CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

COUNCIL ON MENTALLY ILL OFFENDERS

EIGHTH ANNUAL REPORT

December 31, 2009

History and Purpose of the Council

On October 12, 2001, former Governor Gray Davis signed Senate Bill (SB) 1059 (Chapter 860, Statutes of 2001) (Perata) creating the Council on Mentally Ill Offenders (Council). The bill is codified as Penal Code Section 6044 which set forth a sunset date of December 31, 2006. In 2006 Governor Arnold Schwarzenegger signed SB 1422 (Chapter 901, Statutes of 2006) (Margett) which eliminated the sunset date.

The Council is comprised of 11 members, and the legislation designates as permanent members the Secretary of the Youth and Adult Correctional Agency (now the California Department of Corrections and Rehabilitation [CDCR]) and the Director of the California Department of Mental Health (DMH), with the CDCR Secretary serving as the chair and the DMH Director serving as vice-chairperson. Other Council members are appointed as follows: three by the Governor, at least one of whom shall represent mental health; two each by the Senate Rules Committee and the Speaker of the Assembly, each appointing one representative of law enforcement and one representative of mental health; one by the Attorney General; and one superior court judge appointed by the Chief Justice.

The Legislature identified several related purposes of the Council. Its primary purpose is to "investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending." In pursuit of that goal the Council is to:

1) Identify strategies for preventing adults and juveniles with mental health needs from becoming offenders.
2) Identify strategies for improving the cost-effectiveness of services for adults and juveniles with mental health needs who have a history of offending.
3) Identify incentives to encourage State and local criminal justice, juvenile justice, and mental health programs to adopt cost-effective approaches for serving adults and juveniles who are likely to offend or who have a history of offending.

The Council shall consider strategies that:

1) Improve service coordination among State and local mental health, criminal justice, and juvenile justice programs.
2) Improve the ability of adult and juvenile offenders with mental health needs to transition successfully between corrections-based, juvenile-based, and community-based treatment programs.

The Council is authorized to apply for funds from the "federal government or other sources to further the purpose of this article." In addition, in signing the legislation the Governor directed the affected State agencies to identify existing funds that can be used to support this program."

Legislation creating the Council required that the Council "file with the Legislature, not later than December 31 of each year, a report that shall provide details of the Council's activities during the preceding year. The report shall include recommendations for improving the cost-effectiveness of mental health and criminal justice programs." This requirement was changed as a result of the 2006 legislation that directed COMIO's 2007 annual report be submitted to the Secretary of the CDCR. For 2008 and subsequent years, the annual report is once again to be filed with the Legislature.

Composition of the Council in 2009

Chairperson: Matthew L. Cate, Secretary, CDCR
Vice-Chairperson: Stephen Mayberg, Ph.D., Director, DMH

- Joel Fay, PsyD., Mental Health Liaison Officer, San Rafael Police Department
- David Lehman, Chief Probation Officer (retired), Humboldt County, and former member of the Board of Corrections (now the Corrections Standards Authority)
- Wendy Lindley, Judge, Orange County Superior Court
- Duane E. McWaine, M.D., Medical Director, Didi Hirsch Community Mental Health Center, Los Angeles
- David Meyer, J.D., Professor, Institute of Psychiatry, Law and Behavioral Science, Keck School of Medicine, University of Southern California, and former Chief Deputy Director, Los Angeles County Department of Mental Health
- Jo Robinson, M.F.T., Program Director, San Francisco Jail Health and Psychiatric Services
- James W. Sweeney, J.D., Principal, James W. Sweeney & Associates
- Charles L. Walters, Ph.D., Assistant Sheriff, Orange County Sheriff-Coroner Department

Member Changes in 2009

There were no member changes to the Council in 2009. One vacancy remained unfilled this year.

Support Staff

Legal Counsel

Bruce Slavin, Chief of Legal Policy, CDCR, offers legal guidance to the Council.

Executive Officer

Allan Lammers, Retired Annuitant, CDCR, served in the Executive Officer position for the past three years through September 2009. Unfortunately, the present budgetary crisis resulted in the State terminating all contracts for retired annuitants. As a result the Executive Officer position is presently vacant. Staffing was provided by CDCR on an as needed basis from October through December of this year.

Activities of the Council in 2009

Council discussions in 2006 led to the development of eight priorities and goals for 2007 and beyond. An additional ninth goal was added in COMIO's 2007 annual report and a tenth goal has been added in this report. This section sets out the established goals and offers progress notes (**in bold**) as to actions taken by the Council toward achieving each goal during 2009. The overall and far-reaching Council priority is to focus on reentry facilities and partnerships in communities to provide more effective transition for adults and juveniles coming out of institutions. The goals are to:

1. Determine effective minimum standards for assessing mental incompetence in the justice system – ***A "Competency to Stand Trial" Checklist was drafted and approved by Council members in 2008 and was introduced for consideration to the Administrative Office of the Courts Task Force in 2009.***

2. Develop mechanism to educate the Legislature on needs of the mentally ill offender population including need for mental health courts and using greater amount of Proposition 63 funding for mentally ill offenders – ***In 2007 SB 851 was introduced by Senator Darrell Steinberg but was not signed into law. During the 2008 session, SB 851 was reworked and introduced as SB 1651. Due to budget constraints, the bill was not passed in 2008 or in 2009.***

3. Create communication links with programs throughout the State that serve mentally ill offenders in order to develop a "Best Practices" program – ***The first COMIO Best Practices Survey was completed and recognition was given to five extremely effective projects in 2008 (see Appendix D for project descriptions).***

   A new category of "Promising Projects" was added in 2009. Such projects offer exciting direction but may lack statistical support or maturity in terms of length of implementation time (see Appendix B). In March, award presentations were made in conjunction with the California Forensic Mental Health Association's annual conference (see

Appendix A for 2009 recipients). The Council and the Association have developed a very effective collaboration during the past several years. A complete list of all 2009 Best Practices applicants is available in Appendix C.

4. Coordinate a website with CDCR that includes basic information on programs, discussion boards, and links to other agencies – **The COMIO *website is up and running with ongoing updates and enhancements being made. The potential for a podcast capability continues to be assessed.***

   The website URL is: http://www.cdcr.ca.gov/COMIO/index.html.

5. Promote the development of a consistent set of performance measurements and outcome measurements that could serve to gauge treatment effectiveness – ***A volunteer group of experts was formed by one of the Council members during 2008 to develop a common mental health screening tool for use by all jails. Ideally this would function from computer to hard copy. During 2009, a pilot to test the tool was initiated in three counties – San Luis Obispo, San Bernardino, and San Francisco. In addition, the tool has been proposed for consideration to the Administrative Office of the Courts Task Force on Criminal Justice-Collaborative with Mental Health.***

6. Support a collaborative dialogue among mentally ill offender service providers and academia to determine future needs of the mentally ill offenders at the State and local levels, e.g., "From Words to Deeds" conferences – **In 2009 Council members once again were involved in all phases of the annual "From Words to Deeds" Conference *(see "Changing the Paradigm" below).***

7. Consider designing guidelines for an enhanced training approach for law enforcement personnel who deal with the mentally ill out on the streets and within correctional institutions. This is based on a briefing and demonstration provided to the Council at its November 29, 2006 meeting by the Orange County Sheriff's Department. The briefing included a "true-to-life" demonstration scenario of a mentally disabled female (played by an actress) being effectively and peacefully addressed by a Sheriff's Officer (CD available upon request) – ***In 2009 two Council members were actively involved in extending the Crisis Intervention Teams (CIT) concept through the formation of a new statewide CIT organization.***

8. Request the Corrections Standards Authority (CSA) to consider a review of current standards for space requirements in jails and juvenile hall facilities, and recommend staffing and space allocations for mentally ill offender treatment programs as part of normal CSA standards review and revision process (as CSA funds and staffing permit) - ***The CSA approved such a study in May 2008; however, budget considerations delayed the initiation of the study until 2009. In September 2009, the CSA released their report "Jails and the Mentally Ill: Issues and Analysis." An***

Executive Summary including recommendations is available in Appendix E of this report.

9. Explore methodology and strategy to perform a study to determine the number of juvenile offenders in local facilities on psychological medications and to identify the types of diagnoses – ***Originally it was hoped that this goal could be met through the CSA study discussed above in item 8; however, as the consultants developed the study it became necessary to become more focused on fewer issues and this issue was not addressed. There is the possibility of such a study becoming a part of CSA's future periodic review of the standards in Titles 15 and 24 of the California Code of Regulations.***

10. **NEW:** In 2010 the Council intends to carefully review and discuss the recommendations of the newly released and very important CSA study to determine future strategies and actions to be adopted the Council.

Council Members Address "Changing the Paradigm"

Council members are dedicated to the improvement of services for mentally ill offenders whether adult or juvenile. Taking action beyond their role in the Council, members have exhibited an ongoing commitment to stimulating discussion and enhancing dialogue statewide through their involvement with the "From Words to Deeds" Conference series subtitled, "Criminal Justice and Mental Health: Changing the Paradigm." Since its inception in 2004, the purpose of "From Words to Deeds" is to identify and advance strategies to effectively divert individuals with mental illness from jail. Strategies discussed promote early intervention, access to effective treatments, planned reentry, and the preservation of public safety. Each conference features a "what works" segment that reviews successful ideas and projects from around the country for participants to discuss. Also featured are small group discussion opportunities to develop "action steps" so that participants can leave the conference with some guideposts for implementing all or part of what they have learned.

As in the past, several of the Council members were actively involved in conference planning, moderating panels, leading discussion groups, and evaluating this year's From Words to Deeds Conference which was sponsored by the California State Sheriffs' Association, the Eli Lilly Foundation, and Yolo County Supervisor Helen Thompson. The 2009 conference theme sought to come up with strategies for where we go from here. Unfortunately, at present, future conferences are in doubt due to lack of funding support.

Other Council Member Activity

Council members were active in a variety of State and national activities. Several members offered advice and consulting services in and outside California. Council member Jo Robinson participated in a National Institute of Corrections' satellite/internet broadcast titled, "The Mentally Ill in Jail – Whose Problem Is It Anyway?" In addition, members Joel Fay and Charlie Walters were instrumental in creating a statewide CIT training organization that will emphasize the benefits of CIT training and share ideas about improved CIT techniques.

Future Council Meetings for 2010

Typically the Council meets on the third Thursday of every other month beginning in January of each year. The exception is a Wednesday meeting in March when the Council meets in conjunction with the Forensic Mental Health Association's Annual Statewide Conference. For 2010, the Council has established the following tentative meeting dates and locations as follows:

January	21 – CDCR Headquarters Office 1515 S Street – Conference Room 502S Sacramento, CA 95811
March	24 – Seaside, CA - held in conjunction with the Forensic Mental Health Association's Annual Statewide Conference
May	20 – CDCR Headquarters Office 1515 S Street – Conference Room 502S Sacramento, CA 95811
July	15 – CDCR Headquarters Office 1515 S Street – Conference Room 502S Sacramento, CA 95811
September	16 – CDCR Headquarters Office 1515 S Street – Conference Room 502S Sacramento, CA 95811
November	18 – CDCR Headquarters Office 1515 S Street – Conference Room 502S Sacramento, CA 95811

COMIO 2009 Annual Report Appendix A:

Council on Mentally Ill Offenders
2009 COMIO Best Practices Award Recipients

ADULT Category

Supervised Treatment After Release (STAR) - San Bernardino County

STAR has been in operation for ten years. The program was created to affect a shift in institutional response from the criminal justice system to the mental health system and to maintain seriously mentally ill individuals in the least restrictive environment possible consistent with personal and community safety. Well over 600 people (felons included) have been served usually spending 12 to 24 months within the program. An analysis of the behavior of 149 participants over a seven-year period indicates the number of bookings decreased by 64 percent, the number of jail bed days decreased by 65 percent and the number of institutional placement days was reduced by 66 percent. STAR has effectively reduced recidivism for incarceration, shifted the demand for services to the mental health system, and provided significant benefits for consumers in terms of deinstitutionalization.

JUVENILE Category

Integrated Mental Health Assessment and Treatment Continuum for Juvenile Probation and Youth - Sacramento County Collaboration

The River Oak Center for Children began implementing Multisystemic Therapy (MST) in 2004 in collaboration with the Sacramento Probation Department. This was expanded in 2007 to include Sacramento County Mental Health, Quality Group Homes, and Panacea Incorporated. Objectives of the program, which focuses on youth ages 10 to17 for three to five months is to reduce anti-social behavior, improve family problem solving, and enhance positive school and vocational involvement. Nearly 200 clients have been served and 400-plus additional children and family members have benefited from the MST approach. From 2004 to 2008, 73 percent graduated, 72 percent of youth are living at home at time of discharge, 84 percent are in school or working, 82 percent have no new arrests, and 81 percent of parents demonstrate skills necessary to handle future problems. The approach of an effective use of outcome measures offers a strong case for measuring an individual's successful completion of the program.

COMIO 2009 Annual Report Appendix B:

Council on Mentally Ill Offenders
Promising Project Recognition – New in 2009

Typically a notable difference between projects designated as Best Practices and Promising Projects is that the Best Practices Projects have a combination of program maturity and a strong approach to statistical analysis and evaluation used to document success.

JUVENILE Category

Juvenile Mental Health Court

Since inception in 2001, the Los Angeles County Juvenile Mental Health Court (JMHC) has accepted 315 children. It acts as a referral court for all minors found to be incompetent in Los Angeles County and is the only delinquency court in California that specifically accepts children who have been found incompetent by the referring court. Typically, the JMHC probation period lasts two years, and with successful completion of probation, the minor's case may be dismissed. While most cases are considered successful, "there is no yardstick by which all the minors in the JMHC are judged." The diverse collaborative team looks at each child and devises a treatment plan that addresses each child's disabilities as well as strengths.

ADULT Category

Mental Health Court

Inaugurated in 1999, the Placer County Mental Health Court has served about 600 defendants and presently does not receive any funding from any of the collaborative agencies. The Court's success uniquely depends upon commitment from all participants representing diverse and sometimes oppositional agencies. Partner commitment encompasses dedication to improve outcomes of mentally ill offenders including reduced recidivism. While data collection methods are under development, evaluation analysis has not been used to determine success. There is a sense among the participants that jail population and recidivism are reduced and more defendants are receiving not only much needed mental health treatment, but an improved quality of life as well.

Mental Health Court

The Riverside County Mental Health Court originally established in 2001 was reestablished in 2006. Misdemeanors as well as felons are considered for acceptance. Referral can originate from a variety of sources building upon a collaborative that is composed of formerly conflicted agencies. The program objective is to provide individuals with a linkage to mental health treatment outside of detention, identify community resources to facilitate continuity of care, increase treatment compliance, and promote public safety. The two court locations annually serve 115-plus and 70-plus respectively. While the program has not implemented the model (2007 article in the *American Journal of*

Psychiatry) of rigorous data design and evaluation referenced in their application, the project does use measures to determine program success including completion of treatment goals, stabilization of mental illness, and compliance with the terms of probation.

Whatever It Takes Court

Orange County's Whatever It Takes (WIT) Court is a post-adjudication alternative targeting chronically, persistently mentally ill individuals who are homeless or at risk of becoming homeless and have criminal charges. Initiated in 2006, participants are provided intensive mental health and/or substance abuse treatment, case management and an intense level of judicial and probation supervision and monitoring. Similar to other problem-solving courts such as drug courts, this is a collaborative partnership made up of a multidisciplinary team. Unique to the WIT Court is that each participant is assigned a Personal Service Coordinator, at a ratio of one to every ten clients, who provides supportive treatment and assists clients with every facet of their recovery. Ninety-eight individuals have been admitted to the program with 16 being terminated. Of the five graduates, the average length of time from program entry to graduation is 630 days. While this program is immature with a small number of participants, data is being collected and an internal evaluation of the program is planned.

COMIO 2009 Annual Report Appendix C:

Council On Mentally Ill Offenders
2009 COMIO Best Practices
Listing of All Applicants

JUVENILE Category

DJJ UNIT - PUBLIC DEFENDER DIVISION OF JUVENILE JUSTICE (DJJ)
Los Angeles County Public Defender

IMAT – INTEGRATED MENTAL HEALTH ASSESSMENT AND TREATMENT CONTINUUM FOR JUVENILE PROBATION AND YOUTH
River Oak Center for Children (Sacramento)

JUVENILE MENTAL HEALTH COURT
Los Angeles County Probation Department (Lead) and Los Angeles County Superior Court

POST DISPOSITION PROJECT
Los Angeles County Public Defender

ADULT Category

PLACER COUNTY MENTAL HEALTH COURT
Placer County Health and Human Services Department

RIVERSIDE COUNTY MENTAL HEALTH COURT
Western Riverside County Region of Riverside Superior Court

STAR – SAN BERNARDINO COUNTY FORENSIC SUPERVISED TREATMENT AFTER RELEASE PROGRAM
San Bernardino County Department of Behavioral Health

WIT – WHATEVER IT TAKES COURT
Orange County Superior Court

COMIO 2009 Annual Report Appendix D:

Council On Mentally Ill Offenders
2008 COMIO Best Practices Recipients

Adult Category

Behavioral Health Court - San Francisco Superior Court

An evaluation of the San Francisco Behavioral Health Court, one of the only pre-plea felony court programs in the nation, appeared in the September 2007 issue of *American Journal of Psychiatry* indicating that a mental health court can reduce the risk of recidivism and violence by people with mental disorders who are involved with the criminal justice system. Eighteen months after graduation, the estimated risk of these individuals being charged with any new offense was about 39 percent lower than the comparison group and 55 percent lower of being charged with a violent offense. Since its inception in 2003, the Behavioral Health Court has 173 graduates with another 160 currently in the program.

Co-Occurring Disorders Court - Orange County Superior Court

The Orange County Co-Occurring Disorders Court is a post-adjudication alternative for felony drug offenders who have been diagnosed as chronically, persistently mentally ill. The court aims to reduce recidivism by providing coordinated treatment which includes a high level of judicial and probation supervision and monitoring. Average length of program participation is 763 days. Unique to this program is a highly structured yet individualized four-phased treatment and recovery plan design that must be followed by the participants in order to achieve graduation. Since program initiation in late 2002, 123 individuals have entered the program and 40 have graduated.

Mental Health Treatment Court - Santa Clara County Superior Court

The Santa Clara County Mental Health Treatment Court was established in 1997 and is considered the first mental health court in California. A major goal at its initiation was to change the orientation within the County from "jail and prison incarceration" to "community-based treatment" with court-supported intervention and problem solving. In 2006 alone, the program saved 113,344 jail bed days translating into a county savings of $7,874,007 and a savings to the state of California in excess of $16,376,000. Although formal tracking of the program participants was not initiated until 2001, since that time 1,075 have graduated while 262 have been terminated. Presently there are 1,500 people in the program.

COMIO 2009 Annual Report Appendix D (Continued):

Council on Mentally Ill Offenders
2008 COMIO Best Practices Recipients

Juvenile Category

Client Assessment Recommendation Evaluation Project
Los Angeles County Public Defender

The Client Assessment Recommendation Evaluation Project, more commonly known as CARE, operates in the ten juvenile branch offices of the Los Angeles Public Defender with the focus of assessing, identifying, and making effective recommendations to the Juvenile Court to address children's mental health and special education needs at the earliest stages of the court process. This approach involves a multidisciplinary team of psychiatric social workers, mental health professionals, resource attorneys, as well as other clinicians. Since the program's inception in 1999 through June 2007, 11,000 children have received project services. In the 2006-07 fiscal year alone, 1,298 new clients received 7,220 types of services. A recent study found that 76 percent of the youth whose cases were opened and closed between February 2004 and December 2005 had no new charges filed in juvenile or adult court during the subsequent year. During the past four and one-half years, the courts have adopted 83 percent of the CARE disposition recommendations. There are typically 400 youth in the program for a 90-day period.

Court for the Individualized Treatment of Adolescents
Santa Clara County Superior Court, Juvenile Delinquency Division

The Court for the Individualized Treatment of Adolescents (CITA) seeks approaches supportive to the individual, community-based, family centered, and culturally appropriate. It holds the juvenile accountable involving the victim (where possible) and in a collaborative manner, attempts to treat the underlying causes for the juvenile's behavior combined with an objective of reducing recidivism. Initiated on February 14, 2001, CITA is the first juvenile mental health court in the country and has developed an evolving set of graduation criteria that now have been replicated by others throughout the country. CITA has a set population cap of 75 minors at any one time. One hundred seventy-one have successfully completed the one-year program out of 255.

COMIO 2009 Annual Report Appendix E:

"Jails and the Mentally Ill: Issues and Analysis"

A briefing paper developed by the California Corrections Standards Authority (CSA) at the request of the Council On Mentally Ill Offenders (COMIO) – September 2009. To review the complete paper go to the COMIO website at http://www.cdcr.ca.gov/COMIO/index.html .

Executive Summary and Recommendations

WHAT: Interested in helping to improve the continuum of care for people with mental illness who come in contact with the criminal justice system, the California Department of Corrections and Rehabilitation (CDCR) Council on Mentally Ill Offenders (COMIO) asked the Corrections Standards Authority (CSA) to produce a 'white paper' discussing key issues and best practices related to the increasing population of mentally ill people in jails. The paper's goal was to further the effective management of inmates with mental illness by addressing such issues as classification, housing, programming, treatment, staffing and staff training. The paper is intended as a resource for COMIO, CSA, the California State Sheriffs Association (CSSA) and jail managers statewide.

HOW: CSA convened a Mentally Ill in Jails Workgroup, comprised of custody and mental health practitioners from jails across the state to develop the paper. The Workgroup, supported by CSA staff and a consultant, devoted considerable time and effort to producing a relatively brief and readable paper that addresses some of the most pressing issues facing California's jails and presents helpful information to support jails in their ongoing work with mentally ill people who come in contact with the criminal justice system.

MAJOR FINDINGS: In their work with people with mental illness, jails are part of a large and complex system of care. Inextricably connected with treatment providers, state and local mental health agencies, state mental hospitals, courts, inmates' families, advocacy organizations and others who have a stake in the treatment of mentally ill people, jails are faced with a multitude of challenges which they cannot address alone. The major finding of this paper is that it is essential to develop and maintain a unified approach incorporating the many disciplines and agencies that share responsibility for working with mentally ill people in order for California's jails to be effective in serving the mentally ill in custody and facilitating, to the greatest extent possible, their productive reentry to the community after custody.

RECOMMENDATION: *It is a central recommendation of this paper that all those who deal with mentally ill people in jail – those who are and/or should be responsible – come together and work on resolving issues. Multi-agency problems, like those surrounding the treatment of mentally ill, COD and other special needs people in jails, demand multi-agency solutions. Interagency*

*collaboration is at the top of the list of **Best Practices** for serving the mentally ill in jails.*

RELATIONSHIPS

The key issues identified by the Mentally Ill in Jails Workgroups relate to the context in which jails operate as well as to jail operations themselves. It is clear that many of the problems facing jails regarding mentally ill inmates have to do with resource limitations – both the jails and other agencies. Jails are not mental health treatment facilities yet they have to accept people with mental illness who are charged with or convicted of crimes. Mental health treatment facilities – of which there are way too few – have limited capacity and are reluctant to accept people who have come in contact with the criminal justice system, both because they have no expertise in dealing with law breakers (that's corrections' job) and because they fear for the safety of their other clients from mentally ill offenders. In short, resources available in the community affect the demands made on the jail; conversely, the jail's ability to provide mental health services depends on support from the community and beyond. Relationships are therefore critically important.

Department of Mental Health -- Relationships between jails and the State Department of Mental Health (DMH) and its state hospitals, as well as jails' relationships with their local mental / behavioral health agencies are essential to jails' ability to work with mentally ill inmates. Collaboration between mental health agencies and jails not only supports the appropriate treatment of mentally ill people in custody, it also helps remove those who do not belong in jail, facilitates transition for those being released from jail and reduces relapse and recidivism of those who are released.

RECOMMENDATION: *To further existing, and build new, interagency collaborations, dialogue should be established and maintained between sheriff's departments (or local departments of corrections) and departments of mental / behavioral health to cost effectively improve service delivery and resolve problematic issues related to mentally ill people in jails.*

State Hospitals – The Mentally Ill in Jails Workgroup described what it considered critical failings in what should be another mutually supportive relationship – between state hospitals and jails across the state. While state hospitals and jails deal with many of the same people, there is very little coordination or collaboration in the continuum of care.

RECOMMENDATION: *Integration is critically needed between state hospitals and county jails. To improve the continuum of care, reduce or eliminate road blocks to cooperation and seek ways to cost effectively improve services for people determined to be incompetent to stand trial (IST) and other mentally ill people who are the shared responsibility of state hospitals and jails, it is vital that there be ongoing dialogue between sheriff's departments (or local departments of corrections) and the state DMH and its state hospitals. Courts and probation*

departments should also be involved in these discussions as both play important roles in the continuum of care for mentally ill offenders. Toward this end, it is suggested that the Administrative Office of the Courts (AOC), County Supervisors of California (CSAC), California State Sheriff's Association (CSSA), Chief Probation Officers of California (CPOC), and California Mental Health Directors Association (CMHDA) initiate strategic discussions about how to more effectively integrate these interdependent systems of care.

Courts -- Courts make decisions about sentencing, maintaining in jail, sending to state hospitals and/or treating mentally ill offenders in the community. It is extremely important therefore, that jails communicate and maintain productive relationships with their local judges. Keeping officers of the court advised of the jail's issues and concerns, and facilitating liaison with the court will enable smoother transitions and more informed decision making throughout the jail and mental health systems.

RECOMMENDATION: *Jail managers and other key staff are encouraged to build and maintain relationships with judges and other court officers that help keep these important partners up to date on mental health issues in the jail. Strategies that have proven useful in some California jurisdictions include:*

- *Inviting judges to the jail to see how mentally ill offenders are housed and the services offered as well as the limitations and challenges faced by jail staff in providing for these inmates (otherwise the court gets only the inmates' side of the story);*
- *Making presentations at judicial retreats;*
- *Giving judges a contact person at the jail, someone from whom they can get information right away when they need it; and*
- *Asking the court to expeditiously calendar cases affecting mentally ill defendants and to support interagency reentry planning for those mentally ill offenders under the court's jurisdiction.*

Additional Collaborations -- There is a large and growing body of research proving the value of multi-agency collaboration in all kinds of service delivery. Numerous models and samples of *Best Practices* in this regard are described throughout this paper, and more need to be developed. Only in conjunction with each other will the multiple agencies that interact with mentally ill people in the justice system be able to provide an adequate continuum of essential, cost effective and coordinated services.

RECOMMENDATION: *Each county is encouraged to develop a high level, interagency planning process, perhaps in the form of a "Forensic System of Care" (FSOC) for those people involved in the criminal justice system who have mental health and/or COD issues. Similar to the Adult and Children's Systems of Care (ASOC and CSOC), the FSOC would seek to develop comprehensive and integrated plans for the target population's unique needs. The goal of each FSOC would be to maximize integrated efforts among the many stakeholders*

who are (or should be) interested and/or involved in dealing with mentally ill people who come to and through the county's jail(s). Such an integrated approach could be expected to:

- *Clarify roles and responsibilities to enhance service delivery;*
- *Reduce duplication and overlap in service;*
- *Identify and help fill service gaps;*
- *Provide a forum for solving longstanding as well as emerging problems; and*
- *Create a cost effective, collaborative and comprehensive continuum that advances public safety throughout the county.*

JAIL SPECIFIC ISSUES AND RECOMMENDATIONS

Lack of Community Based Treatment Capacity -- Community mental health programs are not sufficiently able to engage the numbers of people needing mental health and COD treatment. There are not enough treatment beds — in communities or in state hospitals – to accommodate all those with serious mental health and COD treatment needs. The dearth of capacity is compounded by the fact that all mental health treatment is voluntary.

In the current fiscal climate, it is highly unlikely there will be program expansion or development of additional treatment beds, at either the local or state levels. Nonetheless, the numbers of mentally ill people needing treatment will continue to increase. The efforts identified as most effective are those that seek to break down the silos and enhance collaboration to better serve mentally ill people within currently existing, albeit limited, resources. These efforts combined with the high level oversight referenced above show great promise of identifying system wide and regional cost reductions.

RECOMMENDATION: *Using available models and additionally developing innovations best suited to each jurisdiction, jails across California should collaborate with mental health, substance abuse and other health agencies to develop integrated treatment for people with mental illness and COD, to keep them out of jail and to reduce relapse and recidivism of those who are incarcerated*

Diversion -- It is treatment effective and cost effective to divert from jail everyone, especially people with mental illnesses, who can be safely managed in the community. Community based diversion programs, such as Crisis Intervention Teams (CIT), Mental Health Courts and wraparound programs, are showing good results in directing people with mental illness into services, before and in lieu of jail.

RECOMMENDATION: *Every effort that can be made should be made to divert mentally ill people from jail. Counties that do not currently have multidisciplinary diversion or integrated treatment teams, adequate community based treatment capacity, Mental Health Courts or Calendars and/or CIT-based or other full service partnership programs providing wraparound services are urged to contact*

agencies that are effectively using these strategies to discuss implementation possibilities.

Screening and Assessment -- For those mentally ill people who are not diverted, jails must provide mental health screening and assessment to identify mental illness, COD, developmental disabilities and important risk factors such as suicide risk and withdrawal from alcohol and other drugs. Mental health assessment will help identify those who are appropriate for general housing, those requiring medication, those needing supportive services and referrals, those requiring specialized housing, and those requiring in-patient treatment.

RECOMMENDATION: *To properly classify, divert and/or house each person entering the system, jails must immediately determine who is exhibiting a mental illness and distinguish among the kinds and degrees of illness incoming inmates are experiencing. It is essential to immediately screen and soon thereafter conduct a competent and comprehensive assessment of inmates who appear to have mental health issues.*

- *Using an objective screening tool, custody or mental health staff must be available to decide if incoming offenders should be booked or diverted to mental health services.*
- *Inmates for whom screening indicates the presence of a mental illness should be provided a mental health assessment, using a validated mental health assessment tool, to determine the scope of the illness and an appropriate housing and treatment plan.*

While trained custody staff can accomplish screening, a trained mental health practitioner must conduct assessment. Jurisdictions that don't have mental health staff available 24/7 might consider the feasibility of using technology, such as televised two-way communication with a mental health professional to conduct assessments.

Housing, Treatment and Medication -- Following in-jail assessment, housing, treatment and medication-related decisions must be made that provide appropriate referrals and specified levels of intervention and management.

Housing – Being realistic about the dire fiscal limitations facing government at all levels, this paper does not suggest that counties must undertake construction of specialized housing for mentally ill inmates in their jails. It does, however, recommend that, when dollars are available, jails should consider building the best possible array of in-jail housing for mentally ill inmates who cannot safely be housed with others. Elements would include individual and group living spaces, proper lighting, confidential counseling rooms and areas dedicated to socialization activities, among other things. Counties are also encouraged to explore the feasibility of developing acute care housing and/or implementing

LPS[1] certified units either in their jails, in their local hospitals or regionally through multi-county consortium agreements.

RECOMMENDATION: *Assuming that the fiscal environment precludes extensive construction at this time, jails must make the best possible housing decisions for mentally ill people in custody given the jail's existing physical plant. The priority must always be to place each inmate in the safest unit, room or cell the jail has available. In jails with different kinds of housing, mentally ill inmates should be placed in a living unit appropriate for their custody classification, assessed kind and degree of illness and their level of functioning. Some people can safely be placed in general population; others require more specialized housing; and still others require in-jail acute care units. In smaller jails, safety cells may be the only recourse for those who must be housed separately, although it is widely recognized that such placements may well exacerbate the mentally ill person's condition.*

It would be beneficial to the field if jail commanders were to share information about effective housing alternatives for mentally ill inmates. Perhaps CSSA or one of the jail associations would be willing to serve as the conduit for disseminating this information.

Treatment / Programming: Treatment for mentally ill inmates should begin as soon as clinically indicated. How and what kinds of treatment will differ from jail to jail and inmate to inmate, but the goal in all cases should be to provide the care necessary to keep the inmate from becoming agitated or decompensating in ways that are harmful to the individual, staff or other inmates. Jails throughout California provide programming to mentally ill inmates as best they can, using jail custody and mental health staff as well as volunteer and community based service providers. Many jails bring in ancillary agencies and volunteers to do a variety of kinds of programming. This paper strongly supports existing efforts and suggests consideration of several additional possibilities which are proving effective in jails' work with mentally ill people in custody.

RECOMMENDATION: *The therapeutic community model is a viable and relatively cost effective way to bring treatment and services to mentally ill people in jail. Therapeutic communities require certain lengths of stay, continuous housing together and involvement of all staff and therefore may not be possible in all jails, but their use can prove effective and should be explored by jails looking to develop or expand cost-efficient programming. Kern County's Jail Administrator may be a helpful resource in this regard.*

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[1] Special secure housing units named for Assemblyman Frank Lanterman and State Senators Nicholas C. Petris and Alan Short, the authors of the 1967 Lanterman-Petris-Short Act (W&IC Section 5000 et seq.) still in use today.

RECOMMENDATION: *Jails should consider designating one or more specific staff member or members as liaison or service coordinators for the mentally ill in custody. Jails are also encouraged to initiate regular discussions among classification, operations, mental health and medical personnel with the liaison to work on issues that come up about people in custody who are – or may be – mentally ill. Those jails that may be unable to assign a staff person to the liaison role should, at the very least, have mental health staff or other personnel, such as trained custodial officers or the jail chaplain, walk through and talk with everyone in administrative segregation every week to identify inmates who may need mental health services and/or specialized housing, as well as those in segregation who could be moved to a different kind of housing. This cost effective kind of 'welfare check' reduces inmates' isolation, can be an important part of a suicide prevention program and helps get the right treatment to each inmate while making the best use of the jail's segregated housing capacity.*

RECOMMENDATION: *Considerable research shows Mental Health Courts to be effective in reducing both recidivism and relapse in mentally ill and COD offender populations. There is a wealth of information available from the federal Bureau of Justice Assistance (BJA) and other agencies about how to start and operate these proven programs. Jurisdictions which have not yet explored this option are encouraged to do so.*

Medication: Jails face a host of issues related to psychological or psychotropic medications. While it is important to maintain continuity of these medications, it is often difficult to get timely information about what drugs an arrestee is actually on. Psychotropics can be prescribed for inmates in jails' general populations but they cannot be administered involuntarily (without informed consent) except in cases of emergency. These medications require extensive record keeping, and constitute a huge budget item, especially for small jails. There are differing medication policies and different psychotropic medications prescribed by state hospitals than are used in jails, confounding continuity of treatment when IST and other inmates are returned to jails from hospitals.

RECOMMENDATION: *There may be benefit in CSSA or the various jail associations, perhaps with help from the California Mental Health Directors Association (CMHDA), convening roundtable discussions or training about formulary and other medication-related issues as well as the potential for a common formulary statewide. It may also be useful to survey jails to determine what formularies they are, in fact, using. Perhaps COMIO would be an appropriate resource for engaging jails, prisons and hospitals in a discussion of the limitations and restrictions jails have on psychotropic medications and concerns about the various entities' formularies.*

Reentry -- The safe and effective transfer of care through linkages to community resources when offenders leave custody, reentry is the final point at which the jail's custody and/or mental health staff and mental health system "in-reach" personnel can engage inmates and connect them with post-release services.

RECOMMENDATION: *The Workgroup suggested that elements of an ideal reentry / transition approach would include:*

- *Case management, i.e., having a case manager*
- *Knowing where the inmate is going and that he or she has a place to go*
- *Providing gap medications*
- *Linking the inmate to programs and services in the community*
- *Helping the person engage with programs and services in the community*
- *Availability of outpatient services in the community and*
- *Coordination between the in-custody psychiatrist and community treatment psychiatrists.*

To cover these bases and maximize reentry efforts to the greatest extent possible, sheriffs' and custody commanders are urged to actively buy into such cost effective and productive strategies as reentry deputies and transition teams as well as "in-reach" support to help with post-release housing, medications for release and getting people to community treatment without breaks in service. The benefits in public safety, relapse and recidivism reduction and justice system dollars saved will more than outweigh whatever costs are involved.

STAFF AND STAFF TRAINING:

Jails must have adequately trained personnel – both custody and mental health – to safely assess, house, program, treat and work with inmates who are mentally ill or have COD. Jails cannot provide any of the care or services discussed in this paper unless they have an adequate number of properly trained personnel. Recruiting mental health personnel is challenging and California's jails continue to have a critical need for additional mental health staff.

Retaining staff and maximizing their effectiveness requires training and support for the difficult jobs they do. It is critical that custody staff be trained to interact with mentally ill inmates just as they are trained to interact and work with all other inmate populations. Mental health staff should receive forensic training to give them a framework for working in the custody environment.

Jails report significant benefits from training correctional and mental health personnel together, and thereby enabling multidisciplinary teams to work with mentally ill people in custody. Additionally, there is significant promise in the use of Crisis Intervention Teams (CIT) for jails, thus training in CIT is recommended for jails to consider.

RECOMMENDATION: *Jails across California are encouraged to seek additional, mental health and COD training for custody staff and to train custody personnel*

with mental health personnel to the greatest extent possible. To augment in-facility and in-service training, the Workgroup also recommends that STC's Correctional Officer CORE course's hours dedicated to mental health and suicide issues be enhanced to provide additional training for custody personnel on dealing with mentally ill people in jail.

RECOMMENDATION: *Custody staff as well as street / patrol officers could effectively be trained in CIT. It is reported that trained officers on the streets make better decisions about bringing a mentally ill person to jail and custody personnel who have had CIT training become more aware of mental health issues, even helping identify mental health resources for people in and leaving custody. It was noted that there should be more than one person trained in CIT in each jail, so there is support for the approach and one staff member isn't carrying the full responsibility for crisis intervention.*