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EFFECTIVELY ADDRESSING THE MENTAL HEALTH NEEDS OF JAIL DETAINEES

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This monograph is being produced as part of a larger effort to address and improve the provision of mental health services for jails, police and the criminal justice system. The overall project is being conducted by:

The National Coalition for the Mentally Ill in the Criminal Justice System

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PREFACE

On April 2, 1990, an event occurred that had major potential for the betterment of the circumstances of mentally ill persons in the criminal justice system. A national collection of mental health, correctional, and law enforcement professionals were joined for the first time by family members and consumers to address critical issues facing every city and county in the U.S. today -- the mentally ill person who comes in contact with the local jail. This initiative was developed by the National Coalition for the Mentally Ill in the Criminal Justice System and the National Association of Counties (NACo) in collaboration with the Community Action for the Mentally Ill Offender (CAMIO) and the Washington State Department of Corrections. The Conference was sponsored by the National Coalition for the Mentally Ill in the Criminal Justice System in conjunction with CAMIO. Special appreciation is extended to the National Association of Counties for its leadership in convening the Advisory Committee of the Coalition, to Michael Benjamin of NACo for chairing it, to Susan Rotenberg for her tireless dedication as chairperson of the Coalition, to Don Richardson of the National Alliance for the Mentally Ill, and to Chase Riveland, Secretary of the Washington State Department of Corrections.

Funding to support the logistical requirements of planning and carrying out the Conference was provided by the National Institute of Mental Health, the National Institute of Alcoholism and Alcohol Abuse, the National Institute of Disability and Rehabilitative Research, and the National Institute of Drug Abuse. Funding for the production of this report was provided by the National Institute of Corrections.

The conferees' goal was to review major research findings in key areas to identify the areas for change and to develop an advocacy strategy to accomplish the goals. The guiding framework for these deliberations was based on four major assumptions:

- mentally ill persons in the local jail are a community problem
- the jail is part of the community
- mentally ill misdemeanants whose illegal behavior usually is survival behavior should be diverted into appropriate mental health treatment services
- mentally ill felons have a right to essential mental health evaluation and treatment services as well as linkage to community services

This monograph brings together the research and program reviews from which the conference deliberations developed, as well as the policy statement that emerged from the deliberations of this unique collection of participants. The results of the research papers and the conclusions of the participants mark a most productive course for the 1990's that hold the promise of improvements in the world of mentally ill persons in the criminal justice system and to all those people who labor in these most challenging and, at times, incredibly hostile environments. Real improvement is possible and demands our attention.

From this work three National Access Initiatives have since begun; in 1992, "Responding to the Mental Health Needs of Youth in the Juvenile Justice System;" and in 1993, "Mental Illness in America's Prisons."

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CHAPTER 1

INTRODUCTION

by Henry J. Steadman, Ph.D.

Why is there so much attention being paid to local jails in the U.S. today? I would posit that it is a result of three major factors: the growth of their inmate populations; the number and proximity of jails themselves; and their impact on local property taxes. From 1978 to 1988, the number of persons on a given day in a jail in the United States increased 117% from 158,394 to 343,569 (BJS, 1990). These numbers meant that in 1988 there were 9.7 million jail admissions and 9.6 million jail discharges (BJS, 1990). Based on Teplin's (Undated) survey of 542 randomly selected pre-arraignment inmates in the Cook County jail (Chicago), 7% of the inmates were severely mentally ill. Nationally, this would mean nationally that there were 679,000 admissions to U.S. jails in 1988 who are severely mentally ill and as many as 672,000 persons released to the community who were severely mentally ill upon admission.

In addition to a large number of people circulating through the jail, these people tend to be highly visible. Jails are locally based. Their detainees are picked up on nearby streets by law enforcement personnel who live in the same communities. These facilities are not distant prisons, staffed by strangers, which hold offenders for years at a time. Finally, the dollars that pay for jails come from county and municipal budgets. This means that increases in their costs become easily identifiable components of a property tax bill. Jails are not nebulous institutions. They are highly visible facilities whose problems have immediate local impacts.

Key issues about jails tend to be overcrowding, public safety, and construction bonds. While these are debated, little is usually heard about mental health services for jail inmates. Nonetheless, there surely is an appreciation on the public's part that detainee suicides are undesirable events and that "psychos" or "mentals" should not be allowed to attack correction officers or other inmates in the jail. Such untoward events, however, seem to be of public concern mainly from the standpoint of maintaining order in the jails and a safe environment for employees, rather than as humane concern for the individual detainee. Jail detainees tend to be seen as receiving their just desserts, which do not include quality health or mental health services. When there is public interest in improving mental health services for detainees, it is often precipitated either by some botched, highly publicized case that has resulted in an inmate suicide or a serious injury to jail personnel by a mentally disordered person, or by litigation about conditions of confinement.

When public interest in services for mentally disordered persons in the jail is sparked, there is often a tension between forces pushing for the diversion of all mentally ill persons from the correctional system and those pushing for quality core services in the jail for detainees. I say "tension" because neither side really is opposed to the other side. Each is just emphasizing a different set of needs. Those forces highlighting diversion for minor offenders

to mental health inpatient settings in lieu of jail, recognize that there are some seriously disordered, violent persons that require secure correctional detention while receiving appropriate services. Reciprocally, those forces emphasizing in-jail services are not looking to further overburden jails with persons whose behavior in no way compromises public safety. The resonating theme of both approaches is that there are some jail detainees badly in need of help for whom the mental health system has been found wanting and for whom the correctional systems should not always be seen as a substitute.

On the one hand, it is clear that detention for minor disruptive behavior resulting from mental illness should not be a cause for detention in local correctional facilities, which are often badly overcrowded. On the other hand, it is equally clear that there is some very serious criminal behavior committed by persons who are seriously mentally ill and the seriousness of that behavior warrants correctional detention to accommodate criminal justice processing and community safety concerns. In the everyday worlds of mental health, law enforcement, correctional administration, and judicial decision-making, however, the picture of who is responsible for what is rarely clear. Instead, the staff of each of these systems constantly is perplexed by difficult cases of persons badly in need of help who have been poorly handled by each of these systems. Moreover, all too often, even the easy cases are mishandled.

In their 1988 report on "Exemplary County Mental Health Programs", the National Association of Counties (NACo) succinctly captured these dilemmas:

> People with mental illness comprise approximately ten percent of the population of local jails. While some of these people must be incarcerated due to the nature of their crimes, a large portion of them are in the criminal justice system because it is the only resource in many communities available to this population (Adams, 1988:2).

That many communities have no resources other than the jail to serve mentally ill persons is true. However, in many cases the problem is more one of poor coordination of existing resources rather than the total lack of resources. Again, the 1988 NACo report aptly describes this situation:

> Jail is inappropriate treatment for people with mental illness who commit misdemeanors or no crime at all. Such individuals need to be diverted from jail to a continuum of services which include crisis intervention, outreach, residential, vocational training, family support, case management and other community support services. Further, individuals with mental illness whose crimes warrant their incarceration need access to appropriate mental health services. These services should be provided either through linkages with the community mental health system, and/or the development of programs to deliver mental health services in the jail setting (Adams, 1988:2).

MAJOR THEMES

The major themes struck thus far and which are at the core of the rest of this monograph are the following:

- both diversion and in-jail mental health services are desperately needed;
- inadequate resources are a problem, but often a greater issue is the poor use of existing resources and the lack of integration of mental health and criminal justice programs;
- mentally disordered offenders require a full array of services, but the priorities vary by the point at which they are in the criminal justice system;
- community safety and individual rights to treatment are both able to be addressed when the pieces of the two systems are properly coordinated and funded;
- good mental health treatment does not conflict with security concerns; and
- the jail and the mental health problems of its detainees must be seen as a community problem.

In many ways, the last of these themes is the most important. In the early 1980's under NIMH grant support, two colleagues and I did a national survey of 42 jail mental health programs (Steadman, McCarty and Morrissey, 1989). The goal of that study was to determine whether there were certain ways to set up and deliver mental health services to jails detainees that were better than other ways. When we examined those programs that were seen as doing the best jobs of providing essential services, we concluded that there was no one best way to provide those services.

In fact, there was a wide variety of ways in which the more successful programs provided their services. However, while there was no one best way to organize and run those services, there were some principles that cut across all the better programs. Of greatest importance was the idea that, the jail and the mental health needs of its inmates were seen as a community problem. That is, in trying to solve the problems associated with the mental health needs of detainees, the jail was not seen as an isolated institution that should be self-sufficient. Instead, it was recognized by all the better programs that it was but one agency in a continuum of community services.

As we noted in our book:

> To establish appropriate services for such persons requires that the jail be seen as but one agency in a continuum of county services. Indeed, some mental disturbance is a function of the incarceration experience itself, ... However, the more common mental health problems are presented by persons whose existing problems are exacerbated by jail or whose current acute episodes

> have precipitated their arrest and incarceration. As such, the jail is attempting to perform its custodial function of safe pretrial detention while addressing the mental health problems of a community member whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs are defined simply as the jail's problem. The jail is a community institution, and the mentally disturbed inmate is a community problem (Steadman, et al., 1989:126).

Indeed, this concept of the jail as a community organization is the basis of both the conceptual framework of the following chapters and the conference that was the genesis of this book. That April, 1990 conference in Seattle, Washington, "Breaking Through the Barriers: The Mentally Ill in the Criminal Justice System," was one the first attempts in the U.S. to develop a partnership between the families of mental disordered offenders, the providers of mental health services, correctional administrators, elected officials, and consumers themselves. That conference included all of these people coming together to assess what the actual problems were, to interactively develop solutions for these problems, and to create strategies for advocating for these solutions. The policy directions and strategies for accomplishing them produced by that conference represents the final chapter in this monograph.

RESEARCH AS A STARTING POINT

At the core of this monograph is the assumption that the most reasonable starting point to plan and implement essential mental health services for the mentally disordered person in the criminal justice system is to review the research that exists about jail detainees, their mental health needs, and current services to meet these needs. That exercise is important not only for the information itself, but also for the framework used to organize it.

Just as jails and prisons are quite different institutions with substantially different sets of mental health needs and programs, so, too, are there radical differences between the needs of jail detainees depending upon their degree of penetration into the criminal justice system. This monograph is organized by the stages of criminal justice processing. That is, we start with the initial contact that the person on the street has with law enforcement personnel, moving from there to arraignment/booking, in-jail services for those who remain after arraignment or sentencing, and, finally, to continuity of care upon release.

Obviously, although a person may be mentally ill and in contact with the police, he/she is not a mentally disordered offender (MDO). They have yet to be picked up and booked which is required to be included in the group of legal statuses usually included as MDO (Monahan and Steadman, 1983). Their initial contact with the criminal justice system is the decision-making of a police officer, almost a triage in the medical framework. At this juncture, the mentally ill person is really a Mentally Ill Potential Offender (MDPO), i.e. their behavior may have violated a criminal law, but until they are booked, they are a mentally ill person for whom the police officer is making a determination of: (1) whether he/she will do anything; (2) whether he/she will bring the mentally disordered person to a mental health facility; or (3) whether he/she will bring the person to the jail for booking. We have included

an in-depth analysis of this phase of the jail detainees experience here in our analyses of jail mental health issues even though it proceeds a jail encounter, because it is as crucial as any in the criminal justice system, particularly in terms of diversion issues. As Adams noted, "... police and sheriffs are pivotal in responding to emergency situations involving people with mental illness, but they should not and cannot be the sole providers of services for this population." (Adams, 1988)

After initial police contact, the subsequent steps in criminal justice processing into which these chapters are divided are booking, in-jail services, and community linkages. At each of these junctures the primary mental health questions and the range of service responses are quite different. As each of these chapters aptly elucidates, who will provide which services under what circumstances to what ends widely varies. In developing strategies for advocacy for resources and programs, one must be precise about with which point in the systems they are dealing and why they are pushing for the changes they want. Much effort in lobbying is wasted because of a lack of precision on the part of advocates. Just as the researcher must ask appropriate, testable questions then accurately measure the right variables and carefully analyze the data to draw proper inferences, so, too, advocates must carefully define the locus of their issues, carefully target their proposed remedies, and rigorously define what they are requesting.

ORGANIZATION OF THIS MONOGRAPH

The American Psychiatric Association's Task Force 1989 report on Psychiatric Services in Jails and Prisons provides a very sophisticated roadmap for understanding and advocating for system change. The entire approach of the APA Task Force was framed around an appreciation of how service needs vary by the detainee's degree of penetration into the criminal justice system. First, the Task Force distinguished between lock-ups, jails and prisons recognizing that the mental health demands of each of these types of institutions were different. Next, in their identification of services that were essential for adequate care, they identified four categories that represent the sequence that actually occurs upon contact with the criminal justice system. These four categories are :

- screening and evaluation;
- crisis intervention;
- treatment; and
- transfer/discharge planning.

As you look at the next four chapters that follow in this monograph, it will be evident that the chapters parallel these four categories of service. The police officer on the street encountering a potentially mentally disordered person and the intake classification officer in the local jail are the frontline screeners. Following their initial screenings, more intensive in-jail screening and fuller mental health evaluation should occur leading to appropriate crisis intervention and other targeted treatment. With the average length of stay in U.S. jails being

three days (BJS, 1990), the final service category, linking detainees to community-based services, is obviously crucial.

The initial goal of each of the chapters is to review the available empirical data about the mental health issues at each of the key junctures in criminal justice processing. These data include both formal research studies, major statutory reforms and descriptions of illustrative programs. It should be cautioned from the outset that even the best of exemplary programs rarely have evaluation data available. The "exemplary" designation is usually based on positive, but unsystematic, verbal reports and an impressive organization of services.

Teplin's chapter focuses on a topic which ordinarily would not be included in a book on jail mental health services, the police. As we said earlier, we felt that this topic was essential since the police are the gatekeepers for the jail and they have vast discretion in regard to who ultimately appears at the sallyport of the jail. Teplin speaks of the police officer as a "streetcorner psychiatrist". This is much the same conception that Cummming, Cumming, and Edell (1965) had a quarter century earlier when they talked of the police officer as a social worker. Both of these depictions recognize the importance of law enforcement personnel in the delivery of mental health services and, therefore, being informed about mental health issues. Equally important is Teplin's admonition that the law enforcement and mental health systems must work cooperatively. Her comprehensive review of the police-mental health research literature and her discussion of seven illustrative programs makes it clear why these conclusions are warranted and why both systems benefit when they collaborate.

Chapter 3 by Ronald Jemelka highlights issues surrounding the initial contact between the mentally disordered person, the police officer and the jail staff. He emphasizes the many ways in which existing case law and professional associations' standards require thorough screening of all inmates for possible mental disorder. His discussion of the Whatcom County Jail in Washington is especially noteworthy for the way in which it demonstrates the particular importance of screening and diversion for the smaller jail. Another significant feature of his chapter is the analysis of the screening form recently developed by Teplin and Schwartz, which is the first empirically derived instrument of its kind.

Joel Dvoskin's chapter accepts the reality that there will always be some mentally disordered persons in local jails and looks at what services are essential for adequate care. His detailed depiction of the Fulton County jail in Atlanta, Georgia is especially valuable for its demonstration of how important a computerized management information system can be for running an effective comprehensive jail mental health program in a large metropolitan jail. Likewise, his articulation of practical tips on the ways in which a multifaceted jail mental health program can be administered reflects an appreciation of the many resistances to successfully developing such programs.

The fifth chapter by Patricia A. Griffin elucidates a component that is especially crucial for mentally disordered persons who come into contact with the jail, case management to link these persons to community-based services. At least half of all admissions to US jails are gone after three days. Based on a recent study by Axelson (1987) in the Fairfax County (VA) jail, there are now some empirical data to support the long-held belief that mentally

disordered persons consistently stay longer in jail compared to other detainees with the same charges due to concerns about their behavior. Nonetheless, it is important to keep in mind that fundamentally jails are not long-term, people-changing institutions. They are short-term, people-processing institutions. If mental health interventions are to "stick," they must outlast the jail detention. The Griffin chapter offers exceedingly rich detail on how difficult this part of service delivery is, but also how rich are the rewards when it is well done. While she finds few pieces of extant research data in which to build good programs, the principles she offers and her analysis of the successes and challenges of linkage to community-based mental health services in the Dade County Jail in Miami, Florida, provide many solid leads in how to proceed.

The final chapter is a position statement developed by the April, 1990 conference of the Coalition for the Mentally Ill in the Criminal Justice System. Written by Eliot Hartstone, this chapter is a compilation of major directions that need to be taken to improve the mental health services for persons coming into the criminal justice system. These directions and strategies are unique in that they represent input of family members of mentally ill persons who have been, and are, in the criminal justice system. Moreover, they represent what is the best summary of actual steps that can be taken to begin to serve a badly underserved population. The implementation of these recommendations will improve the lot of these inmates in both jail and in the community as well as the difficult working conditions of correction officers and correctional administrators.

Before concluding this introductory chapter, there is one more finding from our earlier study of jail mental health program that warrants mention. It warrants mention because it suggests a formula for successful correctional-mental health collaboration where failure has often been seen as an inevitable outcome. The finding to which I refer is that there is no necessary conflict in the jail between the goals of custody and therapy. That is, the need for security in a jail does not in and of itself conflict with the ideology of therapy at the heart of mental health intervention. Good treatment is good security. The mental health staff and correctional staff we interviewed in the better jail programs did not see themselves at odds with one another.

Early detection, diversion, targeted crisis intervention, stabilization and linkage all mean that safe, pre-trial detention occurs. The detainee does not hurt him/herself or anyone else working or detained in the jail. The detainee's right to speedy processing of his/her charges are protected. The living and working environment of the jail are not further compromised. In accomplishing these ends, the mental health professional in no way needs be compromised in their obligations to their client. They do not become a security agent. They are providing their services in one of the most hostile environments to good mental health that exists today in the United States. They treat their patients with integrity and in doing so collaborate with correctional staff to the benefit of everyone detained or working in the jail and, ultimately, to the community at large.

This monograph, while research based, does not pretend to be value-free. Based on the empirical data reviewed and the personal experience and commitment of the authors of these chapters, we believe there is a critical role for mental health professionals and the families of detainees in the funding, planning, and operation of jails. These roles should be in direct

collaboration with both frontline and administrative correctional staff. In addition, both of these groups must work effectively with both elected officials and the general public if the needs of the mentally disordered jail detainee are to be successfully addressed. The jail is a community facility and the entire community, lay and professional, must be involved in solving its problems if the critical needs of the mentally disordered offender are to be addressed successfully.

REFERENCES

Adams, R.D. (1988). Exemplary county mental health programs: The diversion of people with mental illness from jails and in-jail mental health services. National Association of Counties, Washington, DC.

Axelson, G.L. (1987). Psychotic vs. non-psychotic misdemeanants in a large county jail: An analysis of pre-trial treatment by the legal system. (Doctoral Dissertation) George Mason University, Fairfax, Virginia.

Bureau of Justice Standards (1990). Census of Local Jails, 1988, Washington, D.C.

Cumming, E., Cumming, I., & Edell, L. (1965). Policeman as philosopher, guide and friend. Social Problems, 12, 276-286.

Monahan, J. and Steadman, H.J. (Eds.) (1983). Mentally disordered offenders: Perspectives from law and social science. Plenum Press: New York.

Steadman, H.J., McCarty, D.W. & Morrissey, J.P. (1989). The mentally ill in jail: Planning for essential services. The Guilford Press: New York.

CHAPTER 2

POLICING THE MENTALLY ILL:

STYLES, STRATEGIES, AND IMPLICATIONS

by Linda A. Teplin, Ph.D.

Police have traditionally played a major role in referring persons for psychiatric treatment, particularly within the lower socioeconomic strata (Cobb, 1972; Gilboy & Schmidt, 1971; Hollingshead & Redlich, 1958; Liberman, 1969; Sheridan & Teplin, 1981; Sims & Symonds, 1975; Teplin et al., 1980; Warren, 1977; Wilkinson, 1975). Over the years, however, police handling of the mentally ill has been complicated by public policy modifications, for example, deinstitutionalization, more stringent commitment criteria, and cutbacks in treatment programs (Teplin, in press). As a result, the numbers of mentally ill persons involved with police have increased while, at the same time, the police officer's dispositional options have decreased (Teplin, 1983, 1984a, 1984b).

This paper examines the police officer's role as streetcorner psychiatrist. Three areas are explored. First, we provide background information about the legal structure and public policy changes that affect police involvement with the mentally ill. Next, we review the research literature, focusing on the informal rules that police follow to manage the mentally ill within the community. Finally, we present seven model programs that have been implemented to smooth the often complicated relationship between law enforcement and the mental health system.

BACKGROUND

Police involvement with the mentally ill is based on two legal principles: (1) the police power function, that is, to protect the safety and welfare of the public; and (2) parens patriae, which involves protection for the disabled citizen (Fox & Erickson, 1972; Shah, 1975). Most mental health codes specify the parameters of police involvement with the mentally ill and instruct police to initiate an emergency psychiatric apprehension whenever the person is either "dangerous to self or others" or "because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm" (cf. California Welfare and Institutional Code, 1980; Illinois Revised Statutes, 1981). Thus, police involvement with the mentally ill is mandated by the law and is a traditional component of police work (Bittner, 1967).

Although mandated by law, police involvement with the mentally ill is complicated by recent public policy modifications in the mental health system. Thirty years of

deinstitutionalization has increased the sheer number of mentally ill persons (both deinstitutionalized and never institutionalized) living in the community.

Second, recent cutbacks in funding of mental health services mean that outpatient treatment in effect results in "no treatment." An increasing number of mentally ill persons are denied treatment because there are insufficient programs or they lack their own financial resources (Kiesler, 1982; NIMH, 1985). Cutbacks in mental health funding have also reduced inpatient beds available in public hospitals (NIMH, 1985) as well as the breadth of treatment alternatives (Kiesler & Sibulkin, 1987). These reductions in service are all the more critical when we take into account the changing demographic characteristics of the general population. Due to the coming of age of post-World War II babies, the absolute number of young persons at risk for developing psychotic disorders is overrepresented in the population (Bachrach, 1982).

Third, the recent and more rigorous legal standards for involuntary mental hospitalization mean that the presence of mental illness and need for service are insufficient commitment criteria. Rather, the individual must be seriously mentally ill and dangerous to self or others. Many mentally ill persons who would have been committed in years past may now choose to live in the community without treatment.

In sum, the combination of demographic changes in the general population and deinstitutionalization policies has increased the burden of the mentally ill on police. At the same time, more stringent mental health codes and the diminished treatment options have reduced the referral alternatives available to police officers. Clearly, police now operate in a very different community context.

POLICE DECISION-MAKING

The actual disposition of a mentally disordered person is inherently a complex social process. Although the law provides the legal structure and decrees the police officer's power to intervene, it cannot dictate the police officer's response to a specific situation (Bittner, 1967, 1970). Unlike other professionals, the police do not have a body of psychiatric knowledge to use as formulae in the performance of their role (Rumbaut & Bittner, 1979). One study (Cumming, Cumming & Edell, 1965) found that more than one half of the calls to an urban police department involved calls for help with personal problems, thus requiring the responding officer to perform as an "amateur social worker." As with all law enforcement decisions, the police exercise discretion in choosing the most "appropriate" disposition in each situation (Goldstein, 1979; Gottfredson & Gottfredson, 1980; Manning, 1977, 1984; Smith, 1986; Smith & Visher, 1981; Wilson, 1968).

Mental health situations are further complicated by the nebulous definition of mental disorder. There is a large gray area of behavior that, depending upon cultural values, community context, and administrative practice, might be labelled criminal, psychiatric (Stone, 1975), or merely odd (Monahan & Monahan, 1986). In short, police dispositional decisions vis-a-vis the mentally ill are problematic social judgments.

Obviously, the degree of discretion a police officer exercises is determined by the seriousness of the precipitating event. It may be presumed that the degree of discretion is inversely correlated with the seriousness of the incident. For example, police cannot divert a mentally ill person to a treatment facility if he or she has committed a felony (American Bar Association, 1986). Nevertheless, since most incidents with the police occur when the mentally ill are in need of assistance rather than because they have perpetrated crimes (Teplin, 1985), police generally have a great deal of discretion in managing the mentally ill. Police have three major dispositional alternatives: (1) emergency psychiatric apprehension; (2) arrest; and (3) informal disposition.

Emergency Psychiatric Apprehension

Without exception, studies of police find that officers rarely initiate hospitalizations (Teplin, 1983, in press). Bittner (1967) found, for example, that police sought hospitalization only when a situation had the potential to escalate into a "serious problem" (e.g., danger to life, physical health, property, and/or order). Bittner found that there had to be indications of external risk accompanied by signs of serious psychological disorder (e.g., suicide, distortions in appearance, violent acts, bizarre behavior, public nuisances) in order for the police to justify a psychiatric referral. He concluded that, except for cases of suicide attempts, the decision to take someone to the hospital was based on overwhelming and conclusive evidence of illness. Other investigators have also confirmed police reluctance to initiate an emergency psychiatric apprehension (cf. Mathews, 1970; Rock et al., 1968; Schag, 1977; Teplin, 1984b; Teplin & Pruett, in press; Urmer, 1973). Schag (1977) reported that most police-initiated commitments to mental hospitals were precipitated by an overt act or threat of self-harm. Like Bittner, he found that an act of self injury was a prima facie justification for commitment. If an overt act or threat were not present, knowledge of a person's psychiatric history, creation of a public disturbance and bizarre conduct were all considered in initiating a commitment.

Teplin (1984a, 1984b, 1985) and Teplin and Pruett (in press) examined police involvement with the mentally ill by observing officers on their everyday patrol activities for 2,200 hours over a 14-month period; the database included 1,072 encounters involving 2,122 persons and 283 randomly selected officers. She found that less than 12% of the mentally ill persons coming into contact with the police were brought to the hospital.

The evidence indicates that police hesitate to make mental health referrals because of the structural constraints. Rock and associates (1968) found that the more procedural steps there were between the street and hospital, the less likely that police would make an emergency apprehension. Similarly, Matthews (1970) noted that the police officer must calculate how much time alternative courses of action would consume as compared to hospitalization. Teplin (1984b) and Teplin and Pruett (in press) found that the infrequent use of the hospital resulted from the structural characteristics peculiar to the current post-deinstitutionalization milieu. Although state hospitals were once the primary treatment facility, they have been replaced by community-based mental health centers (many housed within private hospitals), which often have very strict admission criteria. Teplin found that police are acutely aware of the reduced number of psychiatric placements available to them and the stringent requirements for admission into the local psychiatric hospital: The person

must be either actively delusional or suicidal. Police know that alcoholics, narcotic addicts, or persons considered dangerous are persona non grata at the hospitals, even if they also exhibit signs of serious mental disorder. Persons with criminal charges pending, no matter how minor, were also unacceptable. It is common knowledge among officers that if a citizen meets the above-mentioned exclusion criteria, hospitalization is not an available disposition.

Teplin also found that police avoid initiating hospitalizations because they are skeptical of the basic tenets of community based care: brief inpatient stays and community placement. Officers perceive rapid release of their "mentals" to be a personal slight on their judgement, a waste of their time, and an unwillingness by the mental health profession to "do something." These findings thus suggest the importance of special educational programs for police. Without cooperative programs between police and the mental health system, the community mental health system unwittingly discourages police from initiating mental health referrals.

Arrest

Several studies indicate that arrest is used to manage the mentally ill (Rock et al. 1968; Matthews 1970; Urmer 1973; Teplin, 1984b; Teplin & Pruett, in press; in contrast, see Jacobson et al., 1973; Monahan et al., 1979; Bonovitz & Bonovitz, 1981). Teplin found, for example, that while the mentally ill suspects are no more likely to commit serious crimes than the non-mentally ill (Teplin, 1985), their arrest rate was significantly higher (46.7% versus 27.9%) (Teplin, 1984b).

There are a number of reasons why the police resort to arrest. The successful resolution of a police-citizen encounter is defined by police as one in which he or she is not required to return to the scene (Bittner 1967), at least during the same shift. Teplin found that to maximize the probability of a successful resolution, police feel obliged to physically remove the mentally ill person from the situation in two types of circumstances: (1) when the mentally ill person publicly exceeds community tolerance for deviant behavior; and (2) when the officer feels there is a high probability that the person will continue to cause a problem if official action is not taken. In such cases, police would initiate either a hospitalization or an arrest.

But hospitals often reject police-referred patients. For example, Steadman et al. (1986) found that "from the clinician's standpoint, the police brought in the wrong cases, that is, the referrals do not meet the legal criteria for admission" (p. 46). Steadman suggested that the problem is that "the police referrals are not disordered enough... when the person is refused admission, the police officer is forced into an arrest that he/she tried to avoid" (p. 46). Teplin found that arrest is often the only disposition available to the officer in four types of situations: (1) when the person is not sufficiently disturbed to be accepted by the hospital, but is too public in his or her deviance to ignore; (2) when the hospital staff anticipates that the person will become a management problem; (3) when the person is thought to be too dangerous to be treated in the hospital setting; and, (4) when the person suffers from multiple problems (e.g., is both mentally ill and alcoholic) and is difficult to place (see also Matthews, 1970; Urmer, 1973). If a person is rejected by the hospital, the only disposition available to police may be arrest.

Teplin found that it is common practice for the police to obtain a signed complaint from a third party (thus facilitating arrest) even in situations where psychiatric hospitalization is thought to be more appropriate than arrest. This would ensure a ready alternative (arrest) if the hospital finds the individual unacceptable for admission. For police officers, arrest is a viable disposition because they assume that the court routinely evaluates both criminal culpability and the need for psychiatric care; thus, police presume that a mental health diversion is easily accomplished within the criminal justice system (Schag 1977).

The following narrative from Teplin and Pruett's (in press) data illustrates a situation in which the jail is the last stop of several in an attempt to place person who is both mentally ill and intoxicated.

> At 8:00 p.m. we...saw that an ambulance was stopping in back of a parked bus... They [ambulance personnel] ran inside the bus and brought out a large burly black man. The officers exclaimed, "Charlie, what are you doing?" Charlie greeted them with equal friendliness. Evidently, Charlie was the neighborhood character...The bus driver, not realizing Charlie was drunk, was afraid he was ill and had called for an ambulance. The paramedics, seeing that Charlie was only drunk, left him in our charge. The officers asked Charlie if he wanted to go to detox and he said "sure"... The people [at detox] took one look at Charlie and would not accept him. Evidently, he was potentially violent and disruptive...The officers asked if they would sign a complaint. They said yes. Evidently he had been [to the jail] so often that they already had a sheet on him so it was easy to get him into a cell. The officer explained to me that Charlie was a problem because he wasn't crazy enough to go to the mental hospital. The people at [the mental hospital] wouldn't accept him because he was potentially violent and often drunk. The detox people didn't want him, even though he was an alcoholic, because he was potentially violent and bothered other patients with his crazy ways. So that left the jail. They would put him in lock-up overnight; he would go to court in the morning and then would be released. In the meantime, they would get him off the street. Charlie was booked for disorderly conduct. The detox facility was the complainant, although he had done nothing disorderly. (Shift #81, Encounter 3).

In sum, the literature suggests that inappropriate arrests of the mentally ill occur for two reasons: first, because of inadequate liaison between police and the mental health system; second, as a result of the failures of the mental health system. Although arrest is not the predominant disposition, at least some mentally ill are arrested when a mental health referral is more appropriate.

Informal Dispositions

Studies of police involvement with the mentally ill have found that informal dispositions predominate (cf. Bittner, 1967; Schag, 1977; Teplin, 1984a, 1984b; Teplin & Pruett, in press). Requiring neither paperwork nor unwanted "downtime" (time off the street), informal dispositions are the police officer's resolution of choice.

Teplin and Pruett (in press) found that were three types of mentally disordered persons who are likely to be handled informally by police: (a) neighborhood characters; (b) "troublemakers;" and (c) quiet "crazies."

Neighborhood Characters reside in the community. Their idiosyncratic behavior(s) and appearance set them apart. Police know them as individuals and give them nicknames: for example, "Crazy Mary," "Mailbox Mollie," "Dirty Dean," and "Ziggy." Neighborhood characters are often thought to need treatment but are not hospitalized because the familiarity, predictability, and consistency of their eccentricities enable the police and the community to tolerate their deviant behavior. Interestingly, familiarity with a citizen's particular psychiatric symptomatology enables the officers to act as a streetcorner psychiatrist. In this way, police play a major role in managing the mentally ill within the community. Teplin told of the following encounter between police and a neighborhood character:

> A lady in the area claims she has neighbors who are beaming rays up into her apartment. Usually...the officer handles the situation by telling the person, "we'll go downstairs and tell the people downstairs to stop beaming the rays," and she's happy. Officer II seemed quite happy about this method of handling the problem (Shift #220).

Troublemakers, unlike neighborhood characters, are unpredictable. Police use informal dispositions with troublemakers because these people are thought to be too difficult to manage in any other way. Their psychiatric symptoms cause disorder in the community and disrupt the routine of the police, as Teplin indicated in the following vignette:

> Whenever she came into the [police] station she caused an absolute disruption. She would take off her clothes, run around the station nude, and urinate on the sergeant's desk. They felt it was such a hassle to have her in the station, and in lock-up, that they simply stopped arresting her. (Shift #036).

Quiet "Crazies," persons whose symptoms of mental disorder are relatively unobtrusive, are also likely to be handled informally. They offend neither the community nor the police with vocal or visual manifestations of their illness. Because their symptoms are neither serious enough to warrant hospitalization, nor disruptive enough to result in arrest, they are handled informally.

> She [complainant] said the man down the block...had been trying...the door next to her restaurant...Both officers recognized the man as a street person...This was clearly a mental health case not going to [the hospital] based on discretion used by the officers...the man was wearing several stocking caps underneath the helmet, a pair of hexagonal shaped glasses, over safety goggles, several scarfs around his neck...4-5 layers of shirts, sweaters, jackets topped by an overcoat...carrying a brown shopping bag...and a cardboard box...Officer I searched him...as Officer I was taking information...the man kept saying "thank you" after he found out he was not going to be arrested...The man said he'd seen a psychiatrist in Kentucky and Indiana. The man said he'd never been to [local hospitals]...Officer II said, "[hospital] probably wouldn't have wanted that man

> anyway." He said they would have let him go when they saw he was coherent and they don't care for the street or shopping bag person...It was clear that Officer II saw [hospital] making clear discriminations about who were likely prospects for being kept there. (Shift #213, Encounter 1).

The police officer's decision to make an emergency psychiatric apprehension, arrest or manage a mentally ill person by informal means is based less on the degree of psychiatric symptomatology than on the socio-psychological and structural factors pertinent to each situation. By and large, the police do not rely on conventional mental health resources for several reasons. Sometimes there are few services or facilities for the kind of mentally ill person the police must handle. If there are appropriate services, the police may not be aware of them. Overall, the mental health system does not assist or utilize police officers in the role of streetcorner psychiatrist.

PROGRAMS[1]

How can we improve the relationship between police and the mental health system? How can we encourage police to make mental health referrals? How do we reduce the number of inappropriate arrests? A number of police departments have become increasingly aware of their pivotal role as a mental health resource. Mental health care providers also are increasingly aware that police officers can direct mentally ill citizens -- many of whom might otherwise never receive treatment -- to appropriate care. This section describes seven communities where the police and the mental health system have established a collaborative relationship: Birmingham, Alabama; Erie, Pennsylvania; Galveston County, Texas; Madison, Wisconsin; Montgomery County, Pennsylvania; Los Angeles, California; and Washtenaw County, Michigan. These seven networks were chosen because they illustrate diverse service delivery possibilities and exemplify a wide range of roles for both law enforcement and mental health professionals.

Table 1 shows the different ways the mental health system provides direct assistance to regular patrol officers. Table 2 compares the important structural features which support and maintain each network. These networks serve populations that vary in size from 117,000 (Erie) to 3,000,000 (Los Angeles); large urban areas, rural counties and mid-sized cities must have networks to fit their unique needs. Many of these networks began in response to public policy changes in the mental health system. For example, deinstitutionalization and an influx of mentally ill citizens were stimuli for programs in Madison, Galveston and Birmingham. Laws requiring 24-hour emergency psychiatric services or increased police involvement spurred officials to form the networks in Erie, Los Angeles and Montgomery County.

Some of these programs did not require increased funding or additional services. The Los Angeles network, for example, which serves a very large population, collaboration was achieved by involving all the major social service agencies, reassigning personnel, and sharing information; new services or facilities were not required. The Washtenaw network likewise did not require new services or facilities and achieved its goal by involving the important governmental and social service agencies.

While each network is unique in some respects, all share a common philosophy: without special training or assistance from the mental health system, law enforcement personnel are ill-prepared to effectively handle mentally ill citizens. All seven networks recognize that mentally ill citizens are ultimately the proper responsibility of the mental health system, but that police officers are a valuable resource if existing mental health services -- whether extensive or sparse -- are provided to the citizens who need them. The Los Angeles, Galveston and Madison programs have diversion of mentally ill citizens to the mental health system as a major stated goal.

Four networks (Birmingham, Erie, Galveston, and Montgomery) relieve regular officers of transporting mentally ill persons to hospitals for evaluation, thus eliminating this particularly frustrating and often unrewarding procedure for police officers. The sheriff's department in Washtenaw pays for taxi transportation if a mentally ill citizen can be taken home or voluntarily referred to a service facility. When officers are responsible for transporting citizens to the hospital and are involved in the evaluation process, the value and difficulty of this effort is recognized. Hospital staff frequently know that the police officer has been specially trained, is aware of other local resources, and is referring a person who likely needs hospitalization. The officer may even know the mentally ill person and his or her treatment plan from previous encounters. Feedback to officers on the outcome of individual cases, streamlined hospitalization procedures, and letters of thanks or commendation are all tangible evidence to regular officers that they make a unique contribution.

All seven networks provide 24-hour access to phone consultation and on-the-scene assistance. Each network has enlisted other local social services agencies, either formally or informally, in their efforts to deliver services. The networks differ, however, in the mode of service delivery. A permanent facility for psychiatric emergencies was the solution in Montgomery County. In Birmingham, civilian social workers operate from police headquarters; in Galveston, specially trained sheriffs work out of the regional mental health center. Three networks (Erie, Galveston and Los Angeles) have special police units to assist officers. Five networks (Birmingham, Erie, Madison, Montgomery and Washtenaw) rely on civilian professionals. All networks but two (Erie and Galveston) train regular patrol officers to screen for mental illness and stabilize situations until a mental health unit arrives.

The following section describes the unique collaborative systems in each of the seven communities.

Birmingham, Alabama

Background and History. In 1977, the University of Birmingham and the police department collaborated on a project where social workers assisted police officers with calls involving the mentally ill or other citizens in need of social services. Initially, graduate students in social work rode with patrol officers and offered advice. After experimenting with various arrangements and structures, the police department currently has a staff of six civilian social workers, two of whom are assigned to the jail.

Although the population of Birmingham is only 283,000, there are an estimated 12-14,000 (Finn & Sullivan 1987) homeless mentally ill persons because this city is the

headquarters for the Supplemental Security Income branch of the Social Security Department. Many people who receive public assistance mistakenly believe they can increase their benefits if they appeal in person to SSI, and they travel to Birmingham (the return address on their benefit checks) with few resources. Because the social workers' intervention is in great demand, officers usually call on them only for assistance with mentally ill citizens.

Structure. The social workers, called Community Service Officers (CSOs), are stationed in police headquarters. They are available to the police around the clock, either on duty (seven days a week, 8 a.m. to 11 p.m.) or on-call. They train all police officers in how to handle cases involving the mentally ill but, if called to the scene of a disturbance, can take over if there is no violence or need for the officer's authority. The CSOs act as liaison among law enforcement, mental health and legal domains and mediate problems between the police and the service agencies. Police officers are informed of the disposition of cases where a CSO has been called to assist. CSOs also review referrals made by officers on their own.

Procedures. The CSO handles referrals, contacts relatives, secures treatment, and pursues hospitalization if necessary, allowing the officer to return to his or her regular patrol. If the citizen is violent, both the officer and the CSO accompany him or her to the hospital. CSOs can take over involuntary examination and hospitalization procedures, which last from two to eight hours. In less severe situations, officers refer citizens to the Salvation Army for overnight shelter, and the CSOs follow-up the next morning. One hospital gives priority to police referrals.

Evaluations, Impact, Success. The CSOs have better access to the mental health-social service world because they are recognized as professionals in this field, thus eliminating many frustrations a police officer faces when trying to obtain similar services for a citizen. Citizens in need of services are also more responsive to the CSOs because the trappings of official and sometimes threatening or negative authority of law officers do not accompany the CSOs.

Birmingham appears to have adequate facilities for the mentally ill -- more than 80 boarding homes, three regional mental health centers, and three hospitals for emergency evaluations (Murphy 1986) -- but there is no coordinated system for delivery of these services. Birmingham has had to devise various funding strategies to maintain this arrangement. A comprehensive system of mental health services does not exist here, yet public officials and the police have persisted in this collaboration. In 1985, the two CSOs on duty handled an average of three calls a day (Finn & Sullivan 1987). During three months in 1986, the police department calculated that over 178 hours of patrol officer time were saved by using CSOs to transport mentally ill citizens for evaluations (Finn & Sullivan 1989).

Erie, Pennsylvania

Background and History. The police chief of Erie and the county mental health administrator initiated an arrangement after a hostage-murder situation involving a mentally ill person in 1972. Since 1966, state law has required that emergency mental health services be available, and the county had already contracted with a local mental health clinic to provide these services.

Structure. The police department and the county's emergency mental health service (Family Crisis Intervention, Inc.) have a written agreement to assist each other as necessary in social problem calls (mental, inebriates, domestic, overdoses, child abuse, etc.). The police department provides, equips and staffs the 201 Unit, a regular police patrol car designated to respond to calls involving the mentally ill. The nine officers assigned to the 201 Unit perform regular patrol duties when not handling special cases.

Procedures. The 201 Unit officers are trained by the Family Crisis Staff to screen for mental illness, to know what social services are available, and what state laws allow and require of them. Regular patrol officers can call the 201 Unit or Family Crisis for advice on how to handle a mentally ill citizen. Because the 201 Unit is not always available to regular patrol officers, the Family Crisis staff is available 24 hours a day for advice or on-site assistance.

If they initiate emergency detention, the 201 Unit officers transport the citizen to a facility for evaluation. If the citizen is not hospitalized, the 201 Unit transports him or her to a shelter or to where he or she was found, if it is safe.

In the written agreement, both parties agree to not "intrude into the jurisdiction of the other" (Finn & Sullivan 1987) and police officers decide when a crime has been committed and whether or not to initiate involvement of the Family Crisis staff. Both parties have also expended considerable effort to identify local human service providers and forge informal alliances with them, even going so far as to train the agencies' staffs how to work with the police, and what laws apply and require.

Evaluations, Impact, Success. The 201 Unit-Family Crisis alliance meets with new programs and works to establish a suitable relationship and expand the alternatives available. They also help smaller law enforcement bodies in the county by conducting training sessions and helping to smooth out the admission process at local hospitals. Family Crisis is available to all police departments in the county for phone consultation or on-site assistance.

Galveston County, Texas

Background and History. In the late 60's and early 70's, deinstitutionalized mentally ill citizens in the jail became a big management problem for the sheriff. A change in the state mental health laws further complicated problems for police: Any officer who learns from a credible source that a mentally ill individual is likely to cause harm to self or others must get a warrant from a judge, take custody and transport the citizen to a hospital for an evaluation.

The sheriff initiated discussions with the mental health center, which grew into a formal community effort involving numerous social service agencies and governmental entities. A county court committing judge and a county psychiatrist, both concerned that the mentally ill in the criminal justice system were not receiving care, involved the court system in the program begun by the sheriff.

Structure. The written agreement is between the sheriff's department, county commissioners, and the regional mental health center. It acknowledges that the three parties

share responsibility to provide emergency mental health and other social services. Each party's role is established in writing and all parties agree on the goals. The original agreement has been expanded to include other county agencies providing social services (welfare department, juvenile service, shelters, etc.). A primary goal is "to avoid inappropriate institutionalization or incarceration" (Murphy 1986).

Five specially trained mental health deputies work out of the Gulf Coast Regional Mental Health-Mental Retardation Center. They work in plainclothes and unmarked cars. At least one officer is available 24 hours a day; two are on duty from 8 a.m. to 8 p.m. The mental health deputies are highly trained in medical and mental health emergencies. They go to the scene of a disturbance or to a centralized location, where they can evaluate a citizen. They can provide referrals, or get a warrant to transport the citizen to a facility for an emergency evaluation. They also screen jail inmates who develop problems and may need to be seen by a psychiatrist. These officers also conduct investigations for the courts to determine the need for psychiatric evaluation or civil commitment.

Procedures. Most calls to the special unit come from other patrol officers or the dispatcher, but some also come from the court, relatives of the mentally ill, emergency medical services or outpatient services. If the citizen is thought to be in need of hospitalization, the mental health deputy assumes responsibility for initiating the emergency evaluation process. After a citizen is released from the hospital, the mental health center offers follow-up support and referrals.

Prior to the collaboration, police officers would take all suspected mentally ill citizens to one hospital, which created friction because of inappropriate referrals and frustration for the officers, who spent many hours waiting at the hospital. Mental health deputies are now trained as paraprofessionals; their referrals are more readily accepted by the hospital. The deputies also have alternatives to hospitalization. Because they work out of the mental health center's offices, the deputies can easily confer with the mental health workers. Law enforcement and mental health records are kept separately, but a mental health file of each contact the unit makes is kept active for six months.

Evaluation, Impact, Success. This program is by all estimates a great success and has won an award for innovation from the American Psychiatric Association. Efficiency of the regular deputies is improved because specialized deputies are available to handle mental health calls. The officers' frustrations are reduced because they now avoid annoying the emergency room staff with inappropriate referrals. Citizens are more likely to receive appropriate services and continuity of care from a coordinated network. Admissions of mentally ill persons to jail have been reduced by 99% (Murphy 1986). Galveston County has the lowest rate of involuntary hospitalization in Texas and one of the lowest in the country (Murphy 1986).

Madison, Wisconsin

Background and History. A police chief who had philosophical conflicts over jailing mentally ill suspects and who believed the police were "frontline social service providers" (National Coalition of Jail Reform 1984) created the position of Social Service Coordinator

in 1973. This innovation coincided with an influx into Madison of deinstitutionalized patients from the state mental hospital. The county mental health center responded to this influx with a comprehensive program to provide clinical and emergency services and a mobile treatment unit.

Both agencies were initiating change simultaneously, which facilitated collaboration. The mental health center staff rode with police officers to learn about police work and recognized the importance of the police viewpoint. Officers experienced with crisis intervention, particularly situations involving firearms or violence, trained the health center staff. The mental health center involved community, business and professional organizations, as well as social service agencies, at the planning stage, which improved the chances for success.

Structure. The city police department and the county mental health center have a formal written agreement. Other social service providers (detox, rape crisis, etc.) are involved informally. The Social Services Coordinator (SSC) -- a police officer -- develops department policy for handling the mentally ill, public inebriates and other citizens who need services, and resolves problems between officers and social service providers. Because this person is in the police department, regular patrol officers are not hesitant to communicate their concerns and problems. The SSC has full-time responsibility to solve these problems.

The county mental health center has operated the Crisis Intervention Service (CIS) since May, 1975. This service is available to police officers anywhere in the county 24 hours a day for phone consultation or on-the-scene assistance. CIS provides emergency intervention as well as non-crisis services such as treatment plans and long-term follow-up.

The mental health center also operates the Mobile Community Treatment Unit, which receives referrals from hospitals, social service agencies and the police. This unit provides intensive follow-up to patients released from the hospital and strives to avert unnecessary hospitalizations and arrests. The goal is to provide long-term community treatment for the chronically mentally ill.

The mental health system extends into the court system and jail. The district attorney's office consults with the mental health center when deciding to charge suspected mentally ill persons and designates four full-time employees to handle probable cause hearings and commitment trials. The county jail has two full-time mental health professionals to screen and counsel inmates. Clients of the mental health center continue to receive treatment if they are arrested and jailed.

Procedures. Recruits receive extensive training conducted by both the SSC and the mental health department's CIS and mobile treatment unit staffs. Patrol officers are given information about known mentally ill individuals in their areas, which prepares them for possible encounters and appropriate dispositions. They are required to consult with the mental health center staff before detaining or transporting a citizen for an involuntary examination. The SSC reviews police reports of encounters with mentally ill citizens to determine if officers understand and follow department policy and to identify citizens who are chronic "offenders." Some of the reports are sent to the mental health center staff for review. The SSC thus

becomes an important element in identifying problems within the police department as well as individual citizens who repeatedly come to the attention of patrol officers. The SSC also monitors the responsiveness of the CIS, a timely response being of great importance to patrol officers requesting assistance.

All police officers have a clear, written policy for dealing with mentally ill citizens and are encouraged to handle cases on their own. Beyond release and referral, officers consult with CIS staff by phone or request on-the-scene assistance to effect voluntary or involuntary examination. State law allows officers to initiate emergency detention procedures without consulting CIS, but the department's policy is that officers should consult first. Officers have the authority to place violent mentally ill citizens in the state mental hospital and even to overrule the evaluating psychiatrist if he or she does not recommend temporary custody. When the offense is merely minor abnormal behavior, the officer can arrest a citizen for statutory violations which, unlike ordinance violations, allow the court to order treatment.

Police officers get feedback, usually in writing, from the mental health center on all referrals. Thus, officers know the results of their interventions and the treatment plans for individual citizens, and it acknowledges the important role police officers play. In exemplary cases, the officer receives a letter of commendation.

Evaluation, Impact, Success. CIS averages 150 referrals a month; one third of these come from law enforcement agencies (Murphy 1986). Both the police department and the mental health center were obviously committed to fostering a successful network early on. During the time officers were being trained in how to refer mentally ill citizens, local hospitals agreed to accept all citizens brought in by the police. CIS policy recognized the difficulty officers face and acknowledged the mental health system's responsibility for mentally ill citizens. Inappropriate hospitalizations and incarcerations have been reduced.

Police call the mental health center an average of 50 times a week (Finn & Sullivan 1987). Both parties are committed to help one another and to involve other community resources, with the main goal being efficient delivery of appropriate services. The county's mental health system seems unusually dedicated to providing a wide range of immediately available services to all mentally ill citizens. The police chief's recognition of the social service aspect of police work is also an inspiring element of this network.

Montgomery County, Pennsylvania

Background and History. In 1966, a new state law required that every county provide 24-hour emergency mental health services. Four years after the passage of the law, emergency services in Montgomery County still were not in place, although a board composed of the mental health center directors was considering methods and designs to comply with the law. The county mental health administrator recommended that a temporary center handle psychiatric emergencies until the six county mental health centers could expand their operations to 24 hours. Before a design and location were fixed, representatives of the criminal justice system and drug and alcohol agencies were involved, expanding the scope of the envisioned service.

The need for a permanent facility became apparent, one to handle not only psychiatric emergencies but drug and alcohol crises as well. An unused building on the grounds of the state mental hospital was renovated with $300,000 from the county and is now used for the services described below.

The Montgomery County Emergency Service (MCES) is a private, non-profit hospital geared to handle psychiatric, drug and alcohol emergencies. It is the county's only designated facility for involuntary commitment and is required by law to evaluate the condition of any suspected mentally ill person brought there.

Structure. In addition to in-patient care and emergency evaluations, the MCES provides a Criminal Justice Liaison, an ambulance service, referral service, emergency detox (alcohol and drug), and a 24-hour hotline. These services are tailored to the needs of persons referred by the police and social service providers, but they are also available to other agencies and any citizen requesting help with a mentally ill friend or relative. Before the emergency service was established, police had only two alternatives: local mental health centers, which did not have 24-hour services, and local hospitals, which were reluctant to admit many of the cases brought in by police.

The Criminal Justice Liaison, a position funded by the police department, trains county police officers and other social service staff in crisis intervention, commitment procedures and appropriate use of emergency services. Police officers receive follow-up information on the citizens they have referred. The liaison also meets with 57 county police chiefs at least once a year to identify problems and handles problems between police departments and social services agencies.

Procedures. Police officers are provided with a "cop card" by MCES with information about how to use MCES services. Officers are encouraged to handle on their own cases which are not serious and to involve the families of suspected mentally ill citizens. MCES provides phone consults and may send its ambulance to the scene for crisis intervention and transport citizens thought to be in need of involuntary commitment to the MCES hospital. Officers may also transport citizens directly to the hospital without consulting the hotline.

Evaluation procedures for emergency commitment have been streamlined. Once the emergency service staff approves an officer's petition for psychiatric evaluation, the officer can return to duty. If the petition is approved, the individual is evaluated by a psychiatrist. If hospitalization is unnecessary, MCES provides referral and transports the citizen home or to another facility and even arranges follow-up. Officers who initiate emergency evaluation procedures are not off the street for hours waiting for the end of the process.

Evaluation, Impact, Success. It appears that groundwork was carefully laid before a plan was put into operation, perhaps because of the slow progress at initial stages, but also perhaps because the range of social problems to be addressed grew. Thirty-five to 40% of MCES patients are referred by police officers (Finn & Sullivan 1987). The county has urban, small town and rural police departments, and the centralized service takes a regional approach to meeting diverse needs. The MCES is almost financially self-sufficient through health insurance reimbursements, fee-for-service operations and government health care programs.

Between 1975 and 1983, the ambulance service alone saved an estimated 8,420 hours of police time (Finn & Sullivan 1987).

Los Angeles, California

Background and History. In 1984, after two fatal incidents involving mentally ill citizens resulted in the deaths of one police officer and two children, the chief of police initiated discussions with top officials of ten criminal justice and social service agencies. The goal was to design a protocol to divert the mentally ill misdemeanant from the criminal justice system into the mental health system.

This arrangement is a written, formal agreement, in effect since April 1985. The main participants are the county department of mental health and the city police department, but the city fire department, city health department, county district attorney's office, city attorney's office, and county regional centers for persons with developmental disabilities also participate. The agreement requires the police and the mental health department to consult with each other when handling the mentally ill.

The agreement to collaborate, plus a new law enacted in 1985, highlighted shortcomings in the mental health services available at that time. Previous to the new law, psychiatric facilities were required to perform emergency evaluations, but the lack of bed space was used as an excuse to refuse police-referred citizens. After the 1985 change, mental health personnel could no longer use the this excuse, and police officers -- by law -- could not be detained longer than necessary to transfer custody of the person. While easing the burden mentally ill citizens place on police officers, the new law revealed an actual shortage of bed space for psychiatric emergencies, and there is now a centralized daily accounting system of available beds. Additional funding was not necessary to operate this network because no new services or facilities were needed.

Structure. The police department expanded and revitalized a mental health emergency command post already in existence. A mobile unit staffed with ten officers trained by the department of mental health provides patrol officers with consultation by phone, evaluates citizens brought to the unit's office, and assists at the scene of crises involving mentally ill citizens. Social service agency personnel are also trained by the mental health department. Officers from the special unit familiarize mental health workers with police issues regarding the mentally ill. The District Attorney's office apprises mental health and ER personnel of legal aspects of commitment.

The mental health department provides 24-hour accessibility to a resource person to resolve particularly urgent situations involving the mentally ill. Mental health and police departments provide each other with 24-hour access to a high level administrator to resolve disagreements. The District Attorney's Psychiatric Section instructs mental health personnel on legal aspects. Police-based information (both arrest history and mental illness contacts) is available to beat officers and mental health workers alike, often preparing them for situations involving dangerous citizens, and the mental health department reciprocates with information from its files to the extent allowed by confidentiality laws.

Procedures. Police officers are required to call the special unit before transporting suspected mentally ill persons to a hospital or booking them for a crime. Special unit officers can recommend the citizen be brought to the command post for a brief evaluation to determine if a more lengthy hospital evaluation is needed. When the citizen needs an emergency evaluation at a hospital, the patrol officer transports him or her. The special unit can locate the nearest available facility through the centralized accounting system for beds. The transporting officer is assured of bed space for the citizen, and the receiving hospital is assured that the citizen has been screened by a mental health unit officer.

Special unit officers and mental health staff can collaborate at the scene and share information on a particular citizen. Police can request that they be notified when a hospitalized patient is released. The District Attorney's office is also available through a 24-hour hotline for on-the-spot legal opinions.

Evaluation, Impact, Success. The special mental health unit receives an average of 550-600 calls a month from LA's 7,000 police officers (Finn & Sullivan 1989). Diversion from the criminal justice system to the mental health system is a stated objective of the agreement (Finn & Sullivan 1987). Mentally ill citizens receive appropriate care with a minimum investment of police time. The original committee of ten, all signatories to the agreement, continues to meet monthly to resolve interagency problems, indicating a continuing high level of commitment.

Washtenaw County, Michigan

Background and History. In 1978, the Michigan State University School of Criminal Justice chose the sheriff's department of this county as a research site to "study and facilitate interagency communication and cooperation between social services and law enforcement" (Finn & Sullivan 1987). The study highlighted the problem posed to the police, and the researchers devised a structure for collaboration to focus on the emergency needs of the mentally ill. A six-month pilot project was tested and, after kinks were ironed out, eventually adopted as a permanent network with written procedures for assisting sheriff's deputies. The county (pop. 265,000) is an urban-rural mixture, also demographically and racially mixed, served by 150 sheriff's deputies.

Structure. The researchers developed a bi-level team structure which involved the county's public service agencies (police, mental health, planning department, social services, health, and the United Way) plus hospital ER staffs and the regional psychiatric facility. The Policy Team is made up of executive directors of the agencies; the Operational Team is made up of mid-level agency managers.

Mental health and sheriff's personnel conducted cross-training at the beginning stages. Training continues but now each department is responsible for its own training. Each agency designates one person as liaison responsible for inter-agency communication and monitoring problems. The most important feature of the network is "readily available communication and decision-making authority at the policy level" and "quick and thorough implementation of policy decisions by the Operational Team" (Finn & Sullivan 1987).

Deputies have 24-hour access to a hotline and a civilian mental health unit which can assist at the scene of disturbances. Deputies participate in discussions at hospitals when a psychiatrist considers involuntary commitment of a citizen referred by police. Deputies are informed of dispositions by the mental health center.

Procedures. The police officers make initial decisions about suspected mentally ill citizens. If the deputy believes the citizen is sober and not injured, he or she phones the mental health center for a recommendation. The options are referral and release, arrest, or hospitalization. Usually friends and relatives are contacted to transport the citizen home or to a hospital for voluntary evaluation. If friends or relatives are not available, the sheriff's department pays for taxi transportation and the deputy returns to regular duty.

If the mental health center clinician believes the citizen needs an involuntary evaluation at a hospital, the clinician contacts the nearest psychiatric facility and makes arrangements. The deputies transport the citizen to the regional psychiatric hospital for a second evaluation. The same options are available at this stage -- referral and release, arrest, or hospitalization.

When citizens are volatile or violent, the mental health center dispatches a two-person team to the scene for crisis intervention. Deputies may also transport citizens directly to the mental health center in extreme cases such as suicide attempts.

Deputies carry two kinds of wallet cards: one with the steps they should follow when handling suspected mentally ill citizens, and one which lists non-emergency services for citizens and their families.

Evaluation, Impact, Success. The initial research project was funded by NIH but none of the agencies involved incurred additional costs or had to add new services to participate in the network. The Policy Team continues to meet to resolve mental health policy issues. It has identified other public health problems and assembled Operational Teams composed of the agencies responsible for each problem.

CONCLUSION

Although managing mentally disordered persons in the community has always been a necessary part of police work, in recent years the police officer's role has been greatly expanded. Resolution of incidents involving the mentally ill are not determined by the legal structure, however. Whether the disordered individual is defined by police to be "bad" (and should be arrested), "mad" (and therefore hospitalized), or merely "eccentric" is highly discretionary. This paper demonstrates that one of the major variables that influences the police officer's dispositional decisions is the presence of a successful liaison with the local mental health facility. This suggests that the two systems -- police and mental health -- must work cooperatively. Mental health systems must acknowledge the importance of police in managing the mentally ill, and assist them by developing cooperative programs. On the other hand, police departments must accept their role as streetcorner psychiatrist. Training is needed, such as that offered in many of the model programs described above. In addition,

police must modify the current rewards structure to reward police for managing the mentally ill. Police officers should be given commendations for making an appropriate emergency psychiatric apprehension in the same way that they are commended for making a "good pinch." If both police departments and the mental health system work cooperatively, the management and treatment of the mentally ill within the community will be greatly enhanced.

Table 1. Model Networks for Collaboration: Assistance to Regular Officers from Mental Health System

Location, population, & year begun	Assistance for officers from: Police	Civilian	Type of assistance available	Regular officers relieved of: Transport	Evaluation & Commitment	Mental health training for all officers	Feedback to regular officers on case outcome
Birmingham, AB 283,000 1977	No	Yes (Social workers)	24-hr. on-site crisis intervention; referral; liaison with social service agencies	Yes	Yes	Yes	Yes
Erie, PA 117,000 1972	Yes (Mental health unit)	Yes (Mental health professionals)	24-hr. police & civilian crisis intervention, on-site & hotline,	Yes	Yes	No	NA*
Galveston County, TX 194,000 1975	Yes (Mental health deputies)	No	24-hr. on-site crisis intervention; screening; referral	Yes	Yes	No	NA*
Madison, WI 180,000 1973	Yes (Dept. liaison/ coordinator)	Yes (Mental health professionals)	24-hr. hotline & on-site crisis intervention provided by mental health department	No	No	Yes	Yes
Montgomery County, PA 650,000 1974	No	Yes (Mental health professionals)	24-hr. hotline, on-site crisis intervention & referral provided by psychiatric hospital	Yes	Yes	Yes	NA*
Los Angeles, CA 3,000,000 1985	Yes (Mental health unit)	No	24-hr. phone consult & on-site crisis intervention	No	No	Yes	Limited
Washtenaw County, MI 265,000 1978	No	Yes (Mental health professionals)	24-hr. phone consult, on-site crisis intervention, referral	No	No	Yes	Yes

*Regular officers' investment of time and effort in handling mentally ill citizens is minimal.

Table 2. Structural Characteristics of Seven Model Networks

Network	Written agreement to collaborate between police & mental health system	Type of emergency psychiatric & community social services available	Annual network expenses & source of funding[1]
Birmingham, AB	No	Several hospitals, clinics, & mental health centers. University Hospital gives priority to police referrals. Salvation Army & "social service agencies"	$200,000 City
Erie, PA	Yes	2 county psychiatric facilities; local hospitals; "dozens of human service providers"	$225,000 State $25,000 City
Galveston County, TX	Yes	Univ. of Texas Hospital; regional mental health center; state mental hospital welfare & human resources dept.; youth shelters, YWCA, area drug & alcohol agencies	$434,000 Regional Mental Health Center
Madison, WI	Yes	Extensive 24-hr. emergency services available from county mental health center; "2 dozen social service agencies, including state mental hospital, rape crisis centers, and detox.	$35,000 City
Montgomery County, PA	No	Permanent emergency psychiatric hospital; "social service agencies"	$170,000 County $2,000 City
Los Angeles, CA	Yes	Various 24-hr. psychiatric emergency units (mandated by law); 10 criminal justice & social service agencies signatories to written agreement	None*
Washtenaw County, MI	Yes	Mental health dept. emergency services unit; 2 hospital-based emergency services; regional psychiatric hospital; major county public service agencies signatories to agreement	None*

[1]Finn, P. & Sullivan, M. (1989).
*Network did not require new facilities or services.

FOOTNOTES

1. The material in this section and in Tables 1 and 2 has been excerpted or adapted from information presented in the following publications:

Finn, P. (1989). Coordinating services for the mentally ill misdemeanor offender. Social Service Review, March, 127-141.

Finn, P. & Sullivan M. (1989). Police handling of the mentally ill: Sharing responsibility with the mental health system. Journal of Criminal Justice, 17, 1-14.

Finn, P. & Sullivan M. (1987). Police response to special populations. U.S. Dept. of Justice, National Institute of Justice.

Murphy, G.R. (1986). Special care: Improving the police response to the mentally disabled. Washington DC: Police Executive Research Forum.

National Coalition of Jail Reform (1984). Removing the chronically mentally ill from jail: Case studies of collaboration between local criminal justice and mental health systems. Washington DC: Author.

REFERENCES

American Bar Association (1986). The ABA Standards for Criminal Jusitce (2nd Edition). Washington, DC: Author.

Bachrach, L.L. (1982). Young adult chronic patients: An analytical review of the literature. Hospital and Community Psychiatry, 33, 189-197.

Bittner, E. (1967). Police discretion in emergency apprehension of mentally ill persons. Social Problems, 14, 278-292.

Bittner, E. (1970). The function of police in modern society. Washington, DC: National Institute of Mental Health.

Bonovitz, J. & Bonovitz, J. (1981). Diversion of the mentally ill into the criminal justice system: The police intervention perspective. American Journal of Psychiatry, 138, 973-976.

California Welfare and Institutional Code 5150 (West 1980).

Cobb, C.W. (1972). Community mental health services and the lower socioeconomic classes. American Journal of Orthopsychiatry, 43, 404-414.

Cumming, E., Cumming, I., & Edell, L. (1965). Policeman as philosopher, guide and friend. Social Problems, 12, 276-286.

Finn, P. (1989). Coordinating services for the mentally ill misdemeanor offender. Social Service Review, March, 127-141.

Finn, P. & Sullivan, M. (1987). Police response to special populations. U.S. Department of Justice, National Institute of Justice, Office of Communication and Research Utilization.

Finn P. & Sullivan, M. (1989). Police handling of the mentally ill: Sharing responsibility with the mental health system. Journal of Criminal Justice, 17, 1-14.

Fox, R.G. & Erickson, P.G. (1972). Apparently suffering from mental disorder. Toronto, Canada: University of Toronto Centre of Criminology.

Gilboy, J.A. & Schmidt, J.R. (1971). "Voluntary" hospitalization of the mentally ill. Northwestern University Law Review, 66, 4-11.

Goldstein, P.J. (1979). Prostitution and drugs. Lexington, MA: Lexington Books.

Gottfredson, M. & Gottfredson, D. (1980). Decision making in criminal justice: Toward the rational exercise of discretion. Cambridge, MA: Ballinger Publishing Co.

Hollingshead, A.B. & Redlich, F.C. (1958). Social class and mental illness. New York: John Wiley & Sons.

Illinois Revised Statutes. ch. 91 1/2 3-606 (1981).

Jacobson, D., Craven, W. & Kushner, S. (1973). A study of police referral of allegedly mentally-ill persons to a psychiatric unit. In J. Snibbe & H. Snibbe (Eds.), The Urban Policeman in Transition: A Psychological and Sociological Review. Springfield, IL: Charles C. Thomas.

Kiesler, C.A. & Sibulkin, A.E. (1987). Mental hospitalization: Myths and facts about a national crisis. Beverly Hills: Sage Publications.

Kiesler, C.A. (1982). Public and professional myths about mental hospitalization: An empirical reassessment of policy-related beliefs. American Psychologist, 37, 1323-1339.

Liberman, R. (1969). Police as a community mental health resource. Community Mental Health Journal, 5, 111-120.

Manning, P. (1977). Police work: The social organization of policing. Cambridge, MA: MIT Press.

Manning, P. (1984). Police classification and the mentally ill. In L. Teplin (Ed.), Mental health and criminal justice. Beverly Hills: Sage Publications.

Matthews, A. (1970). Observations on police policy and procedures for emergency detention of the mentally ill. Journal of Criminal Law, Criminology, and Police Science, 61, 283-295.

Monahan, J. & Monahan, B. (1986). Police and the mentally disordered. In J. Yuille (Ed.), Psychiatry and the police. The Hague, The Netherlands: Martinus Nijhoff.

Monahan, J., Caldeira, C., & Freidlander, H.D. (1979). Police and the mentally ill: A comparison of committed and arrested persons. International Journal of Law and Psychiatry, 2, 509-518.

Murphy, G.R. (1986). Special care: Improving the police response to the mentally disabled. Washington, DC: Police Executive Research Forum.

National Coalition for Jail Reform (1984). Removing the chronically mentally ill from jail: Case studies of collaboration between local criminal justice and mental health systems. Washington, D.C.: National Coalition for Jail Reform.

National Institute of Mental Health (1985). Mental Health, United States, 1985. DHHS Pub. No. (ADM)85-1378. Washington, DC: U.S. Government Printing Office.

Rock, R., Jacobson, M., & Janepaul, R. (1968). Hospitalization and discharge of the mentally ill. Chicago: University of Chicago Press.

Rumbaut, R.G., & Bittner, E. (1979). Changing conceptions of the police role. In N. Morris & M. Tonry (Eds.), Crime and justice: An annual review of research, (Vol. 1). Chicago: University of Chicago Press.

Schag, D. (1977). Predicting dangerousness: An analysis of procedures in a mental center. Unpublished doctoral dissertation, University of California, Santa Cruz.

Shah, S. (1975). Dangerousness and civil commitment of the mentally ill: Some public policy considerations. American Journal of Psychiatry, 132, 501-505.

Sheridan, E. P., & Teplin, L. A. (1981). Police-referred psychiatric emergencies: Advantages of community treatment. Journal of Community Psychology, 9, 140-147.

Sims, A., & Symonds, R. (1975). Psychiatric referrals from the police. British Journal of Psychiatry, 127, 171-178.

Smith, D.A. (1986). The neighborhood context of police behavior. In M. Tonry & N. Morris (Eds.), Crime and justice: An annual review of research (Vol. 8). Chicago: University of Chicago Press.

Smith, D.A. & Visher, C.A. (1981). Street-level justice: Situational determinants of police arrest decisions. Social Problems, 29, 167-177.

Steadman, H.J., Morrissey, J.P., Braff, J., & Monahan J. (1986). Psychiatric evaluations of police referrals in a general hospital emergency room. International Journal of Law and Psychiatry, 8, 39-47.

Stone, A. (1975). Mental health and law: A system in transition. Washington, DC: U.S. Government Printing Office.

Teplin, L.A. (in press). The criminalization hypothesis: Myth, misnomer or management strategy. In Proceedings of NIMH- sponsored State-of-the-Art Workshop on Law and Mental Health, Rockville, MD: National Institute of Mental Health.

Teplin, L.A. (1985). The criminality of the mentally ill: A dangerous misconception. American Journal of Psychiatry, 142(5), 593-599.

Teplin, L.A. (1984a). Managing disorder: Police handling of the mentally ill. In L.A. Teplin (Ed.), Mental health and criminal justice. Beverly Hills: Sage Publications.

Teplin, L.A. (1984b). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. American Psychologist, 39, 794-803.

Teplin, L.A. (1983). The criminalization of the mentally ill: Speculation in search of data. Psychological Bulletin, 94(1), 54-67.

Teplin, L.A., Filstead, W., Hefter, G., & Sheridan, E. (1980). Police involvement with the psychiatric emergency patient. Psychiatric Annals, 10(5), 202-207.

Teplin, L.A. & Pruett, N.S. (in press). Police as streetcorner psychiatrist: Managing the mentally ill. International Journal of Law and Psychiatry.

Urmer, A. (1973). The burden of the mentally disordered on law enforcement. Sacramento, CA: ENKI Research Institute.

Warren, C.A. (1977). The social construction of dangerousness. Los Angeles: University of Southern California.

Wilkinson, G.S. (1975). Patient-audience social status and the social construction of psychiatric disorders: Toward a differential frame of reference hypothesis. Journal of Health and Social Behavior, 16, 28-38.

Wilson, J.Q. (1968). The police and the delinquent in two cities. In S. Wheeler (Ed.), Controlling delinquents. New York: John Wiley & Sons.

CHAPTER 3

THE MENTALLY ILL IN LOCAL JAILS:

ISSUES IN ADMISSION AND BOOKING

by Ronald Jemelka, Ph.D.

When an apprehended person is transferred from the custody of law enforcement personnel to the custody of an officer in a detention facility, a significant criminal justice system boundary is crossed. Once admitted to a jail, that facility assumes responsibility for screening, identifying, and appropriately responding to the mental health care needs of new detainees. Initial detention is an activity which has major implications for the person being detained, for the facility, for the criminal justice system, and for the system of mental health care. Although the period of initial detention is usually brief, there is no other time in the course of an incarceration of greater importance to the detainee's health and well being. Initial jail admission and booking deserves scrutiny for the numerous and crucial health care responsibilities for criminal justice personnel at all levels. It also warrants analysis since it offers so many grounds for potential lawsuits.

What responsibilities do facilities have for the care and treatment of those in custody? What obligations do jails have to screen and identify those who may be in need of mental health care or at risk of suicide, victimization, or violence? What are the legal issues in intake screening? What standards exist regarding intake screening and health care? How can individuals who are mentally ill be recognized in a system for detaining persons who are in the custody of law enforcement or corrections personnel? What tools, techniques, procedures, and training are available to facilitate screening? How can screening and mental health care be improved? What resources are available to improve mental health screening and care? These are the questions this paper attempts to address.

Before proceeding, a few caveats about terminology are worthwhile. The first concerns the term "diversion". The term has been used to describe virtually any contact between a mentally ill person and any member of the criminal justice community, including diversion activities by police, diversion activities at the point of admission and booking into a jail, mental health services offered in jails, programs to facilitate re-entry into the community when a detain is released from jail, and community-based programs which have as their goal the prevention or reduction of contact with the criminal justice system by mentally ill persons.

This chapter focuses exclusively on the reception of a detainee into a jail or lockup. Only those varieties of diversion that occur at the "front door" of the jail will be discussed here. The other topics are covered in the other chapters of this monograph. Whether diversion does occur at the "front door" is a function of a number of factors that will be reviewed in

this paper, such as the availability of programs and facilities in the community. If there are no alternatives, there can be no diversion. The broader issues facing jail administrators is the identification of mentally ill and suicidal individuals as they enter the system, diverting the mentally ill from inappropriate detention if alternatives are available, and providing mental health services to these individuals if they must remain in jail for any reason. In most jurisdictions, diversion alternatives are severely limited or nonexistent. Identification and treatment are the responsibilities facing most jail administrators.

Another caveat concerns our names for jail. There are a variety of names for detention facilities in our communities, including jails, lockups, remand centers, county or municipal prisons, houses of corrections, and detention centers. The generic term "jail" will be used throughout this chapter unless a point is being made about a specific type of detention facility, such as a lockup at a police precinct house or substation. There is tremendous variability in the organization, management, mission, community context, and size among the approximately 3,300 jails in the United States (Bureau of Justice Statistics, 1989). If police lockups are included, the number is closer to 5,000 (Reed, 1989). Holding facilities or lockups are currently used in some jurisdictions to detain individuals during police investigation and prior to arraignment, usually for less than 48 hours. This chapter will address a generic jail context to allow for a straightforward discussion of the issues of identification of mentally ill individuals at admission and booking into detention facilities of any kind.

It should also be noted that this chapters focuses on the point of admission into a detention facility. That may or may not include "booking" into a jail. In many facilities booking will occur a few hours after admission. Booking may occur in a different facility. A person may well pass through several "stop-offs" before being booked into a jail. Further, once the individual is initially booked, there may be subsequent assessments as part of an individual's initial classification. Thus, the individual may spend varying amounts of time in a squad car, at a police precinct house, in a police lockup, in an initial holding or receiving tank[1] of the county jail, in the booking tank of the jail, and then in a classification area before he or she is finally booked, or registered as an inmate of the facility, classified, and given an initial housing assignment.

Proper intake and classification procedures are essential, both to protect the jail and to ensure that legal requirements and the rights of the individual are met. The booking/admissions officer performs critical functions during these procedures, including screening out critically injured or ill persons, or obtaining immediate medical attention for them when they must be admitted. New arrivals must be separated from the general inmate population and from other inmates who may be mentally ill, drunk, or violent. All new inmates must be closely observed for aggressive, suicidal, or other abnormal behavior. Through classification, inmates should be placed at the lowest necessary level of constraint and the highest possible level of activity and program participation at which they will not be a risk to the public, staff, other inmates, or themselves (Ayres 1988; Austin, Baird, Bakke, et al., 1989).

The organization of criminal justice in the local jurisdiction, the size of the facility, the anticipated disposition, and the anticipated length of stay will determine how many moves, "stop-offs", and processing points (interrogation, admission, booking, arraignment, and

classification) the detainee will undergo before being assigned to housing in a jail. In rural areas with small jails, usually there will be no intermediate stops at a police precinct house or lockup. Space and manpower limitations may preclude separating new inmates at admission, booking, and classification from the general inmate population of the jail. In urban jurisdictions with larger jails, there may be multiple points at which the detainee is moved, held, processed and transferred. In some settings, these activities are considered separate processes. In others, all activities are seen as an overall process, usually labeled as classification. Admission is generally viewed as the first step in classification, and is the point at which the jail assumes responsibility for the health and mental health care of the individual being detained. In the next section, we examine major issues in screening the mentally ill as they are admitted into local jails.

MAJOR ISSUES IN JAIL ADMISSION SCREENING

This section examines some of the issues and problems confronting local jurisdictions in adequately screening new admissions to a jail for the presence of mental disorders and related concerns such as intoxication, suicide, vulnerability and assaultiveness. The context of jail operations and current practices are examined first. Standards related to screening are presented next. The role that jail suicides have played in focusing attention on admissions screening is reviewed, followed by a discussion of the current state of legal issues and liabilities related to intake screening. This section ends with a discussion of current gaps and needs in the identification of mentally ill persons as they enter a jail.

The Jail and Community Contexts of Admissions Screening

Issues of overcrowding and limited resources affect screening just as they do all other aspects of jail operations. Currently most jails are overcrowded and many are operating under consent decrees related to overcrowding, inadequate health care, and other concerns. The function of jails necessarily dictates a short length of stay and a high turnover rate. As jail populations increase and capacities are taxed, the screening and booking process is the first point at which the impact is evident. The community context must also be considered. What happens in the jail booking process is influenced by the availability of community services. A thorough understanding of the identification and possible diversion of mentally ill persons out of jails requires a consideration of the local mental health system, substance abuse programs, and other social, health, and housing services.

Problems With Overcrowding. Many jails are now holding inmates well in excess of their rated capacity. American Correctional Association (ACA) standards recommend that jails should operate at 90% of capacity to allow room for expected fluctuations in jail populations. Nationally, all jails were at 85% of capacity in 1985, 96% in 1986, and 98% in 1987 (Bureau of Justice Statistics, 1989). The problem is more acute in jurisdictions with large populations (more than 100 inmates in the 1983 Jail Census): 108% of the rated capacity of these facilities was occupied in 1986; 111% in 1987 (Bureau of Justice Statistics, 1989).

What does this have to do with admission and booking in regard to mentally ill persons? In addition to the obvious increase in the number of persons who must be processed into a jail,

overcrowding reduces the jail's ability to set aside segregated housing for new admissions, booking and classification functions. With bed space at a premium, initial detention, booking and classification areas become a luxury. Resources may no longer be available for separate areas which facilitate initial screening and close observation. Even if available, the length of stay in these reserved areas may need to be reduced, making it necessary to hasten admission, booking, and classification procedures. Newly received persons may not be scrutinized as carefully in this new era of intake screening.

As pointed out by Steadman, et al. (1989):

> It could well be ... that overcrowding has at last become so serious that it overshadows all other local correctional concerns. That is, no matter how important mental health care may be, the provision of adequate space and food necessarily assumes a higher priority.

It is vitally important that recent gains made nationally in improved screening tools, procedures, and training not be lost in the developing environment of overburdened local detention facilities.

High Turnover Rates. The high turnover rate of jail populations further complicates issues of adequate screening at admission. Admissions is one of the busiest areas of jail operation. In 1988, the average length of stay in a jail nationally is approximately 3 days (Bureau of Justice Statistics, 1990). Annual jail admissions are nearly 36 times the average daily population (Bureau of Justice Statistics, Report to the Nation on Crime and Justice, 1988). In 1988, the number of admissions had increased to 9.7 million and the number of discharges, to 9.6 million. Thus, in 1988 there were approximately 53,000 transactions daily, an increase of 12.8% in one year. The current flux of jail populations seriously hampers planning and budgeting efforts and puts jail administrators in the difficult position of having to request significant funding increases every year.

The Community Mental Health Context. A third factor affecting both law enforcement and local corrections authorities is the status of local mental health services. The role that law enforcement and jails have come to play in the mental health services of a local community is well documented in a variety of sources (Steadman, et al. 1989; Jemelka, et al., 1989; Teplin, 1984; Whitmer, 1980; and Lamb, 1984; among others). The availability, accessibility, organization, and quality of local mental health and state hospital services will have a significant impact on the number of new jail admissions who are mentally ill. What happens in the jail booking process cannot be divorced from the availability of these services in the community. The number of mentally ill persons coming into a jail will reflect the adequacy of the local system of care.

Dispositional alternatives available to admission and booking personnel, pretrial services staff, and mental health staff providing services in the jail, also reflect the effectiveness of the local mental health care delivery system. Opportunities to divert the mentally ill out of jail will be directly related to the availability and accessibility of adequate services in the community.

Inadequate funding for community mental health and residential services continues to be a dilemma for most jurisdictions, and economic realities in most states and communities offer little hope for enhancement of the current system of care. Because criminal justice is the system that cannot say no, the impact of inadequate mental health care and increased homelessness is often felt first by police and jail admissions personnel. In addition to inadequate funding, some community mental health care providers simply are reluctant to provide mental health services to mentally ill offenders. They often feel unprepared to serve this population and fear that such clients are more likely to be violent. In fact, some agencies use a history of incarceration or prior felony convictions as exclusionary criteria when screening for program eligibility. To the extent that this attitudinal bias and inadequate funding characterize the local mental health context, diversion will not be possible and the mentally ill will occupy the treatment facility of last resort, the local jail.

The relative costs of mental health care and incarceration may also be a factor affecting the number of mentally ill in local jails. In Seattle, Washington, for example, the cost of inpatient psychiatric care in the city's large public hospital is about $600 per patient per day. The cost of inpatient care at the state hospital approximately 50 miles away is about $250 per day. The cost of adequate community based care which includes housing approaches the state hospital bed day cost. It costs about $30 a night to keep someone in the King County Jail in Seattle. This is not to say that the city of Seattle warehouses the mentally ill in local jails. But these data do illustrate the unwitting economic incentive to do so.

There is a growing consensus that extensive mental health services should not be developed within jail settings. Based on their study of 43 jails in 26 states, Steadman and his colleagues (1989) recommend that the jail should remain primarily a correctional facility with limited but high quality services available in the areas of identification, crisis intervention, and case management at release. Others (Cox, et al. 1989; Kimmel, 1987) have arrived at similar conclusions. It has been argued that development of more extended mental health care services not only duplicates these services in the community but may create incentives for judges, law enforcement personnel, and others to utilize the jail as a viable treatment alternative. The purchase of mental health services from local mental health agencies in conjunction with positive working relationships with state hospitals and/or local hospitals affords optimal mental health service delivery at reasonable costs.

Screening Persons Admitted to Jails: Current Practice

Until recently, very little information about jail mental health care or screening practices was available. The study by Steadman, McCarty, and Morrissey (1989) surveyed 43 jails known to have model mental health programs or that were under court order to improve services. These authors found that 30 of the 43 jails in their sample provided some form of intake screening. Screening was defined as a process completed during intake in which new inmates were routinely asked about mental health status and history, using a standardized form to guide the interview.

Reed (1989) sent a survey to all prison administrators in New York, New Jersey, and Wisconsin. Respondents who reported incidents of suicide, self-injury or litigation were asked to participate in a structured interview focusing on these issues. Her sample consisted of 79

jails, 43 in Wisconsin, 20 in New York, and 13 in New Jersey. However, the author does not indicate overall response rates or biases introduced by non-respondents, leaving the generalizability of her results difficult to assess. She does report that due to turmoil and litigation surrounding jail mental health issues at the time, the New York sample had the lowest participation rate of these three states, where the 20 jails surveyed constituted 34% of those jails contacted.

She found that the most extensive services were being provided in Wisconsin, where the state mental health authority has responsibility for providing mental health care in local jails. The least amount and variety of service was provided in New York jails, where Sheriffs reported little cooperation with local mental health authorities. New Jersey jails were similar to those in Wisconsin, a finding attributed to a history of successful inmate litigation.

Seventy-seven percent of the jails in Wisconsin, 69% of the jails in New Jersey, and 20% of the jails in New York conducted some form of admissions screening (Reed, 1989). Among the 79 jails, screening was performed by a mental health worker in 2 jails (3%) and by jail deputies in 45 jails (58%). No screening occurring in 31 jails (40%). It should be noted that the survey of 20 jails in New York occurred in the summer of 1986, very early in the implementation of the New York State forensic suicide prevention/crisis service program. An intake screening form, procedural guidelines and training package were implemented in New York State in 1986 and 1987 (Cox, Landsberg, and Paravati, 1989). Thus, Reed's data are probably not reflective of current screening practices in New York State. Also, it is unclear how screening was defined in Reed's study.

These two studies are the only examples of surveys of jail mental health screening procedures to date. Generally, the data support the conclusion that about 70% of jails conduct some form of intake screening and that this initial screening is almost invariably conducted by a jail deputy.

Standards

This chapter will not deal with the diverse sets of standards that have evolved for health and mental health care in jails during the last 25 years. At least 35 sets of standards relevant to mental health care in jails exist. A list of these standards by title and issuing organization appears as Appendix A. The reader interested in the development and current status of jail mental health standards is directed to a review of these issues by Steadman, et al. (1989). The current section will focus on standards specific to the identification of mentally ill and suicidal individuals at admission to a jail.

Steadman, et al. (1989) summarized the standards of The American Medical Association (AMA), the American Correctional Association (ACA), and the American Association of Correctional Psychologists (AACP) on intake screening in jails as follows:

> All of the standards rank intake screening as one of the most significant mental health services that a jail can offer ... This assessment is usually described as a three part process. First, the booking officer should review any papers or records that accompany the prisoner. The second step involves asking

> the inmate a series of questions about his or her mental health history. The questions should determine whether the individual has ever attempted suicide, been admitted to a psychiatric hospital, or committed acts of sexual deviancy. The officer should also try to ascertain whether there is a pattern of violence or substance abuse and whether the inmate is currently taking any medication. Finally, the officer should record any visual observation of the inmate's behavior. Of particular interest are signs of delusions, hallucinations, peculiar speech and posturing, disorganization, depression, memory deficits, and evidence of self-mutilation. (p. 34)

In addition to these general requirements, some additional standards are worth noting. The American Bar Association standards (American Bar Association, 1989) emphasize the need for custodial officer training regarding suicide and mental illness. Standard 7-2.6 states:

> It is the responsibility of custodial officials to ensure that mental health and mental retardation services are provided for detainees. To this end, and pursuant to the provisions of Standard 7-2.8, training for all custodial personnel, and especially for personnel responsible for processing new admissions, should include instruction in the identification of symptoms and behavior indicative of mental illness and mental retardation.

ACA's Standards for Adult Local Detention Facilities (1981; 1983 revision) include specific provisions on the observation of newly received inmates. Standard 2-5174 states:

> Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are violent, suicidal, mentally disordered or who demonstrate unusual or bizarre behavior. Suicidal inmates are under continuing observation.

Two well-established sets of standards have added new provisions specific to suicide prevention. The Commission on the Accreditation of Law Enforcement Agencies (CALEA) (1983) requires that, because lockups are not equipped to care for intoxicated or self injurious individuals, arrestees should be under observation by facility staff at all times. The National Commission on Correctional Health Care (NCCHC), through annual conferences, publications, and an accreditation program, has become a leading agency in promulgating standards and accrediting facilities (Steadman, et al., 1989). Their most recent set of standards (NCCHC, 1987) requires a comprehensive suicide prevention plan which includes identification, training, mental health evaluation, monitoring, housing, procedures for intervention in a suicide-in-progress, notification, documentation, and psychological autopsy.

Recent findings of a survey completed by the National Center for Institutions and Alternatives (NCIA) on suicide prevention standards in the states reveal the limited utility of current state correctional standards. This study found that 36 states had mandatory or voluntary standards but, for the most part these state standards were deemed to lack "even the basic criteria for suicide prevention" (National Center for Institutional Alternatives, 1989).

Only eight states included suicidal behavior inquiry at intake, less than one third included suicide prevention procedures, and only six specified suicide management training in their training curriculum for correctional staff. Although nationally accepted ACA standards call for observation every 30 minutes, 19 of the states' standards call for observation periods of an hour or more, and 12 states' standards do not specify a time interval. Four states (Iowa, Maine, South Carolina, and West Virginia) had standards supporting comprehensive suicide training programs (National Center for Institutional Alternatives, 1989).

Jail Suicide

Jail suicide is the most prominent focus of jail admission screening, both from research and litigation perspectives. This section briefly reviews the research literature on jail suicide and discusses the relationship between suicide and mental illness in local jails. Litigation concerns about mental illness and suicide are discussed later in this paper.

The best known research in this area has been conducted by the National Center on Institutional Alternatives (Hayes and Kajdan, 1981; Hayes, 1989). Hayes study involved a survey of jails that experienced a suicide in 1985 or 1986 and collected demographic and personal history data on 339 of the 401 jail suicides reported in 1986. They found:

- 94% of the victims were male;
- 72% were white;
- average age of the victim was 30;
- 75% were held for non-violent offenses;
- 60% were intoxicated at the time of incarceration;
- 30% of all suicides occurred between 12 AM and 6 AM;
- 94% of suicides were by hanging;
- 67% were in isolation cells at the time of their suicide;
- 52% of victims charged with alcohol or drug crimes died within the first three hours of incarceration;
- 78% of victims intoxicated at the time of arrest died within the first 24 hours of incarceration;
- 30% of the suicides occurred in initial holding facilities rather than detention facilities (64% of holding facility suicides occurred in the first three hours of incarceration);

- 89% of all suicide victims did not undergo any form of intake screening as part of their booking process (97% when only initial holding facility suicides are considered);

- suicide prevention programs were found in 58% of detention facilities and 32% of holding facilities.

This work represents the most comprehensive survey of suicides in local jails.

Ivanoff (1989) and O'Leary (1989) provide recent reviews of jail suicide studies, with a particular focus on legal issues and psychological correlates of suicide behavior. Other works in this area which are worthwhile include Jail House Blues, a collection of papers edited by Danto (1973), and the study by Rakis (1984). A recent special issue of the Psychiatric Quarterly on jail suicide (Volume 60, Numbers 1 and 2, Spring and Summer, 1989) contains excellent articles on jail architecture, identification, treatment, and monitoring of suicidal prisoners.

Of particular interest here is the relationship between suicide and mental illness. This relationship is clearly indicated by a study of suicides in Sacramento County (California) jails conducted by Le Brun (1989). He found very high rates of mental illness among the 61 inmates who made 78 suicide attempts in a three year period in the mid 1980's. More than one third of the attempts were made by inmates in a fourteen bed forensic psychiatric inpatient unit. These data indicate the vulnerability of chronically mentally ill persons in jails to suicide, even in a protected environment within the jail. Almost all those attempting suicide had major psychiatric disorders (major depression, schizophrenia, and delusional disorders), and half had multiple DSM-III-R (American Psychiatric Association, 1987) Axis I diagnoses. More than half were experiencing hallucinations or delusions at the time of the attempt. Further, half also had an Axis 2 diagnosis. More than 75% had histories of previous mental health treatment. Most were arrested for violent or personal charges (not defined by the investigator) in the current offense and over 80% had one or more prior arrests.

The relationship between jail suicide and mental illness is also borne out by Ivanoff's (1989) review. She reports high rates of previous psychiatric hospitalizations in suicide victims and those who attempt suicide. She also reports that some studies indicate a relationship between the offender's current psychological functioning and jail suicide attempts.

Le Brun (1989) differentiates between those with single and multiple attempts and presents an argument for considering that there are multiple "profiles" of jail suicide attempters. These include the intoxicated first time arrestee overwhelmed by incarceration, who usually attempts shortly after incarceration. Other profiles include those who cannot tolerate any changes to their support system and those arrested for serious charges who may attempt as their court date approaches. Ivanoff (1989) also proposed some specific subtypes of jail suicide including: (1) the intoxicated nonmentally ill inmate, (2) the mentally ill suicide victim, (3) the environmental or situationally precipitated nonmentally ill suicide victim, and (4) the loss of status or shame-precipitated suicide. The fact that specific subtypes

of jail suicide are beginning to be identified illustrates the evolving understanding of this problem.

Le Brun's study suggests that suicide may be an event masking the issue of mental illness in our jails. Suicide is the precipitating event or symptom that brings about the involvement of the legal system. The underlying issue in many suicide cases is that a mentally ill person is incarcerated with no acknowledgment of their mental illness, no precautions taken to protect the individual from self harm, and no effort made to treat the illness.

Jail suicides have focused attention on booking and screening procedures, and screening of some variety is more likely in jails today as a result of jail suicide litigation and research. Given the readiness of courts to intervene in suicide cases, it is not surprising that there has been progress in the area of suicide detection and prevention. There have not been parallel developments in the identification and treatment of the mentally ill. A focus on improved suicide screening is likely to identify signs of mental illness although this might not be the focus of the screening. Of course, some booking assessment procedures attempt to address mental health status as well as suicide risk. Model screening programs, products and procedures are presented later in this paper.

Jails Versus Lockups. With the focus on jail suicides in recent years, there has been a reduction in suicides in those jurisdictions where efforts to improve screening has occurred (cf. Cox, et al., 1989; Reed, 1989). However, the National Center for Jail Suicide (NCJS) studies (Hayes and Kajdan, 1981; Hayes, 1989) clearly demonstrate that the greatest risk for suicide occurs within the first few hours of incarceration, when a person is intoxicated, and when he or she is in isolation. These are typical characteristics of police lockups. These factors suggest that initial detention facilities which may hold the individual prior to his or her transfer to jail, are more likely settings for suicides.

Seldom are screening procedures in place at these facilities. They are usually small, short term facilities. Staff in these facilities may see suicide and mental health screening as outside the purview of their responsibilities. Despite the increased risk these facilities may present for suicidal behavior, they have often been overlooked in suicide screening programs and in planning mental health screening and crisis intervention services. What is now known about jail suicides suggests that adequate screening should be done at intake into a lockup, regardless of the anticipated duration of stay. Persons should be detained only in facilities that permit screening and crisis intervention early in the admission process.

Legal Issues in Jail Admission and Screening

This section examines key legal issues relevant to the process of jail admission screening. Several papers have guided this review (Cohen, 1985 and 1988; O'Leary, 1989). Also, the work by Lindsay Hayes and his colleagues at the National Center for Institutional Alternatives (Hayes and Kajdan, 1981; Hayes, 1989; Jail Suicide Update, spring, 1987) continues to illuminate important legal and constitutional issues in jail admission screening.

Implications of General Health Care Findings. Three areas of legal opinion regarding health care are worth noting. First is the standard of "deliberate indifference". This standard

has evolved from a series of federal court rulings on the adequacy of health care and mental health care in prisons (Cohen, 1985, 1988). Simply stated, federal courts have generally found in favor of prison systems in suits filed on the basis of inadequate health care, as long as prison administrators and staff have not demonstrated a deliberate indifference to the mental or physical health care needs of the inmate. Errors may have been made in the way a mentally ill person was handled. A jailer may have been derelict in following procedures regarding close observation, or forgot to perform some assigned function that had negative consequences for the inmate. These activities by themselves do not constitute deliberate indifference, necessary to warrant a finding of violation of the Eighth Amendment constitutional guarantee of freedom from cruel and unusual punishment.

A finding of deliberate indifference would be more likely if the facility administration being sued failed to acknowledge the possible presence of mentally ill persons in their custody, failed to develop policies and procedures for their care, or failed to make any attempt to determine that an individual might be mentally ill or suicidal. In Estelle v. Gamble, (429 U.S. at 105-106) Supreme Court Justice Marshall stated:

> A complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment.

Subsequent court rulings have further defined deliberate indifference to include only those instances in which there is a "strong likelihood" rather than a "mere possibility" that inaction would harm the prisoner. Also, deliberate indifference must be demonstrated by a pattern of repeated incidents of negligence by staff, or by demonstration of such "gross deficiencies" in staffing and facilities that inmates are effectively denied adequate health care (Cohen, 1988).

Another important court ruling concerns the difference between physical health care and mental health care. In Bowring v. Godwin, a federal appeals court held that "we see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart" (551 F.2d 47 4th Cir. 1977). Subsequent court rulings have consistently upheld this finding in virtually every case (Cohen, 1988). Denial of mental health care is denial of health care.

A third evolving court standard concerns "serious medical needs". With this phrase appearing often in court rulings, its precise definition has warranted considerable scrutiny. Regarding mental illness, the most definitive statement from the courts can be found in Cody v. Hillard (599 F. Supp 1025): "An inmate experiencing significant personality distress in the form of depression or psychotic symptoms to the degree that he has lost contact with reality not only requires but is amenable to psychiatric intervention and treatment." Cohen (1988) reviews attempts to further define serious medical need as it applies to psychiatric conditions,

and recommends the definition of serious mental illness developed by the Michigan Department of Corrections as the best currently available.

The presence of a well-thought out screening process to identify incoming detainees for mental health problems or suicidal preoccupations is a hedge against litigation on mental health care issues. If efforts are made to screen, identify, and refer mentally ill persons and to ensure that personnel are trained to perform these functions, it will be difficult to demonstrate deliberate indifference. Such a system may fail the inmate for a myriad of possible reasons, but not because the system is deliberately indifferent to the needs of the individual. On the other hand, the absence of screening, referral, and training procedures and services for identifying and treating the mentally ill raises the question of indifference.
Litigation Specific to Jail Screening. While the court rulings summarized above derive primarily from prison contexts, these constitutional standards have been applied to local jail contexts as well. In Inmates of Allegheny County Jail v. Peirce, the court found intake screening, observation and diagnostic areas for new inmates, segregation for mentally disturbed inmates, and medication monitoring inadequate to the extent that it constituted deliberate indifference (487 F. Supp. 638, 642- 43). This case is representative of a number of rulings extending the deliberate indifference standard to local jails. In this case, the court further found that lack of resources is no excuse for poor health care. "As long as a county chooses to operate a jail, it must provide specialized care for the health needs of its inmates, regardless of taxpayer opposition or other seemingly mitigating circumstances" (Steadman, et al., 1989, p.133).

Cohen (1989) concludes that with the right to treatment comes important ancillary rights which have themselves become grounds for litigation, such as the right to assessment and maintenance of adequate health care records.

> "... there exists the legal duty to identify and treat inmates with serious mental disorders ... The right to treatment, at least for serious disorders, would be meaningless without an additional duty to provide diagnosis. There is an ironic twist here in that the duty to diagnose illnesses necessarily sweeps more broadly than the underlying right to care" (Cohen, 1985, p.36).

This interpretation, consistent with exigent court rulings, has profound implications for screening at jail admission. With rights to treatment and ancillary rights to diagnosis or assessment established, it is absolutely essential for jails to develop adequate screening procedures at intake. To do otherwise is to provide fertile ground for subsequent litigation which will be difficult to defend.

O'Leary lists a number of factors that should put jailers on notice for possible risk, including intoxication, medical or mental illness, suicidal statements, and a history of previous suicide attempts. There are numerous law suits which have been successful on the basis of inadequate screening at admission to a jail, related to one or more of these factors. A description of a few exemplary cases follows.

In Kanayurak v. North Slope Borough, a 42 year old Eskimo woman was taken to jail for public drunkenness where she committed suicide by hanging.

> The Alaska State Supreme Court overturned a lower court's dismissal, noting that the police were aware of the personal tragedies the decedent had suffered in a period of four months. During that time, one of her sons had been stabbed to death and another burned to death. Her husband had divorced her. And two weeks before her arrest for intoxication her mother had died. The jury could conclude that clinical judgment was not required for the police to have been on notice of potential suicide (O'Leary, 1989, p. 47).

A case particularly relevant to jail admission screening is Partridge v. Two Unknown Police Officers. In 1980, Michael Wayne Partridge was arrested in Houston, Texas for burglary and theft. Partridge became agitated and violent during the investigation of the crime scene and attempted to kick out the windows of the police car. The arresting officer requested assistance. When the transport arrived, Partridge was still agitated. In response to a police officer's question, the boy's father told the officer that his son had experienced a nervous breakdown. On the way to jail, Partridge, who was handcuffed in the back seat of the patrol car, intentionally struck his head on the plexiglass divider separating the front and back seats.

Once at the jail, Partridge was composed. Neither of the two transporting officers reported their difficulties with the suspect, nor those experienced by the arresting officer. The booking officer was not aware of a previous suicide attempt made by Partridge in the same facility during a prior detention (the records were maintained a few doors down from the booking area). The booking officer did note two medical alert bracelets worn by Partridge and made the entries on the booking card, "heart and mental". He was placed in solitary confinement and hanged himself three hours later. The court overturned a lower court dismissal, finding that the failure of the police to provide a notice of potential suicide was sufficient to underlie a claim of deliberate indifference. This case demonstrates the importance of obtaining an arresting officer's report at booking, and of accessing information when it is available. There were several opportunities for the booking officer to have realized Michael Partridge's suicide potential, but his vulnerable mental health status was not identified.

> The Fifth Circuit court found [that the wrongful death] claim rested squarely on the jail's systematic lack of adequate care for detainees, including: failure to be alert to the risk of suicide; the absence of a written policy or procedure manual; no sharing of the records of the jail's clinic; inadequate staffing; no regular cell-checking procedures; failure of personnel to be alert to the decedent's behavior; and failure to adequately train staff (Cohen, 1988, p.123).

Cohen offers this paragraph as a checklist of minimum requirements for all jails. This case contains most of the critical elements that present liability exposure for the jail admissions process.

Implications for Practice. Several conclusions are warranted from this review. More litigation occurs in settings which have some mental health services than in settings which provide none at all. This finding is likely an artifact of jail size. Reed's study (1989)

indicates that large jails get sued more often than small jails, and large jails are more likely to have screening, referral and treatment programs in place. This fact should not deter jail administrators from developing mental health care within their facilities. A proactive plan for identifying and providing adequate mental health care to those in need is a way to avoid litigation rather than invite it. Not knowing which inmates in custody are mentally ill will not excuse the lack of services. Rather, it is more likely to raise the question of deliberate indifference. As Cohen (1988) notes: "...a corrections department that cannot give a good answer to the question 'How many seriously mentally ill persons do you have?' is inviting a court to mandate an answer " (p. 63).

IMPROVING SCREENING AND INTAKE PROCEDURES FOR MENTALLY ILL OFFENDERS

This section examines model programs and exemplary efforts to improve jail admission and booking screening procedures, and make recommendations for improving the identification and treatment of mentally ill offenders.

Model Programs

This section presents model programs, products, and procedures that have been developed specifically to the deal with screening for mental illness and suicidal potential at admission to a jail. They represent exemplary efforts to improve the identification and treatment of mentally ill persons in local jails. These programs can be categorized into five general areas: (1) broad scale initiatives, usually national in scope, to focus attention on the mentally ill in jails and to facilitate improvements in the state of mental health care in these facilities; (2) changes in statutes and organizational relationships to enhance identification, crisis intervention, and dispositional alternatives to jail for mentally ill persons (Wisconsin and Nebraska); (3) new staffing arrangements and procedures to divert mentally ill persons out of jails early in the admissions or booking process; (4) development of specific screening tools and procedures to improve screening at admission and booking; and (5) specific training curricula and materials to improve the ability of jail staff to identify detainees who may be mentally ill or suicidal.

The programs and procedures outlined below will present implementation obstacles in other contexts, and not all of these programs have survived the rigors of budget cuts, competing needs and administrative changes. Some of the programs reviewed below are well developed and documented, and materials are available to facilitate implementation in other settings. Other efforts are informal, and although they are innovative approaches, little exists in the way of written descriptions, formal policies and procedures. Taken together, these programs represent some of the best efforts nationwide to improve the identification and treatment of mentally ill and suicidal inmates as they are received into local jails.

Broad Scale Initiatives

Several projects have attempted to improve the professionalism and quality of mental health care in jails in the United States. These efforts have been made by such diverse groups

as the National Association of Counties (NACo) Mental Health Project, the American Jail Association, the National Center on Institutions and Alternatives, the National Coalition for Jail Reform, and the National Institute of Corrections. These government agencies, national associations, and not-for- profit organizations provide a variety of services to local jail authorities, including consultation, technical assistance, information clearinghouse functions, newsletters, research, training, training curricula, conferences, and information exchange programs. Many services from these groups are free, or offered at low cost.

The recent National Institute of Justice publication "A Network of Knowledge: A Directory of Criminal Justice Information Sources", presents a summary of the objectives, services offered, user restrictions, addresses, and telephone numbers for 167 organizations offering criminal justice agency assistance, including information on jail admission and booking.

Changes in Statutes and Organizational Relationships

Two recent legislative initiatives illustrate the role that advocates, mental health and criminal justice professionals, and legislators can play in improving health care in local jails. In Wisconsin and Nebraska, laws directly targeting the issues raised in Part II of this paper have been passed, and are discussed in turn below.

Major Provisions of Wisconsin Act 394. In 1987, the Wisconsin Assembly passed Wisconsin Act 394, which intends to assist county mental health agencies and jails in carrying out their responsibilities for providing mental health services to jail inmates, provide appropriate training to jail officers, and
help ensure that adequate and appropriate services are provided to mentally ill inmates.

Major provisions of this state law include the following:[2]

- Jail standards. Act 394 requires the DHSS to establish program standards for jails and houses of correction. The standards must include requirements that each jail or house of correction: a) have crisis intervention services available to inmates for medical illnesses or disabilities, mental illnesses, developmental disabilities and alcohol or other drug abuse problems; and b) develop a written policy and procedure manual which reflects the unique characteristics of the jail or house of correction. The policy and procedure manual must include policies and procedures for screening inmates for medical illnesses or disabilities, mental illnesses, developmental disabilities and alcohol or other drug abuse problems. The manual must also specify the facilities and programs, including outside facilities and programs, which will be provided for long- term inmates.

  Act 394 requires that, effective June 30, 1988, at least 16 hours of preparatory training shall be devoted to methods of supervision of "special needs" inmates, including those who may be emotionally distressed, mentally ill, suicidal, developmentally disabled or alcohol or drug abusers.

- Alternative commitment standard for jail inmates. Generally, under prior law and under Act 394, a person may be committed if he or she is mentally ill, drug dependent or developmentally disabled; a proper subject for treatment; and dangerous to himself or herself or to others under at least one of four standards of dangerousness. However, due to the problem of proving current or recent dangerous behavior of persons who are confined to correctional institutions, an alternative standard has been developed for inmates of state prisons. Under the alternative standard, a showing of dangerousness is not required. A state prison or jail inmate may be committed if he or she is mentally ill, a proper subject for treatment and in need of treatment.

- Reports on mental health treatment of jail inmates. Act 394 requires the sheriff or other keeper of a jail or house of correction to report, annually, to the DHSS, on:

  - The number of jail inmates who were transferred to a state or county treatment facility during the previous year under a commitment, an emergency transfer or voluntarily; and the length of stay of each prisoner in the treatment facility;
  - The number of inmates who were committed during the previous year to outpatient treatment under the new alternative standard and who were treated in the jail with psychotropic medication, as well as each inmate's diagnosis and types of drugs used; and
  - A description of the mental health services available to inmates on either a voluntary or involuntary basis.

Nebraska's New Law on Mentally Ill Offenders. In 1988 the Nebraska legislature passed a law prohibiting the jailing of mentally ill persons who are not accused of having committed a crime (Weseley, 1989).

For counties with a city of 10,000 people or more, jails:

- shall contract with facilities inside or outside the county to provide care for the mentally ill who would otherwise be jailed;

- shall not place individuals in jail due to mental illness.

For counties without a city of 10,000 people or more, jails:

- may contract with medical facilities to provide care for the mentally ill;

- shall immediately notify the Community Mental Health Center (CMHC) when a mentally ill individual is placed in jail indicating the need for placement of the mentally ill person in a medical facility;

- The CMHC shall:
  - Identify an appropriate placement for the individual such as a: 1) Mental health center; 2) State hospital; or 3) Federal, county or private hospital.
  - Report to the jail every 24 hours until placement is identified.
  - Implement an appropriate placement within 24 hours once it is identified.

This law represents another effort at the state legislative level to improve mental health care in local jails. Although many of the provisions of the Nebraska law do not apply to persons charged with crimes, this law institutes linkages between jails and mental health service providers, and establishes requirements for better diagnosis and reporting.

Jail Diversion Programs

This section presents programs which attempt to divert mentally ill persons out of jail at the point of admission, booking, or consideration for pretrial release (bail). Very few formal diversion programs exist which ensure the presence of qualified mental health personnel when needed at the sally port, or admissions area of a jail. The common scenario is for a corrections officer to receive the inmate, perhaps administer some brief screening checklist, and call the shift supervisor if he or she believes the inmate presents special management problems. The shift supervisor, usually a senior corrections officer, conducts a short inquiry, and if he or she agrees with the booking officer's observations, arrangements for a medical or mental health evaluation are made. There are a few programs where qualified staff have been assigned to be either present or on call to respond to needs for immediate assessment of mental health status or suicide potential at booking. Known programs are briefly described below.

The Multnomah County (Portland), Oregon Pretrial Release Section Mental Health Coordinator. In response to a court order to reduce the jail population in Multnomah County, Oregon and the increasing numbers of mentally ill arrestees in that population, the County Pretrial Service Section of the Department of Justice Services hired and trained one counselor for its "Recognizance Office" to deal specifically with the mentally ill arrestee.

This counselor is located in the County's central booking office in the County Courthouse. She is on duty during regular working hours and on call during other shifts. Her average case load is 20 clients per month.

The Circuit and County Courts have given the "Recog Office" the authority to set terms of release for non-violent misdemeanants, and the Sheriff's Department has granted the authority to place "police holds" on those misdemeanants evaluated as a danger to self or others.

The mental health counselor receives referrals from the intake screening personnel, the medical evaluation nurse, sheriff's deputies and jail personnel. She works closely with the District Attorney, Prosecutor's Office, the courts, the Sheriff's Department and booking office staff.

In cases of non-violent misdemeanants, she may arrange with the Prosecutor's Office to get a charge dropped or modified. She may release the arrestee on his own recognizance or to a third party, usually family or friends. She can make referrals and order treatment at various mental health and other social service agencies in the community. Through the "police hold" powers, she may send the arrestee directly to the State Mental Hospital for psychiatric evaluation.

This ceding of authority to one highly trained counselor in the booking facility has resulted in a reduction in the mentally ill population held in the county jail facilities. It has accelerated the removal of the mentally ill arrestee from the criminal justice system to some form of treatment and other social services and reduced the amount of time an identified mentally ill person is held in a jail.

Two other programs worth noting include the Honolulu diversion project and the Denver psychiatric nurse screening program. In Honolulu, Hawaii five case coordinators intercede at the hospital emergency room and the city jail. In the past, the most likely disposition for the mentally ill coming in at these two points has been hospitalization. The diversion project has lowered state hospital admissions by connecting clients in crisis with needed community services, reducing their reliance on hospital emergency rooms, jails and state hospitals. In Denver, Colorado a full time psychiatric nurse at the jail screens incoming prisoners for signs of mental illness at admission. Based on her recommendation, approximately half of the 60 mentally ill prisoners received each month are diverted out of the jail into the custody of community mental health center staff. The program offers an example of how a key staff person in the jail and an adequate array of services in the community can successfully divert mentally ill persons out of jails.

There may be other exemplary programs, but few mechanisms exist for disseminating information about these efforts. Research in this area is virtually nonexistent. Innovative but informal, procedures for facilitating the diversion of the mentally ill may include dropping misdemeanor charges if the person agrees to begin or renew treatment in a local mental health center or a state hospital. These efforts are often not formally documented or even publicized, but can successfully divert mentally ill persons from jails.

Whatcom County (Washington) Jail Mental Health Program. The Whatcom County Jail in Bellingham, Washington, provides a good example of a local community developing the informal mechanisms necessary to serve the mentally ill who come into the jail. Although a small town (approximately 45,000), the community experiences criminal justice and mental health problems usually found in larger cities. Bellingham lies on an interstate highway and is the U.S. city closest to the Canadian border. Additionally, it is a major seaport and serves as the base port for the primary ferry system connecting Alaska and the lower 48 states. The area had once been home to booming lumber, paper, and wood products industries, but with years of cultivation and the downturn in the logging trades, unemployment and related

problems have emerged. For all these reasons, the county has had more crime, mental illness and substance abuse that would be expected in a town of this size. The Whatcom County jail was selected as a research site for this research project on the mentally ill in jails because it had been described as a small jail sensitive to the presence and needs of mentally ill offenders (Jones, 1989).

Based on site visits to the facility and interviews with staff, several aspects of this jail stand out regarding the treatment of the mentally ill. First, the professionalism and attitudes of the staff were notable. Staff were aware of the nature of the mental illnesses exhibited by several detainees, and appropriate services were rapidly obtained for these prisoners. All offenders were received into an initial booking area, with some screening at admission, and more thorough screening at booking, which occurred within a few hours of admission. All new offenders were housed in cells permitting constant direct observation by one or more jail staff, and no one was moved to regular cell housing until it was clear that the individual was not intoxicated, suicidal, or mentally ill. Often more than one officer would interact with new detainees and staff often compared notes on observations and impressions. The staff exhibited a good deal of patience, tolerance, humor and camaraderie and they genuinely appeared to enjoy their work.

Several factors explain the booking procedure and concern for mentally ill or suicidal prisoners observed at this jail. The county sheriff had taken the position that the mentally ill in jail was a significant community issue. To that end he had hired correctional officers with backgrounds in mental health. One individual, who had become a correctional supervisor in the jail, was very knowledgeable about mental health law, and had clinical and diagnostic skills rarely found in corrections officers. Her skills are widely recognized and she regularly provides mental health training to correctional and police officers at the State's Criminal Justice Training Center. Her ability to communicate to jail staff, psychiatrists and other mental health professionals, arresting police officers, pretrial release staff, and public defenders was a unique asset in this setting.

The county sheriff and jail administrator had initiated and sustained other efforts in the community which fostered the sense of a "common client" among law enforcement, mental health, health care, and substance abuse professionals in the county. One was the creation of the "Critical Client Network", in which representatives of these professional groups meet every two weeks to discuss specific cases, work out problems with system boundaries, and brainstorm solutions to community problems. These efforts have fostered the development of strategies for dealing with specific cases. Agency responsibilities are discussed and coordinated plans for interventions by appropriate agencies in the community are developed for each case.

Another coordinated effort is the Adult Detention Project. This program is based on a seldom used state law, allowing a certified chemical dependency counselor to detain an intoxicated persons in jail for up to eight hours. The local detoxification facility was not staffed to handle violent or acutely mentally ill persons who were intoxicated. Through this program, intoxicated persons are held in a safe environment in the jail with medical back up until sober. They can them be transferred to Detox, to a hospital for assessment for mental commitment, or released into the community. This program, which grew out of the Critical Client Network meetings, has benefited the community in several ways. The Detox unit has

a alternative setting to send persons who are uncontrollable. Commitment evaluations can occur later, when the person is no longer intoxicated. The police do not have to arrest and press charges to remove those individuals from the community. The jail staff no longer have to book and process paper work on these detainees. Also, the courts no longer process the myriad minor charges these individuals used to incur (Jones 1989).

These informal practices result in a strong program in the jail in which admission and booking processes play an integral part. Although not a formalized, well-publicized program, this facility and the community embody the jail mental health planning principles suggested by Steadman et al. (1989), discussed earlier. No doubt, similar programs have evolved in other sites as well. Such innovations usually are not well-publicized or described in the literature.

Screening Tools and Procedures

A wide number of screening tools have been developed for the admission/booking process. The Suicide Prevention Intake Screening Guidelines developed as part of the New York State Local Forensic Suicide Prevention Crisis Service Model is recommended to assist intake officers in promptly identifying jail and lockup prisoners who are suicidal. This form takes only five minutes to administer, and detailed instructions on the back of the form direct the officer to notify the shift commander if certain responses are elicited. The screening process includes both face-to-face interview and observation activities, and the referral process includes activities to link inmates with supervision and safety services and to mental health and/or medical treatment services. A copy of this form appears in Appendix B. The interested reader is referred to the articles by Cox, Landsberg and Paravati (1989) and Sherman and Morschauser (1989) for more information on this tool and model.

The National Sheriff's Association. The National Sheriff's Association (Ayres, 1988) has compiled a set of screening forms and procedures in a manual to assist local jails in every step of intake admission, booking and classification. These detailed procedures and guidelines are offered as a model intake procedure for local jails. It draws on other sources, such as the standards reviewed earlier and includes the New York State Suicide Prevention Screening Guidelines, described above. This manual (Ayres, 1988) presents a comprehensive approach to admissions screening that would help to ensure safe, humane care of mentally ill persons at intake. This approach would also serve as a safeguard against litigation on the grounds of poor admission and classification procedures.

The Referral Decision Scale. Another screening tool currently under development is the Referral Decision Scale (Teplin and Schwartz, 1989). This empirically based instrument was developed specifically to screen for signs of mental illness (rather than suicide). The Referral Decision Scale (RDS) was developed on a sample of 728 randomly selected inmates from the Cook County (Chicago) Illinois jail, and subsequently validated on a large sample of prisoners from the North Carolina Department of Corrections. The scale consists of 14 items from the National Institute of Mental Health Diagnostic Interview Schedule (DIS), a reliable, structured interview for assessing the presence of specific psychiatric disorders. Teplin and Schwartz identified fourteen items from the interview which maximally discriminated between groups of inmates who were and were not mentally ill. The instrument appears to be sensitive to the presence of schizophrenia, manic depressive illness, and major depression, the

major psychiatric disorders one would want to screen for in a jail population. The RDS requires extensive training for the interviewer to fully recognize symptoms of these illnesses, but does not need to be administered by a mental health professional.

According to the authors, "The RDS, when used by properly trained personnel, is likely to improve the detection and diversion of detainees suffering from severe mental disorder. In this way, pretrial detainees would have an increased chance of receiving needed mental health services and may be treated in a more appropriate and humane manner." (Teplin and Schwartz, 1989, p. 15). Although more research is needed, this instrument represents one of the most promising efforts in developing a practical instrument to assist in jail mental health screening.

Training

Training is a critical need in most local jails. Two comprehensive training programs for jail personnel have been developed to facilitate screening of new admissions. One is the New York State Model Suicide Prevention Training Program for Local Corrections Officers (New York State Commission on Corrections and New York State Office of Mental Health, 1986; Sovronsky and Shapiro, 1989; Cox, Landsberg, and Paravati, 1989). The other is the Training Curriculum on Suicide Detection and Prevention in Jails and Lockups (Rowan and Hayes, 1988).

Advantages of these training programs are that they are exportable, offer excellent materials at low cost, and can be tailored to the specific training needs of a given locality.[3] Additionally, many of the national organizations addressing jail mental health issues, described in the National Institute of Justice publication "A Network of Knowledge: A Directory of Criminal Justice Information Resources", provide consultation, training, and curriculum training materials to facilitate the meeting of training needs in any local jurisdiction.

SUMMARY

This chapter has attempted to cover the major issues related to jail admission screening of the mentally ill jail detainees. As an overview, the coverage of some topics has been brief and, no doubt, some exemplary programs have been omitted. However, this paper was intended as a useful starting point for those responsible for developing screening programs those interested in specific aspects of intake screening to develop comprehensive, integrated responses to a very serious community problem, the mentally ill person being brought to overcrowded, underfunded local jails.

FOOTNOTES

1. A tank is a phrase often used to designate either a cell block, or group of cells with a special purpose.

2. This summary of the Wisconsin law is excerpted from a well- written, but unknown source.

3. The New York Local Forensic Suicide Prevention Crisis Service Model and training curriculum are available from:

   Utica Print Shop
   44 Holland Avenue
   Albany, NY 12229
   (518) 473-3574

   For additional information contact:

   Judith F. Cox
   Assistant Director
   Bureau of Forensic Services
   NYS Office of Mental Health
   (518) 474-7275

   The Training Curriculum on Suicide Detection and Prevention in Jails and Lockups can be obtained from:

   Lindsay M. Hayes
   National Center for Institutional Alternatives
   635 Slatershane, Suite G-100
   Alexandria, VA 22314
   (703) 684-0374

   OR

   Joe Rowan
   Juvenile and Criminal Justice International, Inc.
   381 South Owasso Boulevard
   Roseville, MN 55113
   (612) 481-9644

REFERENCES

American Bar Association (1989). ABA Criminal justice mental health standards. Washington, D.C.: American Bar Association.

American Psychiatric Association (1987). DSM-III-R: Diagnostic and statistical manual of mental disorders (Third Edition, revised). Washington, D.C.: American Psychiatric Association.

Applebome, P. (1988). With inmates at record high, sentence policy is reassessed. New York Times, April 25, 1988.

Applebome, P. (1987). States spend billions but lag behind rate of imprisonment. New York Times, March 1, 1987.

Austin, J., Baird, S., Bakke, A., McCarthy, D., Buchanon, R., Whitlow, K. (1989). Jail classification system development: Executive summary. Boulder, CO: National Institute of Corrections Jail Division.

Austin, J. & McVey, A. (1989). The 1989 NCCD prison population forecast: The impact of the war on drugs. Focus, December, 1-6.

Ayres, M. (1988). Jail classification and discipline. Alexandria, VA: National Sheriff's Association.

Bowring v. Godwin (551 F. 2d 47 4th Cir. 1977).

Bureau of Justice Statistics (1989). Annual report fiscal 1988. Washington, D.C., U.S. Department of Justice, April, 1989.

Bureau of Justice Statistics (1989). Correctional Populations in the United States, 1987. Washington, D.C., U.S. Department of Justice, December, 1989.

Bureau of Justice Statistics (1988). Report to the nation on crime and justice. Washington, D.C., U.S. Department of Justice, March, 1988.

Cody v. Hilliard (599 F. Supp. 1025).

Cohen, F. (1988). Legal issues and the mentally disordered prisoner. U.S. Department of Justice: National Institute of Corrections.

Cohen, F. (1985). Legal issues and the mentally disordered inmate. In National Institute of Corrections (Ed.) Sourcebook on the mentally disordered offender. Washington, D.C.: U.S. Department of Justice, National Institute of Corrections.

Cox, J.F., Landsberg, G., & Paravati, M.P. (1989, Summer). The essential components of a crisis intervention program for local jails: The New York local forensic suicide prevention crisis service model. Psychiatric Quarterly, 60, 103-118.

Danto, B.L. (1973). Jail house blues. Orchard Lake, MI: Epic.

Estelle v. Gamble (429 U.S. at 105-106).

Hayes, L. (1989). National study of jail suicides: Seven years later. Psychiatric Quarterly, 60, 7-29.

Hayes, L. & Kajdan, B. (1981). And darkness closes in... A national study of jail suicides. (Final report to the National Institute of Corrections). Washington, D.C.: National Center on Institutions and Alternatives.

Inmates of Allegheny County Jail v. Peirce (487 F. Supp. 638, 642-43).

Ivanoff, A. (1989). Identifying psychological correlates of suicidal behavior in jail and detention facilities. Psychiatric Quarterly, 60(1), 73-83.

Jemelka, R., Trupin, E., & Chiles, J. (1989). The Mentally Ill in Prisons: A review. Hospital and Community Psychiatry, 40(5), 481-491.

Jones, W. (1989). Mentally ill offenders. American Jails, Fall, 47-58.

Kimmel, W. (1987). Services for the mentally ill inmate: An exploratory inquiry. National Institute of Mental Health Office of Policy Analysis and Coordination, Rockville, MD, December, 1987.

Lamb, H.R. (1984). Keeping the mentally ill out of jail. Hospital and Community Psychiatry, 35(6), 529.

Le Brun, L. (1989, Winter). Characteristics of male suicide attempts in the Sacramento County jail, 1985-1987. Jail Suicide Update, 2, 1-7.

National Institute of Justice (1988). A Network of knowledge: Directory of Criminal Justice Resources. Washington, D.C. National Institute of Justice.

O'Leary, W. (1989). Custodial suicide: Evolving liability considerations. Psychiatric Quarterly, 60, 31-71.

Rakis, J. (1984). Suicide prevention measures in urban detention facilities throughout the United States. Journal of Prison and Jail Health, 4(2), 91-95.

Reed, S.O. (1989). Reform by decree: Litigation and the provision of mental health services. In R. Rosner & R.B. Harmon (Eds.) Correctional Psychiatry (pp. 243-271). New York: Plenum Press.

Sherman, L. and Morschauser, P. (1989, Summer). Screening for suicide risks in inmates. Psychiatric Quarterly, 60, 119-138.

Steadman, H.J., Fabisiak, S., Dvoskin, J. et al. (1987). A survey of mental disability among state prison inmates. Hospital and Community Psychiatry, 1086-1090.

Steadman, H.J., McCarty, D.W., & Morrisey, J.P. (1989). The mentally ill in jail. New York: Guilford Press.

Teplin, L. (1984). Mental health and criminal justice. Beverly Hills: Sage.

Teplin, L. & Schwartz, J. (1989). Screening for severe mental disorder in jails. Law and Human Behavior, 13(1), 1-18.

Weseley, Don (1989). Jailing of the mentally ill in Nebraska. American Jails, Fall, 12-15.

Whitmer,G. (1980). From hospitals to jails: the fate of California's deinstitutionalized mentally ill. American Journal of Orthopsychiatry, 50, 262-267.

APPENDIX A

American Association of Correctional Psychologists, (AACP). Standards for Psychology Services in Adult Jails and Prisons Beverly Hills: Sage. (1980).

American Bar Association, (ABA) Criminal Justice Mental Health Standards (1989).

American Correctional Association, (ACA). Guidelines for the Development of Policies and Procedures: Adult Correctional Institutions (ACA number 4.13.4). College Park, Maryland: American Correctional Association. (1981).

American Law Institute, (ALI) Model Code of Pre-Arraignment Procedure (1975).

American Law Institute. Model Penal Code III on Treatment and Correction. (1962). Article 304 addresses mentally disturbed offenders.

American Medical Association, (AMA) Standards for Health Services in Jails (1981).

American Medical Association. Standards for Health Services in Prisons. Chicago: American Medical Association (1979).

American Psychiatric Association, Psychiatric Services in Jails and Prisons. Washington, D.C.: American Psychiatric Association (1989).

American Psychological Association, Report of the Task Force on the Role of Psychology in the Criminal Justice System (1978).

American Psychological Association, Standards for Providers of Psychological Services (1981).

American Public Health Association, Standards for Health Services in Correctional Institutions (1976). Section IV addresses mental health care.

Bureau of Operations and Research of the International Association of Chiefs of Police, Inc., Training Key (1979).

Commission on Accreditation for Law Enforcement Agencies (CALEA). Standards for Law Enforcement Agencies. Chapter 72 addresses short term holding facilities.

Comptroller General. Prison Mental Health Care Can Be Improved By Better Management and More Effective Federal Aid. Report to the Congress of the U.S. Washington, D.C.: U.S. General Accounting Office. (1979).

Federal Standards for Prisons and Jails, U.S. Department of Justice Bureau of Prisons (1980).

Federal Bureau of Prisons. Psychology Services Manual-Draft. Washington, D.C.: U.S. Department of Justice. (1983).

Georgia Department of Offender Rehabilitation. Standards for Counseling and Psychological Services. (1981).

Law Enforcement Assistance Administration. Uniform Law Commissioners' Model Sentencing and Corrections Act. Washington, D.C.: U.S. Department of Justice. (1979).

Mental Health Law Project, (MHLP) Model Statute: Civil Commitment [reprinted in 2 Mental Disability Law Reporter 64 (1977)].

MHLP, Model Statute: Mental Health Standards and Human Rights [reprinted in 2 Mental Disability Law Reporter 291 (1977)].

MHLP, Model Statute: Therapeutic Confidentiality [reprinted in 2 Mental Disability Law Reporter 337 (1977)].

Model Developmentally Disabled Offender Act [reprinted in Disabled Persons and the Law: State Legislative Issues 722-729 (B. Sales, D. Powell, R. Van Duizend et al. eds. 1982)].

Model Right/Consent Statute [reprinted in Disabled Persons and the Law: State Legislative Issues 425-452 (B. Sales, D. Powell, R. Van Duizend et al. eds. (1982)].

National Advisory Commission on Criminal Justice Standards and Goals (NAC), Community Crime Prevention (1973).

National Association of Counties, Corrections (1973).

National Association of Pretrial Services Agencies, (NAPSA) Performance Standards and Goals for Pretrial Release and Diversion (1978) (available from National Pretrial Services Resource Center, 918 F Street NW, Washington, D.C. 20004).

National Commission on Correctional Health Care (NCCHC). Standards for Health Services in Jails (1987). This is actually a substantial revision of the 1981 AMA Standards.

Pennsylvania Correction/Mental Health Task Force. The Care and Treatment of Mentally Ill Inmates (1981).

United Nations, Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders. Health Aspects of Avoidable Maltreatment of Prisoners and Detainees. New York: UN. (1975).

U.S. Department of Justice. Federal Standards for Prisons and Jails. Washington, D.C.: U.S. Government Printing Office. (1980).

Form 330 ADM(CC) (3-86)

State of New York
Commission of Correction
Office of Mental Health

APPENDIX B

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME

NAME OF FACILITY	NAME OF SCREENING OFFICER	Detainee showed serious psychiatric problems during prior incarceration. Yes ___ No ___

Check appropriate column for each question.

	Column A YES	Column B NO	General Comments/Observations
OBSERVATIONS OF TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. *If YES, notify Shift Commander.*			
PERSONAL DATA	No Family/ Friends		
2. Detainee lacks close family or friends in the community.			
3. Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member).			
4. Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing job).			
5. Detainee's family or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.			
6. Detainee has psychiatric history. *(Note current psychotropic medications and name of most recent treatment agency.)*			
7. Detainee has history of drug or alcohol abuse.			
8. Detainee holds position of respect in community (e.g., professional, public official) and/or alleged crime is shocking in nature. *If YES, notify Shift Commander.*			
9. Detainee is thinking about killing himself. *If YES, notify Shift Commander.*			
10. Detainee has previous suicide attempt. *(Check wrists and note method.)*			
11. Detainee feels that there is nothing to look forward to in the future. (expresses feelings of helplessness or hopelessness). *If YES, to 10 and 11, notify Shift Commander.*	Nothing to Look Forward to		
BEHAVIOR/APPEARANCE			
12. Detainee shows signs of depression (e.g., crying, emotional flatness).			
13. Detainee appears overly anxious, afraid or angry.			
14. Detainee appears to feel unusually embarrassed or ashamed.			
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention, hearing or seeing things which are not there).			
16. A. Detainee is apparently under the influence of alcohol or drugs.			
B. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? *If YES to both A & B, notify Shift Commander.*			
CRIMINAL HISTORY	None		
17. No prior arrests.			

TOTAL Column A _____

ACTIONS

If total checks in Column A are 8 or more, notify Shift Commander.

Shift Commander notified: Yes _____ No _____

Supervision instituted: Routine _____ Active _____ Constant _____

Detainee Referred to Medical/Mental Health: If Yes:

Yes _____ No _____

EMERGENCY	NON-EMERGENCY
medical _____	medical _____
mental health _____	mental health _____

Medical/Mental Health Personnel Actions: (To be completed by Medical/MH staff)

INSTRUCTIONS FOR COMPLETING
SUICIDE PREVENTION SCREENING GUIDELINES — FORM 330 ADM

GENERAL INFORMATION

This form is to be completed in triplicate for all detainees prior to cell assignment.

Insert top copy in detainee's file. If detainee is referred, give second copy to medical or mental health personnel. The third copy is available for use according to our facility's procedures.

Comment Column:	Use to note: 1. Information about the detainee that officer feels is relevant and important 2. Information requested in questions 6 and 10, and 3. Information regarding detainee's refusal or inability to answer questions (See Below - General Instructions)
Detainee's Name:	Enter detainee's first and last name and middle initial.
Sex:	Enter male (m) or female (f).
Date of Birth:	Enter day, month and year.
Most Serious Charge(s):	Enter the most serious charge or charges (no more than two (2)) from this arrest.
Date:	Enter day, month and year that form was completed.
Time:	Enter the time of day the form was completed.
Name of Facility:	Enter name of jail or lock-up.
Name of Screening Officer:	Enter name of officer completing form.
Psychiatric Problems During Prior Incarceration:	Check YES if facility files show that during prior detention detainee attempted suicide and/or was referred for mental health services. If "unknown", write unknown across space.

INSTRUCTIONS FOR ITEMS 1-17

General Instructions

Check the appropriate YES or NO box for items 1 - 17.

If information required to complete these questions is unknown to screening officer, such information should be obtained by asking detainee to answer questions. However, detainee has a right to refuse to answer.

If detainee refuses to answer questions 2-11, enter RTA (refused to answer) in the Comment Column next to each question. In addition complete the YES or NO boxes only if information is known to you.

If during an otherwise cooperative interview, detainee refuses to answer one or two questions: Check YES in the box(es) next to the unanswered question(s) and enter RTA in the comment box next to each unanswered question.

If detainee is unable to answer all question 2-11, enter UTA (unable to answer) in the Comment Column next to each question. Also enter reason (e.g., intoxicated, not English speaking) for not answering these question in the Comment Column next to question 2. In addition complete the YES or NO boxes only if information is known to you.

Observation of Transporting Officer

ITEM (1) Suicide risk: Check YES or NO box based upon the verbal report of the arresting/transporting officer or upon the screening form completed by the police agency. If YES, notify shift commander.

Personal Data Questions

ITEM (2) Family/friends: Check YES box if someone other than a lawyer or bondsman would (1) be willing to post detainee's bail, (2) visit detainee while he/she is incarcerated, or (3) accept a collect call from detainee.

ITEM (3) Significant loss: Ask all three components to this question—loss of job, loss of relationship and death of close friend or family member.

ITEM (4) Worried about problems: Ask about such problems as financial, medical condition or fear of losing job. Check YES if detainee answers YES to any of these.

ITEM (5) Family/significant other attempted suicide: Significant other is defined as someone who has an important emotional relationship with the detainee.

ITEM (6) Psychiatric History: Check YES box if detainee (1) has ever had psychiatric hospitalization, (2) is currently on psychotropic medication, or (3) has been an outpatient psychotherapy during the past six months. Note current psychotropic medication and name of the most recent treatment agency in the Comment Column.

ITEM (7) Drug or Alcohol History: Check YES box if detainee has had prior treatment for alcohol/drug abuse or if prior arrests were alcohol/drug related.

ITEM (8) Respect and shocking crime: Check YES if detainee is very respected for work, community activities, etc. and/or the crime is shocking in nature, e.g. child molestation.

ITEM (9) Suicidal: Check YES box if detainee makes a suicidal statement or if he responds YES to direct question, "Are you thinking about killing yourself?" If YES, notify shift commander.

ITEM (10) Previous attempt: Check YES box if detainee states he has attempted suicide. If YES, note the method used in the Comment Column. If either YES or NO, check detainee's wrists and note any scars in Comment Column.

ITEM (11) Hopeless: Check YES box if detainee states feeling hopeless, that he has given up, that he feels helpless to make his life better.
If YES to both items 10 and 11, notify shift commander.

Behavior Appearance Observations

YES or NO must always be checked for each of these items. They are observations made by the screening officer. They are not questions.

ITEM (12) Depression includes behavior such as: crying, emotional flatness, apathy, lethargy, extreme sadness, unusually slow reactions.

ITEM (13) Overly anxious, afraid or angry includes such behaviors as: handwringing, pacing, excessive fidgeting, profuse sweating, cursing, physical violence, threatening, etc.

ITEM (14) Unusually embarrassed or ashamed: Check YES box if detainee makes non-elicited statements indicating worry about how family/friends/community will respond to his detention.

ITEM (15) Acting in strange manner: Check YES box if you observe any unusual behavior or speech, such as hallucinations, severe mood swings, disorientation, withdrawal, etc.

ITEM (16A) Detainee under the influence: Check YES if someone is apparently intoxicated on drugs or alcohol.

ITEM (16B) Incoherence, withdrawal, or mental illness: Withdrawal means physical withdrawal from substance.
If YES to both A & B, notify shift commander.

Criminal History

ITEM (17) No prior arrests: Check YES box if this is detainee's first arrest.

SCORING

Be sure to count all checks in column A and enter total in the space provided. Notify shift commander 1) total is 8 or more, or 2) any shaded boxes are checked, or 3) if you feel notification is appropriate.

DISPOSITION

Officer Actions

Shift commander notified: Check YES or NO. Shift Commander should be notified about detainee prior to cell assignment.

Supervision instituted: Check appropriate supervision disposition. This section is to be completed by shift commander. For definition of active, constant and routine see N.Y.S. Commission of Correction Minimum Standards for Local Correctional Facilities.

Detainee referred to medical and mental health personnel: Check YES or NO. If YES, check emergency/nonemergency, medical/mental health. This section is to be completed by shift commander.

Medical/Mental Health Actions

This section should be completed by medical/mental health staff and should include recommendations and/or actions taken.

CHAPTER 4

JAIL-BASED MENTAL HEALTH SERVICES[1]

by Joel A. Dvoskin, Ph.D.

INTRODUCTION

As noted in the introductory chapter of this monograph, while estimates of mental illness among jail inmates vary widely, there is, nevertheless, incontrovertible evidence of the existence of significant numbers of severely mentally ill citizens among jail populations. Given the general overcrowding of prisons and jails across the country, the diversion programs suggested elsewhere in this monograph are clearly necessary. Yet even if such programs were to succeed well beyond current expectations, jails and lockups will continue to house a large number of seriously mentally ill individuals while they are either serving sentences for serious misdemeanors or awaiting trial.

As Axelson (1987) has demonstrated, even among jailed misdemeanants there is significant discrimination against psychotic inmates in accessing various types of pretrial release. Similarly, Valdiserri et al (1986) found that psychotic inmates were four times more likely than non-psychotic inmates to have been incarcerated for less serious charges such as disorderly conduct and threats.

Teplin (1990) demonstrated that the prevalence rates of schizophrenia and major affective disorder are two to three times higher than those of the general population, even after adjusting for demographic differences between the two populations. And since virtually all estimates of mental disability among jail inmates exceed those for prison populations (see, e.g. Teplin and Swartz, 1989), it is safe to assume that the prevalence of mental illness among jail inmates is at the very least equal to that among incarcerated felons. Steadman and his colleagues (1987) demonstrated that the prevalence of severe or significant psychiatric disability among sentenced felons is at least 15 percent; when coupled with severe or significant functional disabilities (which may be due to mental illness, mental retardation, brain damage, or other factors), at least 25% of the inmate population in the New York State Department of Correctional Services were found to be suffering from at least a significant psychiatric or functional disability.

There are a number of reasons why these mentally ill inmates will await trial in jail despite efforts to divert them to alternative dispositions. For some, the instant offense will be severe and unrelated to their mental illness,[2] thus ruling out the dropping of nuisance charges or negotiated insanity pleas. For others, the stress of the jail environment will bring about psychiatric crises in people who were mentally intact in the community (Gibbs, 1987). Finally, with the meteoric rise of illegal drug use in our society, and the well documented

relationship between such drug use and criminal behavior (see, e.g. O'Neil & Wish, 1990; Mirsky, 1988; Petrich, 1976), urban jails especially are facing large increases in the numbers of newly admitted inmates who are toxically psychotic upon arrest.

Once these inmates with severe mental illness or in psychiatric crisis are admitted to jails and lockups, they present a variety of real problems to local correctional administrators. Foremost among these is the possibility of serious injury to staff and other inmates posed by some mentally ill inmates whose behavior is both uncontrolled and violent. Or, mentally ill inmates may be terrified of hallucinations and stay up all night screaming, keeping other inmates awake, and often causing other inmates to become angry and even violent in response. Housing assignments must account for the fears which mentally ill inmates and non-mentally ill inmates often have of each other.

A second set of problems posed by the occurrence of psychiatric crises and the presence of severely mentally ill inmates in local jails and lockups is related to liability. For sheriffs and police chiefs, tragedies such as suicides and restraint-related deaths may have dire consequences. Legal fees can be very expensive even in the absence of adverse judgments or settlements. Public opinion, so seldom sympathetic to jail inmates, nevertheless solidly expects correctional officials at the very least to keep their inmates alive. Finally, despite the general stereotype of "guards" as tough and unfeeling, a successful suicide is often devastating to staff who feel responsible for keeping inmates safe.

Since it is virtually assured that, for some time to come, municipal jails and police lockups will continue to house at least some inmates with psychiatric problems, this chapter will briefly establish the legal necessity of providing services in jails and lockups, examine the essential services which must be available, and discuss various ways of meeting these service needs in light of the tremendous diversity among American jails and lockups.

THE LEGAL REQUIREMENTS FOR IN-JAIL MENTAL HEALTH SERVICES

Singer (1982), and more recently, Cohen (1988) and O'Leary (1989) have written extensively about the legal bases for requiring mental health services in jails and prisons, and about the required components and standards that various courts have established for such services. The following very brief summary is intended to introduce the reader to the basic legal concepts involved.

Most importantly, pretrial detainees have at least the same right to diagnosis, adequate records, and treatment as persons convicted of crimes (Cohen, 1988). A convicted inmate's right to medical and psychiatric treatment in prison is guaranteed by the Eighth Amendment's prohibition against cruel and unusual punishment and stems from the state's role as incarcerator. The Supreme Court has interpreted this responsibility as the duty to avoid "deliberate indifference" to the serious medical needs of inmates (Estelle v. Gamble, 1976). Later, psychiatric needs were specifically included within this standard (Bowring v. Godwin, 1977). To incarcerate someone with deliberate indifference to their significant psychiatric needs is thus viewed as cruel and unusual punishment and may be remedied, often through

class action lawsuits, either by injunctive relief and/or monetary damages, either compensatory and/or punitive.

For pretrial detainees, on the other hand, the right to treatment stems not from the Eighth Amendment, but from the due process rights guaranteed by the fourteenth amendment to the Constitution. Nevertheless, Cohen concludes that "unconvicted detainees posses the whatever rights the convicted possess, and (are) entitled to at least the same level of care."

Cohen lists six essential elements, taken from a prison class action in Texas (Ruiz v. Estelle, 1980), as providing a useful framework for prison administrators planning mental health services:

- systematic screening and evaluation;
- treatment which is more than mere seclusion or close supervision;
- participation by trained mental health professionals;
- accurate, complete, and confidential records;
- safeguards against psychotropic medication which is prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriately administered; and
- a suicide prevention program.

Interestingly, there appears to be no well-established Constitutional right to substance abuse treatment in correctional settings, or surprisingly even to habilitation for mentally retarded inmates and detainees (Cohen, 1988). However, there are several caveats to these apparent oversights. With regard to substance abuse treatment, the provision of detoxification is better viewed as a necessary medical service, and would thus seem likely to be required. Preventive drug abuse treatment, however, does not appear to be Constitutionally required. For mentally retarded inmates, while they may not be entitled to habilitative treatment within correctional settings, they are certainly entitled to treatment for any psychiatric crises or serious mental illnesses they may incur while incarcerated. In the absence of any services geared to the special needs of the retarded (see Santamour & Watson, 1982) it is likely that these inmates or detainees will experience increased stress within the correctional environment, and thus be at increased risk for depression, severe anxiety, or other psychiatric crises.

In addition to Constitutional litigation, correctional administrators who ignore the mental health needs of inmates may also be vulnerable to tort liability such as wrongful death actions in the case of inmates who receive no treatment for severe depression and subsequently commit suicide (O'Leary, 1989). Injuries to staff and other inmates which may result from inadequate mental health services can lead to tort liability (Mental and Physical Disability Law Reporter, 1986), as well as great expense due to occupational injury leave and disability

retirements. Finally, inadequate medical or psychiatric services can result in simple malpractice claims against both medical and mental health providers in the jail.

Thus there is a clear Constitutional requirement that correctional administrators provide for the serious psychiatric needs of those they incarcerate. Deliberate indifference - the Constitutional standard - is not a very demanding one and it should be clear that legal considerations alone will not necessarily lead to ideal or even adequate services. Good public policy will necessitate a balancing of various public policy considerations which include reducing liability, providing humane treatment for prisoners, maintaining the safety of staff and other inmates, and all within a framework of cost effectiveness in an increasingly conservative fiscal environment.

SERVICE COMPONENTS[3]

Steadman and his colleagues (1989) suggest nine possible mental health services for inclusion in local correctional settings: 1) **intake screening at booking**, 2) **evaluation following initial screening**, 3) **assessment of competency to stand trial**, 4) **use of psychotropic medications**, 5) **substance abuse counseling**, 6) **psychological therapy**, 7) **external hospitalization**, and 9) **case management** or linkage of inmates with community mental health agencies following release.

In addition to this list, several other services also warrant discussion. Although it should be encompassed in the above list, the special importance of **suicide prevention** in jails and lockups warrants its treatment as a special category of service. It is also useful to treat **crisis intervention** as a separate service component, for reasons which will be discussed below. Special **housing** options may also be required for inmates whose mental status creates an identifiable risk of harm, whether that harm is self-inflicted or inflicted by predatory inmates. Finally, it is important to take into consideration the indirect role of mental health providers in improving the jail environment; thus **consultation and training** for correctional staff must be included as well.

SCREENING

As the prior chapter has clearly demonstrated, screening must be regarded as the most important service element in correctional mental health (Pogrebin, 1985). Screening is not only a specifically required legal obligation (Cohen, 1988), but is clinically and programmatically essential as well. It is impossible to appropriately treat serious mental illnesses or psychiatric crises without identifying the specific individuals affected. There are a number of acceptable ways to provide mental health screening in jails, but several elements must be present if the screening is to be useful:

Trained staff

Screening must be performed by persons with adequate training. This training will of course depend upon the screening tool being utilized. As we will see below, it is possible to

develop standardized screening tools which can be successfully administered by line staff or licensed practical nurses, provided that they are trained in how to administer each screening instrument, and where to refer those inmates who are identified as being in need of services.

Documentation

The results of the screening must be clearly and legibly documented and available to those responsible for medical care, housing assignment, liaison to outside agencies, and other types of follow-up services. The resulting records must also be maintained in a manner that assures the privacy and confidentiality of each inmate/patient, while at the same time facilitating communication between different mental health and medical providers.

Low Threshold

The screening must have a low threshold for referral to more extensive evaluation. That is, <u>any</u> indication of either history or current evidence of mental illness or psychiatric crisis must result in referral for a follow-up evaluation. For example, any inmate who has ever been psychiatrically hospitalized or who reports ever having attempted suicide should be referred. Likewise, any unusual or eccentric mannerisms or behaviors observed must be specifically documented and referred for further evaluation.

Standardization

By routinely conducting the screening during booking, and by training staff in the screening procedure, one avoids an idiosyncratic process where a mentally ill inmate's chances of being identified depend upon who happens to be on duty when they arrive.

Perhaps the most exciting recent development in the research literature on mental health in jails and lockups is provided by Teplin and Swartz (1989) in their "Referral Decision Scale" (RDS). This scale is the result of a skillful application of sophisticated quantitative psychological research to the real world of local corrections. The RDS requires little time to administer, and requires only trained laypersons, which is especially important in smaller jails with no on-site clinicians. In comparison to Teplin's (1986) recent study showing a 25 percent detection rate among psychotic jail detainees, the RDS demonstrated a detection rate of 79 percent.

The RDS is not intended to eliminate the need for mental health professionals in local corrections. It is simply an effective screening tool to identify for follow-up evaluation those inmates who appear to have psychoses or major depressions. The RDS thus represents the best kind of social science, resulting in the development of a simple useful tool which will improve the lives of mentally ill inmates as well as reduce the potential liability of correctional administrators.

FOLLOW-UP EVALUATIONS

Since screening will often be provided by line staff (e.g. correctional officers or licensed practical nurses) who lack advanced clinical degrees and mental health training, it will be necessary to provide more extensive and detailed evaluations for those inmates initially identified during the screening process as likely to require mental health services during the course of their detention. They must be timely and should be responsive to specific issues raised during the screening. Most importantly, this evaluation must result in practical treatment recommendations within the jail setting. Given the high prevalence of serious mental illnesses in jails, it is likely that the screening process will identify a large number of inmates as needing such evaluations. Since psychiatrists are difficult to recruit and a great deal more expensive than other mental health providers, it makes sense to have these "second level" follow-up evaluations conducted by psychologists, social workers, or psychiatric nurses with advanced degrees. Finally, since the evaluations will be diagnostic in nature, they should generally be done by at least masters level staff with training in psychopathology (Dvoskin, 1989).

It is important to limit these evaluations to issues which have immediate treatment implications. Given the generally limited treatment resources in local correctional settings, full scale psychological test batteries will be unnecessary and wasteful for the vast majority of inmates needing evaluations. The symptoms of a small number of inmates will raise questions that can only be answered by extensive psychological testing, but such testing should be reserved for exceptional cases in order to best utilize scarce resources (Dvoskin, 1989).[4]

For inmates who appear to require psychiatric services such as psychotropic medication, a referral to the psychiatrist will then be in order. It is important to have some capacity for the emergency administration of medication during weekends and nights. On-call psychiatrists may accomplish these consultations via telephone contact with on-site non-psychiatric physicians or registered nurses. Of course, a better course would be 24-hour on-site psychiatrist availability, but this luxury is likely to be found only in a few very large and well-funded jails. In jurisdictions where there is a smaller jail and a local community mental health center with adequate crisis services, it is also an excellent idea to make mobile crisis teams from the community mental health provider available to the jail. Finally, some jails will utilize nearby general hospital emergency rooms for at least some psychiatric emergencies.

CRISIS INTERVENTION

Despite the very best screening and evaluation services, it will still be impossible to identify in advance all inmates who will require psychiatric services during their incarceration or detention. No screen is perfect, and even Teplin's "cutting edge" instruments misses 21 percent of psychotic inmates. Further, certain kinds of psychoses, such as atypical paranoid psychosis, may allow the inmate to appear quite unimpaired even under stress, at least for a while. Most importantly, however, there are a number of reasons why inmates will either appear or be psychologically intact upon intake, and later experience a psychiatric crisis within the jail setting.

Jails, like prisons, are extraordinarily stressful environments. Overcrowding, poor temperature control leading to extremes of cold or heat, noise, filth, and the fear of assault may all contribute to the psychological deterioration of even the most "mentally healthy" inmate. Jails are even more distressing than prisons, since most jail inmates have recently arrived and have a great deal of uncertainty as to their legal and penal futures. For first time offenders especially, their expectations are likely to be colored by television or movie dramatizations which stress the violence in jails. Perhaps most upsetting to first time offenders is the simple truth that jail inmates are not very nice to each other. Younger, smaller, and more physically attractive inmates are whistled at and called "fresh meat." The fear of homosexual rape, whether real or imagined, is an astonishingly powerful psychological stressor. Together, these various stressors can combine to whittle away at psychological defenses, and may lead to psychiatric crises at any time during the course of incarceration.

Another risk factor which persists past the booking process is any preexisting psychological condition which makes a person vulnerable to psychiatric crisis or mental illness. Family histories of affective disorder appear to increase the risk of severe depression which could be triggered by the stresses alluded to above. Certain personality disorders, especially borderline personality disorder, create a variety of risks for psychiatric crises, including suicidal gestures, emotional hyper-reactivity, and acute psychosis (especially in response to being locked up.)

Inmates who experienced physical or sexual abuse or torture as children are likely to experience incarceration as a reenactment of this trauma. Similarly, combat veterans, victims of violent crime, and others suffering from post traumatic stress disorder are especially likely to respond poorly to incarceration.

Thus, local correctional facilities, as a matter of law and sensible policy, must have some sort of quick and easy access to crisis services. These services include **psychotropic medication, one-to-one or other special watch procedures, psychological or counseling services, detoxification** (since drugs may be available inside of the jail), **information** (such as when the inmate will get to see a lawyer or receive visits), and **consultation** with correctional staff about how to handle problematic inmates.

Administration of **psychotropic medications** in emergency situations can be dangerous, especially with newly admitted inmates whose blood toxicity has not been assessed. As the incidence of illegal drug abuse has increased, the likelihood of a psychiatric crisis being due to toxicity has also increased. The safe prescription of medications in emergencies involving newly admitted inmates would thus include a physical examination. Since the time of day will often preclude such safeguards, many physicians will elect such non-pharmacological treatment interventions as seclusion or constant observation to resolve the immediate crisis and keep the inmate safe until services can be obtained. Other facilities will elect to use local general hospital emergency rooms for this purpose.

Special Management

Special management precautions in response to psychiatric emergencies include moving the inmate to a different bed location either to separate violent inmates from others, allow for

easier and more frequent observation, or to be closer to nursing or other services. Often inmates will be put on "special watches" such as constant observation or one-to-one, especially where suicidal intent is suspected.

The special management precautions are required for two reasons. Each facility has an overriding obligation to protect inmates or detainees from foreseeable and preventable harm. They may also follow from the duty to provide medical or psychiatric treatment, although the two considerations will often overlap. In either case, the most important job in any psychiatric crisis in jail is to ensure the safety of all of the people who live and work there. For this reason, crisis response is as much the responsibility of correctional staff as it is of the mental health staff, even where 24-hour mental health staff is available.

Verbal Counseling

Verbal counseling in crises is not only the least intrusive intervention available, often it is the most effective, especially where the crisis is in response to a specific event or the novelty of the incarceration itself. Whether crises occur in inmates with or without longstanding mental illnesses, these crises are often a response to fear. Inmates fear many things in jail, some real and some imagined. Often, simply providing information, spiking rumors, or offering support can significantly improve an inmate's response to his or her situation.

Every jail and police lockup which receives direct admissions from the street must have access to medically supervised alcohol and drug detoxification services. However, it is important to note that this service is primarily medical in nature, and not a mental health service. Obviously, once detoxification is safely accomplished, assessment should be made of any need for subsequent mental health service, but it is worth reiterating that the act of detoxification is a medical function.

Consultation Services

Consultation services, when provided by mental health staff to the correctional staff, can be sophisticated suggestions for handling difficult detainees or as simple as suggesting a cell change or special watch. As will be noted below, what is imperative is that the mental health staff be viewed as supportive of the correctional staff's mission to make the jail safer for everyone.

As with nearly all jail-based mental health services, it is imperative that adequate documentation and communication of crisis responses be maintained. Where off-hour providers are contractors or from other agencies, it is imperative that essential aspects of the crisis and actions taken in response to it be communicated to the mental health and, where appropriate, correctional staff of the jail. For example, if an inmate gets a "Dear John" letter and loudly threatens suicide over the weekend, but is calm and relatively happy by Monday morning, it may mean that he has accepted the loss. It may also mean, however, that he has hatched a plan to complete the suicide and is at increased, rather than decreased risk. It is impossible to make an adequate assessment without full knowledge of the weekend's incident.

One final note about crisis services; the competent resolution of any crisis must include some reasonable effort to prevent its recurrence. When the response is informative, the newly acquired knowledge itself may have a preventive effect. In other cases, however, such as supporting a psychologically fragile inmate through a crisis, might suggest other preventive steps such as ongoing supportive therapy, if not for the duration of the incarceration, at least for a reasonable period of adjustment to the jail. The preventive efforts could also take the form of skill building; e.g. teaching the inmate how to safely "do time." Finally, building social supports, such as helping the inmate to contact family or friends, could also prove effective in preventing a recurrence of the crisis.

SUICIDE PREVENTION

The prevention of suicide in local correctional facilities is a subject which has recently received a great deal of attention both in public policy and research literature (Cox and Landsberg, 1989; Hayes, 1989; O'Leary, 1989; Haycock, 1989; Cox et al, 1989; Sherman and Morschauser, 1989; Rakis and Monroe, 1989; Atlas, 1989). In brief, research has shown that the period of greatest vulnerability is during the first hours of incarceration, which may well occur during the evening or weekends when no clinical professionals are present. While there has been a dramatic increase in jail suicides across the nation during the past few years, a comprehensive statewide program in New York seems to have enabled sheriff and police departments to actually reduce suicides (Cox et. al., 1988.) This program, funded and administered by the New York State Office of Mental Health and the New York State Commission of Correction, is a simple and locally implemented program of staff training and procedure development for identifying and managing high risk inmates to reduce the incidence of suicide in jails and police lockups.

Essential components of jail suicide prevention programs, as outlined by Cox et. al. (1989) include the following:

- policy and procedural guidelines (for correctional and mental health personnel) which outline administrative and direct service actions to identify,manage, and serve high risk inmates;
- suicide prevention intake screening guidelines;
- a training program for jail and lockup officers in suicide prevention; and
- training for mental health personnel who will be working in correctional settings.

The results of the New York program have been impressive. In upstate counties, for example, despite increasing admissions, censuses and overcrowding, jail and lockup suicides have dropped since the program's inception from a high of 30 in 1985 to successive years of 25, 16, and only 8 in 1989 (New York State Commission of Correction, 1989.)

ASSESSMENT OF COMPETENCY TO STAND TRIAL

While a full discussion of this topic is beyond the scope of this paper (see, e.g. Grisso, 1986; Roesch and Golding, 1980), it is certainly worth mentioning that inmates in psychiatric crisis or those with severe mental illnesses are also defendants whose competency to proceed is likely to be questioned. It is certainly not necessary that jails or their mental health programs actually provide competency assessments. Indeed, it may not even be desirable, since such assessments could well drain needed clinical resources away from treatment within the jail.

As Melton and his colleagues (1985) have shown, competency evaluations can nearly always be conducted in outpatient settings, including the community or jails. They argue that to hospitalize competency evaluatees unnecessarily is fiscally wasteful and unnecessarily restricts defendants' freedom. But if these evaluations are provided to courts by the jail at no cost, there is the unfortunate possibility that inmates will be denied pretrial release in order to complete these evaluations. It is therefore prudent to separate the competency evaluation process from pretrial release. For most detainees, these evaluations can be conducted on an outpatient basis in the community when defendants have been released either on bail or their own recognizance.

This is not to suggest that no competency assessments should be done in jail. At least some of the inmates whose competence seems most improbable will be appropriately denied pre-trial release for any of a number of reasons. For these inmates, it is wasteful of staff resources and dangerous to require that they be transported outside of the jail's secure perimeter to a community clinic for evaluation. The point is that while the service should take place in the jail, it should be equally accessible and similarly funded in the free community. This arrangement will avoid both the unnecessary use of jail beds and the unnecessary restriction of freedom of jail detainees who have not been convicted of any crime and who would otherwise be deemed appropriate for pre-trial release.

While slightly tangential to this paper, it is worth mentioning that Melton and his colleagues accurately predicted one other advantage of community based competency evaluations. As community mental health centers have begun to participate in the criminal justice process in various states through the provision of pre-trial forensic evaluations, they have begun to expand this involvement to other areas of the criminal justice system. This increased comfort with criminal justice has in turn led to a willingness to provide direct services in jails and lockups; locations which were previously avoided by most community mental health service providers.

USE OF PSYCHOTROPIC MEDICATIONS

As noted above, the most important consideration in prescribing psychotropic medications to recently admitted jail inmates and detainees is the possibility of preexisting toxicity in their blood due to illegal narcotics, prescription medications, or even accidental intoxication or poisoning. Of course, these concerns are equally important in virtually any emergency psychiatric setting, and psychiatrists who work in correctional settings must be

aware of all of the usual issues which surround emergency psychiatry (see, e.g. Anderson et. al., 1976; Dubin, 1988; Salzman et. al., 1986). In addition to these generic emergency psychiatric concerns, however, there are several other considerations which are especially or even uniquely important in dealing with local correctional patients.

People are seldom put in jail for being especially compliant. It should therefore not be surprising that inmates may present medication compliance problems (Smith, 1989). Inmates who feel oppressed by the criminal justice system often view psychotropic medication ordered by a public physician as an instrument of that oppression. Busy physicians may spend an inadequate amount of time explaining the need for medication, its value to the patients, or what to do about side effects. If dosages are not carefully monitored and adjusted, the patient may experience a variety of unsettling and uncomfortable and even dangerous side effects. As a result, correctional nurses need to take special care when administering medications in the jail to insure that the patients are not "cheeking" medications to appear compliant or to save for later sale. Minor tranquilizers are especially prone to abuse and black market sale within the jail, and are kept off of the formulary in many correctional settings for that reason.

Finally, at least some time should be devoted to explaining to patients the need for psychotropic medication, beyond what may be typically provided for "informed consent." More formal prison-based patient education programs, while still comparatively new, have shown an ability to significantly increase patients' knowledge of the symptoms, causes, and treatments of schizophrenia (Melville & Brown, 1987). Thus, with a relatively small investment of clinical time, truly informed consent can be obtained, while at the same time offering at least the hope of improved participation in the prescribed treatment.

SUBSTANCE ABUSE COUNSELING

While substance abuse treatment is not the focus of this monograph, it is nevertheless true that many severely mentally ill persons also abuse illegal substances and alcohol (Carey, 1989). Indeed, the mentally ill chemical abuser (MICA) is a growing concern among virtually all segments of the mental health system. For these MICA patients, abuse of alcohol and other drugs can exacerbate psychiatric symptoms and even bring about psychotic episodes which may persist after the intoxication subsides. For these patients, the mental health providers in the jail should at the very least attempt to provide some rudimentary information about the dangers of drugs. More importantly, upon discharge from jail, referral should be made to substance abuse treatment programs.

Similarly, substance abusers who are not chronically mentally ill may develop real psychiatric crises when confronted with the stressful jail environment, where they will hopefully be precluded from obtaining the drugs which had habitually helped them through crises on the street. Given the high incidence of drug abuse among jail inmates, the general psychiatric crisis services model will need some modification to remain sensitive to these issues.

In a recent dissertation, however, Mirsky (1988) demonstrated the high prevalence of inmates with multiple occurring disorders, including substance abuse, depression, most often with antisocial personality disorder being the primary syndrome. Thus, she concludes, "intervention programs aimed at substance abusers or depressives which do not address the elements necessary for treating co-occurring character disorders may have a minimal impact on either the detainee or the crime rates."

PSYCHOLOGICAL THERAPIES

In view of the characteristically brief stays in jails, psychotherapy is predominantly aimed not at personality change, but at supporting the inmate through a stressful period of confinement. For inmates who are confused and anxious, frequent and surprisingly brief visits can provide reassurance that the inmate has not been psychologically abandoned. Often, the simple provision of accurate information about the jail or the criminal justice process can relieve a tremendous amount of anxiety and need not always be supplied by mental health professionals.

For more extreme psychiatric crises, intervention might consist of one or a few sessions of relatively long duration. These sessions should focus on identifying personal strengths which will help the inmate to survive the experience. Often, understanding that others have gone through similar crises and survived can be reassuring.

During periods of extreme psychological stress, a real part of the value of a therapist or counselor is to be a non-threatening source of company. It is comforting simply to be listened to, especially when in the middle of what may be perceived as an abusive experience.

In my experience, the type of "therapy" most valuable to jail inmates is often provided by staff who lack formal training but who have a natural ability simply to treat others with dignity and humanity. Often, jail and prison inmates report that they were most helped through a crisis by a particular correctional officer or an LPN.

For those inmates suffering from severe mental illnesses, the immediate focus of therapy is to protect the inmate from deteriorating in response to the jail environment. Schizophrenics especially seem to have trouble adapting to environmental change, and will require support until they have adapted to the jail or been released. The focus of psychotherapy is to provide the seriously mentally ill inmate with a touchstone to aide in reality testing, to avoid withdrawal into psychosis in response to fear of staff or other inmates.

Finally, for short-stay inmates, their tenure in jail may be an important opportunity to refer the person to the social service or mental health service delivery system in the community.

CASE MANAGEMENT

While case management in the community is covered in the next chapter, there is an in-jail case management service of shorter duration that warrants consideration. Mentally disabled inmates have a tendency to get "lost" in the jail when they can manage to avoid a crisis. During periods where they are lost to service, stressors may of course continue to build up in the absence of supportive services. It therefore is important to periodically "check in" with psychologically vulnerable and mentally ill inmates even during periods of apparently good adjustment. These very brief sessions can prove an effective investment if they prevent nore serious exacerbations which require more extensive and costly services.

EXTERNAL HOSPITALIZATION

Hospitalization for emergency psychiatric treatment is often unavailable, especially to smaller jails. Even in states such as New York where such emergency treatment is often provided, the law may require sheriffs to supervise inmate/patients round the clock. For small jails, this requirement can essentially preclude use of the service. The ability to obtain brief psychiatric inpatient care when it is necessary is of tremendous importance not only to the inmate requiring the transfer, but to the jail inmates and staff as well.

Emergency hospitalizations have only one goal -- to stabilize the patient by reducing severe psychiatric symptoms. Hospitalization is very expensive and may not be reimbursed by the state, leaving gaping holes in the budgets of smaller counties or municipalities. Follow-up treatment should continue either in the jail or in the community if pre-trial release can be obtained.

Inpatient hospitalization is often accomplished via transfer to an outside psychiatric hospital or the psychiatric ward of a local general hospital. However, some jurisdictions such as San Diego, California (Meloy, 1985) and Westchester County, New York provide inpatient treatment within the jail itself.

It is also important to realize that many patients whose mental illness is severe enough to warrant hospitalization will also be incompetent to stand trial. Such a finding usually results in transfer to the state-run maximum security forensic psychiatric facility. These hospitalizations tend to be of somewhat longer duration, and have as their goal the restoration of the patient's ability to proceed to trial.

CONSULTATION AND STAFF TRAINING

While screening is essential to identify inmates and detainees in need of clinical attention upon arrival at the jail, their subsequent mental health depends in large part upon the ability of correctional officers to identify inmates in psychiatric distress and make appropriate referrals. It is therefore important to provide officers with basic training in some of the signs of emotional disturbances, and how to inform clinicians in a behaviorally specific manner what exactly led the officer to suspect mental illness.

This training is certainly not meant to create diagnosticians of correctional officers, although correctional officers can certainly supplement the efforts of clinicians by learning to assist inmates in coping with the everyday stresses of incarceration (Lombardo, 1985). Perhaps the most important component of the training is how to access the resources available. Phone numbers, names of providers, and "what to do until the Doctor comes" are all important areas to cover as a routine part of the officer training. As noted above, the curriculum should also include basic suicide prevention training as well.

Consultations will often revolve around the correctional management of inmates or detainees (Brodsky & Epstein, 1982). A simple decision to separate two inmates can often prevent a dangerous assault or a psychiatric crisis, and administrators who learn to trust their clinical staff come to value advice in such decisions. Finally, in addition to positively affecting the mental health of the inmates, mental health professionals can also reduce job-related stress among correctional line staff as well (Dembo, Williams, and Stafford, 1986-87).

SPECIAL HOUSING AND MANAGEMENT OPTIONS

The most common reason for referral of an inmate to mental health services is disruptive or violent behavior, either toward self or others. Frequently, mental health staff will be asked to make a judgment about the level of supervision required to keep the inmate and others safe. Alternatives include one-to-one or constant observation status, movement to a safer or more isolated cell, or movement to a cell nearer to the observation post maintained by staff.

Balancing limited resources with good clinical judgment can be very difficult in managing these situations. In a small jail, for instance, with only two staff on duty, it would be impossible for more than one inmate to be on constant watch status at a time. Fifteen minute watches, on the other hand, leave ample time for a suicide to occur and are likewise unacceptable.

While there are no easy answers to such dilemmas, two considerations can be helpful. First, be creative. Use of a trustee inmate to assist in suicide watches can make the trustee inmates feel more valuable and free up staff time for other duties. In consultations in jails and prisons, I have often heard program managers state that they would very much like to use trustees in this manner, but fear that such a practice would be retrospectively condemned in the event of a successful suicide. Courts will certainly scrutinize such a practice, but in my experience courts tend to support reasonable practices, especially when implemented in a careful and responsible manner. Clearly, if such a practice is adopted, it should include reasonable safeguards such as training for the trustees who will be observing, regular supervision by staff, clear policies, and written documentation of the selection criteria used to select the trustees. Finally, correctional administrators should consult with their own counsel before making a decision. It is, however, my opinion that such a practice clearly improves the jail's ability to prevent suicides.

Other creative approaches include the use of multi-bed dormitories. Company can help alleviate depression, and inmates who are ambivalent about their own suicidality may watch

each other far more diligently than staff. Also, it is easier to watch a group of people in one room than in individual rooms.

The second consideration is to be realistic. It is unfair and clinically inappropriate to order a 5-minute watch when the clinician knows there are inadequate staff to perform it. These orders are perceived by staff as a simple-minded attempt by clinicians to shift responsibility to less well-paid correctional staff. By working together, it is usually possible to work out an arrangement which is both reasonable and clinically appropriate. For example, an order for constant observation will require three staff to observe three inmates in adjoining cells. An order worded "observe every minute", on the other hand, would allow one officer to walk back and forth, and observe all three inmates quite frequently.

SPECIAL POPULATIONS WITH SPECIAL PROBLEMS

In addition to the stressors which pervade jails and lockups, there are a number of special stressors and vulnerabilities which make the experience especially psychologically distressing. Obviously, suffering from a severe mental illness is one such stressor. Schizophrenics, for example, often have great difficulty in adapting to environmental stress. The program components above are designed to recognize and respond to their special needs.

There are, however, other less obvious groups who will require special attention as well. These include mentally retarded detainees; young, weak and attractive men; juveniles; non-English speaking inmates and ethnic minorities; and older inmates. While full scale programs aimed at each group may not be justified or cost effective, it is still necessary to account for their special needs in designing jail mental health programs.

Mentally retarded detainees experience a whole host of added problems in jail. The severity of these stressors will of course depend in part upon the degree of retardation and the life skills possessed by the individual, but cognitive impairment is very likely to increase the confusion and anxiety that often accompanies admission to jail, especially for the first time. Retarded and neurologically impaired inmates may require several repeated explanations in order to understand and retain information, yet overcrowding and the press of too frequent admissions prevent staff from taking the extra time necessary to explain the criminal justice process and the rules of the jail. The result can include increased disciplinary infractions, which can result in punitive segregation that may cause further confusion and anxiety to the retarded inmate. Where possible, correctional counselors should make a special effort to explain slowly and repeatedly to retarded inmates the entire process, including when they can expect to see a lawyer and what to do if someone threatens or attacks them. Referrals may be required to community service providers or to officers of the court to suggest competency evaluations (see, e.g. Williams and Spruill, 1987).

For young, weak, and physically attractive inmates, jail can be a special hell. Whatever predatory instincts exist in the population from whom inmates and detainees are selected seem to be intensified by the jail environment. While much of the sexual behavior in prisons is at least apparently consensual, it has been my experience that the same cannot be said for jails and lockups. Unobserved holding tanks provide an opportunity for gangs of predatory

inmates to sexually assault one weaker one with virtually no fear of prosecution, since the victim's fear of further reprisal for "snitching" will effectively silence any accusation. Thus, for inmates who appear to be feigning mental illness to "manipulate" the correctional environment, it is important for mental health professionals working in the jail to explore the possibility that such inmates are using mental health services in the jail to avoid real and terrifying threats in the cell blocks, while mental health services may not always be indicated, referrals to security staff can sometimes resolve the crisis.

Juveniles are often unsettling to correctional staff and will appropriately receive mental health attention for a variety of reasons. Those who are small of stature are likely targets of sexual aggression. On the other hand, many juveniles are treated as adults by the criminal justice system precisely because they are big and strong and have long histories of violence. These angry, aggressive, and dangerous children, without the benefit of having learned to "do time" safely, are often the cause of a great deal of unnecessary, apparently mindless violence within the jail (see also Rademacher, 1982).

For some ethnic minorities and non-English speaking inmates, jails can be a frightening and oppressive place. Foster (1988) for example, reports that traditional psychiatric approaches may not work well with Native Americans in the Federal prison system. Similarly, in urban areas, clinicians are unlikely to be sensitive to the psychiatric implications of the Native American culture and world-view.

Black and Hispanic people in jail, like those in the free world, are typically less often served by the mental health system (Steadman et. al., unpublished). This phenomenon in part reflects an unwillingness to seek help from predominantly white providers, but may also reflect subtle and even unintentional racism among those same providers. Toch, Adams, and Greene (1987) found a number of ethnic differences in prison infractions, and concluded that subcultural and psychological predispositions may converge to produce prison adjustment problems.

Older inmates, despite their relatively small numbers, present special problems as well. In addition to being vulnerable to predatory inmates, they are especially likely to be dependent on alcohol (Washington, 1989). For mature first offenders, their arrest may cause them to feel especially humiliated, and to fear ostracism from family and friends in the community. Finally, older detainees are more likely to be experiencing neurological problems such as dementia, problems which may have been causally related to the behavior which brought about their arrest.

As noted above, victims of child sexual or physical abuse, as well as other crime victims and combat veterans, may well encounter symptoms of post-traumatic stress disorder while in jail. The phenomenon of being locked up in a very small space by intimidating male authority figures can be frighteningly reminiscent of childhood experiences. For female inmates, especially those who have survived such abuse, the entire process can seem abusive, including strip searches, showering under observation, etc. In our work with incarcerated females in New York, inmates frequently report long histories of sexual violence at the hands of fathers, husbands, boyfriends, and strangers (see also Browne, 1987). This abuse is often directly

linked to the instant offense, as in the case of women who kill abusive spouses to protect themselves or their children.

Female detainees may have a variety of other special problems in adapting to correctional settings (Sobel, 1980). These include the possibility of pre-existing pregnancies which require pre-natal medical care, as well as recent mothers whose forced separation from their infant children can contribute to severe post-partum depression or even psychosis (see, e.g. McGaha, 1987).

A MODEL PROGRAM - THE FULTON COUNTY (GEORGIA) JAIL

One example of an innovative approach to mental health services in a large urban jail is to be found in Atlanta's Fulton County Jail and is directed by Dr. Lloyd Baccus (1990). Housing some 2200 inmates, the Fulton County Jail (FCJ) was relocated into new facilities in November of 1989. Its mental health program was contracted to Correctional Mental Health Associates in 1987 in response to Fambro v. Fulton County, in which a Federal Court found FCJ's medical and mental health programs to be unconstitutional. At the time, the entire medical service consisted of 1.5 hours of sick call per day, 5 days per week, conducted by a general practitioner.

A key feature of the FCJ program is immediate screening of every admission to the jail, 24 hours per day. This screening is accomplished during the normal work day by an experienced registered psychiatric nurse and during evenings, nights, and weekends by either registered or licensed practical nurses who have been specially trained for this task. The screening takes place as a routine part of the booking procedure, and always precedes classification and housing assignment within the jail. The screening also includes a standardized suicide assessment screening similar to that used in New York and other states (Cox et al, 1989). Psychiatric consultation is available to the screening nurse by phone 24 hours per day, with on-site consultation as needed.

The initial screening tends to have a relatively low threshold for further evaluation. That is, any inmate who has a significant history of psychiatric treatment, prior hospitalization, or appears to be acting strangely during booking is automatically referred for further assessment. If a psychiatric crisis is evident, the inmate will be transferred to one of two mental health housing options within the jail, and for any inmate with an apparent need for further mental health services, a follow-up evaluation is scheduled. These follow-up evaluations occur immediately upon transfer to mental health housing, or within 24 hours for inmates judged suitable for placement in general population.

For acutely psychotic or suicidal individuals, there is an acute psychiatric infirmary which occupies one of the facility's housing units. This acute service consists of 14 single bed cells with clear plexiglass doors facing a nursing and security station. There is a licensed practical nurse on duty 24 hours per day, seven days per week, under the supervision of a registered psychiatric nurse. Programming is limited in the acute service, with psychotropic medication and reduced stimulus the major therapeutic modalities. It is important to note that this acute service employs an aggressive short-term symptom reduction strategy, with an

average length of stay of approximately 72 hours. It is designed for one purpose: to resolve and stabilize acute psychiatric crises. Rehabilitative programming is ill suited to the mental statuses of the inmates housed there, and would be a waste of time in view of the brief duration of the treatment there. As soon as the psychiatric crisis is resolved, the inmate is either returned to general population or moved to the "chronic" unit (see below.)

A second level of mental health housing is to be found in two other housing units, each consisting of 18 cells and 36 beds. These 72 beds, perhaps misleadingly called the "chronic" unit (see Dvoskin and Steadman, 1990), provide longer term psychologically safe housing for inmates whose psychiatric crises may be resolved but whose psychiatric disability precludes their successful adaptation to the general population. These inmates will often serve their entire period of jail incarceration in this unit, where they receive a variety of services as appropriate. Most are receiving psychotropic medication, which is delivered by the nurses assigned to the nearby acute unit.

For inmates housed in general population, certain mental health services are still available. These include prescription of psychotropic medication, medication monitoring, and supportive counseling. Chemical dependency and medication compliance groups are conducted twice weekly by a registered psychiatric nurse with extensive substance abuse treatment experience.

One interesting aspect of this program is its close relationship to the emergency room at Grady Memorial Hospital in Atlanta. When inmates are in acute psychotic states, the prevalence of illicit drug use has, according to Dr. Baccus, created a need to almost assume toxic psychosis. These cases are quickly referred to the emergency room to assess the need for detoxification or other acute medical services prior to returning the inmate to jail for psychiatric follow-up.

Finally, for inmates with minor charges, there is often a decision to drop the charges in order to civilly commit the person to the Georgia Department of Human Resources (GDHR). For seriously mentally ill inmates who are deemed incompetent to proceed to trial for more serious crimes, GDHR also provides secure hospitalization at its regional hospital's forensic unit. The FCJ program, which is contracted through Correctional Mental Health Associates, costs less than $600,000 per year. It employs a total of 12.5 full time equivalent staff, made up of the following:

- 1.5 FTE psychiatrists
- 1 MSW social work supervisor
- 3 BA level social workers
- 2 registered psychiatric nurses
- 5 licensed practical nurses

In general, this program provides comprehensive assessments within clinically appropriate time frames, as well as follow-up monitoring by an experienced nursing staff. The special housing options provide both acute symptom reduction and psychologically safe housing for the severely and persistently mentally ill inmates whose disability would place them at risk within the general population. Given the brief lengths of stay of most jail inmates, this program focuses on responding to psychiatric crisis. This narrow focus on a specific treatment mission has helped the staff to develop a strong sense of professionalism and accomplishment.

Thus, at an annual cost less than $600,000, Fulton county has created a program which effectively[5] addresses the entire range of essential services without wasting resources on services which can be better provided elsewhere in the criminal justice process or the community. Specifically, the Fulton County program provides:

- mental health screening upon admission as part of the initial medical exam;
- timely follow-up evaluation by non-medical clinicians;
- referral to competency assessment where appropriate;
- psychotropic medication where safe and appropriate;
- short-term substance abuse counseling and referral to substance abuse treatment agencies upon release;
- short-term supportive psychotherapy aimed at helping the inmate to survive the jail experience;
- access to outside hospitalization where needed; and
- referral to needed human service providers upon release.

Each of these services is focused on the immediate legitimate needs of the inmate, without pretense of long-term treatment except for rare individuals who may be serving one-year sentences and who suffer from serious and persistent mental illnesses. As noted in the introduction, jails are designed to process people, not to change them. The Fulton County program recognizes this fundamental principal and is designed to allow this processing to be achieved with as little psychological damage as possible, and in a manner which will maximize the safety of everyone who lives or works within the jail.

A MODEL PROGRAM - THE RENSSALEAR COUNTY (NEW YORK) JAIL

Smaller jails are obviously more limited in the amount of funding available for mental health programming. Yet they are likely to be held to the same high standard of mental health care as larger jails, whether by accrediting bodies (e.g. American Association of Correctional Psychologists, 1980; American Psychiatric Association, 1989) or by the courts. The Renssalear

County Jail (RCJ) is a 102-bed facility located in Troy, New York. It is an 77 year old building, ill-suited to the needs of a modern jail. The building's design is quite weak from a security perspective, forcing the staff to maintain tighter controls over inmates than would be the case in a more secure setting. There is also grossly inadequate program space. The small indoor recreation area was at one time a coal storage bin and has neither natural light nor ventilation. Due to the poor physical space for indoor recreation, most inmates do not even choose to take advantage of the opportunity. The jail, like many jails, is plagued with frequent overcrowding, and the County must spend needed fiscal resources to board excess inmates with other nearby jails who may have a few empty beds. Movement of inmates within the building takes place predominantly on one staircase, and is likewise a security nightmare. There is only a small space for a library. Inmates are fed in one multi-purpose room, which is too small and also serves as meeting space for any group programming. To complete the dire picture, there are only 10-12 inmate jobs available to the average census of 107 inmates, resulting in forced idleness among the vast majority of the jails inmates and detainees.

Due to its small size, RCJ employs visiting nurses on a contractual basis five days per week. A contract physician does routine sick call one day per week, although a nearby general hospital's emergency room is available for any medical emergencies.

Fortunately, the Renssalear County Department of Mental Health has for many years recognized the importance of providing mental health services in its county jail. To meet this challenge, the Department has since 1980 employed one full-time staff member at the jail. Currently, this one-man program is Don Hogan. The results of his efforts are a tribute to the value of creativity and interagency collaboration.

Since there is only one of him, Mr. Hogan has learned to extend his influence on the jail in a variety of ways. First, his focus upon liaison activities places many of the resources of the County's generic mental health system at the disposal of the jail. The most important example is the jail easy access to psychiatric services in the nearby general hospital emergency room.

SUMMARY AND CONCLUSIONS

Jails can seem like virtual seas of human service need for which the resources will never be adequate. Thus, administrators must take into account which services are most costly and unavailable (particularly those provided by psychiatrists) and use these resources judiciously. Other mental health professionals, such as social workers and psychiatric nurses, are less expensive, more available, and more likely to be more culturally and ethnically similar to the inmates they will serve.

In order to provide adequate mental health services within jails and police lockups, resources must be focused on short term crisis services designed to identify, protect, and treat those inmates who are most vulnerable to suicide, injury, or severe psychological distress in the jail. Programs which attempt to do too much -- i.e. to provide a comprehensive mental health service delivery system within the jail -- are likely to waste resources and end up doing nothing very well.

Each of the services described in this chapter need to be available to inmates, but they do not have to be provided by or within the jail itself. The diversity of opinion on the appropriate auspice and location of jail mental health services rivals that of the services themselves. It is not especially important whether services are provided by the County's Sheriff or its Department of Mental Health, or whether the services are brought to the inmates or the inmates are brought to the services. What is important is that resources are used in the most efficient manner, and that each inmate has timely access to the essential services that the law and human decency require.

FOOTNOTES

1. The author wishes to thank Fred Cohen, Patricia Griffin-Heilbrun, and Judy Cox for their helpful suggestions.

2. Virkkunen (1974), for example, reported that only about one third of violent offenses committed by schizophrenics occurred during psychotic episodes.

3. See also Lamb et al. (1984) and Brodsky (1982)

4. There are of course another appropriate use of routine psychological testing. Standardized tests have been used as part of the classification process. Various systems have been developed (see, e.g. Megargee, 1976; Edinger et al., 1982) which utilize computer scored psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI) to make security and program classification decisions. Standardized testing may also prove useful in furthering research on the mental health needs of inmates and detainees. Nor am I suggesting that use of psychological test batteries as part of a competent psychological assessment has no value. However, in the real world of inadequate resources, it is most unlikely that any jail would have enough psychologists to provide time-consuming clinically administered batteries to more than a small fraction of patients needing follow-up evaluation.

5. In regard to Fambro v. Fulton County, Dr. Baccus notes that since the program's inception in 1987, there have been no complaints by either the plaintiffs or the court in regard to mental health services at Fulton County Jail.

REFERENCES

Alberti v. Sheriff of Harris County, Texas (1975).

American Association of Correctional Psychologists (1980). Standards for psychology services in adult jails and prisons. Beverly Hills: Sage.

American Psychiatric Association (1989). Psychiatric services in jails and prisons: Report of the task force on psychiatric services in jails and prisons.

Anderson, W.H., Kuehnle, J.C., & Catanzano, D.M. (1976). Rapid treatment of acute psychosis. American Journal of Psychiatry, 133, 1076-1078.

Atlas, R. (1989). Reducing the opportunity for inmate suicide: A design guide. Psychiatric Quarterly, 60(1).

Axelson, G. (1987). Psychotic versus non-psychotic misdemeanants in a large county jail: An analysis of pre-trial treatment by the legal system. (Doctoral Dissertation) Fairfax, Virginia: George Mason University Psychology Department

Baccus, L. Personal communication, February 3, 1990.

Bowring v. Godwin 551 F2nd 44, (4th Cir. 1977).

Brodsky, C.M. & Epstein, L.J. (1982). Psychiatric consultation through continuing education in correctional institutions. Comprehensive Psychiatry, 23(6).

Brodsky, S.L. (1982). Intervention models for mental health services in jails. Crime and Delinquency Issues, No. 82-1181.

Browne, A. (1987). When battered women kill. New York: Free Press, 23.

Carey, K.B. (1989). Emerging treatment guidelines for mentally ill chemical abusers. Hospital and Community Psychiatry, 40(4).

Cohen, F. (1988). Legal issues and the mentally disordered prisoner. Washington, D.C.: National Institute of Corrections.

Cox, J.F. & Landsberg, G. (1989). Introduction to special issue on jail suicide. Psychiatric Quarterly, 60(1).

Cox, J.F., Lansberg, G., & Paravotti, M.P. (1989). The essential components of a crisis intervention program for local jails: The New York local forensic suicide prevention crisis service model. Psychiatric Quarterly, 60(1).

Dembo, R., Williams, L., & Stafford, B. (1986-87). The impact of providing mental health and related services at a youth detention center on staff stress. Journal of Prison and Jail Health, 6(1).

Dubin, W.R. (1988). Rapid tranquilization: Antipsychotics or benzodiazepines? Journal of Clinical Psychiatry, 49(12).

Dvoskin, J. (1989). The Palm Beach, County, Florida, Forensic Program. In Steadman H.J., D.W. McCarty & J.P. Morrissey, The mentally ill in jail: Planning for essential services.

Dvoskin, J. & Steadman, H.J. (1989). Chronically mentally ill inmates: The wrong concept for the right services. International Journal of Law and Psychiatry, 12, 203-210.

Edinger, J.D., Reuterfors, D.L., & Logue, P.E. (1982). Cross-validation of the Megargee MMPI typology: A study of specialized inmate populations. Criminal Justice and Behavior, 9(2).

Estelle v. Gamble (1976). 429 U.S. 97.

Foster, D.V. (1988). Consideration of treatment issues with American Indians detained in the Federal Bureau of Prisons. Psychiatric Annals, 18(12), 698-701.

Gibbs, J.J. (1987). Symptoms of psychopathology among jail prisoners: The effects of exposure to the jail environment. Criminal Justice and Behavior, 14(3).

Grisso, T. (1986). Evaluating competencies: Forensic assessments and instruments. New York: Plenum.

Haycock, J. (1989). Manipulation and suicide attempts in jails and prisons. Psychiatric Quarterly, 60(1).

Hayes, L.M. (1989). National study of jail suicides: Seven years later. Psychiatric Quarterly, 60(1).

Inmates of Allegheny Co. Jail v. Pierce (1980).

Lamb, H.R., Schock, R., Chen, P.W., & Gross, B. (1984). Psychiatric needs in local jails: Emergency issues. American Journal of Psychiatry, 141(6).

Lombardo, L.X. (1985). Mental health work in prisons and jails: Inmate adjustment and indigenous correctional personnel. Criminal Justice and Behavior, 12(1).

Megargee, E.I. (1976). The prediction of dangerous behavior. Criminal Justice and Behavior, 3.

McGaha, G. (1986). Health care issues of incarcerated women. Journal of Offender Counseling, Services, and Rehabilitation, 12(1).

Meloy, J.R. (1985). Inpatient psychiatric treatment in a county jail. Journal of Psychiatry and Law, 13(3-4).

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. (1987). Psychological evaluations for the courts: A handbook for mental health professionals and lawyers. New york: Guilford.

Melton, G.B., Weithorn, L.A., & Slobogin, C. (1985). Community mental health centers and the courts: An evaluation of community- based forensic services. Lincoln: University of Nebraska Press.

Melville, C. & Brown, C. (1987). The use of patient education in a prison mental health treatment program. Journal of Offender Counseling, Services, and Rehabilitation, 12(i).

Mental and Physical Disability Law Reporter (1986). Suicides and other deaths. 10(6).

Mirsky K.A. (1988). Antisocial personality, substance abuse disorders, and depression in an urban county jail (Doctoral Dissertation). Chicago: Northwestern University.

New York State Commission of Correction (1989). 1988 annual data compendium. Albany, NY.

O'Leary, W.D. (1989). Custodial suicide: Evolving liability considerations. Psychiatric Quarterly, 60(1).

O'Neil, J.A. & Wish, E.D. (1990). Drug use forecasting research update. Research in Action; December, 1989: National Institute of Justice.

Petrich, J. (1976). Rate of psychiatric morbidity in a metropolitan county jail population. American Journal of Psychiatry, 133(12).

Pogrebin, M. (1985). The crisis in mental health care in our jails: Jail and the mentally disordered: The need for mental health services. Journal of Prison and Jail Health, 5(1).

Rademacher, D.A. (1982). Juveniles in jail: Special issues for a population subgroup. Crime and Delinquency Issues, No. 82-1181.

Rakis, J. & Monroe, R. (1989). Monitoring and managing the suicidal prisoner. Psychiatric Quarterly, 60(1).

Roesch, R. & Golding, S. (1980). Competency to stand trial. Urbana-Champagne, Illinois: University of Illinois Press.

Ruiz v. Estelle, 53 F.Sup. 1265 (S.D. Texas 1980).

Salzman, C., Green, A.I., Rodriguez-Villa, F., & Jaskiw, G.I. (1986). Benzodiazepines combined with neuroleptics for management of severe disruptive behavior. Psychosomatics, 27(1) (Supplement).

Santamour, M.B. & Watson, P.S. (1982). The retarded offender. New York: Praeger.

Sherman, L.G. & Morschauser, P.C. (1989). Screening for suicide risk in inmates. Psychiatric Quarterly, 60(1).

Singer, R.G. (1982). Providing mental health services to jail inmates: Legal perspectives. Crime and Delinquency Issues, No. 82-1181.

Smith, L.D. (1989). Medication refusal and the rehospitalized mentally ill inmate. Hospital and Community Psychiatry, 40(5).

Sobel, S.B. (1980). Women in prison: Sexism behind bars. Professional Psychology, 11(2).

Steadman, H.J., Fabisiak, S., Dvoskin, J., & Holohean, E. (1987). A survey of mental disability among state prison inmates. Hospital and Community Psychiatry, 38(10).

Steadman, H.J., Holohean, E., & Dvoskin, J.A. (unpublished manuscript). Estimating mental health need and service utilization among prison inmates.

Steadman, H.J., McCarty, D.W., & Morrissey, J.P. (1989). The mentally ill in jail: Planning for essential services. New York: Guilford.

Teplin, L. (1986). Mental disorder in an urban jail: Final report. (NIMH Contract #RO1MH32884). Rockville, MD: National Institute of Mental Health.

Teplin, L. & Swartz, J. (1989). Screening for severe mental disorder in jails. Law and Human Behavior, 13(1).

Toch, H., Adams, K., & Greene, R. (1987). Ethnicity, disruptiveness, and emotional disorder among prison inmates. Criminal Justice and Behavior, 14(1).

Valdiserri, E.V., Carroll, K.R., & Hartl, A.J. (1986). A study of offenses committed by psychotic inmates in a county jail. Hospital and Community Psychiatry, 37(2).

Virkkunen, M. (1974). Observations of violence in schizophrenia. Acta Psychiatrica Scandanavica, 67, 353-357.

Washington, P.A. (1989). Mature mentally ill offenders in California jails. Journal of Offender Counseling, Services, and Rehabilitation: Special issue on older offenders, 13(2), 161-173.

Webster, C.D., Menzies, R.J., & Jackson, M.A. (1982). Clinical assessment before trial. Toronto: Butterworths.

Williams, W. & Spruill, J. (1987). The criminal justice/mental health system and the mentally retarded, mentally ill defendant. Social Science and Medicine, 25(9).

CHAPTER 5

THE BACK DOOR OF THE JAIL: LINKING MENTALLY ILL OFFENDERS TO COMMUNITY MENTAL HEALTH SERVICES

by Patricia A. Griffin, Ph.D.

The previous three chapters have dealt with key issues in the areas of initial police contacts with mentally ill persons, admission screening in jails, and the treatment of mentally ill jail detainees. This chapter will focus on the transition between jail and community mental health services for mentally ill offenders as they are returned to the community---the "back door" of the jail.

Most jail mental health program descriptions include screening, evaluation, and treatment but rarely address what must happen to continue that treatment once the inmate leaves the jail. This is a curious oversight, given the universal agreement that we can not "cure" severe, long-term mental illness, but we must instead provide a system of continuing care (Meyerson & Herman, 1983). Unfortunately, there has been insufficient attention to the system of continuing care offered the mentally ill who become involved in the criminal justice system, particularly for those in jails. Continuity of treatment for this group is especially important given their vulnerability to decompensation, their lack of strong ties to the community, and their potential for disturbing behavior as a function of mental illness.

This chapter will review the very limited literature describing links between jails and community mental health services for mentally ill jail detainees. Specific strategies for strengthening treatment linkages will be proposed and a number of unresolved issues will be highlighted.

RESEARCH

Very little has been published in the area of jail to community mental health treatment linkages, either empirical or theoretical. Some descriptive and anecdotal articles material is available, little of which has specifically addressed the links between the jail and community mental health services. Nor is much available concerning the implications of this intersection of criminal justice and mental health for public policy and systems of mental health care.

Articles published between January 1976 and December 1988 were identified through the following computerized databases: PSYCHINFO, PSYCHALERT, Criminal Justice Periodical Index, Sociological Abstracts, MEDLINE, and EMBASE. A second PSYCHINFO computer search was done on the jail mental health literature published prior to 1976 and between 1988 and November of 1989. Several of the articles described here were culled from the more general discharge planning literature.

The preceeding chapters have described the number of mentally ill found in jails, how they get there, systems for admitting them, and programs for treating them. Now we turn to the issue of ensuring aftercare for mentally ill offenders when they leave jail. This discussion will be structured around a series of important questions.

The first question is how many mentally ill inmates released from jails are provided aftercare treatment plans. Again, the literature is almost nonexistent. Hawaii's new diversion project (Hawaii State Department of Health, 1989; RJW Foundation, 1989) funded by the Robert Wood Johnson Foundation, focuses on the intake unit at the District Cellblock for the island of Oahu where inmates are held for arraignment. In planning this pilot program, staff estimated that 85% of the cellblock population identified as mentally ill had been released in the past without formal treatment plans. The exceptions were those inmates requiring emergency psychiatric hospitalization.

The following question asks how long do mentally ill persons stay in jail and is there enough time to arrange for aftercare? This is a reasonable question given the recent Department of Justice statistics (1990) reporting the average length of stay for most jail inmates is three days. That short period of time is hardly sufficient for screening and initial treatment, much less the provision of aftercare arrangements.

Once again, we find little research in this area although a recent dissertation by Axelson (1987) sheds some light on the topic. Axelson compared the duration of pre-trial confinement of a group of psychotic misdemeanors with that of two other groups: 1.) "referred" misdemeanants--jail detainees referred for evaluation and/or treatment who showed some psychiatric symptoms but were not diagnosed as currently having a psychotic process; and 2.) "nonreferred" misdemeanants--jail detainees not referred for evaluation or treatment.

The investigator's results found psychotic misdemeanants spent six and a half times longer in confinement than the non-referred misdemeanants although they had fewer charges, less severe charges, and lower bail bonds. Axelson suggested that several factors worked together to extend the jail length of stay for the psychotic offenders including the requirement that they be competent to stand trial in order to face their charges (and the resulting court procedures, evaluations, and treatment to restore competency) and the lack of personal and community resources to meet bond.

Although the investigator did not measure the duration of confinement for mentally ill felony defendants, there is little reason to believe they would experience a significantly different process. Axelson's research suggests there is frequently adequate time for jail and community mental health staff to arrange aftercare linkages prior to release from the jail for mentally ill defendants.

Finally, we move to the question of how many jails actually provide linkages to community mental health services for their mentally ill offenders. Morgan (1982) reviewed 81 program descriptions of jail mental health delivery systems in the United States for a "state-of-the-art" survey of current jail practices. Although she asked jails to outline their specific mental health services delivered and listed "follow-up/referral" as a discrete program component, she did not report the responses to this particular program component. Perhaps too few jails described providing this service to include the results in the summary of the survey.

The most comprehensive research on the provision of mental health aftercare linkages in jails was done by Steadman, McCarty, and Morrissey (1989) in their review of mental health services provided by 43 jails in 26 states. Thirty-three of the jails studied were chosen because they had sent representatives to National Institute of Corrections training workshops held in 1979 on the development of mental health care in jails. The other ten were chosen because they had, or shortly expected, better than average mental health programs in their jails.

Steadman and colleagues looked specifically for case management services at time of release. Such services were defined as the process of linking mentally ill inmates with appropriate community agencies capable of providing ongoing treatment. To be rated as having such services, the jails had to show evidence of making aftercare appointments for all mentally ill inmates, or at least for a subgroup (such as those needing psychotropic medication). In addition, referrals must have been made for offenders with a variety of mental health problems. Providing inmates with names and addresses of possible community services was not sufficient to qualify as "case management at release". The investigators distinguished between case management for mental health services as opposed to substance abuse services.

Of the 43 jails, only 7 (16%) provided case management services for mentally ill offenders upon release. This number was substantially higher for substance abusing offenders: 16 (37%) of the jails provided such services. No explanation was given for this difference. Why should jails be more willing to provide case management services for substance abusers than mentally ill offenders upon release? Perhaps organizations such as Treatment Alternatives to Street Crime (TASC), which specifically target offenders with substance abuse problems and offer the courts treatment alternatives to incarceration, are responsible for this greater availability of aftercare planning for substance abusers.

Steadman et al. studied eight different jail mental health components: screening, evaluation, medication, competency exams, substance abuse treatment, therapy/counseling, inpatient care, and case management at release. Of these, the most heavily emphasized were those which helped jails to manage disruptive inmate behavior. The jails attached far less importance to those services that would have longer-term consequences or affect the mentally ill offenders' behavior upon release from the jail. There was a general perception that what occurred in the community following an inmate's release was not a jail concern.

It is noteworthy, however, that this situation improved over time. When Steadman et al. returned 15 to 20 months later to examine changes over time in the jails' mental health programs, they found three jails had added case management services for inmates upon release

Thus, nearly one-fourth of the jails surveyed had some aftercare linkage systems as of 1982, and nearly all the jails with an over 250 daily inmate population had these services.

Further support for the lack of aftercare linkages from jails to community mental health comes from research in a large Florida city examining community providers' perceptions of mentally ill offenders. Nuehring and Raybin (1986) surveyed community mental health and social service providers regarding their history of providing services to mentally ill offenders released from the jails. Although the providers questioned were chosen because they were most likely to have worked with this group, they reported little contact with the target population. The exception was staff of programs specifically aimed at mentally ill offenders. The community providers reported they were most likely to have served offenders being released from the state forensic hospitals than from their local jail. This is an interesting response given that over 90% of the Florida forensic hospital discharges at that time were made to local jails and rarely directly to the community. It also suggests closer working relationships between forensic hospitals several hundred miles away than with the jail in the same city as the mental health providers. Nuehring and Raybin's work indirectly supports the idea that jails tend to be isolated from the network of community mental health services.

A review of the empirical literature relevant to jail-community mental health linkages for aftercare demonstrates a paucity of useful research findings regarding this issue. In summary, we have learned that few jails provide aftercare linkage services and the majority of mentally ill detainees are released from jail without mental health referrals. We have also learned that misdemeanant mentally ill stay longer in jail which suggests that there is more time available to make linkages for aftercare than possible for non-mentally ill jail detainees.

Next, we turn to a review of program descriptions and other related literature.

STRATEGIES USED BY PROGRAMS TO LINK MENTALLY ILL INMATES TO COMMUNITY MENTAL HEALTH SERVICES UPON THEIR RELEASE FROM JAIL

There are a variety of ways in which jail mental health programs can facilitate continuity of care for mentally ill offenders returning to the community. Some of the most important, and potentially most effective, will be discussed in this section. These mechanisms were selected from the descriptive literature on jail mental health treatment programs, which rarely addresses aftercare linkages in any detail, and have been observed through experience in Florida developing such programs in conjunction with local jails. Six basic principles emerged as the heart of effective linkage strategies.

Referrals for aftercare upon release from the jail must be a clearly articulated goal of the jail mental health treatment program.

This principle has been articulated in a number of different sources. One good example of such an explicit program goal is found in the New York state model of suicide prevention and crisis intervention for jails and local detention facilities (Cox, Landsberg, & Pavarati, 1989). Their sixth Client Goal is to: "Provide continuity of care for all mentally ill

prisoners upon their release from a jail or detention setting". Steadman et al also include release planning as one of their essential components of jail mental health services. More specifically, they state: "Correctional Administrators should concentrate on developing mental health services in the areas of identification, crisis intervention, and case management at release" (1989, p. 136). The intermediate mental health care unit in the District of Columbia jail sets making a "smooth transition into the community" as an explicit goal of treatment (Edwards & Coner, 1983). This program uses the initial psychosocial asssessment to develop plans for both treatment and aftercare.

The most explicit and far-reaching articulation of aftercare linkage standards for jail mental health programs is outlined in the 1989 American Psychiatric Association Task Force Report on "Psychiatric Services in Jails and Prisons." These guidelines build upon the standards developed by the American Medical Association for health services in jails and prisons, recently revised by the National Commission on Correctional Health Care. The APA guidelines expand upon the mental health services standards set by the NCCHC by providing more detail and guidance.

Discharge/release planning services are cited as one of the core components of essential psychiatric services in jails. The other core components are screening, crisis intervention, and treatment.

More specifically, the APA guidelines define discharge/transfer planning to include "all procedures through which inmates in need of mental health care at time of release from jail to the community are linked with appropriate community agencies capable of providing on-going treatment" (APA, 1989, p.25).

Such explicit goals represent proactive attempts that must be made to enhance the prospects for a successful transition from jail treatment programs into local community mental health center programs. It is not sufficient to have aftercare services available in the community and expect released jail inmates to take advantage of them; as has been noted, "we do these persons no favor by simply making our services available and then waiting for patients to use them" (Lamb, Schock, Chen, & Gross, 1984). Axelson (1987) elaborated further on this theme:

> The aim is not to infantilize these clients or assume they are incapable of taking on responsibility; it is rather a matter of actively collaborating in that responsibility. It is also a matter of realistically accepting the fact that many chronic patients will require such intervention, even though it should be ideally otherwise.

Close collaboration between the criminal justice and the mental health systems must occur.

The very nature of aftercare linkage requires the close collaboration of all parties involved. While a jail treatment program itself can be established and operated without such collaboration, the development of links from that program into the community cannot. Such collaboration has consistently been described as crucial to the success of aftercare linkage development A description of three New Jersey jail programs include specific

recommendations to encourage cooperative efforts between the correctional and mental health systems in providing services in the jail (Craig, McCoy, & Stober 1988). They emphasize coordination, flexibility, and linkages with courts, attorneys, probation, mental health, and social service agencies. The authors of the New York Suicide/Crisis Intervention model (Cox, Landsberg, & Pavariati, 1989) also stress collaboration in their practical guide to developing any treatment programs for this population.

Such collaboration, of course, is much easier to preach than to practice. While we describe criminal justice as a "system", in actuality there are several different systems (corrections, law enforcement, judges, attorneys, and so on) overlapping with each other and rarely acting in concert. The same comment can be made of the mental health "system". A number of parties have a legitimate interest in mentally ill jail detainees; because of the adversarial nature of our legal system, such interests are frequently in conflict with each other. One way to balance these conflicting interests in this context is to remain focused on the necessity to provide appropriate mental health aftercare whatever the legal disposition of the defendant.

One good example of collaboration for mentally ill offenders is the Criminal Justice-Mental Health Task Force in Jacksonville, Florida. This group has met bimonthly for several years and is chaired by the chief administrative judge. Meetings are held in his chambers, a setting which encourages serious discussion. Representatives from the Clerk of the Court, Public Defender's, and State Attorney's Offices attend regularly along with community mental health, jail, and local state mental health agency staff. Others, such as state hospital, substance abuse, and law enforcement staff may attend as well, depending upon the topic. The Task Force has addressed issues such as jail transfers for involuntary hospitalization, administrative orders to facilitate the movement of mentally ill offenders through the criminal justice process, diversion of the misdemeanant mentally ill, and community supervision of Not Guilty By Reason of Insanity clients. While the attempts to balance the interests of all involved has at times proven difficult, the process of bringing together everyone responsible has improved both treatment and criminal justice processing of mentally ill offenders in this county.

A similar task force has been formed in Daytona Beach, Florida. Other Florida counties have used their jail oversight committees, required by Florida statutes, to address the problems of the mentally ill incarcerated in their jails. One successful example was the jail oversight committee in Tallahassee designed to ease the over-crowding situation in the jail. Mentally ill inmates were identified as a major problem for jail operations by this group. They worked together over several months, and eventually approached the County Commission for funds to contract with the local community mental health center for jail mental health treatment and court evaluation services.

Formal agreements to collaborate are useful strategies to encourage initial involvement and continued cooperation. Wisconsin's Department of Health and Social Services developed sample "Interagency Agreements" to assist local jails and community mental health programs develop services for the mentally ill in jail and define their respective roles (Wisconsin Legislative Council Staff, 1986). These sample agreements are instructive for several reasons. First, they list clearly the various components to providing appropriate mental health care for

the target population. Second, they provide a concrete place to start collaboration; so often, groups will come together to address serious problems but will have difficulty finding a productive starting point. Finally, the sample agreements are an excellent example of a state agency's ability to provide leadership to local jails and community mental health services in resolving the many issues around mental health care for jail detainees.

Release planning must begin in advance of release from the jail.

An individualized plan for aftercare should be developed well before release (Jemelka, Trupin, & Chiles, 1989; Steadman, 1989). The old axiom that discharge planning begins at admission apply directly to jails given inmates' short length of stay and likelihood of unexpected release. Release planning should be integrated into the ongoing evaluation and treatment procedures rather than performed on a case-by-case or crisis basis (Arboleda-Florez & Holley, 1987). Obviously, the inmate will be leaving the jail at some point, probably without much notice, and the treatment plan should anticipate this prospect.

Release planning should include provisions for continuing psychotropic medication if the individual is being prescribed medication while in the jail. Arrangements should be made for a medication appointment, renewal of prescription, and an interim supply of medication until the physician providing aftercare can continue the individual's psychotropic medication. The plan should be developed with the input of the individual and reviewed with him/her prior to and at time of release. Copies of the plan should be given to the individual and relayed to the local community mental health program expected to provide treatment.

Good mental health relationships should be developed prior to release from the jail to encourage follow-up by the individual. Some community mental health centers specifically assign staff to cover both the jail and local clinics. This "continuity of caregivers" (Torrey, 1986) not only encourages uninterrupted treatment but helps clients be more comfortable when they go to the local community mental health center for aftercare upon release from the jail (National Coalition, 1984). Developing good relationships with mental health staff while in the jail may increase the likelihood that the client will continue with treatment in the community (Meyerson & Herman, 1983; Axelrod & Wetzler, 1989).

Release planning should include preparing the mentally ill inmate for release from the jail. As part of the treatment relationship developed in the jail, the individual should be encouraged to continue treatment in the community. This can be done in a variety of ways, including the provision of written information regarding community services and the specific medication he/she is receiving, and group sessions to discuss and educate mentally ill offenders about the need for continuing treatment in the community (Axelrod & Wetzler, 1989). The relationship between lack of treatment/medication compliance and repeated criminal involvement should be addressed directly when relevant. In addition, jail mental health staff should also inform inmates about their professional ties to community providers and their willingness to work with their colleagues to facilitate treatment.

If time permits, as in the case of sentenced jail inmates, counseling should focus on preparing inmates to cope with the very different demands made by jails and the community. Jails require the ability to live in closely confined spaces, frequently over-crowded conditions,

and under highly regimented time schedules (Belcher, 1988). Skills adaptive for jails settings are frequently maladaptive for independent living in the community. Counseling can help released jail inmates prepare for these significant changes.

"Continuity Agents" should be in place to ensure continuity of care.

Responsibility for aftercare linkages should be clearly defined. Staff should be identified to ensure that all mentally ill inmates leaving jails have referrals for aftercare. Such staff should "anticipate and mitigate barriers to care" (Bachrach, 1988), thereby reducing the possibility that gaps in service delivery will occur.

These same staff should work to reestablish relationships between mentally ill jail detainees and their current community mental health providers, and establish new connections for inmates who have no previous ties to local services. This process of connecting and reconnecting inmates with community mental health services is integral to successful aftercare. One of the myths about mentally ill in jails is that they do not belong to the local system of mental health care. Somehow they are all seen as homeless or transient, with no previous history of local mental health treatment. Three years ago, the community mental health center in Daytona Beach, a stopping point for many transients heading south for warmer weather, began reviewing the daily arrest notices published in the newspaper. They were surprised to learn how many of those arrested were active clients. The community mental health center in Tallahassee, Florida had a similar experience when they started providing regular mental health services to the jail. Clients lost to outpatient services and case management were often found Monday morning in the jail when reviewing the weekend's new admissions. Helping the community mental health center locate their "lost" clients is one useful basis for building stronger ties between the jail and community mental health.

Effective procedures should be used to encourage aftercare.

The procedures by which referrals for aftercare are made influence the degree of follow-through for mental health services (Carroll, 1990). In some communities, individuals wait as long as six weeks for an initial intake appointment for medication at local community mental health centers. Given jail detainees' increased risk for involvement with the criminal justice system, this is clearly too long. One study demonstrated better follow-up on the part of mentally ill persons between hospitalization and first aftercare appointment when the waiting period was shortened from fifteen to eight days (Axelrod & Wexler, 1989). Another study found follow-up letters and phone calls to be effective in encouraging aftercare compliance from inpatient to outpatient settings (Meyerson & Herman, 1983). These procedures could be similarly useful in the transition from jail to community treatment.

In order to be most effective, "Continuity Agents" should continually develop a widening network of community resources (Rock, 1987). These pivotal staff do much to advocate for this population and facilitate their integration into community mental health services. When working with a population that community mental health providers are reluctant to serve, the linkage staff must take a particularly cooperative, flexible approach. They must be willing to make accommodations to smooth the way for community providers' cooperation. Consistently and honestly providing referral information in a useful format,

being accessible by phone and in person, and following up on the referrals to see how they worked out helps to build strong working relationships.

"Continuity Agents" must ensure that relevant information reaches the right people. Much fragmentation occurs because information is not shared in the most effective fashion (Dvoskin, 1989). Frequently, clients "fall through the cracks" between jails and community mental health centers because appropriate information about an individual's needs for continuing mental health care is not transmitted accurately or in a timely fashion to those who need it. Likely recipients include judges, attorneys, jail staff, family, and local providers of mental health services. Jail mental health programs must see beyond the reaches of their immediate treatment settings and find ways to share their valuable information to the benefit of the individuals they serve.

As "Continuity Agents" build their network of aftercare resources, they should develop directories of these resources and disseminate the information (Rock, 1987). One example of a resource directory was developed by the Community Liaison Unit of Florida State Hospital's Forensic Service (Zabitosky, Brown, Mathers, & Heilbrun, 1989) describing the mental health services offered in Florida jails. Florida has sixty-seven counties and over one hundred jails. This directory contains a page for each county outlining the mental health resources provided in that county's jails. It also lists who provides aftercare services from the community mental health center and which local state mental health agency staff member is responsible for over-seeing continuity of care for the local system. The directory is up-dated regularly and, although primarily for the use of the state hospital staff, is disseminated throughout the state.

Finally, as important as "Continuity Agents" are in facilitating aftercare, the links between jails and community mental health should be strong enough to survive personnel changes among the individuals doing the linking. Policies and procedures formalize what are often personal relationships between individual jail and community mental health staff.

QUESTIONS STILL TO BE ADDRESSED

Many issues regarding the development of adequate links between jails and community mental health for mentally ill detainees remain to be addressed. Research, legal analysis, and the development of a technology for facilitating aftercare linkages are needed.

First, the unpredicatable nature of jail discharges must be acknowledged and analyzed in order to facilitate any improvements in the links between jails and community mental health services. Jail inmates typically have a short length of stay, are released into the community with little or no advance warning, and can not be held in jail pending completion of planning for mental health treatment once legal disposition is made. In other words, releases from the jail are based on legal rather than clinical reasons. This presents major difficulties to mental health providers accustomed to more "predictable" release decisions.

For instance, sometimes jail inmates are not been stabilized in treatment prior to disposition of their charges and resulting release from the jail (Lamb, Schock, Chen, & Gross, 1984). These cases obviously require special attention. Research should address the frequency

with which this occurs, and the special mental health needs it creates in the community. Identification of this particularly vulnerable group is a vital component of consistent, comprehensive linkages to local community mental health services.

Communication within the criminal justice system is a problem. Jail nurses frequently describe the experience of coming to work to find their mentally ill inmates released without warning or the opportunity to make aftercare links. Sometimes this is the result of security concerns on the part of jail administration, particularly in those cases in which the offender is being transferred to another facility. In many cases, however, the jail treatment staff are unaware of the offender's current legal status in the criminal justice system. Not surprisingly, court personnel, such as judges and attorneys, are equally unaware of the inmate's current mental health status and the need for continuing treatment. In order to ensure that mentally ill offenders receive appropriate treatment at all points in the criminal justice system, particularly when they are moving from one setting to another, there must be increased communication between the courts and the treatment systems. Research should focus on where those "information gaps" are likely to occur, and how they can most effectively be closed. Mechanisms should be developed to manage the reality that mentally ill offenders often leave jails unexpectedly and without notice to mental health staff, either in the jail or the community.

A further problem is the tendency for some jurisdictions to release jail detainees directly from the courtroom after a hearing so that the individuals are not actually jail "discharges" at all. Local jurisdictions must analyze the flow of their mentally ill through the criminal justice system, identify the various discharge points, and provide appropriate interventions for arranging aftercare at each of those points.

In Florida, we have proposed a variety of ways to track mentally ill offenders through the criminal justice system to ensure they are receiving mental health services at all points in time. New positions called Forensic Specialists have been established to perform this function. Their job first involves identifying mentally ill inmates in the criminal justice system and then working work with jail staff, attorneys, judges, forensic hospitals, probation officers, case managers, local community mental health, and others to ensure treatment as their clients move through and out of the criminal justice system. Forensic Specialists work in conjunction with case managers and other mental health providers by providing them with the specialized knowledge needed to effectively work with this population and acting as liaisons to the criminal justice system.

Forensic Coordinator positions have also been established in the local state mental health offices to focus on the systems issues surrounding this population. These staff are responsible for identifying gaps in the system of continuing care, providing training for both mental health and legal staff, planning for future services, and establishing joint criminal justice-mental health task forces to resolve problems. Massachusetts has a similar statewide regional management system with forensic managers responsible for the oversight of court-based and county correctional mental health services in their region (Governor's Special Advisory Panel on Forensic Mental Health, 1989).

Legal issues must be addressed in some depth to provide guidance to jail administrators, their treatment staff, and community providers working with the jail. For instance, the issue of legal liability for post-discharge (Johnson, McKeown, & James, 1984) should be examined. Are there legal mandates to provide aftercare linkages for mentally ill leaving the jail? If so, what are they specifically and how do those mandates differ for offenders leaving jail with mental health problems as contrasted to those with physical health problems?

O'Leary's work analyzing the liability of custodial suicide (1989) provides some basis for a beginning look at these complex legal issues. A reading of his work suggests that a breakdown in the transmittal of clinical data regarding suicide may add to the legal exposure of the custodial institution. This exposure is likely to be greater in situations where clinical resources are available but not used and where medical advice has been obtained but not followed. O'Leary suggests that responsibility for transmitting clinical data regarding suicide risk may include the point at which the inmate leaves the custody of the institution.

If this is true for suicidal jail detainees, then a case might be made that severely mentally ill detainees require a similar transmittal of clinical information to avoid becoming at risk of dangerous to themselves as a result of the decompensation of their mental illness. The analagous case here to the suicidal risk situation described above is that the jail had a knowledge of the detainees' mental health needs but failed to transmit that information (O'Leary, personal communication, April, 1990). A legal case might be made for deliberate indifference on the part of the custodial institution.

Further legal precedents might also come from the developing standards regarding the treatment of mentally ill in jails; i.e., American Psychiatric Association's recent standards for psychiatric services in jails and prisons. The courts, in their attempts to sort out custodial liability for mental health care, may well look to mental health professional organizations and their disseminated standards of care for guidance.

Next, the whole area of confidentiality for these kind of linkage services must be considered. The mental health programs described in three New Jersey jails (Craig, McCoy, & Stober, 1988) emphasized the importance of inmates voluntarily agreeing to treatment. Hopefully, this will cover many mentally ill in jails. But what about those inmates who refuse treatment or aftercare referrals? How often does this occur and under what circumstances? It is likely this group has comparable or greater needs for linkages to mental health services, and also presents some risk for repeated criminal offenses as a result of their mental illness. What sort of mechanisms can be used to deal effectively with this group of individuals? The Dane County, Wisconsin Police Department developed a position for a social service liaison to make referrals and work closely with social service agencies (National Coalition, 1984). This person provides the local community mental health center with copies of all arrest reports of individuals coming in contact with law enforcement who seemed to have some mental illness. Confidentiality of this sworn police officer is not the same as for treatment staff.

Could jails set up a similar position to notify the local community mental health center of offenders leaving the jail in need of treatment? Whether or not this approach is the best available, it is crucial to address the inherent conflicts between confidentiality and continuity of care, and find some workable resolutions. Some states, New York and Florida for example,

have expanded their legal parameters of confidentiality to allow for the sharing of mental health information between mental health providers and correctional systems for the purpose of continuity of care. These laws, and others like them, should be examined more carefully to develop models for use in other jurisdictions.

Clear guidelines should also be developed for having offenders sign release of information forms with acknowledgements of the limits on the use of this information by treatment providers. Individuals charged with crimes have a special concern about the ways in which treatment and other descriptive information are used. Mental health providers should be aware of this and act accordingly.

Research should focus on the barriers to continuity of care for mentally ill inmates leaving jails. Barriers to care, especially housing, have been described by some author (Lamb, 1984; Fenn, 1987; Warner, 1989; Lamb et al, 1984) and attributed to the mentally ill person's involvement in the criminal justice system. We need to know how often and under what circumstances this occurs. A good start has been made by Nuerhing and Raybin (1986) in their examination of criminal justice, mental health, and social service staff beliefs about community-based care for mentally ill offenders. The researchers found mental health professionals to be more optimistic than criminal justice professionals regarding the provision of community treatment to this population. In general, the community mental health providers felt mentally ill offenders were appropriate for community treatment but needed large amounts of structure, security, and control. The researchers suggested that programs for this population should address the dual nature of their problems (histories of both criminal behavior and mental illness) and provide closely supervised residential care. Further research is needed to explore other community mental health staff concerns that affect the provision of aftercare services to this population.

Florida's experience suggests that close collaboration between the local criminal justice system, forensic hospitals, jails, and community mental health system can break down many of these barriers to placement. In 1986, it was almost impossible to place a mentally ill offender with a homicide charge into a community residential program in Florida. That situation has changed over the last few years, and now several programs, both those oriented specifically to the forensic population and those serving the nonforensic severely mentally ill, have shown a willingness to focus more upon mental health status than legal status. It took years though of encouragement, opportunity, and persistence in the face of much rejection to accomplish this. Many times, it also took the "right" first client in order to pave the way for others.

Reluctance remains in many communities, but progress is possible. This is particularly true when community mental health staff perceive mentally ill offenders as part of their community and requiring similar services as their other clients.

Jail staff can facilitate better understanding of mentally ill offenders by opening the jail doors for tours of their facilities and training offered by their staff. Often community mental health staff are intimidated by the perceived dangerousness of jail inmates, the emphasis on security, and the physical environment of the jail. Familarizing them with the

structure and operation of the jail can lessen that intimidation and encourage professional exchange.

The reverse is true also. Jail staff should leave their facilities to visit community mental health settings, attend local planning and problem solving meetings, participate in community mental health organizations, and avoid fading into their "invisible" jail institutions. Visibility and activity are often keys to increased service provision of community services for mentally ill jail detainees. More work should be done to suggest ways to increase jail staff visibility and activity in the community network of providers.

Finally, serious consideration must be given to who is actually responsible for providing the linkages from the jail into community mental health services. Is this the jail's responsibility because it houses mentally ill offenders and has responsibility to provide them care and safe-keeping? Is it the responsibility of the local community mental health center because it is responsible for the provision of mental health treatment to all members of the community? Does the responsibility belong to the courts because they control the legal disposition of the offender and resulting movement from the jail? This thorny issue is rarely addressed in the literature, yet its resolution "makes or breaks" the provision of aftercare linkages from the jail for mentally ill offenders.

Under any circumstance, it is difficult to decide who is responsible for the glue that holds all the pieces together. In the case of aftercare linkages from the jail to community mental health, all parties must collaborate in order for the linkages to be consistent, timely, and effective. Further work is needed in the analysis of this issue at all levels---economic, legal, service provision, and needs of the mentally ill jail detainee.

CONCLUSION

This chapter has reviewed the relevant literature, suggested a number of strategies to facilitate jail-community mental health linkages for aftercare, and raised questions for future discussion. It is an initial step in the development of stronger relationships between jails and community mental health to serve their mutual clients. Much work needs to be done. It is the author's hope that by drawing this literature together and describing the various issues, continuity of care for mentally ill people leaving the back door of the jail will be furthered. For both jails and community mental health services, this critical juncture is an ideal point for collaboration and improved services for mentally ill jail detainees.

REFERENCES

Adams, R.D. (1988). Exemplary county mental health programs: The diversion of people with mental illness from jails and in-jail mental health services. Washington, D.C.: National Association of Counties.

Adams, R.D. (1988). Mental health factsheet: Diverting people with mental illness who commit minor offenses from jails. Washington, D.C.: National Association of Counties.

American Psychiatric Association (1989). Psychiatric services in jails and prisons: Report of the task force on psychiatric services in jails and prisons. (Task Force Report No. 25). Washington, D.C.: American Psychiatric Association.

Arboleda-Florez, J.E. & Holley, H.L. (1987). General hospital forensic units: A new approach to forensic psychiatry. International Journal of Offender Therapy and Comparative Criminology, 31, 11-19.

Axelrod, S. & Wetzler, S. (1989). Factors associated with better compliance with psychiatric aftercare. Hospital and Community Psychiatry, 40, 397-401.

Axelson, G.L. (1987). Psychotic vs. non-psychotic misdemeanants in a large county jail: An analysis of pre-trial treatment by the legal system. (Doctoral Dissertation) George Mason University.

Bachrach, L.L. (1988). The homeless mentally ill and mental health services: An analytical review of the literature. In Lamb, R. (Ed.), The homeless mentally ill: A task force report of the American Psychiatric Association, Washington, D.C., 1984.

Belcher, J.R. (1988). Are jails replacing the mental health system for the homeless mentally ill? Community Mental Health Journal, 24, 185-195.

Bloom, J.D., Bradford, J.M., & Kofoed, L. (1988). An overview of psychiatric treatment approaches to three offender groups. Hospital and Community Psychiatry, 39, 151-158

Byers, E., Cohen, S., & Harshbarger, D. (1979). The quantity and quality of aftercare services: Relationship with recidivism in mental hospital patients. Canadian Journal of Behavioral Science, 11, 11-20.

Carroll, A. M. (1990). Referral practices and patients' follow-up. Hospital and Community Psychiatry, 41, 478.

Cox, J.F. & Landsberg, G. (1989). Future directions. Psychiatric Quarterly, 60, 185-188.

Cox, J.F., Landsberg, G., & Pavarati, M.P. (1989). A practical guide for mental health service providers in local jails. In H.J. Steadman, D.W. McCarty, & J.P. Morrissey, The mentally ill in jail: Planning for essential services (pp. 151-171). New York: Guilford.

Cox, J.F., Landsberg, G., & Pavarati, M.P. (1989). The essential components of a crisis intervention program for local jails: The New York local forensic suicide prevention crisis services model. Psychiatric Quarterly, 60, 103-117.

Craig, T., McCoy, E.C., & Stober, W.C. (1988). Mental health programs in three county jails. Journal of Prison and Jail Health, 7, 15-26.

Dvoskin, J. (1989). The Palm Beach County, Florida forensic mental health services program: A comprehensive community-based system. In H.J. Steadman, D.W. McCarty, & J.P. Morrissey, The mentally ill in jail: Planning for essential services (pp. 178-197). New York: Guilford.

Edwards, H. & Coner, A. (1983). Intermediate care program for mentally ill detainees: Development and implementation. Psychiatric Annals, 13, 716-722.

Fenn, H.H. (1987). The jail psychiatric inpatient ward: Structure, population, and problems. Journal of Prison and and Jail Health, 6, 128-139.

Finn, P. & DeCuir, W. (1988). Law enforcement and the social service system: Handling the mentally ill. FBI Law Enforcement Bulletin, July, 1-7.

Governor's Special Advisory Panel on Forensic Mental Health (1989). Final report. (Document No. 300-8-89-811261). Commonwealth of Massachusetts: Author.

Halpern, W.I., Arkins, V., Mitchell, Freeling, N., & Healy, B. (1981). Continuity of mental health care to youth in the juvenile justice network. Hospital and Community Psychiatry, 32, 114-117.

Harris, M., & Bergman, H.C. (1988). Case management and continuity of care for the "revolving-door" patient. New Directions for Mental Health Services, 40, 57-62.

Hawaii State Department of Health (1989). The diversion project: Bridging a gap in Hawaii's mental health service delivery system. MHD News, 1-3.

Jemelka, R., Trupin, E., & Chiles, J.A. (1989). The mentally ill in prisons: A review. Hospital and Community Psychiatry, 40, 481-491.

Johnson, J., McKeown, K., & James, R. (Eds.) (1984). Removing the chronically mentally ill from jail: Case studies of collaboration between local criminal justice and mental health systems. Washington, D.C.: National Coalition for Jail Reform.

Kal, E. (1977). Mental health in jail. American Journal of Psychiatry, 134, 463-476.

Lamb, H., Schock, R., Chen, P., & Gross, B. (1984). Psychiatric needs in local jails: Emergency issues. American Journal of Psychiatry, 141, 774-777.

Lamb, H., Weinberger, L., & Gross, B. (1988). Court-mandated needs in local jails: Emergency issues. American Journal of Psychiatry, 141, 774-777.

Meyerson, A.T. & Herman, G.S. (1983). What's new in aftercare? A review of recent literature. Hospital and Community Psychiatry, 34, 333-342.

Modlin, H., Porter, L., & Benson, R. (1976). Mental health centers and the criminal justice system. Hospital and Community Psychiatry, 27, 716-719.

Monahan, J. & McDonough, L. (1980). Delivering community mental health services to a county jail population: A research note. Bulletin of the American Academy of Psychiatry and the Law, 8, 28-32.

Morgan, C.H. (1982). Service delivery models: A summary of examples. In Mental health services in local jails: A report of a special national workshop. Rockville, MD: U.S. Dept. of Health and Human Services.

Nielsen, E.D. (1979). Community mental health services in the community jail. Community Mental Health Journal, 15, 27-32.

Nuehring, E.M. & Raybin, L. (1986). Mentally ill offenders in community based programs: Attitudes of service providers. Journal of Offender Counseling, Services & Rehabilitation, 11, 19-37.

Ogloff, J.R.P. & Otto, R.K. (1989). Mental health intervention in jails. In P. A. Keller and L. G. Ritt (Eds.), Innovations in clinical practice: A source book (Vol. 8). Sarasota, Fl: Professional Resource Exchange.

O'Leary, W.D. (1989). Custodial suicide: Evolving liability considerations. Psychiatric Quarterly, 60, 31-71.

Otto, R.K. & Ogloff, J.R.P. (1988). A manual for mental health professionals working with jails. Lincoln, Nebraska: Nebraska Dept. of Public Institutions.

Petrich, J. (1976). Psychiatric treatment in jail: An experiment in health-care delivery. Hospital and Community Psychiatry, 27, 413-415.

Pogrebin, M. (1985). Jail and the mentally disordered: The need for mental health services. Journal of Prison and Jail Health, 5, 13-19.

Reali, M. & Shapland, J. (1986). Breaking down barriers: The work of the community mental health service of Trieste in the prison and judicial settings. International Journal of Law and Psychiatry, 8, 395-412.

Robert Wood Johnson Foundation (1989). Honolulu begins new diversion program. Insites: Program in Chronic Mental Mental Illness Newsletter, 2, 6.

Rock, B.D. (1987). Beyond discharge planning. Hospital and Psychiatry, 38, 529-530.

Runck, B. (1983). Study of 43 jails shows mental health services and inmate safety are compatible. Hospital and Community Psychiatry, 34, 1007-1008.

Singer, Mike (1990). Jail psychiatric services: Some comments and challenges. Forum: Newsletter of California Forensic Mental Health Association, January, 10-11.

Steadman, H.J., McCarty, D.W., & Morrissey, J.P. (1989). The mentally ill in jail: Planning for essential services. New York: Guilford.

Steadman, H. & Ribner, S. (1980). Changing perceptions of the mental health needs of inmates in local jails. American Journal of Psychiatry, 137, 1115-1116.

Torrey, E.F. (1986). Continuous treatment teams in the care of the chronically mentally ill. Hospital and Community Psychiatry, 37, 1243-1247.

U.S. Department of Justice (1990). Census of local jails 1988. Bureau of Justice Standards Bulletin.

Warner, R. (1989). Jail services and community care for the mentally ill in Boulder, Colorado. In H.J. Steadman, D.W. McCarty, & J.P. Morrissey, Mentally ill in jail: Planning for essential services (pp. 198-213). New York: Guilford.

Wisconsin Legislative Council (1986). State requirements and assistance relating to mental health services for inmates of county jails (Staff Brief 86-11). Madison, Wisconsin: Author.

Zabitosky, S., Brown, M., Mathers, L., & Heilbrun, P.G. (1989). Directory of Florida jail mental health services. Chattahoochee, Florida: Florida State Hospital.

CHAPTER 6

THE MENTALLY ILL AND THE LOCAL JAIL: POLICY AND ACTION

by Eliot Hartstone, Ph.D.

BACKGROUND

The National Coalition for the Mentally Ill in the Criminal Justice System is an organization established in 1989 to facilitate the development and implementation of policy and programs to more effectively deal with the problems of the seriously mentally ill in the criminal justice system. The Coalition directs its attention toward national, state, and local criminal justice, mental health, and drug/alcohol abuse decision-makers.
Based on extensive planning, the Coalition held a national work session in April 1990 in Seattle, Washington entitled, "Breaking Through the Barriers." This work session, funded by a variety of federal agencies[1] and hosted by Community Action for the Mentally Ill Offender (CAMIO)[2], provided a vehicle for those involved and concerned with the provision of mental health services for the mentally ill offender (MIO) to meet and collectively seek solutions to the problems faced by this population.[3]

Fifty individuals participated in the work session. Included among the participants were: advocates; consumers and family members; federal, state, and county agency administrators; corrections officers; mental health professionals; police chiefs; researchers; and state senators.[4]

After hearing and discussing the research findings included in the four prior chapters of this book, the 50 participants were divided into four work groups, each focusing on the MIO at one of four stages of coming into contact with the local jail (i.e., initial contact; jail admission/booking; jail-based services; and discharge planning).[5]

Each work group met for two days with the task of:

- identifying the major problems experienced by the MIO in receiving mental health services; and
- proposing program and policy initiatives to mitigate the identified problems.

In addition, each group offered strategies or actions that could be undertaken at the federal, state, or local level to help bring about the desired interventions.

The purpose of this chapter is to summarize and highlight the work session products. These products resulted from work session participants using both research data and their own "real world" experiences to: (1) identify the major problems faced by the MIO; (2) recommend desirable interventions to better assure appropriate services to this population; and (3) suggest strategies to be undertaken by advocates and public officials to bring about the desired changes.

CONFERENCE CONTEXT

Before summarizing the outcome of the "Breaking Through the Barriers" proceeding, we would like to share with the reader the opening presentation of the meeting, delivered by Ms. Susan Rotenberg. We believe this presentation provides the reader with the information necessary to understand the background and context of, this unique meeting.

> The problems posed by persons with mental illness in our jails are many and great. The numbers have been increasing and promise to grow even higher, without clear, coordinated, meaningful, and effective intervention. Many barriers exist to adequately address this problem, which in reality are many problems, and the next two days will give us an opportunity to explore and evaluate ways of breaking down the barriers and identifying meaningful strategies.
>
> Historically, there have been sporadic attempts to approach these issues. I do not know of any attempts nationally that have included the National Associations and Institutes that are gathered in this room, coming, together, linking up with the family members and consumers, to look for solutions. This is indeed a beginning for "Breaking Through The Barriers."
>
> I would like to say something on the long overdue need for advocacy. The need for national leadership and commitment in seeking meaningful solutions to intolerable problems, and the national coalition.
>
> When I talk about advocacy for persons who come into contact with the criminal justice system, my thoughts go to my own personal experiences with my son, who is one of the homeless, mentally ill, who falls deep within the black holes that exist in the System. The black holes in our System greatly affect the health of the mentally ill person and the potential for that person's recovery. The family unit becomes a part of that black hole, experiencing the same trauma and inadequacy as families do during times of war, and there are simply no adequate resources. Most often families who share this experience painfully separate, and their outrage turns into apathy.
>
> We parents are long overdue with our advocacy in building a strong constituency group for these mentally ill persons, as we have done so effectively for the general population group of the mentally ill. I feel personally that the parent groups from the general population of the mentally

ill across the United States have experienced a complex set of problems of their own, having to deal with this illness, having preferred to ignore these issues and problems. Today, I can correctly say that the families and consumers that fall into the black holes of the system are still experiencing stigma, ignorance, apathy, and ambivalence.

This population group encounters a wide array of barriers. So, too, do we as family members sharing the plight of our mentally ill loved ones. The families who do not experience the Criminal Justice system have reacted to those families very similarly to how our systems and communities act, with the same popular strategies to deal with these persons is not to deal with them at all. This is not acceptable and has become, and is becoming a loud message across the nation. We parents are now advocating that all families that suffer mental illness should follow with their advocacy this illness, wherever it goes. If we don't, we can not any longer call our advocacy responsive to the needs of persons with mental illness.

As advocates, we need to begin healthy relationships with the Criminal Justice System. It is long overdue for the development of the Coalition for the Mentally Ill in the Criminal Justice System. It is equally as important for our advocacy as for national professional associations, and the National Institutes represented here tonight; because no longer can mental health systems call themselves responsive to the needs of persons with mental illness without a healthy relationship with the Criminal Justice System.

It will be all of these relationships in this room that challenge us and promise to be a vehicle that brings us to a meaningful change.

I would like to say that the need for a national leadership and commitment in seeking meaningful solutions to intolerable problems has been sorely lacking. People with serious mental illness comprise up to 10% of the population of local jails. A large portion of them are in the Criminal Justice System because it is the only resource in many counties.

What we are confronting is a national problem that will require national leadership, advocacy and commitment. At our National Work Session starting tomorrow, hopefully we will develop, as our goal, a national consensus, coupled with a national strategy, that unifies and guides local efforts. Your support of this direction will have significant impact on the lives of many individuals.

The movement that started in the 60's, the de-institutionalization of the mentally ill, was a national effort that came with promises and commitment. Many believe that national leadership did not live up to its promises and commitments, and as a consequence, contributed to the crises and chaos that jails are experiencing today.

I do not believe that these growing numbers of individuals in jails are coincidental, or that this was a planned alternative. I believe that for too long this tragedy has been neglected and denied, and that jails have been used as a substitute treatment system for the mentally ill.

Jails, in my mind, are not appropriate facilities for the treatment of mental illness; they are not prepared, nor do they desire to be a substitute treatment facility. Mind you, jails have important roles to play and that role needs to be carefully examined and clearly articulated.

The true measure of the success of this Work Session will not be the new information, but what you can do with the information you receive.

Our task is not to just listen, but to become vehicles of change in our spheres of influence.

TARGET POPULATION

The "Breaking Through the Barriers" work session addressed the needs of a specific population -- those who are mentally ill and come into contact with the local jail.

The term "mentally ill" means different things to different people. As used by the meeting participants, the term refers to "adults having a disabling mental illness, which includes schizophrenia and/or an affective disorder. These individuals can also have a secondary diagnosis."

Regarding contact with the police and/or entering local jails,[6] individuals can be charged with: a misdemeanor, a non-violent felony, or a violent felony. With regard to in-jail services, all three types of potential offenders are addressed by this document. However, it is important to note that in discussing diversion to community mental health services, the meeting participants excluded the individual charged with a violent crime, and limited discussion to the MIO charged with a misdemeanor or, on a case-by-case basis, a non-violent felony.

INITIAL CONTACT

As noted by Teplin (see Chapter 1), the police officer regularly serves as a "street corner psychiatrist," and is often the point of entry for the mentally ill into the criminal justice system. As such, the first stage in the criminal justice system addressed by the work session participants was contact with law enforcement personnel on the street.

The Problem

The key problem identified was:

Often times seriously mentally ill people are inappropriately channeled by the police into the criminal justice system.

Although the police are often perceived as having great discretion to arrest or divert the mentally ill person, a variety of specific factors were identified that precipitate the inappropriate arrest of the mentally ill:

- Despite research data to the contrary, there is a general public perception that most mentally ill persons are violent and dangerous. The police officer may share the public's misperception, or be influenced by the public's fear.

- Police officers do not have sufficient training in the recognition and identification of the mentally ill. Consequently, it is likely that a sizable number of mentally ill persons are arrested unbeknownst to the police.

- Based on the police officer's relatively limited involvement with the mentally ill and the stigma attached to these individuals, dispositions for the MIO may be a low priority to the police.

- Many of the mentally ill individuals with whom the police come into contact are not accepted at any placement other than the jail. They are often rejected by specific facilities or programs as: too dangerous, not sick enough, too sick, suffering from drug/alcohol addiction, or failing to meet specified treatment criteria. As such, real alternatives for diversion may not exist or be perceived as inaccessible.

- The police, mental health providers, and families do not have a comprehensive understanding of each other's concerns.

- Unlike other successful police activities, there are no rewards given to the police for successfully handling the disposition involving the mentally ill.

Policy Initiatives

To combat the problems cited above, six areas of concern were identified by the work session participants. These initiatives include establishing:

- cross-training;

- enhanced identification of the mentally ill;

- accessible program alternatives and no-decline agreements;

- mental health/substance abuse treatment programs;
- transport alternatives; and
- clearinghouse activities.

Cross-training. Work session participants concurred that police officers, mental health professionals, substance abuse professionals, and family members of mentally ill persons each have something valuable to teach the others, and the cross-training of these groups should result in a reduction in the inappropriate jailing of the seriously mentally ill.

Specifically, it was recommended that cross-training include the following:

- Police officers should be trained to enhance their recognition and identification of the seriously mentally ill. Training should assist the police officers in:
  - differentiating between mental and physical illness;
  - being aware of available resources for this population; and
  - identifying co-occurring alcohol/drug/mental health disorders.
- Mental health personnel should be trained to:
  - understand appropriate police roles and practices;
  - recognize cues of impending violent behavior;
  - take appropriate actions for personal safety; and
  - understand the criminal justice system.
- Families should be trained to:
  - understand appropriate police roles and practices;
  - take appropriate actions for personal safety; and
  - protect the safety of family members by reducing the potential for the escalation of violence.

Enhanced Identification of the Mentally Ill. The consensus of the work session participants was that a fundamental key to diverting the seriously mentally ill from jail is police identification and discretionary placement of the mentally ill. As such, the following actions were suggested:

- Establishing a team approach (i.e., police, mental health providers, and family members) to develop polices and procedures for how the police are to respond to the mentally ill.
- Utilization of special teams (e.g., specially trained civilian personnel or specially trained police personnel) to respond to calls regarding mentally ill persons in the community.

- Having a 24-hour referral/evaluation/diversion (R.E.D.) program available to the police.

Accessible Programmatic Alternatives and No-decline Agreements. Noting that diversion is impossible without a comprehensive set of diversionary alternatives available to the police, it was determined by participants that:

- residential alternatives must be made available for the housing and treatment of mentally ill persons who would otherwise be booked into jail; and

- formal written agreements should be negotiated between mental health, substance abuse, hospital, housing, and police authorities to ensure that mentally ill persons are not inappropriately excluded from programs because of their involvement with the criminal justice system.

Moreover, the agreements should be binding and not include artificial "escape clauses" for such factors as non-availability of beds; include private as well as governmental hospitals; and include emergency response by mental health agencies.

Mental Health/Substance Abuse Treatment Programs. As an increasing problem is the co-morbidity of the MIO, it is recommended that treatment facilities should not refuse a referral because of the co-morbidity of the referred person. Rather, training should include the goal of increasing awareness of the frequency and characteristics of co-morbidity.

Transport Alternatives. Since the mentally ill may be denied treatment due to the hardship imposed on the police in transporting these individuals to the mental health providers, the work session recommended that mutual agreements for the transport of mentally ill persons be worked out between local agencies, including: the police, hospitals, crisis centers, parents, and mental health providers. The nature of these agreements should reflect locally established priorities.

Clearinghouse Activities. To enable all involved parties to benefit from the experiences and hard work of others, it is suggested that one or more national agencies assume a clearinghouse function to disseminate information on:

- model programs;

- mutual agreements; and

- research concerning the diversion of mentally ill persons from jail.

ADMISSION AND BOOKING

After an individual is picked up by the police and the decision to arrest is made, the next step in criminal justice processing is for jail personnel to accept custody of the arrested person (admission) and conduct the necessary intake procedures (booking). When a person is

detained in a facility, that facility assumes responsibility for that person's need for food, shelter, safety, health care, and mental health care. As noted in Chapter 3, the right to treatment carries with it the right to screening and evaluation.

The Problem

In the area of admission and booking, the key problem identified was:

Those admitted to jail often do not receive adequate or timely screening for mental health needs, and those who are in need of services are rarely diverted into appropriate mental health or substance abuse facilities or programs.

Major factors described as contributing to this problem were seen as:

- Correctional staff do not have sufficient training on mental health issues and, as such, often do not have the skills needed to screen inmates for mental health problems and needed services.

- Training of mental health staff to work with the MIO is often inadequate. Consequently, the inmate may be transported to several locations before he/she is finally screened.

- For a variety of reasons (e.g., lack of precedent, confidentiality concerns, or inadequate training about other systems), lack of communication across system boundaries. This results in an absence of information available to the jail about the client's history of mental health treatment or previous suicide attempts.

- There is a lack of diversion options within the community, as a result of both their unavailability or unwillingness of staff to treat the MIO. Without such options, even the seriously mentally ill individual detained for a misdemeanor must remain in jail.

- Fiscal incentives are often lacking for community mental health providers to admit the incarcerated mentally ill.

- Difficulties exist in determining the primary problem of the client that needs to be treated first: drugs, alcohol, or mental illness. Clients can be shuffled from one system to another, or not have their most pressing problem addressed.

- Once a mentally ill person is arrested, attitudes towards that person change. They are feared by the public, and are not viewed sympathetically by care providers, policy makers, or legislators. This serves to perpetuate the system's failure to adequately address the needs of this population.

- Although standards exist for screening and treating the MIO, there is no formal system to monitor compliance or consequences for noncompliance.

Policy Initiatives

The work session participants identified a variety of interventions intended to increase the likelihood that: (a) individuals admitted into a jail will receive professional and timely mental health screening, and (b) those detained for misdemeanors and possibly non-violent felons will be diverted into appropriate treatment programs and facilities.

Interventions proposed by the participants were directed at:

- screening standards and monitoring activities;
- multiple levels of mental health screening;
- family involvement;
- access to diversion placements;
- cross-training; and
- public education.

Specifically, the following interventions were proposed.

- Specific standards for screening should be developed, revised, and expanded to include monitoring and sanctions for noncompliance. The standards should be reviewed against national policy.
- The standards should require that arrested persons be screened within two hours of apprehension, either by professional staff and/or with a standardized, proven instrument.
- Initial screenings should have a "low threshold" that results in immediate referral to a second level evaluation conducted by professional mental health staff (i.e., social worker, psychiatrist, or registered nurse), and the inmate should be held in safe confinement until that evaluation occurs. Psychological testing should be based on specific patient needs not simply be a general practice.
- All jails should have access to immediate detoxification, substance abuse, and mental health services when needed. Incentives need to be developed and be available for inter-agency collaboration for serving clients with multiple needs.
- Specific laws and procedures need to be reviewed to determine which confidentiality protections promote the well-being of persons in the criminal justice system, and which ones inhibit needed services. Available data should be retrievable both within and across service systems.

- Families should be involved in screening as soon as possible in order to insure the fullest range of relevant information be available.

- There should be financial incentives for community mental health centers to provide mental health services (including screening) to local jails. Funding sources to jails should consider mental health services equivalent to other medical services in regard to reimbursement for those services.

- Cross-training and/or orientation programs need to be offered for mental health professionals, court personnel, and judges.

- Training curricula for correctional and mental health staff should be periodically reviewed and updated to better train:

  - mental health staff to work with inmates; and
  - correctional staff to better understand mental health issues.

- Extensive education needs to take place to change the public perception of the mentally ill in the context of the criminal justice system.

JAIL BASED SERVICES

Although the diversion of MIOs from jails to mental health facilities and programs is often desirable, many mentally ill persons must remain in jail due to the seriousness of their charges. Moreover, even if all of the recommendations directed at screening and diversion outlined in the preceding section were successfully implemented, the jail would still be responsible for providing mental health services to those individuals who are: (a) awaiting trial for a violent felony; (b) assessed as too great a security risk for diversion; or (c) appropriate placement. Consequently, there will always be mentally ill inmates in local jails in need of short-term mental health treatment.

The Problem

Regarding in-jail services, the key problem identified was:

> **Although mental health services to the MIO are legally mandated, the delivery of these treatment services is inconsistent and, as such, the MIO may be at risk of substantial physical and/or psychological harm.**

In discussing factors contributing to the risk imposed upon these inmates, the work group followed closely the work of Dr. Joel Dvoskin reported in Chapter 4, and noted the following.

- There is a lack of coherency and consistency in the various professional standards for providing mental health services in jails. These inconsistencies lead to conflicting legislation, services, and policy.

- Often times, no clinical professionals are present at crucial periods for new inmate admissions (i.e., weekends and evening hours). This increases the likelihood that: (a) individuals who are suicidal upon admission will not be identified or closely monitored, and (b) individuals who are experiencing psychiatric crisis at the time of admission due to drugs will not receive necessary physical examinations.

- Inmates are subject to decompensation and resultant psychiatric crisis as a result of the extremely stressful environment inherent in the jail (e.g., overcrowding, noise, filth, fear of assault, and lack of control).

- Many MIOs are also alcohol or substance abusers. Individuals experiencing co-morbidity frequently are only treated for one of these two very serious problems, whereas successful intervention requires help for both concerns.

- Jails are not perceived as part of the community, and community mental health providers are reluctant to work with the mentally ill in jails. As such, jails rarely receive the support and back-up needed from community mental health providers.

- Failure to document and communicate crisis information and responses increases the likelihood that the mentally ill inmate will harm himself or others after shifts change.

- Mentally ill inmates who avoid crisis have a tendency to get "lost" in jail and, without support, these inmates may be moving toward psychiatric crisis.

Policy Initiatives

A series of interventions to identify, protect, and treat those inmates vulnerable to suicide, injury, or severe psychological stress while in the jail was suggested. Recommended interventions were directed at:

- national standards;

- establishing mental health and corrections partnerships;

- special jail-based housing options for the MIO;

- crisis intervention; and

- case management.

The specific interventions proposed by the work group are listed below.

- Correctional officers need to be trained to:
  - identify signs of emotional disturbance;
  - access the appropriate resources available; and
  - inform clinicians in a behaviorally specific manner about what led the officer to suspect mental illness.

- Jails have an obligation to provide housing options which will protect inmates assessed, on a case-by-case basis, to be at risk of physical or psychological harm by providing:
  - observation;
  - support;
  - protection; and
  - centralized mental health services.

- Housing options may be accomplished by:
  - setting aside an appropriate number of cells (small jails); or
  - establishing a special unit for such inmates (large jails).

- Crisis intervention needs to be immediately accessible 24 hours a day. A psychiatrist must be available (internal or external) at all times to prescribe psychotropic medication as needed.

- Drug and alcohol detoxification and basic drug and alcohol education must be provided within the framework of co-morbidity.

- All crisis intervention activities need to be documented in writing and communicated across shifts.

- Jails are a part of the community, and community mental health should not arbitrarily exclude the mentally ill jail detainee from needed services.

- Practical procedures need to be operationalized for transporting inmates who need to be moved to mental health facilities. This transport service should be available to the sheriff/police through agreements with the hospital.

- Jails should create a social worker position, funded through a community mental health center, and place this position in the jail full-time. This person should serve as a "case manager" for the mentally ill inmate.

- Research is needed on suicide and staff trauma in reaction to a suicide in the jail. Consideration should be given to placing suicidal inmates in double or dormitory cells to prevent isolation.

- Screening suicidal inmates should be a high priority.

- Persons with mental illness should not be denied program opportunities in the jail because of mental illness.

- Special populations (i.e., deaf, developmentally disabled, and cultural and ethnic minorities) should receive services appropriate to their needs. These services should accommodate for barriers to treatment such as, but not limited to, language differences, sensory impairments, and/or cultural differences.

COMMUNITY LINKAGES

Due to the short-term nature of jail confinements, long-term mental health services are rarely needed. Likewise, it is important that individuals identified as mentally ill while in jail receive the appropriate mental health services upon their release. This means a careful consideration of how the jail and community services can be linked. Thus, the fourth stage of the criminal justice system considered at the "Breaking Through the Barriers" work session was establishing community linkages for the MIO where he/she can receive needed assistance upon his/her discharge from the jail.

The Problem

In regard to linking community-based mental health services with jail services, the key problem identified was:

> **The large majority of inmates identified in the jail as mentally ill appear to be discharged with no formal discharge plan or arrangements for community mental health services.**

In discussing factors that contributed to this problem, the participants in the work session listed the following:

- No one is responsible for continuity of care.

- There is a lack of communication about the MIO within and across systems (i.e., jail, families, mental health, court, prison, hospital, law enforcement, and corrections).

- There is no advocate for the MIO making certain that he/she receives essential services upon release.

- Due to the large number of people regularly entering and leaving the jail, jail release procedures tend to be chaotic.

- There are no formal procedures in place to assure that individualized release plans are prepared for the MIO.

- There is a lack of family and inmate/patient involvement in developing release plans for the MIO.

Policy Initiatives

In identifying interventions to address the problems listed above, the work group offered specific suggestions for:

- attributing responsibility;
- coordinating communication and services within and across systems;
- formalizing release procedures for the MIO;
- preparing comprehensive release; and
- increasing family and patient input.

Detailed interventions recommended by the community linkages work group are listed below.

- Jails should be held responsible for establishing linkages with mental health services. Such linkages should be made upon admission of offenders when initial assessment indicates a history of mental illness and/or suicide attempts, or evidence of current mental health impairments becoming evident.
- Jails should be held accountable for developing linkages with mental health services through:
  - written procedures;
  - designating a liaison between jail and mental health services;
  - written affiliation agreements with local mental health services to provide follow-up care upon release of inmates requiring such services; and
  - quality assurance procedures.
- Mental health should be held accountable for providing:
  - jail mental health services information regarding prior treatment of an incarcerated client;
  - continued contact with the client while incarcerated;
  - appropriate services to MIOs upon release from jail; and
  - consultation with the jail regarding mental health services.
- Coordinating councils should be established at county and state levels to:
  - facilitate communication;

- assure the provision of appropriate mental health care for MIOs at all points in the criminal justice system and upon release;
- develop protocols addressing confidentiality; and
- advocate for the development of essential services, including housing, substance abuse, and on-going case management.

▸ The coordinating counsels should include: judges, defense attorneys, prosecutors, court administrators, jail administrators, mental health providers, mental health administrators, substance abuse providers, substance abuse administrators, state hospitals, law enforcement officers, advocacy groups, and any other appropriate constituency groups.

▸ Formal and detailed release/transfer procedures should be developed for the MIO.

▸ The release/transfer plan should be developed by mental health treatment staff, and include:

- appointments with community mental health providers;
- prescriptions and/or medications;
- family involvement;
- housing arrangements;
- transportation; and
- entitlement plans.

▸ The discharge plan should be reviewed, agreed upon, and given to the offender, the defense attorney, probation, the court, and the mental health center.

▸ The rights of the mentally ill should be expanded to include the need for continuity of care by expanding the definition of the treatment system to include jail and courts, and limiting the court's ability to subpoena jail treatment staff.

▸ Family involvement should be increased by:

- having families contacted for information at admission;
- consulting families at the time release plans are developed; and
- utilizing appropriate release forms to facilitate family involvement.

▸ Inmate involvement should be increased by:

- reviewing the plan with the detainee/inmate;
- giving the final plan to the detainee/inmate; and
- preparing the detainee/inmate to follow the release plan through: medication compliance groups or individual counseling concerning medication; consultation concerning individualized personal needs (e.g.,

shelter, entitlement, programs, and medical services); and provision of brief individualized skills/behavior training.

STRATEGIES FOR IMPLEMENTING PROPOSED POLICIES

The work groups not only proposed policy initiatives to address the problems faced by the MIO, but suggested some national, state, and local level strategies that could be undertaken to help bring about these interventions.

While each work group focused on a particular point in the criminal justice system, the strategies offered cut across all four points in the system, and are presented here as such.

Specifically, work session participants suggested the following.

- Standards should be developed by national organizations on the diversion and treatment of the MIO. These standards should be adopted by state and local governments. Direction for developing the standards would be provided by the National Coalition for the Mentally Ill in the Criminal Justice System.

- State and local governments should establish mechanisms for monitoring and rewarding compliance with these standards. These could be developed in conjunction with the National Coalition and the National Institute of Corrections Jail Center.

- National organizations (i.e., NIC, NIMH) should make certain that local and state criminal justice and mental health agencies are aware of, and have access to existing tools, techniques, and instruments used for screening/identifying mentally ill inmates.

- Those advocating better mental health services for the MIO in the jail should make presentations at conferences for county officials, judges, professional organizations, and civic groups, and seek support for holding statewide conferences focused on meeting the needs of this population.

- Funding for demonstration projects used to test innovative programs and polices for serving the MIO should be a priority of NIMH, NIC, NIAAA, and NIDA.

- Mental health and corrections partnerships should be formed at the state and local levels. These partnerships should:

  - define and implement the role of an advisory board;
  - determine the role of advocacy groups;
  - include inter-agency, cooperative efforts to secure funds for the MIO;
  - include legislative coalition building at the state and local levels to address the needs of this population;

- include regularly scheduled meetings regarding the care and treatment of the MIO; and
- utilize staff exchanges within the criminal justice, mental health, and substance abuse systems.

- Local advocates must lobby for funding to provide mental health services at the local level. Ultimately, it must be remembered that jails are county or municipal facilities, so it is at those political levels that funds must be shaken loose.

- A centralized information system should be developed within each mental health jurisdiction for quick access to responsible treatment providers. Access to this information must be made available to jail staff.

- Academic institutions should develop a curricula to train individuals to have the professional skills to work with the MIO in jail settings.

CONCLUSIONS

Based on research findings, work experience, and family knowledge, work session participants concluded that, for a variety reasons, the MIO is often:

- inappropriately channeled by police into the criminal justice system;

- denied adequate or timely screening upon being admitted to a local jail;

- placed at risk of physical and/or psychological harm due to inconsistent mental health services provided by local jails; and

- discharged to the community from local jails with no formal discharge plan or arrangements for community mental health services.

Work session participants identified a list of specific factors that produced these problems, and proposed a series of policy interventions that could be implemented to remedy these problems. Chart One (Appendix C) provides a summary listing of these contributing factors and the participants' policy recommendations.

Recognizing that regardless of how well-designed, proposed initiatives are that they do not necessarily work their way into practice, work session participants proposed a variety of strategies targeted at federal, state, and local levels intended to promote the implementation of the recommended interventions. One important idea droving many of their deliberations was that needed funds should be seen as support for necessary community mental health programs that should already be in place. These resources should not be seen as special new dollars for criminal justice programming. These are services the entire community needs and to which they are entitled. The specific strategies to reach these goals included:

- the development, endorsement, and local adoption of national standards;
- improved dissemination of existing knowledge (e.g., screening tools and techniques, and model programs) by national organizations and agencies, as well as advocates for better treatment for the MIO;
- establishing mental health and corrections partnerships;
- advocacy for local funding of mental health services for the MIO in both the community and the jail;
- development of a centralized information system within each mental health jurisdiction; and
- academic training of professionals to cross over the criminal justice and mental health systems.

While much work was undertaken by the "Breaking Through the Barriers" participants, these efforts constitute only a first step in destroying these barriers. Those concerned with the delivery of mental health services to the MIO will need to examine the suggestions developed, adapt them to meet specific local conditions and arrangements, and seek the support of those with the power to implement change or secure needed funding.

Clearly, a key new force in accomplishing these goals are the families of the mentally ill persons and consumers caught up in the mental health system. They have special insights and commitment that offer new hope that major changes can occur that will benefit both the person with mental illness and the entire community. In moving towards these ends, the 50 individuals who devoted their time to the "Breaking Through the Barriers" work session show the commitment, passion, and energy that will help the 1990's take a more humane approach to this population. Their efforts should be applauded by all.

FOOTNOTES

1. Federal agencies funding the work session included: the National Institute of Mental Health, the National Institute of Alcoholism and Alcohol Abuse, the National Institute of Corrections, the National Institute of Disability and Rehabilitative Research, and the National Institute of Drug Abuse.

2. CAMIO is a Seattle based advocacy group that joins criminal justice professionals, mental health professionals, and interested families and citizens to advocate for the mentally ill in the criminal justice system.

3. While all individuals participating were invaluable to the success of the "Breaking Through the Barriers" work session, two people warrant special commendation. It was through the hard work and dedication of the two co-chairpersons of the work session -- Ms. Susan Rotenberg and Mr. Donald Richardson -- that this meeting was held, and such a uniquely diverse and experienced group of participants was recruited. The success of this meeting is largely the result of their commitment and passion.

4. A list of all 50 work session participants and their affiliation is provided in Appendix A.

5. A listing of those participants assigned to each work group is provided in Appendix B. In addition, Appendix B displays those individuals responsible for conducting each group (facilitators) and recording the outcome of each group's efforts (recorders).

6. As discussed in Jamelka's chapter, the term jail include all types of local detention facilities (e.g., jails, lock-ups, remand centers, houses of correction, and detention centers). While the April 1990 meeting was directed at those in jail, a work session planned for 1991 will focus on the seriously mentally ill offender in prison.

APPENDIX A

National Work Session for the Mentally Ill in the Criminal Justice System

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APPENDIX B

NATIONAL WORK SESSION

Work Groups

GROUP I - INITIAL CONTACT

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R	Cheryl Davidson		Dr. Carl Leukefeld
	Nick Demos		Susan Rotenberg
	Sue Dickinson		Linda Teplin
	Steve Harris		Anthony Travisono
	Eliot Hartstone		Ecford Voit
	Ann Klinger		Dr. Henry Weinstein

GROUP II - BOOKINGS / DIVERSION

	Michael Benjamin		Ron Jemelka
	Dr. Fulton Caldwell	R	Tissia Kemp-Brown
	Sharon Chaney		Wayne Kimmel
	Ray Coleman		Roy Pracil
	Mary Dickerson		Fran Ruddick
	Nancy Fernandez	F	Myra Wall
	Terry Fitzgerald		Ted Wilson

GROUP III - IN JAIL SERVICES

	John Ambrose		Sheriff Art Martinak
	Jim Andrych	F	Dr. Joseph Palmer
	J. Benedict Centifante		Don Richardson
	Joel Dvoskin		Hank Steadman
	Howard Hellinger		Melissa Warren
R	Frank Kokorowski		Senator Don Wesely

GROUP IV - COMMUNITY LINKAGES

	Jim Barbee		Robert Moon
	Pam Casey		Al Nerio
	Meredith Davis		Charles Pisano
R	Steve Freng	F	Karen Portin
	Patricia Griffin Heilbrun		Tom Posey
	Mark Lopez		Barbara Rankin

F = Facilitator
R = Recorder

APPENDIX C

INITIAL CONTACT

Key Problem

* The mentally ill are inappropriately channeled by policy into CJS.

Factors Contributing to the Problem

- o Misperceptions of the mentally ill as dangerous.
- o Insufficient training of police to identify MIO.
- o Low priority attributed to MIO.
- o No alternative placements available.
- o Insufficient sharing of information.
- o Police not rewarded for successfully handling MIO cases.

Proposed Intervention

- o Implement cross-training of police, mental health professionals, and families.
- o Enhance identification of the MIO.
- o Make available programmatic alternatives for division.
- o Establish treatment programs for those who are both mentally ill and substance abusers.
- o Develop transport alternatives.
- o Establish clearinghouse activities.

ADMISSIONS/BOOKING

Key Problem

* Lack of adequate and timely screening for a new admission's mental health needs, and those needing assistance are rarely diverted into appropriate programs and facilities.

Factors Contributing to the Problem

- o Insufficient training of corrections staff to identify mentally ill.
- o Mental health staff not trained to work with offender population, leading to refusal to admit for screening.
- o Lack of communication across systems leading to under identification at the jail.
- o Lack of diversion options.
- o Lack of fiscal incentive for community mental health to admit MIO.
- o Difficulty addressing needs of those with co-morbidity.
- o Public attitudes toward mentally ill make low priority.
- o No formal system for monitoring implementation of screening standards.

Proposed Intervention

- o Develop standard for screening test, including monitoring and sanctions for non-compliance.
- o Screening conducted either by professional or via accepted standardized tool, and within 2 hours of admission.
- o Low threshold of initial screening, resulting in referral to professional mental health staff.
- o Access to immediate detoxification, substance abuse, and mental health services as needed.
- o Review confidentiality protection laws to promote well-being.
- o Get families involved in screening.
- o Establish financial incentives for community mental health to assist jails.
- o Identify the true costs for implementing cross-training for mental health professionals, judges, and jail staff.
- o Public education.

JAIL BASED SERVICES

Key Problem

*Mental health service in jails is inconsistent, placing MIO at risk of physical and/or psychological harm.

Factors Contributing to the Problem

- o Lack of coherency and consistency in standards.
- o Clinical professional not present at key times.
- o Jail environment promotes deterioration and psychiatric crisis.
- o Individuals suffering co-morbidity rarely treated for both concerns.
- o Frequent failure to document and communicate crisis information.
- o Mentally ill inmates "get lost" in jail.

Proposed Intervention

- o Training of corrections officers to identify mentally ill, access resources, and inform clinicians.
- o Jails must provide appropriate housing options for MIO.
- o Crisis intervention accessible 24 hours a day.
- o Establish mental health and corrections partnerships.
- o Develop practical transporting procedures.
- o Jails identify case managers for MIO.
- o Provide appropriate services for special populations.

COMMUNITY LINKAGES

Key Problem

*The large majority of inmates identified as mentally ill are discharged with no formal discharge plan or arrangements for community mental health services.

Factors Contributing to the Problem

- o No one assigned or responsible for continuity of care for MIO.
- o Lack of communication across systems.
- o No advocate for MIO on outside.
- o No formal procedures to assure development of discharge plan.
- o Lack of family and inmate participation in developing release plan.

Proposed Intervention

- o Jails should be made and held accountable for establishing linkages with mental health services.
- o Mental health should be made and held accountable for providing information to jails, continued contact, and service upon release.
- o Coordination councils should be established on state and county levels to facilitate communication, assure mental health services for MIO, and advocate for essential services.
- o Formal and detailed release procedures developed by mental health professionals, and reviewed and agreed to by all relevant parties.
- o Increase family and inmate involvement in release plans of inmate.