hub for violations/questions and make corresponding changes to increase service delivery.	Lead Departments: County Counsel, DMH Office of Public Guardian Key Partners: DHS, Hospital Association, Provider networks, SAPC	Existing Funding Source(s): Lead departments and key partners utilize existing resources to develop HIPAA practices and protocols. Existing Staffing: Several staff coordinate HIPAA services across lead and key partner departments. Additional Funding Source(s) to Expand: Funding may be needed to evaluate, define, and provide accessible public information regarding HIPAA. Additional Staffing Needed to Expand: Staffing resources may be leveraged through existing infrastructure with small cost to improve delivery incurred.	Federal level: HIPAA needs reform at the federal level. County level: LA County should apply HIPAA consistently and in a way that supports patient well-being and acknowledges the caregiver role.	Commitment from lead departments and key partners to improve practices and community education about HIPAA in communities impacted by behavioral health needs specifically in communities of color. Monitor the impact of new practices and community education on communities of color that are highly impacted by the social determinants of health.	Year 1 Metrics: 1a. Identification of at least 5 best practices and or improvements. 1b. Implementation of defined HIPAA approach that provides a meaningful exchange of information. 1c. Notices released and trainings done in at least 30% of facilities that utilize HIPAA practices. 1d. Development of one central hub and # of violations and concerns logged and/or resolved Year 2 Metrics: 2a. Notices released and trainings done in at an additional 30% of facilities that utilize HIPAA practices. Year 3 Metrics: 3a. Increase in # of formal conversations with patients to pursue a release of information and communication of this information to support networks.	Potential Impact: Describe patients that are connected to a social support network and are open to having access to their health information. Unintended Consequence: Patients who are not approached about granting access to health information to their social support network. Patients that are still in the process of behavioral health stabilization and are not able to grant social network access. Patients who do not have a social network to support them. Patients who will be denied treatment because of their prior justice involvement, gang involvement, serious cases, arson, or have to register on a list. Interventions: Ensure that all health and social service professionals administer best practices and routinely check in

							with patients especially after connecting to the patient's social support network and after behavioral health stabilization. Support recommendation # 6 so that patients that do not have a social support network can be connected to a Community Health Worker and/or other peer navigator for additional support.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
6. Improve, enhance, and integrate case management opportunities and points of contact and engagement for Community Health Workers and peer support organizations to connect with clients and their families/loved ones outside of justice involvement and pre/post incarceration. Create robust community education -especially in impacted communities - about services tailored to people who identify as cisgender women, LGBQ+, or TGI so that incarceration is not the first	Year 1: 1a. Research models in place today and assess their success, as well as the equitable distribution of these resources based on geographic need. 1b. Conduct an inventory of existing or proposed case management services to determine how to streamline and/or leverage existing practices and avoid duplication of services. 1c. Make recommendations for improvement and adaptation to meet the needs of ATI recommendation especially regarding collaboration between	Lead: Departments: DMH, DHS (ODR, WPC), DPH, CBOs that manage community health workers, ODR, Whole Person Care	Existing Funding Sources: All lead departments and partners have existing funding allocations that employ Community Health Workers and Peer Support Navigators. Existing Staffing: All lead departments and partners employ CHWs and peer navigators Additional Funding Sources: Funding needs to be renewed to ensure CHWs and Peer Support Organizations can	Federal and State: Support Cal-AIM changes to ensure consistent funding for CHWs and peer support organizations. County level: Support expansion of CHW and peer support model to ensure service delivery is equitably distributed across all SPAs.	Commitment from leadership and program staff to ensure that communities impacted by incarceration and the social determinants of health are racially and geographically represented in contract decisions and workforce. Ensure community health workers are representative of the clients that are being served, including but not limited to lived	Year 1 Metrics: 1a. Increase in # of CHWs that are employed using an equity framework across LA County. 1b. Inventory and real time data resources to support an understanding of CHW, Peer Support, and organizational capacity. 1c. Creation of at least 5 improvements and adaptations that will support the integration of this recommendation into ATI work by	Potential Impact: Individuals that are connected to a CHW and/or Peer Support Specialist due to existing funding sources that are supporting Lead Departments like Medi-Cal, etc. Unintended Consequence: Individuals with justice involvement, serious offenses, gang involvement, who are without documentation have private health

point of contact for services. Give peer support organizations and Community Health Workers access to real-time data on treatment availability to streamline the referral process. **Expand / Scale Program** **New Program**	CHW/Peer Resource with other county departments. 1d. Support recommendation 59 to determine how service hours can be expanded to evenings and weekends for County staff and subcontractors to be more client friendly, including 24- hour on call services to reduce costs. 1e. Create a set of values and approaches for case management so that services are integrated and not duplicated depending on the population served especially for special service delivery for women, LGBQ+ and TGI groups. 1f. Give peer support organizations and Community Health Workers access to real-time data on treatment availability to streamline the referral process. Include feedback and leadership from impacted communities as highlighted in recommendation 55. <u>Year 2:</u> 2a. Create community level health campaigns in each SPA to raise awareness about existing services including: integrated case management opportunities and organizations providing a wide variety of resources to ease the transition into the community for justice involved individuals <u>Year 3:</u> 3a. Employ a mechanism to evaluate the delivery of services through case		continue providing services after 2020 due to the changes in Federal Medi-Cal Waivers. <u>Additional Staffing Needed:</u> Add frontline staff, Staff training, Database creation/IT solution		experience, community health workers/promotoras that are culturally competent and can provide in-language services to meet the needs of the clients. Revisit resource distribution decisions to reduce the racial immigration and linguistic disparities that exist for communities that attempt to access services	connecting the resource to multiple strategic collaboration opportunities based on department need. 1d. Increase in the # of Families/cases connected to these workers <u>Year 2 Metrics:</u> 2a. # of education sessions across different SPA # of participants, questions address, # of people referred/enrolled in case management, treatment services <u>Year 3 Metrics:</u> 3a. Run an evaluation of this recommendation to identify gaps in service and provide recommendations to address those gaps to ensure communities of color and LGBQ+/TGI are well informed and connected to services	insurance, elderly people, those who are unhoused, and/or do not have the necessary documentation to participate. Also, programs have limited funding which limits the time these resources are provided to individuals. <u>Interventions:</u> Allocation of funding specifically for patients who are unhoused, without documentation who might not be enrolled in a health insurance or program to cover medical expenses. Support of flexible funding recommendation #21 to support additional needs for clients when it comes to obtaining necessary paperwork. Generate gap funding to support continuous peer support for individuals that might be cycling in and out of care. Expand and develop this case management system without any barriers to accessing services based on justice involvement, serious cases, gang

	management and community health workers to justice involved individuals and people who identify as LGBQ+/TGI Continue supporting the implementation of integrated case management opportunities and peer support organizations to increase access to services						involvement, or arson.
Goals and Recommendations	**Key Actions**	**Lead Department and Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Proces**	**3-Year Metrics & Targets**	**Expanded Scope**
7. Establish effective restorative justice programs for the adult justice-involved population by learning from existing County programs and other programs, especially those serving youth. **New Program** **Expand / Scale Program**	Year 1: 1a. Partnering with Office of Diversion and Reentry or other groups located in a highly justice-impacted community, as identified in the Million Dollar Hoods Map of LA County to create an incubator office to create a model for restorative justice (RJ) and community justice (CJ) practices including: 1). Developing multi-lingual printed and multimedia materials and training programs for community- based members to facilitate RJ dispute resolution meetings and begin training programs to inform individuals and groups in the community and law enforcement of RJ services before and after justice involvement; 2). Develop a connection with law enforcement and community members for referrals to the RJ program; 3). Identify appropriate locations in the community, including libraries and CRA related banks with community rooms which are free to the program where RJ and CJ meetings can take	Lead Departments: DHS/ODR, PD, service providers. Primary partners may include city prosecutors and other municipal programs. Key Partners: Los Angeles City Attorney, Office of Violence Prevention under Dept. of Public Health, Youth Justice Coalition, Community Justice Initiative Trust Fund	Existing Funding Source(s): Unknown but consider looki at the Neighborhood Justice Programs operating costs ou of the Community Justice Initiative TrustFund to estim the operation/expansion of F programs Existing Staffing: Look at available staff withi the lead Department as well those in the Neighborhood Justice Program Additional Funding Source(to Expand: Office space for coordinator of programs and community outreach. Eventually, possib in year three, additional offi and personnel will be neede wherever programs are implemented throughout the county. Funding for 5 or more coordinators and funding to pay community members for training and facilitation of RJ and first responder programs (these people could possibly include	State level: Change to mandate non-violent pre-trial persons to be referred to RJ and community based programs and services. County level Policy change for Los Angeles County law enforcement departments to refer non-violent justice involved people to a RJ Program as an alternative to a trial. Assess pre-trial program in Sacramento for violent justice involved people to determine its viability for the LA County program.	Making sure that all organizers and participants receive training in the meaning of the terms 'racial equity' and 'cultural humility' as a basis for participation, including the importance of racial equity in the workplace and job outreach. Researching and collecting policing and community data through the lens of race, including information about unhoused individuals and people without documentation Making use of census data and the data included in the Million Dollar Hoods Map of LA County to become sensitive via statistical and socio-economic data to the unique character of each community being served	Year 1 Metrics: 1a. Number of organizations and individuals trained in restorative justice. 1b. Number of organizations and individuals utilizing multi-lingual restorative justice programs. 1c. Number of individuals connected to restorative justice programs though printed and multimedia materials generated. 1d. Number of partnerships between restorative justice programs and libraries, banks, community groups, churches and businesses to initiate conflict resolution programs. 1e. Number of CJ and first responder group programs to accomplish effective community	Potential Impact: Development of a restorative justice program for adult justice involved population Unintended Consequences: Anticipation of problems for people with gang involvement, serious offenses, arson, socio/economic challenges, including being unhoused and without documentation, and programs to help them in advance of their problems manifesting into serious offenses. Interventions Provide referrals to jobs, RJ and CJ programs, training, mentoring, resources, education, housing, healthcare, etc.

	place. 1b. Develop outreach and approaches to dialogue with community members about their vision for community action instead of law enforcement involvement and approaches to implementation of that vision. Generate multi-lingual and multimedia outreach and meetings for community involvement with solutions for social problems. 1c.Contact organizations, educational institutions, churches and businesses in the area about initiating in-house RJ and CJ programs. 1d. Develop a protocol to ensure the privacy of all participating individuals 1e. Develop a first responder emergency program led by DMH psychiatric professionals with trained community support 1f. Request ongoing data collection and feedback from administrators and participants about programs, number of participants and evaluation of outcomes 1g. Do an annual meeting with County of Los Angeles ODR to share information on the collection and annual synthesis of data collection about RJ and CJ projects and accumulation of feedback from participants on behalf of		members of justice impacted families); funding to pay for participant travel to RJ and CJ meetings. Funding for participants in the first responder training and action program. Funding for phones, computers, duplicating machines, office supplies, travel, printed and multimedia materials for programs including technology. Training of volunteers <u>Note:</u> Sessions with community and individuals can take place either in regional offices and/or local libraries and CRA connected banks with community rooms which are free for public use. <u>Additional Staffing Needed to Expand:</u> Personnel to oversee accomplishing goals: preparation of curriculum for RJ training facilitators, CJ community participants and first responders participants preparation of multi-lingual outreach printed and multimedia materials to inform community about RJ, CJ programs and first responder programs grant writer for funding from public/private partnerships outreach to members of the			based responses to people with conflicts and/or drug and/or psychiatric problems in the community. <u>Year 2 Metrics:</u> 2a. Number of conflict-involved people who participated in RJ sessions and outcomes. 2b. Number of community members who participated as RJ facilitators and support. 2c. Completion (Y/N) of written assessment of the RJ process by including institutional organizers, parties involved, community participants, churches, businesses, organizations, and first responders with descriptions, examples, and analysis of successes and imperfect outcomes. <u>Year 3 Metrics:</u> 3a. Number of people involved in newly developed and continuing programs.	Expansion of RJ programs to people who have committed serious offenses. These RJ programs, if successfully completed, could lead to elimination of charges and expungement of records, as is being currently tested in Sacramento.

	improving programs 1h. Approach organization leaders who already have successful RJ and CJ programs for information about their programs. Below are organizations with community-based experience that could provide insight into their programs and processes: Youth Justice Coalition https://youthpassagew ays.org/partners/youth-justice-coalition/ Provide training in community based responses to social problems and restorative justice program for dispute resolution. City of Los Angeles: Neighborhood Justice Program https://www.lacityattorney.org /njp Safety Mediation mediate@lacity.org Los Angeles County Office of Diversion and Reentry Program: Youth Diversion and Reentry Program: Taylor Schooley tschooley@dhs.lacounty.gov San Diego Restorative Justice https://www.sdrjmp.or g/ Excellent training program for volunteers throughout San Diego County to facilitate RJ meetings; educational program for community The program estimates that it		community to be RJ facilitators and CJ participants in community based dialogues and first responders (including people from justice impacted families) outreach to religious organizations, businesses and educational institutions to facilitate dialogue about appropriate conflict resolution structures within their organization and protocol for RJ and CJ programs outreach to law enforcement departments for referrals for non-violent justice involved individuals and to people before contact with criminal justice system or after reentering society, including to gangs in the area. security protocol for personnel and participants on-line program data and feedback site and report generation office management, communications and scheduling of RJ and CJ programs			

	costs $4,000-$5,000 per person going through RJ program; this program is not funded by a city or county agency. Restorative Response Baltimore https://www.restorativeresponse.org/ Excellent community based and driven programs to solve social problems Impact/Justice:https://impactjustice.org/impact/restorative-justice-diversion/ Sacramento diversion program The program pairs victims and offenders before they are convicted, and offenders who complete the program can avoid having a criminal record. Possible model for LA County “See a man, be a man,” A program to transform lives of young men of color. Contact Torrance Brannon Reese, 323-864-2656, familisoul@gmail.com ; www.sambaum.us Additional Resources: "Restorative Justice: Why Do We Need It?" video by Brave New Films: https://youtu.be/8N3LihLvfa0 "Introduction to Restorative Approaches" video by Resolve Consultants: https://youtu.be/gJJxbn1VjYo "What is Restorative Practices" video by the International Institute for Restorative					

	Practices: https://youtu.be/_obyZY4XzaI "Unapologetic: Interpersonal Conflict Guide" zine: http://rjposters.com/zine/ · These RJ artist posters: http://rjposters.com/ <u>Year 2:</u> 2a. Continue multi-lingual community member RJ outreach and training in incubator community. 2b. Continue RJ meetings with referrals from law enforcement and the community. 2c. Continue CJ dialogues and educational sessions for community action instead of justice involvement including first responder training. 2d. Continue multi-lingual outreach to community groups, churches, businesses and educational institutions and assist with appropriate solutions for social problems within their own group. 2e. Conduct a written assessment of the RJ process by including institutional organizers, parties involved, community participants, churches, businesses, organizations, and first responders with descriptions, examples, and analysis of successes and imperfect outcomes.					

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10, Advocate for changes to expand services and populations covered by Medi-Cal, MHSA, and/or to support integrated service delivery for system-involved individuals and their families, which could provide a source of sustainable funding to support ATI recommendations related to an integrated system of prevention and care. **Policy / Practice Change**	Year 1: 1a. Research current usage of services for all levels of care including but not limited to inpatient treatment, crisis residential treatment, outpatient treatment, co-occurring treatment (including sober living, residential rehabilitation). Identify at what age services are utilized and the type to assess coverage for early intervention treatment. 1b. Develop a plan to create a significant number of co-occurring (inpatient/outpatient) services available. 1c. Assess barriers to linking individuals with co-occurring developmental delays/cognitive impairment and behavioral health issues to Regional Centers. (a) Develop a plan to more efficiently connect Regional Centers	Lead Departments: Department of Mental Health (DMH), Department of Public Health, DHS Key Partners: Department of Substance Abuse & Control (SAPC) Office of Diversion & Reentry Department of Children and Family Services (DCFS) Department of Public Social Services (DPSS) CalWORKs and General Relief. Health Homes Advocacy firms Board of Supervisors, LAHS (Los Angeles Family Housing), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health), BHS (Behavioral Health Services), ST Joseph's medical center, Harbor interfaith, Drug Policy Alliance (DPA), Translatin@ coalition, volunteers of America, LACADA, SSG, Regional Centers, Public Defender, Alternate Public Defender	Existing Funding Source(s): Include: CalAIM waiver, MH Court Linkage program, consider redirect existing funding resources from some county departments, such as DCFS, DPSS, and others Existing staffing: Evaluate the current staffing within lead departments and key partners Additional funding source(s) to Expand: Coverage to expand prescription coverage and services. Behavioral Health, Medical, Housing, Co Occurring treatment, Inpatient and Outpatient To expand outreach centers and services hubs in under resourced areas. Additional Staffing Needed to Expand: Staffing needed for expansion for quality control/expediting approval process including initial applications.	Federal level: H.R. 1329 (Tonko and Turner) would allow states to reestablish Medicaid coverage 30 days before an inmate is released. H.R. 1345 (Hastings), would remove limitations on Medicaid, Medicare, Supplemental Security Income (SSI) and Children's Health Insurance Program (CHIP) benefits for pre-trial inmates of jails, detention centers, and prisons State level: Consider creating an additional funding source to expand services that are not one time or time limited AB 362 (Eggman) would authorize certain jurisdictions to pilot safe consumption sites aim at connecting individuals to life saving services.	Require services providers to report on the referrals of folks covered by Medical, MHSA to different systems of care and outcomes based on race and immigration status to reduce disparities and ensure access to services for all affected populations	Year 1 Metrics: 1a. Required county agencies to report on the enrollment of patients in multiple systems of care Year 2 Metrics: 2a. Compare the number of individuals with serious mental health illness, SUD being served in community settings versus those admitted in a correctional facility, utilize the results to assess the effectiveness of treatment programs and inform changes in practice Year 3 Metrics: 3a. Integrated Services must be located and accessible within close proximity of city districts experiencing high levels of homelessness, drug use, and neighborhoods where LASD and LAPD spent the most on incarceration	Potential Impact: This recommendation focuses on expanding integrated services for justice involved individuals Unintended consequences: Leaving behind folks who have not been involved in the justice system, but find themselves in need of Mental Health, SUD services. Interventions Allow for the expansion of services to reach other populations not covered by Medical, MHSA such as low-income individuals or immigrants without documentation and ensure the protection of client's information, privacy and confidentiality

	programs and DMH/DHS programs with a foundational understanding that people who have developmental delays may also have substance abuse issues, mental health issues, or be justice-involved. 1d. Conduct needs assessments in all service planning areas to identify resources (behavioral health clinics, medical clinics, pharmacies, rehab centers, services HUBs, etc.) that can be added to address the needs specifically for those areas. 1e. Develop a plan to ensure that all communities are being served relative to their needs and look at other programs being implemented connecting folks to services, such as the Trieste Project. 1f. Research data to compare services being used and the amount of services going unpaid to		Development of improved management information system, such as call centers	<u>Proposed Change:</u> Additional state funding will be needed to increase housing and placement options and build out resources needed for various types of diversion programs			

	identify services that can be given expanded coverage. 1g. Improve coverage for non-coercive substance use treatment, including but not limited to residential substance use treatment, residential co-occurring (mental health, substance use, medical) treatment. 1g. Research services utilized by people without documentation to expand Medicare and Medi-cal coverage. 1h. Incorporate comprehensive analysis including wealth, debt, region/neighborhood, dependents, into the application process to expand Medi-Cal eligibility. 1i. Expand research on new medications being utilized for both behavioral health and medical needs to expand prescription coverage						

	based on growing trends. 1j. Complete evaluation and assess practices on how Medi-Cal keeps records of people's medication history and needs to improve approval process for medications and services. 1k. Research/Identify barriers to getting medication approved by Med-ical/MHSA within short time frame and develop a plan to remove barriers. 1l. Research number of patients in inpatient care who have families and assess the needs of those families to expand coverage for support services including but not limited to childcare. 1m. Conduct research on the efficacy of LA Care and Health net managed care plans as compared to public healthcare plans and assess factors such as length of time to						

	approve medications, treatment, and what treatment and medications are approved. 1n. Evaluate the flexibility of funding sources for public health, mental health, health services, criminal justice and social services to serve shared clients(outside of one model of care); assess local match requirements for Medi- Cal and Drug Medi-Cal (DMC) funded services; and determine what existing services are covered by current funding and service areas that need to be expanded. (a) Develop plans to expand services in the identified areas (b) streamline the application process to allow various providers to apply for DMH funding. 1o. Advocate for State Budget proposals to help counties, such as Los Angeles to develop innovative plans to						

	increase access and quality county mental health services for the diversion of individuals with serious mental illness and ensure patients are served in community settings <u>Year 2</u> 2a.Based on evaluation: Expand coverage for all levels of care; including but not limited to: inpatient treatment, crisis residential treatment, co-occurring treatment, bed expansion, length of treatment covered, after care assistance for all vulnerable populations including individuals regardless of immigration status (transportation, mobile units if available, housing, sober living, sobering centers, safe consumption spaces). 2b.Continue building up in the core programs of DMH in prevention, early intervention and MH services to expand partnerships with other county departments, school districts, and community partners to reach and support system involved individuals and						

	their families experiencing mental health illnesses. 2c. Based on evaluation expand Medi- Cal/MHSA services to include evidence based prevention services including but not limited to: early mental health/substance use intervention and assessment in school and community based behavioral health services for youth and families, psychoeducation on identifying and addressing mental health symptoms and substance use issues. 2d. Provide full Medi-cal/Medicare coverage to people without documentation. 2e. Develop a management information system that keeps comprehensive records of medications and services previously used by patients which can expedite approval for new medications and services being recommended by treatment teams and improving continuity of care while ensuring patient confidentiality. <u>Year 3:</u> 3a.The Board of						

	Supervisors will continue to identify and secure additional, permanent funding from State and local budgets to expand and improve services to establish and continue to administer a funding source to support integrated service delivery for system-involved individuals and their families.						

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Goals and Recommendations	Key Actions	Lead Department &Key Partners	Funding, Staffing & Facilities Needed:	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
11.Optimize and increase the appropriate use and process for mental health conservatorship and assisted outpatient treatment, and resource them accordingly. **Expand / Scale Program Policy / Practice Change**	Year 1: 1a. Formalize and implement the link between jail and conservatorships through an explicit policy encouraging the use of LPS conservatorship for people who have been diverted from the criminal justice system and who are currently in jail custody, who, because of a mental disorder, are considered gravely disabled under the statute. Develop protocols to determine who will receive treatment in the Forensic In-Patient unit vs. in a locked community setting. 1b. Designate additional agencies (as permitted by current statute and happening on a pilot basis) to directly apply to the	Lead: DHS/CHS, DMH, DPH, PD Partners: NAMI, ODR, community-based providers (full-service partnerships, etc.), state hospitals	Existing Funding Source(s): ERS beds can be provided through MHSA funding. Medicaid funding should be maximized. AOT: MHSA Existing Staffing: AOT: 15 staff; CHS and LASD: jail discharge staff, Mental Health Court, DMH, OPG, providers and contractors Additional Funding Source(s) to Expand: Acute and sub-acute care will need greater state funding through 1991 Realignment Mental Health dollars. IMD Exclusion Waiver could help increase availability of Medicaid federal matching funds	Current Policy: Conservatorship recommendations are primarily initiated for those who are hospitalized. Proposed Change: Conservatorship recommendations can be initiated by provider sources, as is currently happening in the OPG pilot program. Sufficient statutory authority currently exists for the local mental health director and/or the director's designee(s) to initiate the conservatorship process. However, legislative change should be sought if there are local barriers to initiating conservatorships from the community. The existing statutory requirement of an	Obtain a formal commitment from DMH, CHS, NAMI, and other key partners that racial equity in the use of LPS conservatorships is critical. In collaboration with community partners and individuals with lived experience, apply a racial equity analysis to new or modified conservatorship policies to identify potential unintended consequences and a plan to mitigate potential harm. Develop a plan to collect data and monitor unexpected outcomes. Collect and report baseline numbers regarding the initiation of and outcomes for conservatorships, including those diverted away from or coming	Number of conservatorships initiated for people who have been diverted from the criminal justice system, and 1, 3 and 5-year recidivism data 1, 3 and 5-year recidivism data for individuals diverted and placed under conservatorships. Number of conservatorships initiated by provider sources (outside of the state hospitals) 1,3, and 5-year recidivism for individuals placed under conservatorships initiated by provider sources outside of state hospitals. Number of additional agencies directly applying to the court for LPS conservatorship Number of forensic full-service partnerships under the aegis of additional County	Potential Impact: Individuals and their families / loved ones who are gravely disabled because of a mental disorder Unintended Consequence: Family members / loved ones who are not aware that these changes make their loved one eligible for assistance and may not know how to advocate for them. It is also important to prevent any abuse of the conservatorship process and relationship, so conservatorships must be monitored closely. Interventions: Develop widespread and ongoing public education and a system actor campaign to explain the reforms and how to request

	court for LPS conservatorship. 1c. Explore expanding forensic full-service partnerships under the aegis of additional County agencies. 1d. Provide standardized training to assist family member conservators on system navigation. Refer families and clients coping with the challenges of living with serious mental health disorders to organizations that provide those services. 1e. Develop training and practice protocols so that conservatorship recommendations are more frequently initiated by provider sources (hospitalization is not required to do this). Monitor the outcomes of the OPG pilot program on this. Explore the possibility of families initiating the		<u>Additional Staffing Needed to Expand:</u> AOT: 35 Ensure that jail discharge, conservatorship investigator and public conservator, court-related and provider staffing positions are adequate, ensuring the staff capacity to conduct rigorous data collection and analysis, as well as training to family members and other advocates and stakeholders on the conservatorship process. <u>Additional Facilities:</u> Expand capacity of both IMD and ERS beds to create flow and alleviate bottleneck of bed crisis for acute/sub- acute patients. Increase number of FSP and ERS slots. 10/20 DMH report notes 32 ERS beds in development at MLK. AOT currently has 300 FSP and 60 ERS slots and recommends additional 300 total beds. Add co-occurring disorder residential treatment slots, based	10 days of the establishment of a conservatorship should be strictly enforced by the court (see W.I.C. §5352.6). That plan is developed by the treatment provider and its tasks, deadlines and outcomes should be strictly enforced by the court. California should apply for the IMD Exclusion Waiver.	from jail custody, based on race. In collaboration with community and individuals with lived experience, set annual goals and interim benchmarks to reduce and eliminate racial disparities in the initiation and outcomes of conservatorship, including criminal justice involvement. Based on the data collected, determine specific racial disparities and set goals and benchmarks based on that data. Develop a feedback loop for all stakeholders involved in the LPS process on racial disparities in the process or use of conservatorship, and a process to plan active responses to identified racial disparities.	County agencies, beyond DMH. Percent of family member conservators, advocates and other stakeholders satisfied with expanded use and process for LPS conservatorship Number of agencies added as county partners to increase in the capacity of support-based placement and wraparound services	more information and assistance in exploring LPS conservatorship.

	petition process, not just agencies. 1f. Strengthen current LPS conservatorship investigator data requirements. The LPS conservatorship investigator should be required to collect, track and report efficiency and effectiveness data, as well as data about conservatees' criminal justice involvement, including arrest, court outcomes, incarceration and recidivism. 1g. Expand the capacity of support- based placement and wrap-around services as an alternative to IMD placement for conservatees. Similar options should be explored for placement during the conservatorship investigation and court process to facilitate clients being treated in the appropriate level of care. T-Con powers may be adequate to accomplish these tasks.		on DMH 10/19 "Addressing the Shortage of Mental Health Hospital Beds Report."				

	1h. Identify necessary funding to expand AOT services and capacity. Implement plan to provide AOT services at full capacity. <u>Year 2:</u> 2a. Based on the LPS conservatorship investigator data collected, process simplification and task reduction should be undertaken to improve the initiation and establishment of conservatorships. The metrics currently collected should be examined to determine whether they are adequate to serve this purpose. DMH should establish a pilot project to test and validate these approaches. Process and outcomes data should be compared to current practices and used to review and revise practice. <u>Year 3:</u> 3a. Survey the stakeholders involved in LPS conservatorship and AOT services, including the justice partners, to determine the level of provider, advocate and family member/loved						

	ones' satisfaction with the ATI and other reforms undertaken in Years 1 and 2. Review and publicly report data to determine whether LPS conservatorship and AOT services have been expanded and improved, and whether these changes have prevented or reduced involvement of people who are gravely disabled with the criminal justice system. Adjust practice and/or policy accordingly.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
12. Support and broaden implementation of community-based harm reduction strategies for individuals with mental health, substance use disorders, and/or individuals who use alcohol/drugs, including but not limited to	Year 1: 1a. Evaluate current harm reduction services (e.g., syringe exchange, fentanyl test strips, naloxone) services, accessibility (e.g., fixed location, mobile, number of locations)	Lead Departments: DHS, DMH, DPH Key Partners Substance Abuse Prevention and Control (SAPC) and its network of SUD Providers including OTPs, SEPs, and other MAT providers and	Existing Funding Source(s): Consider utilizing CALAIM funding, continue to utilize training resources for MAT expansion, and available resources of	Federal Level: HR 2482 (Tonko) is a bill that would allow doctors and physicians to prescribe buprenorphine for addiction without the DEA waiver, as is	Ensure that communities of color and vulnerable populations disproportionately impacted by OUD and the criminalization of SUD (African Americans, Latino, Asian-Pacific Islander	Year 1 Metrics: 1a. Number (increase) of SEP providing OTPs 1b. Expand SEP in high need areas such as South LA and East LA Year 2 Metrics:	Potential Impact: The implementation of this recommendation would help connect individuals with MH, SUD needs to services in a community setting

sustained prescribing of psychiatric medications and medication assisted treatment. **Expand / Scale Program Policy / Practice Change**	and total investment compared to the anticipated in need 1b. Evaluate the capacity of Opioid Treatment Programs (OTP) prescribing Medications for Assisted Treatment (MAT) and opportunities for partnerships with syringe exchange programs to increase coordination between harm reduction programs and SUD treatment programs. 1c. Evaluate the expansion of reduction options through identifying other areas of high need. 1d. Implement efforts to expand access to Naloxone (overdose prevention medication) for patients at SUD treatment programs and Recovery Bridge Housing sites, co-occuring treatment programs, and any currently existing harm reduction programs; reduction program; and (a) Identify barriers and issues related to mental health providers prescribing psychiatric medications to patients who continue to use substances (b) Develop a plan to	the Substance Abuse Service Helpline (SASH); and Department of Mental Health and its ACCESS line, Drug Policy Alliance (DPA), Board of Supervisors, LAHSA (Los Angeles Housing Authority), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health), BHS (Behavioral Health Services), ST Joseph's medical center, Harbor interfaith, Translatin@ coalition, volunteers of America, LACADA, SSG, Regional Centers, Public Defender, Alternate Public Defender	groups already providing harm reduction services. Existing staffing: Evaluate the staff capacity within lead departments and key partners. Additional funding source(s) to Expand: Inpatient beds, transportation, hubs to link individuals to available treatment options to expand upon the Sobering Center and Wellness Center Models. Additional Staffing Needed to Expand: Needed to expand capacity/services offered at local Syringe exchange programs; and to pilot new programs that serve individuals who are actively using substances, increase the capacity of MAT providers, treatment counselors.	currently allowed for pain relief. State Level Extend and or/ get rid of the sunset date for the operation of SEP by 2021 AB 362 (Eggman) would allow certain jurisdictions to pilot overdose prevention programs Increase funding for the AIDS Clearinghouse which provides supplies to syringe exchange programs. Increase funding for Drug Treatment Navigators through SEPs. County level: Consider looking at a county policy change to allow individuals with a diagnosis to be sent to a local inpatient hospital.	and Native America) have meaningful access and are informed of available treatment services and that treatment and services are culturally and linguistically appropriate and are available regardless of immigration status	2a. Number (through a report) of naloxone doses distributed in treatment facilities and Recovery Bridge Housing as well as on the number (or percent) of housed individuals who are active users to inform practices Year 3 Metrics: 3a. Number of reversed overdoses (for the sustainability report) 3b. Number of referrals to mental health services and drug treatment (for the sustainability report) 3b. Number (increase) of community-based MAT and SEP services, as well as SUD services for individuals in all stages of the SUD recovery process	Unintended Consequences: People who have not received a medical diagnosis or who are active users but would benefit from harm reduction services such as clean needle exchange programs or overdose prevention services. There would be an expansion of evidence-based harm reduction services (e.g. SEP and Overdose Prevention Programs) in communities where constituents might not be familiarized with these types of services/treatment options. As a result, community education and engagement are key to successful program integration in these communities. Interventions: Implement a stigma-reduction campaign that is culturally and linguistically appropriate through the development and circulation of evidence based information and town halls with health professional experts Ensure that programs

	1e. Expand housing opportunities for individuals who are in the active state of using drugs. 1f. In an effort to expand harm reduction strategies in the county, conduct research on harm reduction services being done in other jurisdictions including international models such as Canada's safe injection services and explore the capacity of syringe exchange programs, to expand health services to individuals struggling with problematic use and who are in the active state of using substances (a) Model overdose prevention programs as a point of entry to provide referrals to counseling services and drug treatment. 1g. Identify and implement opportunities to promote the availability of OTP and SEP services within the community and SUD treatment network, including adding SEP sites to the Substance Abuse						do not require sobriety, and provide harm reduction services

	(accuchecks, insulin, etc.), and substance use disorder. 1i. Increase beds in locked Skilled Nursing Facilities (SNF), increase capacity of co- occurring mental health and substance use disorder programs to be able to accommodate patients with higher medical need 1j. Improve Service and Bed Availability Tool (SBAT) to include the bed availability for programs across the treatment spectrum for people with behavioral health diagnoses, substance use disorders, and co-occurring medical needs (SBAT is not currently updated with beds). Ensure that SBAT is updated daily. Assess efficacy and availability by conducting research with focus groups of people who are not versed in behavioral						

	health, substance use, or medical language. 1k. Identify and adopt treatment models that include SUD for stimulants and methamphetamines. <u>Year 2:</u> 2a.Increase knowledge of Medication Assisted Treatment (MAT), including where and how to access MAT services 2b. Better integrate SEPs into substance use disorder (SUD) treatment services continuum and build bidirectional referral processes so individuals can easily access services depending on their goals along the harm reduction to sobriety continuum; and (a) Integrate or enhance case management and recovery peer navigation services to facilitate referrals to and retention in treatment. 2c. Implement strategies to address barriers to continuing psychiatric						

	medication prescribing for individuals who continue substance use, at minimum within the Department of Mental Health system. 2e. Expand the number of beds in locked SNFs, capacity of programs for people with co- occurring mental health diagnosis, substance use disorder, and high need medical diagnosis <u>Year 3:</u> 3a. Identify strategies to expand community-based MAT and SEP services that comply with existing Drug Enforcement Administration (DEA) restrictions and/or seek to implement pilot projects. Further expand efforts to decriminalize drug possession and work to remove other treatment barriers to make MAT and other treatment options more accessible. 3b. Develop a report to inform sustainability in order to identify and secure funding to expand non-coercive SUD services for individuals in all stages of the SUD recovery process (pre-contemplation, contemplation,						

	preparation, action, and/or maintenance). 3c.Creating Drop-in Wellness Centers, treatment on-demand access to care, housing (interim and permanent), drug testing centers, no-appointment clinics, and continue the implementation and expansion of overdose prevention centers 3d.The Board of Supervisors will continue to identify and secure additional funding from State and local budgets to expand and improve services.						

Alternatives to Incarceration Work Group
Intercept 0 Preliminary Implementation Plans

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets	Expanded Scope
13. Deliver integrated mental health and substance use disorder services, rather than parallel services, including building partnerships between DPH-SAPC & DMH for residential co-occurring disorder (COD) services. **Policy / Practice Change** **New Program**	Year 1: 1a. Advocate to remove additional documentation barriers (See MHSUDS 15-028) for individuals in Methadone Maintenance treatment to go beyond the state time limit on counseling, currently the state only requires 200 minutes of counseling per month as allowed under Drug Medi-Cal by the State. 1b. Given the short window of interest to enter drug treatment, it's important to create opportunities between county agencies and other organizations to share real time information on available harm reduction treatments grounded in non-coercive treatment strategies 1c. Open contracts with community organizations for additional beds and	Lead Department: DPH-SAPC, DMH Key partners: LA CARE, Providers including OTPs, SEPs, and other MAT providers and the Substance Abuse Service Helpline (SASH); and Department of Mental Health ACCESS line, Co-Occurring Integrated Care Network (COIN) Special Service for Groups - Alliance division, DHS, ODR, Regional Centers	Existing Funding Source(s): Consider utilizing CalAIM funding, the current DMS-ODS waiver & DMC. Evaluate AB 109, Prop 64 allocations as other potential funding sources. Existing staffing: Evaluate staff capacity within lead departments and key partners. Additional funding source(s) to Expand: Housing options for individuals enrolled in outpatient treatment, and facilities to offer COD residential services. Programming: miscellaneous client needs including but not limited to: clothing, food, transportation, education and training.	State Level Advocate for a statewide funding plan to build out and further expand the resources needed for various types of co- occurring disorder (COD)services	Educate health care providers to communicate in non- judgmental ways with awareness of inherent bias and non-judgmental listening with folks experiencing COD Ensure meaningful access for patients with COD and that patients are informed of available treatment services. Ensure treatment and services are culturally and linguistically appropriate and are available regardless of immigration status	Year 1 Metrics: Track county providers as well as community organizations providing COD services Year 2 Metrics: Increase the number of residential beds for folks with COD to decrease the waiting period to less than a day - Year 3 Metrics: Conduct an evaluation on the number of folks with COD and who are supported through residential programs, utilize the results to inform the continued expansion and improvement of service delivery	Potential Impact: Increase residential services for individuals experiencing co-occurring disorders Unintended Consequences: The recommendation does not address the initiation or progression of substance use, mental health needs, particularly among youth and young adults Also, currently people with serious offenses, arson cases, gang involvement, and/or without documentation status are barred from accessing services, particularly mental health services.

	provide access to transportation for individuals who are unhoused or who do not have transportation readily available and seeking to enter into drug treatment, the programs also need to ensure the protection of client's information, privacy and confidentiality. 1d.Implement an Education campaign on information about Health Net and LA CARE <u>Year 2:</u> 2a. Expand funding and model for field-based services for substance use services. 2b. Determine which residential treatment providers currently have contracts with DPH- SAPC and DMH, and are able to deliver services for individuals with both specialty mental health and SUD services (Special Service for Groups - Alliance Division Co-Occurring Disorder program); (a) jointly (DPH-SAPC and DMH) finalize the admission and service standards, and funding streams to		<u>Additional Staffing Needed to Expand:</u> Residential substance abuse providers with the necessary training and willingness to accept a co-occurring population. Program staffing as well as funding people (likely current DHS or DMH staff) to assess the needs of currently existing programs and plan on how to expand these programs. Include in program staffing: Program managers, program coordinators, clinicians (including art therapists), case managers, SUD counselors, psychiatrists, employment specialists.				<u>Interventions</u> Increase funding and access to evidence- based youth prevention programs and support the expansion of mental health and trauma informed support programs for this group Remove barriers that people with serious offenses, arson cases, gang involvement, and/or without documentation status face when trying to accessing these services.

	serve this shared population; and (b) initiate joint COD residential services. 2c. Determine where DPH-SAPC and DMH operational practices (e.g., contracts, entry points) can be streamlined to reduce duplication and/or inefficiencies that impact ability to achieve integrated care at the administrative level; and (a) identify opportunities for DPH- SAPC and DMH to leverage funds for prevention services to reduce initiation or progression of substance use mental health needs, particularly among youth and young adults who have none to minimal involvement in the justice system but who are exposed to the possibility of engaging in this behavior (b) Ensure that prevention programs are science based and go beyond an abstinence-only approach. (Note: Consider the Safety First Curriculum launched by the Drug Policy Alliance, which adheres to research-based prevention and drug education						

	principles while equipping teens to make safer choices about drug use). Year 3: 3a. Develop and initiate an implementation plan for at least one of the strategies identified in Year 2 that will advance COD integration efforts for individuals with both conditions. 3b. Continue securing funding streams to provide and make accessible MH and SUD treatment to unhoused, low income individuals.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
14. Support parity between the mental health and substance use disorder systems and available services. **Policy / Practice Change**	Year 1: 1a. Evaluate capacity to increase client and patient services on days and at times that are convenient to patients and enable participation in employment,	Lead Department: DPH & DMH Key partners: DHS, CEO, SAPC. workforce development organizations Board of Supervisors	Existing Funding Source(s): Medical funding source Existing staffing: Evaluate the staff capacity within lead departments and key partners.	Proposed change: Increase Cross-Department Communication to improve the coordination of service delivery and	Develop and provide culturally humility resources about treatment services to patients and train providers on non-	Year 1 Metrics: 1a. Number of uniform expanded service options that support parity between the two service need. 1b. Funding available to cover costs of service parity.	Potential Impact: Increase access to mental health and SUD treatment services Unintended Consequences:

	education and other social activities not tied to the health condition, including operating and opening centers 24/7. 1b. Expand funding and model for evidence based services for substance use services. 1c. Advocate at the State-level with the California Department of Health Care Services to streamline application process to become a Medi-Cal certified or licensed provider; and reduce the time it takes for site certification, particularly for SUD services under the Drug Medi-Cal program which is approved at the State level unlike mental health services which occurs at the local level. 1d.Develop a system to integrate existing mental health programs, substance use disorder programs, and (when necessary) programs for people with developmental disabilities. Identify barriers in the current system including policies that indicate that these treatment programs should be separate and make changes to support the	LAHS (Los Angeles Family Housing) PATH (People Assisting the Homeless) JWCH (John Wesley Community Health) BHS (Behavioral Health Services) St Joseph's medical center Harbor interfaith Translatin@ coalition Volunteers of America LACADA SSG Regional Centers	<u>Additional funding source(s) to Expand:</u> More funding will be needed for capacity building at the provider and staff levels To address client's needs including but not limited to: housing, clothing, food, transportation, education and training as well as the establishments of centers providing COD services <u>Additional Staffing Needed to Expand:</u> Administrative staff, case managers, MAT providers, program staffing as well as funding people (likely current DHS or DMH staff) to assess the needs of currently existing programs and plan how to expand these programs, others include: Program managers, program coordinators, clinicians (including art therapists), case managers, SUD counselors, psychiatrists, employment specialists	allocation of resources.	judgmental communication. Require DMH & DPH to release annual outcome evaluations regarding referrals and outcomes based on race/immigration status to support the implementation of this recommendation. Ensure streamlined services are available, meaningful and accessible regardless of immigration status/ and for other vulnerable populations.	1c. Difference between available and needed funding. <u>Year 2 Metrics:</u> 2a. Number of uniform expanded service options that support parity between the two service needs. 2b. Number of developed and implemented training curriculums for medical and front-line personnel. 2c. Number of developed and implemented workforce training curriculums for people with co- occurring disorders to support along with outcomes like the percentage of people connected to employment opportunities. <u>Year 3 Metrics:</u> 3a. Number of uniform expanded service options that support parity between the two service needs. 3b. Completion of monitoring and evaluating treatment services and resident outcomes to inform changes and further support the implementation of this recommendation.	Not enough resources to expand these two systems of care and it's not feasible for DPH to be solely responsible for funding efforts to achieve parity with mental health <u>Interventions</u> Increase funding opportunities to maximize resources Legislative and county policy changes needed to support parity between MH and SUD systems, which will support increased access to care across all vulnerable populations

	implementation of this recommendation. <u>Year 2</u>**:** 2a. Scale up programs to offer financial aid, tuition reimbursement, and/or payment of certification fees to become a registered and/or certified SUD counselors, and provide a more robust training opportunities to assist in building the capacity of this much needed workforce as there are growing opportunities within the health, mental health, and SUD fields for individuals with these credentials; and support opportunities for individuals with lived experience to pursue this work and who may not have the financial resources to complete educational requirements. 2b. Train medical and front-line personnel or responders on available treatment options for individuals who are experiencing co-occurring disorders. 2c. Offer Employment opportunities for people with co-occurring disorder**s**						

	Year 3: 3a.Evaluate and enhance the transition of care between MH and SUD services leading to these types of care and ensure that services are accessible and available.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
15. Remove time limits to service provisions that prevent access to long term health, mental health or substance use disorder treatment plans. **Policy / Practice Change**	Year 1: 1a. Evaluate existing mental health, substance use, and co-occurring disorders programs to develop an understanding of the range of lengths of time that clients need treatment. 1b. Develop program policies and contracts that recognize that individuals will begin treatment with a wide range of needs, barriers, strengths, and abilities and develop program	Lead Department: DPH & DMH Key Department: CEO and Measure H; DPH-SAPC for RBH; LAHSA, DMH, DHS Housing for Health, Board of Supervisors LAHS (Los Angeles Family Housing) PATH (People Assisting the Homeless) JWCH (John Wesley Community Health) BHS (Behavioral Health Services) St Joseph's medical center	Existing Funding: Consider utilizing funding allocated through Measure H, non-DMC/Medi-Cal fund, Realignment, and Federal Block Grants, and intrafund transfer could be potential payers for extended lengths stay Existing Staffing: Evaluate the staff capacity within lead departments and key partners. Additional Funding source to Expand: More facilities to provide services on demand.	Federal Level: Address federal Housing and Urban Development (HUD) definition of homelessness that adversely impacts individuals in residential treatment 90 days or more. State Level Research potential state policies that could contribute to the implementation of this recommendation	Ensure service providers provide treatment information tailored to the needs of patients and have open dialogues about different recovery paths Ensure services are culturally and linguistically appropriate and are available regardless of immigration status.	Year 1 Metrics: 1a. Evaluate the rate at which individuals are admitted across MH, SUD treatment services. Year 2 Metrics: 2a. Conduct an assessment on the percentage of people placed in permanent housing after or continue enrollment in MH and SUD treatment to enhance prevention and recovery services. Year 3 Metrics: 3a.Increase reporting requirements for service providers and patients in order to identify ways to minimize/get rid of time limits preventing long term health access to services.	Potential Impact: Increase access to treatment by reducing or modifying time limit barriers, which will increase retention. Unintended Consequences: In removing time limits there is the risk of experiencing staff capacity limitations causing patients to be discharged at an earlier time. Ensure people with serious offenses, arson cases, gang involvement, and/or without documentation status are not prevented from

	that bases treatment length on client's actual needs. 1c. When patients' time limits are up, provide the option of continuing with inpatient treatment if medically necessary according to clinical staff or allow them to move into transitional housing or ensure that they have a warm hand off to recovery along the treatment trajectory. (Note: Individuals transitioning from residential SUD treatment or another institutional setting can receive up to 180 days of Recovery Bridge Housing [RBH] if enrolled in concurrent SUD outpatient treatment within DPH's system of care). 1d. Advocate to the California Department of Health Care Services (DHCS), and by extension and where feasible the Centers for Medicaid and Medicare Services (CMS) the importance of (1) the waiver of the Institutions for Mental Disease (IMD) exclusion for mental health and substance use disorder	Harbor interfaith Translatin@ coalition, Drug Policy Alliance (DPA), Harm Reduction Coalition, Volunteers of America LACADA SSG Regional Centers	<u>Additional Staffing Needed to Expand:</u> Staffing to assess current programs and develop new programming and contracts, staff to improve SBAT and staffing to run and work at Call Center.				accessing longer treatment plans. <u>Intervention:</u> Increase awareness about the necessity of recovery support services and provide evidence-based education and information about OUD/SUD, and resources available for prevention and treatment. Allocate a funding streams to sustain staff and service capacity. Ensure AB109 individuals get access to longer term treatment plans.

	(SUD) residential services, and (2) removal of the length of stay cap on residential services, and minimally maintain and not reduce the current cap, to support parity efforts. Ensure that individuals regardless of immigration status and seriousness of offense have access to these services.(3)The county must fund a total state/day cap and include as needed language, adult side – education. 1e. Develop relationships with key organizations providing harm reduction services and other stakeholders to ensure information is easily accessible to create multiple points of entry into services. <u>Year 2:</u> 2a. Establish a call center operated 24/7 where people can call in and receive information on available services. 2b. Assess SASH as a model for call center and develop a plan to expand SASH to include other types of treatment beyond substance use.						

	2c. Improve Service and Bed Availability Tool (SBAT) to include the bed availability for programs across the treatment spectrum for people with behavioral health diagnoses, substance use disorders, and co-occurring medical needs (SBAT is not currently updated with beds). (1) Ensure that SBAT is updated daily (2) Assess efficacy and availability by conducting research with focus groups of people who are not versed in behavioral health, substance use, or medical language. <u>Year 3:</u> 3a. Require a long-term process and commitment to resolve barriers that might come up in the future preventing members of different communities to access treatment, employment and housing and continue to secure permanent funding.						

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Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
18. Create a system that contributes to and/or offsets the cost to family members and caregivers for housing loved ones within their home or in the community through options such as tax credits, stipends, vouchers, motel conversions, or partial pay options. *Utilize this system to address the cost of family members caring for the child of an incarcerated loved one, including transportation assistance to support the child visiting their parent in jail to maintain a strong relationship, and to support cisgender women, LGBQ+ people, and TGI people who act as caregivers of children, elderly family or loved ones.* **New Program** **Policy / Practice Change**	Year 1: 1a. Convene health/housing agencies to assess potential dollars to be used immediately for the implementation of this recommendation. 1b. Identify advocacy agenda. (1)Part of agenda setting should be assessing how to drive new money to communities of color within the target population. 1c. Continue building up on the subsidies for DMH clients living in Board & Care Facilities. The program assists DMH clients to obtain and maintain housing at a licensed residential facility (Board & Care) by providing funds for rent, personal and incidental expenses and /or enhanced services that may be needed due to their mental illness 1d. Ensure an active collaboration of DMH with other departments to identify resources for family members and other supports of the client in order to maintain stable housing. Year 2: 2a. Begin advocating for funding streams through the	Lead Departments: DMH, CEO Key Partners: DHS, State MHSA program, other agencies providing treatment, case management services	Existing Funding: The Board and Care Expansion is funded by the Mental Health Services Act and Whole Person Care consider keeping and increasing if possible this funding stream. Existing Staffing: Evaluate the staff capacity within lead departments and key partners. Additional Funding source to Expand: Stipends, voucher, motel conversation, and partial pay options. Additional Staffing Needed to Expand: Increase staffing for strategy, advocacy, and eventually for implementation of this recommendation.	State Level: Expansion of MHSA and/or creation of new stipends, tax credits, or other financial to support families caring of loved ones with mental illnesses in a home environment.	Educate providers about how to incorporate racial equity principles in the delivery of services Research to understand disproportionate financial impact on specific subpopulations dealing with caring for family with disabilities. Explore potential for multi-lingual outreach based on different locations (benefits offices, information from medical providers, etc.).	1 yr metrics: 1a. Evaluate outcomes of the Board and Care to advocate for expansion and improvements. 2 yr metrics: 2a. % of funding increase to continue providing those under a care system with a home setting. 3 yr metrics: 3a. Evaluation of the implementation of this recommendation to advocate for expansion and changes(1) department overseeing this type of housing assistance option (2) financial options that were more widely used and accessed (3) # of people served and % of them placed in permanent housing.	Potential Impact: Increase the support to family members and caregivers for housing loved ones within their home or in their community Unintended Consequences Barriers to housing justice involved family members, especially those with sex crime, serious offenses, gang involvement, and arson convictions Interventions Identify barriers that keep families and caregivers from housing justice involved individuals, especially those with sex crime, serious offenses, gang involvement, and arson convictions and remove possible

	legislation to support those giving care in a home setting. Potential reallocation of local funds. Year 3: 3a.Secure legislative victories and begin working on local implementation of state policy changes. 3b.Streamline the application process and ensure that case managers provide assistance and inform individuals on eligibility requirements If there is a limited amount that a family/caregiver can be eligible for require case managers to connect them with other permanent housing options. 3c. Assess how to remove barriers that keep families from housing justice involved individuals, especially those with sex crime, serious offenses, gang involvement, and arson convictions get access to these services by changing policy.						barriers through policy changes.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
19. Create an individualized/personalized master transition plan for displaced individuals. **Expand / Scale Program** **New Program**	Year 1 1a. Evaluate the extent of transitional planning (a) what does the current transitional planning entails? 1b. Explore ability to tightly coordinate housing/care	Lead Departments: DMH, DPH, DPSS Key Partners: DHS, LAHSA, Housing Initiatives and other agencies	Existing Funding: Consider utilizing MHSA funding for a wide variety of housing resources including capital needed to	Proposed Change: New transfer policies across the County	As much of the housing and health programs in the County serve People of Color at higher rates, when programs or facilities shut down/scale back	Year 1 Metrics: 1a. Number of agencies that participate in transfer plan coordination. Year 2 Metrics:	Potential Impact: Provide individualized housing services to displaced individuals

	placements between different housing and health service agencies 1c. Ensure that individualized housing plans/service include all clients who are unhoused including re-entry clients 1d. Identify funding streams to open contracts with different landlords to increase housing options for a variety of groups (justice involved, without documentation, unhoused, sex crime, serious offenses, gang involvement, and arson conviction.) <u>Year 2:</u> 2a. Draft policies and procedures to enable personalized transition plans when individuals are set to be displaced from programs or housing locations 2b. Track trends in individualized transition plans to monitor fluctuations in transition plans from year to year to recommend changes and further support the implementation of this recommendation <u>Year 3:</u> 3a. Agencies need to begin implementing transition plans and organize ongoing meetings to assess and streamline continuity of care/housing placements.	overseeing housing accessibility	develop Permanent Supportive Housing projects as well as the Flexible Housing Subsidy Pool (FHSP) voucher <u>Existing Staffing:</u> Unknown <u>Additional Funding source to Expand:</u> Funding streams will be needed to further expand housing resources, look to philanthropy resources and local partner jurisdictions (cities within LA County) <u>Additional Staffing Needed to Expand:</u> Training for providers to create and fulfill transition plans. Potential agency staffing increase to coordinate housing or service slots and fulfill referrals.		(without transfer plans to guarantee service continuity) they are likely to cause Angelinos of color to fall out of housing and supportive service connections. These setbacks can be very detrimental for the health of clients, as well as eroding trust in government which may lead to folks disengaging from government services. Ensure services are culturally and linguistically appropriate and are available regardless of immigration status to the extent possible by federal and state law.	2a. Average number of days for transfer placements. 2b. Number of identified best practices to support tighter coordination of housing services. <u>3yr metrics:</u> 3a. Percentage or number of housing fluctuation trends through individual transition plans to recommend improvements.	<u>Unintended Consequences:</u> The vacancy rate is below 2% in LA County presenting a barrier to assisting clients including those with local or Federal subsidizes locate a unit as is the lack of/limited number of interim housing available in some parts of the LA County. Currently, housing for justice involved individuals, especially those with sex crime, serious offenses, gang involvement, and arson conviction is nearly impossible to access. <u>Interventions:</u> Initiate an education campaign in different neighborhoods about the detrimental effects of being unhoused. Expedite the process for housing and shelters

Alternatives to Incarceration Work Group
Intercept 0 Preliminary Implementation Plans

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
20. Expand or refine affordable successful housing models designed for and tailored to justice-involved individuals with mental health and/or substance use disorder needs, specifically: (a) short- term treatment inclusive of acute inpatient, AB 109 and forensic inpatient (FIP) and IMD subacute beds; (b) interim housing inclusive of clubhouse living with supportive employment, recovery bridge housing and sober living; and (c) permanent subsidized housing inclusive of independent living and board and care facilities. **Expand / Scale Program**	Year 1 1a. Identify permanent housing options currently available for justice involved individuals. 1b. Assess current acceptance rate for permanent support housing (PSH) and identify barriers impacting those who are denied access. 1c.Research/Identify service providers currently providing outpatient services to PSH and other housing options (includes but not limited to sober livings, transitional housing) 1d. Complete a needs assessment for short-term treatment inclusive of inpatient, IMD, subacute, and crisis residential beds and increase funding in order to increase the number of beds. 1e. Research and pilot models in other jurisdictions including: (a) 1811 Eastlake in Seattle, which provides supportive housing to formerly homeless adults with chronic alcohol use disorders. It addresses the needs of unhoused adults who were previously the heaviest users of publicly-funded crisis services. 1811 Eastlake is the	Lead: CEO, DHS, DMH, DPH. A primary partner may also be LACDA. Key Partners: Board of Supervisors, LAHSA (Los Angeles Family Housing), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health) · BHS (Behavioral Health Services), ST Joseph's medical center, Harbor interfaith, Translatin@ coalition, Drug Policy Alliance (DPA) Volunteers of America, LACADA, SSG, SAPC, Regional Centers, Public Defender Alternate Public Defender, Full Service Partnership Programs (FSP)	Existing Funding: Consider utilizing Measure H funding Evaluate the usage of MHSA funding for the provision of onsite supportive services Existing Staffing: Evaluate the staff capacity within lead departments and key partners Additional Funding source to Expand: Transportation services for linkage Treatment options including inpatient and outpatient, interim and permanent housing Additional Staffing Needed to Expand: Research, expansion of service providers, new housing developments, construction, administrators, housing supplies, career development staff	State level: Advocate for additional funding streams, particularly to serve those with justice involvement which disqualifies them from federally-funded housing (arson, sex crimes, certain drug drug charges) Advocate to increase housing services to individuals who fall within the AB 109 criteria	Ensure that individuals are given housing accommodations within close proximity of their support network and treatment services Create and place educational fliers about available housing options in community centers, churches, and other local places where information can be accessible Ensure services are culturally and linguistically appropriate and are available regardless of immigration status	Year 1 Metrics: 1a. Number of affordable housing models developed or established tailored to justice-involved individuals with mental health/SUD needs. Year 2 Metrics: 2a. Amount of funding provided to subsidize expansion of innovative affordable or shared housing models to serve this population. Year 3 Metrics: 3a. Complete (Y/N) evaluation of housing pilot models to further expand the program based results	Potential Impact: Provide justice involved individuals and people with MH and SUD needs with interim and permanent housing opportunities Unintended Consequences: Past criminal records makes it difficult for people to be eligible for housing supporter by federal rental subsidy. Including: sex crime, serious offenses, gang involvement, and arson conviction Interventions: Assess comparative outcomes of innovative affordable housing and more mainstream housing interventions for justice-involved individuals. Identify an alternative funding stream to provide an ongoing rental subsidy to

	subject of multiple rigorous evaluations and has received recognition both nationally and internationally for its effectiveness. Create housing for people who are unable to maintain sobriety with a fundamental understanding/agreement that all people deserve safe housing. (b) another potential pilot effective model is overdose prevention programs to connect individuals who are in the active state of using substances access health care and housing services <u>Year 2</u> 2a. Address identified issues on acceptance rates to PSH and housing available to justice involved people including but not limited to reducing restrictions on obtaining housing. 2b. Encourage LA City Council and the Board of Supervisors to consider changing or getting rid of the requirements that delay the constructions of housing projects 2c. Expand current PSH units/models to provide more beds and onsite services including behavioral health, medical, and substance use treatment. (1)Expand and develop contracts with service providers to expand outpatient services available to PSH,						ensure affordability for those individuals who do not qualify for a federal subsidy. Including: people with sex crime, serious offenses, gang involvement, and arson conviction Remove barriers for sober living spaces to include treatment options from a harm reduction perspective.

	transitional housing, sober livings and other identified housing options. Year 3 3a. The Board of Supervisors will continue to identify and secure additional, permanent funding from State and local budgets to expand and improve services. 3b. Create an oversight committee or executive board which includes service providers, community members, and justice involved individuals to monitor needs for housing and services. 3c. Evaluation of housing pilot models (ex: Model in Seattle) who are unable to maintain sobriety, as well as overdose prevention programs to share the findings for further program expansion based results						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
21. Create and scale up innovative programs that comprehensively provide housing, wraparound services, and career- track employment for justice-impacted	Year 1: 1a. Facilitate County discussions with agencies and providers about innovative/promising housing interventions for impacted	Lead Departments: CEO, DMH & DPH Key Partners: DHS, LAHSA, HCID, PHAs, ODR,	Existing Funding: Look at NCC, workforce development funding, Mental Health Services Act Funds, Drug Medical, and	State level: Advocate for a policy change to allow justice involved individuals access government grants to facilitate their	Employ cultural consultants to help connect justice involved individuals with services and/or advocate for the need to incorporate cultural	Year 1 Metrics: 1a. expansion of innovative affordable or shared housing models to serve this population Year 2 Metrics:	Potential Impact: Develop a comprehensive program/approach to provide housing,

individuals. Ensure the availability of programs that meet the needs of and are tailored to people who identify as cisgender women LGBQ+, and/or TGI. **Expand / Scale Program** **New Program**	individuals including LGBQ+/TGI. 1b. Conduct a gap analysis (a) Define mechanisms to support providers and increase their capacity to provide assistance to more individuals 1c. Develop and implement a process to ensure service providers are educated and trained on how to connect different types of populations to housing options that meet their needs 1d. Talk with returning citizens to identify housing types missing. 1e. Utilize WDACS' multiple career track opportunities to support justice-involved individuals, LGBQ+/TGI find stable employment and provide additional support to increase retention 1f. Educate, inform, and support individuals seeking to obtain a college degree 1g. Consider how to address additional barriers faced by elderly justice involved people who might not be able to hold a job for their income. <u>Year 2:</u> 2a. Require agencies and providers to be trained/scaled up to provide innovative housing. 2b. Facilitate culturally aware, trauma-informed, low barrier training for housing providers.	WDACS, SEP (providing Medication Assisted Treatment), staff overseeing Housing Initiatives and other agencies overseeing housing accessibility, ODR, Board of Supervisors, LAHS (Los Angeles Family Housing), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health) · BHS (Behavioral Health Services), ST Joseph's medical center, Harbor interfaith, Translatin@ coalition, Volunteers of America	leveraged with a variety of State, federal and County dollars. <u>Existing Staffing:</u> Evaluate existing staffing within lead departments and key partners <u>Additional Funding source to Expand:</u> Innovative housing programs that include wraparound services <u>Additional Staffing Needed to Expand:</u> Evidence based, non-coercive treatment services, career counselors and housing developments	enrollment in 4yr universities <u>Proposed change:</u> Subsidies/credits for shared housing innovation	understanding and sensitivity in the delivery of services Ensure services are culturally and linguistically appropriate and are available regardless of immigration status	2a. run an evaluation of the accessibility of the new programs to connect justice involved and LGBQ/TGI to housing, health care services, and employment 2b. Survey participants served through the programs to make improvements <u>Year 3 Metrics:</u> 3a. Evaluate the implementation of this recommendation to inform advocacy and changes to continue providing life enhancing services to these two groups.	services and career-track employment <u>Unintended Consequences:</u> Barriers are more pronounced for individuals with sex crime, serious offenses, gang involvement, and arson conviction As well as for people on parole and probation because they have a harder time finding employment due to current justice involvement. <u>Interventions</u> Increase housing, employment options to individuals with: sex offenses, serious offenses, gang involvement, arson conviction, people who are elderly, and people on parole/probation.

	Year 3: 3a. Scale up and deliver services for these two groups 3b. Convene to measure outcomes and make strategic adjustments						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
22. Develop partnerships with and between landlords, County departments, providers, and communities/neighborhoods that increase housing options and support residents in maintaining housing, including onsite management staff. Incentivize the creation and reservation of sufficient units for short - and long - term housing options for people who identify as LGBQ+ and/or TGI. **Policy / Practice Change**	Year 1: 1a. Convene City and County agencies that regularly work with landlords to discuss the development of new partnerships (1) discuss how different agencies interact with community organizations or neighborhood councils. (2) host meetings with key providers to inform them of changes and improvements 1b. Carry out gaps analysis for housing needs of LGBTQ+/TGI communities. 1c. organize partnerships for County housing providers working with private landlords, and facilitate learning groups to strengthen care coordination in these subsidized housing settings Year 2: 2a. Create and enact strategy to engage landlords and the community, specifically	Lead Departments: Homeless Initiative Key Partners: LAHSA, DMH, DHS, HCID, PHAs, ODR, other agencies overseeing housing accessibility, SEPs (providing Medication Assisted Treatment), staff overseeing Housing Initiatives and other agencies overseeing housing accessibility, ODR, Board of Supervisors, LAHS (Los Angeles Family Housing), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health) · BHS (Behavioral Health Services), ST Joseph's medical	Existing Funding: Measure H funding stream Existing Staffing: Unknown but evaluate the existing staff within lead departments and key partners Additional Funding source to Expand: Vouchers, partial payment options Additional Staffing Needed to Expand: Training to liaise with landlords, case management services, and other staff needed to sustain and regulate partnerships	County Practice Establish a network of landlords, providers, and communities/neighbor rhood, housing program experts and consultants in partnership with community members to increase housing options and support retention	Inform landlords of the determinants of homelessness affecting specific demographics and increasing mortality rates	Year 1 Metrics: 1a. Number of partnerships established, is this information being shared with providers, across departments? Year 2 Metrics: 2a. Track increases in housing placements in the communities most impacted by incarceration. Year 3 Metrics: 3a. Quantity of housing placements provided in the subsidized, private market and the share of them specifically serving LGBQ+/TGI.	Potential Impact: Establishment of new partnerships to increase housing accessibility for individuals including those who identify as LGBQ+/TGI Unintended Consequences: There is a great need for more landlords who are willing to lease to individuals with justice involvement, those who identify as LGBQ+/TGI, those without documentation, sex registry, elderly people, serious offenses, gang

	around citing supportive housing (long and short term) 2b. Ensure that this strategy includes consideration of barriers preventing landlords from leasing their property to individuals with these identities: sex registry, elderly people, serious offenses, gang involvement, or arson convictions. Specifically look to empower landlords of color within the most justice- impacted communities of LA and LA County. Year 3: 3a. Review progress and remaining relational barriers to additional housing to continue supporting the implementation of this recommendation	center, Harbor interfaith, Translatin@ coalition, Volunteers of America					involvement, or arson convictions. Interventions Opportunity to outreach and support landlords of color from communities/neighborhoods affected by gentrification, over-incarceration and strategic, racialized disinvestment to support residents with special identities
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
23. Work with Housing State Funding, DHS Housing Programs, and Housing projects for people experiencing homelessness and mental health and/or substance use disorders. **Practice / Policy Change**	Year 1: 1a. Host meetings with DHS, HCID, and other state Housing funding entities to discuss housing gaps in LA. 1b. Create a strategic advocacy plan to encourage new funding for those experiencing homelessness and mental health and/or substance use disorders. 1c. Develop and offer housing options for people who are in the active state of using substances and consider	Lead Departments: DMH, DPH, CEO, DHS Key Partners: LAHSA, HCID, ODR, SAPC, and its network of contractors, other agencies overseeing housing accessibility, SEPs (providing Medication Assisted Treatment), Board of Supervisors, LAHS	Existing Funding: Look at MHSA, DHS, DMH funding streams Existing Staffing: Evaluate existing staff within lead and key partners Additional Funding source to Expand: Housing programs and projects to serve unhoused individuals	State level Consider advocating for a comprehensive budget proposal or policy to increase funding to provide housing options and services onsite to those experiencing homelessness with bi and tri-morbidity	Based on the annual homeless count, compared the numbers of unhoused individuals with MH or SUD who have been placed on transitional/permanent housing based on demographics at the end of each year Build on existing education campaign highlighting the homeless issue in the	Year 1 Metrics: 1a. Number f housing options available for people in all stages of the SUD recovery process (pre- contemplation, contemplation, preparation, action, and/or maintenance) Year 2 Metrics: 2a. Evaluate the housing placement of	Potential Impact: Design strong housing programs to improve recovery Unintended Consequences: While DMH has worked to provide permanent housing for unhoused individuals and families with a mental illness, there needs to be an effort

	overdose prevention programs as support systems to ease the transition to housing that are culturally and linguistically appropriate and can meet the wide range of needs of the reentry population 1d. Continue to build up on the DPH model of the co-location of permanent housing with non-coercive treatment on site, as well as in the Full Service Partnership Programs (FSP) targeting the forensic population with psychiatric disabilities. <u>Year 2:</u> 2a. Begin advocacy at the state level for funding streams to run housing projects for unhoused individuals and those struggling with MH and SUD. 2b. consider eligibility requirements for some local resources to target populations with SUD and MH needs who are also justice involved (particularly when they are ineligible for federal subsidies). 2c. Convene community groups and service providers to envision how to develop a network of transitional housing program experts and consultants to create residential programs and facilities that	(Los Angeles Family Housing), PATH (People Assisting the Homeless), JWCH (John Wesley Community Health) · BHS (Behavioral Health Services), ST Joseph's medical center, Harbor interfaith, Volunteers of America	with MH and SUD Provision of onsite supportive services including case management and specialty mental health, SUD services in PSH <u>Additional Staffing Needed to Expand:</u> Outreach workers, administration, and other staff overseeing the housing programs, projects and supportive services		county and shade light on the demographics and even on the mortality rates based on race to change negative attitudes towards unhoused individuals Ensure services are culturally and linguistically appropriate and are available regardless of immigration status	individuals with these behavioral needs include: demographics, age, and enrollment in treatment. Share data to support and secure additional funding 2b.# of legislation, budget proposals proposed, signed to increase funding for housing opportunities <u>Year 3 Metrics:</u> 3a. Continue measuring increases in all types of subpopulation-specific housing inventory in LA	to reach the re-entry population, especially those with MH, SUD and/or COD needs People with sex registry, elderly people, serious offenses, gang involvement, or arson convictions are barred from accessing public housing. <u>Interventions:</u> Identify an alternative funding stream to provide an ongoing rental subsidy to ensure affordability for those individuals who do not qualify for a federal subsidy Find ways to ease the barriers to housing for people with , sex registry cases, elderly people, serious offenses, gang involvement, or arson convictions

	provides support to individuals/parents undergoing OUD/SUD, MH, COD recovery services and their children with the goal of placing them in permanent housing. 2d. This group should also consider how to educate providers on how to become City/County agency subcontractors to gain funding and serve these groups' needs. <u>Year 3:</u> 3a. Continue to support initiatives that could place individuals in MH, SUD treatment in permanent housing, such as overdose prevention programs.						

Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
25. Establish a partnership with the State	<u>Year 1</u>	<u>Lead Department:</u> LA County	<u>Existing Funding:</u>	<u>State level:</u>	Contracting county agencies and contracted	<u>Year 1 Metrics:</u>	<u>Potential Impact:</u> This

Department of Occupational Rehabilitation and coordinate with other agencies, including but not limited to WDACS, regarding economic and employment opportunities. Develop partnerships to create opportunities specifically for people who identify as LGBQ+, TGI and /or cisgender women by incentivizing employers to participate. **Policy / Practice Change Expand / Scale Program**	1a. The State DOR will identify those agencies both county and community operated that currently provide vocational rehabilitation and job placement. 1b. Convene leaders from state and county workforce development agencies and community-based organizations to collaborate on a plan to improve access to a range of employment services tailored to people with mental illness, including basic job readiness services, skills training, transitional subsidized employment opportunities, and supported employment or Individual Placement Support (IPS) services. 1c.Evaluate current best practices in these agencies and identify opportunities to expand and/or modify employment services in order to address the unique barriers to employment faced by people with mental illness and/or substance use disorders and justice involvement. 1d. Evaluate current best practices and identify opportunities to expand or tailor services to address specific employment barriers faced by cisgender women and	Department of Health Services, Office of Diversion and Reentry (ODR) <u>Key Partners:</u> LA County Workforce Development, Aging, and Community Services (WDACS), LA County Department of Mental Health (DMH), State Department of Occupational Rehabilitation (DOR), CA Employment Development Department (EDD)	State DOR funds, State WIOA funds. U.S. Department of Labor grants, U.S. Department of Justice grants, SAMHSA grants, County Mental Health Services Act funds, State Prop 47 program funds, State Realignment/AB 109 funds, Prop 64 grants <u>Existing Staffing:</u> Evaluate the staff capacity within lead departments and key partners <u>Funding source to Expand:</u> Continue to fund existing programs and additional funding will be needed for training and additional staff, possible expansion or addition of facilities. There may be existing facilities that can be leveraged to provide services from State DOR, LA County DMH, and	Pursue legislation to decrease these barriers wherever possible Potential legal or policy changes include: Removal of legal restrictions barring individuals with criminal records from accessing certain employment opportunities and occupational licensing. Creation/expansion of policies to protect individuals with mental illness, SUD, cisgender women, and people who identify as LGBQ+ or TGI from discrimination in the hiring process. Policies to require employers to ensure an inclusive workplace and accommodations as needed for people with mental illness, SUD, cisgender women, and people who identify as LGBQ+ or TGI.	employment service providers work together to develop a shared statement committing to creating a culture of racial equity Require county agencies to provide racial equity training to contracted service providers during onboarding process. County agencies establish baseline metrics for outcomes by race and include requirements to collect data and monitor process outcomes and impacts by race in service provider contracts (suggested metrics listed in 3-year metrics column). County agencies in collaboration with contracted service providers develop a process and forum for gathering feedback from impacted communities on the planning, implementation, and evaluation of employment services.	1a. Percent of participants referred to employment services who enroll in those services, estimated separately for MI, SUD, cisgender women, LGBQ+, and TGI subpopulations, as well as including race. 1b. Percent of participants who enroll in employment services that complete those services, estimated separately for MI, SUD, cisgender women, LGBQ+, and TGI subpopulations, as well as including race. 1c. Percent of participants obtaining competitive employment <u>Year 2 Metrics:</u> 2a. Percent of participants who retain employment for one year (or another time interval) after obtaining it 2b. Percent of participants who advance in their	recommendation focuses on increasing employment services for people with mental illness, SUD, cisgender women, and people who identify as LGBQ+ or TGI. <u>Unintended Consequences:</u> Because of its focus on these specific groups, it doesn't include a recommendation to develop/strengthen/expand employment services for a broader group of people impacted by the justice system. People who don't fall under the identified categories in the recommendation including: people on the sex registry, elderly people, serious offenses, gang involvement, or arson convictions have a much more difficult time

	people who identify as LGBQ+ or TGI. 1e.Develop standardized needs assessments to identify the individualized combination of job readiness, behavioral health, and supportive services needed for each participant. 1f. Develop a strategy to reduce stigma, ensure employers across sectors provide access to competitive job opportunities and offer an inclusive workplace for justice involved individuals and people with mental illness, substance use disorders, cisgender women, and people who identify as LGBQ+ / TGI. (1) This includes engaging employers, industry associations, and training providers on committing to increase representation of people with mental illness, substance use disorders, cisgender women, and people who identify as LGBA+ or TGI in high-growth sectors that offer career pathways and family sustaining wages, such as technology, construction, healthcare, social assistance, and others. <u>Year 2:</u> 2a. Develop and release competitive solicitations for		WIOA funded career centers. <u>Additional Staffing Needed to Expand:</u> Additional staffing and training to provide employment services tailored to these populations.	Policies to strengthen/expand CA's Fair Chance Act protecting people with criminal records from discrimination in the hiring process.	County agencies build an internal processes and mechanisms for agency and service provider staff to reflect, learn and make improvements to program design and implementation to advance racial equity. (Note: Consider policies being implemented by SAMHSA to expand Health Equity https://www.samhsa.gov/behavioral-health-equity)	employment and obtain wage increases 2c. Percent of participants receiving family sustaining wages <u>Year 3 Metrics:</u> 3a. Percent of participants obtaining, retaining, and advancing in their employment and wage increases by race (following metrics above) 3b. Complete (Y/N) evaluation to track how the programs have expanded in order to advocate for funding to sustain them and serve a much larger # of impacted populations	obtaining employment. <u>Interventions:</u> Utilized information learned through piloting services to make recommendations for expanding services for others impacted by the justice system. Incentivize the creation of employment services, housing and other services for people who don't fall under the identified categories in the recommendation including: people on the sex registry, elderly people, those with serious offenses, gang involvement, or arson convictions.

	community-based service providers to expand or pilot employment programs tailored to the needs of people with justice involvement, mental illness, SUD, cisgender women, and people who identify as LGBQ+ or TGI. 2b.Provide training to staff of contracted service providers and government agencies administering the programs on best practices to meet the job readiness needs of these populations. 2c.Monitor implementation and track program outcomes. (1)Gather feedback from participants and community members on service quality. <u>Year 3</u> 3a. Conduct a process and impact evaluation of these programs and make recommendations for program improvements, expansion, and sustainability.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
26. Expand supported employment opportunities for persons with mental health, substance use, or co-occurring disorders,	<u>Year1</u> 1a. Implement an IPS-Individualized Placement and Support program- https://ipsworks.org/index.php/	<u>Lead Departments:</u> CEO, DHR, DHS/ODR, DMH, DPH	<u>Existing Funding:</u> SAMHSA grant, County funds, and DPSS funding streams	<u>State level:</u> Possible changes to state legislation to allow for funding to	Contracting county agencies and contracted employment service providers work together	<u>Year 1 Metrics:</u> 1a. Percent of participants referred	<u>Potential Impact:</u> Facilitate employment services for individuals with mental health,

including flexible funds for basic client's needs to find employment (e.g., birth certificates, etc.). **Expand / Scale Program**	what-is-ips/ (Note: **IPS** Supported Employment is an evidence-based approach to support employment for people who have a mental illness that has been extensively researched and proven to be effective compared to standard employment services. The program needs to be fully funded and implemented as soon as possible in a designated high-need area to use as a comparison pilot to the Hollywood pilot in recommendation #23 1b. Identify opportunities to expand or build upon existing supported employment programs tailored to meet the needs of people with serious mental illnesses, SUD and those with justice involvement. 1c. Identify the range of necessary support required to find, secure and maintain employment/educational opportunities and the costs associated with providing these supports (e.g. transportation, cell phones, clothing, healthcare (including dental, mental care, housing assistance, legal services, childcare, family reunification services, support groups, and assistance with obtaining	Key Partners: LA County Workforce Development, Aging, and Community Services (WDACS), State Department of Occupational Rehabilitation (DOR) Drug Policy Alliance (DPA) CA Employment Development Department (EDD)	Existing Staffing: Initially use existing agencies staff and facilities to administer support Additional Funding source to Expand: Additional funds needed for participant needs, expansion of pilot programs Additional Staffing Needed to Expand: Employment training for people with MH, SUD, & COD	be used for participant needs Further explore and expand options to provide employees more workplace protections against voluntary and involuntary employer drug testing. Employees need to be protected against drug testing when employees are using medical marijuana and other treatment options such as MAT and buprenorphine for health care treatment or as part of their substance use treatment plan. AB 882 (McCarty) would prohibit an employer, regardless of the number of employees, from discharging an employee for testing positive for a drug that is being used as a medical-assisted treatment, under the care of a physician or licensed treatment program	to develop a shared statement committing to creating a culture of racial equity. County agencies provide racial equity training to contracted service providers during onboarding process. County agencies establish baseline metrics for outcomes by race and include requirements to collect data and monitor process outcomes and impacts by race in service provider contracts (suggested metrics listed in 3-year metrics column). County agencies in collaboration with contracted service providers develop a process and forum for gathering feedback from impacted communities on the planning, implementation, and evaluation of employment services. County agencies build an internal processes	services for basic client needs who enroll in those services, estimated separately for MI, SUD, and COD subpopulations, as well as including race. 1b. Percent of participants who enroll in services for basic client needs that complete those services, estimated separately for MI, SUD, and COD subpopulations, as well as including race. Year 2 Metrics: 2a. Percent of participants who retain employment for one year (or another time interval) after obtaining services for basic client needs 2b. Percent of participants who advance in their employment and obtain wage increases after obtaining services for basic client needs	substance use or co-occurring disorders Unintended Consequences Potentially leaving behind unhoused individuals who have not been connected to treatment services. Including: people on the sex registry, elderly people, serious offenses, gang involvement, or arson convictions have a much more difficult time obtaining employment. Interventions: In connecting unhoused individuals with treatment services and housing options, ensure that they are also provided with information on available employment services (e.g. training programs, college credits)

	documents and IDs consistent with gender identity). 1d. Provide community-based service navigation support to support employment program participants to assist them with accessing necessary supports and other public benefits to meet basic needs. Current reentry intensive case management services provided by DHS Whole Person Care and Office of Diversion and Reentry can be modeled and expanded for this purpose. 1e.Identify sources and secure funding to cover the cost of these necessary supports and service navigation for individuals to obtain and maintain employment. 1f.Create a plan for participants to stay connected to ongoing support and health services in their community (1).Evaluate need for expanded hours to provide maximum coverage. 1g. Ensure that employment opportunities are expanded to people who are in the active state of using substances. <u>Year 2</u> 2a. Evaluate progress and outcomes to modify support as the data dictates. <u>Year 3</u> 3a.The county will continue to support and allocate funds for the implementation of this recommendation.			<u>County Policy:</u> Allow staff who are not integrated members of the mental health to be part of the IPS implementation and have access to training and fidelity reviews to ensure adherence to the model and technical assistance for IPS teams	and mechanisms for agency and service provider staff to reflect, learn and make improvements to program design and implementation to advance racial equity. (Note: Consider policies being implemented by SAMHSA to expand Health Equity: https://www.samhsa.gov/behavioral-health-equity)	2c. Percent of participants receiving family sustaining wages after obtaining services for basic client needs <u>Year 3 Metrics:</u> 3a. Percent of participants linked to and receiving supportive services to meet basic client needs that are obtaining, retaining, and advancing in their employment and wage increases by race (following metrics above) 3b. Complete (Y/N) evaluation to track how the programs have expanded in order to advocate for funding to sustain them and serve a much larger # of impacted populations	Ensure individuals who have not been connected to treatment services. Including: people on the sex registry, elderly people, serious offenses, gang involvement, or arson convictions have a much more difficult time obtaining employment have access to these services and an outreach campaign is done to alert them of these services.

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28. Incubate new innovative employment programs for people with serious mental health disorders. **Expand / Scale Program** **New Program**	Year1 1a. Study successful supported employment programs in California as well as other states and countries that use an "Employment First" approach. Additionally, study employment programs that have been successful at preparing and connecting people facing barriers due to justice involvement to jobs as well as the results of promising programs currently in operation including: Innovation Coordinated Employment Strategy Program TRIESTE pilot program in Hollywood Pilot:(see " A ray of hope from abroad " https://enewspaper.latimes.com/infinity/latimes/default.aspx?pubid=50435180-e58e-48b5-	Lead Departments: DHS, DMH, & WDACA Key Partners: Office of Diversion and Reentry (ODR), LA County Workforce Development, Aging, and Community Services, State Department of Occupational Rehabilitation (DOR), CA Employment Development Department (EDD), SAMHSA	Existing Funding: consider utilizing, DMH resources, Mental Health Services Act (MHSA), DMC, Innovation funds, as well as Prop 64 grants, & SAMHSA grants Existing Staffing: Unknown Additional Funding source to Expand: existing programs based on outcomes and other employment services for people with serious mental health disorders Additional Staffing Needed to Expand: Build staff and facilities from the ground up	State level: Possible changes to legislation to allow for the flexible use of funds to fund employment programs and/or assign new funding sources for new pilot programs	Contracting county agencies and contracted employment service providers work together to develop a shared statement committing to creating a culture of racial equity. County agencies establish baseline metrics for outcomes by race and include requirements to collect data and monitor process outcomes and impacts by race in service provider contracts (suggested metrics listed in 3-year metrics column).	Year 1 Metrics : 1a. Percent of participants with MI referred to employment services who enroll in those services, estimated separately by race. 1b. Percent of participants with MI who enroll in employment services that complete those services, estimated separately by race. Year 2 Metrics : 2a. Percent of participants with MI who obtain	Potential Impact Expand employment services for individuals with serious mental health disorders Unintended Consequences Employment services not easily accessed by those treated through DPH for SUD. The recommendation leaves out people who may not have a behavioral health need, people with only justice involvement, and

	8e0c-236bf740270e&edid=e185a153-eaf3-4a2d-8557-95cecd05a44c) Review programs that have received SAMHSA grants (See:https://www.samhsa.gov/gainscenter/grant-grantees/transforming-lives-through-supportedemployment-program) 1b. Evaluate the outcomes of the above pilot program and advocate for expansion based on the results Year 2 2a. Develop and/or expand pilot programs based on a review of best practices for a recovery oriented employment and education service and employment/education services for people with justice involvement. 2b. Fund and run the pilot program with quarterly review of progress and outcomes. Year 3 3a. Determine feasibility of permanent program based on outcomes and funding requirements.		with new ideas, innovative approaches to truly support and expand employment opportunities		County agencies in collaboration with contracted service providers develop a process and forum for gathering feedback from impacted communities on the planning, implementation, and evaluation of employment services. County agencies build in internal processes and mechanisms for agency and service provider staff to reflect, learn and make improvements to program design and implementation to advance racial equity.	employment, within one year (or another time interval) of completing the program, estimated separately by race 2b. Percent of participants with MI who retain their job , within one year (or another time interval) of obtaining employment, estimated separately by race 2c. Percent of participants with MI who advance in their employment or their wage increases, estimated separately by race 2d. Percent of participants receiving family sustaining wages 3yr metrics: 3a. Percent of participants linked to and receiving supportive services to meet basic client needs	people with no justice involvement. Interventions Develop specific standards to make sure patients treated across departments get employed, enrolled in education, etc. Some of these initiatives could be funded by DMC Ensure innovative employment programs provide access to individuals who do not have behavioral health needs, including People with only justice involvement, People with no justice involvement, people on the sex registry, elderly people, serious offenses, gang involvement, or arson convictions.

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Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets	Expanded Scope
31. Remove barriers to treatment, employment, and affordable housing, including recovery housing based on stigmatization and discrimination due to record of past convictions through local and state legislative intervention or updating County policies. **Policy / Practice Change**	Year 1: 1a. Fund public education outreach on employment rights, so community members are informed of the unlawful employment practice under the Fair Employment and Housing Act (FEHA) for an employer to include on any application for employment any question that seeks the disclosure of an applicant's conviction history and educate community members on the automated record clearance system for qualifying low-level offenses. 1b. Expand on the Fair Chance Hiring Campaign aimed at informing the private sector of the new hiring consideration of individuals with lived experience and train and prepare new hires 1c. Evaluate existing barriers preventing justice involved individuals from accessing treatment and recovery housing opportunities and provide, implement steps to make these services more accessible while also ensuring the distribution of information to make individuals aware of available services Year 2: 2a. Implement education campaigns about the harmful effects of stigma and its	Lead Departments: CEO, DHR, DHS, DMH, DPH, DPSS, and other agencies overseeing housing and employment services Key Partners: Treatment providers, Harm Reduction service providers like SEP, Public Defender's office, ADP, Drug Policy Alliance (DPA), WDACS, ODR	Existing Funding: Incorporate funding streams through the county's annual year budget proposal Existing Staffing: Evaluate the staff capacity within lead departments and key partners Additional Funding source to Expand: Establish a series of grants at the county to encourage referrals and placements of justice involved individuals in transitional housing Develop a formerly Incarcerated Students Reentry Program grants to support programs serving formerly incarcerated students enrolled in community colleges (SB 575 Bradford) and four year universities Funding will be needed to expand the number of facilities to better serve populations in need of inpatient	Federal Level: H.R. 1329 (Tonko and Turner), would allow states to reestablish Medicaid coverage 30 days before an inmate is released At the federal and state level advocate for policy changes on the three-year criminal history look-back periods for Section 8 housing State Level: AB 1076 (Ting) was signed by the governor on 2019 and will mandate that the state Department of Justice automatically clear records of arrests that did not result in a conviction after the statute of limitations has passed. Most of the records eligible involve drugs or property crimes. Advocate for a state policy to ease the enrollment of justice involved individuals	Employ cultural consultants to help connect justice involved individuals with services and/or advocate for the need to incorporate cultural understanding and sensitivity in the delivery of services Ensure that services are culturally and linguistically appropriate Collect data on the barriers that exist with regards to race, ethnicity, and immigration status	Year 1 Metrics 1a. Number of employer & employee trainings to remove barriers and reduce stigmatization/discrimination Year 2 Metrics: 2a. Complete (Y/N) bi-annual reporting on the placement of folks with prior offenses in treatment, employment and housing, share these findings and identify next steps for actions necessary to sustain the implementation of this recommendation Year 3 Metrics: 3a. Number (2) of state legislative efforts signed to minimize barriers to services for this group	Potential Impact: Increase opportunities for individuals with prior offenses to access treatment, employment and recovery housing Unintended Consequences: Barriers are more pronounced for individuals with sex crime, serious offenses, gang involvement, and arson convictions Interventions Increase, employment, treatment, and housing options for individuals with sex crime, serious offenses, gang involvement, and arson convictions Allocate funding sources to develop diverse housing options Increase funding for workforce development, and recruitment efforts to secure employment

	adverse impact on the individuals who want to seek help for OUD/SUD in order to change negative attitudes towards justice involved individuals suffering from OUD/SUD 2b. Implement peer support services to include family and/or friends in the treatment and/or recovery process. <u>Year 3:</u> 3a.Establish a network of transitional housing program experts and consultants in partnership with community members to develop a task force to better understand the barriers, needs of justice involved individuals 3b. Develop a county strategy to implement and support existing transitional housing programs for justice involved individuals in need of employment and treatment services.		treatment for those who are justice involved <u>Additional Staffing Needed to Expand:</u> Referrals, employment, treatment services, and peer support networks	in MH & SUD treatment <u>AB 53 (Jones- Sawyer)</u> This bill would extend Ban the Box protections in the application process for rental property where landlords cannot ask about conviction histories in the initial application process. Further explore and expand options to provide employees more workplace protections against voluntary and involuntary employer drug testing. Employees need to be protected against drug testing when employees are using medical marijuana and other treatment options such as MAT and buprenorphine for health care treatment or as part of their substance use treatment plan. AB 882 (McCarty) would prohibit an employer, regardless of the number of employees, from discharging an			options for individuals with sex crime, serious offenses, gang involvement, and arson convictions

				employee for testing positive for a drug that is being used as a medical-assisted treatment, under the care of a physician or licensed treatment program At the county level, allow for individuals with COD or enrolled in outpatient treatment to be provided with housing options Ensure county agencies, such as DPSS and the Public Defenders offices work together to clear records in a much more comprehensive way			

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Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
35: *Significantly increase the number of DMH Psychiatric Mobile Response Teams (PMRTs) to reduce service wait times.* **Expand or Scale Program**	Year 1: 1a. Determine the number and capacity of current mobile response teams as well as the areas which they serve and their volume and response times throughout the day. 1b. Using data, determine the number of additional PMRTs needed to improve response times; the areas in which services should be expanded, and how response times can be improved. 1c. Consider expansion of other response/intervention measures	Lead: DMH Partners: DHS, DPH, CEO, County Counsel, ISD, community partners Deputy Director and MHCPM, III with oversight over PMRT	DMH recommends enhanced staffing of 70 additional positions ($9,000,000 less revenue offset). This will increase staffing to 18-20 hours per day. Continue to monitor over time particularly if changes in 911 policies result in an increase in calls being routed to DMH.	Incentivize working after hours shifts. Sponsor/support state measures that support development of educational/profession pipelines for behavioral health crisis workers.	Factor in which areas are most impacted by carceral responses to behavioral health crises when determining areas in which services should be expanded. Determine if there are differences in response times to neighborhoods that may lead to racial inequities. Monitor response times by neighborhood, outcomes of clients by	Completion of a list of data needed, including call volume by neighborhood; type of response/outcome of call. Percent of calls responded to in___timeframe (based upon baseline information). Percent of calls that ended in hospitalization. Percent of calls that ended in incarceration.	Potential Impact: Individuals experiencing a mental health crisis, their families, non-profit partners, and county departments. Unintended Consequence: TAY comprise a high proportion of the incarcerated population. Those with a history of juvenile justice or child welfare involvement have specialized needs and

	and efficacy and efficiencies of each with an eye to development of an overall plan to provide necessary services in a timely manner. 1d. Consider coordination with other County services – medical, SUD, etc. <u>Year 2</u>**:** 2.a. Develop plan for expansion of PMRTs including priorities, identification of staffing, , need for additional hires, resource and budget needs; improvement of response times; response time goals; and metrics for measuring success. 2.b. Obtain budget approval, begin to implement expansion plan (hire staff; contract for responses, etc.). <u>Year 3</u>**:** 3a. Provide training and put in place new PMRT teams in place. 3b. Put in place expanded and/or new contracts with community organizations for additional acute, sub-acute and forensic in-patient beds.				race to ensure racial inequities are addressed at the earliest possible time. Provide RE & cultural humility training to all staff with ongoing boosters.	Percent of calls that resulted in law enforcement response (before, during, or after PMRT dispatch). Percent of calls that resulted in connections to PMRT services.	benefit from different engagement strategies Connection to additional crisis response teams that can support specific communities with mental health needs like HOME, etc. can be explored <u>Interventions:</u> Develop specialized teams that work with TAY and/or individuals with a history of juvenile justice involvement have specialized needs and benefit from different crisis intervention strategies. Determine whether additional specialized homeless teams can service individuals in crisis and the geographic areas they serve.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
36. Increase DMH ambulance contracts to	<u>Year 1</u>: 1a. Determine the number and capacity of current DMH ambulance contracts as well as	<u>Lead:</u> DMH/DHS/DPH <u>Partners:</u>	DMH recently amended the contracts to increase the rates that has since drastically improved the		Assess neighborhood differences in ambulance services/response time		<u>Potential Impact:</u> Individuals experiencing a behavioral and/or

improve PMRT response times. **Practice Change**	the areas which they serve, response times throughout the day, volume, and the services provided/how ambulances are used. Identify factors affecting response times. 1b. Using data, determine what is needed to improve response times and services in all service areas, identifying those areas with most pressing needs, the number of additional contracts needed and the capacity of current providers, given appropriate funding levels. 1c. Using data, determine what alternate methods of suitable transportation, if any, may be available to more efficiently and effectively provide needed services in a timely manner. Consider coordination with other County departments utilizing ambulance services. <u>Year 2:</u> 2.a. Develop plan to improve ambulance response times, including adding additional contracts or increasing capacity as appropriate. 2b. Identify target response times, performance metrics, and coordination with crisis intervention/911/ACCESS Line calls. 2c. Develop budgets and begin bidding process.	CEO, County Counsel, ISD, community partners Deputy Director responsible for Outreach and Triage, MHCPM, III responsible for the Access call center.	ambulance response times. Continue to monitor over time particularly if changes in 911 policies result in an increase in calls being routed to DMH.		that may map onto racial inequities. When identifying alternate methods of suitable transportation, ensure quality of service is not disparate based on neighborhood or race. Make sure expansion or capacity building addresses any racial inequities that existed in response times and services.		physical health crisis, their families, non-profit partners, and county departments. <u>Unintended Consequence:</u> Specialized ambulatory care could support the community based system of care. DMH is in the process of developing specialized ambulatory care that supports people with mental health needs. The model is not specifically geared towards supporting individuals with substance use needs. Mobile Intensive Care Nurses (MICN) frequently work with ambulatory care services to provide specialized approaches to respond to a physical and/or mental health crisis. This collaboration can be leveraged when seeking to increase ambulance contracts. <u>Interventions:</u> Determine if specialized ambulatory

	2d. Monitor improvement in wait times and adjust contracts accordingly <u>Year 3:</u> 3a. Complete bidding process and execute contracts. Begin implementation of plan.						care services for people with behavioral health needs (mental health, SUD, and COD) can be effectively added to this recommendation. Assess whether MICN effectively de-escalates crisis and stabilizes individuals before hospitalization to determine if that workforce should be increased to collaborate with the increased ambulatory care services.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
37. Create another option for behavioral health crises, i.e., CBO behavioral health services through an app. **New Program**	<u>Year 1:</u> 1a. Identify means by which behavioral health services are delivered to those in need and how patients are connected with such services. 1b. Identify existing search engines, call lines, apps, referral services, and community-based response teams existing in the community. 1c. Study how other jurisdictions connect patients with services, particularly through use of technology, and how other	<u>Lead</u>: DMH/DPH/CBO <u>Partners</u>: DHS, DPH, CEO, CIO, County Counsel, ISD; other County Departments; community partners	Consultant or IT expert Countywide CIO Staffing for plan once developed. Grants to CBOs to provide community-based behavioral health crisis response.	Review county policies to identify necessary changes. Sponsor/support state legislative and budget measures that fund, study, or otherwise incentivize pilot programs for community-based behavioral health crisis response programs.	Incorporate plan to ensure accessibility and readability of app or other means of referral. Focused investment in community-based behavioral health services and community-based crisis responses in communities and neighborhoods most impacted by carceral responses to behavioral health need.	Percent of clients linked to community-based services. Percent of providers who are satisfied with behavioral health services app, as indicated by survey administered under Key Actions.	<u>Potential Impact:</u> Individuals experiencing a behavioral health crisis, their families, non-profit partners, and county departments. <u>Unintended Consequence:</u> TAY comprise a high proportion of the incarcerated population. Those with a history of juvenile justice or child welfare

	1d. Consider hiring consultant and developing a plan that connects patients with other county services, such as medical, SUD, etc. 1e. Identify the services, including County providers and CBOs, to which patients are to be referred/linked. <u>Year 2:</u> 2a. Develop plan to connect patients with services via technology and other means. 2b. Evaluate impact of various options. <u>Year 3:</u> 3a. Begin to implement plan. 3b. Deploy survey of providers to determine level of satisfaction with behavioral health services app.						engagement strategies Creation of behavioral health service system through an app is connected to the development of internal and external databases that is also situated inside of the infrastructure section of the ATI recommendations. <u>Interventions:</u> Develop specialized databases that TAY and/or individuals with a history of juvenile justice involvement have access to. Connect behavioral health service system app with external database recommendations within the Infrastructure section of the report.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**

38. Expand, diversify, and strengthen non- crisis mobile response teams to address gaps, including: (a) following through with clients in (imminent) crisis to avert involuntary hospitalization; (b) involving peers in mobile response teams that connect to individuals' gender identity; (c) developing system for outreach workers to respond to non-law enforcement calls; (d) assisting people who identify as TGI, LGBQ+ and/or cisgender women who are in an emerging crisis and/or need community-based conflict resolution. **New Program** **Expand and/or Scale Program**	Year 1: 1a. Using data, identify gaps in services and analyze how non-crisis reasons teams can be strengthened and diversified. 1b. Study programs in other jurisdictions and identify best practices, including those utilizing peer and outreach workers. 1c. Identify and expand on those County programs that are most effective. 1d. Identify how technology can be used to improve services (including response, follow up, etc.). 1e. Identify community-based programs that provide peer and outreach workers for responses/calls and the capacity of each to expand. 1f. Identify practices that lead to increased law enforcement contact and/or incarceration with an eye towards eliminating them. 1g. Review existing policies with an eye to diversifying and strengthening non-crisis response teams and following up on clients. 1h. Identify possible data sharing opportunities to improve services to clients.	Lead: DMH/DMH/CBOs Partners: DHS, DPH, CEO, County Counsel, ISD, LAHSA, community partners Manager of the DMH ACCESS line	Staffing plan to be developed after evaluation of other options	Review County policies to identify any necessary changes Create protocols on how to effectively coordinate various response levels Sponsor/support state legislative and budget measures that fund, study, or otherwise incentivize pilot programs for CBO behavioral health response programs	CBO partnerships reflect the diversity of populations served. Collect data on client outcomes by race to assess any inequities. Ensure expansion addresses inequities that exist. Monitor client outcomes by race to ensure new inequities are not created.	Percent of clients successfully linked to follow-up services Percent of responses that ended in hospitalization Percent of responses that ended in incarceration Percent of responses connected to non-crisis mobile services by____% Percent of responses that resulted in law enforcement response (before, during, or after non-crisis mobile team response)	Potential Impact: Individuals experiencing a non-crisis behavioral health need, their families, non-profit partners, and county departments. Unintended Consequence: TAY comprise a high proportion of the incarcerated population. Those with a history of juvenile justice or child welfare involvement have specialized needs and benefit from different engagement strategies Connection to additional non-crisis response teams that can support specific communities with mental health needs like LAHSA HET, etc. can be explored Interventions: Develop specialized teams that work with TAY and/or individuals with a history of juvenile justice involvement have specialized needs and benefit from

	Year 2: 2a. Develop plan to expand, diversify and strengthen mobile response teams. 2b. Develop plan to maximize use of technology to improve patient services, including follow- up services and linkage to CBOs. 2c. Develop partnerships with CBOs who provide peer and outreach workers. Identify appropriate vehicles (contracts) for the provision of such service. 2d. Provide training and technical assistance to CBOs who wish to participate in providing peer and outreach services. 2e. Change and add policies as appropriate. 2f. Develop plan to improve coordination and communication between County departments serving health, mental health, SUD, and other needs of patients, through cooperation and data sharing. Year 3: 3a. Begin to implement plans. 3b. Train 911, 211, ACCESS and other employees providing non-crisis intervention services and develop protocol for dispatch and referral to those services, as well						different crisis intervention strategies. Determine whether additional specialized homeless teams can service individuals with non-crisis behavioral health needs and which geographic areas they serve.

	as audit/accountability plan for ensuring appropriate dispatch/referral.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
39. Invest in public education and law enforcement education campaigns to encourage the use of DMH ACCESS, SASH, suicide prevention and other helplines, and the CBO Network on homelessness, mental health, substance use and stigma. **New Program**	Year 1: 1a. Develop education and awareness goals and hire a marketing consultant to develop education and public awareness campaign and assist in identification of goals. 1b. Determine what law enforcement training exists in the County, including CIT training and training by local law enforcement agencies. Identify local agencies to be trained. 1c. Consult with community partners to determine present community understanding of and experience with these call lines and to collaboratively, align understandings of the call lines, and develop education and public awareness campaign. Year 2: 2a. Develop education and public awareness campaign based on consultant's and community partners' recommendations and budget for same. 2b. Developing training module to ensure that law enforcement is educated on the use of various	Lead: DMH/DPH Partners: LASD; local law enforcement; DHS; LAHSA; CEO, County Counsel; community partners, Peer Support networks.	Communications consultant to identify the best methods to reach the maximum number of people. Grants to CBOs to conduct community outreach and public education.		Targeted and tailored investment on public education about call lines and CBO network in communities and neighborhoods most impacted by carceral responses to behavioral health needs.	Percent of calls that ended in hospitalization. Percent of calls that ended in incarceration. Percent of calls that resulted in law enforcement response. Percent of calls through DMH ACCESS, Substance Abuse Helpline, and other call lines that lead to connections to services.	Potential Impact: Individuals experiencing behavioral health needs, their families, non-profit partners, and county departments. Unintended Consequence: TAY comprise a high proportion of the incarcerated population. Those with a history of juvenile justice or child welfare involvement have specialized needs and benefit from different engagement strategies. Public education marketing is connected to the communications recommendations within infrastructure and CIT training has a recommendation contained in Intercept 2. Interventions:

	helplines and community resources available. 2c. Consider developing computerized directory of responses to be used by law enforcement, which would be kept as current as possible. Consider developing partnerships between law enforcement and CBOs. <u>Year 3:</u> 3a. Implement education and awareness campaign. 3b. Implement law enforcement training.						Develop specialized communication plans that target TAY and/or individuals with a history of juvenile justice involvement have specialized needs and benefit from different crisis intervention strategies. Ensure public education marketing and consultant hiring connects to the infrastructure section of the ATI plan. Ensure that CIT training identification is guided by the implementation plan in intercept 2 pertaining to this issue.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
40. Establish, expand, enhance, and coordinate the database and tools available for real -time bed availability for all justice and health system partners. for all justice and health system partners. **Expand/Scale Program** **New Program**	<u>Year 1:</u> 1a. Map the current number of crisis beds by time of bed, provider, location, license, and capacity. (Define "crisis bed.") 1b. Using data, determine the number of additional beds needed by area, license and type	<u>Lead</u>: DMH/DPH/DHS <u>Partners</u>: County Counsel, LASD; LAHSA, CEO, DA, PD, ODR; community partners, various cities (to assist in locating beds) and state licensing agencies.	Database/IT consultant on data system to capture information from all departments. Funding for additional resources to meet identified needs.	Community care licensing requirements Flexible use of beds to meet demands Consider exploring expedited licenses/zoning/environmental approval	Collect data by race and neighborhood on individuals able to access crisis beds expediently according to individual circumstances, and those not able to. Monitor improvements in crisis bed access by race and neighborhood.	Average wait time for higher levels of care. Percent of clients effectively linked to the appropriate level of care. Percent of crises that end in hospitalization.	<u>Potential Impact:</u> Individuals experiencing behavioral health needs, their families, non-profit partners, and county departments. <u>Unintended Consequence:</u>

	(identifying which areas and types are most needed).[1] 1c. Assess the capacity of current providers to add more beds, given appropriate funding levels. 1d. Coordinate with other County Departments to begin developing a real-time bed availability database for mental health, medical, and SUD beds, including identifying the who/how the database will be created/updated, specifications to ensure uniformity; and means by which CBOs will provide data, etc. 1e. Develop budgets; resources needed to support expansion of beds and to create database. <u>Year 2:</u> 2.a. Develop plan to increase the number of crisis beds by location, license and type of bed.	DMH Countywide resource management		mechanisms via state/local law.	If outcomes differ by race or neighborhood, create a feedback loop to stakeholders.	Percent of crises that end in incarceration.	TAY comprise a high proportion of the incarcerated population. Those with a history of juvenile justice or child welfare involvement have specialized needs and benefit from different engagement strategies. "Crisis beds" are yet to be defined and it is unclear if it will incorporate people with mental health, substance use, and co-occurring disorder. <u>Interventions:</u> Develop specialized crisis beds that target TAY and/or individuals with a history of juvenile justice involvement

[1] DMH October 2019 Report on Residential Services: Crisis Now, a coalition led by the National Association of State Mental Health Program Directors (NASMHPD), has put forward a model of pre-hospital crisis care that has proven successful in several jurisdictions including Arizona. If their model were applied to LA County, they estimate that we would need roughly **486 behavioral health urgent care center beds/chairs, 413 short-term crisis beds (e.g. crisis residential treatment), and 75 mobile crisis response teams (assuming 4 clients served per team per day)** along with robust services to coordinate and support them (including call centers). If these were in place and fully supported, they estimate we would need only 1,307 mental health hospital beds in total across the county to provide acute psychiatric care6 .

Of course, this model is a formulaic estimate. Many aspects of our county and system of care are uniquely challenging, including differences in client populations, disparities and inequities, geography, and so on. It is likely that our county's true needs differ from the estimates in this model; they could be lower, or they may be even higher. Nevertheless, models like this are important because they are useful, even if they may not be exactly "right". They highlight potential gaps in our system of care, and even more importantly they show us a different paradigm of how the system could work.

At a minimum, models like this, especially when our system differs, should prompt us to examine how well we are meeting the needs of our clients for these types of services. In contrast to what the Crisis Now model suggests we need, **our current pre-hospital services network has only 132 urgent care beds, 81 crisis residential beds, and 45 mobile crisis response teams (not including law enforcement co-response teams)**, although there are many more of these types of beds currently in development. We have closer to 2,400 mental health hospital beds. **We also have 69 psychiatric emergency beds across 3 facilities operated by the LA County Department of Health Services (DHS), though they often must operate at a capacity much above this.** But these beds are needed to triage the crisis cases that are most likely to merit hospitalization. Due to lack of availability of both prehospital crisis services and acute hospital beds, the DHS psychiatric emergency rooms are almost always overcrowded, making it extraordinarily difficult to meet the needs of the most acute clients in crisis.

	2b. Review and revise contracts with CBO to include reporting requirements, ability to interface with database, and performance standards. 2c. Provide training and technical assistance to CBOS to increase their capacity and to contract with the County. 2d. Continue to develop and plan and begin building a real-time bed availability data base. <u>Year 3:</u> 3a. Put in place expanded and or new contracts with CBOs for additional crises beds. 3b. Continue to build and implement a real-time bed availability data base.						have specialized needs and benefit from different crisis intervention strategies. Ensure that "crisis beds" definition and the increase of these resources support individuals with a broad range of behavioral health disorders and other specialized needs.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
41. Develop and expand a decentralized range of clinical spaces countywide and ensure that current sites are sufficiently resourced. **Existing and new** **Expand/scale program**	<u>Year 1:</u> 1a. Map existing clinical spaces by location, type, license, community served, and capacity. 1b. Study needs and gaps in various communities and develop a plan to expand services/location to fill those gaps. Determine whether services will be provided by County employees, CBOs, or combination.	<u>Lead:</u> DMH/DPH.CBOs <u>Partners:</u> DPH, DHS, CEO, County Counsel, ISD, ODR, LAHSA, other County departments, community providers, local jurisdictions.	Develop additional clinical space in more welcoming environments. Develop staffing and hiring plans for the additional clinical programs.	Address NIMBY issues (including by lowering zoning and related barriers) in siting new clinical spaces. MOUs to provide integrated treatment sites.	Collect information on neighborhood/service area when considering site expansion. Evaluate information on clinical space type with area demographics to assess and ensure racial equity with expansion.	Number of clinical spaces where clients can seek out treatment.	<u>Potential Impact:</u> Develop an integrated and collaborative system of care for all people impacted by the social determinants of health and incarceration.

	1c. Study other jurisdictions/programs to determine most efficient/effective way to provide services and develop best standards. 1d. Consider setting standards to make clinical spaces welcoming so that patients want to utilize them. 1e. Consider offering mental health, medical and SUD services at same locations and offering other County services (such as DPSS) and other services (employment, daycare, training, etc.) at locations or nearby. 1f. Integrating access lines, PMRT etc. with services for seamless transition of care. 1g. Provide training and technical assistance to CBOs. 1h. Identify ability of CBOs to offer services in other service areas. Work with and support CBOs who are willing to expand into other service areas. <u>Year 2:</u> 2a. Continue above; develop budget, resource needs, contracting mechanisms, and CBO relationships, etc. necessary to support implementation of plan.						<u>Unintended Consequences:</u> If policies do not change; People with justice involvement, serious offenses, arson cases, immigration status, or people who are not insured will continue to be denied access to community based services in the decentralized range of clinical spaces developed. Elderly people on parole could potentially be left out considering they are being released from the state prisons. They will need services and might have serious offenses which is a barrier to accessing LA County services. <u>Interventions:</u> Remove policies that prevent people with justice involvement, serious offenses, arson cases, immigration status, or people who are not insured from accessing services,

	2b. Work with local jurisdictions and communities to house clinic spaces. <u>Year 3:</u> 3a. Implement plan.						housing, and resources. Allocate funding specifically for patients who are unhoused, have serious offenses, arson cases, elderly people on parole, non citizens who might not be enrolled in a health insurance or program to cover medical expenses. Support of flexible funding recommendation 21 to support additional needs for clients and providers. Coverage for behavioral health and medical health needs for people who do not have insurance and supplemental funding for people who do have insurance that does not cover the full scope of needed treatment. Miscellaneous client and provider needs including but not limited to: housing, clothing, food,

							transportation, education and training
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
42. Improve staffing of DMH ACCESS line to minimize caller wait times and ensure live operator coverage 24 hours, 7 days a week. **Expand/Scale Program**	Year 1: 1a. Review existing staffing, volume, patterns and types of calls, staff training and protocol, and other policies to determine what can be done to minimize wait times, ensure timely connection to appropriate services (including handoff to PMRT and other responders), streamline process, and ensure live coverage 24/7. 1b. Evaluate and study technology, training, and protocol used by other call centers and identify best practices. 1c. Working with partners, gather caller experiences and input on DMH ACCESS line and recommendations for changes. 1d. Develop staffing plan, identify necessary resources/supports, and make changes utilizing technology and any necessary policy, training, or protocol revisions. Identify performance metrics and develop audit/accountability plan. Year 2: 2a. Prepare budget and obtain approval to proceed.	Lead: DMH Partners: DHS, DPH, CEO, County Counsel, ISD. other County Departments, community partners	Consultant to advise on call centers and best practices. Consultant to assist with gathering caller experiences and input (e.g. survey design, outreach plan). Develop a staffing pattern for increased staffing, including classification of staff answering calls.	Provide incentives for working after hours.	Collect data on calls by neighborhood, and race if possible. If underutilization is identified by neighborhood and/or race, then take responsive actions. ACCESS line staffing plan should reflect diversity in population of clients served. RE and cultural humility training for all staff.	Average wait time for calls to the Access line. Average time for callers to be connected to services. Percent of clients linked to appropriate services. Percent of calls that result in referral to law enforcement. Percent of calls that result in referral to 911.	Potential Impact: Individuals experiencing a behavioral health crisis, their families, and county departments. Unintended Consequence: There is no mention of improving access to the system by expanding staff that speak a variety of languages so that all Los Angeles community members can utilize the service more efficiently. Interventions: Incorporate the evaluation of language needs across communities that are utilizing the service and accommodate this need by hiring the appropriate staff to provide culturally humble services.

	Year 3: 3a. Implement plan.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity Commitment/Process**	**3-Year Metrics & Targets**	**Expanded Scope**
43. Train 911 operators and dispatch on mental health screening to direct calls involving behavioral health crises that do not require a law enforcement response towards DMH's ACCESS line (e.g., integrate DMH line with 911 or allow direct access from 911 operators to ACCESS). Train 911 operators and dispatch to allow callers to request a responder that connects to the gender identity of the individual in crisis. **New Program**	Year 1: 1a. Identify and evaluate current practices and policies as well as technologies and interface. 1b. Working with 911 partners and community partners, identify areas in which training is required, situations faced by 911 operators, and questions they have. 1c. Identify standards and establish uniform criteria and protocol for determining when EMS, DMH, or law enforcement response should be dispatched. Identify standards and establish uniform criteria and protocol for identifying behavioral health crises. Year 2: 2a. Develop training plan, priorities, and supporting budget/resources. 2b. Develop audit/accountability plan. Year 3: 3a. Implement plan.	Lead: DHS/EMS, DMH, Primary partners would also include County and municipal fire departments and law enforcement agencies. Partners: Cities; law enforcement; DPH, ISD, CEO, County Counsel; County Emergency Medical Services Commission; POST, community partners.	Enhance staffing to ACCESS in order to accommodate an increased call volume. Possible acquisition of technology if needed to streamline dispatch of DMH responders.	Evaluate, review and update policies and procedures related to routing of 911 calls. Support development of statewide standards for dispatcher training on identification and referral of behavioral health crises. Sponsor/support state legislative and regulatory measures that provide for integrating behavioral health crisis response into 911/emergency dispatch. [*See* 11 Cal. Code of Regs. § 1018 and *See* Los Angeles County Emergency Medical Services Commission, Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies, Final Report (Sept. 2016); Los Angeles County Emergency Medical Services Commission,	Collect data on calls by neighborhood, and race if possible. If underutilization and/or differential responses times are identified, then take responsive actions. ACCESS line staffing plan should reflect diversity in population of clients served. Racial equity and cultural humility training for all staff.	Percent of calls that end in hospitalization. Percent of calls that end in incarceration. Percent of calls that result in law enforcement response. Percent of calls routed to DMH or EMS.	Potential Impact: Individuals experiencing a behavioral health crisis, their families, and county departments. Unintended Consequence: There is no mention of improving access to the system by expanding staff that speak a variety of languages so that all Los Angeles community members can utilize the service more efficiently. Interventions: Incorporate the evaluation of language needs across communities that are utilizing the service and accommodate this need by hiring the appropriate staff to provide culturally humble services.

				Los Angeles County's 9-1-1 Dispatch and Field Response to Mental Health and Substance Abuse Emergencies Survey (Jan. 17, 2019).]			

Alternatives to Incarceration Work Group
Intercept 2 Preliminary Implementation Plans

Goals & Objectives	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets
45. Substantially increase the number of co-response teams. **Expand/Scale Program**	Year 1: 1a. Form a workgroup comprised of LASD, DMH, DHS (including ODR), and DPH to do the following: • Confirm the number of co-response teams (baseline)currently serving the area served by LASD (DMH/LASD currently report 33 MET teams) • Collect data to identify the number of calls (and individuals) serviced by co-response teams, the time and location of the call, the time spent on the calls, the disposition of the call and the unfulfilled need for MET services, the number of individuals who avoided incarceration as a result of co-response team efforts as well as any other pertinent information. • Analyze the data collected to identify target response times, areas and hours in which additional co-response teams are needed; possible efficiencies; appropriate staffing and team composition (such as including peer counselors); whether certain calls may be more appropriately serviced by other types of teams; and other pertinent data. • Using the above data (and considering the COC recommendation) continue the expansion of MET teams, identifying the number of additional MET teams needed; where and when they are needed; their composition/staffing; whether some	Lead: LASD, LAPD, DMH, police agencies within Los Angeles Counties Partners: DHS (including ODR), DPH, Community based organizations	Existing Funding Source(s): Office of Diversion & Re-Entry, AB109 and LASD funded. Cities fund own MET/SMART teams. DMH and MHSA funds for clinicians. Existing Staffing: 33 Regional MET teams today. LAPD fields 17 teams per day. Small cities vary Additional Funding Source(s) to Expand: Office of Diversion & Re-Entry, AB109 for LASD MET MHSA funds for clinicians. Cities fund own MET/SMART teams. Additional Staffing Needed to Expand: Need teams for MET (LASD). Refer to Civilian Oversight	Some changes may need to be made to municipal codes, etc. to allow LASD to provide services to municipalities. Changes may be needed to the County Code depending on how municipalities are to compensate the County for additional MET services.	Commitment from County leadership on racial equity to be reflected in policies and procedures; hiring publications and practices; staff training (to include implicit bias training); leadership participation in town hall and community meetings with representatives of community groups and other community outreach; evaluations of employee performance; etc. Development of client satisfaction surveys with management taking appropriate action to address community concerns relating to racial equity and to address any unintended consequences. Development of baseline numbers tracking pertinent information identified in metrics section by race for each individual co-	Year 1 Metrics: Work group formed. Analysis conducted. Plan developed. Baseline established: # of co-response teams, # individuals served, % of individuals connected to services. Goal established: # of expanded co-response teams, # of additional individuals served, % of individuals connected to services. *Quarterly: Compare baseline and progress toward goal including:* i. Increase in number of co-response teams. ii. Increase in number of individuals served by co-response teams. iii. Increase/decrease in wait times iv. # of individuals connected to services or arrested. v. Review for racial equity

	calls should be handled by other types of teams including how such calls could be channeled to the other teams and possible efficiencies. Teams should be equitably distributed throughout the County. • Using above data, develop a plan to expand MET Teams and to fully integrate the teams with CBSOCs to connect clients to ongoing services, including policies and procedures, performance metrics, etc. 1b. Identify associated funding, staffing, and overhead requirements and necessary bid and procurement requirements. Prepare a hiring plan incorporating principals of racial equity. 1c. Review policies and practices of the co-response teams to address negative impact created inadvertently by current practices or unintended consequences of current and future practices [mental health responders wearing visible bullet proof vests] <u>Year 2:</u> 1a. With respect to areas served by LASD: • Begin implementation of plan by beginning procurement and hiring processes; begin expansion into areas of most need; continue to develop relationships with CBSOC who may receive clients from co-response teams. 1b. With respect to service areas served by other law enforcement entities:		Commission and CY 2018 MET Report for detailed recommendations. Suggest 16 LASD+DMH personnel if the County wants to provide MET units and intake booking diversion for small police departments (MET units to fill the gaps in coverage in cities that cannot afford 24x7)		responder (to include client comments by individual co-responder) to include additional training or adjustments as necessary to achieve goals of racial equity. Establishment of racial equity goal metrics and/or targets and a mechanism to evaluate and improve racial disparities.	issues/unintended consequences. Identified local law enforcement agencies using MET services. Identified local law enforcement agencies not using MET services. Approached local law enforcement agencies re expanding use of MET services or starting use of MET. Local law enforcement Metrics developed to measure progress. **This plan does not preclude the Sheriff's Department from moving forward with recommendations to grow MET teams based on previous studies and recommendations from the COC.*

	• Determine how law enforcement in other jurisdictions responds to behavioral health crises within their jurisdictions. • Identify ways in which LASD could augment existing co-response network to meet the needs of areas served by other law enforcement agencies and further the goals of ATI. • Explore with other jurisdictions the possibility of offering MET services to augment their existing co-response networks or provide co-response services in those jurisdiction that currently do not have an existing system. The County should emphasize the benefits of its MET services and the furthering of ATI goals. Note: 39 other jurisdictions have their own co-response teams and, currently, LASD MET teams may respond in those jurisdictions if requested to do so by local jurisdiction as part of mutual aid. Some of these jurisdictions only provide coverage during limited hours.) • Determine the number of additional MET teams that would be needed to fulfil the goals of ATI in non-LASD jurisdictions. (LASD estimates that the smaller cities needs could be met with 10 additional MET teams and four desk personnel). Consider					

	whether cities want full MET teams or whether they want the County to provide behavioral health personnel to work with their own officers. • Based on the foregoing, create a plan for augmenting the co-response capacity of other jurisdiction. Plan should be consistent with goals of racial equity and further ATI goals. In considering passing the expense of the additional teams to other jurisdictions, the County should consider the cost savings to the County of diverting individuals to CBSOC. The plan should include performance metrics and goals. • Draft proposals for submission to other law enforcement entities, beginning contract negotiations and start to implement plan. <u>Year 3:</u> 3a. Continue Implementation of the above plans. 3b. Review the implementation of the plans and performance metrics to make any necessary change or improvements. 3c. Review the implementation of the plans to ensure that they are being equitably implemented and that any unintended consequences are addressed.					

Goals & Objectives	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**

46. Train all law enforcement officers in Los Angeles County in a formal Crisis Intervention Team (CIT) curriculum, including information on appropriate responses to people who identify as TGI, LGBQ+ and/or cisgender women, and refresher courses, that incorporate connections and networking with neighborhood-specific community-based resources with a treatment-first, harm reduction approach. SMART/MET teams to receive substantially more specialized training. **Expand/Scale Program**	Year 1: 1a. Working with law enforcement agencies, community representatives, CBOs, other County Departments and the LA County Gender Responsive Advisory Committee, study crisis response (CIS) training curricula for law enforcement and behavioral health partner members of cross functional teams offered by LASD and other jurisdictions nationally. 1b. Develop and augment LA County CIS intervention training (CIS) (32 hour and 8-hour refresher) for crisis response teams and patrol deputies. Training should include at a minimum: 1c. Training based on harm reduction, treatment first models 1d. Instruction on engaging people identified as TGI, LGBTQ+ and cis-gender women. 1e. Education on local community resources available to deal with individuals experiencing behavioral health crises. (Training should be viewed as an opportunity to network with these organizations.) 1f. The inclusion of a Department of Mental Health instructor in each applicable law enforcement course. 1g. A post-training test. 1h. Consider using a "train the trainer" approach.	Lead: LASD, LAPD, police agencies within Los Angeles Counties Partners: DMH, DHS-ODR, DPH, Community based groups		State block grants to cities to train more officers in CIS and other relevant training curricula. Establish an LA County standard for crisis intervention training. Board of Supervisors should make recommendations for state mandated minimum MET training.	Ensure training is culturally inclusive and focuses on gender responsivity and racial equity by inviting review by community representatives, CBOs and the LA County Gender Responsive Advisory Committee. Training should include education on the history of racism and racial inequities in LA County mental health and justice systems. Commitment from leadership on racial equity to be reflected in training materials, policies and procedures and announcements regarding training; staff training (to include implicit bias training); leadership participation in town hall and community meetings with representatives of community groups; evaluations of employee performance; etc.. Development of client satisfaction surveys with management taking appropriate action to address community	Year 1: 1a. Study for development of CIS training curriculum completed. 1b. CIS initial training (32 hour) and refresher (8 hour) curriculum developed for law enforcement co-response teams and patrol deputies based on recommendations in the key actions. 1c. Possibility/advisability of working with POST explored to adopt special certification for crisis intervention using LA training as standard. 1d. If applicable, finalized adoption with POST or other accrediting agency of the CIS curriculum for co-responding and patrol officers. 1e. CIS training curriculum developed for non-law enforcement co-responders. 1f. Trainings reviewed for racial equity. Year 2: 2a. Plan developed for the implementation of CIS training for County employees 2b. Trained 10-25% of the law enforcement co-response teams and patrol deputies in the CIS curriculum in Year 2.

	1i. 8-hour training for patrol deputies should take place at or before time the start patrolling. 1j. Develop an LA County co-responder CIS for non-law enforcement partners (also incorporating the above subjects). 1k. Continually review training curriculum and delivery to ensure it developed and presented in a way that is culturally inclusive and focusses on gender responsivity and racial equity and when possible, solicit input from community representatives, CBOs, other County Departments and the LA County Gender Responsive Advisory Committee. 1.l Explore the possibility and advisability of working with POST to adopt special certification for crisis intervention officers using the developed LA County CIS training as a standard. 1m. Explore the possibility and advisability of working with POST to get POST to adopt the LA County training for patrol officers as part of a POST standard. 1n. Develop training for behavioral health specialists/peers, etc. who respond with or to law enforcement in crisis situations). 1o. Explore other platforms for CIS training including online/ video training. <u>Year 2:</u> 2a. Develop plan for the implementation of CIS training for County employees, identifying the number of trainings required				concerns relating to racial equity. Development of baseline numbers tracking pertinent information identified in metrics section by race for each individual co-responder (to include client comments by individual co-responder) to include additional training or adjustments as necessary to achieve goals of racial equity. Establishment of racial equity goal metrics and/or targets.	2c. Plan developed for the implementation of CIS training for County employees. 2d. Trained 10-25% of LA County co-responder non-law enforcement partners in the CIS curriculum in Year 2. 2e. Training reviewed for racial equity. <u>Year 3:</u> 3a. Train 20-60% of the law enforcement co-response teams and patrol deputies in the CIS curriculum in Year 3. 3b. Train 20-60% of LA County co-responder non-law enforcement partners in the CIS curriculum. 3c. Training reviewed for racial equity. 3d. Refresher training in all categories is provided as needed.

	and timeline. Identify frequency of training for behavioral specialists/peers who respond with/to law enforcement. 2b. Periodically review training curriculum (including test results), make any appropriate adjustments and when possible, solicit input from community representatives, CBOs and the LA County Gender Responsive Advisory Committee. 2c. Work with non-LA county law enforcement to encourage them utilize or integrate LA County training model. 2d. Develop automatic system for tracking CIS training for County personnel by employee, showing when training required, when training completed, when refresher required, when refresher completed. System should notify supervisors so they can ensure deadlines met. 2e. Develop system and timeline for implementation of tracking system. <u>Year 3:</u> 3a. Review and if necessary, develop CIS refresher training to include updated information on community based resources, etc.					

Goals & Objectives	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Racial Equity**	**Legislative & Policy Changes Needed**	**3-Year Metrics & Targets**
47. Promote a practice where law enforcement officers, whenever possible and appropriate, release	<u>Year 1:</u> 1a. Study options for the development of a Crisis Coordination System (CCS) that can be delivered on the regional level, for patrol and cross-functional team law enforcement	<u>Lead</u>: LASD, LAPD, police agencies within Los Angeles Counties	This should be part of an overall integrated real-time system to track service and resource availability.	Commitment from LAC leadership on racial equity and involvement of people with lived		<u>Year 1:</u> 1a. Study completed. 1b. Plan developed to establish CCS.

individuals with clinical behavioral health disorders at the time of contact and ensure a warm introduction to supportive services. **Expand/Scale Program**	officers to connect individuals in crisis with timely access to community service. System should include triage and: • Determine and verify whether individual is currently receiving services from a provider to whom individual could be connected. • Provide for quick in-person response to location and transport/connection to service provider. • Provide immediate information to patrol officers to tell them where to transport patient for services (UC, Sobering Center, etc.). • Provide means for patrol officers to connect individual to services (without transport, if appropriate), such as by placing call to provider and having the provider speak to individual in crisis, make appointment for individual to be seen in a timely manner with follow-up, or connecting individual to their current provider. 1b. Identify community resources that can provide timely responses to law enforcement officers engaging people experiencing behavioral health crises who are in need of a warm handoff to CBO or County service providers. 1c. Identify number of currently existing cross-functional response teams involving law enforcement agencies that can respond to patrol requests and their ability to respond 24/7.	<u>Partners</u>: DMH, DHS-ODR, DPH, (SAPC) Community based groups		experience in planning and evaluating Crisis Coordination System (CCS.) Development of baseline numbers track pertinent information identified in metrics section by race for each program participant. Establishment of racial equity metrics and/or targets. Provide recommended adjustments as necessary to achieve goals of racial equity. Apply racial equity analysis to any programs developed to meet this recommendation.		1c. Plan developed to implement CCS. 1d. Measurement of progress toward goals set in plan on a quarterly basis.

	1e. Develop plan for implementing CCS across the LA County identifying when patrol officers will contact CSS, who will provide CSS triage services, relationship between CSS and current MET teams, additional staffing/ overhead/ facilities requirements, target response times, needs to link with other County systems (bed availability/data sharing/ACCESS/211/911), procedures and deadlines and goals for each stage of implementation. 1f. Develop performance metrics and tracking system. <u>Year 2:</u> 2a. Hire additional staff and begin to develop data base of community resources. 2b. Expand services in needed areas based on the assessments in accordance with plan. <u>Year 3:</u> 3a. Continue efforts in Year 2.					

Goals & Objectives	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Racial Equity**	**Legislative & Policy Changes Needed**	**3-Year Metrics & Targets**
48. Develop and expand pre-arrest and pre-booking diversion programs, using decentralized, cross-functional teams to coordinate behavioral health assessments and connections to community-based systems of care, for	<u>Year 1:</u> 1a. Establish pre-arrest and pre-booking diversion programs that reduce: • The number of individuals with unmet substance use, mental health, housing, employment and health needs entering the criminal justice system for low-level offenses.	Lead partners: DA, DHS/ODR, DPH, LASD, PD. Primary partners may include cities with their own prosecutors' offices and other law enforcement agencies. Partners: Probation Dept, LAHSA, Alt	<u>Existing Funding Sources:</u> Federal Department of Justice (DOJ) supporting LEAD Hollywood through 2020 and LEAD East LA through 2022. Board of State and Community	Commitment from LAC leadership on racial equity and involvement of people with lived experience in PAD Work Group membership and evaluation process.		All metrics to be measured against most recent local data available. Number of participants enrolled in pre-arrest and pre-booking diversion programs. Reductions in: • # people in jail with SUD/mental illness

people whose justice system involvement is driven by unmet behavioral health needs, in coordination with law enforcement and community providers. **Expand/Scale Program**	• The number of days participants who are convicted of crimes are incarcerated and/or under supervision. 1b. Establish pre-arrest and pre-booking diversion programs that increase access to and utilization of: • Resources and service options at, or prior to, point of arrest/pre-booking. • Trauma informed and person-centered, Harm Reduction services. [This will require significant increase in LA County service capacity addressed in intercept 0 and 1] Referral and linkage to care based on client-led service planning. • Harm reduction education, services and case management, including overdose education and access to naloxone for participants, prevention and treatment for soft tissue infections and other pressing health issues facing participants. • Utilization of preventative care and treatment for health and mental health challenges. • Legal assistance in addressing current and future challenges with the justice system. • Interim Housing. • Permanent Supportive Housing or Rapid-Rehousing. • Substance use services when participants prioritize these services.	Public Defender, DPH SAPC, DMH, LARRP, DPA	Corrections (BSCC) for LEAD South LA/ North Long Beach through June 2020. Proposition 47 for LEAD Hollywood through 2021. <u>Possible Resources:</u> Philanthropy (look to philanthropy ATI team). Local partner jurisdictions (cities within LA County). <u>Additional Funding to Expand LEAD Program:</u> YEAR 1 Increase from 200 to 800 participants in LEAD programs; $3.8m. YEAR 2 Increase from 800 to 1,600 participants in LEAD programs: $10.6m YEAR 3 Increase from 1,600 to 2,400 participants in LEAD programs; $17.2m	Development of baseline numbers track pertinent information identified in metrics section by race for each PAD diversion program. Provide recommended adjustments as necessary to achieve goals of racial equity. Establishment of racial equity metrics and/or targets and a process to evaluate and improve racial disparities. Evaluate existing LEAD Policy Committee membership to ensure appropriate representation by affected populations with a strong emphasis on racial equity and involvement of people with lived experience. Apply racial equity analysis of LEAD and other PAD		• # of days in jail among participants Improvements in: • Health/ mental health/ SUD outcomes among participants • Housing outcomes among participants • Employment outcomes among participants Cost analysis *per participant* to provide pre-arrest services vs comparative costs for current justice system costs AND compared to other diversion program(s). Each of the three operational LEAD sites are currently being evaluated by independent researchers (Keck School of Medicine at the University of Southern California and Cal State Long Beach.) Any new site or program metrics should be comparable to existing/previous evaluations. This will ensure data can be compared across LEAD sites.

	1c. Establish Pre-Arrest/Pre-booking Diversion (PAD) Work Group to review and assess local, regional and national models of pre-arrest and pre-booking diversion program models. PAD-WG should**:** • Include members of groups overseeing existing pre-arrest diversion programs including LA County LEAD Policy Committee. • Coordinate with other existing pre-arrest/ pre-booking efforts to ensure any recommendations align with local efforts/contexts. • Conduct wide ranging cost analysis including a review of all costs associated with people being processed through traditional justice system including arrest, citation, detention, legal costs to prosecute, defend and court fees, probation/ parole, mandated services such as mandatory SUD treatment via Drug or other specialty courts. Other critical costs to other public systems, including those associated with a) removal of children from families of those incarcerated, dependency court fees, legal representation, foster care and processes involved in family reunification; b) utilization of emergency medical services including first responders/emergency personnel and emergency rooms; c) Public assistance programs frequently utilized by justice involved individuals including housing			program reports and evaluations.		

	services and services for homeless individuals with justice histories, employment training and placement programs, benefits (general relief, SSI, unemployment insurance etc.) • Produce recommendations for implementation of new programs and expansion of LEAD or other existing programs based on evaluation and input from existing pre-arrest/ pre-booking diversion programs. • Study the possibility of pre-arrest and pre-booking diversion for persons whose arrestable offense may not be considered low level. <u>LEAD Expansion:</u> Concurrent to LEAD expansion, PAD-WG will evaluate effectiveness of the program and provide findings to guide all future LEAD efforts including existing LEAD expansion efforts. Implement recommendations of LEAD Expansion motion generated plan (2/1/19) to sustain existing LEAD programming for current participants and increase the number of LEAD sites in LA County from 2-6 over three years by: <u>Year 1:</u> 1a. Increase from 200 to 800 participants in LEAD programs. <u>Year 2:</u> 2a. Increase from 800 to 1,600 participants in LEAD programs.					

	<u>Year 3:</u> 3a. Increase from 1,600 to 2,400 participants in LEAD programs. For each LEAD site: • Establish LEAD Operational Work Group (OWG) that includes law enforcement, prosecution, service provider and County program management. • Develop and approve LEAD Policies and Procedures that include offenses eligible for diversion and roles/responsibilities of each OWG partner • Establish goal for law enforcement referrals into LEAD, either by pre-arrest/pre-booking diversion or social contact • Provide trauma-informed and holistic intensive case management services using a harm reduction framework for all participants enrolled in LEAD. • Offer harm reduction supplies, overdose education and naloxone to all participants referred to LEAD.					

Alternatives to Incarceration Work Group
Intercept 3 Preliminary Implementation Plans

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity Commitment/Process	3-Year Metrics & Targets	Expanded Scope
53. Improve and expand return-to-court support services to reduce failures to appear. **New Program**	Year 1: 1a. Establish a "return to court" network system lead by the ATI Pretrial Agency (ATIPA), prioritizing relationships with the health departments and community-based organizations which offers support to individuals who have return-to-court obligations. • Identify gaps in current practices and services not currently available through county departments and community-based organizations. 1b. Develop and give priority funding to service delivery networks between community-based partners and health care providers in order to provide individualized return-to-court plans to system involved individuals. 1c. Develop a platform consolidating available housing and other supportive services, such as free cell phones, child care, transportation (bus tokens, ACCESS, taxi), prepaid phone cards and TAP cards for people who have court dates, job	Lead: APD, ATI Pretrial Agency (ATIPA), PD Partners: CBO's, District Attorney, City Attorney County Health Agencies			Year 1: 1a. Quarterly monitor 1) return to court rates, and 2) service linkage/usage data with a race analysis and cross analyze with LAPD and LASD return to court arrests rates (as demonstrated by "Policing the Unemployed in Los Angeles"). 1b. Report return to court rates and service linkage data, cross analyzed with LAPD and LASD arrest rates, of failures to appear to ATIPA on a quarterly basis. 1c. Report return to court rates and service linkage data, cross analyzed with LAPD and LASD arrest rates, of failures to appear to service delivery networks working in zip codes driving racial disparity. 1d. Evaluate RE outcomes with	Percent of people receiving services during pre-trial phase. Percent of individuals who receive return-to-court support services among those released pre-trial phase. Expand inpatient beds by 50 % Rate of returns to court among individuals released pre-trial. Percent of individuals who report being satisfied with return-to-court support services. Percent of individuals who receive return-to-court support services within 5 miles of their place of residence. (Yes/No) Establishment of "return-to-court" network system. (Yes/No) Completion of assessment of gaps in current return-to-court practices and services.	Potential Impact: People currently involved in the county court system, health providers, non-profits, and other county departments will be impacted by this recommendation. Unintended Consequence: Current partnerships between non-profits and health providers do not incorporate return-to-court support services. Interventions: Work with existing Health Homes structure to leverage health and non- profit partnerships to support return to court supportive services. Work with health and social service departments and partners to utilize client resources (e.g.

	training and placement, health services, mental health services and substance use treatment. The platform will clearly identify services that are available to all individuals, regardless of legal status. • Develop a system of voluntary referrals to social services and community-based organizations, with services offered only on a voluntary basis, independent from people's criminal cases. 1d. Establish a system of phone call, text, letter and email reminders, including development of a digital application. 1e. Form a criminal justice working group consisting of ATIPA, prosecutors, Public Defender, DMH, DHS, DPH, and the Superior Court to address modeifying procedural rules and practices (as noted below) to maximize successful compliance with court ordered hearings and appearances of individuals identified as needing behavioral health assistance. • Non-essential court hearings are optional; • Judges schedule required court dates for specific time windows,				personnel facilitating return to court services via ATIPA every six months. 1e. Track voluntary referrals and service usage facilitated through consolidated platform based on race report quarterly. 1f. Establish an advisory committee of directly impacted individuals to analyze successes and challenges of voluntary referral system and develop annual mechanism for feedback and recommendations changes in practice with coordination consolidate platform personnel and service providers. 1g. Establish data collection processes to gain feedback from individuals utilizing return to court services to assess efficacy. <u>Year 2:</u> 2a. Integrate quarterly reports developed in Year 1 and analysis from committee of impacted communities from (1c above) into planning for expansion of community	(Yes/No) Completion of platform consolidating available return-to-court support services. (Yes/No) Completion of return-to-court reminders system and its digital application.	transportation through ACCESS).

	so that people do not need to appear in court in the early morning for proceedings that might not begin until the late afternoon, or vice versa; • Courts implement uniform rescheduling policies that allow people to reschedule a certain amount of court dates per case without the court's permission, in case last minute obstacles, like a medical or childcare emergency arise; • Courts maintain hotlines and websites that allow for ease of rescheduling; • There are grace periods for non-appearance (ex. Warrant grace periods) • Individuals are cited out rather than arrested by police agencies when the person is arrested as a result of a warrant. <u>Year 2:</u> 2a. Capture key metrics, including: • Number of people receiving services • Return to court rate of populations serviced • Efficacy of services by				based services anticipated in Year 2. 2b. Establish clear race equity benchmarks for reduction of return to court arrests, increase in return to court via return to court network system, and improvement of community based service usage, using analysis from item A. 2c. report to ATIPA consolidated platform, and criminal justice working group the current progress towards benchmarks at the beginning of Year 3. <u>Other Racial Equity Commitments:</u> ATIPA/PPSC should commit to addressing pre-trial inequity through public transparency and publishing data collecting surrounding pre-trial failure to appear, returns to court, use of services across race. All entities conducting needs assessments should commit to hiring and prioritizing personnel from communities most relevant to RE priorities		

	surveying those receiving services • Geographic distribution of services and needs 2b. Develop plan for expansion of community-based service network. 2c. Identify and secure additional and ongoing funding from state and local budgets to expand and improve county and community-based services Year 3: 3a. Capture key metrics (see above) and develop funding and expansion plan to improve delivery quality and breadth of services. 3b. Identify and secure additional and ongoing funding from state and local budgets to expand and improve county and community-based services. community-based organizations serving the neighborhoods identified in year two, to increase their capacity to expand and to contract with the County				established in Y1 item A and regularly review to inform ongoing personnel needs. Year 3: 3a. The county should review how effectively it administered funding to service providers operating in geographic areas relevant to RE benchmarks and review to improve funding resourcing in priority areas. Establish metrics and/or targets		
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
54. Create a front-end system with behavioral health professionals that solicits information about unmet behavioral health needs so prosecutors can	Year 1: 1a. Through the ATI Pretrial Agency (ATIPA), establish a pilot program designed to be evaluated and refined for expansion countywide.	Lead: ATI Pretrial Agency (ATIPA) Partners:			Year 1: 1a. Track and report quarterly and by race, outcomes of diversion programs using this system; including cases	Percent of detained individuals whose behavioral health needs are assessed before charges are filed.	Potential Impact: People currently involved in the county court system with behavioral health needs, health

offer diversion instead of filing charges or can file reduced charges, for individuals whose justice system involvement is driven by those needs.
 	
New Program
	• Develop a streamlined and integrated system where persons records across DHS, DMH, and other relevant departments can be readily accessed to make meaningful biopsychosocial assessment.
	  ○ Explore the legal parameters for information sharing without consent.
	  ○ Develop a consent-based system of information sharing.
	1b. Evaluation should involve a biopsychosocial evaluation that offers recommendations regarding standard of care community based therapy and treatment, independent of law enforcement.
	
	1c. Identify detained individuals who are already participating in treatment programs – including MAT, outpatient psychiatric care, AOT, LPS, ODR/CBR and
		All health agencies, Community Based Providers, District Attorney, City Attorney, Public Defenders, Alternate Public Defenders, County Counsel			where charges were dropped, not filled, or reduced for people with mental health needs.
					
					1b. Establish clear benchmarks for success by developing annual goals for increase in diversion and decrease in pre-trial population with behavioral health needs. Benchmarks should be informed by RE analysis and priorities.
					
					1c. Train all personnel facilitating collection and use of information for diversion purpose in RE framework and benchmarks and solicit explicit commitment to meet those goals.
					
					1d. Hire and onboard personnel with attention priority for developing team of health professionals form communities most impacted by incarceration.
					
					1e. Assess progress towards benchmarks biannually.
					
					<u>Year 2:</u>
						Percent of individuals with known behavioral health problems who are diverted pre-trial.
						
						(Yes/No) Development of integrated data systems for biopsychosocial assessments.
						
						(Yes/No) Establishment of on-call network between health departments and prosecuting agencies.
						
						(Yes/No) Completion of pilot program to improve communication between health departments and prosecuting agencies.
						
						(Yes/No) Completion of evaluation of pilot program.
							providers, non- profits, and other county departments will be impacted by this recommendation
							
							<u>Unintended Consequence:</u> Individuals with chronic and/or terminal medical needs are not currently included. Individuals that have experienced trauma are not captured through existing behavioral health databases.

	other DMA treatment programs – to assist in identifying if the behavior for which the individual was detained is behavioral health related so to effectuate immediate re-linkage to the treatment program. 1d. Identify programs that are already providing diversion and prevention services and complete a thorough assessment of resources and delivery systems needed to more effectively provide services and decrease interaction with the justice system. 1e. Treatment programs to include but limited to housing assistance, financial assistance, mental health services, medical services, and employment linkage. 1f. Establish an on-call network between county health departments and prosecuting agencies to access housing and treatment status in order to prevent cases from being filed. <u>Year 2:</u>				2a. Report RE outcomes assessed by ATIPA, to CBOs at end of Year 1. 2b. Assess whether current practices are meeting RE goals for reduction in pre-trial population and report to ATI and CBOs. 2c. Establish mechanisms for feedback from diverted people, prioritizing communities impacted by racial inequity, and their families to refine practices towards RE benchmarks/reduction of pre-trial population. Feedback should be analyzed by committee of directly impacted individuals, their families, and health professionals who use the front end system. 2c. Develop RE training for judges using the analysis from Year 1 and Year 2, items A and B.		

	2a. Evaluation of outcomes and assessment of trajectory to reach established pre-trial population reduction plan, benchmarks and milestones. Year 3: 3a. Evaluation of outcomes and assessment of trajectory to reach established pre-trial population reduction plan, benchmarks and milestones.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
55. Develop a strengths and needs-based system of pretrial release through an independent, cross-functional entity, situated outside of law enforcement, to coordinate voluntary needs and strengths assessments expeditiously upon booking, and to provide relevant information to court officers to make informed release decisions. **New Program**	Year 1: 1a. The Board of Supervisors will identify and/or create an independent, cross-functional entity to provide pretrial services (ATI Pretrial Agency). 1b. The ATI Pretrial Agency (ATIPA), in consultation with community-based organizations (CBOs) and County Health Departments, will develop a voluntary and confidential strengths and needs assessment and a protocol for administering the assessment for the purpose of identifying community based support options, including treatment, placement, and housing. 1c. ATIPA will identify staff to conduct confidential behavioral health assessments for the purpose of identifying	Lead: APD, ATI Pretrial Agency (ATIPA), PD Partners: Board of Supervisors, DHS, DMH, DPH, Courts, Prosecutors, Sheriff, City police department, Superior Court, CBOs			Year 1: 1a. Establish explicit commitments by ATIPA and Permanent Pretrial Steering Committee (PPSC) entity to address current and historic trends regarding race and equity in criminal justice system. Analysis should include arrests rates, reasons for arrests, drivers of incarceration, and social determinants of health for impacted populations using, for example, data published by Million Dollar Hoods. 1b. Train all persons developing, administering, and conducting review of needs assessment tool	Percent of detained individuals whose behavioral health needs are assessed within 48 hours after being booked" Percent of detained individuals in need of behavioral services who are connected to them before arraignment. (Yes/No) Establishment of ATI Pretrial Agency. (Yes/No) Development of ATIPA strengths and needs assessment and protocol for administering it. (Yes/No) Establishment of ATIPA notification system between lock- up	Potential Impact: Individuals that are considered to be pretrial (around 40% on any given day), community based organizations, and county departments. Unintended Consequence: Individuals that are currently enrolled in behavioral health and social service programs can be assessed multiple times and dually enrolled in programs. Coordination of ATIPA, system partners, community

	community-based support options. Assessments will remain confidential between the detained individual, the community advocate, and defense counsel. • The purpose of assessments it strictly to provide supportive services and care coordination for detained individuals upon release from custody, and for program evaluation. The assessments will not be used as evidence against the individual in any court proceedings. 1d. ATIPA will establish a notification system between lock-up jail facilities county-wide to facilitate timely assessments for detained individuals. 1e. After the voluntary assessment is completed, ATIPA will be responsible for connecting individuals to services. • This process should be available from the point of initial arrest through post arraignment. 1f. ATIPA will maintain a case management system that will facilitate program evaluation for demographic and regional community needs for services and infrastructure.				in analysis and commitments established in item A. 1c. Biannual review of outcomes produced by needs assessment tool and its impact towards benchmarks for reduction in pre-trial detainment. 1d. Conduct an annual review of needs assessment to tool by ATIPA, CBOs, PPSC, Health Departments and Committee of Directly impacted community members with the goal of refining the tool to protect RE goals established ATIPA process. 1e. Assess the efficacy and applicability of the tool to reducing pre- trial detention across multiple intercepts 0-3 with an emphasis on meeting established ATIPA RE benchmarks for reduction in pre- trial population. <u>Year 2:</u> 1a. Increase in funding to CBO (Year 2, 1a) should be driven by findings of PPSC, as	jail facilities to facilitate assessments for detained individuals. (Yes/No) Completion of ATIPA case management system. (Yes/No) Identification of data that will be published to the County's Open Data portal. (Yes/No) Beginning of publication of data to County's Open Data portal. (Yes/No) Establishment of Permanent Pretrial Steering Committee	based organizational partners through the establishment of a steering committee or work group needs to be situated in a department or agency. <u>Interventions:</u> Seem to be answered by recommendation 39 and can be coordinated with data recommendations within infrastructure. ATIPA may be a part of the ATI Initiative recommendations so that it may utilize the staff to implement steering committee needs, influence data system development, and connect to contractual/capacity building opportunities for non-profit partners.

	1g. ATIPA will identify relevant data sets for collection and publication. • ATIPA will regularly publish datasets to Los Angeles County Open Data and will notice publication to the court, service providers, and CBOs. 1h. The Los Angeles County Board of Supervisors will establish a Permanent Pretrial Steering committee that work with stakeholders, including system-involved individuals and their families, to identify gaps in service provision and develop long-term plan to fund specific social service needs by demographic and regional communities. <u>Year 2:</u> 2a. The Board should consider an increase in resources for community based supportive services informed by the findings from the Permanent Pretrial Steering Committee. 2b. The Board should consider streamlining funding accessibility for community-based organizations informed by the findings from the Permanent Pretrial Steering Committee. 2c. The County should identify and secure additional and ongoing				well as commitments established in Year 1. <u>Other Racial Equity Commitments:</u> ATIPA should, in coordination with county established PPSC (Item 1h under key actions), establish explicit outward facing commitment to use and refinement of needs assessment tool to meet RE goals, guided by RE principles, grounded in analysis developed in item A.		

	funding from state and local budgets to support the expansion of community-based services informed by the findings of the Permanent Steering Committee. <u>Year 3:</u> 3a. The Board should consider an increase in resources for community based supportive services informed by the findings from the Permanent Pretrial Steering Committee. 3b. The Board should consider streamlining funding accessibility for community-based organizations informed by the findings from the Permanent Pretrial Steering Committee. 3c. The County should identify and secure additional and ongoing funding from state and local budgets to support the expansion of community-based services informed by the findings of the Permanent Steering Committee.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
56. Institute a presumption of pretrial release for all individuals, especially for people with behavioral health needs, whenever possible and appropriate, coupled with warm handoffs to community-based systems of care, to provide targeted services, if necessary, to	<u>Year 1:</u> 1a. Implement pilot program of presumption of release that prioritizes pre-arraignment release. 1b. Expand and appropriately fund the Offices of the Public Defender and Alternate Public	<u>Lead:</u> APD, ATI Pretrial Agency (ATIPA), PD <u>Partners:</u> CBOs, Service providers, County Health Departments, sheriffs, Prosecutors		<u>Proposed Change:</u> The County should explore advocating for the following: • Decriminalization of sex work, drug use, public intoxication,	<u>Year 1:</u> 1a. Conduct a review of Los Angeles and national (where jurisdiction is comparable and/or relevant) of release practices and race equity or disparity outcomes.	Percent increase in funding to PD/APD, relative to FY2020 levels. Percent of detained individuals who are released pre-arraignment. Number of navigators coordinated by ATIPA;	<u>Potential Impact:</u> Individuals with clinical behavioral health disorders impacted by the justice system. <u>Unintended Consequence:</u>

help individuals remain safely in the community and support their return to court. **New Program Practice/Policy Change**	Defender to provide an increase in staffing resources for pretrial arraignment representation to expedite release. 1c. Establish a network of behavioral and medical health providers and community based advocates coordinated by the ATIPA, to provide immediate assessment and navigation support for detained individuals, prior to booking, to expedite connection to supportive services. 1d. Analyze current practices employed in the LA County jail to identify individuals with clinical behavioral health disorders to design systemic changes necessary to ensure immediate and effective identification, including ruling out bio/medical source symptoms. 1e. Expand a network of navigators, coordinated by the pretrial services entity, who can be in court at arraignment to assist in providing information to counsel and the court when necessary. 1f. Create a confidential and voluntary notification and communication facilitation system to alert primary providers/caseworkers about the incarceration of one a provider's clients so they can participate in the assessment, advocacy and			quality of life crimes and survival "crimes". Advocate for appropriate prosecutorial decision-making at all stages of the proceedings, whether a crime is charged or not, taking into account the presence of mental illness, substance use disorder, homelessness and any other mitigating factors which could suggest that an alternative to incarceration strategy would appropriately be employed. Prosecutors should also consider the larger picture in the interest of justice, including any collateral consequences of charging, conviction or prolonged incarceration, such as adverse employment	Establish foundational guidelines of release practices and subsequent metrics to ensure RE priorities are protected and achieved in presumption of release practices. Review should include data analyzed with specific lens towards RE, "Summary of Research studies related to racial disparities in pre-trial detention" (Prison Policy Initiative, 2019). 1b. Track number of releases for individuals with behavioral health disorders, handoffs, and treatment outcomes across race. 1c. Quarterly report data above to ATI and PPSC. 1d. Train all clinical personnel, public defenders, and DA's in presumption of innocence frame with a RE lens, including foundational guidelines and metrics from above. 1e. Conduct internal quarterly review within ATIPA/PPSC teams responsible for facilitating POR of	percent of staff in justice agencies who have completed training on the system of presumption of release. (Yes/No) Implementation of presumption of release pilot program. (Yes/No) Establishment of network of behavioral and medical health providers to provide assessment and navigation support for detained individuals pre-booking and expedite connection to supportive services. (Yes/No) Completion of analysis of current practices in the County jail to identify individuals with clinical behavior health disorders. (Yes/No) Creation of notification system to alert primary providers/case workers about the incarceration of a client. (Yes/No) Establishment of model to deliver data to community based advocates, providers,	Individuals that are impacted by the justice system, but do not have a behavioral health disorder are not included in the current recommendation. Individuals that are undocumented are also likely left out of this recommendation. Interventions: Expand the population that can access the pretrial release opportunity to include all people impacted by the justice system including undocumented individuals. *Utilize expanded scope sections within Intercept 3 to support community based system development.

	pretrial release support of that client, with appropriate waiver. 1g. Transportation to services is coordinated and provided by and not limited to ATIPA in collaboration, with community-based providers. 1h. Release of the individual is not contingent on the availability of services; however the Los Angeles County Board of Supervisors must prioritize building the decentralized system of care in order to meet service needs. 1i. Implement justice partner training program on the system of presumption of release. 1j. Streamline funding accessibility for community based organizations and County Health Agencies to support capacity building for pretrial services (Funding). 1k. Establish data collection requirements to allow public and government to evaluate the outcomes of the pretrial system and create a feedback loop where all outcomes are shared with all systems actions. (Metrics and Targets). 1l. Create a transparent model that delivers legally appropriate data to community based			results, barriers to housing, and immigration consequences. Encourage the prosecution, public defenders and alternate public defenders to evaluate promotion policies to reflect the value of holistic representation, including diversion and non-trial assignments and outcomes. The goal is to incentivize diversion by changing evaluation processes for promotion. The elimination of fees for any conditions of pretrial release or pretrial detention. Encourage a harm reduction approach during the pretrial release period, discouraging reincarceration for lapses in compliance with conditions. Develop a comprehensive process to identify and resolve an individual's criminal legal case obligations county- wide, including	outcomes using data from item 1b. 1f. Facilitate presumption of release trainings of judges using a RE frame that highlights disparities in pre-trial release across race. Training should be developed by ATIPA, PSA, directly impacted communities and CBOs working specifically at the intersection of race and pretrial detention. <u>Year 2:</u> 2a. Continue data collection quarterly and review. 2b. Report foundational guildelines and metrics to CBOs with analysis of the first 4 quarters of data and review, assessment of strategies adopted throughout the year to meet RE benchmarks established by ATIPA/PPSC, and outcomes. 2c. Host a presumption of release review with lead departments and directly impacted leaders to review the status of RE and decarceration benchmarks. Strategies	justice partners, and judges. <u>Year 2 Metrics:</u> (Yes/No) Completion of audits of fiscal impact. <u>Year 3 Metrics:</u> (Yes/No) Completion of audits of fiscal impact.	

	advocates, providers, justice partners and judges. Year 2: 2a. Conduct an audit of fiscal impact. 2b. Collection and redistribution of any cost savings to a countywide network of services. 2c. Identify and secure additional and ongoing funding from state and local budgets to expand and improve county and community-based services. Year 3: 3a. Conduct an audit of fiscal impact. 3b. Collection and redistribution of any cost savings to a countywide network of services. 3c. Identify and secure additional and ongoing funding from state and local budgets to expand and improve county and community-based services.			outstanding infractions and warrants, in order to enhance release, increase court efficiency and remove barriers to life sustaining needs.	for improving presumption of release practices towards RE benchmarks should be integrated into ongoing trainings with judges and with relevant personnel facilitating presumption of release and warm hand-offs. Other Racial Equity Commitments: ATIPA/PPSC should commit to POR practices that provide a model for correcting documented trends (national and local) detainment of Black people pre-trial.		
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
57. At the earliest point possible, connect individuals to a personal advocate or community member to assist them in navigating the justice system process and assist in advocating for diversion	Year 1: 1a. The ATI Pretrial Agency (ATIPA), in collaboration with community-based organizations, develops a community advocate pilot program in order to provide immediate advocacy support upon arrest.	Lead: The ATI Pretrial Agency (ATIPA) Partners: Community based organizations and service providers, all				Percent of detained individuals who receive advocacy services coordinated by ATIPA. Number of community advocates coordinated by ATIPA.	Potential Impact: Individuals with behavioral health and mental health needs, intellectual adult development disabilities, people with physical

opportunities. These advocates, whenever possible, should include and be trained to provide tailored help/referrals to people who identify as LGBQ+, TGI and/or cisgender women. **New Program**	1b. Target populations for this pilot program include: individuals with behavioral health and mental health needs, intellectual adult developmental disabilities, people with physical disabilities, trans and gender non-conforming people, LGBQ+ people, cis women, pregnant people, primary caregivers, and young adults age 18-25. 1c. Develop a system that allows detained individuals to request and contact an advocate with knowledge and training relevant to the needs of specific disproportionately impacted demographics (ie. Trans and gender non-conforming people, cis women, etc). 1d. Advocates will be coordinated by the ATIPA, and operated by community -based organizations. 1e. Establish a system of notification between law enforcement and the ATIPA to facilitate immediate connection between the detained individual and community advocates upon booking. 1f. All consultations and assessments conducted or shared with advocates will remain confidential between system involved individual, the advocate, and defense counsel. Develop	County Health Departments, Public Defenders				Percent of advocates coordinated by ATIPA who come from system-impacted populations or communities. (Yes/No) Implementation of ATIPA community advocate pilot program. (Yes/No) Completion of ATIPA plan to recruit, train, and coordinate community advocates. (Yes/No) Development of system for detained individuals to request and contact a community advocate (Yes/No) Establishment of notification system between law enforcement and ATIPA to facilitate connecting detained individuals to community advocates upon booking. (Yes/No) Development of protocols to protect defendant rights from disclosure of consultations and assessments.	disabilities, trans and gender-non-conforming people, LGBQ+ people, cis women, pregnant people, primary caregivers and young adults 18-25 <u>Unintended Consequence:</u> Individuals that do not fit the criteria above will not be able to access and advocate to support them in navigating the justice system. <u>Interventions:</u> Expand pilot to incorporate all people impacted by the justice system to connect with expansion efforts in year 3.

	protocols to protect defendant rights from disclosure of consultations and assessments. 1g. Consult with DA regarding operation of its Victim Services Division, with the purpose of improving services to survivors, including transformative justice services. <u>Year 2:</u> 2a. Conduct and prepare an evaluation and report of Phase 1 implementation of advocacy services program, including 1) efficiency and effectiveness of consultation and connection to services, 2) community needs and gaps in services by demographic and regions, 3) interface between advocacy services and early provision of defense representation needs, 4) success of recruitment efforts in disproportionately impacted communities and among system-impacted demographics, 5) communication between ATIPA, law enforcement and advocates, and 6) measurable outcomes , including recidivism rates and jail population reduction. 2b. Reinvest cost savings from any reduction in incarceration costs to community based supportive services based on the assessments of community needs.						

	2c. Streamline funding accessibility for community based organizations to support capacity building. 2d. Establish permanent local funding streams to support the expansion of community-based services. 2e. Identify and secure additional funding from state and local budgets to expand and improve services. 2f. Expand advocacy services to all individuals involved in the criminal court process. <u>Year 3:</u> 3a. Conduct and prepare an evaluation and report of Phase 1 implementation of advocacy services program, including 1) efficiency and effectiveness of consultation and connection to services, 2) community needs and gaps in services by demographic and regions, 3) interface between advocacy services and early provision of defense representation needs, 4) success of recruitment efforts in disproportionately impacted communities and among system-impacted demographics, 5) communication between ATIPA, law enforcement and advocates, and 6) measurable outcomes , including recidivism rates and jail population reduction.						

	3b. Continue expanding pilot program to provide advocacy services at point of contact with law enforcement and in non-custody cases. 3c. Identify and secure additional funding from state and local budgets to expand and improve services and successfully recruit advocates from disproportionately impacted communities and demographics.						

Alternatives to Incarceration Work Group
Intercept 4 Preliminary Implementation Plans

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets	Expanded Scope
58. Improve equal access to all treatment resources for justice-involved individuals, wherever they may be (in or out of custody) by: (a) directing health agencies to change eligibility criteria and increase capacity and funding to ensure behavioral health treatment facilities are available in all stages of court process; (b) creating a more rapid referral and response process for MH and Co-Occurring placements at all levels; (c) developing a	Year 1: 1a. Review criteria for admission to key levels of Mental Health care including but not limited to: Full Service Partnership (FSP), Enriched Residential Services (ERS), Outpatient, IMD, ODR Housing Program, Men's Community Reintegration (MCRP), Women's Community Reintegration Program (WCRP). 1b. Identify health agencies and behavioral health treatment facilities who are currently	Lead: APD, CEO, DHS/CHS/ODR, DMH, DPH, PD Partners: ATIPA Prosecutors Providers (i.e. SSG)	Additional Funding Source(s) to Expand: Activate Medi-Cal for this population. Additional Staffing Needed to Expand: investment in community health workers to facilitate access to diversion and services.		Assess access and admission to treatment and care by racial demographics. Review the policies and procedures of County and community health care providers that inform eligibility and treatment and their impact by racial demographics. Develop policy standards for treatment providers receiving County funding in order to help address	Identification of current populations who encounter barriers to service linkages. (Yes/No). Average turnaround time on referrals to key levels of care. Estimated for each of the populations that encounter barriers to service linkages. Average wait times for slots, beds, and outpatient appointments. Estimated for each of the	Potential Impact: Increase the number of people in LA County who have access to mental and behavioral health care. Expand the mental health and behavioral health treatment available. Remove barriers to service linkage, especially for high risk and high need populations.

coherent strategy and connecting every qualifying individual to an appropriate court-based program at inception of diversion dialogue; (d) refining multiple points of entry within Intercept 3 for MH and SUD services; (e) ensuring in-custody involvement of CBOs for services; and (e) expanding capacity and removing archaic barriers at all levels of care. **New Program** **Expand/Scale Program**	providing services to justice-involved individuals and identify ways that they can expand or develop new contracts. 1c. Significantly increase funding to programs that will allow for providers to increase capacity and services. 1e. Optimize use of Medi-Cal funding and services. 1f. Determine the current population who encounters barriers to service linkage. (e.g. fire setters, people with unresolved cases, sex registrants, allegations of violence, funding exclusions, legal status, etc.), and explore existing or new resources including those that will safely serve those with high risk behaviors in the community. 1g. Expand and/or create new resources at <u>all</u> levels of care for people who are mentally ill or who have a co-occurring disorder, other health condition, etc. 1h. Review Data and rationale (or create a method to do so) on the average turnaround time on referrals to key levels of care. 1i. Review data on current wait times for slots, beds, and outpatient appointments.				barriers to entry for racial demographics most impacted by the carceral system. Incentivize necessary policy change by developing funding standards for treatment providers receiving funds through the County. Conduct bi-annual assessments of the efficacy and applicability of policy changes and their impact on access and quality of treatment by racial demographics.	populations that encounter barriers to service linkages. Percent of individuals who do not access treatment. Estimated for each of the populations that encounter barriers to service linkages. Creation of cross agency database of outcomes such as program completions, walk-aways, re-arrests, etc. (Yes/No). Completion of system to look up whether justice-involved individuals have a behavioral health or medical diagnosis that could cause behavioral health symptoms. (Yes/No). Creation of 24-hour DHS/DMH/DPH hub with database of providers and available resources. (Yes/No.) Resources available at all levels of care: implementation team should identify which resources should be monitored: beds, treatment slots, etc., and how they should be measured (e.g. number of beds or year-over-year percent change in number	Decrease wait times for services for people with behavioral health and mental health needs. Streamline communication between courts and service providers to improve referral systems. Increase funding and expansion of community based treatment.

	Determine which levels of care can potentially shorten turnaround times for referral/response, and placement, and update the current system. 1j. Collect data and rationale on the number of individuals who do not access treatment. Explore ways to further engage and link those who can benefit from treatment. 1k. Review and refine current clinical navigational programming pathways to treatment. Design user-friendly referral system to navigation teams. 1l. Enhance cross-communication between specialty courtrooms and county programs to allow navigation teams referral access. 1m. Create cross agency database to include outcome data to include both positive and negative outcomes, such as program completions, walk-aways, re-arrests, etc. 1n. Create rapid referral and response by developing a system to look up whether or not justice-involved individuals have a behavioral health diagnosis or a medical diagnosis that could be causing behavioral health					of beds.).	

	symptoms. 1o. Develop a 24-hour DHS/DMH/DPH hub that has an accurate and consistently updated database of providers including information about where there are beds and treatment slots available at all levels of care. 1p. Establish linkages to community based primary care to ensure continuity of care and avoid decompensation of biomedical and behavioral health. <u>Year 2:</u> 2a. Expand eligibility for services where legally possible, ensuring a safe and clinically sound environment for all participants. 2b. Create new resource pathways for barriers to linkage. 2c. Monitor the progress on expansion of resources for all levels of care. 2d. Work with key partners to systematically mitigate the barriers to rapid turnaround for referral and linkage. 2e. Review dual pathway referral system for volume, ease of use by referral source and capacity for coordination between navigators. <u>Year 3:</u>						

	3a. Continue the efforts to successfully develop and expand actions items from year 1 and 2						

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets	Expanded Scope
59. Create a robust AB 1810 Diversion scheme—PC 1001.36 and 1170(a)(1)(B)(iv) and 1370.01(a)(2)—to identify early on persons eligible for diversion and develop pathways countywide to connect individuals to appropriate mental health programs to accomplish the goals of pre-conviction diversion and respond to all other present and future diversion opportunities, including pre- and post-conviction. **New Program**	Year 1: 1a. As directed by the ATI Pretrial Agency (ATIPA), establish a work group to conduct a review of and report on existing MH Diversion programs, procedures and practices countywide, including a detailed account of the current funding sources, and the staffing resources deployed by participating county departments, the court, and other agencies. 1b. Evaluate alternative models of court supervision of MH Diversion to determine which will insure equal access to and program delivery of MH Diversion across the county; for example, MH Diversion cases/individuals would all be assigned to one designated courtroom in each courthouse or judicial district, or MH Diversion cases would be handled in every courtroom in every courthouse across the county. 1c. Collaborate/liaison with the Pre-Arrest /Pre- Booking (PAD) workgroup established in Intercept 2: Recommendation 36,	Lead: APD, DA, DHS, CHS, ODR, DMH, DPH, PD			Include a racial equity analysis in the evaluation of alternative models of court supervision of MH Diversion to determine which will insure equal access to and program delivery of MH Diversion to racial demographics most impacted by the criminal legal system. Assess the success and efficacy of PAD collaboration in reducing the number of people incarcerated and diverted to treatment from racial groups disproportionately impacted by the criminal legal system. Develop key benchmarks of success for diversion and treatment completion for racial groups disproportionately impacted by the criminal legal system. Develop training and hiring practices for the mental health diversion teams to	Completion of ATIPA report on existing MH Diversion programs, procedures, and practices. (Yes/No) Number of individuals for whom MH Diversion was requested. Percent of individuals placed on MH Diversion (out of those for whom MH Diversion was requested) Percent of individuals who successfully complete MH Diversion (out of those placed in MH Diversion) Number of MH Diversion teams that provide mental health evaluations per PC 1001.36.	Potential Impact: People currently involved in the county court system, health providers, non-profits, and other county departments will be impacted by this recommendation. Unintended Consequence: Individuals that are impacted by the justice system, but do not have a mental health/behavioral health disorder are not included in the current recommendation. Individuals that are undocumented are likely left out of this recommendation. Interventions: AB 1810 specifically targets individuals who have a mental illness. Interventions for the other vulnerable populations in the

	to facilitate data/information sharing to identify individuals connected to services pre-arrest/pre- booking who are subsequently incarcerated. 1d. Establish an ongoing collaboration/liaison with PAD to share data/information to identify service and program gaps in pre-arrest/pre-booking diversion programs to facility improvement in the outcomes of post arrest/pre-trial MH Diversion. 1e. Track, collect, and review data on the number of individuals for whom MH Diversion was requested, the number of individuals placed on MH Diversion, and the number of individuals who successfully completed MH Diversion. 1f. Develop a system/procedure to monitor outcomes for individuals placed on MH Diversion throughout the course of the diversion period. 1g. Provide performance based incentives and MH Diversion education/training for prosecutors and defense counsel on mental health issues, policies, and the diversion laws. 1h. Develop and resource MH Diversion teams to provide mental health evaluations, evidence as required in PC				increase representation of racial demographics most impacted the criminal legal system. Review outcomes from current PC 1001.36 related pilots through a racial equity lens for successful completion, recidivism, barriers to timely appropriate placement for racial demographics most impacted by the criminal legal system. Review and reporting on existing MH Diversion policies, programs, procedures and practices should include a racial equity component.		criminal justice system must be addressed in early Intercepts 2 and 3 and in Recommendations 42, 44, 45, 46, 47, and 48 of Intercept 4.

	1001.36, and MH Diversion treatment programs. These mental health teams may be comprised of mental health professions, including PSWs, psychologist/psychiatrists, staff from DMH, DHS, ODR, DPH, medical case workers, housing navigators, and CENS and other substance use staff. 1i. Expand existing resources for DHS, and other providers, to provide more MH Diversion pursuant to PC 1370 for individuals found incompetent to stand trial. 1j. Review outcomes from current PC 1001.36 related pilots for successful completion, recidivism, barriers to timely appropriate placement. <u>Year 2:</u> 2a. Continue to expand treatment resource to individuals who qualify for MH Diversion. 2b. Review outcome data for Year 1. 2c. Review and report on existing MH Diversion policies, programs, procedures and practices for each participating county department, and other agencies. Identify service and performance gaps.						

Alternatives to Incarceration Work Group
Intercept 5 Preliminary Implementation Plans

Goals & Recommendations	Key Actions	Lead Department & Key Partners	Funding, Staffing & Facilities Needed	Legislative & Policy Changes Needed	Racial Equity	3-Year Metrics & Targets	Expanded Scope
69. Incentivize community treatment facilities to accept patients from jail who have clinical mental health needs, substance use disorders, and/or co-occurring disorders (COD). **Practice Change**	Year 1: 1a. Engage providers to identify barriers to accepting any/additional patients described in Recommendation 49. Engage county departments to identify barriers to expand funding/services to patients described in Recommendation 49. 1b. Using data, determine which neighborhoods are most in need of additional mental health, substance use and/or co-occurring disorder treatment beds, specifically for people returning from LA County jails and other jails/prisons. Examine service accessibility and utilization among people potentially exclusionary offenses (eg. arson, etc). 1c. Assess the capacity, quality, accessibility and cultural humility of services provided by organizations currently providing mental health, substance use, and co-occurring disorder beds for people returning from LA County jails, to add more beds, given appropriate funding levels. 1d. With providers and community input, develop	Lead: DMH/DPH - SAPC/DHS Partners: Community partners, Contracted service providers, CEO, County Counsel, other county departments, where appropriate	Existing Funding Source(s): Drug Medi-Cal, MHSA, possibly SAMHSA Existing Staffing: Both in jails and on the community side. On community side, lack of providers who can take on patients with COD leaving incarceration. On jail side, not enough custody assistants to help with coordinated releases to treatment provider staff. Additional Funding Source(s) to Expand: Funding for significant expansion of COD beds necessary to meet current needs. Potential funding sources include existing funders of reentry, mental health, and/or SUD treatment services providers and others: Proposition 47, Proposition 64, BSCC, AB109, CDCR, Additional Staffing Needed to Expand:	Current Policy: Examine licensing regulations for facilities potentially serving patients described in rec 49 (see key actions for 49d), to identify any barriers. Proposed Change: TBD based on identified barriers	Collect baseline data on current community treatment utilization by race/ethnicity. Monitor increase in treatment utilization by race/ethnicity on a semi-annual basis and identify methods to increase utilization. Ensure mental health, SUD treatment, and COD treatment services are culturally humble and accessible. Develop plan to build capacity of treatment facilities to recruit, hire, and train staff that provide culturally humble services that reflect the needs of the community.	Number of beds available in community treatment facilities who accept patients from jail with clinical mental health needs, substance use disorders, and/or co-occurring disorders. (baseline # for each condition). Breakdown of access/utilization by race/ethnicity; by gender identity and sexual orientation. Breakdown by available services and geography, and services for women, LGBQ+, TGI people. Percent bed fill average. Number of people leaving jail who need inpatient/outpatient care, broken down by patients with SMI, SUD, and COD. ODR Roadmap – If ~55% divertible out of 5134 =	Potential Impact: People who are being released from incarceration and have behavioral health needs will be impacted. Unintended Consequence: Individuals with certain offenses (ex: arson, etc.) are potentially excluded from accessing some treatment facilities. Individuals that are on the verge of recidivating do not always have access to culturally humble community treatment facilities. Interventions: Support organizations in accessing liability coverage to admit incarcerated individuals with particular offenses. Work with treatment facilities to be an

	potential financial and non-financial incentives for treatment facilities to accept more patients mentioned in Recommendation 49, including people who have been further marginalized due to their charges or on the verge of recidivating. Identify contracting changes and amendments necessary to implement incentives, as well as capacity building needs for service providers. Identify legislative or policy change(s) necessary to implement expansion of COD treatment beds. <u>Year 2:</u> 2a. Provide training and technical assistance to community-based organizations serving the neighborhoods identified in year one, to increase their capacity to expand and to contract with the County 2b. Implement financial and non-financial incentives developed in 2c. Collect data for program improvement. <u>Year 3:</u> <u>Continued implementation of 49f.</u>		If additional contracting and program management needed, staffing resources may be required.			2,800 placements needed on given day. How much money facilities get for patients with each type of contract and level of care.	accessible resource for individuals who have previous convictions, are on the verge of recidivating, and need behavioral health support.
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
70. Change release time for men to match those of women from CRDF to avoid	<u>Year 1:</u>	<u>Lead</u>: DHS Correctional Health Services, LASD	One existing custody assistant who handles coordinated releases,	LASD implements policy change, or restart efforts to pass Getting	Collect coordinated release data, by subtype (release to agency, release	Number of people currently staffing IRC	

overnight release without direct link to programs, interim housing, safe place, or transportation. Increase coordinated releases for clients exiting directly to a program and provide funding to expand CBO intake hours. If not exiting directly to a program, notify family members of a person's release (with that person's permission) with enough time for family to pick them up, and increase use of coordinated releases to family. **New Program Practice Change**	1a. Improve release date prediction for improved release planning care coordination • Increase LASD staffing in the Inmate Reception Center (IRC) Records unit to allow for more frequent recalculation of release dates for fully sentenced clients receiving release planning services. • Develop and implement an automated mechanism to notify release planning staff of release date updates/changes for clients receiving release planning services. 1b. Planning for increased coordinated release planning: • Identify funding for expanded intake and service hours (evening and weekend) by community services providers • Identify funding for expanded coordinated release services • Increase LASD staffing resources (custody assistants) to handle a larger number of coordinated releases for people exiting directly to programs, so that a specific time and date for	<u>Partners</u>: Community partners, contracted service providers, DMH, DPH, CEO, County Counsel, LAHSA, other county departments, where appropriate	LASD Community Transition Unit. Funding from inmate Welfare Fund. Would need to identify funding for additional custody assistant position(s) to meaningfully expand coordinated releases. Per LASD, a change in release times (i.e. not releasing people overnight), would impact jail housing units.[1] Potential funding sources and/or enhanced rates for community providers to expand intake hours (nights and weekends).	Home Safe Act (SB 42 in 2019; vetoed by gov) Possibly for drug Medi-Cal and/or DMH reimbursable services, separate rate for weekend/after-hours intake	to family, overnight release, etc.) by race/ethnicity. Develop new family coordinated release policies with community engagement from communities and families impacted by incarceration. In collaboration with individuals with lived experience, develop policies and procedures to ensure equitable access to new coordinated release policies. Track use of new coordinated release policies by race/ethnicity. Develop process to assess use and impact of coordinated release by race/ethnicity.	Records unit for release date prediction Number of current coordinated releases per FTE Number of people released after-hours and weekends, by gender, by race/ethnicity Release date prediction accuracy Number of coordinated releases, by subtype (release to agency, release to family, overnight release, by release time), by race/ethnicity, by gender	

	release can be set and linkage facilitated. • Develop plan for coordinated releases from LA County jail to family members of incarcerated people. Year 2: 2a. Continue to implement and improve release date prediction services. 2b. Implement: • Expanded intake and service hours by community service providers • Expanded coordinated release services, with additional staffing and services • Family coordinated release program, with the ability to make adjustments as the program matures Year 3: Continuation of above.						
Goals & Recommendations	**Key Actions**	**Lead Department & Key Partners**	**Funding, Staffing & Facilities Needed**	**Legislative & Policy Changes Needed**	**Racial Equity**	**3-Year Metrics & Targets**	**Expanded Scope**
71. Develop and fund a transition shelter within a few blocks from all county jail facilities from which people are released, operated by community-based organizations with safe, welcoming overnight stays for people released after hours with a range of	Year 1: 1a. Identify funding, sites, zoning issues and/or legislative/policy changes needed for transition shelters in downtown Los Angeles and Lynwood, near TTCF/MCJ and CRDF, respectively.	Lead: CEO, DHS, DMH, DPH-SAPC Partners: Community partners, CEO, LAHSA, LASD, other county departments, where appropriate.	Capital project; space for shelters near TTCF and CRDF necessary for program. Funding for CBOs to provide services 24/7 at both locations.	Legislative and policy changes are unlikely, but may be necessary for transition shelters. See Key Actions for 1a.	Through community engagement and stakeholder input for Downtown and Lynwood sites, ensure services are culturally humble, trauma informed, and affirming of the varied needs of recently incarcerated people.	In early stages of project, 1a is the most important target that does not have corresponding metrics. Post service delivery: # of people seeking services, by type, by time of day.	Potential Impact: People that are being released from incarceration, non-profits, and county departments. Unintended Consequence:

support. Create transition shelter beds for people who identify as LGBQ+, TGI, and/or cisgender women so they do not have to remain incarcerated for a safe transition to the community. **New Program** **Practice Change**	1b. With community and partner agency input, identify services needed at the proposed transition shelters to serve people leaving incarceration in a gender responsive and trauma-informed manner. Develop contracting mechanism and documents. <u>Year 2:</u> 2a. Implement contracts for CBOs to provide culturally humble, gender-affirming services at downtown and Lynwood shelter sites. 2b. Continue to evaluate and improve services based on need, participant feedback, community input and data analysis.		Funding for program management and performance improvement.		Collect utilization data by race/ethnicity, and compare against data of people released from LASD custody to see if there are utilization disparities. Wherever possible, maintain opportunities for flexibility to implement changes based on participant feedback, community input, and ongoing data collection and analysis.	# of people released from jail after-hours, by facility.	Little to no capital funding that supports the development of infrastructure for non-profits. Services centered around jails and may not answer the needs of actual communities. However, the 24-hour accessibility of culturally humble services within safe walking distance from release by trusted community providers for people who were unpredictably released, do not have loved ones or resources to support their reentry, and/or released after hours, could have significant impacts for people at most risk upon release. <u>Interventions:</u> Utilize some of the recommendations in the infrastructure section to develop a funding pool that supports capital projects for non-profits.