

# ***JAILS AND THE MENTALLY ILL: ISSUES AND ANALYSIS***



*A BRIEFING PAPER DEVELOPED BY*

***THE CALIFORNIA CORRECTIONS STANDARDS AUTHORITY (CSA)***

*AT THE REQUEST OF*

***THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND  
REHABILITATION (CDCR)***

***COUNCIL ON MENTALLY ILL OFFENDERS (COMIO)***



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# ***JAILS AND THE MENTALLY ILL: ISSUES AND ANALYSIS***

## ***SUMMARY OF MAJOR POINTS***

PRIMARY FINDING: The major finding of this paper is that it is essential for there to be a unified approach incorporating the many disciplines and agencies that share – or should share – responsibility for working with mentally ill people in local custody. Multi-agency problems, like those surrounding the treatment of mentally ill, COD and other special needs people in jails, demand multi-agency solutions

### KEY POINTS

- Dialogue is needed with Departments of Mental Health / Behavioral Health, state hospitals, courts and court officers and community based providers of mental health services.
- It is essential for jails to screen incoming inmates for mental health issues and to do more comprehensive mental health assessments of those whose screening identifies serious mental health problems.
- Jails must make the best possible housing decisions for mentally ill people in custody considering each jail's unique physical plant design. The priority must always be to place each inmate in the safest unit, room or cell the jail has available.
- Treatment and programming should seek to keep the mentally ill inmate from behaving in ways that are harmful to the individual, staff or other inmates. Among strategies that are currently proving effective in California jails, the paper suggests consideration of designating one or more staff member(s) as liaison or service coordinators for the mentally ill in custody.
- Many California counties utilize Mental Health Courts, which have been shown to be effective in reducing both recidivism and relapse in mentally ill and COD offender populations.
- Interagency discussion is needed about formulary and other medication-related issues.
- Reentry efforts such as reentry deputies and transition teams are cost effective and productive at reducing recidivism.
- Jails 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.

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## ***EXECUTIVE SUMMARY***

**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.

**Departments 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 systemwide 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 screening can be accomplished by trained custody staff, assessment must be conducted by a trained mental health practitioner. 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<sup>1</sup> 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

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<sup>1</sup> 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.

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.*

**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.*

# **JAILS AND THE MENTALLY ILL: ISSUES AND ANALYSIS**

*For people with serious mental illnesses and complex disabling conditions, criminal justice involvement is an expectation—not an exception.... Despite the efforts of states, counties, providers, clinicians, and advocates, the system is organized for failure, with jail as the ultimate safety net. ... We are all capable of—and responsible for—engaging in a process to improve care for this population.<sup>2</sup>*

## **I. INTRODUCTION – Purpose and Processes**

In early 2009, the Corrections Standards Authority (CSA) was asked by the California Department of Corrections and Rehabilitation's (CDCR) Council on Mentally Ill Offenders (COMIO) to produce a 'white paper' discussing key issues and best practices related to the increasing population of mentally ill people in jails. To further the effective management of inmates with mental illness, the paper was charged with addressing such issues as classification, housing, programming, treatment, staffing and staff training. The paper was intended to be a resource for COMIO, CSA, the California State Sheriffs Association (CSSA) and jail managers statewide.

To develop the paper, CSA convened what it called the Mentally Ill in Jails Workgroup, comprised of custody and mental health practitioners from jails across the state. These subject matter experts met on several occasions to brainstorm major mental health issues affecting jails and share their knowledge, insights and hands-on experience about dealing with the mentally ill in jails. A wealth of information was produced about problems, strategies, successes, and evolving approaches that are working in jails in California and across the country.

Distilling that information into a relatively brief and readable paper, the Workgroup has sought to address as many as possible of the most pressing issues and to present helpful information and recommendations that will support jails in their ongoing work with mentally ill people who come in contact with the criminal justice

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<sup>2</sup> American Psychiatric Association, *Psychiatric Services* 'ps.psychiatryonline.org ' June 2009 Vol. 60 No. 6, page723

system. While it does not attempt to tell jails what to do, the paper does suggest strategies and collaborations that might prove beneficial.

The paper begins with a brief overview, acknowledges fiscal limitations, suggests consideration of the terminology to use when referring to mentally ill people in jails, and reaffirms that many of the mentally ill people in jails have substance abuse issues as well and thus are suffering from co-occurring disorders (COD). The next section deals with critically important roles and relationships and – in what may be the most important recommendations the Workgroup makes – proposes a series of key collaborations. Next the paper deals with specific, jail-based issues and, finally, it discusses staffing and staff training issues affecting jail personnel’s ability to work effectively with people who are mentally ill.

A note to the reader – throughout the paper, successful programs and interventions are highlighted with the words “***Best Practice***” and “***Best Practices***” in bold face italic print. In these instances, the paper is seeking to point out efforts worthy of consideration for replication or expansion and intends the “***Best Practice***” designation to be understood generically, rather than in its specific, research-related sense. We urge the reader to consider the efforts designated as “***Best Practice***” / “***Best Practices***” as something to look into, even though the particular program may not yet have been subject to rigorous evaluation research which earned it the proven best practice title. Some of the programs we point out are fully researched evidence based practices; some are tested best practices, and some are emerging or promising practices that appear to be effective but have not yet been subject to evaluation studies.

## II. OVERVIEW and SYSTEMWIDE CONSIDERATIONS

**Background:** In the 1970s, then-Governor Ronald Reagan closed California's large mental hospitals in order to "deinstitutionalize" the mentally ill and encourage their treatment in local communities. Over the intervening 30-plus years, this well intentioned effort has proven to have serious downside effects. Communities were not prepared to treat and care for all of the mentally ill in their populations; families were often left without treatment resources, either locally or at the state level. There was nowhere to turn for help, except to the one place that MUST accept almost everyone brought to it – the jail. Rather than deinstitutionalize people with mental illness, California has shifted many of them from one kind of institution – mental hospitals – to another – its jails and prisons.

**Numbers:** The national GAINS Center estimates that approximately 800,000 people with serious mental illness are admitted annually to U.S. jails and that, among these admissions, the preponderance (72%) also meet criteria for co-occurring substance abuse disorders.<sup>3</sup>

A 2009 American Psychiatric Association study "found that 14.5% of male and 31.0% of female inmates recently admitted to jail have a serious mental illness, [confirming] what jail administrators already know – a substantial proportion of inmates entering jails have a serious mental illness and women have rates two times those of men."<sup>4</sup>

California's jails, according to CSA's Jail Profile Survey (JPS) for the end of 2007 (the most recent data available), reported having 27,450 open mental health case files for the statewide jail population of 82,662 inmates. This should not be interpreted to mean that one-third of all jail inmates were mentally ill, but does suggest that a mental health query or procedure was reported to have been initiated for 33% of the statewide

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<sup>3</sup> National GAINS Center, [http://gainscenter.samhsa.gov/html/jail\\_diversion/what\\_is\\_jd.asp](http://gainscenter.samhsa.gov/html/jail_diversion/what_is_jd.asp)

<sup>4</sup> American Psychiatric Association, *New Study Released on Prevalence of Serious Mental Illness Among Jail Inmates*, Psychiatric Services 60:761-765, June 2009,

jail population. In that same time frame, jails reported that 9,263 inmates were receiving psychotropic medications.

These data make it abundantly clear that mentally ill people constitute a significant proportion of jails' populations. Jails face multiple fiscal demands and other complex problems related to their care.

**Resources:** Throughout its discussions, the Mentally Ill in Jails Workgroup was acutely aware that money is tight everywhere. Jails, departments of mental / behavioral health, service providers and support agencies of all kinds are suffering from fiscal limitations and there is no end in sight. The financial outlook seems likely to remain dismal for the foreseeable future. Budgets are being cut; some agencies are being shut down and those that are still operating are being forced to make all kinds of adjustments that reduce their service capacity.

To help stem the tide of service losses, the Legislature suggested that counties use their Mental Health Services Act (MHSA) (Proposition 63) dollars to fund needed mental health programs, including those for mentally ill people in jail. While this might be possible in some places, many counties have prohibitions against using MHSA monies for criminal justice clients. Then too, the Legislature is considering redirecting some MHSA monies from counties to pay for what were formerly state-funded services. The State Sheriff's Association (CSSA), in collaboration with the California Mental Health Directors Association (CMHDA), developed a questionnaire asking sheriffs about their involvement in their counties' MHSA planning efforts. Regardless of the findings of that survey, competition for MHSA funding is, and will remain, fierce.

Even before the current fiscal crisis, there was no dedicated funding stream for mental health services in jails. Funding sources like grants were plugged in when they were available, but at their best they were short term and unpredictable.

Given the limitations facing everyone, the only reasonable recommendation is that all affected agencies pull together to maintain services to the greatest extent possible and to fix those parts of the continuum of service that need fixing. Agencies are going to have to 'work smarter,' collaborate more, share what resources they have and develop mutually beneficial priorities. Some cost-shifting – moving mental health money and criminal justice money around – might be needed to fund alternatives,

diversion and treatment that helps get mentally ill people out of jail and keeps those who are out of custody from coming back.

**Terminology – “Mentally Ill Offender (MIO)”:** A concern that came up early in the Workgroup’s deliberations was that the term “mentally ill offender (MIO),” might itself be a problem. While convenient and recognizable, the MIO designation may have the effect of doubly stigmatizing people with mental illness who are in jail. It was suggested that the field might be well served to consider using a term like “mentally ill person in jail” to clarify our thinking about who these inmates are.

There are several reasons to give this notion some thought, not the least of which is that there is no consistent or uniformly accepted definition of “mentally ill offender.” The term is understood differently not only from county to county but often within counties, within jails in the same county and between custody and mental health personnel in the same jail. At what point does a person suffering from a mental illness become a “mentally ill offender”? At what point is a lawbreaker determined to be mentally ill? Can we tell if a person’s behavior is caused by mental illness or is just criminal? If a person is acting oddly in the community and the police bring him or her to jail, is that person an MIO? Is the senior with dementia who throws a sugar bowl at a nurse an MIO? Must an inmate have a persistent and severe mental illness to be an MIO? Is an inmate who develops psychiatric symptoms in custody an MIO?

There are no generally agreed upon answers to these and similar questions, yet we designate certain individuals as “mentally ill offenders” and treat them as somehow different from people who are only mentally ill or only offenders. Perhaps changing the language we use would make no difference, but, on the other hand, changing the term might help us all remember we are dealing with real people who are individuals with the disease of mental illness.

**Co-occurring Disorders (COD):** This document uses the term “co-occurring disorders” and its acronym “COD” to describe what is also known as “dual diagnosis,” i.e., a combination of both mental illness and substance abuse disorders. Most of the individuals with mental illness who come in contact with the justice system also have

substance abuse disorders. Throughout this paper, the terms “mental illness” and “mentally ill” should be understood to include co-occurring disorders.

Co-occurring disorders are a serious and compelling concern throughout the mental health service delivery system as well as in jails. According to a report issued in November 2008 by the California Department of Mental Health (CDMH) Mental Health Services Oversight and Accountability Commission (MHSOAC) Workgroup on COD, COD are pervasive and disabling, yet they do not receive the treatment and attention necessary to reduce their impact. People with COD are said to “have more medical problems, poorer treatment outcomes, more negative social consequences and lower quality of life. They are disproportionately over-represented among arrestees, foster care placements, veterans, hospitalizations and the homeless.”<sup>5</sup>

While the MHSOAC Workgroup is recommending development of statewide policy and procedures to integrate services for people with COD, jails continue to be faced with service providers that refuse to handle those who have COD. Even though, in many counties, Departments of Mental Health and Departments of Alcohol and Other Drugs are combined, silos exist resulting in little, if any, cooperation. Mental health providers often do not know how to effectively treat the individual with COD; their programs work only when a single diagnosis can be made.

There are nationally recognized model programs that demonstrate cost-effective ways to reduce the financial impact of co-occurring disorders and simultaneously improve overall quality of care and clinical outcomes. One of these is the Screening and Brief Intervention for Substance Abuse Treatment (CASBRIT) pilot program in San Diego; others in California include the Full Service Partnerships developed under AB 2034 and the MHSA and the Substance Abuse and Crime Prevention Act (Proposition 36) program.<sup>6</sup>

***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*

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<sup>5</sup> MHSOAC Report on Co-Occurring Disorders, 11/10/08, page 2

<sup>6</sup> MHSOAC, op. cit., pp. 10-11 – Unfortunately, the Governor has proposed elimination of Prop. 36 funding to save the state \$108 million

*people with COD to keep them out of jail and/or to reduce relapse and recidivism of those who are incarcerated.<sup>7</sup>*

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<sup>7</sup> Readers are encouraged to review the recommendations of the MHSOAC “*Report on Co-Occurring Disorders: Transforming the Mental Health System through Integration*,” November 10, 2008, the key elements of which include: integrated care, partnerships, collaboration, training and a comprehensive continuum of services for mental illness and substance abuse.



### III. RELATIONSHIPS

The Workgroup wrestled with the question of whether this paper should be limited to only what goes on in the jail. Members felt very strongly that they would be remiss – and in fact it would be impossible to address all the issues related to the mentally ill in jails – if the paper failed to talk about the multiple partners, stakeholders and others who share responsibility for people with mental illness who come in contact with the criminal justice system. This paper therefore incorporates issues related to agencies that share responsibility with jails for people with mental illness.

Because diversion from jail and reentry / transition after jail are key elements of a fully functioning continuum of care, this paper talks about pre- and post-incarceration issues as well as in-custody concerns and makes recommendations that extend beyond what jail managers alone can accomplish.

Throughout its deliberations, the Workgroup stressed the very real facts that:

- Jails are only part of the puzzle and
- Jails must be supported by a network of positive and productive interagency relationships in order to handle justice system involved mentally ill people appropriately.

The many other agencies and organizations that have responsibility for people who are mentally ill include the state and local departments of mental / behavioral health, state hospitals, courts, treatment providers, community based organizations, advocacy groups and families. All must be involved in helping jails work with the mentally ill in custody.

***Departments of Mental Health (DMH):*** 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 the mentally ill offender population. However, some mental health / behavioral health departments appear to consider jail mental health services ancillary to their core responsibilities, not primary.

In so far as jails are, and will continue to be, responsible for dealing with people who are mentally ill, jails need the support of the State DMH and local departments, agencies and service providers. Jails require the support of, and partnerships with, mental health agencies to provide the services, training and trained personnel essential to best handle the mentally ill who are in jails.

In some counties, partnerships are strong and productive; in others relationships are tenuous and vital support is lacking in such important areas as:

- 24-hour mental health staff at jail booking facilities to help custody staff determine if a person being booked has a mental illness or COD, is safe to be housed with others or is a threat to self or others;
- Crisis intervention as an alternative to safety cell placements for potentially suicidal inmates;
- Nursing and mental health staff for longer than 8 hours a day to help with assessment and provision of the mental health services assessment identifies as needed for mentally ill individuals in custody;
- Help with reentry planning for inmates who are about to be released as well as referrals to ongoing services and/or medication after jail.

Yes, budgets are tight; everyone is being asked to do more with less; however, since we're all in the same boat, it seems essential for everyone to be rowing in the same direction. Sharing challenges through collaboration, multidisciplinary planning and cooperation is cost effective and produces positive outcomes – a win/win for the agencies involved, as well as for the clients who receive treatment from those agencies.

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 Mental Hospitals:** There are 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. Jails feel they’re being used as ‘holding tanks’ for mentally ill people who have been found by the court to be incompetent to stand trial (IST) and a ‘dumping ground’ for those IST patients who have been transferred to hospitals and commit an offense while in the hospital.

*Incompetent to Stand Trial (IST) and Waiting List Issues:* Due to resource limitations, hospitals have very strict “one-in/one out” policies, extensive backlogs and long waiting lists for jail inmate admissions. Jails, as a result, house mentally ill people – whom the court has determined to be incompetent to stand trial and has ordered into state mental hospitals for stabilization – for six (6) to nine (9) months and sometimes longer waiting for a hospital to accept them. While in jail awaiting hospital admission, these mentally ill people are not getting the treatment they need; they are often difficult and disruptive in the jail environment and cause significant hardships for jail staff, other inmates and mental health service providers who work in the jail.

A thoughtful examination of the multiple issues jointly affecting jails and state hospitals – especially those related to IST patients, such as the pace of treatment and competency restoration – would prove beneficial to both state hospitals and jails. Such an examination could lead to additional creative alternatives in inmate/ patient management, such as a DMH grant to Liberty Healthcare to efficiently program IST inmates, formerly sent to hospitals, while in custody at local jails.<sup>8</sup> The grant project is piloting ways for waiting time to be used productively so patients are restored to custody while in jail and the costs of housing these inmates is recouped by the local jurisdiction. Additional efforts of this sort are needed to improve the continuum of care.

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<sup>8</sup> For information about the Liberty Healthcare program, contact Ken Carabello, Director of Operations for Liberty Healthcare at 310.584.1581 or by email to Kcarabello@Libertyhealth.com.

Litigation: Although litigation against hospitals is costly and time intensive and doesn't always produce the desired results, several counties have asked the courts for orders to show cause; some have filed class action law suits. San Francisco has been securing show cause orders the defiance of which cause the hospital to be found in contempt; San Francisco reports this has been effective in getting the state hospital to accept SF's inmates more expeditiously. In Riverside County, the Public Defender filed a class action suit for a case the P.D. felt was taking too long to admit; Patton found a bed immediately and the case was dropped. In a 2006 Sacramento County suit, the court ruled that DMH had seven (7) days to place IST inmates in Napa State Hospital; this resulted in Sacramento County's inmates being placed at the top of Napa's waiting list. Good news for those counties; unfortunately, however, one county's success is every other county's loss. Since state hospitals have a limited number of beds, accepting one county's IST inmates extends the waiting time for inmates from all other counties.

While all jails are affected by the 'dumping ground' part of the state hospital relationship, the counties in which state hospitals are located – Los Angeles, Fresno, Napa, San Bernardino and San Luis Obispo – are particularly acutely affected. Napa County, for example, says that when an IST patient in Napa State Hospital commits a crime, charges are filed through the District Attorney's Office and hospital police bring the person to the jail. And there that person (who is still legally IST) stays – for weeks and months – while the whole competency process is repeated, a bed opens up and the hospital reaccepts them. It is notable that IST patients, charged by state hospitals with new offenses, are delivered to the local jail, not returned to the county from which they were ordered into the hospital.

Misdemeanants: For people in jail on misdemeanor charges, matters are even worse. State hospitals don't accept them unless the county has a preexisting contract with the hospital, even if they are found incompetent to stand trial. (Note that, if there is a contract, the cost is borne by the county; i.e., the county pays for treatment for misdemeanants whereas the state pays for treatment for felons.) In many counties, these IST misdemeanants spend an inordinate amount of time in jail (surely not the least restrictive environment required by law), being "restored to competency." They serve incrementally more time than people charged with misdemeanors who are not

mentally ill and, when they are released, they do not have adequate support to follow through on their outpatient treatment. At some point, this could become a patients' rights issue. Some jails have even lobbied their D.A.s to elevate misdemeanors to felonies so the IST person can get referred to a state hospital.

These terribly tangled processes affect patients' rights, criminalize mentally ill people and constrain them to inappropriate settings. They jam jails with people who need treatment, while impeding their chances of getting the treatment they need. No one benefits – not mentally ill patients or their families, not mental health service providers, not jails or hospitals and not the communities to which mentally ill misdemeanants are eventually returned. It is critical that programs outside of jail be developed for the misdemeanor IST.

***RECOMMENDATION:*** *Integration is critically needed between state hospitals and county jails. To improve the continuum of care, reduce or eliminate roadblocks 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:** As noted above, courts are at the center of a great number of decisions made about mentally ill offenders. There is a need to educate the judiciary about issues and problems jails may be having with state hospitals, as well as with community service providers and others who should be involved in getting mentally ill people in the justice system appropriate care. To address some of these issues, the National Judicial

College has produced a guidebook for judges entitled “*Effective Judging for Busy Judges*” that includes information about implementing problem solving court principles and considering collateral information beyond just the facts of the case at hand. California’s AOC is working on guidelines for judges to better prepare them for dealing with offenders who are mentally ill. Jails could help judges further their understanding by making concerted efforts to communicate the jail’s struggles and concerns.

**RECOMMENDATION:** *Jail managers and/or 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:** Jails deal not only with people who are mentally ill and/or have COD, but also with those who have developmental disabilities, autism, dementia and traumatic brain injuries, to name just some of the conditions requiring treatment in and supported transition from jail. All too often, people with these conditions sit in jail waiting for various agencies and systems to decide how best to handle them. In one small county jail, an 85 year old woman with Alzheimer’s stayed in the jail’s booking area for months while Adult Protective Services refused to take her; she had thrown something at another group home resident and thus was labeled ‘violent.’ Other jails report having had elders denied hospital services because they were ‘criminals.’ Some counties have been unable to apply for conservatorship for mentally ill inmates because

the Public Guardian felt the individuals were not gravely disabled since they were receiving food, shelter and clothing in the jail; San Francisco has argued successfully that, because food and shelter will cease on release, the individuals in question were or would be gravely disabled.

There is a large and growing body of research proving the value of multi-agency collaboration. Numerous models and samples of what we are calling **Best Practices** in this regard are described throughout this paper. Some examples are:

- The San Bernardino County Jail system's *Consensus Committee*, which meets regularly to work on improving services for mentally ill offenders in jails and after release;
- The San Diego County Jail system's *multi-disciplinary team* that identifies inmates having behavioral or mental disorders and develops a behavior management plan as well as a reentry plan to ensure the person is referred to supportive services upon his/her release;
- San Francisco's jails hold a *monthly meeting* facilitated by a Superior Court Judge, with the Mental Health Director, the Conservator's Office, a Deputy Public Defender, a Deputy DA, the Director of Jail Psychiatric Services, the Placement Coordinator and the Director of the Forensic Assertive Case Management Team (FACT) to discuss problem cases and improve services;
- Marin County has an *Interagency Behavioral Health Criminal Justice Committee (BHCJC)* whose goal is to inform policy development and foster interagency collaboration, and a *Forensic Multidisciplinary Team (FMDT)* that meets monthly to help law enforcement develop individualized action plans for responding to mentally ill individuals within their jurisdictions.

Other jurisdictions too have interagency teams and task forces working collaboratively to create an integrated continuum of care for inmates with mental illnesses or COD.

**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 – get 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.*

Recalling that the Mentally Ill Offender Crime Reduction (MIOCR) Grant Programs required local law enforcement, corrections and mental health agencies and other community based service providers to work together to address the challenges posed by mentally ill people in the justice system, the Workgroup also strongly recommends that high level, interagency planning processes be put in place by counties throughout California once again. Perhaps such efforts could be related to (but not attached to) each county's Mental Health Service Act (MHSA) plans; however, MHSA plans address all mental health service issues in a county. The plans the Workgroup is suggesting should be focused primarily, if not solely, on the mentally ill and people with COD who come in contact with the criminal justice system. There would be significant benefits – and cost savings – for counties to develop high-level coordinating councils or planning committees and for those bodies to build and implement countywide coordinated action plans for working with the mentally ill in jails.

***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.*

## IV. PRIORITIES FOR JAIL SYSTEMS

In broad terms, the priorities for jails dealing with mentally ill arrestees and inmates are: to divert those who do not require custody; to make competent and comprehensive assessments; to have appropriate housing, treatment and programming; to be able to transfer care upon release; and to have an adequate number of staff trained in mental health issues. These priorities are discussed in this section and the next. Staffing and staff training issues, so important to jails' ability to effectively work with mentally ill inmates, are addressed in Section V.

***DIVERSION FROM JAIL:*** Some people ask, "Why is mental health care the jail's problem?" There are those who feel very strongly that jails are not designed to appropriately treat and handle people who are mentally ill, that jails cannot provide the necessary range of services. They say that, for years, jails have reluctantly opened the doors to take care of mentally ill people because no one else would do it, but nevertheless, jails are not appropriate for people who are mentally ill.

Whether or not jails are right places for people with mental illness, they are nonetheless the places to which mentally ill people who break the law are – and will continue to be – brought. So the question must be, first of all, how best to step up early identification and crisis intervention efforts to help divert mentally ill people, inappropriate for jails, prior to booking.

Among ***Best Practices*** in this regard are Kern County's *Mobile Evaluation Team (MET)*, a mobile pre-arrest diversion team that is keeping people who are mentally ill out of jail, and Sonoma County's *Integrated Recovery Team* that identifies seriously mentally ill clients and those with COD in the community and provides intensive services to keep them out of jail and out of the hospital.<sup>9</sup>

***Treatment Beds:*** While some systems can divert to emergency mental health units or hospitals people who are suicidal or seriously acting out, many local mental health

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<sup>9</sup> Information about these and other programs is available on the CSA website under Publications, Mentally Ill Offender Crime Reduction Grant program evaluations.

facilities will not take those they perceive as violent or who are charged with a crime. Some counties' jails are not equipped to handle this type of inmate, yet the counties simply do not have any other treatment beds to put them in. El Dorado County, for example, reports that, even when a mental health practitioner agrees an inmate is 5150-eligible, the person is left in the jail because there are no treatment beds to transfer him/her to.

It is clear – there are nowhere near enough mental health treatment facilities in communities. Those that do exist are not anxious to take what they call “penal code patients,” and especially not those they believe to be violent and/or aggressive. So, while diversion to treatment facilities is often the best choice, it is often not a realistic possibility.

The Workgroup proposed several creative ideas for addressing this deficit in community based treatment beds.

- One was to ask the *State DMH to revise its standard limiting Psychiatric Health Facilities (PHFs) to a maximum of 16 beds*. Changing this regulation upward would allow expansion of existing facilities so they could accept more 5150 clients and treat additional mentally ill people who would otherwise languish in jails.
- A second proposal was to encourage mental health agencies to join forces with jails to *develop cost effective diversion services for mentally ill people that would extend the reach of existing dollars.*<sup>10</sup>
- A third possibility is to urge counties to target some of their *MHSA funding to local mental health facilities so they could accept more mentally ill offenders*.
- The Workgroup also proposed developing *regional, in-custody acute care facilities*, like the Coalinga State Hospital for example, to which counties that don't have acute care or other treatment beds could send their 5150 inmates for stabilization. Such regional facilities could operate under joint powers or similar agreements among the counties involved and would meet a need none of the individual jurisdictions could fill alone. Were such facilities to be placed in rural locations, special efforts would

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<sup>10</sup> Note that MHSA funds cannot be used for involuntary services

have to be made to recruit, hire, train and retain mental health practitioners to staff them.<sup>11</sup>

*Mental Health Courts: A **Best Practice*** (although not yet scientifically validated, peer reviewed and replicated with the same results and thus actually a “Promising Practice”), *Mental Health Courts* are helpful in diverting mentally ill people from jail. Mental Health Courts involve multiple agencies in providing integrated services. They are so collaborative and cost efficient that more than a quarter of California counties<sup>12</sup> are currently operating Mental Health Courts and/or Mental Health Calendars of one sort or another. Evaluations find that these targeted problem solving courts support the continuum of services both by helping to keep inappropriate people out of jails and by providing treatment teams that help with offenders’ programming when in jail.

*Crisis Intervention Teams and Training (CIT)*: Another **Best Practice** proven effective in diverting mentally ill people from jail, as well as preventing them from being brought to jail in the first place, are *Crisis Intervention Teams and Training (CIT)*. Marin, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Barbara, Sonoma (and other counties) are doing CIT and contend use of this strategy helps keep the mentally ill out of jails. It is possible that CIT could be paid for by MHSA Workforce Education and Training (WET) funds; sheriff’s departments interested in implementing this strategy should check into this possibility with their local MHSA administrators.

Sonoma County uses CIT as the training foundation supporting two parallel mental health **Best Practices** programs – a *Community Intervention Program (CIP)* and an *Integrated Recovery Team (IRT)*. Both are funded by the County’s MHSA. The CIP works to identify those in the community that may be underserved or marginalized and have had difficulty accessing services. The IRT identifies seriously mentally ill clients in the community who need both mental health treatment for their mental illness and co-

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<sup>11</sup> Jails might consider contacting the Mental Health Services Oversight and Accountability Commission (MHSOAC) Workforce, Education and Training (WET) Committee for help addressing the problems related to finding mental health professionals in isolated and/or rural areas.

<sup>12</sup> Mental Health Courts are in place in Alameda, Contra Costa, El Dorado, Los Angeles, Marin, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Francisco, San Luis Obispo, Santa Clara, Sonoma, Stanislaus and other counties. San Diego is in the planning process for a Mental Health Calendar

occurring disorder treatment for their substance abuse. The CIP team works in most of Sonoma's local communities, spending time in homeless shelters and interacting with law enforcement to identify people with serious mental illness in an attempt to engage them in treatment. The CIP also works directly with law enforcement in outlying cities in Sonoma County to identify well known members of the community who appear to have mental health issues. On a planned basis, CIP staff seeks to make contact with these community members in an effort to engage them in services before law enforcement has to intervene. The IRT provides intensive services in the MHSA style of "whatever it takes" to keep people in the community and out of the jail and the hospital. Sonoma reports that these two programs – both of which are based on the **Best Practice Forensic Assertive Community Treatment (FACT)** model that uses full service partnerships to provide wraparound services – are "having great success impacting the numbers of seriously mentally ill that wind up in custody."<sup>13</sup>

**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 the agencies identified above that are effectively using these strategies to discuss implementation possibilities.*

**SCREENING AND ASSESSMENT:**<sup>14</sup> Mentally ill people enter county jails from a number of directions. Some are arrested for more or less serious crimes. Some are brought to the jail by patrol officers who observe (often repeated) erratic behavior and determine the person should be taken into custody. Some are brought to jail because families, who can't get help in the community, end up calling law enforcement to deal

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<sup>13</sup> Sonoma County programs of note email from Lt. David House, Sonoma County Sheriff's Department, 4/29/09

<sup>14</sup> Screening, generally conducted by custody staff, indicates the probability that a problem or condition exists, e.g. mental illness, substance abuse, co-occurring disorder or etc, and is used to guide appropriate housing and suggest if further evaluation is needed. Assessment, which should be conducted by a mental health practitioner, is a diagnostic evaluation using objective criteria to document the presence or absence of disorders, psychosis, dementia or etc, and is the precursor to establishing a diagnosis and treatment plan.

with a family member's behavior problem. Some mentally ill people come from local group homes that seek fresh charges to remove problem patients to jail. Some community based psychiatric treatment facilities call their local jails to come arrest and take to jail patients who strike out at another patient or a staff member. State hospitals too sometimes look for fresh charges on which to have patients taken to jail.

In broad generalities, three major types of mentally ill people are brought to jail: 1) W&IC Section 5150<sup>15</sup> candidates who can be sent to a hospital or treatment facility – although many are sent right back to the jail; 2) those who can't be sent to a hospital or treatment facility because, given their offenses or violence, no one will take them; and 3) people who are not candidates for 5150 but are exhibiting behavior that suggests they need mental health intervention. This latter category often includes people with COD and those with dementia and/or other developmental or neurological disorders.

***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 screening can be accomplished by trained custody staff, assessment must be conducted by a trained mental health practitioner. Jurisdictions that don't have mental health staff available 24/7 might consider the feasibility of using technology, such as*

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<sup>15</sup> Welfare and Institutions Code Section 5150: When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

*televised two-way communication with a mental health professional, to conduct assessments.*

While Title 15 and other regulations require screening, and everyone knows it is critical to determine who needs to be provided specialized housing or sent for 5150 evaluation as soon as possible, this can't always happen at the point of intake / booking. There are several reasons screening is sometimes delayed:

- Some individuals are too agitated to be screened; jails cannot screen or assess people who are under the influence or acting out in ways that interfere with the booking process;
- There is no available staff person trained in mental health screening; many small county jails do not have nursing or other mental health staff available 24/7 and trained custody personnel may be involved in other duties;
- A large number of bookings occur at the same time; even large jails can sometimes (often?) be overwhelmed by the volume of bookings they have to deal with.

In these instances, people who don't meet the criteria for being sent to a hospital (or those the hospital won't take) are placed in safety or administrative segregation cells, restraint chairs, or whatever is the safest place for the inmate and staff until a mental health person can get to the person for assessment to enable decisions about classification and appropriate housing. This is not ideal, but when it is the best that facilities can do, every effort must be made for screening and, when indicated, assessments to be conducted as soon as possible. A status assessment is required at least every eight (8) hours for people in safety cells or restraint chairs.<sup>16</sup>

Related to the recommendation that jails use an objective screening tool and a validated assessment instrument, the reader is advised that, at the time this paper was being written, COMIO had developed and was field testing a new mental health assessment tool for jails. Although this instrument has not yet been validated and some

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<sup>16</sup> California Code of Regulations, Title 15, Minimum Standards for Local Detention Facilities, Section 1055, Use of the Safety Cell

reviewers have significant reservations about it, the latest version of the proposed instrument is attached to this paper as Appendix 1.

Records: An additional consideration related to assessment -- and to the placement and housing decisions that follow – is that, at intake, jails need incoming inmates' mental health records, including community treatment history information, to make the right decisions. Custody staff needs information from Mental Health quickly so they'll know how to classify and house a newly booked inmate. Since housing is required to be in the least restrictive setting appropriate to each person's level of functioning, information about the inmate's health, mental health and disabilities is critical for the decision making process. Continuity of care requires that jail mental health staff get written verification as to medication the inmate may be taking and/or has been prescribed.

Some large counties have electronic record keeping systems that give jail mental health staff rapid access to mental health records; however, this is not the case in most places. In fact, there are jails that *never* get mental health records for people in custody, even when those people recycle through the same jail time and again. Where they are available, electronic medical and mental health records are an enormous asset.

**RECOMMENDATION:** *Wherever possible, agencies should seek to maintain medical and mental health records electronically and to ensure compatibility among electronic records systems among county agencies. Integrated electronic medical / mental health records would enable staff to have historical data (from previous bookings, other counties, etc) at booking, eliminate the costly and unwieldy practice of starting a new record at each intake, and potentially allow the compilation of historical medical record files for frequent users of jail and/or hospital and/or mental health services.*

HIPAA: Not only do some jails experience delays in receiving records, several jails – especially those with private health / mental health care providers – have been told that



federal HIPAA<sup>17</sup> rules preclude their being able to get inmates' mental health records. Both custody and mental health experts dispute that interpretation; they say that mental health care providers in jails and county mental health departments are part of the same system and are therefore able to share records. Moreover, as members of multidisciplinary treatment and intervention teams, custody personnel are entitled to access information necessary for the custody and care of mentally ill people in jail.

**RECOMMENDATION:** *Jails being told their access to mental health information is denied because of HIPAA should ask their county counsel to meet with jail and county mental health administrators to work out difficulties related to, and processes for, record sharing. It may also be productive for CMHDA and CSSA to convene a joint committee to develop a HIPAA compliant mechanism for sharing patient related information to enhance continuity of mental health care for people coming into custody that would be applicable to all jurisdictions.*

National Alliance on Mental Illness (NAMI) Contact Sheet: Several county jails have adopted medical information forms from the National Alliance on Mental Illness (NAMI) that allow family members to provide information to the jail on an inmate's mental health and medical needs. The forms give information on prior and current mental health diagnoses and treatment, current medications and any adverse reactions to medications, suicide concerns and other mental health or medical concerns. This information is invaluable in providing appropriate housing and care for inmates with a mental illness. These forms have been adapted to each county in which they're used and are posted as links to those counties' websites. NAMI California also has a link to these forms on its website.<sup>18</sup>

**RECOMMENDATION:** *Because the NAMI contact sheets can provide information that is helpful in jails' screening, booking and classification processes, every jail should look into accessing this resource. Jails might also consider making the forms available in the*

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<sup>17</sup> The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule – information about HIPAA is available on the internet at [www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/index.html)

<sup>18</sup> Information about NAMI is available on the internet at <http://www.nami.org/>

*jail's public lobby and on its web site for family members to access and use. The sheets are effective because they allow family members or other 'collateral' contacts to share information with the jail on behalf of the inmate, who may be unable to disclose important medical and mental health information and history.*

**HOUSING IN JAIL:** What happens after assessment? In the best of all worlds, the inmate is placed, either in a unit of the jail appropriate to his or her mental illness and level of functioning or in a mental health hospital or treatment facility, where his or her custody levels as well as mental health treatment needs can be safely and appropriately addressed. However, not every jail or jail system has dedicated housing units for seriously mentally ill inmates nor, as discussed previously, are there enough mental health beds – especially acute care beds – in communities to which mentally ill offenders can be referred. As a result, some mentally ill offenders never get to appropriate housing or treatment, in or out of the jail.

Housing: Different kinds of in-jail housing are appropriate for mentally ill inmates depending on the inmates' assessed kinds and degrees of illness and their levels of functioning. While every agency seeks to place mentally ill inmates in the safest places for them, there are often big differences in capacity between large and small counties and large and small jails.

San Diego, for example, has a **Best Practice** psychiatric security unit and a floor dedicated to inmates with mental health issues who do not need the psychiatric security unit. San Diego also houses some mentally ill inmates in regular living units. There are psychiatrists who do psychiatric sick call clinics and evaluate patients in safety cells seven days a week in the four of seven jails where mentally ill inmates are housed after having been identified. In a special course offered 8 hours every two months on recognizing and caring for mentally ill inmates, new custody and mental health personnel receive training together. In one jail, an interdisciplinary group has team meetings every other week and develops and carries out behavior management plans and interventions together. These interventions frequently, but not in all cases, include psychiatric care.

**Best Practices** in San Bernardino County include housing mentally ill inmates throughout the County's jails depending on the inmates' levels of functioning. There is also a transitional step down unit in its largest jail where inmates are stabilized after admission / booking and prepared for placement in general population as they reach an appropriate level of functioning. Custody and healthcare personnel assigned to this transitional unit are provided additional training in working with the population. Deputies assigned to this unit are on the CIT training priority list.

In Alameda County, the Santa Rita Jail uses its 90-bed administrative segregation unit and a **Best Practice** 190-bed specialty mental health unit for mentally ill inmates who require separate and/or specialized housing. Suitable mentally ill inmates are placed in general population. Also consistent with **Best Practices**, trained deputies and mental health personnel work together to identify treatment needs, medication issues and hazardous conditions. Alameda also contracts for beds in the Santa Clara County Jail's 40-bed LPS unit

Marin County has a **Best Practice** Special Housing Pod for mentally ill inmates and people requiring protective custody.

**Best Practices** in Sonoma County include two modules dedicated to inmates with mental illness. One is for the more acutely ill and is staffed 24/7 with County Mental Health personnel. Both are overseen by an assigned lieutenant and two sergeants. Selected deputies who receive quarterly training on mental health issues are assigned to work in these two modules.

Housing in a Safety Cell: Mental health professionals contend that it is often counter-therapeutic to house a mentally ill person in a safety cell; being segregated instead of getting the interpersonal crisis intervention by a trained mental health professional that they need is likely to exacerbate their illnesses. Nonetheless, due to facility and resource constraints, some small counties' jails have to house mentally ill inmates in holding, administrative segregation, safety or sobering cells for weeks and sometimes months at a time. These jails simply do not have any other place to house people who must be separated from the general population.

Where there are options, however, it is recommended that there be a limit to the length of time an inmate can be housed in a safety cell. Title 15 requires medical and

mental health checks and regular review by a watch commander for retention in a safety cell.<sup>19</sup> Additionally, several large counties have established internal policies in this regard, saying that after 24 hours, the person must be removed either through a 5150 process or by placement somewhere else in the jail. Of course, extensive housing in a safety cell or sobering cell should be avoided to the greatest extent possible for mentally ill inmates as well as for all others.

*Construction of Appropriate Mental Health Housing:* In a different fiscal climate, a paper such as this would propose construction of 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. However, since new construction is highly unlikely for the foreseeable future given the state of the economy, jails must continue to focus on making the most of, and doing the best they can with, what they have.

*LPS Facilities / Units:* An additional noteworthy, facility-related **Best Practice** is the development of acute care, *LPS facilities or units*<sup>20</sup> in, or available to, county jails. San Diego has two LPS hospital units in its jails – one for men and one for women. Deputies who are assigned to these units receive extensive training, are incorporated into the multidisciplinary treatment team and unit programs and have committed to work in these units for a minimum of one year. Santa Clara County has a 40-bed LPS unit in its jail and allows neighboring counties to contract to use those beds on an as-needed basis. As mentioned previously, Alameda County transports mentally ill inmates from the Santa Rita jail to Santa Clara's LPS unit when an acute care bed is required. Orange and Los Angeles Counties have LPS facilities in their jail systems; Riverside County has three (3) LPS beds in the jail ward of the County Hospital and San Francisco has a jail unit at San Francisco General Hospital.

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<sup>19</sup> Title 15, Section 1055, Use of Safety Cell

<sup>20</sup> 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

Although it can be quite expensive to build and operate an LPS certified facility, counties are encouraged to explore the feasibility of developing acute care housing and/or implementing LPS 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 each facility'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 person from becoming agitated or decompensating in ways that are harmful to the individual, staff or other inmates.

Treatment can be augmented by entities other than jail and/or mental health staff. Many jails bring in ancillary agencies and volunteers to do a variety of kinds of programming. Groups such as AA / NA / DRA (Dual Recovery Anonymous) can be very helpful in enhancing a jail's service capacity. Sonoma County, for example, has an in-custody treatment program, called *PATHS* which incorporates instructors from

County Mental Health, Alcohol and other Drug Services, NAMI and private volunteers to provide a comprehensive program addressing COD issues. Along with educational and religious services, these kinds of groups and programs should be available to mentally ill inmates to the greatest extent possible.

*Therapeutic Communities:* One way to maximize existing physical plants without specialized construction is to introduce *therapeutic community model programming*. Acknowledged as a **Best Practice**, the therapeutic community model can make a difference in many kinds of existing spaces. Kern County reports that the therapeutic community model is working well even in its indirect supervision facilities. Intensive staffing and services that support the therapeutic model are brought into designated living units during the day, effectively turning them into ‘direct supervision’ and service-rich environments. San Francisco has also done this within the structure of an indirect supervision facility, allowing ongoing therapeutic groups, socialization and milieu.

**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.*

*Liaison Deputies / Service Coordinators:* Another very effective **Best Practice**, exemplified in Stanislaus County and elsewhere, is designating a *deputy to serve as a liaison or service coordinator for mentally ill inmates*. In Stanislaus, this specialized deputy is responsible for ensuring that mentally ill inmates are identified and provided appropriate interventions. He scans intake information and incident reports; coordinates with the Court, County Behavioral Health and Probation; and deals with everything from hygiene to releases to make sure that no one in the jail’s custody ‘falls through the cracks.’ Stanislaus’ service coordinator deputy worked with the jail’s classification and housing staff to make a living unit available for mentally ill inmates who do not need the system’s specialized mental health unit but could not make it in general population

housing. Previously funded by the County's MIOCR grant, the service coordinator deputy's salary was picked up by the Sheriff's Department when the grant ended because the position has proven to be a viable and cost effective way to help manage mentally ill offenders in custody.

San Bernardino, Kern and other counties also have *liaison officers* who make sure referrals are appropriate and court appearances are kept, as well as helping to reduce the isolation of mentally ill offenders in custody. Sonoma County has *treatment teams* comprised of classification, mental health, operations, medical staff, jail program staff and team leaders who are jail deputies; the teams meet weekly to provide liaison and seek to create integrated service delivery.

***RECOMMENDATION:*** *Jails that have not already done so 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. Jails 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. The goal would be 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.*

**Mental Health Courts:** Discussed previously as a resource for diversion, *Mental Health Courts* are also **Best Practices** for treatment. Mental Health and COD Courts in Orange County and Santa Clara County have been recognized as national and state leaders. These and other examples of Mental Health Courts provide a coordinated treatment approach, consistent oversight and wraparound services for mentally ill offenders and those with COD.

Sonoma County's *Forensic Assertive Community Treatment (FACT) Program*, is an example of a Mental Health Court focused on "identifying seriously mentally ill and COD offenders in the local jail and offering them an opportunity to access mental health treatment as part of a mental health / probation / court integrated intensive program, one of the goals of which is to limit the number of days clients spend in jail." Among its multiple program elements, FACT's reentry component "operates four homes housing three clients each; two of these homes are specifically for clients who have been chronically homeless. Because these are HUD funded, client's rental rate is 1/3 of their income. All clients in the program are housed in safe and sober environments and many find permanent housing that will remain once they are discharged from FACT."<sup>21</sup>

FACT and other Mental Health Courts work because they are multi-agency, collaborative entities utilizing integrated treatment teams to help with offenders' in-jail and after- jail programming as well as with diversion. The judiciary, prosecutors, public defenders, probation officers, mental health and other service provider agencies work together with offenders and often their families to develop case plans to address the client's many and complex needs. Case plans are overseen by caseworkers who stay with their small caseloads from the clients' entry into the Court until completion of their involvement.

***RECOMMENDATION:*** *Considerable research shows Mental Health Courts to be effective in reducing both recidivism and relapse in mentally ill and COD offender populations.<sup>22</sup> 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:*** It is extremely important to assure continuity of psychological medications for inmates coming into, in and leaving jails. However, medications

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<sup>21</sup> FACT annual Report, September 12, 2008

<sup>22</sup> California Courts: Programs: Collaborative Justice, "Mental Health Courts," [www.courtinfo.ca.gov/programs/collab/mental.htm](http://www.courtinfo.ca.gov/programs/collab/mental.htm); Bazelon Center for Mental Health Law, "The Role of Mental Health Courts in System Reform," [www.bazelon.org/issues](http://www.bazelon.org/issues); Linda Wasserman, "St. Louis County Municipal Mental Health Court: Problems and Possibilities in Therapeutic Jurisprudence," COURTS TODAY, April/May 2007



prescribed to treat the symptoms of psychoses and other mental and emotional disorders can generate big problems in jails. Inmates abuse them. Jails often have to work very hard to get collaborating / corroborating information in a timely fashion, i.e., at intake, to determine what medications an arrestee is actually on; inmates are pretty good at saying the right thing to get the meds they want or can use for barter. Psychotropics can be prescribed for inmates in jails' general populations but they cannot be administered involuntarily (without informed consent) except in cases of emergency.<sup>23</sup> They require extensive record keeping, and they constitute a huge budget item, especially for small jails. Moreover, different psychotropic medications are prescribed by state hospitals than are used in jails, confounding continuity of treatment when IST and other inmates are returned to jails from hospitals.

There are management problems when a patient arrives at the jail accustomed to medications the jail doesn't use because they are known to be abused. People returned from state hospitals are accustomed to getting medications PRN – 'as the occasion arises,' meaning the inmate can have the meds whenever she or he feels they're needed. Jails report that mentally ill patients, even those who have been stabilized, are resistant to changes in medication and medication-related policies, thus the differences between state hospital and jail approaches can result in making the return to jail from the hospital a difficult transition.

*Involuntary Medication:* Title 15, Section 1217 governs jails' use of psychotropic medications, including the administration of such medications on an emergency basis. Additionally, legislation passed in 2007, SB 568,<sup>24</sup> authorizes jails to administer antipsychotic medications, pursuant to a psychiatrist's recommendation and a court's order, to an inmate found mentally incompetent to stand trial and awaiting transfer to a state hospital. Due to sunset in January 2010, this measure requires concurrence of the Board of Supervisors and the County Sheriff as well as authorization by the County Mental Health Director and demands a lot of time and training for jails to implement. Smaller counties say they cannot afford to do all SB 568 requires.

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<sup>23</sup> Per Title 15, Section 1217, Psychotropic Medications

<sup>24</sup> Chapter 566, Statutes of 2007, which amended PC Section 1369

Several counties are considering, or have implemented, the necessary procedures. The CMHDA Forensic Committee's web site<sup>25</sup> has a listing of the counties implementing this procedure; jails interested in pursuing SB 568 authorization could look for experienced help at this site.

The Workgroup expressed concern related to SB 568 that, while it applies to inmates awaiting placement in a state hospital, it is unclear whether the same is true for those returned from hospitals to stand trial. One interpretation is that, when a defendant is returned to a county jail for a hearing or a trial, a medication order would have to follow from the state hospital. In cases in which a defendant is remanded to county jail after he/she is found competent to stand trial and there is no medication order from the state hospital, if the trial process is lengthy and the defendant decompensates, SB 568 may be invoked.

This is one of a number of issues that would benefit from discussion between state hospitals and county jails. As suggested earlier in this paper, involuntary medication, common formularies, hospitals' long delays in admitting inmates found incompetent to stand trial (IST), their "one in / one out" policies and their eagerness to return patients to jails when the patient acts out in the hospital could and should be discussed in interdisciplinary forums to alleviate what is now a serious disconnect between state hospitals and jails. Seeking to bridge the gaps through communication and coordination would go a long way to improving the care provided mentally ill people in the justice system.

Common Formularies: While integrating medications across systems may be desirable, it remains true that jails must be able to eliminate medications of abuse to the greatest extent possible. Jails cannot make certain medications available to hospital returnees without jeopardizing the safety of the jail.

Many jails use the MediCal formulary in order to provide consistency between in-jail medications and the ones mentally ill people get in the community after jail from MediCal supported community treatment facilities. CDCR too uses the MediCal

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<sup>25</sup> [www.cmhda.org](http://www.cmhda.org)

formulary. Thus there could be value in seeking to have all jails use the MediCal formulary or, as an alternative, developing a common formulary for all California jails and prisons or at least for all jails.

**RECOMMENDATION:** *There may be benefit in CSSA or the various jail associations, perhaps with help from the 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 / TRANSITION:** Very much to their credit, jails across California are focusing on, and collaborating in, transition and post-custody efforts that are producing promising outcomes. Reentry – the safe and effective transfer of care through linkages to community resources when offenders leave custody – is increasingly becoming a consideration in mentally ill inmates' treatment plans from day one.

"In-reach": Among the kinds of reentry or transition efforts needed are "in-reach" as well as outreach elements. To facilitate the former, jails are encouraged to expedite security clearances for community providers who are willing to come into the jail to begin planning and coordinating inmates' transitions. "In-reach" helps with post-release housing, medications for release and getting people to community treatment without breaks in services.

A **Best Practice** example of coordinated reentry planning is Marin County's *Support & Treatment after Release (STAR)* program. STAR is a collaborative effort between the Sheriff's Office and Community Mental Health to treat mentally ill offenders with the goal of reducing recidivism and improving the quality of life for clients and citizens. A STAR Team member meets with mentally ill and COD inmates prior to their release to prepare them for treatment and help with their transition out of jail; the team

provides such services as working with the Probation Department on, and monitoring probationers' compliance with, treatment-related conditions of probation. The STAR Team has broad authority to place and monitor people in community programs; the STAR Deputy works closely with social workers to help participants with housing and job readiness and seeks to ensure that medications are provided at release and after. The Deputy also can conduct blood draws and blood tests to make sure people are taking their psych meds. Many STAR participants are required to go to a DMH clinic every day to take their medications; STAR deputies help with that too when necessary and/or possible.

Other examples of reentry **Best Practices** include San Luis Obispo County's *Forensic Coordination Team* and El Dorado County's pilot *Reentry Deputy /Team*. The Reentry Deputy, seeking to assist transitions for mentally ill inmates leaving the Lake Tahoe jail, has a particularly difficult assignment given the paucity of services and low cost housing resources in the Lake Tahoe area.

*Homeless Mentally Ill Inmates:* It is vitally important for there to be programs targeting inmates who are homeless or at risk of being homeless, many of whom have COD. Such efforts should provide a range of services and interventions, including finding places for participants to live. A stellar example of such a **Best Practice** program is Kern County's *Adult Transitional Team (ATT)*. ATT is "a full service partnership team, culturally appropriate and recovery oriented, to serve adults who have previously been underserved, inappropriately or un-served because traditional mental health services were not effective in engaging them or meeting their needs. ATT's service population often suffers from COD, has a history of involvement with the criminal justice system and is homeless or at risk of becoming homeless."<sup>26</sup>

Inmates are referred to the year long, intensive supervision ATT by one of two *Personal Service Coordinators (PSCs)* who screen inmates at the Kern County Jail, Central Receiving Facility and Lerdo Pretrial Facility. The PSCs engage those who meet the program's criteria to develop discharge plans and facilitate the transition process. Focused on reducing homelessness, incarcerations and hospitalizations and

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<sup>26</sup> ATT Program Description and Fact Sheet, provided by Lt Kimberly Trujillo, Kern County S O

increasing education and employment, ATT involves participants in selecting the services and supports needed to meet their goals and provides linkage to services and supports including assistance with housing, transportation, medication monitoring, benefit acquisition, employment assistance, home visitation and crisis management.

Of the 164 clients the ATT served in its first two years (2006-07 and 2007-08), only 13 were returned to custody. The one-year recidivism rate for program participants was only 8% as compared to their pre-program one-year recidivism rate of 41%. In ATT's first year of operation, participants – who had collectively spent 7,168 days in jail in the previous year – spent only 492 days in jail, saving Kern County \$600,840 in incarceration costs. In the second year, participants who had accounted for 6,430 jail bed days in the prior year, were incarcerated for only 432 days, a reduction of 5,998 days that saved Kern County another \$539,820.<sup>27</sup>

Sonoma County, along with its coordinated release of inmates to its **Best Practice Forensic Assertive Community Treatment (FACT) Program**, also has a *jail discharge liaison position* staffed by a bi-lingual licensed person. This staff person plays a key role in the triage of inmates to local community mental health services for the seriously mentally ill or, for those with less serious mental health needs, to local health clinics providing behavioral health services in the primary care setting.

**RECOMMENDATION:** *The elements of an ideal reentry / transition approach 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.*

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<sup>27</sup> Ibid.

*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.*

## V. **STAFF and STAFF TRAINING**

Jails cannot provide any of the care or services discussed in this paper unless they have an adequate number of personnel trained in mental health issues. Mental health professionals willing to work in the custody environment are particularly difficult to find, let alone retain, even in the current economic climate. Recruiting personnel is challenging, and then, if jails or county mental health departments are successful in hiring clinicians to work in jails, keeping them becomes a tug of war with CDCR and state hospitals. Both the Coleman case related to adults and the Farrell case affecting the Division of Juvenile Justice require CDCR's adult prisons and juvenile correctional facilities to have more mental health staff available to inmates and wards more of the time, and the state pays better than most local agencies can. So, California's jails continue to have a critical need for mental health staff.

Retaining staff to work in jails and maximizing their effectiveness requires training and support for the difficult jobs they do. Custody staff must 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. Behavior management requires that jail staff and mental health service providers be familiar with jail policies and procedures and with appropriate kinds of interventions for people in the jail setting who have mental illnesses, COD and developmental disabilities. Jail deputies, clinicians, community based service providers and contract providers who come into the jail need to be trained in, and knowledgeable about, how to safely and appropriately deal with the variety of conditions and illnesses inmates have.

Some jails, such as San Diego's for example, have deputies who are assigned exclusively to mental health units and receive in-depth, specialized training to work with mentally ill inmates. In this **Best Practice**, custody and mental health personnel work as integrated teams that maximize jails' ability to provide safety, security and service delivery. Combined training strengthens the integrated team and, in fact, offering combined training for custody and mental health staffs is itself a **Best Practice**.

Training jail staff with mental health personnel is proving very effective where it is in place. In Kern County's jails, all personnel get mental health training, although mental health staff remains primarily responsible for crisis intervention and the more detailed mental health interventions. San Bernardino offers joint training for nursing, mental health and custody personnel who work with inmates assigned to that county's jails' sheltered housing unit. Riverside County too provides joint training. Custody officers in San Diego County get some mental health training from a board certified psychiatrist. San Diego reports that its highly integrated program offers the opportunity for mental health personnel to answer questions for custody and vice versa. Agencies seeking to set up similar courses are advised to contact the National Institute of Corrections (NIC) which has training material available.

***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.*

*Crisis Intervention Team (CIT) Training:* As was discussed in an earlier part of this paper, most of the counties represented on the Mentally Ill in Jails Workgroup have Crisis Intervention Team (CIT) training; often it is available primarily for patrol, not jail, officers; however, Riverside County provides its CIT training to main jail staff exclusively and San Mateo County, whose CIT is co-sponsored by Mental Health and the Sheriff's Department, has trained many custody, as well as patrol, staff. In Marin County, the STAR Team Deputy is responsible for facilitating countywide CIT training, which is a four day, 36 hour course for deputies and officers teaching them how to handle calls involving people who are mentally ill. The Workgroup felt strongly that jails would benefit from training their custody deputies in CIT. MHSW Workforce Education and Training (WET) funds might be applicable for this training.



**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.

## **VI. CONCLUSION**

This document has addressed some – though surely not all – of the many complex and difficult problems that staff working in California’s jails face when encountering people who are mentally ill or have COD. It has attempted to raise awareness about key issues as well as potential strategies for addressing those issues. It has sought to foster discussion and further thought about ways to improve the delivery of mental health care to people with mental illness who come in contact with the criminal justice system.

When COMIO first asked CSA to undertake development of this paper, COMIO was looking for changes to existing standards and/or new standards relating to the mentally ill in jails that could be added to the Title 15 Minimum Standards for Local Detention Facilities. However, in light of CSA’s inclusive Executive Steering Committee (ESC) process for standards development and modification, and given the fact that jail standards are reviewed for modification on a regular schedule with the next review occurring in the coming year, COMIO determined and CSA agreed that the paper should lay the groundwork for potential standards by raising key issues, rather than trying to make standards setting its key focus.

Therefore, the Mentally Ill in Jails Workgroup presents this paper to the attention of jail commanders and mental health professionals working in and with jails. It is the Workgroup’s hope that the paper will prove useful in terms of operating California’s jails, providing appropriate services to mentally ill people in jails and informing revisions and/or additions to the Minimum Standards for Local Detention Facilities,

Although this paper is completed, it is COMIO’s and CSA’s intention to continue to facilitate discussion and collaborations that are beneficial in solving problems and advancing best practices related to the mentally ill in jails.

**APPENDIX 1**

**DRAFT**

**JAIL MENTAL HEALTH ASSESSMENT INSTRUMENT**

**Jail Mental Health Assessment**

**DRAFT**

**Inmate's Name:** \_\_\_\_\_  
**Gender:** \_\_\_\_\_  
**Screener:** \_\_\_\_\_

**Assessment Date:** \_\_\_\_\_  
**Arrest Date:** \_\_\_\_\_  
**Ethnicity:** \_\_\_\_\_  
**Age:** \_\_\_\_\_

**Suicide Risk**

- A. Are you feeling like killing yourself?  Yes  No
  - a. Plan \_\_\_\_\_
  - b. Means \_\_\_\_\_
  - c. Lethality Assessment:    High                       Moderate                       Low
  - d. Do you have a history of suicide attempts? If so, how, when, where?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- B. Have you attempted to kill yourself in custody?  Yes  No  
If so, how, when? \_\_\_\_\_
- C. Has a family member or close friend committed suicide?  Yes  No
- D. Do you know anyone who has committed suicide?  Yes  No
- E. Did the patient express feelings of hopelessness?  Yes  No
- F. Are there signs and symptoms of depression?  Yes  No
- G. Is the inmate currently
  - a. Intoxicated?  Yes  No
  - b. Withdrawing?  Yes  No

**Violence Risk**

- A. Are you feeling like you want to hurt someone?  Yes  No  
Assess for:
  - a. Observable behaviors
  - b. History of violence
    - a. Method, means
    - b. Intended victims
  - c. Is a Tarasoff notification required?  Yes  No
- B. Does the inmate have a history of violent behaviors in custody?  Yes  No  
If so, when? \_\_\_\_\_
  - a. Towards inmates?  Yes  No
  - b. Toward staff?  Yes  No
- C. Is the inmate currently
  - a. Intoxicated?  Yes  No
  - b. Withdrawing?  Yes  No

**Grave Disability Assessment**

- A. Is the inmate's safety compromised (unable to follow jail routine, basic directions, etc.)?  
For example:
  - Inadequate nutritional intake even though food and drink is provided.
  - Drinking from the toilet or eating out of the garbage.
  - Unable to attend to daily ADL's.  Yes  No
- B. Do you have a HX of receiving any involuntary TX due to grave disability?  Yes  No

**DRAFT**

**Current Mental Status and Behavior** (circle all that apply)

- Affect: Restricted, Blunted, Broad, Flat, Labile, Irritable, Tearful, Expansive, Appropriate
- Appearance: Unkempt, Disheveled, Careless, Neat and Clean, Dirty, Malodorous, Meticulous, Inappropriate, WNL
- Behavior: Aggressive, Sleep Disturbances, Appetite Disturbance, Agitated, Hyperactive, Isolative, Assaultive, Self-Mutilation, Bizarre, Impulsive, Hypervigilant, Not Remarkable
- Cognition: Poor Concentration, Confused, Memory Impairment, WNL
- Intelligence: Likely below average, Likely within average range, Likely above average, Needs investigation
- Mood: Anxious, Irritable, Sad, Dystymic, Depressed, Elevated, Euphoric, Euthymic, Other
- Thought Content: Obsessive, Delusional, Paranoid Ideation, Phobia, Hallucinations, Thoughts of Suicide
- Thought Process: Tangential, Circumstantial, Concrete, Loose Associations, Flight of Ideas, Racing Thoughts, Thought Blocking, Disorganized, Preservative, Incoherence, WNL
- Speech: Rapid, Slurred, Soft, Unintelligible, Loud, Mute, Pressured, Normal
- Orientation: Person, Place, Time, Situation

Additional Mental Status Comments:

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**Psychiatric History**

A. Do you have a HX of receiving mental health treatment?  Yes  No  
If so, when and where?

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B. Do you currently have a mental health provider or case manager?  Yes  No

Place \_\_\_\_\_

Phone # \_\_\_\_\_

C. Have you ever been hospitalized against your will?  Yes  No

D. Do you receive SSI?  Yes  No

E. Are you conserved?  Yes  No

F. Do you have any family members with mental illness?  Yes  No

G. Residence/living situation \_\_\_\_\_

H. Highest level of education  GED  HS  Some College  College Degree

**Psychiatric Medication History**

A. Have you ever been asked to take psychiatric medications?  Yes  No

B. Are you currently taking psychiatric medications?  Yes  No

Medication \_\_\_\_\_

Last Dose \_\_\_\_\_  
Dose Frequency \_\_\_\_\_  
Prescriber \_\_\_\_\_  
Verified \_\_\_\_\_  
Medication Compliance \_\_\_\_\_

**Substance Use**

A. What substances do you use?

ETOH	How much: _____	How often: _____	How long: _____	Last used: _____
Methamphetamines	How much: _____	How often: _____	How long: _____	Last used: _____
Cocaine/ Crack	How much: _____	How often: _____	How long: _____	Last used: _____
Opioid	How much: _____	How often: _____	How long: _____	Last used: _____
Cannabis	How much: _____	How often: _____	How long: _____	Last used: _____
Inhalants	How much: _____	How often: _____	How long: _____	Last used: _____
Hallucinogens	How much: _____	How often: _____	How long: _____	Last used: _____
Rx/OTC	How much: _____	How often: _____	How long: _____	Last used: _____
Ecstasy/Club drugs	How much: _____	How often: _____	How long: _____	Last used: _____
Tobacco	How much: _____	How often: _____	How long: _____	Last used: _____

B. Have you ever experienced any problems detoxing from any substances?  Yes  No

If yes, what substance and what difficulties did you have? \_\_\_\_\_

C. Substance Abuse TX History

- a. Peer lead (AA/NA)  Yes  No
- b. Outpatient  Yes  No
- c. Residential  Yes  No

D. Is there a family history of substance abuse?  Yes  No

**Developmental Disabilities**

A. Does the inmate appear to have a developmental disability?  Yes  No

B. Are you a client of the Regional Center?  Yes  No

If yes, has the Regional Center been contacted?  Yes  No

- a. Who: \_\_\_\_\_
- b. When: \_\_\_\_\_

**DSM IV Diagnosis**

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