



September 9, 2019

**Los Angeles County  
Board of Supervisors**

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First District

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

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

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

**Christina R. Ghaly, M.D.**  
Director

**Hal F. Yee, Jr., M.D., Ph.D.**  
Chief Medical Officer

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

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patient-centered, cost-effective  
health care to Los Angeles County  
residents through direct services at  
DHS facilities and through  
collaboration with community and  
university partners.*

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Acute psychiatric inpatient care – Acute psychiatric inpatient care is the most intensive level of psychiatric care. Treatment is provided in a secure locked facility that is medically staffed with a multimodal approach. Daily evaluations by a psychiatrist, 24-hour skilled psychiatric nursing care, medical evaluations, and a structured milieu are required. The goal of an inpatient psychiatric hospitalization is to stabilize the individual who is experiencing acute psychiatric symptoms with a relatively onset or marked decompensation of a more chronic condition. To be suitable for acute psychiatric hospitalization, the individual must meet criteria for a WIC 5150 hold; meaning, the person must be a danger to themselves, a danger to others, and/or gravely disabled due to a serious mental disorder. ODR currently has access to 18 beds of acute psychiatric inpatient care on a dedicated ward at Olive View-UCLA Medical Center. Inpatient services can be reimbursed by an individual's insurance and the ODR team is working with DHS Finance as well as with the Department of Mental Health (DMH) and other entities to ensure that we maximize state and federal funding sources for reimbursable inpatient services. OSHPD regulates the design and construction of inpatient psychiatric facilities.
- Sub-acute psychiatric inpatient care (also referred to commonly as a locked IMD<sup>1</sup>) – Sub-acute psychiatric inpatient care is a step down from an acute psychiatric hospitalization and a step up in acuity from a conventional skilled nursing facility. This setting includes comprehensive inpatient care designed for someone who is medically fragile and/or has an acute illness, injury, or exacerbation of a disease process. Treatment is generally rendered immediately after, or instead of, acute hospitalization. Typically, treatment addresses one or more complex medical conditions in the context of a person's underlying chronic illnesses. Services can be reimbursed by an individual's

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

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

- Specialty Interim Housing – Interim housing provides persons being diverted from jail with temporary housing in a safe and supportive short- to medium- term environment. While in interim housing, participants' clinical needs are addressed and stabilized. Additionally, this setting connects participants to permanent supportive housing opportunities in their communities. Interim housing is R2 (multifamily residential) zoned housing. ODR has generally found that smaller (20-30 bed) settings that feel like a home are more conducive to clients' success. Sites are staffed 24-hours and include resident aides, case manager(s), and LVNs. Currently services in interim housing are rendered by ODR contracted Community-Based Organizations (CBOs), and beds are "leased" by ODR in order to ensure access for ODR clients.
- Skilled nursing care – A skilled nursing facility provides medically necessary professional services such as nursing care and/or rehabilitation services. Skilled nursing facilities provide round-the-clock assistance with healthcare and activities of daily living. Services can be reimbursed by an individual's insurance. ODR currently contracts for access to skilled nursing facility beds within the community on an individual case basis. OSHPD regulates the design and construction of skilled nursing facilities.
- Medical recuperative care – Medical recuperative care provides temporary housing and medical care for persons who do not require hospitalization but are too ill or frail to recover from a physical illness or injury in a lower level of care. The goal is to facilitate a process of healthy recovery that homelessness, or less supportive environments, might impede or prevent. Additionally, medical recuperative care is provided at lower cost than hospital care. Recuperative care facilities are R2 (multifamily residential) zoned residential housing or buildings with commercial zoning. Services are rendered by ODR contracted CBO providers, and beds are "leased" by ODR in order to ensure access for ODR clients.
- Psychiatric recuperative care – Psychiatric recuperative care provides temporary housing and psychiatric care for persons who do not require inpatient psychiatric hospitalization but have psychiatric needs that require a high level of support. On-site services include medication education and monitoring, observation, case management, and therapeutic support. Like medical recuperative care, psychiatric recuperative care facilities are R2 (multifamily residential) zoned residential housing or building with commercial zoning. Currently, services are rendered by ODR-contracted CBO providers and beds are "leased" by ODR in order to ensure access for ODR clients.
- Residential substance use disorder treatment – Residential substance use disorder treatment is a commonly used intervention for individuals with substance use or co-occurring mental and substance use disorders that need structured 24-hour care. Treatment occurs in licensed residential facilities. ODR partners with the Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) to refer clients to residential substance use treatment and is working with SAPC to identify beds that could be dedicated to diversion clients. Residential substance use treatment requires Department of Health Care Services (DHCS) licensed facilities. For this setting, ODR can access community-based residential substance use disorder treatment beds funded

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

- Permanent supportive housing – Permanent supportive housing pairs long-term rental assistance/subsidies with long-term intensive case management services. Permanent supportive housing can be either a scattered site (e.g., units within community-based multifamily apartments with landlords willing to accept rental assistance and work with ODR's population) or project-based (e.g., ODR secures housing through partnerships with affordable housing developers). Project-based sites have space for case management offices and community activities. Rental subsidies are provided through Housing for Health's Flexible Housing Subsidy pool (FHSP). Intensive Case Management Services (ICMS) is provided through ODR. There is an effort underway to secure federally funded Housing Choice Vouchers (Section 8) in addition to the locally funded FHSP. The FHSP is also used to support placement of ODR clients in licensed Adult Residential Facilities, also known as Board and Cares. These facilities may serve as long-term residences for those who need support with their activities of daily living.
- Social rehabilitation-based acute diversion units – Social rehabilitation-based acute diversion units offer clinical interventions for individuals experiencing an escalating psychiatric crisis, and provide rapid engagement, assessment, and intervention in order to prevent further deterioration. Based on the principles of social rehabilitation<sup>2</sup>, it is a voluntary alternative to Psychiatric Emergency Services. The Dore Clinic, located in San Francisco, funded primarily with Medi-Cal dollars, accepts patients from law enforcement in lieu of booking and connects them to their associated crisis residential housing program, which is often located in community urgent care centers.
- Intensive crisis residential treatment programs – Intensive crisis residential treatment programs provide housing for up to two weeks for people experiencing mental health crises who also have medical needs. These crisis residential programs can be linked directly to social rehabilitation-based acute diversion units and offer ICMS and a path to longer-term interim and permanent housing. These potential pre-booking diversion settings would consist of transitional housing settings with commercial zoning or R2 zoned residential housing that could be connected to the urgent care centers described above. The Dore House (which is connected to the Dore Clinic noted above) in San Francisco, is an example of this model and is funded via Medicaid dollars.
- Intensive outpatient substance use services – Intensive outpatient (ASAM level 2.1) services are outpatient substance use disorder treatment services that are appropriate for patients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Such services are provided to clients for a minimum of nine hours and a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical

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

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

- **Recovery housing** – Recovery Bridge Housing (RBH) is defined as a type of abstinence-focused, peer-supported housing that provides a safe interim living environment that is supportive of recovery for patients (age 18+) who are homeless or unstably housed. Clients in RBH must be concurrently in substance use disorder treatment in outpatient, intensive outpatient, opioid treatment program, or outpatient withdrawal management settings. The services provided in RBH vary, and include peer support, group and house meetings, self-help, and life skills development, among other recovery-oriented services. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
- **Withdrawal management** – Withdrawal management, also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal symptoms from alcohol, sedatives, opioids, and other substances. The goal of withdrawal management is to facilitate safe withdrawal from substances and to provide the appropriate level of support during the withdrawal period, which then allows the client and treatment team to work together to determine an optimal ongoing substance use disorder treatment approach. Withdrawal management services can be provided in outpatient, intensive outpatient, residential, or inpatient settings, when determined to be medically necessary and in accordance with an individualized treatment plan. Withdrawal management services include intake and assessment, observation (to evaluate health status and response to prescribed medication), medication services, and discharge planning.

### **Additional Staffing Capacity Required to Expand Diversion Opportunities**

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

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

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

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

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

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

### **The sources of funds that could support the programs**

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

- **Mental Health Services Act (MHSA)**: California's MHSA permits expenditures in the following areas: 1) Community Services and Supports (CSS), 2) Capital Facilities and Technological Needs (CF/TN), 3) Workforce Education and Training (WET), 4) Prevention and Early Intervention (PEI), and 5) Innovation (INN). ODR's current efforts most closely align with areas 1 and 5.
  - Area 1: MHSA funding is currently used to support DMH Full-Service Partnership (FSP) teams that serve ODR clients, though funding is not sufficient to meet the demand for such services. Area 1 also includes outreach and engagement with underserved populations and the MHSA Housing Program includes development of permanent supportive housing.
  - Area 5: 5% of MHSA funding is distributed to counties for the Innovation (INN) component. Counties use these funds to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of INN is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. The purpose of an INN project is to increase access to underserved groups, increase the quality of services including measurable outcomes, promote interagency and community collaboration, and increase access to mental health services including but not limited to permanent supportive housing.

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

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

- Medicaid (Medi-Cal): DHS is exploring opportunities to draw down Medicaid funding to support the case management costs associated with interim and permanent supportive housing. However, Medicaid already funds other levels of care referred to in this report (e.g., acute and sub-acute psychiatric care, substance use disorder treatment and skilled nursing care). DHS, DMH, and DPH will work together to be sure we are maximizing available opportunities to leverage Medicaid reimbursement to pay for eligible services and placements to which individuals are entitled.
- Federal Housing Vouchers: ODR has historically relied on ODR funding sources for rental subsidies but is currently seeking to secure federal rental subsidies to augment the number of clients and populations that can be diverted. A similar locally based strategy would be to consider amending the Los Angeles County Development Authority's administrative plan to request an additional preference under the Housing Choice Voucher Program (Section 8) to prioritize a specified number of diversion client applicants. This is a strategy that has been successfully employed to provide greater access to rental assistance subsidies for persons experiencing homelessness via the Coordinated Entry System. The strategy would need to include sufficient client services and administrative resources to maximize the likelihood of a successful, long-term housing placement.
- Measure H: Measure H is a quarter cent sales tax in Los Angeles County that was designed to address homelessness and provide services and housing. A portion of Measure H funding is allocated for interim housing for individuals exiting institutions (inclusive of hospitals) and it is reasonable to explore opportunities to designate set asides in Measure H funded beds for diversion clients.

#### **The legislative and/or policy changes needed**

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

#### ***Proposed Federal Legislation***

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

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

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

- HR 1329: HR 1329 is bipartisan legislation that empowers states to expand access to Medicaid services for incarcerated individuals up to 30 days before release from jail or prison. When putting forward this legislation, the sponsor stated, "Empowering states to deliver needed treatment to individuals as they transition out of the criminal justice system not only helps the individuals address their [medical and mental health] needs, but also makes our communities safer, saves money over the long term, and delivers vital services to a truly vulnerable group of people."
- HR 1345: The U.S. Supreme Court's interpretation of the Eighth Amendment requires government entities to provide medical care to all inmates, but people who are incarcerated in a county jail or juvenile detention facility typically lose their Medicare, Medicaid, Children's Health Insurance Program (CHIP) or Supplementary Security Income (SSI) benefits, even if they have not been convicted of a crime. As a result, local governments are burdened with the expense of providing health care to thousands of men, women, and children awaiting trial. Indeed, requiring county governments to cover health care costs for inmates who have not been convicted places an unnecessary burden on local governments, which have already been negatively impacted by widespread budget deficits and cuts to safety net programs and other essential services. Terminating benefits to inmates who are awaiting trial also taints the presumption of innocence and disproportionately affects low-income and minority populations who do not have the means to post bail, which paradoxically would enable them to continue receiving benefits.

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

#### *Federal Legislation Needed*

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

*Proposed State Legislation*

- **SB 282:** This bill requires the California Department of Corrections and Rehabilitation (CDCR) to transfer all funds from the Integrated Services for Mentally Ill Parolees (ISMIP) program to the California Department of Housing and Community Development (HCD) for the newly created Supportive Housing Program for Persons on Parole, to provide permanent supportive housing and wraparound services to mentally ill parolees who are homeless or at risk of homelessness. This bill recognizes that individuals on parole are seven times more likely to recidivate when homeless than when housed. Evidence shows that supportive housing, or housing that is affordable to people on parole living in extreme poverty that does not limit the length of stay and offers tenants services promoting housing stability, reduces recidivism and improves the tenant's ability to recover from mental illness. After a 2017 UCLA study showed that the ISMIP program did not significantly reduce recidivism, this bill was proposed with the goal of strengthening programs for our most vulnerable people on parole to promote evidence-based, wraparound services, including rental subsidies, in an amount adequate to allow mentally ill parolees experiencing homelessness, or at risk of experiencing homelessness upon release from prison, to obtain and maintain housing stability during and after the term of parole, thereby reducing recidivism among those with a history of homelessness.
- **SB 665:** SB 665 would use MHSA funds to provide services to individuals in county jail or who are under mandatory supervision. This would not apply to those in state prisons or those in jail that are convicted of a felony. The use of these funds would go through the same public process required for all MHSA programing. Regarding this Senate Bill, Senator Umberg stated, "With the number of incarcerated who are suffering from mental health issues and limited funding sources for treatment, it is critical to explore the flexibility of existing mental health funding sources and that is what this bill would do."

*State Legislation Needed*

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

**IT resources needed**

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

#### **Practice and/or cultural transformations needed in individual departments**

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

#### **NEXT STEPS**

- 1) **Provide this report to the ATI:** The ATI final report will be presented in December of 2019. We hope this preliminary report will provide important information for the group to consider as it develops implementation plans for their recommendations, which include but go beyond the scope of this report.
- 2) **Develop plans to better understand the diversion potential among the jail population struggling with addictions as well as other medically complex populations:** DHS and DPH will partner together to consider potential options and pathways in support of substance use diversion efforts, including ultimately a formal study of the divertability among substance use disorder populations. ODR will also continue to work to expand and study diversion of medically fragile individuals.
- 3) **Support development of a siting plan for needed community-based capacity:** This report presents estimates of the numbers of resources needed, particularly for those with serious mental illness who are thought to be appropriate for diversion. Next, the County should determine how these resources could be developed and built and how to start the capital and real estate process to create them. As requested in the August 13, 2019 Board motion, “Exploring a Decentralized Continuum of Community-Based Services and Care for Los Angeles County,” the CEO and Department of Public Works with input from DMH, DPH and DHS will report back on a specific siting plan, including the number of beds that are required and the estimated cost for construction or renovation.
- 4) **Engage in continued partnership and advocacy with the State regarding support for diversion efforts:** The Board could consider sending a letter to the Governor asking

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

- 5) **Promote legislative agenda:** County stakeholders and representatives from the Los Angeles County Departments will provide support for the CEO's efforts in working to get the bills described herein passed, including visiting and speaking with policy makers in Sacramento.
- 6) **Explore modifying Measure H Plan:** Efforts could be made to investigate whether the Measure H Plan could be modified and explore opportunities to designate set asides in Measure H funded beds for diversion efforts.
- 7) **Maximize MHSA dollars:** The Los Angeles County's current efforts in diversion most closely align with MHSA's expenditures in CSS and INN areas; the potential applicability to diversion of other MHSA funding categories is unclear. Further exploration of the feasibility of dedicating MHSA funds, across all categories, to support diversion efforts would be informative and provide the Board with valuable information on potential ongoing sources of funds for diversion programs.
- 8) **Calculate staffing needs:** Future reports will provide information on additional staff needed to ramp up and support diversion at scale, providing detailed ratios of staff by classification per patients served, including consideration of the need for additional staffing among County justice partners.

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

CRG:ko

#### Attachments

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

## SPECIAL REPORT

April 17, 2019

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

**OFFICE OF DIVERSION  
AND REENTRY**

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

## Introduction

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

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

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

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

## Methods

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

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

## Results

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

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

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

## Conclusions

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

May 11, 2019

## Addendum

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

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

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

<sup>1</sup> Overall JMH population ( $N=5134$ ) compared to combined diversion study sample ( $n=500$ ) using Fisher's exact test

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



SARAH B. HUNTER, ADAM SCHERLING

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

## A Study of Participants' Housing Stability and New Felony Convictions

### KEY FINDINGS

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

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

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

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

## Methods

We used ODR data that represented participants enrolled in the supportive housing program between

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

April 2016 and April 2019. The data set provided participant demographic information and clinical diagnosis as determined by ODR personnel. We summarized this information to help describe who is being served by the program.

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

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

## Findings

### Program Participants

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

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

**91%**

had stable housing  
after 6 months

**74%**

had stable housing  
after 12 months

**86%**

had no new felony  
convictions after  
12 months

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

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

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

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

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

**78%** mental health disorder (psychotic and bipolar disorders most prevalent)

**51%** psychotic disorder

**58%** substance use disorder

**39%** co-occurring mental health and substance abuse disorders

**19%** substance abuse disorder (only)

**3%** serious physical health issue or pregnant

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

The study samples featured in our outcome analyses ( $n = 187$  and  $n = 96$ ; i.e., those who were housed at least six and 12 months prior to the end of

the study period) were similar to the total population in terms of demographic, service utilization and clinical diagnoses.

### Housing Stability

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

TABLE 1

## ODR Supportive Housing Participant Characteristics

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

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

### Six Months

Of the full group of 187 individuals, 169 people were in a permanent housing situation at six months. One individual had moved to a higher level of care and therefore was not considered in the calculation. The remaining 17 people were documented as living in temporary or unstable living conditions: jail or prison (*n* = 8), returning to interim housing or the

street (*n* = 3), residing in a substance use disorder treatment program (*n* = 1), or in an “other/unknown” status at exit (*n* = 5).

### Twelve Months

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

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

## Felony Rates

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

## Conclusions

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

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## About This Report

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

## RAND Justice Policy Program

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

Questions or comments about this report should be sent to the project leader, Sarah B. Hunter, at [Sarah\\_Hunter@rand.org](mailto:Sarah_Hunter@rand.org).



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

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

**Abbreviations:**

LOC: Level of Care

ALOS: Average Length of Stay

FIP: Forensic Inpatient Unit

HOH: High Observation Housing

MOH: Moderate Observation Housing

SUD: Substance Use Disorder

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<sup>1</sup> Based upon the Los Angeles Sheriff's Department Mental Health Count

<sup>2</sup> Based upon "P level" clinical distinctions within housing levels

<sup>3</sup>  $C \times D = E$

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

<sup>5</sup>  $E \times F = G$

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

<sup>7</sup> 365 days per year  $\div$  H

<sup>8</sup>  $G \times I = J$

<sup>9</sup> Acute inpatient based upon 6C unit at OVMC, other settings based upon Housing for Health average LOS, Detox and Substance Use settings based upon SAPC average LOS

<sup>10</sup> 365 days per year  $\div$  K

<sup>11</sup>  $J \div L = M$

<sup>12</sup> 1000 ODR interim housing placements are already in supply, thus 1,579 are needed.

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

<sup>14</sup> Year 1 begins with current number of persons already in ODR PSH, 1000 units are already in current supply

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