OUR BROTHERS' KEEPER:

A LOOK AT THE CARE AND TREATMENT OF MENTALLY ILL INMATES IN ORANGE COUNTY JAILS

GRAND JURY 2015-2016

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EXECUTIVE SUMMARY

Orange County jails have become de facto mental health care treatment facilities. Nationally, the number of individuals with serious mental health issues in prisons and jails now exceeds the number in state psychiatric hospitals tenfold. One official confirmed to the Grand Jury that jail is the primary treatment facility for mental health issues in the Orange County community. According to a local father, who became an advocate for people with mental illnesses after his son took his own life in 2014, "Our [Orange County] jail is the 8th largest mental health facility in the country" (Gerda, March 2016).

Jails are generally short-term city or county-level facilities housing inmates who are awaiting trial or sentencing, as well as those who are serving relatively brief sentences, usually less than one year (Urban, 2015). Orange County jails house approximately 6,000 inmates at any given time. Approximately 20% (1,200) of those inmates have some type of documented mental health diagnosis. According to the Orange County Health Care Agency, from January 2015 through October 2015, 10,586 persons who entered the Orange County Jail system were identified as having a mental health diagnosis. An additional 2,962 inmates were diagnosed with acute mental illness, for a staggering total of 13,548 mentally ill inmates moving through the Orange County jails over a 10 month period. Despite this high number, only one of the Orange County Jails, the Intake and Release Center, contains a designated mental health unit for male inmates. Approximately 89% of male inmates with a diagnosed mental illness are housed in the general jail population. They may receive prescribed medication to help stabilize and/or alleviate their psychiatric symptoms, but they do not receive therapeutic treatment specific to their mental illness through structured programs.

Educational programs are available in varying forms for general population inmates but the focus of these programs is not on mental health therapy, but rather on general rehabilitation, regardless of mental health status. In fact, therapeutic treatment for male mentally ill inmates is reserved for a maximum of 10 inmates housed in the Intake and Release Center's Crisis Stabilization Unit on Mod L. This is less than 1% of the total mental health population in the Orange County jails.

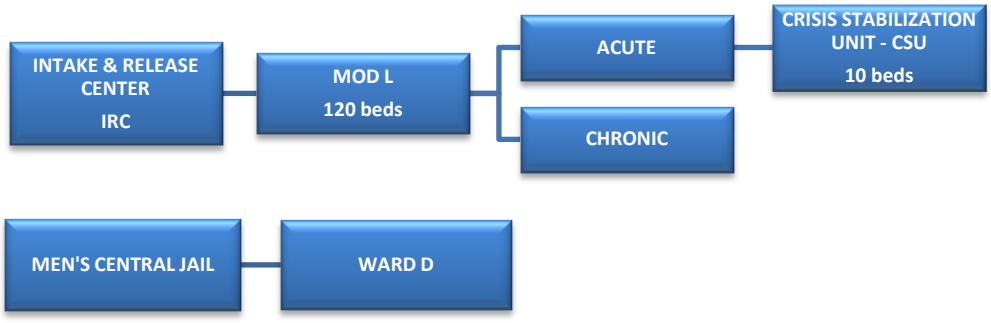

Figure 1 – Orange County Jail Men's Mental Health Treatment Areas

The care and treatment of criminal offenders with mental health issues is under great scrutiny across the United States. In Orange County, by default, their care is left in large part to law enforcement and Correctional Health Services. The Grand Jury studied several factors that affect this care and treatment, including therapy options, laws and statutes, clinical staffing, court and community resources, and data collection/analysis.

In 2008, the United States Department of Justice (DOJ) initiated an investigation into Orange County jail conditions, with subsequent visits in 2010 and 2013. The DOJ provided written findings in 2014, which included concerns focused on limited mental health care options in the Orange County jails. In particular, the report cited the need to provide improved treatment programs for mentally ill inmates.

Through the process of investigation and interviews, along with a review of the 2014 Department of Justice findings, the Grand Jury found that the jail system provides treatment services to a small percentage of the total inmate population diagnosed with some type of mental illness. The Grand Jury has provided a number of recommendations to improve therapeutic treatment. These include developing and implementing:

- Therapeutic and educational programs and curriculum specific to the needs of mentally ill inmates throughout the jail system
- A system for the collection and analysis of data related to the mentally ill population
- A debriefing protocol aimed at decreasing safety cell use
- A plan to address outstanding issues identified by the Department of Justice
- A plan to expand the number and type of Collaborative Courts

BACKGROUND

The National Alliance on Mental Illness (NAMI) defines mental illness as a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis (National, 2016).

As early as 1694, legislation passed by the Massachusetts Bay Colony authorized confinement in jail for any person "so furiously mad as to render it dangerous to the peace or the safety of the good people for such lunatic persons to go at large" (Treatment, 2014). By the 1820s a shift occurred and many Americans believed putting mentally ill people in prisons and jails was inhumane and uncivilized. Dorothea Dix led the reform movement, asserting effective treatment of the mentally ill is not possible in prison and jails and the people running the prisons and jails

were not trained to provide such treatment. By 1847 it was generally accepted that mentally ill people belonged out of jails and in mental hospitals, which were mostly state run.

Seventy-five (75) public psychiatric hospitals were established by 1880, when there were 50 million people living in the United States (as of April 30, 2016 there were 33,730 million). At that time, most mentally ill persons who had previously been in jails had been transferred to state mental hospitals and thus, "insane persons" constituted only 0.7 percent of the American prison and jail population. For slightly over a hundred years people previously housed in jails were relocated to mental hospitals for treatment.

This practice began to change in the 1960s with the "deinstitutionalization" of mental hospitals. According to the Treatment Advocacy Center 2014 study, because the majority of patients being discharged from hospitals were not given follow-up psychiatric care and relapsed into psychosis, some inevitably committed misdemeanor or felony acts, usually associated with their untreated mental illness, and were arrested. By the early 1970s the disastrous effects of closing state run mental hospitals were becoming apparent. The situation has continued to deteriorate until present day, where society has, by default, reverted to the inhumane solution arrived at in 1694 by determining that the most appropriate care and treatment modality for arrestees with mental illness is prison or jail (Treatment, 2014).

As the jails struggle to adapt to the overwhelming challenges of treating mentally ill inmates in an environment that is traditionally punitive rather than therapeutic, they are held accountable not only in the court of public opinion, but also by the Department of Justice (DOJ). The DOJ recently reached a settlement with nearby Los Angeles County, in *United States of America v County of Los Angeles and Los Angeles County Sheriff Jim McDonnell, in his Official Capacity (2015)* requiring the implementation of sweeping mental health care reforms throughout the county jail system. The investigation determined a pattern of constitutionally deficient mental health care for prisoners, among other inadequate practices (Joint, 2015). This settlement puts neighboring counties, including Orange County, on notice that the Department of Justice is keeping a close eye on the care and treatment of mentally ill inmates.

Over time, the Orange County Health Care Agency, Orange County Sheriff's Department, and Orange County Superior Court have looked to programs outside of the jail system and have earmarked money for the establishment of community-based programs and support to enhance the care and treatment of mentally ill persons who have been arrested and incarcerated, or who are at high risk to reoffend. The best examples of treatment for mentally ill arrestees outside of jail are the Collaborative Courts system and the California Forensic Conditional Release Program (CONREP), both of which provide an alternative to jail for people who meet the criteria.

The Grand Jury also reviewed notable laws enacted by the State Legislature which aid in the treatment of mentally ill individuals. Proposition 63, also known as the Mental Health Services Act (MHSA), helps fund many of the voluntary community mental health programs and services in Orange County. Another law, which provides services to chronically mentally ill people, is Laura's Law, also referred to as Assisted Outpatient Treatment (AOT).

Previous Grand Jury Reports

Although previous Grand Juries have looked at the interaction of law enforcement with mentally ill persons outside the jail system, no previous Grand Jury in Orange County has studied in-depth the plight of the mentally ill inmate while he is housed in the Orange County jail system.

Scope of Study

This Grand Jury study focuses on mental health treatment options available to male inmates within the Orange County Jail system (for the purposes of this study, the Women's Jail has been excluded), which includes the following six areas:

1. Care and treatment of mentally ill inmates in the Intake and Release Center, Mod L
2. The role of Correctional Health Services (medical and clinical) staff in the treatment process
3. Inmate education services provided through the Sheriff's Department
4. Sheriff's Department and Correctional Health Services staff training
5. Laws, statutes, and court proceedings related to mental health issues
6. Quality assurance programs

METHODOLOGY

The Grand Jury utilized the following research methods to conduct this study:

Review and Analysis of:

- Current academic studies
- Current newspaper articles
- Research on mental health in the United States
- Research on mental health in the State of California
- Los Angeles and Orange County Department of Justice investigation results
- Sheriff Department policies and procedures

- Correctional Health Services policies and procedures
- Previous Grand Jury reports and responses from County Officials
- Correctional Health Care quality assurance programs
- Sheriff's Department quality assurance programs
- Correctional Health Care and Sheriff Department orientation and training requirements and curriculum
- California Code of Regulations, Title 15 – Crime Prevention and Corrections
- California Penal Code
- Applicable Mental Health Case Law
- Internal documents from Correctional Health Care
- Internal documents from the Sheriff's Department

Interviews with Senior Management in:

- The Sheriff's Department
- Correctional Health Services
- Behavioral Health Services
- Health Care Agency

Interviews with:

- Public Defender staff
- District Attorney staff
- County Counsel staff
- Collaborative Courts staff
- Correctional Services Deputies
- Correctional Health Services providers
- Office of Independent Review

Observation/Tour of:

- Community Collaborative Courts
- Jail facilities/Mod L
- San Bernardino County Sheriff's Department Restoration of Competency (ROC) Program

INVESTIGATION AND ANALYSIS

Department of Justice (DOJ) Involvement with Orange County Jails

In 2008 the Department of Justice (DOJ) initiated an on-site investigation of the Orange County Jail system, with subsequent visits in 2010 and 2013. The investigations focused on use of force and lack of medical care, based on previous incidents that resulted in inmate deaths or other negative outcomes. On March 4, 2014, the Department of Justice sent a close-out letter to the County Executive Officer and the Sheriff, acknowledging that the County had taken "extensive remedial measures" to address the Department of Justice's concerns. The report highlighted "two important qualifiers to our otherwise positive review of jail conditions" – the use of force and medical care. Under medical care, it cited "a limited array of mental health treatment and housing options, resulting in an over-reliance on unsafe segregation cells and more restrictive interventions" (Department, 2014).

Two Department of Justice concerns stand out: 1. Staffing and housing configuration issues result in poor supervision of certain general population and special needs units; 2. A limited array of mental health treatment options results in over-reliance on unsafe segregation cells and more restrictive intervention.

The DOJ correspondence also cited the following concerns:

- The County has not evaluated jail housing and treatment programs for prisoners with mental illness, nor has it adopted a more integrated therapeutic model. (The Constitution requires a level of treatment that goes beyond just having the most acutely ill seen by medical staff.)
- The system relies heavily on placing the most seriously ill prisoners in isolation cells and offering therapeutic treatment only to those most acutely ill individuals.
- The therapeutic treatment provided may not reach prisoners who may be quite ill, but are also not the most obviously in need of mental health care.
- The jail deals with the most immediate urgent needs, but needs to act to prevent mental health crises and provide adequate transition programs to every inmate who needs it.
- The current system leads to high risk prisoners being housed in unsafe physical settings that are neither therapeutic nor adequately supervised.
- The jail does not provide for a cohesive system of therapy and treatment, which can lead to transition problems for mentally ill prisoners at different stages in their illness and result in unnecessary, restrictive practices (e.g., forced medication).

In a section of the Department of Justice correspondence entitled "Remedial Measures," several recommendations were proffered. The most pertinent state:

- The County should continue to improve mental health services to provide a more integrated system of care.
- In managing the housing and treatment of prisoners with mental illness, the County should avoid using difficult to observe cells (e.g., the 4th floor isolation cells.) for housing prisoners with mental illness. *(Note: – 4th floor isolation cells on the Men's Central Jail are no longer used for mentally ill inmates, however, safety cells provide a similar function and are equally as restrictive).*
- The County should work with the medical provider to broaden the array of treatment and housing options.
- The most acutely ill prisoners will require the most intensive supervision but the jail also needs more intermediate levels of care and supervision for prisoners who may be more stable, but are still unable to live safely in general population. *(Note: – At this time the only housing that meets this recommendation is Ward D on the Men's Central Jail, which has16 designated mental health beds).*

Through investigation and interviews, the Grand Jury concluded that the therapeutic concerns identified in the 2014 Department of Justice report, along with the recommended remedial measures, have only been partially implemented. In order to provide the level of therapeutic treatment recommended by the Department of Justice, the Grand Jury believes all concerns and recommendations should be formally implemented by the Sheriff's Department and Correctional Health Services.

Mod L Care and Treatment of Inmates with Mental Health Issues

According to the Stanford Law School Three Strikes Project, which poses the question, "When did prisons become acceptable mental healthcare facilities?" mentally ill people who find themselves in the jail system tend to be subjected to far harsher sentencing than people without a mental illness who commit the same crime. This study also asserts that mentally ill inmates are more likely to be sexually assaulted, have higher suicide rates, and commit more rule violations that result in harsh disciplinary action. The Grand Jury learned through research that people unable to navigate the complex dynamics of prison life need to be housed in an area supervised by professionals who understand and can treat their special needs, regardless of the circumstances that brought them to incarceration. The Grand Jury interviewed many Correctional Health Services staff members from several disciplines and found that they demonstrated professionalism, sensitivity to their unique clientele, and a desire to achieve quality standards.

The Sheriff's Department and the Health Care Agency/Correctional Health Services have established a Memorandum of Understanding which details the specific tenets for provision of medical and mental health care and treatment throughout the Orange County jail structure.

Health care professionals, including psychiatrists, nurses, social workers, marriage/family therapists, and mental health specialists/psychiatric technicians are available on Mod L in some combination 24 hours a day, seven days a week to address medical and nursing needs as well as provide case management services. Psychiatrists are assigned exclusively to Mod L. nurse practitioners are utilized throughout the rest of the Intake and Release Center and at other Orange County jail facilities to provide mental health medical care.

Each person who enters the jail system receives a medical screening during the booking process, which includes identifying symptoms and/or history of mental illness. Clinical staff completes a more comprehensive mental health assessment when initial concerns are identified. Based on their own assessment and information gathered, medical personnel determine medication needs, provide input on housing designation, and make decisions as to whether a person might require a psychiatric hold order.

Mod L and Ward D are the only designated male mental health treatment areas for all of the Orange County jails. Mod L is located at the Intake and Release Center and Ward D is located nearby, at the Men's Central Jail. Mod L houses three levels of mentally ill inmates – crisis, acute, and chronic. It is made up of six sectors, for a total of 120 beds. Mod L also houses a small number of inmates who have been accused of a felony crime but were deemed incompetent to stand trial (IST). The Crisis Stabilization Unit is an acute unit located within the Mod L sector. It contains ten designated beds for the most seriously mentally ill. Ward D, which has 16 beds, is considered a transition unit for chronically ill inmates who are not ready to be housed with the general population.

Given the high number of inmates with a documented mental health diagnosis (approximately 1,200) and the limited number of beds on Mod L, it is inevitable that most inmates with a mental health diagnosis will be housed somewhere other than Mod L or Ward D. This leaves approximately 89% of jail inmates with a mental health condition housed within the general population of the jails.

Due to the limited number of beds for mentally ill inmates, psychiatrists assigned to Mod L must constantly reassess each inmate's mental health needs. Inmates who stabilize are reassigned to the general jail population. Correctional Health Services and Sheriff's Department staff collaborate to reassign inmates from the Crisis Stabilization Unit, whose needs are less critical than a new arrival's, to another section of Mod L, or they place them directly into the general housing area. Several staff told the Grand Jury that despite the jail and Correctional Health staff's best efforts to maintain the correct balance, with limited space for mental health care, inmates transferred to general housing areas often return to Mod L after failed attempts to integrate.

Safety Cells in Mod L

Inmates in Mod L are assigned single bed cells. An inmate may be moved to a safety cell temporarily to prevent imminent harm to self or others. Although safety cells are extremely isolating, they are not considered isolation cells. Sheriff's staff uses isolation cells in the general population for inmate discipline. Isolation cells have a bed, a sink and a toilet, which safety cells lack. Safety cells are located in three areas throughout the jail system – Intake and Release Center Triage, Intake and Release Center Mod L, and the Women's Jail. For the purposes of this study, the Grand Jury concentrated on the three safety cells located in Mod L.

A safety cell can be described as a small locked cell with padded walls from floor to ceiling, a closed viewing panel, food slot, and a thin, bare mattress on the floor next to a grated hole in the floor, which serves as a toilet. The cell padding will not prevent self-injury, but it may lessen the effect depending upon how much time is spent trying to self-inflict injury between 15 minute observation periods. There is no sink for washing hands before meals or after using the toilet, and Correctional Health Services staff verified to the Grand Jury there is no process in place for ensuring the opportunity to wash hands. Staff who complete observation rounds at 15 minute intervals provide access to toilet paper, and flush the toilet from outside the cell. There is a light on inside the safety cell at all times. Cameras are also located in the cell so the person can be observed from the nursing station. As a suicide precaution, inmates are only allowed to wear a safety gown, which resembles a hospital gown made with heavy fabric. According to Sheriff Safety Cell Policy (2104.3), Correctional Health Services staff may withhold the mattress and/or safety gown if deemed a hazard, which renders the inmate naked on a lightly padded floor. No personal items are allowed inside the safety cell. Several staff stated that it is cold inside the cell. When the Grand jury inquired as to how an inmate stays warm, one staff member suggested the inmate roll into a ball. Other staff had no answer at all.

The National Sheriff's Association and the Treatment Advocacy Center published a joint report in April, 2014, titled, *The Treatment of Persons in Prisons and Jails: A State Survey*. One of their significant findings was that mentally ill prisoners are much more likely to spend time in solitary confinement than other prisoners. According to the report, "The effect of solitary confinement on mentally ill prisoners is almost always adverse. The lack of stimulation and human contact tends to make psychotic symptoms worse" (Treatment, 2014). A briefing paper developed by The California Corrections Standards Authority (CSA) echoed this concern, stating, "Mental Health professionals contend that it is often counter-therapeutic to house a mentally ill person in a safety cell; being segregated instead of getting the interpersonal crisis intervention by a trained mental health professional that they need is likely to exacerbate their illness" (California 2015).

In their investigation of the Orange County Jails in March 2014, the Department of Justice stated, "We have warned for some time that some of the suicide [safety] cells do not sufficiently

mitigate the risks for suicidal prisoners. Indeed, at least one successful suicide and a number of serious attempts have occurred in the most problematic housing areas cited in this letter."

At the request of the Grand Jury, Correctional Health Services staff provided data for safety cell admissions from January through October 2015. The total number of admissions per month varied from 3-9, with a total of 77 admits. The number of days an inmate spent in the safety cell varied from 1-5 days. The Grand Jury was told that on rare occasions an inmate has stayed in the safety cell several days due to disruptiveness, however, statistics over a ten month period demonstrate that approximately 40% of inmates stay in the safety cell for more than one day (30% stay for two days and approximately 10% for 3 days or more). A Correctional Health Services clinician told the Grand Jury that inmates are often forcibly medicated prior to being taken to a safety cell and usually fall asleep.

Correctional Health Services and Sheriff's staff rotates observation checks every 15 minutes for as long as the person is in the cell. Staff observations are documented in a log that includes a section for staff remarks and/or observations. A redacted sample reviewed by the Grand Jury had mostly single word comments, such as "sleeping," "resting," "quiet." None of the comments indicated that the inmate was disruptive, trying to hurt himself, or was otherwise non-compliant, including his behavior at the time of entry. The inmate was placed in the safety cell at 1:30 PM and exited at 8:00 AM the next morning, for a total of 18 ½ hours in the safety cell.

According to the Correctional Health Services Safety Cell Policy (8609), "Any CHS clinical staff member can recommend safety cell placement for an inmate who has committed an act that is the result of a mental disorder and is significantly dangerous to the inmate or another person." The policy does not define the type of acts, how staff determines that the behavior is specifically tied to a person's mental disorder, or what constitutes a significantly dangerous act, which places the burden upon individual clinical staff to make recommendations based on their own experience and judgment. The Safety Cell Admission Form, which is initiated by Correctional Health Services staff, includes a section that requests a description in "measurable and observable terms" of the behavior warranting admission to the safety cell. One check and balance to this procedure is that a psychiatrist must provide a written order prior to safety cell placement, unless there is no psychiatrist on duty, in which case a qualified mental health professional may order temporary placement, with follow-up verification by the psychiatrist later, usually by phone. The policy does not define which staff are qualified mental health professionals.

The Correctional Health Services Safety Cell Policy (8609) also states that inmates in safety cells are evaluated at least once every two hours by nursing staff to "offer fluids, observe overall medical condition, and *evaluate whether continued retention in the safety cell is indicated* [italics added for emphasis]" The criteria for removal from a safety cell are vague – "A CHS clinical

staff member may assess whether the inmate has regained sufficient control to be removed from the safety cell. This assessment will be reviewed with the CHS psychiatrist who will make the final decision for removal." The policy does not define which classes of clinical staff members are competent to complete the assessment, but more importantly, it does not define" significant control." Again, this places the burden upon individual clinicians to define the level of control the person has gained based on their own experience and judgment. Some Correctional Health Services staff stated they are hesitant to awaken a sleeping individual to move him back to his cell as inmates have rights regarding uninterrupted sleep. However, if the inmate awakens, staff could move him back to his cell any time, except for the fact there is no psychiatrist there to authorize the move.

The Grand Jury provided the following scenario to several clinical staff members, asking if this sequence of events would be accurate:

> The psychiatrist on duty writes an order and an inmate is transferred to a safety cell at 3:00 PM. The psychiatrist goes home for the day at 5:00 PM. At 7:00 PM the inmate shows no signs of agitation, tells Correctional Health Services staff he has no intention of doing further harm to himself or others, and would like to go back to his regular cell. Fifteen minute observations documented by Sheriff and Correctional Health Services staff indicate that he is calm and compliant. Can he be released back to his cell at that time?

The answer provided by staff members was ambiguous. While some staff agreed that the inmate meets the established criteria for release, some also stated the inmate must be evaluated by the psychiatrist prior to release. If the psychiatrist has gone home for the day, the inmate will be evaluated and released the next morning, upon the psychiatrist's visual assessment. When asked if the psychiatrist could be called at home and assured by a clinical staff member that the inmate was assessed to have "gained significant control," could the psychiatrist authorize release, again the answer was ambiguous. The psychiatrist could authorize release, but many staff are hesitant to call the psychiatrist at home for this purpose. Contradictorily, most staff will call the psychiatrist at home to obtain the order to place an inmate in the safety cell. According to the Judge David L. Bazelon Center for Mental Health Law, an inmate "should be released from seclusion or restraint as soon as the immediate physical danger is diminished…." (Judge, 2016)

California Code of Regulations (CCR), Title 15, Crime Prevention and Corrections Section (§1055), which defines the parameters of safety cell retention, states:

> An inmate shall be placed in a safety cell only with the approval of the facility manager, the facility watch commander, or the designated physician; continued retention 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.

Orange County Correctional Health Services has designated that only a psychiatrist may authorize safety cell release. Nurse practitioners, who regularly substitute for psychiatrists in other parts of the jail, are on duty daily until midnight and could perform this function. However, a spokesperson for the Health Care Agency indicated that suicidal ideation is a significant consideration when determining if it is safe for someone to be released back to their regular cell and that psychiatrists are best suited to determine exit criteria for this reason. In all other parts of the jail system Nurse practitioners regularly evaluate inmates for suicide risk.

As a therapeutic intervention, placement in a safety cell must be viewed as a treatment failure. Staff was unable to successfully intervene at a lower level of agitation or distress to prevent escalation to the point a safety cell was the only viable option. The Judge David L. Bazelon Center for Mental Health Law asserts, "Seclusion and restraint are safety measures. Their use, particularly when it is recurrent or protracted – represents a treatment failure and should be addressed at such. Seclusion and restraints can lead to death, serious physical injury, and trauma. People subject to seclusion and restraint experience it as frightening, humiliating, and dehumanizing." (Judge, 2016)

The Grand Jury reviewed the Crisis Stabilization Unit Policy, Restraints and Seclusion (7490). During an interview with a top official, the Grand Jury was told that seclusion is not used and there was no designated seclusion cell on Mod L, yet the Grand Jury was provided a segregation cell policy as part of the current Crisis Stabilization Unit's Policy Manual. When asked how a seclusion cell differs from a safety cell, staff stated there is basically no difference in the level of isolation or its function. According to the Restraint and Seclusion policy, locked seclusion is a physically imposed condition that limits an inmate's freedom of movement. It is used as a means for keeping an inmate from harming himself or others, which is the same purpose identified for safety cell use. Additionally, the Restraint and Seclusion policy indicates that seclusion can be ordered by a psychiatrist for four hours, with an order for one additional four hour period as needed, compared to a safety cell, which has no defined maximum.

One major difference between a seclusion cell and a safety cell is that a debriefing meeting is held for use of restraints and seclusion, however, no debriefing meeting is required after placement in a safety cell. According to the Judge David L Bazelon Center for Mental Health Law, the inmate "should participate in a post-event debriefing with professional staff to better understand what occurred and how to prevent recurrence." (Judge, 2016)

The Restraints and Seclusion policy includes a debriefing meeting, held within 24 hours of an event, for the purpose of:

1. Assisting the inmate to identify the precipitant of the event, and suggest methods of more safely and constructively responding to the incident;
2. Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the inmate avoid or cope with those incidents;
3. Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan;
4. Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and facility policies;
5. Provide both the inmate and staff the opportunity to discuss the circumstances resulting in the use of seclusion or behavior restraints, and strategies to be used by staff, the inmate or others that could prevent the future use of seclusion or behavior restraints.

Since there is functionally no difference between seclusion and safety cells, the Grand Jury concludes that a debriefing should be held for each safety cell use. The debriefing process turns a treatment failure into a treatment opportunity, especially when suicidal ideation or attempts are a concern.

Clinical Services

Psychiatrists

The Orange County Jail currently employs three fulltime and two part-time psychiatrists for the entire Orange County inmate population. An additional psychiatrist is currently in the hiring process. On any given weekday there can be as many as four psychiatrists on duty during the day. Occasionally they provide weekend coverage and are available by phone as needed. They are responsible for the care and treatment of all inmates in Mod L and some outpatient psychiatric clinic coverage within the Intake and Release Center.

Psychiatrists prescribe medication to inmates but do not initiate psychotherapy. The use of voluntary or involuntary medication (both emergency and non-emergency) may assist with the stabilization of an inmate so that therapeutic interventions can be introduced. According to a study titled, *An Alternative Approach: Treating the Incompetent to Stand Trial*, "The court specifically held that the provision of medications alone to mentally ill defendants did not legally constitute the kind of treatment efforts that are required to restore someone to mental competency."

Psychiatrists transfer care of a patient to a nurse practitioner when the patient leaves Mod L. This practice may disrupt continuity of care for inmates who are then housed in the general population

and have a mental health diagnosis. The jail currently employs only three nurse practitioners for all but approximately 120 inmates with mental health issues who are assigned to Mod L. In total, only eight medical staff (physicians and nurse practitioners) are responsible for the 1,200 or so inmates with mental health issues.

Psychiatrists provide direction for the daily medical care of Mod L patients. They evaluate inmates new to the unit, assess the need for conservatorship, participate in weekly interdisciplinary team meetings, and prescribe medication. They also constantly assess and reassess inmates to determine their need to stay in Mod L or their ability to transfer to the general population. They do not conduct therapy with the inmates nor do they oversee or provide guidance in the group therapy programs instituted by case managers and nursing staff. Some of the psychiatrists are bilingual, but none are proficient in Spanish, a predominant language spoken by inmates in the jail system.

On June 6, 2015, the Orange County Register published an article entitled "County Answers Plea for More Mental Health Care," in which an Orange County Jail psychiatrist spoke to the disparity in staffing ratios between Los Angeles and Orange Counties. Los Angeles employs 35-40 psychiatrists for approximately 15,000 inmates compared to Orange County, which at the time the article was written, employed three psychiatrists for 6,000 inmates. This equates to a psychiatric caseload of approximately 400 in Los Angeles, compared to a psychiatric caseload of approximately 2,000 in Orange County. Although the psychiatric staff number has improved slightly since the article was published, the ratio remains vastly out of balance. A Correctional Health Services employee stated it is difficult to recruit psychiatrists to work at the Orange County Jail because they can make significantly more money if they work in one of the neighboring counties. According to the County of Orange Human Resources Current Salary Schedule, psychiatrists make $16,707 - $19,356 monthly (Human 2016). One Correctional Health Services staff member said the salary in a neighboring county is substantially higher, even as much $50,000 - 100,000 annually. The Grand Jury was informed that the Board of Supervisors has recently authorized a pay increase for psychiatrists, which will make working for the Orange County Jail more competitive for future candidates. A spokesperson for the Health Care Agency has expressed a desire for additional psychiatrists but due to salary restrictions, there is a general lack of interest to work for Orange County in this capacity.

Case Management

Case manager is a broad term for a variety of disciplines, including Marriage Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), Psychologist, and Licensed Psychiatric Technicians (LPT). Although each discipline has varying levels of education and experience and is paid according to their classification, the basic functions are the same, with a few exceptions. Mod L case managers are generally Licensed Psychiatric Technicians. Although Mod L is the

section of the jail that houses the highest number of acutely mentally ill inmates, Licensed Psychiatric Technicians, who have a lower level of education than Marriage Family Therapists or psychologists, facilitate the majority of therapy groups on Mod L.

Case managers are clinicians employed through Correctional Health Services. There are eleven case managers for the approximately 1,200 inmates with mental health diagnoses. Two are assigned fulltime to Mod L to provide therapeutic services to inmates with acute psychiatric issues, and others have a partial Mod L caseload. Other case managers are assigned caseloads that include inmates with mental health issues that are housed in the general population. Their tasks include assessing their clients for mental health issues, including history, presentation, jail housing needs and psychiatric medication needs. They also discuss inmate progress with other team members at weekly treatment team meetings if the case is complicated or if the person is one of the ten inmates housed on the Crisis Stabilization Unit. One of their primary focuses is discharge planning, which connects their client with community and/or court services, in order to provide continuity of care after release.

Case managers on Mod L carry a caseload of 30-35. In the general jail population, case managers handle a caseload between 50-100 inmates. Case managers on Mod L interact with the acute inmates at least one time weekly. When someone in their caseload is moved to general housing in another part of the jail system they hand the case over to a different case manager who will see their new client within three days of transfer. Inmates sometimes come and go so quickly they never see a case manager, either in Mod L or the general housing area.

Case managers who are assigned inmates in general housing units are required to see their clients every 30-60 days after making initial contact with an inmate. They evaluate how the inmate is getting along with other inmates, whether or not he is feeling suicidal, if he is hearing voices and if he is taking his medication as prescribed. If the case manager determines an inmate is psychologically fragile, visits are more frequent. Additionally, the inmate can complete a request form to see the case manager in the clinic. If the inmate refuses to take medication and is stable, the case manager will most likely close the case, however, according to the Department of Justice, in a Joint Settlement Agreement Regarding the Los Angeles Jails, prisoners in High Observation and Moderate Observation Housing, and those with a serious mental illness who reside in other housing areas of the jails, will remain on an active mental health caseload and receive clinically appropriate mental health treatment, regardless of whether they refuse medication." (United, 2015)

If an inmate who has been transferred from Mod L to general population housing cannot cope, he will go back to Mod L. If Mod L is full, he will go to the triage area in the Intake and Release Center until deputies can secure a bed on Mod L. The Grand Jury was told that there are not enough resources for the mentally ill in jail but they do the best they can.

Case managers try to ensure continuity of care by making appointments for inmates upon release. Orange County has a wealth of community resources available to individuals seeking therapeutic help but according to staff interviewed, resources are not always easy to access. The case manager will make an appointment with the mental health clinic within 24 hours of discharge so the client can continue their medication but many do not follow through and keep their appointments. Discharge plans are tracked in terms of referrals to community services to see which services former inmates are utilizing the most. This information is then provided to Correctional Health Services management along with other monthly statistics regarding inmate release.

Inmate Education and Therapeutic Services

Mentally ill inmates who reside in the general jail population do not receive any counseling or education specific to treatment of their mental illness. The Sheriff's Department provides programs and classes available to the general jail population that would be of great benefit to those with mental health issues, but mentally ill inmates often do not qualify for the programs and there is often no room to accommodate them.

Inmate Services: Correctional Programs

The Orange County Sheriff's Inmate Services Division includes Correctional Programs. Approximately 400 volunteers and 28 paid staff help with tasks mandated by the California Penal Code to ensure the inmate is connected to the outside world. The paid staff of 28 includes Correctional Program Technicians (CPT), Educational Services Coordinators (ESC), Supervisors and Managers. CPTs, also referred to as coaches, are trained by the National Institute of Corrections and need to qualify in order to run inmate training programs such as "Thinking for a Change," the use of motivational interview techniques, and Cognitive Behavioral Therapy.

Classes consist of basic educational programs (including GED), vocational programs (workforce readiness), behavior modification, substance abuse, and life skills (anger management). Staff stated it is difficult to implement effective interventions due to the daily flux of the jail population. There are no classes designed specifically, either within the Department of Inmate Services or Correctional Health Services, to address the needs of mentally ill inmates. Since many mentally ill inmates also have co-occurring substance abuse disorders, they do benefit from substance abuse meetings, such as Alcoholic and/or Narcotics Anonymous, which are held in the jail.

According to Sheriff's Department staff, the best approach for providing effective intervention is to connect the individual to services after release through social services, health care, probation

and the courts. The Orange County Community Correction Partnership (CCP), headed by the Probation Chief, meets quarterly to discuss long-term solutions and post-custody resources. This group includes the Sheriff, District Attorney, Health Care Agency, Social Services, and the Public Defender.

Trying to meet the needs of the entire jail population is a daunting task. Currently, the funding for the Inmate Services Division comes from two sources – the inmate commissary and inmate telephone charges. The revenue combines to constitute the Inmate Welfare Fund. As of June 2016, the rate jails can charge for inmate phone usage will be drastically reduced due to an FCC mandate, resulting in approximately $4.3 million in lost revenue annually. It will be incumbent upon the County to find a new source of funding when this revenue source is gone.

Lack of classroom space is another issue that makes providing inmate services very difficult. In one of the men's jail there are three classrooms for 2,500 inmates and in another jail there is only one classroom, so it is not surprising that there is a waitlist for classes. In order to fully address education needs and possible rehabilitation, the Sheriff's Department and the Health Care Agency need to think outside the box to find a solution to this problem. Currently, due to the implementation of Proposition 47 primarily, the jail population is down, which leaves room to potentially repurpose some areas for other uses.

One improvement that will enhance treatment services in the future is the expansion of the Musick jail facility. The Sheriff's Department has received a total of $180 million in grant money for future development of this facility. The tentative completion date is 2019. The staff at the new facility will focus on inmate training and rehabilitation, which will include greatly increasing space for classroom instruction (County, 2015). Staff interviewed stated services for the most critically mentally ill inmates will remain at the Intake and Release Center due to the need to stabilize newly processed inmates. Additionally, the concentration of most medical and clinical services will still be located at the Intake and Release Center, although Correctional Health Services has budgeted for mental health staff, including a psychiatrist, for the Musick expansion.

Therapeutic Treatment on Mod L

The primary mode of therapeutic activity for male mentally ill offenders in the entire Orange County Jail system is contained in one small section of Mod L. This small concentration of therapeutic intervention does not appear to be adequate to meet the needs of the mentally ill jail population. The Grand Jury was told by some staff that jail is not a therapeutic environment. One County employee who works closely with mentally ill inmates echoed this sentiment by indicating not only is Mod L non-therapeutic, the conditions are offensive.

Correctional Health Services facilitates four group therapy sessions daily for the Mod L inmate population. Although there are 10 beds in the Crisis Stabilization Unit, groups average 2-8 participants. All groups are conducted in an open space in Mod L, with staff and inmates coming and going. Some staff stated that the other approximately 110 inmates in Mod L could benefit from participating in the group therapy sessions, but there is no mechanism in place that makes this possible.

The nursing staff facilitates a morning group that focuses on activities of daily living and medication compliance. According to a Behavioral Health Services staff member, the purpose of group is to encourage the performance of self-care activities such as showering, shaving, brushing teeth, and keeping their space clean.

Correctional Health Services case managers facilitate the remaining three daily therapy groups. The purpose of the case management facilitated groups is to assist the inmates in gaining insight, raising consciousness, and preventing recidivism, but the Grand Jury was not provided any data demonstrating that therapeutic groups accomplished these goals. A Correctional Health Services employee told the Grand Jury that therapy sessions focus on a wide variety of topics, including emotional regulation, cognitive behavioral techniques, social skills training, relaxation techniques, safety, and the importance of boundaries. Although group therapy is the only therapeutic treatment on the Crisis Stabilization Unit, some of the case managers who facilitate these groups were unable to articulate a list of topics covered and could not adequately explain the therapeutic outcomes they hoped to achieve in their groups. Some group facilitators described activities such as watching movies and coloring. Some also said sometimes inmates just talk about what is on their mind.

The Grand Jury inquired into the methodology for facilitating groups and it appears there is no coordinated system. Some staff interviewed stated that they do not receive training specific to facilitating a therapy group for mentally ill inmates; they get group ideas from other case managers. Although senior staff provided the Grand Jury with a daily calendar of general therapy topics, many staff that facilitate the groups did not appear to use it. There is no structured curriculum defining what content should be included under a specific topic, or the purpose/outcome to be achieved.

Some mental health providers told the Grand Jury their main objective is to keep the inmate safe. Therefore, they try not to start in-depth conversations they cannot finish due to a variety of factors such as lack of privacy, potentially limited time in jail, and safety concerns. Some mental health professionals told the Grand Jury that if they could make changes they would hire more staff for groups, have fewer Mod L inmate restrictions, initiate more activities, and schedule more time out of cells.

The Grand Jury reviewed the *Thinking for a Change* curriculum as a possible therapeutic intervention in the men's jail and found it potentially beneficial. *Thinking for a Change* is a

cognitive–behavioral curriculum developed by the National Institute of Corrections that concentrates on changing the criminogenic thinking of offenders. *Thinking for a Change* stresses interpersonal communication skills development and confronts thought patterns that can lead to problematic behaviors (Crime, 2106). According to Correctional Health Services staff, they have submitted an application to the National Institute of Corrections for on-site training.

The Health Care Agency should consider implementing *Thinking for a Change*, or a similar program, both in Mod L and particularly in the general population where therapeutic interventions for the diagnosed mentally ill are woefully lacking. Expanding the program will necessitate augmenting the number of facilitators and also finding a space to hold classes. The Health Care Agency uses a fairly private corner of Mod L to hold group therapy sessions for Crisis Stabilization Unit inmates. Due to the shortage of space everywhere, other creative solutions will have to be evaluated for the general population.

Staff Training

There are two separate entities that need specialized training when interacting with mentally ill inmates in the jails: Sheriff's deputies and Correctional Health Services staff.

Sheriff's Deputies

Sheriff's deputies begin their formal training in mental health in the Sheriff's Academy using courses certified by the California Commission on Peace Officer Standards and Training (POST) and the Correctional Standards Authority (CSA). POST basic academy training offers courses that assist deputies in dealing with people who have special needs. The overview to Chapter Four, which addresses mental illness, states, "Peace Officers must become familiar with the behavioral and psychological indicators of mental illness in order to determine if an individual is a danger to others, danger to self or gravely disabled and to determine an appropriate response and resolution option." (California, POST)

In addition to this training, the POST requirement also includes Advanced Officer Training, which consists of twenty-four hours of training every two years in compliance with the POST requirements. Advanced Officer Training offers a variety of courses but currently does not specify the number of hours for, or frequency of, on-going training for dealing with citizens with mental illness inside or outside the jail.

The Sheriff's policy for dealing with mentally ill persons is in the Field Operations Manual, Section 29. The policy discusses symptoms of mental illness and physical conditions that look like mental illness. It also discusses how to talk to a disturbed person.

The Grand Jury was told in an interview that deputies are the eyes and ears of Correctional Health Services. They need to be aware of overt and subtle changes in behavior. As such, members of Orange County Correctional Health Services provide ongoing training for deputies who are assigned to the jails. Correctional Health Services offers suicide/risk prevention training to deputies quarterly. Correctional Health Services case managers provide two hour training to Mod L deputies twice a year, as well as training in use of safety cells. Senior Correctional Health Services staff told the Grand Jury they have ongoing talks with deputies regarding inmate mental health issues. Deputies do a good job communicating their concerns about inmates to medical staff and medical health staff and there is close collaboration between deputies and Correctional Health Services staff. Several members of Correctional Health Services told the Grand Jury that deputies assigned to Mod L are selected carefully, as not all work well with this population. The Sheriff's Department tries to assign deputies to Mod L based on their desire to be there and their temperament. They need to be sensitive to those with a mental health diagnosis and understand the most effective ways to communicate with them.

Because of the large numbers of inmates suffering from various levels of mental illness, the Grand Jury believes all deputies should be well trained in both the recognition of mental illness and signs of decompensation, and in techniques proven to deescalate situations and calm those inmates in distress. When interviewed, some deputy sheriffs expressed both a desire and a need for on-going, in-depth training in this area of policing.

Correctional Health Services

Correctional Health Services provides the other major component to mental health care in the jails. This healthcare department is made up of psychiatrists, psychologists, registered nurses, and various levels of mental health practitioners, some of whom function as case managers. All receive their professional training at various universities and colleges before they are hired to work in Orange County jails.

Those doing the hiring look for people with the right attitude towards mental illness when they are interviewing to fill a position. New staff receives on-the-job training. All new nurses are paired with a seasoned nurse and stay in their first rotation for 4-5 months before moving on to complete a rotation through various sections of the jails. It takes about a year-and-a-half to complete the rotation. Nurses are not trained specifically to conduct therapy groups with Mod L inmates.

The Mentally Ill and the Law

There are laws and statutes that regulate the lives of those who are incarcerated. When an individual is mentally ill, the legal system is particularly complicated. Some factors that may impact a mentally ill individual include the use of forced medication and delayed trial proceedings due to incompetency to understand the charges and/or assist the defense attorney in his own defense. Those representing mentally ill individuals are obligated to protect the person's best interest and constitutional rights. The Grand Jury examined some of these laws and discussed them at length with the Public Defender's Office, the District Attorney's Office, and other representatives of the court.

It is the responsibility of a defense attorney or public defender to zealously represent an individual who is arrested and facing trial and a potential jail sentence. To this end, they look at all the elements of the crime with which their client is charged, including possible mental health issues. They may request a psychiatric evaluation of their client in order to make a determination as to whether the client is able to assist in his own defense.

Penal Code §1368: Incompetent to Stand Trial

Under California State and Federal law, all individuals who face criminal charges must be mentally competent to help in their defense: [*The Constitution of the United States*, Amendment 5., *Dusky v United States:* 362 U.S. 402 (1960), *Jackson v Indiana:* 406 U.S. 715 (1972), *Freddy Mille v Los Angeles County* (2010)]. By definition, an individual who is incompetent to stand trial (IST) lacks the mental competency required to participate in legal proceedings. While a person may be IST due to mental illness, or other reasons such as a developmental disability, this study focuses on the former.

The 1960 U.S. Supreme Court decision *Dusky v United States* found that the defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding of the proceedings against him" (Dusky, 1960). Being competent means the defendant must both understand the charges brought against him and have sufficient mental ability to help his attorney with his defense. The 1972 U. S. Supreme Court decision *Jackson v Indiana* found the state violated a criminal defendant's constitutional right to due process by involuntarily committing an individual for an indefinite period of time because of his incompetency to stand trial. The U.S. Constitution, as well as the California State Constitution, states no person shall be deprived of life, liberty, or property without due process of the law.

Under state law, when a defendant's mental competency to stand trial is in question, the courts must follow a specific competency determination process before the defendant can be brought to trial. Figure 2 below summarizes this process (Legislative, 2012).

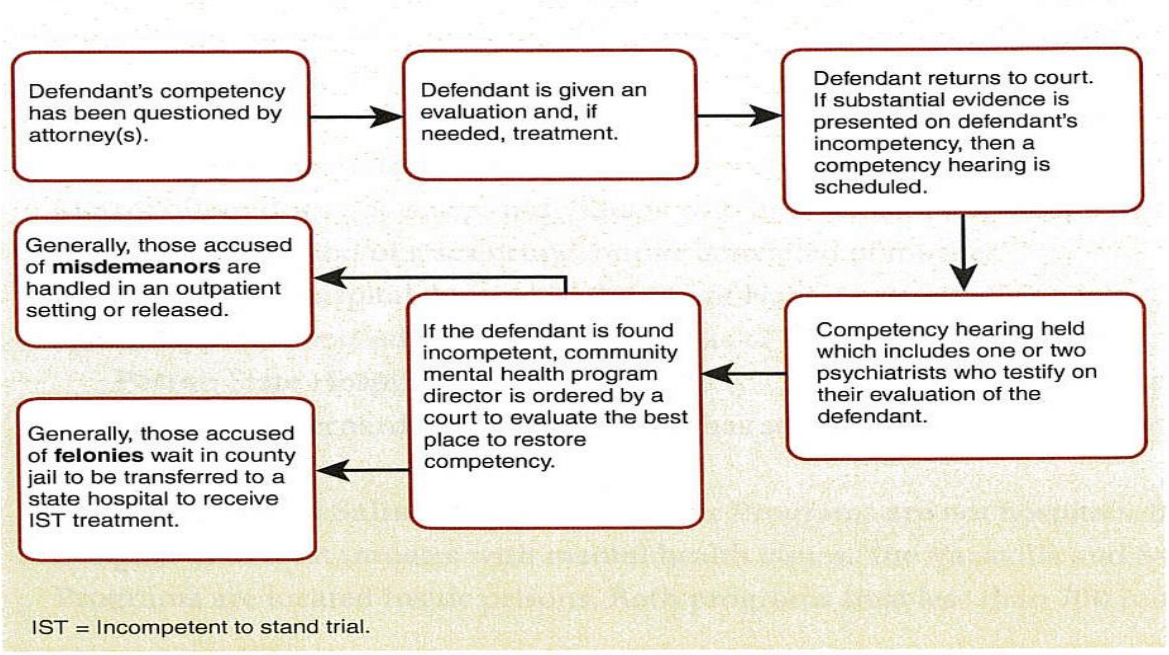

Figure 2: Determination of Mental Competency Process

It is typically the responsibility of the defense attorney to declare doubt that the client can assist in his defense, however, the court also can observe and make a determination on mental capacity. If the defendant is being tried on a misdemeanor, this entire process can create a dilemma for the defense because being declared IST and the ensuing restoration to competency (ROC) could potentially take much longer than the sentence the client would serve had he gone to trial and been found guilty. The potential outcome is that the defendant will be incarcerated much longer than necessary. The best outcome for a misdemeanant if the charges are not dropped is to undergo an assessment and receive a referral from the Conditional Release Program to receive services. If the charges are dropped, the public defender will initiate a support process that same day to get their client help.

In both felony and misdemeanor cases the Court assesses the mental health evaluations. The individual has a right to a trial on the issue of competency but usually the court makes the determination. If the Judge declares the person incompetent to stand trial (IST), a §1370 is filed, and the process moves forward to have the individual restored to competency in a state hospital if being held on a felony charge, or referred to an outpatient program if the charge is a misdemeanor.

The Crisis Stabilization Unit in the jail is not designed and staffed to restore competency to those who have been declared incompetent to stand trial by the court. Until recently, the only avenue was admission to a state hospital that has a restoration program. The Grand Jury learned the Public Defender's Office is filing more Habeas petitions, which the court is granting in an effort

to expedite treatment for restoration of competency and admit those individuals to a ROC program. The Grand Jury heard that, when the state hospital learns a petition for Habeas Corpus has been filed with the court, a bed in the state hospital opens up the day before the scheduled hearing.

Healthcare professionals in and outside the County of Orange told the Grand Jury the individual sometimes returns from a state hospital too soon and is so overly medicated (but compliant) he is still not able to assist in his own defense. The Grand Jury was told that in some cases inmates are drugged instead of counseled and only rarely given one-on-one therapy. Upon returning to jail, the inmate may refuse to take his medication, thus running the risk of decompensating before the trial date. If that happens, the process begins again.

There may now be an alternative to the Orange County court sending an inmate to a state hospital for restoration of competency in the form of a program initially established in 2011 by the San Bernardino Sheriff's Department (SBSD). This alternative is a jail-based program that also works to restore competency. Besides saving money, it saves time – a critical factor when an individual is incarcerated. According to San Bernardino statistics, in 2009-2010, the average length of stay in jail for pre-sentenced IST inmates was 765 days. In 2009-2010, the average length of stay in jail for pre-sentenced **non**-IST inmates was 42 days (Fillman, 2014). The huge discrepancy in time has to do with the current state hospital process of restoring an individual to competency.

The wait time for Orange County IST inmates is generally between 60-120 days. In the meantime, the inmate's general needs are being met in jail but there is no attempt to restore competency. In *Freddie Mille v Los Angeles County* (2010) the Second District Court of Appeal held that the common practice of providing medication alone to mentally ill defendants in jail "did not legally constitute the kind of treatment efforts that are required to restore someone to mental competency" (IN, 2010). Thus the transfer of an inmate to a treatment facility in a timely manner is legally required and the courts recommend that it be completed in no more than 30-35 days. See Appendix B for the court's discussion and decision on the *Freddie Mille* case and Habeas Corpus which has a bearing on Habeas petitions in Orange County. While the courts have recommended IST commitments be transferred to a state hospital within 35 days, lack of physical space combined with staffing issues and the time needed for treatment makes this recommendation impossible.

The jail-based program in San Bernardino, which began as a California Department of State Hospital Pilot program and was so successful the San Bernardino Sheriff's Department (SBSD) expanded it, as of this writing has 54 of 96 authorized beds filled. It is currently accepting inmates from San Diego and Los Angeles Counties. This is an award-winning program whose objective is a fast track to "restoration of competency" and thus, it is commonly referred to as the

ROC program (Fillman, 2014). It is a less costly alternative to state hospital admission and helps reduce the state hospital waitlist. It also enables patients to receive more timely treatment. A private healthcare contractor, which runs the program, takes responsibility for all paperwork and sees that it is completed correctly. The Department of State Hospitals carries the financial burden and SBPD is responsible for all inmates once they are admitted to the program. The private contractor puts all the pieces together, including positive reinforcement, encouraging participation and compliance with the program. Psychiatrists see patients daily and there is an increased amount of programming for inmates. San Bernardino referred to the private contractor as an innovative and fantastic partner.

Statistics as of October 2013 show the average length of treatment for restoring defendants to competency in the San Bernardino program was 14-150 days. Eighty-nine percent (89%) of defendants were restored to competency in less than 90 days. The court upheld competency findings 98% of the time. Ninety percent (90%) of defendants were prescribed psychotropic medication and, using a compliance incentive program, 87% were fully compliant. This program saved San Bernardino County Sheriff's Department more than 150,660 jail beds since its inception in 2011(Fillman, 2014). San Bernardino officials say they have looked at this program from every angle and there is no downside. They view it as a "win-win."

Although Orange County has small IST numbers (approximately 5-10 at any given time), even one person who remains in jail because there is no room in a state hospital puts the County at risk of a lawsuit pursuant to *Jackson v Indiana* and *Freddy Mille v Los Angeles County* discussed above. Also, defense attorneys, who must responsibly represent their client, are justifiably troubled at the length of time their client spends in jail with his case going nowhere. Under the state Determinate Sentencing Law, IST defendants are not permitted to stay in a state hospital longer than three years or the maximum prison term the court could have sentenced the defendant to serve if he was found guilty, whichever is shorter. This reality creates the aforementioned dilemma for defense attorneys who recognize that their client could be looking at spending more time in jail for being acutely mentally ill than a guilty verdict and subsequent sentence would have imposed upon him, had he been found guilty. What if he is found **not** guilty?

At the time of this writing, the Grand Jury understands that Correctional Health Services and the County of Orange now have contractual agreements in place with the San Bernardino Sheriff's Department ROC program to place Orange County inmates declared incompetent to stand trial in the San Bernardino program. It is likely inmates needing admittance to a state hospital will be going to the San Bernardino program as early as June 2016. The Grand Jury appreciates the efforts of Orange County executive administrators who have worked to find a solution to restore competency in a timely manner for those inmates declared IST.

Lanterman-Petris-Short Act (1972): California Welfare and Institution Code 5150: Riese Hearings

The Lanterman-Petris-Short (LPS) Act concerns the involuntary civil commitment of an individual to a mental health institution in the State of California. Pursuant to the California Welfare and Institutions Code, it is commonly referred to as a §5150 hold. Other holds under this Code section include: a §5250: 14 day extended hold; and a §5270: 30 day extended hold. Individuals on a §5250 or a §5270 have a right to counsel and their attorney can file a Writ of Habeas Corpus, which would result in the court having to justify the individual's continued detention.

It is not against the law to be mentally ill. If inmates can take care of their basic needs and manage life adequately, they are not considered gravely disabled. If a mentally ill inmate refuses to take medication and is not in danger of harming himself or others, no treatment is forced on him.

However, if an inmate is not coping well in jail, decompensating and refusing medication, he may be placed on a §5150 hold. At that point he is becoming a danger to himself and/or others. It is then necessary to either convince him that it is in his best interests to take medication, or petition the Court in the form of a Riese Petition, also called a medication capacity hearing, to forcibly medicate him.

The inmate must be informed orally of the nature of the mental illness that is the reason for medication; the likelihood of improving or not improving without medication; any reasonable alternative treatments that are available; the name, type, frequency and method of administration of the proposed medication and the length of time it will be administered. Patients who are hostile or mute are to be provided with a medication booklet. The doctor must verbally or physically offer the medication and, if it is refused, the act constitutes the refusal. If the Riese Petition is granted, the inmate is medicated against his will. Medical staff told the Grand Jury they estimate they average two to four Riese Petitions per month.

There can be a conflict between the statute that the Court uses to declare an individual incompetent to stand trial (California Penal Code §1368) and the statute that allows for an individual to be medicated against his will, if he is a danger to self and/or others (Welfare and Institutions Code §5150). If an inmate is going through the legal process of being declared incompetent to stand trial and begins to decompensate, if Correctional Health Services initiates a Riese Hearing and the petition is granted, or if the inmate becomes mentally "stable" as a result of medication, it may affect the competency petition.

The Grand Jury was told a doctor recommending a Riese Hearing does not know the court status of the inmate and is objectively providing sound medical treatment to stabilize him. Medical staff said that they would not change their approach if they knew about the pending incompetent to stand trial hearing and occasionally staff does know, if there is a note in the inmate's chart. Correctional Health Services stated they would not initiate a Riese Hearing to interfere with a competency hearing as that would not be in the best interests of the inmate, but rather an attempt to manipulate the courts.

The defense attorney has a fiduciary obligation to represent the client and the choices he makes. In a Riese Hearing, that may mean advocating against forced medication. There is legal precedent for refusing medication (*Sell v United States*. 539 U.S. 166 [2003]) but it is doubtful an attorney would argue against the use of medication simply because it would restore their client's ability to assist in their own defense and nullify a competency petition.

Additionally, a Riese Hearing, and forced medication is only a short-term solution that must be revisited each time a §5250 or §5270 hold expires. The only potentially real solution is a holistic approach that involves treatment with the proper medication on a long-term basis, coupled with significant restoration therapy and family/community support. For an extended discussion of LPS, W&I §5150, and Riese Hearings, see Appendix B.

Assisted Outpatient Treatment (AOT): Laura's Law

The 2012-2013 Orange County Grand Jury published *To Protect and To Serve*, a study of the interaction between sworn officers and the mentally ill homeless. In an attempt to keep mentally ill individuals out of jail and to reduce recidivism, it recommended that the Orange County Board of Supervisors find a way to adopt and implement California AB1194, Laura's Law, also known as Assisted Outpatient Treatment (Orange, 2012-2013).

Laura's Law potentially gives mentally ill individuals who qualify for the program treatment and services necessary before they become dangerous or gravely disabled so they do not have to be involuntarily hospitalized, jailed, or suffer other consequences of untreated mental illness (California, 2012). Laura's Law allows persons suffering from mental illness to receive medical intervention on an outpatient basis.

In May 2014 the Board of Supervisors adopted Laura's Law. Orange County thus became the largest county in California to fully implement the law and a model for Laura's Law in the State. The Board recognized the unnecessary cost of repeated hospitalizations and incarceration is too great and, as former Orange County Supervisor and current State Senator John Moorlach pointed out: "We cannot allow our jails to be the predominant location for housing mentally ill people" (OC Register, 2014).

To qualify for admission to the Laura's Law program, a person must suffer from mental illness, be unlikely to survive safely in the community without supervision, and have a history of lack of compliance with treatment. They must also have a recent history of violence, incarceration or hospitalizations because of mental illness. Also, the individual must have required two psychiatric hospitalizations within the last 36 months or placement in a correctional facility due to mental illness, or the mental illness resulted in one or more attempts or threats of serious and violent behavior toward themselves or others within the last 48 months (California AB1194). The Orange County Health Care Agency works with eligible clients for approximately 60 days before applying Laura's Law.

A health care executive told the Grand Jury the program is very successful. Forty percent (40%) of referrals come through the jails. Assisted Outpatient Treatment personnel work with case managers in the jails to find services for inmates. They will meet with potential clients in the jail and, if the criteria is met, Assisted Outpatient Treatment can refer services. Assisted Outpatient Treatment staff will also pick up clients from jail upon their release and take them directly to whatever services they need. Referrals can also come through the Court. These referrals are for misdemeanants who are in need of an outpatient mental health services program to satisfy court orders for restoration of competency.

Behavioral Health Services has established a team of health care professionals who screen individuals deemed good candidates for Laura's Law and, if accepted, can enroll them in services. These professionals include clinical psychologists, clinical social workers, mental health specialists, licensed vocational nurses, registered nurses, marriage and family therapists and administrative and office specialists who direct, collect data and analyze the program to ensure quality.

According to Behavioral Health Services, in its first four months of implementation, (October 2014-January 2015), Laura's Law had nearly 500 inquiries, an average of four per day, but not a single person has been ordered into treatment against his or her will. There were 310 inquiries for information only and 169 treatment referrals. Nineteen individuals were already enrolled in a mental health program and 34 voluntarily entered treatment. One hundred forty-four (144) cases were resolved without a court hearing and 18 cases were referred to substance abuse/other community programs. There were 24 outstanding cases.

After 18 months (October 2014-January 2016), there were 1,060 inquiries for information only and 613 inquiries for treatment referrals. Sixty-one individuals were already enrolled in a mental health program and 166 voluntarily entered treatment. Behavioral Health Services closed 576 cases and were unable to locate 174 others. There are 55 open cases and three contested cases.

The Orange County Health Care Agency will continue to monitor the effectiveness of Laura's Law by collecting and analyzing data, with a view to evaluating the law's effectiveness with regard to reducing homelessness, incarceration, and hospitalization.

According to the Orange County Healthcare Agency and the AOT Administrator, Assisted Outpatient Treatment has turned out to be an access point for families to call when they do not know how to help their loved ones. "Two of the key ingredients of our success is having persistence and having patience. We have unconditional, positive regard for our members, no matter what they do. We welcome them in with open arms, no judgment" (Orange 2016).

The Mentally Ill and Community Therapeutic Programs

Orange County Collaborative Courts Program

> "What happens is I start getting bad thoughts and I can't get them out of my head. I can't think about anything else…. I need help. I don't want to come in and out of prison my whole life. My history of violence has landed me in institutions but I feel like what is even worse than being locked up is that my behavior and my actions have gotten me alone. The alone feeling I have is brutal. I'm dying inside for help."
> From the speech of a 2014 participant, requesting admission to the program.

Collaborative, or problem solving courts, are specialized court tracks that address underlying issues present in the lives of individuals who come before the court on criminal matters. Many times these underlying issues include some form of mental illness and co-occurring substance abuse issues.

There are four specific mental health courts as well as four community courts that address mental health issues. Figure 3 below, the Collaborative Court system, depicts their organization and the issues they address.

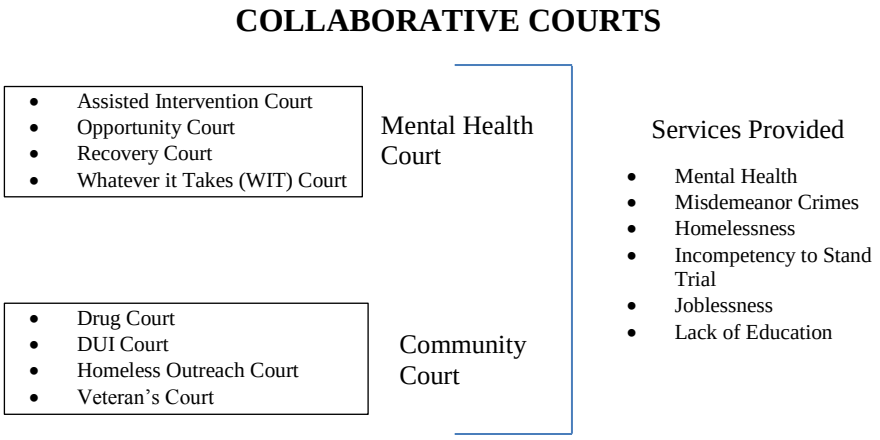

Figure 3: The Collaborative Court System

This collection of outreach court services has saved the County a significant amount of money, reduced recidivism, and thus jail beds, but most importantly – wasted lives. The Grand Jury believes these services have benefited the County and society at large and contributed to the quality standard of living many residents of Orange County enjoy.

Mental Health Courts use a collaborative approach that includes the resources of a judicial officer, the Offices of the Public Defender and the District Attorney (who follow the client, address legal issues and review progress), representatives from Mental Health Services (who provide all the evaluations for entrance into the various program), a private provider under County contract to provide treatment services, and the Probation Department. These programs are voluntary and are at least 18 months in length. They include substance abuse treatment, psychiatric services and counseling, assistance with housing, and other support services as needed. To qualify for Whatever It Takes (WIT) and Assisted Intervention (AI) court programs the individual must have a documented mental health diagnosis. The other mental health courts, Opportunity and Recovery, do not have the full complement of resources and partnership noted above. This is in part because their clients may not need all the services, or because County services, through the Health Care Agency, are not available due to financial restraints and classification restrictions. Eligibility criteria for other collaborative and community courts vary.

Similarly, representatives from the Court, the VA Healthcare System Long Beach, the California Department of Rehabilitation, Legal Aid Society of Orange County, and the Orange County Health Care Agency staff the Community Court. This collaboration ensures people can get proper assistance immediately. The Court offers a wide variety of supportive services for offenders who are homeless, addicted or mentally ill. There are also onsite supportive services available to walk-ins without an active criminal case. Please See Appendix C for a complete list of all collaborative courts and contact information.

All collaborative courts utilize evidence-based practices to achieve outstanding results, as noted in statistics in the 2015 Collaborative Courts Annual Report. This approach is key to obtaining reductions in recidivism, enhanced community safety, and in assisting participants to live productive and fulfilling lives. Those who graduate from one of the Collaborative Courts have an extremely low recidivism rate.

Of the 2,039 Drug Court graduates who have been out of the program for three years, only 28% were re-arrested within that time for any offense – far lower than the recidivism rate of 74% for comparable offenders who did not participate in Drug Court.

Of the 1,236 repeat-offense drunk drivers who have graduated from DUI Court, only 9.9% of those who have been out of the program for five years have had a subsequent DUI conviction

within that time – far lower than the re-conviction rates of 21% and 25% for second and third time DUI offenders statewide.

Of the 258 mental health court graduates, all of whom had severe mental illness and substance addiction, only 34.9% have been re-arrested.

Of the 76 graduates of Veterans Treatment Court, only 8 have been re-arrested, for a recidivism rate of 10.5%.

Mental health court programs provide significant savings to the County because they reduce 911 calls, law enforcement contacts, arrests, hospitalizations, involuntary commitments, trials and incarcerations. In 2013, the County calculated the cost of a bed in jail at $135.92 per day. In 2015, the mental health court programs saved 5,501 jail bed days prior to the application of custody credits, resulting in a cost savings of $747,696. Since its inception, the mental health courts have saved more than $8,755,500 in jail bed costs.

In 2014, the Department of Justice, Bureau of Justice Assistance, and the Center for Court Innovation designated the Orange County Community Court as a National Mentor Site, one of only four in the country. Other court jurisdictions visit Orange County Community Courts, observe team meetings and court sessions and learn best practices for establishing their own effective Community Court systems. As a national teaching site, the Orange County Community Court receives visits by court staff and justice partner personnel from state, federal and tribal agencies.

These courts are only as effective as the number of persons they can reach. The Grand Jury learned that there are individuals who, although they meet the majority of criteria for mental health court, are missing one small component of eligibility and thus cannot be admitted. There is also a gap between drug court and mental health making it impossible for some individuals to qualify for either court. There is also a need for the establishment of additional Collaborative Courts that meet the needs of the existing clientele because the established Collaborative Court qualifying enrollments are full.

Veteran's court functions under the auspices of the Veteran's Administration in Long Beach. Not all veterans are eligible for VA services. The County needs a veteran's court that is funded through County resources so that the vast numbers of Orange County veterans who are suffering distress from conditions such as Post Traumatic Stress Disorder (PTSD) can receive services. There is a need for Collaborative Courts that address the needs of this population.
Proposition 63 is the 2004 voter-approved Mental Health Services Act (MHSA), which applied a 1% tax on Californians earning $1 million or more. The County uses some of these monies to fund mental health programs throughout the County, including parts of Laura's Law. MHSA

monies also help fund WIT court. Funding a Collaborative Court expansion would be a prudent and effective use of MHSA money.

The California Forensic Conditional Release Program

Also known as CONREP, this program is a community outpatient mental health program designed specifically for persons with mental disorders and special conditions of treatment ordered as a result of Court or Board of Parole Hearings action. The State of California funds the program and each county contracts with the Department of State Hospitals.

The purpose of CONREP is to provide comprehensive community outpatient treatment and supervision to several different Penal Code classifications of individuals, including mentally disordered offenders (PC. §2962 or §2970). When an individual enters the CONREP program, he is required to sign a document that sets forth the terms and conditions of the program. Violating those terms and conditions is grounds for revocation of the agreement and admission to state hospital. Please see Appendix D for a discussion of the CONREP program.

Last year, Orange County CONREP had a total of 140 cases. There are currently 47 outpatient cases. These are usually the IST cases that are being charged with misdemeanor crimes and whose court cases will continue once the individuals are restored to competency. IST misdemeanants are usually housed somewhere in the community and therapists begin working with them immediately because their potential sentence will be no more than a year. The therapist develops a treatment plan based on the alleged crime. If the individual is not cooperative and will not take medication he is ordered by the court to a state hospital. If the individual is found by CONREP to be gravely mentally ill, it will initiate steps toward conservatorship.

Potentially violent felons, or those who are alleged to have committed violent crimes, are not candidates for this program.

Quality Assurance

The Grand Jury evaluated the systems in place for quality assurance and risk management activities as a means of addressing the ongoing issues with mental health care and treatment identified by the Department of Justice. Although the Health Care Agency/Correctional Health Services and Sheriff's Department work collaboratively through a Memorandum of Understanding, they have separate quality assurance activities and do not have an integrated approach for sharing data. They do have several standing meetings to discuss information that affects both entities. Examples of these meetings include Mortality Reviews and Critical Incident Reviews. Additionally, Correctional Health Services and the Sheriff's Department meet biweekly for Standard Operation Meetings to discuss a variety of topics and problem-solve

potential issues. Staff from Correctional Health Services and the Sheriff's Department also has a standing check-in meeting weekly at the Intake and Release Center.

Health Care Agency (HCA)/Correctional Health Services (CHS)

The main source of shared information within Correctional Health Services is via the Quality Management Committee (QMC), which meets quarterly. Committee members include managerial representatives from Pharmacy, Nursing, Dental, Medical, Mental Health, and Operations. Psychiatric staff is not represented on the committee, nor are Case Managers. The Mental Health Service Chief and Medical Director represent the mental health group. Routine reports are presented to the committee. None of the reports speaks directly to the Department of Justice concerns regarding the "limited array of mental health treatment and housing options that result in over-reliance on unsafe segregation cells and more restrictive interventions."

The Grand Jury reviewed a sample of Quality Management Committee minutes over the span of a year. The minutes, which summarize report information, cite current data on the agenda topics only. The discussion section of the minutes provided snapshot statistical data in specific reports but did not include comparison data or trending over time, nor did it indicate any discussion by the committee of the information presented. There were few recommendations for quality improvement or risk reduction noted in the minutes, leading the Grand Jury to conclude that either the minutes were incomplete or there is non-adherence to the report format.

The Crisis Stabilization Unit, which houses the most acutely mentally ill people, identifies a Quality Improvement Committee (QIC) in its Quality Improvement Policy 7600. A Health Care Agency employee told the Grand Jury that this is an outdated policy and that mental health concerns were reported via Quality Management Committee meetings. According to the policy, the purpose of the committee is to enhance the quality of inmate care delivered in the Crisis Stabilization Unit, identify important problems or concerns in the care of inmates, objectively assess the cause and scope of identified problems or concerns, and implement appropriate corrective action to the extent possible. As noted above, mental health data, including suicide attempts or other self-injurious behavior, is presented to the Quality Management Committee sporadically. Officials associated with the Crisis Stabilization Unit and Mod L stated that no data is kept on anything related to medical treatment in these areas. Another medical staff stated that Correctional Health Services staff did not have access to reports related to medical or mental health services.

During the course of the Grand Jury's investigation, several requests for data regarding the care and treatment of mentally ill inmates were made during interviews with various Sheriff and Correctional Health Services staff. While some of the requested information was readily available, data that would typically be considered routine was not easily accessible. Some of the

mental health related data requested is not kept or monitored by anyone. Staff routinely directed the Grand Jury to other entities who they thought might keep the type of data requested. One example of this is safety cell data. Due to the extreme conditions associated with a safety cell, along with Department of Justice concerns, trends and analysis of safety cell usage may assist in reducing the number of uses, or even reduce the amount of time spent in the safety cell. Although data is kept on the number of times the safety cell is used per month, no aggregate data is collected regarding the average length of stay, the number of times an inmate utilizes the safety cell multiple times, times/day of week safety cell most often utilized, injuries sustained while in the safety cell, or use of forced medication in conjunction with the safety cell.

There are several examples of data collection regarding the care and treatment of mentally ill inmates that would provide greater insight into current practices and assist staff in developing quality improvement activities in Mod L and the Crisis Stabilization Unit. A few examples include analysis of therapy group effectiveness in the Crisis Stabilization Unit, data on inmates who leave Mod L for regular housing and then return to Mod L, data on inmates who leave Mod L for the regular housing and ultimately get assaulted or assault other inmates, and data on inmates who are declared Incompetent to Stand Trial (IST).

Sheriff's Department

Quality assurance and risk management activities are generated from two main sources in the Sheriff's Department – Strategy. Accountability. Focus. Evaluation. (S.A.F.E.) and the Jail Compliance and Training Team (JCATT). The two entities are both under the umbrella of the Sheriff's Department, but work independently of each other.

S.A.F.E

The S.A.F.E. Division was initiated in 2008 as a method for reviewing various aspects of the Sheriff's Department, including civil litigation, risk management, critical incidents, crime analysis, policy and training, worker's compensation, etc. The Grand Jury found this department to be effective in gathering and analyzing data related to various aspects of the Sheriff's Department. Inmate care and treatment in the jail system is excluded from S.A.F.E. data collection, except for use of force in the jails. There are no formal reports which provide Sheriff Command staff or Correctional Health Services tracking and trending of patterns over time related to jail activity, nor are there any quality improvement activities specifically associated with this review process.

Jail Compliance and Training Team

The quality assurance and risk management component associated specifically with incarceration is the Jail Compliance and Training Team (JCATT). None of the JCATT staff has a quality

assurance background but all have experience with staff training. One main task is maintenance of the Custody and Courts Operations manual, which includes policies on the housing, care and treatment of inmates. JCATT is also responsible for identifying jail trends and issues and posting training materials on its intranet website, handling discoveries/subpoenas/ Public Record Act (PRA) requests, completing standard reports, and initiating research on special projects as assigned. The completed reports and projects are made available to Sheriff Command staff and others as identified. There is no formal Quality Assurance Committee or other systematic process for reviewing reports, tracking trends, or initiating quality improvement plans based on information contained in the reports.

Inmate Services Division

Staff from the Inmate Services Division stated that the current data system is antiquated. Data systems throughout the Sheriff's Department are isolated since there is no centralized database. An updated, centralized system would evaluate the effectiveness of treatment programs for inmates, which would also assist with maintaining and possibly increasing educational funding for inmates.

The Sheriff's Department is currently addressing the lack of a centralized database by pursuing a new integrated system, identified as the Jail Management System. According to staff, the Request for Proposal (RFP) process should be completed by July 2016. The new system will reduce redundancies and increase efficiency. Many work process flows must be completed prior to purchase of the new system, as they will be combined into one comprehensive database that can be cross-referenced. Due to the complexity of the Jail Management System as it is currently imagined, implementation is not expected to be completed for one to two years. The data analysis piece will be one of the last components in place, but once it is incorporated the system is expected to have long term trending capabilities.

Inmate Grievance Process

California Code of Regulations, Title 15, §1073 mandates that a written policy and procedure must be in place to ensure inmates have the opportunity to file a grievance related to several conditions of confinement, one of which is medical care. The Sheriff's Department has taken the lead in the grievance process for the correctional system, but Correctional Health Services also plays a significant role, as it addresses all medical care complaints, which includes mental health care and treatment.

The Grand Jury requested data on grievances that had been filed in 2015. The Sheriff's Department was unable to provide the data within a reasonable timeframe. When data was collected for the Grand Jury it was with the caution that it was probably inaccurate. According to a County official, the Grand Jury request alerted them to an issue with the quality assurance

component of the grievance process. No one in the Sheriff's Department officially analyzes grievance data for trends on the major complaint areas, but some information is received and reviewed with Command staff.

According to the Sheriff's Department, the Department of Justice expressed concern during one of their investigations that the grievance system does not work as it should. Changes have since been made to the process but monitoring to ensure those changes are effective remains an issue.

Grievances related to medical care and treatment are forwarded to Correctional Health Services, which has a system in place for tracking and analyzing grievance data. Grievance Process Policy (1013) indicates that findings related to the grievance process should be included in a Quality Improvement program. Further, qualitative data should be maintained for all types of grievances and outcomes in order to identify opportunities for improving services. A review of Quality Management Committee meeting minutes indicated that Inmate Grievance reports are submitted for committee review on a regular basis. The minutes reflected data collected but the Grand Jury found no evidence of committee discussion of the report information, data analysis, trending/comparison over time, or recommendations for quality improvement activities.

The Future of Incarcerated Mentally Ill Individuals in Orange County

According to the Stanford Law Study, voters and policymakers are demonstrating a greater willingness to separate true criminals from those whose actions are not driven by aggression, violence, or ill-intent. The concept of vengeance can no longer be treated as the sole or primary focus of criminal sentencing, but should instead be treated as only one of several factors (including individual culpability and rehabilitation) that inform a just sentence. Persistent injustices of modern criminal law must not be ignored, including the fact that a dominant root of much criminal activity is mental illness. (Steinberg, 2015)

Orange County policymakers have shown a desire to address issues of incarcerated mentally ill individuals. According to an article in the Voice of OC (March 2016), and confirmed by interviews with County staff, Orange County officials from the Probation Department, the Health Care Agency, and the Board of Supervisors traveled to Washington DC to attend a national summit, which focused on reducing the number of adults in jail with mental illness and substance abuse disorders (Voice, 2016). The *Stepping Up Initiative*, which is spearheaded by the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Association, is working to advance counties' efforts to address mental illness in the jails by developing a system level plan. They are building on the foundation of innovative and evidence-based practices already being implemented across the country and are working with partner organizations with expertise in the complex issues addressed by the Initiative. The cost to

counties of our current system of incarcerating mentally ill individuals is unsustainable. This collaboration seeks to treat problems such as mental illness and addiction as a public health issue, not a criminal justice issue (Stepping).

Additionally, in April 2016, the Board of Supervisors held a public forum on Orange County's mental health system. According to an article in the Voice of OC (April 2016), people in attendance voiced concerns that the current criminal justice system is both ineffective and unjust for people with mental health issues (Gerda, 2016). The hope is that Orange County will become a model for an effective mental health system that can deter an individual from becoming involved in the criminal justice system.

FINDINGS

In accordance with *California Penal Code* Sections 933 and 933.05, the 2015-2016 Grand Jury requires (or, as noted, requests) responses from each agency affected by the findings presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled "OUR BROTHERS' KEEPER: A look at the Care and Treatment of Mentally Ill Inmates in Orange County," the 2015-2016 Orange County Grand Jury has arrived at 22 principal findings, as follows:

F.1. Mod L, located in the Intake and Release Center, has an insufficient number of beds to accommodate all mentally ill inmates who would benefit from regular interaction with medical, psychiatric, nursing, and case management services. The lack of bed space for the number of mentally ill inmates who need acute services supports the Department of Justice concern that the jail needs to act to prevent mental health crises and provide adequate transition programs, not just to deal with the most immediate urgent needs.

F.2. Correctional Health Services provides minimal mental health treatment services in the form of therapy groups to less than 1% of the total jail population diagnosed with some type of mental illness, which precludes therapeutic treatment to most mentally ill inmates.

F.3. The Intake and Release Center has no system for ensuring humane treatment of an inmate in a safety cell. Examples include: the inmates are cold, they sleep next to a grate that is used as a toilet, and no water is available for the inmate to wash hands after the use of the toilet and prior to eating meals.

F.4. Correctional Health Services uses the safety cell as a substitute for treatment. There are no measurable and observable criteria for moving someone into a safety cell, or immediately removing inmates when they are no longer a threat to themselves or others, which has the potential to result in the use of safety cells for disciplinary purposes.

F.5. A psychiatrist is the only person authorized to remove an inmate from a safety cell, however, one is not always available to do so, which may result in a longer term of confinement than necessary.

F.6. Correctional Health Services staff does not hold a debriefing meeting after each use of the safety cell. Therefore, CHS is unable to identify how the treatment failure occurred and to help prevent future occurrences, including suicide attempts.

F.7. Neither Correctional Health Services nor Sheriff's Department staff collects or analyzes data related to safety cell usage other than how often it is used, and therefore, neither has any quality improvement or risk management activities to assist in reducing safety cell use.

F.8. The Orange County Jail does not have a Restoration of Competency treatment program, to the detriment of inmates declared incompetent to stand trial by the courts. Wait time for transfer to a state hospital does not meet the directive of the court system to transfer within 30-35 days.

F.9. Data demonstrates that the Collaborative and Community Courts provide effective treatment services for mentally ill offenders who qualify for the programs.

F.10. Collaborative Courts save the County a significant amount of money in decreased incarceration and recidivism rates.

F.11. The current number of jail psychiatrists is not sufficient to meet the needs of the general inmate population diagnosed with mental illness. This shortage has resulted in extended periods of time inmates spend in safety cells, as well as a lack of psychiatric services in all but a very small portion of the Orange County Jails. The Department of Justice findings support the concern that therapeutic treatment may not reach prisoners who may be quite ill, but are not the most obviously in need of mental health care.

F.12. Orange County has become a model for successful implementation of Laura's Law in the State of California. Behavioral Health Services keeps comprehensive statistics on all aspects of Laura's Law and therefore can effectively analyze the program's strengths and weaknesses.

F.13. Correctional Health Services does not provide therapeutic treatment services to inmates with a chronic mental health diagnosis in most parts of Mod L or in any of the general jail housing. This small concentration of service supports the Department of Justice concern that the jail does not provide for a cohesive system of therapy and treatment.

F.14. There is a lack of adequate classroom space to conduct educational classes for inmates who would benefit from participation in inmate services programs.

F.15. Correctional Health Services has no written guidelines, no formal course of study, and no specific training for case managers or nursing staff who conduct group therapy sessions on Mod L Crisis Stabilization Unit.

F.16. Sixteen beds in Ward D are insufficient to meet the needs of the large number of inmates with chronic mental health issues outside of Mod L.

F.17. Although the Sheriff's Department has a Memorandum of Understanding with the Health Care Agency to provide mental health care services to Orange County jail inmates, the two entities do not have a formal system in place for sharing mental health data that affects both entities.

F.18. The Jail Compliance and Training Team, made up of Sheriff's Department personnel, does not include anyone with a Quality Assurance background. Although the Jail Compliance and Training Team completes standard reports and provides them to Sheriff's Command staff, it does not consistently collect and analyze data over time to identify trends.

F.19. The Sheriff's Department has designated sergeants in each jail facility to enter inmate grievances into a centralized database, but there is no organized system in place for selecting data from the database or analyzing trends, and therefore, no quality improvement activities take place to identify or address potential issues.

F.20. The Health Care Agency/Correctional Health Services collects health care related grievance data and presents it to the Quality Management Committee on a regular basis, however, the data is not formally analyzed to identify trends and the Quality Management Committee minutes do not demonstrate discussion on the implementation of quality improvement activities based on the data presented.

F.21. Neither the Sheriff's Department or Correctional Health Services has developed and initiated a formal process to address or track lingering issues identified in the 2014 Department of Justice correspondence. Additionally, they do not have a formal system in place to track improvement plans that may have been put into place to correct Department of Justice concerns.

F.22.The Crisis Stabilization Unit does not have a system in place to collect or analyze data. Additionally, they do not have any formal quality improvement activities specific to Mod L treatment services, and therefore are unable to objectively evaluate the effectiveness of therapy groups.

RECOMMENDATIONS

In accordance with *California Penal Code* Sections 933 and 933.05, the 2015-2016 Grand Jury requires (or, as noted, requests) responses from each agency affected by the recommendations presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled "OUR BROTHERS' KEEPER: A Look at the Care and Treatment of Mentally Ill Inmates in Orange County Jails," the 2015-2016 Orange County Grand Jury makes the following 17 recommendations:

R.1. The Sheriff's Department should establish an ad hoc committee by December 31, 2016 to review space utilization in the Intake and Release Center with the goal of establishing additional units where inmates with mental health issues can be housed in closer proximity.
F1, F16, F21

R.2. The Health Care Agency/Correctional Health Services should develop a therapeutic program by October 31, 2017 that includes a formal course of studies to include **all** inmates in Mod L, and provide training to facilitators to ensure consistency.
F2, F13, F15, F21

R.3. The Health Care Agency/Correctional Health Services should develop a process by December 31, 2016 to ensure that safety cell entrance and exit criteria are clearly defined, measurable, and observable.
F4, F5, F6, F21

R.4. The Sheriff's Department and the Health Care Agency/Correctional Health Services should implement a protocol to ensure an inmate in a safety cell has access to water for washing hands after using the toilet and before and after meals by September 30, 2016.
F3, F21

R.5. The Sheriff's Department should develop a plan to eliminate the environmental issue of inmates being excessively cold in safety cells by December 31, 2016.
F.3, F21

R.6. The Health Care Agency/Correctional Health Services should develop a protocol by December 31, 2016 to authorize nurse practitioners to release inmates from a safety cell.
F5, F21

R.7. The Health Care Agency/Correctional Health Services should establish a debriefing protocol by December 31, 2016 to address each safety cell use in order to properly evaluate any treatment failure and put a plan in place to reduce reoccurrence.
F6, F21

R.8. The Sheriff's Department and the Health Care Agency/Correctional Health Services should collaborate on a process by December 31, 2016 to collect and analyze the following safety cell data:

- the average length of stay
- the number of times an inmate is moved to the safety cell more than once
- the day and times safety cells are most utilized
- any injury sustained on the way to, or inside the safety cell
- the use of forced medication in conjunction with safety cell use

Data should be incorporated into risk reduction activities that are monitored by the Sheriff's Department and the Health Care Agency/Correctional Health Services.
F7, F17, F18, F21

R.9. The County should provide financial assistance through the budgetary process, or some other means such as the Mental Health Services Act (Prop 63) by June 30, 2017, for additional Collaborative Court services that can reduce the current wait list and serve a greater number and variety of mentally ill offenders.
F9, F10

R.10. The Health Care Agency should develop a recruitment strategy for hiring additional full time psychiatrists by December 31, 2016, in order to better meet the needs of mentally ill inmates throughout the Orange County jails.
F11, F21

R.11. The Health Care Agency/Correctional Health Services should develop and implement therapeutic and educational curricula specific to the needs of mentally ill inmates in all parts of the Orange County jails by June 30, 2017.
F2, F13, F15, F21

R.12. The Sheriff's Department and the Health Care Agency should collaborate to initiate Thinking for a Change, or a similar therapeutic program, in all areas of the jail, including Mod L, by June 30, 2017, and give first priority to inmates with a mental health diagnosis.
F2, F13, F14, F21

R.13. The Sheriff's Department and the Health Care Agency/Correctional Health Services should integrate quality assurance data into their regular standing meetings, or establish a new standing committee by December 31, 2016, where the data includes:

- use of safety cells
- the effectiveness of transfers out of Mod L into the general jail population
- inmate grievances

F17, F19, F20, F21

R.14. The Sheriff's Department should expand the S.A.F.E. division to include a quality risk management team that will collect and analyze data throughout the jail, with a component that will address services provided to mentally ill inmates by June 30, 2017. Consideration of expansion should include incorporating the Jail Compliance and Training Team (JCATT) into S.A.F.E.
F18, F21

R.15. The Sheriff's Department should establish a standing quality management committee that meets at least quarterly to review and analyze data with the goal of improving inmate services by December 31, 2016. The Committee should include representatives from Command Staff, S.A.F.E., JCATT, and Mod L medical, nursing, and case management staff.
F18, F19, F21

R.16. The Sheriff's Department should develop and implement a plan by December 31, 2016 to ensure that the jail grievance policy and procedure is followed.
F19

R.17. The Health Care Agency/Correctional Health Services should review its quality management committee structure by December 31, 2016 to ensure issues identified in reports are thoroughly analyzed. Trends should be identified and addressed through quality improvement activities. The minutes of the meeting should reflect committee discussion and decisions regarding trends. Minutes should also reflect follow-up actions taken to ensure resolution of identified issues.
F20, F21, F22

REQUIRED RESPONSES

The California Penal Code section 933 requires the governing body of any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the governing body. Such comment shall be made *no later than 90 days* after the Grand Jury publishes its report (filed with the Clerk of the Court). Additionally, in the case of

a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such elected County official shall comment on the findings and recommendations pertaining to the matters under that elected official's control *within 60 days* to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code Section 933.05 subdivisions (a), (b), and (c), detail, as follows, the manner in which such comment(s) is to be made:

(a) As to each Grand Jury finding, the responding person or entity shall indicate one of the following:

(1) The respondent agrees with the finding.

(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

(b) As to each Grand Jury recommendation, the responding person or entity shall report one of the following actions:

(1) The recommendation has been implemented, with a summary regarding the implemented action.

(2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.

(3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

(c) If a finding or recommendation of the Grand Jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the Grand Jury, but the response of the Board of Supervisors shall address only those budgetary /or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with Penal Code section §933.05 are required from:

Responses Required:

Responses are required from the following governing bodies within 90 days of the date of the publication of this report:

90 Day Response Required:	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8	F 9	F 10	F 11	F 12	F 13	F 14	F 15	F 16	F 17	F 18	F 19	F 20	F 21	F 22
Board of Supervisors	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X			X	X	X

90 Day Response Required:	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	R 10	R 11	R 12	R 13	R 14	R 15	R 16	R 17
Board of Supervisors		X	X	X		X	X	X	X	X	X	X	X				X

Responses are required from the following elected agency or department head within 60 days of the date of the publication of this report:

60 Day Response Required:	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8	F 9	F 10	F 11	F 12	F 13	F 14	F 15	F 16	F 17	F 18	F 19	F 20	F 21	F 22
Sheriff/Coroner	X		X				X	X					X	X		X	X	X	X	X	X	

60 Day Response Required:	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	R 10	R 11	R 12	R 13	R 14	R 15	R 16	R 17
OC Sheriff	X			X	X			X				X	X	X	X	X	

Responses Requested:

Responses are requested from the following non-elected agency or department heads:

Response Requested:	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8	F 9	F 10	F 11	F 12	F 13	F 14	F 15	F 16	F 17	F 18	F 19	F 20	F 21	F 22
Health Care Agency		X		X	X	X	X	X	X	X	X	X	X	X	X		X			X	X	X

Response Requested:	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	R 10	R 11	R 12	R 13	R 14	R 15	R 16	R 17
Health Care Agency		X	X	X		X	X	X		X	X	X	X				X

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APPENDIX A: ACRONYMS

AB 109: Assembly Bill 109; also Proposition 47- Public safety legislation passed in April 2011 that shifted responsibility for certain population of offenders from the state to the counties. Known as "California Public Safety Realignment Act of 2011.

AI: Assisted Intervention Court. One of the courts in the Orange County Collaborative Courts system.

AOT: Assisted Out-patient Treatment: *California AB 1194*, also known as Laura's Law is court ordered out-patient treatment.

CCP: (Orange County) Community Correction Partnership

COD: co-occurring disorder (such as mental illness and drug abuse occurring at the same time)

CONREP: California Forensic Conditional Release Program: a community outpatient mental health program

CPT: Correctional Program Technician

CSU: Crisis Stabilization Unit: a division in Mod L housing of the IRC (see below) which houses the most acutely mentally ill.

DOJ: Department of Justice

FCC: Federal Communications Commission

HCA: (Orange County) Health Care Agency

HIPAA: Health Insurance Portability and Accountability Act of 1996: legislation that provides data privacy and security provisions for safeguarding medical information.

IRC: Intake and Release Center: area of the Orange County Central Jail where individuals are initially processed and finally released.

IST: Incompetent to Stand Trial: A court declaration on competency which results in the filing of a §1370.

JCATT: Jail Compliance and Training Team: part of the Sheriff's Department jail management system.

LCSW: Licensed Clinical Social Worker

LPS: Lanterman-Petris-Short Act: *California Welfare and Institutions Code section 5000* et seq. concerns the involuntary civil commitment to a mental health institution in the State of California.

LPT: Licensed Psychiatric Technicians

MFT: Marriage Family Therapists

MHSA: Mental Health Services Act: Proposition 63: applies a 1% tax for the funding of mental health programs on Californians earning $1 million or more.

MOU: Memorandum of Understanding

NP: Nurse Practitioner

OIR: Office of Independent Review: Orange County office which, at the time of this writing, advises the Sheriff.

PhD: a doctorate degree based on three years of study and a dissertation.

POST: Peace Officer Standards and Training: California officer training standards

PRA: Public Record Act

PTSD: Post Traumatic Stress Disorder: A mental health condition.

QIC: Quality Improvement Committee

QMC: Quality Management Committee

ROC: Restoration of Competency: Program offered in state mental hospitals and in the San Bernardino Sheriff's Department program that, when completed successfully, enables an individual to participate in his/her defense at trial.

S.A.F.E.: Strategy. Accountability. Focus. Evaluation.: Quality assurance division of Orange County Sheriff's Department.

SBSD: San Bernardino Sheriff's Department

VA: Veteran's Administration

WIT: Whatever It Takes: One of the courts in the Orange County Collaborative Courts system.

APPENDIX B: Discussion of Applicable Laws

Freddie Mille v Los Angeles County

Lanterman-Petris-Short Act: Welfare & Institutions Code Section 5150, et al

Riese Hearings

Freddie Mille v Los Angeles County

In *Freddie Mille v Los Angeles County* (2010) the Second District Court of Appeal held that the common practice of providing medication alone to mentally ill defendants in jail "did not legally constitute the kind of treatment efforts that are required to restore someone to mental competency." Thus the transfer of an inmate to a treatment facility in a timely manner is legally required and the courts recommend that it be completed in no more than 30-35 days.

> Here, following the commitment order, Mille was kept in the county jail for 84 days before the sheriff transferred him to Patton for evaluation and treatment. The fact the county jail administered antipsychotic medication to Mille while he was housed there, pursuant to section 1369.1, was not a substitute for a timely transfer to Patton for evaluation and treatment to restore Mille's competence to stand trial.
> The sheriff's failure to transfer Mille was first called to the attention of the trial court 30 days after the commitment order, when the public defender filed the initial petition for writ of habeas corpus challenging Mille's prolonged confinement in the county jail. We conclude, minimally, instead of denying Mille's initial petition for writ of habeas corpus, filed June 3, 2009, the trial court should have ordered the sheriff to deliver Mille promptly to Patton for evaluation and treatment. (In *re Stoliker* (1957) 49 Cal.2d 75, 78 [habeas corpus is proper remedy to secure confinement under proper authority].) Likewise, on the facts presented, this court should have granted the habeas petition which Mille filed in this court on June 26, 2009, and directed Mille's immediate transfer to Patton. (Court of Appeal, Second District, Division 3, California. *IN RE: Freddy MILLE,* on Habeas Corpus. No. B217102. Decided: March 3, 2010. KLEIN, P. J.)

This case is particularly germane to the discussion of IST individuals in Orange County jails because the Grand Jury learned that public defenders are citing this decision in court in order to expedite their client's transfer out of jail and into a state hospital where they can be restored to competency. Filing a petition of Habeas Corpus focuses the Court's attention on the reality that the individual is being detained in jail, where there is no treatment for his mental condition, and thus he is no closer to an adjudication of the charges brought against him. The defense attorney can argue that incarceration of his client is a violation of his constitutional rights and, if successful, the Court may order the inmate's release.

The Grand Jury also learned that, when the public defender files a Writ of Habeas Corpus, the state hospital is able to find the inmate a bed the day before the hearing.

Lanterman-Petris-Short Act: Welfare & Institutions Code, Section 5150 et al; Riese Hearings

> §5150. (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county
> may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. At a minimum, assessment, as defined in Section 5150.4, and evaluation, as defined in subdivision (a) of Section 5008, shall be conducted and provided on an ongoing basis.

The Lanterman-Petris-Short (LPS) Act, as cited above sets the precedent for modern mental health commitment procedures in the United States. It deals with the involuntary civil commitment of an individual to a mental health institution in the State of California, pursuant to the California Welfare and Institutions Code, and is commonly referred to as a §5150 hold. Other holds under this Code section include: a §5250: 14 day extended hold; and a §5270: 30 day extended hold. Individuals on a §5250 or a §5270 have a right to counsel and their attorney can file a Writ of Habeas Corpus, which would result in the court having to justify the individual's continued detention.

In 1991, the California legislature enacted SB 665, mandating informed consent, emergency medications and capacity hearings procedures to implement *Riese*: the 1987 judicial decision recognizing mental health patients' rights to give or refuse consent to medication.

If an inmate is not coping well in jail, refusing medication and decompensating he/she may be placed on a §5150 hold. At that point he/she is becoming a danger to himself/herself and/or others. When an inmate is placed on a §5150 hold, the next step is to either convince them that it is in their best interest to take medication or petition the Court in the form of a Riese Petition, or medication capacity hearing, to forcibly medicate the inmate.

At the core of Riese is the legal presumption that all mental health clients are competent. Under the law, "No person may be presumed incompetent because he or she has been evaluated or treated for a mental disorder, regardless of whether such evaluation or treatment was voluntarily or involuntarily received" (California W&I Code §5331). In Orange County, the jail psychiatrist makes the determination that someone is gravely disabled. The Crisis Stabilization Unit (CSU) team discusses and determines the need for a Riese Petition. The nurse completes the required paperwork and notifies the public defender. Specific requirements for a Riese Hearing include:

- Informed consent;
- Offer of medication and refusal;
- Petition for a capacity or Riese Hearing;
- Presentation of the case by the treating physician;
- Rebuttal (County Counsel);
- Right of Review;
- Court Ruling

The standard of proof at Riese Hearings is "clear and convincing evidence." This means that the evidence is "so clear as to leave no substantial doubt, sufficiently strong to command the unhesitating assent of every reasonable mind." *(Lillian F. v. Superior Court*, 160 Cal. App. 3d 314, 320, 206 Cal. Rptr. 603, 606 (1984)). This is a very high standard; considerably higher than "probable cause" and beyond that required in most civil proceedings, "preponderance of evidence."

APPENDIX C: COLLABORATIVE COURTS

Collaborative Court programs at the Community Court include Drug Court, DUI Court, four Mental Health Courts, Veterans Treatment Court, and Homeless Outreach Court (Community Court brochure).

COURT	CONTACT	INFORMATION
Drug Court	Kim Parsons	657.622.5816 **kparsons@occourts.org**
DUI Court	Kim Parsons	657.622.5816 **kparsons@occourts.org**
Mental Health Courts ➢ AI Court ➢ WIT Court ➢ Opportunity Court ➢ Recovery Court	Jim Mahar	657.622.5818 **jmahar@occourts.org**
Veterans Treatment Court	Kim Parsons	657.622.5816 **kparsons@occourts.org**
Homeless Outreach Court	Kathi Chapman	657.622.5985 **kchapman@occourts.org**

APPENDIX D: The California Forensic Conditional Release Program (CONREP)

There is greater flexibility with IST individuals charged with felonies not considered violent or with misdemeanors. Misdemeanor IST defendants and individuals charged with nonviolent felonies may be placed directly in CONREP for outpatient treatment for restoration. (Penal Code §1601, §1601(a) and (b), §1630, 1370.01(a)(1)(A).

The CONREP is an outpatient treatment and supervision program for individuals who are under forensic commitments with the Department of State Hospitals and who the court has determined can be treated safely and effectively in the community (Penal Code §1602, §1603). Programs are administered by County and funded by the State of California. The Department of Mental Health contracts with County mental health programs, private agencies, or non-profits to provide services.

The purpose of CONREP is to provide comprehensive community outpatient treatment and supervision to several different Penal Code classifications of individuals, including mentally disordered offenders (PC. §2962 or §2970). Services provided to individuals entering the CONREP program include:

- Individual therapy
- Group therapy
- Home visits
- Contacts with family, friends, and the community
- Screenings for drug and alcohol use and
- Periodic assessment

When an individual enters the CONREP program, he/she is required to sign a document that sets forth the terms and conditions of the program. Violating the terms and conditions is grounds for revocation and return to state hospital. An individual who is re-hospitalized is committed until the court or the Board of Parole Hearings decides he/she is ready to try community treatment once more. Only the court can and will discharge the commitment once the individual has achieved competency to stand trial. If the court determines the individual will never be competent to stand trial, the court will place him/her on "Murphy" Conservatorship (P.C. §1370; §5008(h) [2]) in order to attend to the fact that he/she remains dangerous and unable and/or incompetent to manage his/her own affairs. If an individual still needs treatment after his/her commitment is terminated, CONREP staff will put him/her in touch with mental health services and a therapeutic program in the community.