CALIFORNIA DEPARTMENT OF CORECTIONS AND REHABILITATION
COUNCIL ON MENTALLY ILL OFFENDERS
NINTH ANNUAL REPORT
April 12, 2011

History and Purpose of the Council

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

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

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

1. Identify strategies for preventing adults and juveniles with mental health needs from becoming offenders.

2. Identify strategies for improving the cost-effectiveness of services for adults and juveniles with mental health needs who have a history of offending.

3. Identify incentives to encourage State and local criminal justice, juvenile justice, and mental health programs to adopt cost-effective approaches for serving adults and juveniles who are likely to offend or who have a history of offending.

The Council shall consider strategies that:

1. Improve service coordination among State and local mental health, criminal justice, and juvenile justice programs.

2. Improve the ability of adult and juvenile offenders with mental health needs to transition successfully between corrections-based, juvenile-based, and community-based treatment programs.

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

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

Composition of the Council in 2010 with Appointing Authority

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

- David Lehman, Member, COMIO (Senate Rules Committee)
- Stephen Manley, Judge, Santa Clara County Superior Court (Chief Justice George)
- David Meyer, J.D., Professor, Institute of Psychiatry, Law and Behavioral Science, Keck School of Medicine, USC (Assembly Speaker)
- James W. Sweeney, J.D., Legislative Advocate, California State National Association for the Advancement of Colored People (Governor Davis)
- Charles L. Walters, Ph.D., Assistant Sheriff, Orange County Sheriff-Coroner Department (Attorney General Lockyer)

Membership Changes - 2010 (Former Members)

- Joel Fay, PsyD., Mental Health Liaison Officer, San Rafael Police Department
- Wendy Lindley, Judge, Orange County Superior Court
- Duane E. McWaine, M.D., Medical Director, Didi Hirsch Community Mental Health Center, Los Angeles
- Jo Robinson, M.F.T., Program Director, San Francisco Jail Health and Psychiatric Services

Membership Changes - 2010 (New Members)

- Stephen Manley, Judge, Santa Clara County Superior Court

Support Staff

- **Legal Counsel**
  Bruce Slavin, Chief of Legal Policy, CDCR, provides legal guidance to the Council
- **Executive Officer**
  Vacant

Activities of the Council in 2010

Council discussions in 2006 led to the development of eight priorities and goals for 2007 and beyond. An educational ninth goal was added in COMIO's 2007 annual report and a tenth goal has been assessed in this report. This section sets out the established goals and offers progress notes (**in bold**) as to the actions taken by the Council toward achieving each goal during 2010. The overall and far-reaching Council priority is to focus on reentry facilities and partnerships in communities to provide more effective transition for adults and juveniles coming out of institutions. The goals are to:

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

2. Create communication links with programs throughout the State that serve mentally ill offenders in order to develop a "Best Practices" program – The first COMIO Best Practices Survey was completed and recognition was given to several extremely effective projects in 2009. A new category of "Promising Projects" was added in 2009. Such projects offer exciting direction but may lack statistical support of maturity in terms of length of implementation time. **Due to vacancies among the Council and personnel changes, the Best Practices and Promising Projects selections for 2010 were moved into the 2011 Council activities**

3. Coordinate a website with CDCR that includes basic information on programs, discussion boards, and links to other agencies. The COMIO website is up and running with ongoing updates and enhancements being made. The potential for a podcast capability continues to be assessed. **The Council evaluated the social media sites (Facebook, YouTube, Twitter, Flickr, and blogs) created and posted by CDCR for the COMIO website.**

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

4. Promote the development of a consistent set of performance measurements and outcome measurements that could serve to gauge treatment effectiveness – A volunteer group of experts was formed by one of the council members in 2008 to develop a common mental health screening tool for use by all jails. Ideally, this would function from computer to hard copy. During 2009, a pilot to test the tool was initiated in three counties – San Luis Obispo, San Bernardino, and San Francisco. In

addition, the tool has been proposed for consideration to the Administrative Office of the Courts Task Force on Criminal Justice-Collaborative with Mental Health.

5. **NEW:** In 2010 the Council intends to carefully review and discuss the recommendations of the newly released and very important Corrections Standards Authority (CSA) study to determine future strategies and actions to be adopted by the Council. Because of the importance of the CSA recommendations, they are included as Appendix B.

COMIO Strategic Plan

At the COMIO meeting in March 2010, the Council voted for the first time to develop a strategic plan. The members agreed that over the course of its lifetime, the Council had engaged in some fruitful discussions with stakeholders and produced a number of useful reports in furtherance of its statutory mandates. However, while its statutory objectives had been clear from the outset, the Council had not developed a plan for meeting those objectives or any means for measuring whether objectives had been met. In addition, the Council had yet to develop an objective beyond those set forth in the original legislation. Thus, the members unanimously agreed that the development of a strategic plan was necessary.

Despite not convening meetings in May and July due to a lack of a quorum, staff work commenced on the development of a strategic plan under the guidance of Stacie Sormano from CDCR's Division of Correctional Health Care Services. With Ms. Sormano's leadership, the Council completed a draft plan that includes a vision, mission, goals, and cross-cutting strategies designed to meet those goals. The Council hopes to vote formally to adopt the strategic plan at its next meeting.

Other Council Member Activity

Council members were active in a variety of State and national activities. Most of the activities for 2010 revolved around setting up the strategic plan. The Council and the Forensic Mental Health Association of California are examining the feasibility of a joint venture website to support the efforts of community-based organizations who are working to end the criminalization of individuals with mental illness and who provide effective treatment, programs, resources, and services for these individuals.

COMIO Meetings

COMIO meetings are typically held on the third Thursday every other month beginning in January from 11:00 a.m. until 1:00 p.m., unless otherwise noted on the schedule below:

2010

January 21 CDCR Headquarters
1515 S Street – Suite 502 South, Sacramento, CA 95811
THIS MEETING CANCELLED

2010
(Continued)

February 18	CDCR Headquarters 1515 S Street – Suite 502 South, Sacramento, CA 95811 11:30 a.m.- 1:30 p.m.
May 20	CDCR Headquarters 1515 S Street – Suite 502 South, Sacramento, CA 95811
July 15	CDCR Headquarter 1515 S Street – Suite 502 South, Sacramento, CA 95811 **THIS MEETING CANCELLED**
September 16	CDCR Headquarters 1515 S Street – Suite 502 South, Sacramento, CA 95811
November 18	Consortium for Community Services-Member Center 250 Dos Rios Street, Suite A1, Sacramento, CA 95811

2011

January 20	CDCR Headquarters 1515 S Street – Conference Room 502S, Sacramento, CA 95811
March 23	Seaside, CA (held in conjunction with the Forensic Mental Health Association's Annual Statewide Conference)
May 19	CDCR Headquarters 1515 S Street – Conference Room 502S, Sacramento, CA 95811
July 21	CDCR Headquarters 1515 S Street – Conference Room 502S, Sacramento, CA, 95811
September 15	CDCR Headquarters 1515 S Street – Conference Room 502S, Sacramento, CA 95811
November 17	CDCR Headquarters 1515 S Street – Conference Room 502S, Sacramento, CA 95811

COMIO 2010 Annual Report Appendix A:

Council on Mentally Ill Offenders
2010 COMIO Best Practices

Listing of All Applicants

Northern California Regional Facility New Horizons Program
Los Angeles County Co-Occurring Disorder Court (CODC)
Sonoma County Sheriff's Office, Detention Division PATHS
Juvenile Justice Program Integrated New Family Opportunities (INFO)

COMIO 2010 Annual Report Appendix B:

"Jails and the Mentally Ill: Issues and Analysis"

A briefing paper developed by the Corrections Standards Authority at the request of COMIO – September 2009. To review the complete paper go to:

http://www.cdcr.ca.gov/COMIO/docs/MENTALLY_ILL_IN_JAILS_PAPER%20.pdf

Executive Summary and Recommendations

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

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

MAJOR FINDINGS: In their work with people with mental illness, jails are part of a large and complex system of care. Inextricably connected with treatment providers, state and local mental health agencies, state mental hospitals, courts, inmates' families, advocacy organizations, and others who have a stake in the treatment of mentally ill people, jails are faced with a multitude of challenges which they cannot address alone. The major finding of this paper is that it is essential

to develop and maintain a unified approach incorporating the many disciplines and agencies that share responsibility for working with mentally ill people in order for California's jails to be effective in serving the mentally ill in custody and facilitating, to the greatest extent possible, their productive reentry to the community after custody.

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

RELATIONSHIPS

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

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

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

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

RECOMMENDATION: *Integration is critically needed between state hospitals and county jails. To improve the continuum of care, reduce or eliminate road blocks to cooperation, and seek ways to cost effectively improve services for people determined to be incompetent to stand trial (IST) and other mentally ill people who are the shared responsibility of state hospitals and jails, it is vital that there be ongoing dialogue between sheriff departments (or local Departments of Corrections) and DMH and its state hospitals. Courts and probation departments should also be involved in these discussions as both play important roles in the continuum of care for mentally ill offenders. Toward this end, it is suggested the Administrative Office of the Courts, California State Association of Counties, California State Sheriffs' Association (CSSA), Chief Probation Officers of California, and California Mental Health Directors Association (CMHDA) initiate strategic discussions about how to more effectively integrate these interdependent systems of care.*

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

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

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

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

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

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

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

JAIL-SPECIFIC ISSUES AND RECOMMENDATIONS

Lack of Community Based Treatment Capacity – Community mental health programs are not sufficiently able to engage the numbers of people needing mental health and COD treatment. There are not enough treatment beds – in communities or in state hospitals – to accommodate all those with serious mental health and COD treatment needs. The dearth of capacity is compounded by the fact that all mental health treatment is voluntary. In the current fiscal climate, it is highly unlikely there will be program expansion or development of additional treatment beds, at either the local or state levels. Nonetheless, the numbers of mentally ill people needing treatment will continue to increase. The efforts identified as most effective are those that seek to break down the silos and enhance collaboration to better serve mentally ill people within currently existing, albeit limited, resources. These efforts combined with the high-level oversight referenced above show great promise of identifying system wide and regional cost reductions.

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

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

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

Screening and Assessment – For those mentally ill people who are not diverted, jails must provide mental health screening and assessment to identify mental illness, COD, developmental

disabilities, and important risk factors such as suicide risk and withdrawal from alcohol and other drugs. Mental health assessment will help identify those who are appropriate for general housing, those requiring medication, those needing supportive services and referrals, those requiring specialized housing, and those requiring inpatient treatment.

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

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

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

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

Housing – Being realistic about the dire fiscal limitations facing government at all levels, this paper does not suggest that counties must undertake construction of specialized housing for mentally ill inmates in their jails. It does, however, recommend when dollars are available, jails should consider building the best possible array of in-jail housing for mentally ill inmates who cannot safely be housed with others. Elements would include individual and group living spaces, proper lighting, confidential counseling rooms, and areas dedicated to socialization activities, among other things. Counties are also encouraged to explore the feasibility of developing acute care housing and/or implementing LPS1 certified units either in their jails, in their local hospitals or regionally through multi-county consortium agreements.

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

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

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

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

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

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

Medication – Jails face a host of issues related to psychological or psychotropic medications. While it is important to maintain continuity of these medications, it is often difficult to get timely information about what drugs an arrestee is actually on. Psychotropics can be prescribed for inmates in jails' general populations but they cannot be administered involuntarily (without informed consent) except in cases of emergency. These medications require extensive record

keeping, and constitute a huge budget item, especially for small jails. There are differing medication policies and different psychotropic medications prescribed by state hospitals than are used in jails, confounding continuity of treatment when IST and other inmates are returned to jails from hospitals.

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

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

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

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

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

STAFF AND STAFF TRAINING

Jails must have adequately trained personnel – both custody and mental health – to safely assess, house, program, treat, and work with inmates who are mentally ill or have COD. Jails cannot provide any of the care or services discussed in this paper unless they have an adequate number of properly trained personnel. Recruiting mental health personnel is challenging and California's jails continue to have a critical need for additional mental health staff. Retaining staff and maximizing their effectiveness requires training and support for the difficult jobs they do. It is critical that custody staff be trained to interact with mentally ill inmates just as they are trained to interact and work with all other inmate populations. Mental health staff should receive forensic training to give them a framework for working in the custody environment. Jails report

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

RECOMMENDATION: *Jails across California are encouraged to seek additional mental health and COD training for custody staff and to train custody personnel with mental health personnel to the greatest extent possible. To augment in-facility and in-service training, the Workgroup also recommends that STC's Correctional Officer CORE course hours dedicated to mental health and suicide issues be enhanced to provide additional training for custody personnel on dealing with mentally ill people in jail.*

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