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## **Mentally Ill Offenders in California's Criminal Justice System**

*By Marcus Nieto*

*Prepared at the Request of  
Assembly Member Helen Thomson  
Chair, Assembly Select Committee on Mental Health*

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C A L I F O R N I A

R E S E A R C H B U R E A U

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## EXECUTIVE SUMMARY

National and state crime rates have been steadily declining since 1994. Analysts credit low unemployment, favorable demographics (fewer young males), community policing and tougher sentencing laws with keeping the nation's streets safer. Despite the reduction in crime rates, however, California is experiencing overcrowded jails, overcrowded prisons, court-ordered jail population caps, and increased demands for offender medical and mental health services.

California state prisons are under court order requirements to provide mental health services to mentally ill inmates. However, criminal justice administrators report that California county jail programs are ill equipped to respond effectively to the needs of mentally ill offenders. Jail administrators and other correctional officials identify mental health services as one of the most serious correctional needs.<sup>1</sup> Responding to a 1994 survey of the National Institute of Justice, administrators nationwide described their mental health programs as "grossly understaffed" and in urgent need of program development and intervention by mental health organizations.<sup>2</sup>

This report discusses what is known about the mentally ill in California county jails and state prisons, gives examples of what local correctional institutions are doing to identify and provide medical care to the mentally ill, and offers selected policy options. However, the discussion does not address the growing concern over mental disorders and substance abuse that affect 20,000 juveniles in locked facilities across the country.

Some of the report's key findings include:

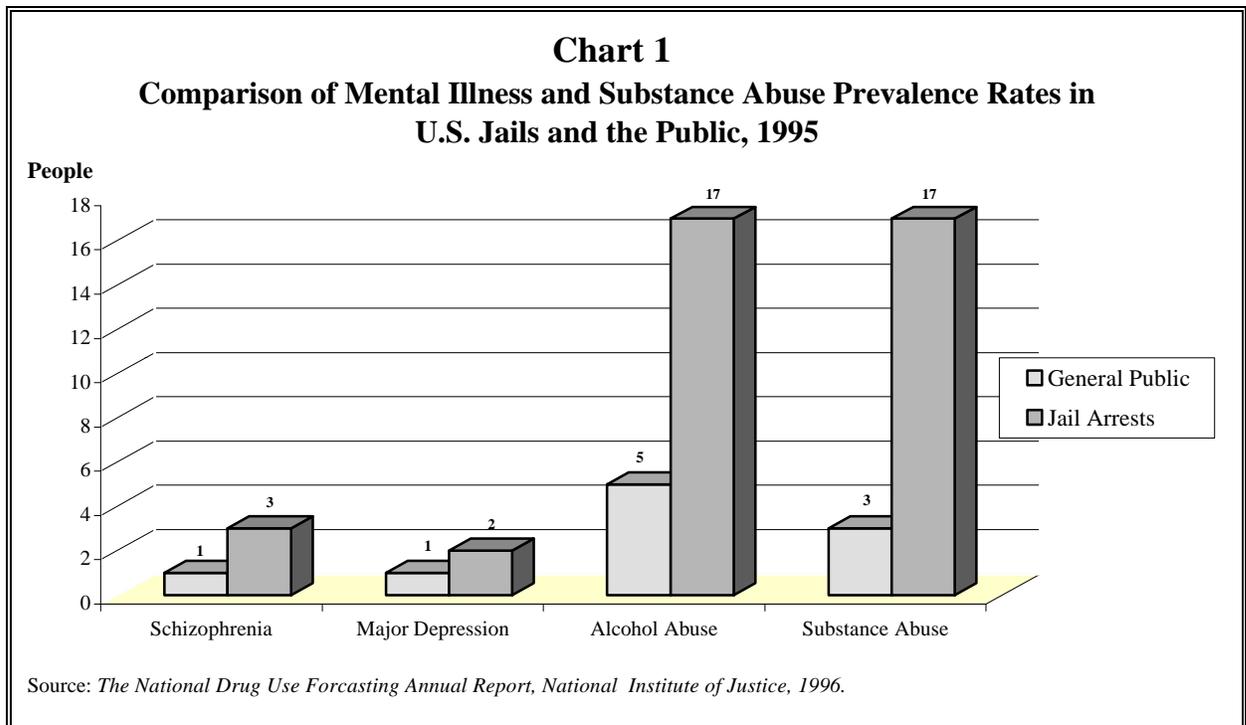
- An estimated 10-15 percent of offenders who enter the local criminal justice system are mentally ill, the same as in the state correctional system.
- Local correctional systems do not engage in long range strategic planning on how to best identify and serve the mentally ill offender at the local level. For example, such a plan could establish an integrated and planned response that might reduce the number of mentally ill people who come into contact with the criminal justice system.
- No county jail facilities have licensed correctional treatment beds for the mentally ill.
- There are insufficient aftercare treatment and services for mentally ill offenders leaving the local and state criminal justice system, and a severe lack of coordination among service providers.
- There are some innovative collaboration between community mental health providers and local law enforcement to identify and treat mentally ill people and to keep them out of the criminal justice system.



## MENTALLY ILL OFFENDERS IN THE LOCAL CRIMINAL JUSTICE SYSTEM

### How Many People With Mental Illnesses Are Incarcerated?

According to a Los Angeles County jail psychiatrist, “we run the largest mental health facility in the county.” Former Sacramento County Sheriff Glenn Craig says he operated the “second largest mental health facility in the county” (the first being the county mental health treatment center where the indigent mentally ill are often taken by police officers).



According to a National Institute of Justice study, the difference between the number of people suffering from mental illnesses and substance abuse in the U.S. criminal justice system, and those in the general population, is startling.

Researchers conservatively estimate that 10 to 15 percent of California county jail inmates are mentally ill on any given day: between 8,000 and 12,000 people. The annual associated costs to police and sheriffs departments to handle mentally ill offenders (transfer and escort costs, arrest and booking, and detention) are estimated to be \$445 million and \$160 million respectively, \$605 million in total.<sup>3</sup>

#### *Responsibility Shifts to Counties—A Brief Policy Background*

In the mid-1950s, Congress passed the National Mental Health Act and the Community Center Act. The latter provided seed money to states to create community-based facilities and to replace state hospitals as the primary mental health care centers. California lawmakers enacted concurring legislation requiring counties to assume a larger role in managing and maintaining a community-based mental health system, in contrast to the mental health institutions operated by the state (*Short-Doyle Act of 1957*).

However, managing mentally ill patients under community control, with limited local financial resources, was difficult for California counties. This problem led to a further “realignment” (*AB 1288, Statute of 1991*), allowing the state and counties to negotiate a fixed funding amount for most mental health services (50/50 match). Under the *AB 1288* realignment, the state continued to detain the most serious mentally disturbed patients (which today includes sexually violent predators) while the majority of patients remained the responsibility of counties. A series of laws have since fine-tuned the state-county relationship by increasing the flexibility and financial incentives for counties to provide services. However, these levels of service continue to vary widely from one county to another, and funding has remained at or below previous levels.

California’s local mental health system is overwhelmed by the sheer volume of people in need of care and treatment. Today, it is a widely held view that many people have fallen through the local mental health delivery system’s financial and service cracks. Many of them end up in the county or state correctional system.<sup>4</sup> In 1998, the Governor signed two bills (*Chapters 501 and 502, Statutes of 1998*) which appropriated \$27 million for competitive demonstration grants over a four-year period to counties that expand or establish a cost-effective continuum for mentally ill offenders to reduce crime, jail crowding and criminal justice costs. As many as 45 counties have applied for the Mentally Ill Offender Crime Reduction Demonstration (MIOCR) grants, which will be awarded by the end of May, 1999. The program requires collaboration between local mental health providers and the criminal justice system, including diversion, aftercare treatment, data collection and evaluation (see Appendix A).

Aftercare is a most critical element to the long-term success of any correctional-based mental illness or substance abuse treatment program. While the MIOCR grants are a positive step, many local criminal justice officials argue that the problem of providing care to the mentally ill in a correctional setting may be difficult to solve without stable funding and more resources.

### **Who are the Mentally Ill Offenders in California County Jails?**

Mentally ill repeat offenders are a significant percentage of California’s jail population. While there are no exact figures, a 1991 study (conducted by the Los Angeles County Board of Supervisor’s Task Force on the Incarcerated Mentally Ill), estimated that 90 percent of the mentally ill offenders receiving mental health services in the county jail were repeat offenders. The Task Force also concluded that mentally ill offenders were incarcerated ten times or more for minor crimes and misdemeanors.<sup>5</sup>

Many mentally ill offenders are homeless, having committed what one study characterizes as “crimes of survival.”<sup>6</sup> In addition, the impaired reasoning sometimes associated with mental illness can lead to crimes such as shoplifting, loitering, trespassing, public intoxication, petty theft and vandalism, and disturbing the peace. Some mentally ill offenders also display aggressive violent behavior, have long histories of institutionalization, and/or exhibit a diminished ability to function independently in jail or other detention settings.<sup>7</sup> A Sonoma County Assistant Sheriff in charge of county detention services reports that over a one month period, 14 offenders were responsible for

committing 96 misdemeanor and felony non-violent crimes before they were diagnosed in jail as mentally ill.<sup>8</sup>

People with both mental and substance abuse disorders also enter the local criminal justice system with alarming frequency. A 1997 U.S. Department of Justice study found that 78 percent of the jail detainees surveyed reported using illegal substances of some kind (excluding alcohol) before or during their time of arrest. A 1997 report estimated the range of jail detainees with co-occurring mental health and substance abuse disorders as between 3-11 percent.<sup>9</sup> An earlier study found that an estimated 7 percent of jail inmates had co-occurring mental health and substance abuse disorders.<sup>10</sup> According to a national study, 63 percent of all jail detainees (average 1995 daily jail census was 591,040) on any given day have a mental illness or a substance abuse disorder, and 5 percent have both. This means that approximately 320,000 jail detainees and inmates in U.S. jails were affected by mental health or substance abuse problems in 1995, of which 25,350 may have had serious mental illnesses and co-occurring substance abuse disorders.<sup>11</sup>

Under the best of circumstances, the screening, diagnosis, and assessment of individuals with co-occurring mental illness and substance abuse disorders is very difficult. These disorders are often under-diagnosed in the criminal justice setting, leading to misdiagnosis, over-treatment with medications, neglect of appropriate interventions, inappropriate treatment planning and referral, and poor treatment outcomes.<sup>12</sup> Some pilot project screening protocols and treatments are now being developed with funding by the National Institute of Corrections and the Center for Substance Abuse Treatment. However, California county jails are not among those funded.

### **Do Mentally Ill Offenders Have Access to Treatment?**

Many counties operate substance abuse and mental health diversion programs which help people who have become involved in the criminal justice system. These programs vary from county to county and offer a wide range of applications. Some programs link people in need of treatment with community services after court charges are dropped (when appropriate). Others help incarcerated individuals receive the treatment they need while in jail. Other programs allow individuals convicted of a crime to serve their sentences in the community provided they remain in treatment. There are no state or local aggregated cost or outcome data by which to evaluate the success or failure of these diverse county programs.

Researchers find that diversion programs alone are insufficient to protect mentally ill persons from re-occurring illnesses or from committing more crimes.<sup>13</sup> A mentally ill person who voluntarily receives outpatient treatment in the community may stop taking medication, and many do. Some stop when they feel better, and others develop a fear of their medication. One study concluded that as many as 67 percent of all patients in the U.S. who are diagnosed with a severe mental illness are arrested within six months of discharge from psychiatric hospitalization.<sup>14</sup>

Some mentally ill people on prescribed medications turn to street drugs, suffer a mental breakdown, and are subsequently arrested for committing petty crimes. Once in jail,

mentally ill offenders are often unable to recognize their illness and refuse medication. They may “decompensate,” and lose touch with reality. A psychotic break can result in referral to a hospital, where doctors can prescribe medication, and in some cases force the detainee to take it under a court order. Once the psychosis is under control, the mentally ill inmate returns to jail. The illness may have several cycles a year, each of which may involve the criminal justice system. One expert contends that, “we have created a revolving door in which mentally ill people cycle from clinics to homelessness to jail.”

### **Mentally Ill Female Offenders in the Local Criminal Justice System**

Although women represent only a small percentage of jail detainees, studies show that they are more likely than male inmates to be diagnosed with serious mental illnesses. For example, a 1996 prevalence study of mental illnesses among male and female admissions to a large urban jail found that 9 percent of males and 19 percent of females had diagnosable serious mental illnesses. Acute conditions of serious mental illnesses were found in 6 percent of males and 15 percent of the women being booked into the jail. Post-Traumatic Stress Disorder and major depression are the most serious conditions found among female inmates.<sup>15</sup> Among jail detainees with serious mental illnesses, 75 percent of women and 71 percent of men have co-occurring mental disorders and substance abuse disorders.<sup>16</sup>

There are very few institutional resources in California county correctional facilities dedicated to treating female offenders who suffer from co-occurring mental disorders (with the exception of Los Angeles). Most county mental health treatment resources are dedicated to male offenders. In addition, few community programs are linked to female prisoners when they are released from custody. As a consequence, this high-risk population does not have good access to rehabilitation services.

Most women in county jails have been incarcerated for illegal drug activity. According to a California Research Bureau Report:<sup>17</sup>

- Approximately 85 percent of women in California jails who are incarcerated have been convicted of illegal drug activity or were convicted of another offense in which drugs or alcohol were a contributing factor.
- Prior to arrest a high percentage of female inmates had drug or alcohol usage during pregnancy.
- Approximately five percent of the women who give birth statewide each year use illicit drugs during their pregnancy.
- Women convicted of alcohol and drug-related penal code violations have a high rate of recidivism and a disproportionate involvement with Child Protective Services.

Los Angeles has the largest county correctional outpatient and inpatient mental health program for women in the state. The mental health outpatient program is operated by the Los Angeles County Department of Mental Health and can serve up to 200 inmates in a segregated section of the jail. It is designed to stabilize female offenders who demonstrate a need for mental health care at the time of booking, and adjudicated female inmates who need care and treatment while serving their sentences. The jail has a 50-bed psychiatric unit on site for high security female offenders with serious psychiatric

conditions, and access to 48 psychiatric beds at Metropolitan State Hospital for lower security offenders in need of psychiatric treatment.

Recent improvements in the Los Angeles County jail mental health program resulted in part from a U.S. Department of Justice, Civil Rights Division investigation which found that unconstitutional conditions existed at the county jail, including a deliberate indifference to the inmates' mental health needs (mental health services in state correctional institutions have also been improved due to court orders).

Other pilot projects dedicated to drug court treatment and mental health counseling for female offenders include:

- The *Women Treatment Network* (WTN) in San Francisco is a five-year demonstration project started in 1996 for women offenders who have been identified as drug abusers. The goal of the project is to create a case-managed change in the way women offenders are identified and treated for drug abuse. The project is funded through a grant from the U.S. Department of Health, Center for Substance Abuse Treatment.

The county probation department manages the program and is guided by a collaborative of county criminal justice officials. Women offenders in custody who are eligible for the program receive drug counseling and education in the first phase of the program for a period of at least 90 days, depending on the length of sentence. After completion, offenders become part of a case-managed system and are referred to a substance abuse provider for further treatment. Progress is monitored by a program caseworker who also serves as a resource person for other offender services including mental health. There is an integrated management information system for most county offenders in the San Francisco criminal justice system, including this program.

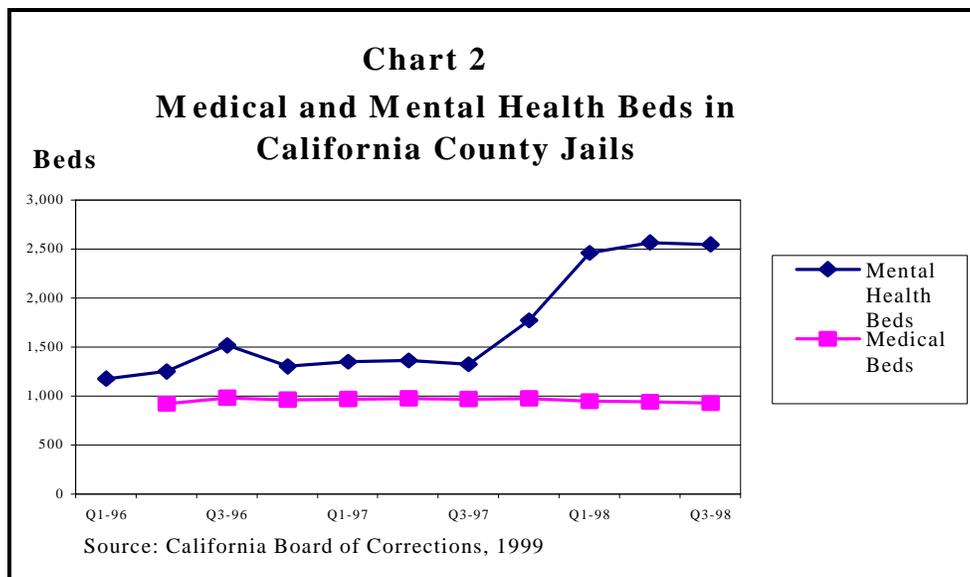
- The *Sisters Project*, started in 1994, is a San Francisco County jailed-based residential drug treatment program for sentenced female offenders who are serving sentences of between 180 and 365 days. The program is managed by Walden House Residential Treatment in conjunction with the county jail. The project is funded by grants from the Center for Substance Abuse Treatment, the California Department of Alcohol and Drug Abuse and the National Institute of Corrections. Walden House uses a therapeutic approach to their treatment and collaborates with the *Women Treatment Network* for aftercare services. Up to 100 offenders are treated annually in the program. Offender information and tracking data are included in the county criminal justice management information system.

### **Mental Health Service in the Local Criminal Justice System**

There are no statewide data on the prevalence of mental illness in county jails, as noted above. Counties do not report to the state the amount of money they spend for mental health services in their correctional facilities, the number of mentally ill offenders, nor the level of services provided. Los Angeles and Santa Clara counties recently began keeping statistics on the number of offenders who required mental health services, but

numbers vary based on the quality of screening. The California Board of Corrections estimates that counties spend \$40 million per year on mental health treatment within their correctional facilities.

The annual *Jail Profile Survey* report, published by the California Board of Corrections, began reporting quarterly jail census data in 1996, including medical and mental health bed usage. As shown in the following chart, this data confirms the growing importance of county jails as mental health facilities.



### **How are Mental Health Services Provided by County Detention Facilities to Mentally Ill Offenders?**

Mental health services inside county jail facilities are usually provided under contract by county departments of mental health or community mental health providers. Some county correctional facilities contract with university hospitals and private or non-profit hospitals to provide mental health treatment and inpatient care. Most county jails do not provide on site psychiatric inpatient care for serious mentally ill offenders. Los Angeles County jail is an exception. It has approximately 470 inpatient, outpatient, and intermediary care beds available for mentally ill offenders. But according to Los Angeles mental health officials operating the jail programs, these are not nearly enough for the estimated more than 3,000 mentally ill offenders in the county jail on a daily basis. County jails in Santa Clara, Orange, and Sacramento also provide some emergency psychiatric inpatient services on site for severely mentally ill offenders.

No county correctional facilities (including the Los Angeles County jail) are licensed to provide correctional treatment center services. The California Department of Health Services (DHS), Licensing and Certification Division which is responsible for licensing all health care facilities in the state, has expressed concern about this. In December of last year, a memorandum was issued by the DHS to all county sheriffs in the state notifying them that they could not provide inpatient services in their county jails without a Correctional Treatment Center (CTC) license issued by the department. California

*Health and Safety Code, Division 2, Section 1250 (j) (1)*, authorize CTCs to provide the following health care services: medical, surgical, psychiatric, psychological, nursing, pharmacy, dental, dietary, laboratory, radiology, prenatal, and other as approved by the Department of Health Services.

### **Mental Health Screening**

Because of overcrowding in California’s county and city jails, people arrested for misdemeanors are usually booked, cited and released without medical or mental health screening. Research indicates that a lack of medical screening even for minor offenses can contribute to the criminalization of mentally ill people. Due to their impaired reasoning, they may not understand the importance of appearing in court and may subsequently be served warrants for “failure to appear.”<sup>18</sup>

Screening felony offenders for mental illness is initiated by jail personnel or nurses, either through an interview or by observation or some form of medical questionnaire. Questions include, “Have you ever received treatment for a psychiatric disorder? “or” Are you currently taking medication?”<sup>19</sup> Medical and mental health jail guidelines developed by the Board of Corrections and the California Medical Association (as required by *Penal Code Section 6030*), do not specify standards for jail-based mental health screening, nor do they specify the qualification of the jail personnel required to perform the screening (see Attachment B). Most counties provide a minimum level of training for jail intake screening personnel through courses offered by the Peace Officers Standards and Training (POST). County jails in Los Angeles, Sacramento, San Francisco, Santa Cruz, and Alameda have established more extensive screening procedures involving medically trained deputies and mental health and/or nursing professionals.

### **Innovative Local Mental Health Service Programs**

If a police officer stops or detains an individual and determines that the individual is in need of mental health care, the officer must take that person to a psychiatric emergency room for evaluation. It is the officer’s responsibility to remain with the person until he or she is treated and released or discharged into custody (*Welfare and Institution Code 5150 and Penal Code 4011*). This process may take from two-to-four hours of an officer’s time.<sup>20</sup>

In Los Angeles County, the community mental health department, the sheriffs department and the city police have created “MET/SMART” teams that respond to police calls to help detainees in need of mental health care. These teams have the authority to commit a detainee to a psychiatric inpatient facility. The primary goal of MET/SMART, however, is to help persons in crisis take medication, make doctor’s appointments and assist their arrival, and link to other community services such as housing. The mission is to do whatever it takes to keep a person out of a hospital or a jail. The MET/SMART teams allow police officers to instead respond to normal duty calls or more pressing emergencies.

Other counties have designed innovative diversion programs to keep mentally ill people out of jail, but case management and housing problems are a concern.

Orange, San Diego, Ventura, and Solano Counties have developed programs designed to meet their correctional mental health needs (see Attachment C for additional details).

- *Orange County Correctional Mental Health Program*: This program provides a wide range of psychiatric services to inmates in the Orange County jail, who are identified as being at risk as a result of severe mental illness. The primary treatment goals are to facilitate coping in jail and to prevent serious maladaptive or self-destructive behavior.
- *Solano County Forensic Alternative Community Treatment (FACT)*: This program is designed as a diversion for individuals with severe and persistent mental illnesses. It provides alternatives to incarceration for misdemeanor offenders and post-release supervised community treatment alternatives for some felony offenders.
- *Ventura County Forensic Alternative Community Treatment (FACT)*: This program provides community-based mental health services and forensic supervision to chronic mentally disordered misdemeanants, and not to felony offenders, to divert them from the local criminal justice system.
- *San Diego County Psychiatric Emergency Response Team (PERT)*: This program provides officers in the field an opportunity to transfer a detainee for immediate psychiatric evaluation in local facilities, and appropriate interventions. It includes mental health training for law enforcement officers.

### **What Other States are Doing To Address Mental Health Needs in the Criminal Justice System**

According to the National Conference of State Legislatures, the state of Texas has the most comprehensive approach to treating and managing mentally ill offenders in a criminal justice setting. In 1997, Texas created the Interagency Council on Mentally Retarded, Developmentally Disabled, and Mentally Ill Offenders, with authority to oversee a broad range of activities that include the following:

- Develop a local and statewide treatment plan for offenders with mental impairments.
- Evaluate in-state and out-of-state programs for offenders with mental impairments.
- Serve as the primary funding agent for distributing federal, state, and other public and private funds for mental health services in the criminal justice system.
- Collect and distribute information about treatment programs to law enforcement.
- Develop and implement pilot projects.
- Report annually to the Texas Legislature.

Council members include directors of state adult and juvenile criminal justice agencies as well as mental health officials. The intent of the legislation is to lead to reduced mental health costs and better coordination among all levels of Texas government.

Attachment D contains detailed information about other local comprehensive and interdisciplinary project approaches to managing mentally ill offenders. These projects have been funded for study by the Substance Abuse and Mental Health Services Administration including several that are listed below.

- *Arizona-Maricopa County and Pima County Intervention Programs:* The Pima County program begins with an in-take worker at the Pre-Trial Services in the county jail. Based on the in-take interview, Pre-Trial Services provides the court with a summary and conditions of release, an initial appearance is scheduled within 24 hours. Pre-Trial Services then contacts the Community Partnership of Southern Arizona. This organization has a full-time criminal justice specialist who develops, implements, and coordinates diversion programs throughout the community.

The Maricopa program is a post-booking jail diversion partnership between the Arizona Department of Behavioral Health, Arizona Department of Corrections and Com-Care, a private provider. Com-Care works directly with the police departments, mobile mental health teams, urgent care centers, prosecutors, public defenders, attorneys and judges to advocate for the treatment of persons with a serious mental illness in the legal system.

- *Maryland-Wicomico County: The “Phoenix Project”* for women springs from a highly successful post-booking services model called Maryland Community Criminal Justice Treatment Program (MCCJTP), which operates in 20 of 24 counties in Maryland. The project is a pre-booking diversion program focused on women who are both mentally ill and suffering from drug abuse and their children. This program has several components: A formal interagency agreement linking several social service agencies together to help mentally ill females in the justice system; training on signs and symptoms of mental illness and substance abuse for police; a 24 hour Mobile Crisis Unit; and an integrated intensive mental illness/substance abuse disorder outpatient treatment program.
- *Oregon-Lane County Mental Health Intervention Project:* Clients are interviewed at the jail by the jail-based Mental Health Specialist who meets with the District Attorney for negotiation. Depending on the circumstances, the case can go to Drug Court where the specialist will work with the client’s attorney or Public Defender to negotiate placement in either the Sacred Heart Hospital Psychiatric Unit or Lane County Psychiatric Hospital, or a myriad of local residential or community-based organizations. Additionally, there is a strong collaboration between Lane County Sheriff’s Office, Lane County Police Department, Lane County Psychiatric Hospital, Cahoots Mobile Mental Health Team, Buckley House, (Sobering and Detox), and others where all partners have a similar commitment to the population with co-occurring disorders.



## MENTAL HEALTH CARE IN STATE DETENTION FACILITIES

The following discussion is drawn from a 1998 California Research Bureau report, *Health Care In California State Prisons*, by Marcus Nieto. The report is available from the Bureau or on its website at: [www.library.ca.gov](http://www.library.ca.gov), under *CRB Reports*.

Two major lawsuits have focused attention on the condition of mental health care in state prisons: *Gates vs. Dukemejian* (1989) and *Coleman vs. Wilson* (1992). The *Gates* case alleged inadequate psychiatric care to outpatient inmates at the California Medical Facility in Vacaville. A consent decree was reached by the two parties, resulting in better access and treatment for outpatient inmates. The *Coleman* case alleged that the entire state prison mental health care system (including screening, medical records, treatment and access to care) was inadequate and constituted cruel and unusual punishment. The lawsuit was prompted by a series of heat and medication-related deaths of prisoners receiving psychotropic drugs at California Medical Facility in Vacaville. In response, a federal court order required the Department of Corrections to develop a plan to remedy deficiencies. The court also appointed a Special Master to oversee the California Department of Corrections' (CDC) efforts to develop a system-wide Mental Health Service Delivery System (MHSDS).

According to the 1992 Scarlett Carp Report (systemwide mental health needs assessment), the average proportion of mentally ill inmates in the California state prison system at any one time is about 8 percent. CDC medical staff estimates that 10 to 18 percent of the inmates passing through prison reception intake centers require some form of mental health service.<sup>21</sup> (That figure is less than the 29 percent cited in the *Coleman vs. Wilson* case, in which the court found that inmates with serious mental disorders were receiving inadequate psychiatric care and treatment.) Based upon the CDC staff estimate, on any given day up to 27,600 inmates housed in CDC facilities could require mental health services. According to a recent national study by U.S. Department of Justice, as many as 10 percent of all prison inmates suffer from one or more of the most severe mental illnesses: schizophrenia, manic depression or major depression. This incidence is four times greater than that found in the general population.

Prior to the *Coleman* consent decree, many of CDCs intake mental health screening procedures and the treatment approaches used at its reception centers, were ineffective in identifying inmate mental health problems. The department's Mental Health Service Delivery plan, developed in response to the *Coleman vs. Wilson* lawsuit, includes the following elements:

- Procedures for screening and identifying mentally ill inmates;
- Staffing standards for mental health care;
- Access to mental health care in mainline prisons;
- Proper use and monitoring of psychotropic medication;
- A committee process (medical and custodial staff) to place and/or retain a mentally ill inmate in administrative segregation or segregated housing units (previously custody staff had sole responsibility);
- Monitored use of tasers, 37mm guns, mechanical restraints, and involuntary medication;

- Regular maintenance of mental health records; and
- Development of a mental health information tracking system.

Pre-screening reviews and psychometric evaluations for mental health are now a standard part of the CDC's reception center intake screening process. The process begins after an inmate arrives on a bus from a county. Inmates are immediately screened by CDC staff for tuberculosis and for any possible psychiatric condition. They answer a simple question and answer form. If a "red flag" is raised by an inmate response, a psychologist can intervene to determine an appropriate level of care. If there are no "red flags," the inmate will move forward for other custodial and administrative processing. Many of the custodial staff at reception centers go through an annual series of mental health training classes which are designed to help identify and treat inmates with mental health problems.

After 72 hours in a CDC intake reception center, an inmate will receive a more thorough health care screening, including a diagnostic test which identifies most of the expected 10 to 13 percent of inmates requiring psychiatric evaluations. A psychiatric evaluation should follow within 18 days, provided the inmate has completed all required health care screening. The result is that inmates are screened or evaluated for mental illness at four different levels within the reception center process to prevent them from falling through cracks in the system.<sup>22</sup>

### **Levels of Mental Health Care at Prison Reception Centers**

If an inmate requires immediate placement in a secured bed for observation of mental illness, he will be removed from the mainline reception area and placed in a correctional treatment center or infirmary crisis bed on an outpatient basis. Patients in correctional center treatment (CTC) crisis beds generally require short term stays of less than ten days. In most cases, the patients are suicidal, severely depressed, acutely psychotic, or suffering panic attacks. In an extreme case in which an inmate has serious mental disorders requiring intensive care, he will be immediately referred for inpatient treatment to either the California Medical Facility in Vacaville, the California Men's Colony in San Luis Obispo or Atascadero State Hospital, depending on the availability of beds.

Reception center medical staff classifies inmates into broad categories to determine the appropriate level of mental health care. Two of those categories are used extensively: inmates in need of inpatient evaluation and inmates with major mental disorders. Each type of inmate is placed in a separate housing group.

Seventy percent of the inmates with major mental disorders suffer from psychosis resulting from chemical reactions in the brain. According to Wasco State Prison Dr. David Lewengood. Mind-altering drugs such as LSD, PCP, and methamphetamine are generally the primary causes. These patients can usually heal within six months with proper care. They are then reassigned from the reception center to the mainline prison population. Very few inmates are held longer than six months at state prison reception centers for mental health reasons.

Some patient inmates on psychotropic drugs are very sensitive to heat, which left untreated could be fatal. Therefore inmates on psychotropic drugs who are awaiting assignment to a mainline prison are required to participate in a “heat plan” (as required by the *Coleman vs. Wilson* decision) designed to prevent adverse reactions. On warm days, for example, these inmates must be brought inside their residential units to cool down and prevent any type of heat reaction or stroke. When the temperature exceeds 85 degrees in their cells they are required to take cool showers to lower body temperatures. Prison health care officials contend that mentally ill inmates assigned to any prison are required to participate in a heat plan regardless of the situation.

Prison reception centers are not equipped to treat drug addiction. The general operating assumption is that most inmates have already been screened and treated for drug-related problems in county jail detoxification facilities prior to sentencing, as required by law (*California Administrative Code, Title 15, Division I, Section 1213*). However, there is no local or state monitoring to ensure that county jails comply with this requirement. Anecdotal information suggests that even when county level offenders volunteer for drug or alcohol treatment, there often are no programs available in county jails. Additionally, it is rarely the practice of counties to provide medical or mental health information about inmates when they arrive at state prison reception centers from county jails.

### **Mental Health Care in Assigned Prison Settings**

All inmates who are treated for mental illness, or who require some type of mental health care, are given another psychological evaluation shortly after arriving at their assigned prison, to determine if they need continuing psychiatric or mental health care. If further care or treatment is needed, there are several possible levels of care available, depending on the circumstances. The least intrusive intervention (correctional case management system or CCMS) involves medication and counseling and is available at all state prisons for inmates living in the general population. Inmates requiring a higher level of care, or who are not adjusting well to prison life, are placed in one of twelve prisons with a special housing unit (Enhanced Outpatient Program or EOP) where they can receive daily supportive and therapeutic care. Inmates are usually identified for placement in one of the twelve EOP prison programs before they leave the reception center.

Many EOP mental health programs rely on contract psychiatric staff to meet minimum EOP program needs. According to CDC Health Care Services Division officials, the lack of resources and staff to treat the mentally ill is related to recruitment problems, staff pay and prison location. (There is a 14 percent psychiatric staff vacancy rate in state prisons.)

Medication is an important aspect of mental health care and treatment. As expensive new and experimental treatment drugs are introduced into the market, state prison inmates are entitled to use them. However, in some cases, prison EOP programs and acute care hospitals are exceeding or reaching their pharmaceutical funding. According to observations and discussions with acute care hospital staff, intra-prison budgetary procedures contribute to this problem. In theory, each prison facility (especially level four facilities for high-risk inmates) should budget for the number of resident inmates requiring mental health care, including therapeutic drugs. However, when inmates are temporarily transferred to another facility, such as an acute care hospital, that facility

assumes all medical and therapeutic responsibility but does not necessarily receive the necessary budget support.

### **Parole Aftercare**

The Department of Corrections Parole Division operates five Parole Outpatient Clinics (POCs)-one each in San Diego, Los Angeles, San Francisco, Sacramento, and Fresno. These clinics are exclusively for mentally ill parolees and are staffed by licensed psychiatrists and psychologists. Last year these clinics served nearly 9,000 parolees (about 9 percent of all parolees) at a cost of \$11 million, or about \$1,200 per parolee in addition to the average parole cost of \$2,145. Do to demand for POC services and treatment slots, a large number of parolees in need of mental health care do not have access to them. An estimated 70 percent of the inmates who received some type of mental health care while in prison do not receive the same level of care while on parole. In addition, more that 50 percent of the parolees who were treated for mental illnesses while in prison live outside the range of the five POCs and, as a result, require a substantial amount of attention from parole agents.

Some correctional officials estimate that for every parole agent caseload of 80 parolees, seven received mental health care while in prison and subsequently require as much as 30 percent of the agent's time. According to county mental health officials, "parole agents refer these parolees to us and they end up unannounced in our office looking for help." State parole division officials contend that these parolees, having been returned to their place of origin, are the responsibility of county mental health programs. Parolees with mental illnesses who do not receive care are at-risk for re-offending or violating their condition for parole.

According to CDC officials, serious consideration is being given to shifting responsibility for managing parole mental health treatment services from the Parole Division to the Department's Health Care Services Division (HCSD). Many prisoner advocate groups have long held the view that the Parole Division does not have the resources or expertise to operate and manage psychiatric outpatient parolees. Whether the proposed management change takes place or not, there will still be an unmet need for parolees living outside the five urban POC service areas. The goal of reducing the number of parolees with mental health needs who commit new crimes or violate their parole, depends in part on the availability of aftercare services.

### **Conditional Release Program (CONREP) For Mentally Ill Offenders**

The California Board of Prison Terms (BPT) is responsible for conducting parole suitability hearings for prison inmates and setting parole release dates. Other BPT responsibilities include reviewing inmate requests to reconsider the denial of good time credits, setting parole length and conditions for release, and conducting parole revocation hearings. The BPT is also responsible for administering any special conditions for parole of inmates who are diagnosed with specific mental illnesses.

One BPT program for mentally disordered offenders involves both the Department of Corrections and the Department of Mental Health. The Conditional Release Program

(CONREP) is a relatively small but successful program charged with the treatment and supervision, in community settings. Mentally ill persons are referred by the BPT to the Department of Mental Health. These mentally disordered offenders were transferred to state hospitals by the Board of Prison Terms, and subsequently to conditional release outpatient programs as a condition of parole. Other eligible offenders include patients who are not guilty by reason of insanity and patients who are incompetent to stand trial. Participants who met the following criteria are eligible for participation:

- The crime involved force or violence;
- A major mental disorder was a cause or aggravating factor in the commission of the crime;
- The disorder is not in remission or cannot be kept in remission without treatment;
- The prisoner must have been in treatment in prison for 90 days or more in the past year; and
- The person must represent a substantial danger of physical harm to others.

Patient inmates who successfully complete treatment in secured hospital facilities are released under heightened supervision (such as periodic urine screening for drugs, unannounced home visits, etc.) and receive ongoing mental health care in the community. As of September 1998, there were 591 mentally disordered offenders housed in state hospitals and 121 receiving outpatient treatment by CONREP, at an average cost of \$21,879 per participant. Studies find that CONREP offenders are four times less likely to re-offend after release than are unconditional release offenders because of their closely monitored aftercare treatment.<sup>23</sup> The success of the CONREP is comparable to that of similar programs in New York and Oregon.<sup>24</sup>

Despite the relative success of the CONREP, not all mentally disordered offenders who are eligible for parole receive an evaluation screening prior to leaving the Department of Corrections or Department of Mental Health secure facilities. At the end of 1997, over 17 percent (1,108) of all mentally disordered offenders eligible for parole had not received a parole evaluation.<sup>25</sup> Department of Corrections officials state that the reason is inadequate clinical resources to conduct the proper medical evaluation.

A growing number of state prison inmates are diagnosed as mentally disordered while in prison. Many of these mentally disordered inmates can be healed during their sentence, but a sizable percentage require a level of care and treatment equivalent to that received by offenders in the Department of Mental Health's, CONREP program. When these CDC inmates are placed on parole, their conditional release is not as stringent as that for mentally disordered offenders in the CONREP program. Consequently, their parole revocation rates are substantially higher than for CONREP parolees.



## **LEGISLATIVE AND ADMINISTRATIVE OPTIONS**

(While not necessarily the recommendations of the author or the Bureau, the following are potential options for action).

### **Screening, Education and Training**

Many California county jails are overcrowded, resulting in offenders with minor crimes being released after booking without medical or mental health evaluation. As many as 10 to 15 percent of the offenders entering the criminal justice system suffer from mental illnesses. Many are repeat offenders. The first step in treating mental illness, and removing mentally ill individuals from the local criminal justice system, is to identify persons who are ill at the point of entry.

- The Legislature could require the California Board of Corrections to develop detailed guidelines specifying how county jail personnel should screen potential mentally ill persons at the time of booking. Current Board of Correction guidelines allow a great deal of flexibility in the mental illness screening process. Presumably, these requirements would be mandated and require state funding.
- The Peace Officers Standards and Training (POST) organization could create and offer continuing education programs about mental illness for public safety personnel, including front line police officers, jail and detention level personnel, 911 operators, firefighters, etc.
- Counties could contract with mental health providers to screen newly arrested prisoners, including a diversion and treatment program. Again, state funding would be required.
- The Los Angeles County collaborative model MET/SMART (see page 9) could be funded as a statewide program. This might effectively free up police to patrol more serious criminal activities.

### **Integrating Local and State Criminal Justice and Mental Health Information Systems**

Strategic planning to identify and serve mentally ill offenders at the local level is severely lacking, according to Board of Correction officials. There is currently no systematic or coordinated statewide plan that links the criminal justice and mental health information systems. Many advocacy groups are recommending the creation of a statewide management information system.<sup>26</sup> For example, county justice and mental health agencies are unable to exchange and share information about mentally ill persons in a timely manner.

- The Legislature could convene a Blue Ribbon Task Force composed of local criminal justice and mental health officials to discuss how to best create a statewide information system, including issues of confidentiality.

- The Legislature and the Governor could direct the Office of Criminal Justice Planning to apply for a U.S. Department of Justice grant to develop a cross-jurisdictional, automated statewide mentally ill offender database. The state could fund counties to develop local databases of active mentally ill patients who enter the criminal justice system, including automated links to a statewide mentally ill offender database. The purpose would be to facilitate diversion and treatment.

### **Local Aftercare and Treatment for Mentally Ill Offenders**

Researchers have found that a continuum of services for mentally ill offenders that includes prevention and intervention can reduce crime, jail overcrowding and criminal justice costs.<sup>27</sup> However, most jail mental health treatment programs serve only a small portion of offenders within the system.

- Inmates who successfully complete in-custody mental health treatment programs could be placed in specialized probation caseloads and be required to participate in probation day-reporting centers as part of their aftercare surveillance. Random drug testing for probationers on medication and counseling, employment services, and other life skills could be part of the day-reporting center curriculum. Inmates who demonstrate increased responsibility could be placed in less intensive or regular probation caseloads.

### **Mental Health and Drug Abuse**

There are no combined drug and mental health treatment programs in any of California's county jails. The reason is that the ideal length of treatment for an effective program outcome is usually longer than the jail sentence. In addition, insufficient time and resources are devoted to prerelease planning and linked aftercare services. Limitations included weak or nonexistent aftercare, mismatches between lengths of programs and time in jail, budget constraints and staff training. Options might include

- Require better coordination among federal, state, and local funding agencies.
- The Legislature could provide pilot funding treatment for women offenders with co-occurring mental and drug disorders in jail and aftercare services while in transition from jail to independent living in the community. Where appropriate, pilot funding could be provided for family services that include accommodations for those with infants and children.
- The state could focus attention and funding on expanding aftercare services for county inmates who are released from custody after completing drug treatment. An effective strategy might incorporate other county services such as mental health, health services, adult education and social services as part of the multisystemic approach to reducing recidivism.

## **Aftercare and Treatment for Mentally Ill Parolees**

Based upon California Department Corrections staff estimations, on any given day up to 27,600 inmates housed in CDC facilities require mental health services. The Department of Corrections Parole Division operates five Parole Outpatient Clinics, which are devoted exclusively to mentally ill parolees. Due to demand for POC services and the limited treatment slots, a large number of parolees in need of mental health care can not access them. An estimated 70 percent of the inmates who received some type of mental health care while in prison do not receive the same level of care while on parole. In addition, more than 50 percent of the parolees who were treated for mental illnesses while in prison live outside the range of the five POCs.

- It might make sense for the Legislature to place primary responsibility for the mental health treatment of state parolees with community mental health agencies or mental health providers, in concert with the Department of Mental Health. Again, state funding for this effort would be required.
- The Departments of Mental Health and Corrections could build on the positive preliminary results of the CONREP program. This would require a long term, stable funding base that would also serve the mentally disordered inmates who do not currently qualify for CONREP programming (There are some federal grant programs, such as the Byrne Memorial grants, that could fund aftercare and mental health treatment programs).
- The Legislature could require mentally disordered parolees who violate the terms of their parole, or who fail to maintain a required treatment regimen and aftercare program, to be committed to either a locked psychiatric facility for treatment or a less restrictive mental health treatment program that meets the parole's treatment needs.

## **Evaluation Studies**

Surprisingly little is known about the impact of different mental health strategies in the local criminal justice system. The Board of Corrections is currently providing competitive grant funds to counties to create continuums of care for mentally ill offenders (see page 4 for details—MIOCR grant program). While not all counties will be funded, those that do will have to evaluate their programs. However, researchers have found that self-administered evaluations are not the most objective way to measure outcomes. A good program evaluation to determine which pilot programs work and which ones do not should be conducted by an independent contractor.

- The Board of Corrections could be given responsibility to coordinate an independent state evaluation study of local mentally ill offender grant programs. Counties that do not receive funding could also be included.
- The Legislature could fund local evaluation studies of the effectiveness of different models of mental health programs as operated by county criminal justice agencies, mental health agencies, or state parole programs.

- Specialized caseloads for mentally ill offenders who are jointly managed by local probation officers and mental health providers could be established as pilot projects, with specific outcomes as measurable goals.
- Federal Substance Abuse grants if obtained, could fund the supervision or monitoring of co-occurring mentally ill probationers who are substance abusers. Some of the federal funding could be used for evaluation purposes.

**Attachment A**

**California Mentally Ill Offender Crime Reduction Program**

**Chapters 501 and 502, Statutes of 1998  
(SB1485/Senator Rosenthal)**



## **Mentally Ill Offender Crime Reduction Program**

### **Authorizing Statutes**

Chapter 501, Statutes of 1998 (SB 1485-Rosenthal) requires the Board of Corrections (BOC) to administer and award competitive grants to counties that expand or establish a cost-effective continuum of graduated responses for reducing crime, jail crowding and criminal justice costs related to mentally ill offenders. The law also requires the BOC, in consultation with the state Departments of Mental Health (DMH) and Alcohol and Drug Programs (DADP), to evaluate the effectiveness of these four-year grants and to report its findings to the Legislature annually.

Chapter 502, Statutes of 1998 (SB 2108-Vasconcellos) appropriates \$27 million for Mentally Ill Offender Crime Reduction grants. Of this amount, the legislation earmarks up to \$2 million for planning grants to counties and up to five percent to the BOC for administering the program.

### **Demonstration Grant Eligibility**

Counties must establish a Strategy Committee comprised, at a minimum, of the sheriff or county department of corrections director, the chief probation officer, the county mental health director, a superior court judge, representatives of local law enforcement agencies and mental health provider organizations, and a client from a mental health treatment facility.

The Strategy Committee must develop a Local Plan for providing a cost-effective continuum of graduated responses, including prevention, intervention and incarceration, for mentally ill offenders. Prevention and intervention strategies must include mental health or substance abuse treatment and long-term stability following release from custody.

The Local Plan must identify specific outcome and performance measures that enable the BOC to assess the effectiveness of strategies for reducing crime, the number of early releases due to jail crowding and local criminal justice costs.

Counties must provide a local match of at least 25 percent of the grant amount.

### **Demonstration Grant Selection**

The BOC, in consultation with DMH and DADP, must consider at a minimum the following criteria in awarding grants to counties:

- Percentage of the jail population with severe mental illness;
- Demonstrated ability to administer the program, and to provide treatment and stability for persons with severe mental illness;
- Demonstrated history of maximizing federal, state, local and private funding sources; and
- Likelihood that the program will continue after state funding ends.
- The BOC must also give priority to proposals, which include additional funding beyond the 25 percent local match.

## **Mentally Ill Offender Crime Reduction Grants Proposal Evaluation Criteria**

### **Bidder's History of Past Efforts - 12 points**

The bidder supplies information concerning the history of past efforts in the areas of program design, implementation, management, and success; collaborative, multi-disciplinary and innovative approaches to problem solving; and obtaining and maximizing funding. Taken together, this information makes a good case for the bidder being able to develop and manage an effective Mentally Ill Offender Crime Reduction Grant.

### **Need for the Program - 15 points**

The Local Plan makes a clear and compelling argument for the need for the program, and the content of the proposed program effectively addresses the need. There is a direct and well-articulated relationship between the described needs and the manner in which the proposed program will address those needs.

### **Collaborative, Multi-Agency, Multi-Disciplinary - 15 points**

The proposed program includes significant collaboration, multiple-agency involvement and multi-disciplinary participation. Written MOUs are included that document the scope and level of the collaboration and involvement. The uniqueness of collaborating agencies is appropriately utilized in the design of the program.

### **Probability of Success - 10 points**

This criterion concerns the degree to which the proposal rater is convinced that the program will be successful based upon the rater's assessment of the reasonableness, practicality, and appropriateness of the program design.

### **Evaluation Design - 12 points**

The program evaluation design contains the following elements: 1) a methodology and research design; 2) a complete and clear research plan; 3) meaningful hypotheses; 4) appropriate hypothesis-testing procedures; and 5) an appropriate and adequate sample.

### **Likelihood That Program Will Continue - 10 points**

The proposal indicates that there will be support to continue the program if it is proven effective. Examples are provided of past instances where grant programs were continued. Detailed plans and commitments to seek and develop funding alternatives are discussed. The budget demonstrates increasing county fiscal responsibility over the 4-year life of the grant.

### **Proposal Quality - 15 points**

The bidder submits a well presented proposal that contains all the required contents, including: a) the activities associated with the development of the Local Plan; b) the commitment of the members of the Strategy Committee; c) a detailed assessment of existing resources for mentally ill offenders across the continuum of responses (from prevention to hospitalization); d) specific and detailed identification of gaps in services; e) a description of the methodology that will be used to implement the recommendations in the plan, including a discussion of specific activities, funding alternatives and timelines; f) an explanation of the program evaluation approach and methodology; g) a description of the method for assessing the cost effectiveness of the program; and h) a clearly presented budget.

### **The Oral Presentation - 8 points**

The oral presentation is appropriately related to, supportive of, and consistent with the Local Plan and the proposal. Areas identified in the technical review as needing clarification, if any, are addressed fully and in a concise manner.

## Local Plan Model

To qualify for Mentally Ill Offender Crime Reduction (MIOCR) demonstration project funding, each county grant application must be based upon the findings and priorities developed in a completed Local Plan.

The Local Plan must summarize the existing system services available to mentally ill offenders including the role of system partners, if applicable. A major goal of the Local Plan is to identify strengths and needs regarding services available.

A key role for the members of the county's MIOCR Strategy Committee is to prioritize the defined needs and include such decisions in the Local Plan. Priorities identified should form the foundation upon which your county develops a proposed demonstration project to be submitted for funding consideration. To insure completeness, a model Local Plan format must include the following:

1. Background summary of your county's local justice system as it relates to mentally ill offenders.
2. Description of existing continuum of graduated responses, including prevention, intervention and incarceration for mentally ill offenders in jail.
3. Present role of collaborations and/or partners (public and private).
4. Strengths of present system.
5. Needs and/or issues in present system, including the size of your county's mentally ill offender population and, if appropriate, the target population(s) your program plans to address.
6. Proposed goals for providing a cost-effective continuum of graduated responses, including prevention, intervention and incarceration for mentally ill offenders, along with outcome measures of evaluation design to determine *what works*. (The use of an experimental design is the favored approach.)
7. Role of partners and collaboratives in solutions.
8. Appendices (e.g., identification of need and prioritization of target population(s); demographics and community mapping data; and information and intelligence sharing systems related to outcome measures).

**Attachment B**

**California Board of Corrections Title 15**

**Article 5: Classification and Segregation  
&  
Article 10: Medical/Mental Health Services**



## **Article 5 - Classification and Segregation**

### **1050. Classification Plan.**

- a. Each administrator of a temporary holding, Type I, II, or III facility shall develop and implement a written classification plan designed to properly assign inmates to housing units and activities according to the categories of sex, age, criminal sophistication, seriousness of crime charged, physical or mental health needs, assaultive/non-assaultive behavior and other criteria which will provide for the safety of the inmates and staff. Such housing unit assignment shall be accomplished to the extent possible within the limits of the available number of distinct housing units or cells in a facility.

The written classification plan shall be based on objective criteria and include receiving screening performed at the time of intake by trained personnel, and a record of each inmate's classification level, housing restrictions, and housing assignments.

Each administrator of a Type II or III facility shall establish and implement a classification system which will include the use of classification officers or a classification committee in order to properly assign inmates to housing, work, rehabilitation programs, and leisure activities. Such a plan shall include the use of as much information as is available about the inmate and from the inmate and shall provide for a channel of appeal by the inmate to the facility administrator. An inmate who has been sentenced to more than 60 days may request a review of his classification plan no more often than 30 days from his last review.

- b. Each administrator of a court holding facility shall establish and implement a written plan designed to provide for the safety of staff and inmates held at the facility. The plan shall include receiving and transmitting of information regarding inmates who represent unusual risk or hazard while confined at the facility, and the segregation of such inmates to the extent possible within the limits of the court holding facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1051. Communicable Diseases.**

Upon identification, the facility manager shall segregate all inmates with any suspected communicable diseases until a medical evaluation can be completed. To determine if such segregation shall be made in the absence of medically trained personnel at the time of intake into the facility, an inquiry shall be made of the person being booked as to whether or not he/she has or has had any communicable diseases or has observable symptoms of communicable diseases, including but not limited to, tuberculosis, hepatitis, sexually transmitted diseases, AIDS, or other special medical problem identified by the health authority. The response shall be noted on the booking form and/or screening device.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1052. Mentally Disordered Inmates.**

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures which provide for the identification and evaluation of all mentally disordered inmates with segregation, if necessary to protect the safety of the inmate or others. If a physician's opinion is not readily available, an inmate shall be considered mentally disordered for the purpose of this section if he or she appears to be a danger to himself/herself or others or if he/she appears gravely disabled. A physician's

opinion shall be secured within 24 hours of identification or at the next daily sick call, whichever is earliest.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1053. Administrative Segregation.**

Except in Type IV facilities, each facility administrator shall develop written policies and procedures which provide for the administrative segregation of inmates who are determined to be prone to escape, prone to assault staff or other inmates, or likely to need protection from other inmates, if such administrative segregation is determined to be necessary in order to obtain the objective of protecting the welfare of inmates and staff. Administrative segregation shall consist of separate and secure housing but shall not involve any other deprivation of privileges than is necessary to obtain the objective of protecting the inmates and staff.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1054. Administrative Removal - Type IV Facility.**

In Type IV facilities, the administrator shall develop written policies and procedures which provide for the administrative removal of an inmate for the safety and well being of the inmate, the staff, the program, the facility, and/or the general public. Such removal shall be subject to review by the administrator on the next business day.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1055. Use of Safety Cell.**

The safety cell described in Title 24, Section 2-470A.2.5, shall be used to hold only those inmates who display behavior which results in the destruction of property or reveals an intent to cause physical harm to self or others. The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures governing safety cell use.

In no case shall the safety cell be used for punishment or as a substitute for treatment.

An inmate shall be placed in a safety cell only with the approval of the facility manager or the watch commander. The facility manager may delegate authority to place an inmate in a safety cell to a physician. Continued retention in a safety cell shall be reviewed a minimum of every eight hours. A medical assessment shall be completed within a maximum of 12 hours of placement in the safety cell or at the next daily sick call, whichever is earliest. The inmate shall be medically cleared for continued retention every 24 hours thereafter. A mental health opinion on placement and retention shall be secured within 24 hours of placement. Direct visual observation shall be conducted at least twice every thirty minutes. Such observation shall be documented.

Procedures shall be established to assure administration of necessary nutrition and fluids. Inmates shall be allowed to retain sufficient clothing, or be provided with a suitably designed "safety garment," to provide for their personal privacy unless specific identifiable risks to the inmate's safety or to the security of the facility are documented.

NOTE: Authority cited: Section 6030, Penal Code, Reference: Section 6030, Penal Code.

### **1056. Use of Detoxification Cell.**

The detoxification cell described in Title 24, Section 2-470A.2.3, shall be used for the holding of inmates who are a threat to their own safety or the safety of others due to their state of intoxication and pursuant to written policies and procedures developed by the facility administrator. Such inmates shall be removed from the detoxification cell as they are able to continue in the processing. In no case shall an inmate remain in a detoxification cell over six hours without an evaluation by a medical staff person or an evaluation by custody staff, pursuant to written medical procedures in accordance with Section 1213 of these regulations, to determine whether the prisoner has an urgent medical problem. Intermittent direct visual observation of inmates held in the detoxification cell shall be conducted no less than every half hour.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1057. Developmentally Disabled Inmates.**

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the identification and evaluation of all developmentally disabled inmates.

The health authority or designee shall contact the regional center on any inmate suspected or confirmed to be developmentally disabled for the purposes of diagnosis and/or treatment within 24 hours of such determination, excluding holidays and weekends.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1058. Use of Restraint Devices.**

The facility manager, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices. In addition to the areas specifically outlined in this regulation, at a minimum, the policy shall address the following areas: acceptable restraint devices; signs or symptoms which should result in immediate medical/mental health referral; availability of cardiopulmonary resuscitation equipment; protective housing of restrained persons; provision for hydration and sanitation needs; and exercising of extremities.

Restraint devices shall only be used on inmates who display behavior which results in the destruction of property or reveal an intent to cause physical harm to self or others. Restraint devices include any devices which immobilize an inmate's extremities and/or prevent the inmate from being ambulatory. Physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.

Inmates shall be placed in restraints only with the approval of the facility manager or the watch commander. The facility manager may delegate authority to place an inmate in restraints to a physician. Continued retention in restraints shall be reviewed a minimum

of every two hours. A medical opinion on placement and retention shall be secured as soon as possible, but no later than four hours from the time of placement. The inmate shall be medically cleared for continued retention at least every six hours thereafter. A mental health consultation shall be secured as soon as possible, but in no case longer than eight hours from the time of placement, to assess the need for mental health treatment.

Direct visual observation shall be conducted at least twice every thirty minutes to ensure that the restraints are properly employed, and to ensure the safety and well-being of the inmate. Such observation shall be documented. While in restraint devices all inmates shall be housed alone or in a specified housing area for restrained inmates which makes provision to protect the inmate from abuse. In no case shall restraints be used as a punishment, or as a substitute for treatment.

The provisions of this section do not apply to the use of handcuffs, shackles or other restraint devices when used to restrain inmates for security reasons.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

## **Article 10 - Medical/Mental Health Services**

### **1200. Responsibility for Health Care Services.**

a. In Type I, II, III and IV facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

Each facility shall have at least one physician available to treat physical disorders. In Type IV facilities, compliance may be attained by providing access into the community; however, in such cases, there shall be a written plan for the treatment, transfer, or referral in the event of an emergency.

b. In court holding and temporary holding facilities, the facility administrator shall have the responsibility to develop written policies and procedures which ensure provision of emergency health care services to all inmates.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1202. Health Service Audits.**

The health authority shall develop and implement a written plan for annual statistical summaries of health care and pharmaceutical services that are provided. The responsible physician shall also establish a mechanism to assure that the quality and adequacy of these services are assessed annually. The plan shall include a means for the correction of identified deficiencies of the health care and pharmaceutical services delivered.

Based on information from these audits, the health authority shall provide the facility administrator with an annual written report on health care and pharmaceutical services delivered.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1203. Health Care Staff Qualifications.**

State and/or local licensure and/or certification requirements and restrictions apply to health care personnel working in the facility the same as to those working in the community. Copies of licensing and/or certification credentials shall be on file in the facility or at a central location where they are available for review.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1204. Health Care Staff Procedure.**

Medical care performed by personnel other than a physician shall be performed pursuant to written protocol or order of the responsible physician.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1205. Medical/Mental Health Records.**

a. The health authority shall maintain individual, complete and dated health records which shall include, but not be limited to:

1. receiving screening form/history;
  2. medical/mental health evaluation reports;
  3. complaints of illness or injury;
  4. names of personnel who treat, prescribe, and/or administer/ deliver prescription medication;
  5. location where treated; and,
  6. medication records in conformance with Section 1216.
- b. The physician/patient confidentiality privilege applies to the medical/mental health record. Access to the medical/mental health record shall be controlled by the health authority or designee.

The health authority shall ensure the confidentiality of each inmate's medical/mental health record file and such files shall be maintained separately from and in no way be part of the inmate's other jail records. The responsible physician or designee shall communicate information obtained in the course of medical/mental health screening and care to jail authorities when necessary for the protection of the welfare of the inmate or others, management of the jail, or maintenance of jail security and order.

- c. Written authorization by the inmate is necessary for transfer of medical/mental health record information unless otherwise provided by law or administrative regulations having the force and effect of law.
- d. Inmates shall not be used for medical/mental health record keeping.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

## **1206. Health Care Procedures Manual.**

The health authority shall, in cooperation with the facility administrator, set forth in writing, policies and procedures in conformance with applicable state and federal law, which are reviewed and updated at least annually and include but are not limited to:

- a. summoning and application of proper medical aid;
- b. contact and consultation with private physicians;
- c. emergency and non-emergency medical and dental services, including transportation;
- d. provision for medically required dental and medical prostheses and eyeglasses;
- e. notification of next of kin or legal guardian in case of serious illness which may result in death;
- f. provision for screening and care of pregnant and lactating women, including postpartum care, and other services mandated by statute;
- g. screening, referral and care of mentally disordered and developmentally disabled inmates;
- h. implementation of special medical programs;
- i. management of inmates suspected of or confirmed to have communicable diseases;
- j. the procurement, storage, repackaging, labeling, dispensing, administration-delivery to inmates, and disposal of pharmaceuticals;
- k. use of non-physician personnel in providing medical care;
- l. provision of therapeutic diets;
- m. patient confidentiality and its exceptions;
- n. the transfer of pertinent individualized health care information, or individual documentation that no health care information is available, to the health authority of another correctional system, medical facility, or mental health facility at the time each inmate is transferred. Procedures for notification to the transferring health care staff shall allow sufficient time to prepare the summary. The summary information shall identify the sending facility and be in a consistent format that includes the need for follow-up care, diagnostic tests performed, medications prescribed, pending appointments, significant health problems, and other information that is necessary to provide for

- continuity of health care. Necessary inmate medication and health care information shall be provided to the transporting staff, together with precautions necessary to protect staff and inmate passengers from disease transmission during transport.
- o. forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution shall not be performed by medical personnel responsible for providing ongoing health care to the inmates.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1206.5. Management of Communicable Diseases in a Custody Setting.**

- a. The responsible physician, in conjunction with the facility administrator and the county health officer, shall develop a written plan to address the identification, treatment, control and follow-up management of communicable diseases including, but not limited to, tuberculosis and other airborne diseases. The plan shall cover the intake screening procedures, identification of relevant symptoms, referral for a medical evaluation, treatment responsibilities during incarceration and coordination with public health officials for follow-up treatment in the community. The plan shall reflect the current local incidence of communicable diseases which threaten the health of inmates and staff.
- b. Consistent with the above plan, the health authority shall, in cooperation with the facility administrator and the county health officer, set forth in writing, policies and procedures in conformance with applicable state and federal law, which include, but are not limited to:
  - 1. the types of communicable diseases to be reported;
  - 2. the persons who shall receive the medical reports;
  - 3. sharing of medical information with inmates and custody staff;
  - 4. medical procedures required to identify the presence of disease(s) and lessen the risk of exposure to others;
  - 5. medical confidentiality requirements;
  - 6. housing considerations based upon behavior, medical needs, and safety of the affected inmates;
  - 7. provisions for inmate consent that address the limits of confidentiality; and,
  - 8. reporting and appropriate action upon the possible exposure of custody staff to a communicable disease.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1207. Medical Receiving Screening.**

With the exception of inmates transferred directly within a custody system with documented receiving screening, a screening shall be completed on all inmates at the time of intake. This screening shall be completed in accordance with written procedures and shall include but not be limited to medical and mental health problems, developmental disabilities, and communicable diseases, including, but not limited to, tuberculosis and other airborne diseases. The screening shall be performed by licensed health personnel or trained facility staff.

The facility administrator and responsible physician shall develop a written plan for complying with Penal Code Section 2656 (orthopedic or prosthetic appliance used by inmates).

There shall be a written plan to provide care for any inmate who appears at this screening to be in need of or who requests medical, mental health, or developmental disability treatment.

Written procedures and screening protocol shall be established by the responsible physician in cooperation with the facility administrator.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 2656 and 6030, Penal Code.

### **1207.5 Special Mental Disorder Assessment.**

An additional mental health screening will be performed, according to written procedures, on women who have given birth within the past year and are charged with murder or attempted murder of their infants. Such screening will be performed at intake and, if the assessment indicates postpartum psychosis, a referral for further evaluation will be made.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1208. Access to Treatment.**

The health authority, in cooperation with the facility administrator, shall develop a written plan for identifying, assessing, treating and/or referring any inmate who appears to be in need of medical, mental health or developmental disability treatment at any time during his/her incarceration subsequent to the receiving screening. This evaluation shall be performed by licensed health personnel.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1209. Transfer to Treatment Facility.**

A mentally disordered inmate who appears to be a danger to himself or others, or to be gravely disabled, shall be transferred to a treatment facility designated by the county and approved by the State Department of Mental Health for diagnosis and treatment of such apparent mental disorder pursuant to Penal Code section 4011.6 or 4011.8 unless the jail contains a designated treatment facility unless appropriate facilities and personnel, as determined by the local mental health director, are present in the jail for this purpose. Inmates found unable to be cared for adequately within any jail shall be transferred to a designated treatment facility as soon as possible.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1210. Individualized Treatment Plans.**

- a. For each inmate treated by a mental health service in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.
- b. For each inmate treated for a major medical problem in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1211. Sick Call.**

There shall be written policies and procedures developed by the facility administrator, in cooperation with the health authority, which provides for a daily sick call conducted for all inmates or provision made that any inmate requesting medical/mental health attention be given such attention.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1212. Vermin Control.**

The responsible physician shall develop a written plan for the control and treatment of vermin-infested inmates. There shall be written, medical protocols, signed by the responsible physician, for the treatment of persons suspected of being infested or having contact with a vermin-infested inmate.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1213. Detoxification Treatment.**

The responsible physician shall develop written medical policies on detoxification which shall include a statement as to whether detoxification will be provided within the facility or require transfer to a licensed medical facility. The facility detoxification protocol shall include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

Facilities without medically licensed personnel in attendance shall not retain inmates undergoing withdrawal reactions judged or defined in policy, by the responsible physician, as not being readily controllable with available medical treatment. Such facilities shall arrange for immediate transfer to an appropriate medical facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1214. Informed Consent.**

The health authority shall set forth in writing a plan for informed consent of inmates in a language understood by the inmate. Except for emergency treatment, as defined in Business and Professions Code Section 2397 and Title 15, Section 1217, all examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, or conservatees, the informed consent of parent, guardian or legal custodian applies where required by law. Any inmate who has not been adjudicated to be incompetent may refuse non-emergency medical and mental health care. Absent informed consent in non-emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

## **1215. Dental Care.**

The facility administrator shall develop written policies and procedures to ensure emergency and medically required dental care is provided to each inmate, upon request, under the direction and supervision of a dentist licensed in the state.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

## **1216. Pharmaceutical Management.**

- a. The health authority in consultation with a pharmacist and the facility administrator, shall develop written plans, establish procedures, and provide space and accessories for the secure storage, the controlled administration, and disposal of all legally obtained drugs. Such plans, procedures, space and accessories shall include, but not be limited to, the following:
  1. securely lockable cabinets, closets, and refrigeration units;
  2. a means for the positive identification of the recipient of the prescribed medication;
  3. procedures for administration/delivery of medicines to inmates as prescribed;
  4. confirming that the recipient has ingested the medication or accounting for medication under self-administration procedures outlined in Section 1216(d);
  5. that prescribed medications have or have not been administered, by whom, and if not, for what reason;
  6. prohibiting the delivery of drugs by inmates;
  7. limitation to the length of time medication may be administered without further medical evaluation; and,
  8. limitation to the length of time required for a physician's signature on verbal orders.
  9. A written report shall be prepared by a pharmacist, no less than annually, on the status of pharmacy services in the institution. The pharmacist shall provide the report to the health authority and the facility administrator.
  
- b. Consistent with pharmacy laws and regulations, the health authority shall establish written protocols that limit the following functions to being performed by the identified personnel:
  1. Procurement shall be done by a physician, dentist, pharmacist, or other persons authorized by law.
  2. Storage of medications shall assure that stock supplies of legend medications shall be accessed only by licensed health personnel. Supplies of legend medications that have been dispensed and supplies of over-the-counter medications may be accessed by either licensed or non-licensed personnel.
  3. Repackaging shall only be done by a physician, dentist, pharmacist, or other persons authorized by law.
  4. Preparation of labels can only be done by a physician, dentist, pharmacist, or other persons, either licensed or non-licensed, provided the label is checked and affixed to the medication container by the physician, dentist, or pharmacist before administration or delivery to the inmate. Labels shall be prepared in accordance with section 4076, Business and Professions Code.
  5. Dispensing shall only be done by a physician, dentist, pharmacist, or persons authorized by law.
  6. Administration of medication shall only be done by licensed health personnel who are authorized to administer medication acting on the order of a prescriber.
  7. Delivery of medication may be done by either licensed or non-licensed personnel, e.g., custody staff, acting on the order of a prescriber.
  8. Disposal of legend medication shall be done in accordance with pharmacy laws and regulations and requires any combination of two of the following classifications: physician, dentist, pharmacist, or registered nurse. Controlled substances shall be disposed of in accordance with the Drug Enforcement Administration disposal procedures.

- c. Policy and procedures on "over-the-counter" medications shall include, but not be limited to, how they are made available, documentation when delivered by staff and precautions against hoarding large quantities.
- d. Policy and procedures may allow inmate self-administration of prescribed medications under limited circumstances. Policies and procedures shall include but are not limited to the following considerations:
  - 1. Medications permitted for self-administration are limited to those with no recognized abuse potential. Medications for treatment of tuberculosis, psychotropic medication, controlled substances, injectables and any medications for which documentation of ingestion is essential are excluded from self-administration.
  - 2. Inmates with histories of frequent rule violations of any type, or who are found to be in violation of rules regarding self-administration, are excluded from self-administration.
  - 3. Prescribing health care staff document that each inmate participating in self-administration is capable of understanding and following the rules of the program and instructions for medication use.
  - 4. Provisions are made for the secure storage of the prescribed medication when it is not on the inmate's person.
  - 5. Provisions are made for the consistent enforcement of self-medication rules by both custody and health care staff, with systems of communication among them when either one finds that an inmate is in violation of rules regarding self-administration.
  - 6. Provisions are made for health care staff to perform documented assessments of inmate compliance with self-administration medication regimens. Compliance evaluations are done with sufficient frequency to guard against hoarding medication and deterioration of the inmate's health.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1217. Psychotropic Medications.**

The responsible physician, in cooperation with the facility administrator, shall develop written policies and procedures governing the use of psychotropic medications. An inmate found by a physician to be a danger to him/herself or others by reason of mental disorders may be involuntarily given psychotropic medication appropriate to the illness on an emergency basis. Psychotropic medication is any medication prescribed for the treatment of symptoms of psychoses and other mental and emotional disorders. An emergency is a situation in which action to impose treatment over the inmate's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

If psychotropic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition. The medication shall be prescribed by a physician in written form in the inmate's record or by verbal order in dosage appropriate to the inmate's need. Verbal orders shall be entered in the inmate's record and signed by a physician within 72 hours. The responsible physician shall develop a protocol for the supervision and monitoring of inmates involuntarily receiving psychotropic medication.

Psychotropic medication shall not be administered to an inmate absent an emergency unless the inmate has given his or her informed consent in accordance with Welfare and

Institutions Code Section 5326.2, or has been found to lack the capacity to give informed consent consistent with the county's hearing procedures under the Lanterman-Petris-Short Act for handling capacity determinations and subsequent reviews.

There shall be a policy which limits the length of time both voluntary and involuntary psychotropic medications may be administered and a plan of monitoring and re-evaluating all inmates receiving psychotropic medications, including a review of all emergency situations.

The administration of psychotropic medication is not allowed for disciplinary reasons.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1218. Inmate Deaths.**

The health authority, in cooperation with the facility administrator, shall establish written procedures to ensure that there shall be a medical review of every in-custody inmate death.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1219. Suicide Prevention Program.**

The facility administrator and the health authority shall develop a written plan for a suicide prevention program designed to identify, monitor, and provide treatment to those inmates who present a suicide risk.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1220. First Aid Kit(s).**

First aid kit(s) shall be available in all facilities. The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kit(s). In Court and Temporary Holding facilities, the facility administrator shall have the above approval authority, pursuant to Section 1200 of these regulations.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

### **1230. Food Handlers.**

The responsible physician, in cooperation with the facility administrator, shall develop written procedures for medical screening of inmate food service workers prior to working in the facility kitchen. Additionally, there shall be written procedures for education and ongoing monitoring and cleanliness of these workers in accordance with Section 114020 the Health and Safety Code, California Uniform Retail Food Facilities Law.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

**Attachment C**

**County Mental Health Diversion Programs**



## **Orange County In-Jail Treatment Program**

Correctional Mental Health provides a wide range of psychiatric services to inmates of the Orange County Jail System, identified as being at risk as a result of having severe mental illness. The primary goals of treatment are to facilitate coping in the jail and to prevent serious maladaptive or self-destructive behavior. During initial intake, inmates are assessed in terms of their need for mental health services and are then triaged to dedicated treatment or sheltered housing areas within the jail as appropriate. Psychiatric counseling, medication, social case management, crisis intervention and discharge planning services are provided to inmates as a part of this program. Correctional Mental Health also provides services to the general population, such as mental health evaluation and diagnostic screening, case management, crisis intervention and substance abuse referral services.

### **Forensic Alternative Community Treatment (FACT)-Solano**

The FACT program is administered by the Solano County Health and Social Services Department, and is designed as a diversion program to provide alternative to incarceration for misdemeanor offenders, and post-release supervised community treatment alternatives for some felony offenders, all of whom have been diagnosed with severe and persistent mental illnesses. FACT refers pre-arraignment jail inmates with mental illness to appropriate treatment centers, and serves as a liaison between the court and mental health systems in the development and Implementation of diversionary treatment plans. FACT also collaborates with correction, judicial/legal and mental health personnel prior to sentencing to develop alternative sentencing programs, when appropriate, and provides follow-up services upon discharge for people assessed as living at risk for re-offending. Under the direction of the County Director of Mental Health, the FACT program operates as a partnership between mental health, the courts and the jail system in Solano County.

### **Forensic Alternative Community Treatment (FACT)-Ventura**

FACT is a specialized mental health and social services program administered by the Ventura Health Care Agency, Mental Health Department, Adult Forensics Services, working in partnership with jail medical/psychiatric services, Ventura County Sheriff's District Attorney, Public Defender, Public Guardian, Correctional Services and Municipal Court. The program provides community-based mental health services and forensic supervision to chronically mentally disordered misdemeanants in an effort to divert them from the correctional/criminal justice system to the mental health system. FACT interventions included pre-arraignment evaluation and recommendations for community-based care, alternative sentencing plans, and post-release discharge planning.

### **Psychiatric Emergency Response Team (PERT)-San Diego**

San Diego's PERT program has three primary goals: to provide PERT Team responses to calls from officers in the field who believe they have come in contact with a mentally disordered person (allowing the original officers to return to their primary mission of

public safety); to provide better outcomes for the mentally disordered person by preventing inappropriate incarceration or hospitalization; to provide expanded and enhanced education for law enforcement officers and mental disordered. The responding PERT Team, comprising a licensed mental health professional and an officer, provide on-site assessment, intervention and referrals. People who are gravely disabled or a threat to themselves or others are transported to a facility for evaluation. Follow-up occurs as appropriate. Community outreach is a component of the program. The program is a collaboration of the San Diego Alliance for the Mentally Ill, the San Diego Police Department and San Diego Mental Health Services.

**Attachment D**

**Model Mental Health Intervention and Diversion Programs  
in the United States**



## **Connecticut – Hartford, Bridgeport, New Haven, and Norwich/New London Counties**

### **Intervention**

These court-based diversion programs have mental health staff based in the first appearance court to divert offenders with co-occurring disorders. By having mental health staff working in the court, strong relationships have been developed with judges, bail commissioners, public defenders, district attorney's and court staff. Each morning, diversion staff from the Connecticut Mental health Center receives a list from the Bail Commissioner's office that they cross-reference with their database to see who is currently in their system. They also take referrals from court personnel who recommend an interview based on behavior while an individual is waiting for his or her hearing. Staff interview the defendant and develop a plan for diversion. This plan is coordinated with the Public Defender and the Bail Commissioner and upon completion is presented to the presiding judge. Diversion staff maintain case management through the court system and plan for release. Following release, case management is referred out to community-based organizations/outpatient providers.

### **Study Group**

One hundred dually diagnosed individuals who are diverted from one of the courts with a diversion program.

### **Comparison Group**

One hundred individuals who meet eligibility criteria, but are not diverted because no diversion program is in place.

### **Project Contact:**

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## **Hawaii - Oahu and Kauai**

### **Intervention**

#### **Kauai**

This informal pre-booking program utilizes community connections to divert seriously mentally ill misdemeanants. The program is jointly funded by the adult Mental Health Division of the Hawaii Department of Health, Wilcox Hospital, and Mahilona Hospital. Diversion staff includes a psychiatrist, nurse, social worker, and social work supervisor and works closely with the emergency room physician.

#### **Honolulu**

Project Outreach is a pre-booking program that has one staff person who is the single point of contact for police officers. She arranges for individuals to be diverted from arrest and jail, creating linkages with community mental health services following an individual's evaluation.

Honolulu Diversion Project. Helping Hands of Hawaii operates this post-booking diversion program via a subcontract administered by the Adult Mental Health Division of the Department of Health. Clients are arrested and while at the Honolulu Police Department are interviewed by the Oahu Intake Service Center at 3 a.m. where they are screened for signs of mental illness. From the jail, clients are transported to the district courthouse at 6 a.m. Then they are seen by a Diversion Case Coordinator who makes a determination by their 8:30 a.m. arraignment as to whether not an individual is appropriate for diversion services.

#### **Study Group**

One hundred twenty-five individuals in the pre-booking study group 115 individuals in the post-booking study group.

#### **Comparison Group**

Eighty to 100 individuals booked on Maui and the Big Island.

#### **Project Contact:**

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Hawaii Department of Health  
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## **New York – New York**

### **Intervention**

The Jail Diversion Initiative is a joint initiative of the New York University School of Social Work, the New York City Department of Mental Health, the New York State Office of Mental Health, and NYC-LINK.

NYC-LINK is a program sponsored by the New York City Department of Public Health (NYSOMH) and is jointly run by Health and Hospitals Corporation/Office of Correctional Health Services (H.H.C./C.H.S.) and Federation Employment & Guidance Service (F.E.G.S.), providing diversion, discharge planning and transition services to mentally ill clients who are being released from confinement in city jails, or state or federal prisons.

The Linkage Planners are situated at Rikers Island. They meet potential clients to determine eligibility through a comprehensive intake assessment. Following an eligibility determination, Linkage Planners work with clients to develop a comprehensive discharge plan with appropriate referrals and regular meetings in discharge planning groups.

Clients are then transferred to the community-based Transition Management Team prior to their release from confinement. Transitional Support Counselors advocate in the community and courts on behalf of the clients. Transitional Support Counselors also provide case management services, including referrals to community service providers and assistance in obtaining medication and entitlements. Transition management services are provided on an intensive basis in the community for approximately two months following release. Less intensive follow-up is conducted for two years post-discharge. Peer support and prescription medication services are also offered through the NYC-LINK Program.

### **Study Group**

Three hundred detainees who are program participants in the NYC-LINK Jail Diversion program.

### **Comparison Group**

Three hundred incarcerated inmates who are matched on eligibility criteria.

### **Project Contact:**

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## **Oregon - Multnomah County**

### **Intervention**

This pre-booking diversion program, modeled after Memphis, features a strong collaboration between the Multnomah County Police Department and the Crisis Triage Center. Individuals with co-occurring mental illness and substance abuse problems are diverted prior to arrest and are treated at the Crises Triage Center. The Crisis Triage Center works closely with community-based organizations in developing a plan for individuals following treatment.

### **Study Group**

Two hundred individuals identified by police and brought into the Crisis Triage Center.

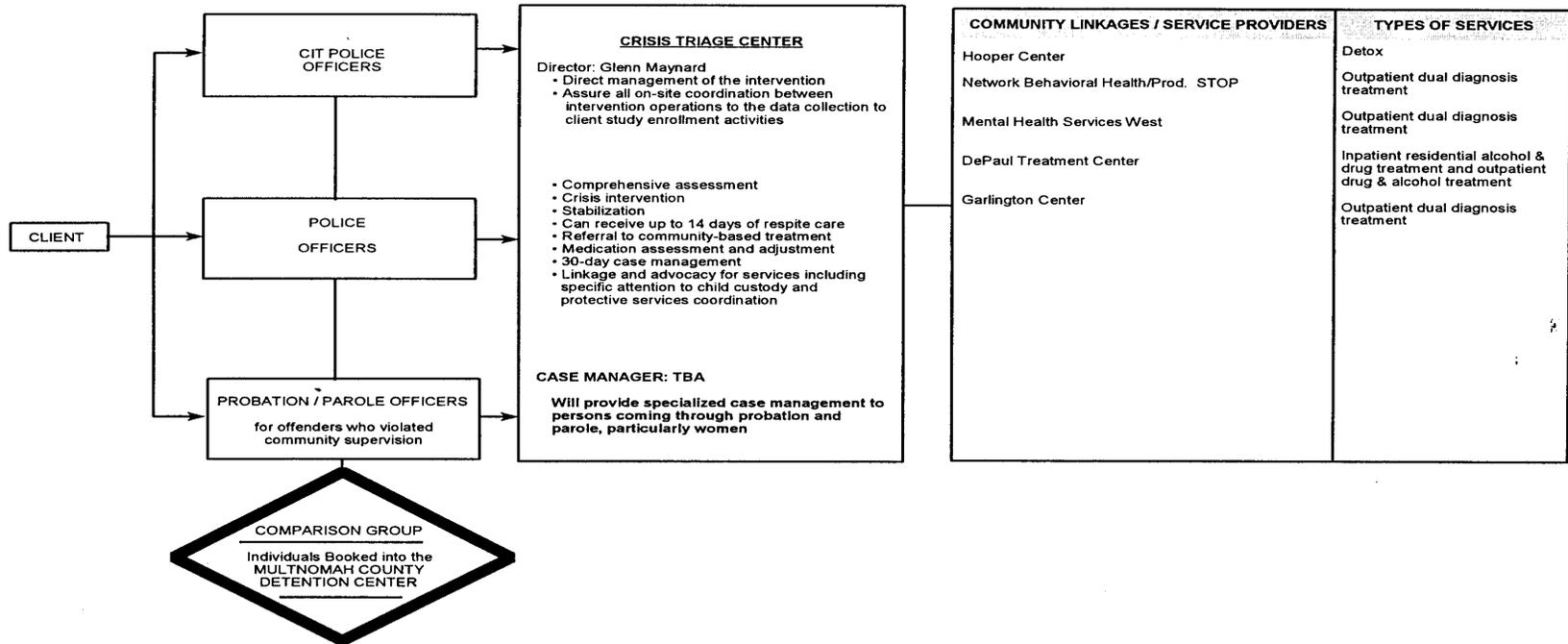
### **Comparison Group**

Two hundred individuals identified at the Multnomah County Detention Center in their special unit for individuals with mental health issues.

### **Project Contact:**

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# Oregon – Multnomah County



## **Pennsylvania – Bucks County and Montgomery County**

### **Intervention**

Montgomery County emergency Services (MCES) offer pre-booking diversion, post-booking diversion and “co-terminous jail diversion.” The pre-booking program occurs when psychiatric treatment has been accessed in lieu of arrest. Post-booking diversion occurs through regular and direct communication with the county jail where individuals in the jail who have mental health and substance abuse problems are identified by regular and direct communication with the county jail where individuals in the jail who have mental health and substance abuse problems are identified by regular screenings or trained correctional officers or they are already known to MCES. Options include conditional release negotiated by MCES on their behalf with the promise of mental health services. Alternatively, charges may be dropped once they are identified as an MCES client who may benefit more from mental health treatment than from new criminal entanglement.

“Coterminous jail diversion” occurs when police take an offender into custody, then deliver the offender directly into psychiatric treatment and also file charges against him or her. In this case, even though the offender has been arrested and has a new charge, he or she has been diverted from criminal incarceration. There can be a variety of dispositions to these cases that range from charges being dropped to returning the client to court to responding to the charges filed.

The diversion is supported through police training, the 24-hour crisis response team, inpatient treatment, and case managers.

### **Study Group**

One hundred and fifty individuals with serious mental illness and substance abuse problems who are diverted through MCES in Montgomery County.

### **Comparison Group**

One hundred and fifty individuals from Bucks County Correctional Facility.

### **Project Contact:**

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## **Tennessee - Memphis**

### **Intervention**

The Memphis pre-booking jail diversion program consists of a Crisis Intervention Team comprised of highly trained Crisis Intervention Officers who function as part of the police regular patrol division (110/700 uniformed patrol officers). These officers have received training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, empathy training from mentally ill individuals, exposure to the role of family with the mentally ill, legal training in mental health and substance abuse and information resources for those in a mental illness crisis. The program includes immediate responses, referrals and and/or transportation to a university emergency service. The university emergency service -- "The Med" -- accepts all police referrals with no refusals.

### **Study Group**

Two hundred individuals who are diagnosed with mental illness and substance abuse disorders and are diverted to "the Med."

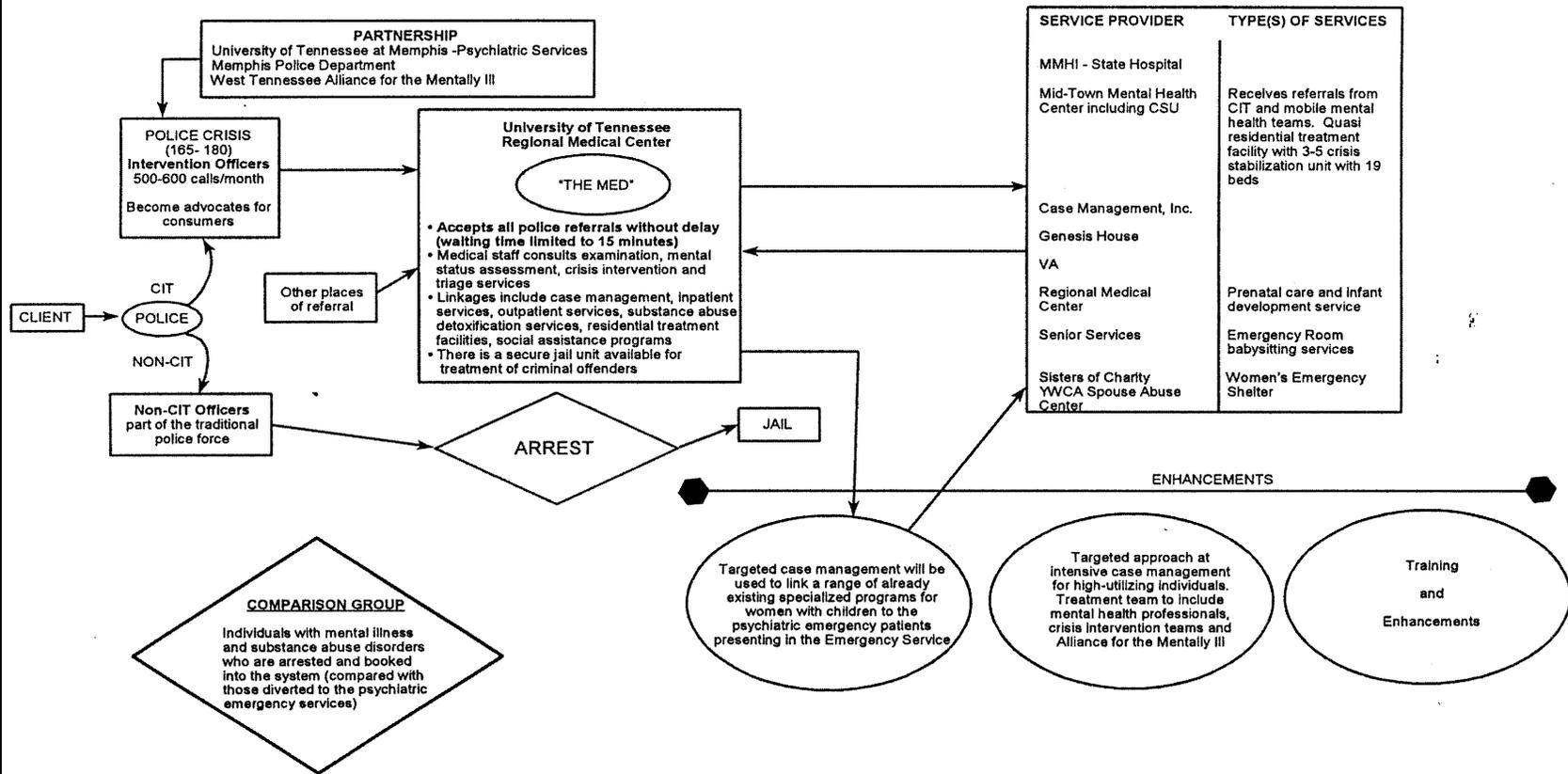
### **Comparison Group**

Two hundred individuals who are arrested and booked into the jail system with psychiatric disorders.

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# Tennessee – Memphis



## ENDNOTES

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