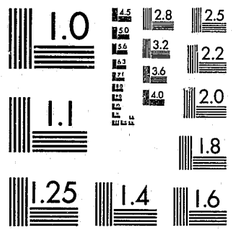

THE SPECIAL NATIONAL WORKSHOP ON MENTAL HEALTH SERVICES IN JAILS

SERVICE DELIVERY MODELS

September 26 - 29, 1978
Baltimore, Maryland

EPARTMENT OF JUSTICE • NATIONAL INSTITUTE OF CORRECTIONS

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ON MENTAL HEALTH SERVICES IN JAILS

SERVICE DELIVERY MODELS*

by Carole H. Morgan

September 26 - 29, 1978
Baltimore, Maryland

This paper was prepared under Grant No. AO-6 from the National Institute of Corrections for the Special National Workshop on Mental Health Services in Jails. The Workshop was co-sponsored by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration; the National Institute of Mental Health; and the National Institute of Corrections, under the Law Enforcement Assistance Administration Contract No. J-LEAA-022-6.

*Revised report

January 1979

ACKNOWLEDGEMENTS

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ABSTRACT

This report was developed through a four-phase process consisting of literature review, interviews with a broad range of interested and involved individuals, written information requests and on-site evaluations of programs providing mental health services in jails.

The task undertaken was to identify and evaluate existing service delivery programs and to select several systems to serve as replicable models for the Special National Workshop on Mental Health Services in Jails. Inquiry was focused upon the provision of services in intake/screening/classification, prevention, staff training, crisis intervention, on-going treatment, and follow-up referrals.

While the "program description" response sample was relatively small, several generic trends could be interpreted. Salient statistical tables are included, along with recommendations for subsequent research.

Finally, the seven systems which were selected represent a variety of viable methods for mental health - jail service delivery. The narrative descriptions were designed to facilitate systemic comparisons and implementation considerations. Each program explanation includes its unique jail and community characteristics, operational inception, mental health definition, service delivery policies and procedures, security staff - mental health training, management implications and facility blueprints.

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The jail represents,
symbolically at least,
the level of compassion, humanity
and concern for human dignity
that prevails in our society.

SERVICE DELIVERY MODELS

Part I: Survey Screening/Selection

INTRODUCTION:

According to the 1977 Sourcebook of Criminal Justice statistics, there were 3,921 jails[1] in the United States, estimated to annually process from one-and-a-half to five-and-a-half million persons (Gibbs, 1978: 1). Based upon recent trends and projections, the average number incarcerated each year will continue to grow, despite the fact that many facilities have already surpassed their designed maximum housing capacity. In addition to the increasing size of jail populations, there has been a noticeable change in the behavior of the individuals maintained in the jail. The most apparent change, observed by experienced jail staff, has been in the character of persons booked into the jail. Individuals in need of mental health care have become so prevalent in detention facilities, in fact, they are now considered a priority management and treatment problem. These observations and concerns seem amply supported by both literature review and the most recent research reported in the Workshop papers of Brodsky, Gibbs, Gove, Megargee, and Singer. It has further been noted that the jail populations seem to be increasingly composed of the more "hardened" offenders who cannot make bail and who are ineligible for personal recognizance releases or the proliferating diversionary projects. At the same time, the mentally ill are becoming overrepresented in the jails because of increasing criminal arrests, albeit often for frivolous charges, since arrest and booking are regarded as the most reliable way of securing involuntary detention of mentally disordered persons.

1. Jails are defined as locally administered adult institutions with authority to hold persons for longer than 48 hours.

One reason contributing to this present state of affairs has been the mental health efforts to deinstitutionalize psychiatric hospital patients over the past decade. The studies of Penrose (1939), Biles and Mulligan (1973), and Allodi et al. (1977) which reported an inverse relationship between the population of psychiatric hospitals and jail populations substantiate the staff impressions and may very well account for the current phenomenon.

Although the explanations for this relationship differ, the consensus seems to be that there are essentially two alternative ways (mental health or criminal justice) available to the community for "disposing of the aberrant." (Allodi, et al, 1977: 4)

Therefore, the release of persons from mental hospitals without proper survival skills, placements, or supervision and the simultaneous enactment of more stringent commitment standards led, almost inevitably perhaps, to encounters with the criminal justice system for many individuals. Despite mental health Community Support Programs which have been established to assist released patients and to intervene in this alternative processing, the jails are still too frequently being used as a disposal for both the mentally ill and the mentally retarded.[2/]

In many areas this is devastating for the incarcerated because the jails have been without adequate preparation, direction, or mental health support in the management and treatment of those most needing services. Consequently, today's jail is the storage place of "last resort" allowing society to warehouse citizens who have manifested deviant or socially disruptive behavior.

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2. "Mentally ill" and "mentally disordered" are used interchangeably and when included with the "mentally retarded" are considered "persons in need of mental health care."

Moreover, despite the protestations of sheriffs and jail administrators about the inappropriateness of housing the mentally ill in jail, this situation seems unlikely to change in the foreseeable future.

There are, at least, two major factors upon which one can predict the continued booking of mentally disordered or mentally retarded persons into the jails. One factor is the unlikelihood that the policies or procedures for state mental hospitalizations will drastically change in the near future. The resumption of vast psychiatric institutionalizing of mental patients is improbable, due to the ongoing debates over involuntary treatment and commitment standards, "least restrictive setting" litigated patients' rights, dangerousness predictability, professional responsibilities, and mental health service objectives.

The other factor which indicates the continued jailing trend is the growing public intolerance with the repeated criminal acts of the psychiatrically released offenders and the recurrent nuisance behavior of the mentally retarded. Consequently, law enforcement intervention has been increasingly requested by the community to resolve or remove the "problem."

Jail management and inadequate treatment problems which result from the incarceration of these persons can also be expected to continue, unless certain conditions and past professional relationships are changed. The link between jails and human services has traditionally not been strong. Few community representatives have expressed interest or offered services for jail populations or programs. Few jail managers have heretofore sought to cultivate outside agency involvements within their facilities. Whenever prior contacts were attempted between corrections/law enforcement and mental health/social service representatives, the experiences were typically

unsuccessful and often reinforced the dichotomy of mutually believed stereotypes and antagonistic attitudes. Brodsky's explanation of the consequences of the encounters between jail personnel and mental health staff is indicative of the process. (Brodsky, 1978: 6-7)

However, there has been a growing concern demonstrated recently by jail personnel who are confused and frustrated with present conditions and who understand that new methods for coping with the increasing mental health - jail problems are mandated. This unprecedented situation has evolved from and been further compounded by the jail's revised social role. The jail's relationship to the inmate, community, and criminal justice system has been undergoing analysis and transition. The current controversy revolves around the jail's obligation to detain or treat and has been exacerbated by diverse standards, judicial interpretations and inconsistent political pressures.

Although efforts to inform, clarify and systematize have already been undertaken by jail professionals to reduce some of the management difficulties, the need for additional outside assistance with mental health treatment has been universally recognized and expressed.

Therefore, while different modalities can be adopted to address this issue within each community, every solution should involve the development and efficient utilization of resources and referrals. This means that there has to be local, regional, and national action-planning with integrated communication and program implementation. Through coordinated and cooperative jail and human services endeavors, the most cost effective strategies for the management and treatment of mentally disordered offenders can be provided. This comprehensive problem-solving approach will, hopefully, inhibit the existing cycle of "finger-pointing" abdication of responsibility and the "buck-passing" alternative processing of people who are in need of mental health care.

DESIGN PROBLEMS:

In recognition of this need for cooperation and as an initial step to facilitate local efforts, the NIMH (National Institute of Mental Health), LEAA (Law Enforcement Assistance Agency), and NIC (National Institute of Corrections) co-sponsored the September 1978 Special National Workshop on Mental Health Services in Jails. One of the fundamental planning tasks was to conduct a "state-of-the-art" survey to evaluate the existing mental health - jail service delivery systems and to identify replicable "model" operations.

A major obstacle encountered, which limits this survey, is the lack of data regarding the existence of interdisciplinary communications networks. Many programs undoubtedly exist throughout the nation that should be investigated for verification and acknowledged for their innovation or operation.[3] Because of the limited data readily ascertainable about individual mental health - jail projects, this initial survey sample is not all inclusive and the research methodology is admittedly unsophisticated. The results are viewed as interesting but inchoate and demand follow-up exploration.

The Workshop and this paper will, hopefully, serve as catalysts for the development of information and the utilization of consortiums locally, regionally, and through the resource/referral system of the National Institute of Corrections. Subsequent inquiry and program sharing would then be more comprehensive and scientific. Extensive and continuing programmatic research is necessary to measure the estimated effects of various service delivery models and to provide a consistent data base for comparability.

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3. A case in point is the Alabama program cited in Brodsky's paper (1978: 28). For whatever reasons, this seemingly successful relationship was not mentioned by the jail or mental health center when sent a program description request.

Another difficulty which affected the survey responses and should be considered in the pursuit of interdisciplinary communications designs, is the fundamental language barrier between mental health and criminal justice professionals.

This issue surfaced repeatedly when program managers attempted to answer questions about their mental health services. The genesis of their concern was the definition of "mental health." In addition, public interest has been aroused with regard to this matter in a political arena juxtaposed with the taxpayers' revolt against unnecessary or misunderstood requests for government appropriations:

> "...Nowhere does it (The President's Commission on Mental Health) define specifically what mental health is.
>
> The closest the report comes in 2,242 pages is to say that 'opinions vary on how mental health and mental illness should be defined' and that 'available data are often inadequate or misleading.'" (Beck: 1978)

While perhaps irreconcilably dismissed by mental health workers, the question posed by Alexander Pope in his eighteenth century Moral Essays, Epistle III remains as pertinent for the jail and community as ever:

> "Who shall decide when doctors disagree?"

Since the mental health professionals have not agreed upon their meanings, it is little wonder that jail personnel and the public can't understand who and how to treat for what.

Because the intent of this survey was to acquire as much information as possible about what operationally existed in the field, the interpretation

of "mental health" was left open. The single survey parameter was to essentially exclude those services established exclusively for substance abusers.

In accord with the ambiguity of terms, the continuum of responses received from jail program representatives gives the estimated percentage of mentally ill in jails between 0 - 60%.[4] The mentally retarded incarcerated in their jails range between 0 - 25% of the population.

Another example of perceptual and language differences was shown by duplicate surveys returned from four separate projects. One program description was completed by a mental health staff member and the second by a jail representative, apparently each unbeknownst to the other. Although substantively comparable, the subjective emphasis and explanations were conspicuously distinct. (Further discussion of these results will be provided with Part II survey statistics.)

Consequently, because of the paradigmatic discrepancies, "mental health" systems were reviewed with consideration for each jail's conceptualized needs and objectives, as well as reviewed for the following basic service components: intake/screening/classification, prevention, crisis intervention, on-going treatment, and follow-up/referral. Also, discussions with the involved mental health and jail staff were required during the on-site evaluations for model service delivery selections.

4. This would seem to correlate with the disparate research studies which explain the extent and nature of the problem. (Brodsky, Gibbs, Gove, Megargee, etc.)

DISTRIBUTION:

Although ideal, it was impossible to contact each of the approximately 4,000 jails.

Since it was not known to what extent program information was available at the local, regional, and national levels, a broad scope of inquiry was chosen. The initial method for data collection included literature review, written and verbal requests for program identification or referral.

Table 1 illustrates the distribution of the letter sent to state level agencies or associations and the response rate. Effort was made to keep the inquiries balanced in terms of requests sent to mental health, criminal justice and mental retardation representatives.

Table 2 illustrates the distribution of the letter sent to conference participants and members of interested or involved affiliate organizations and the response rate.

Table 3 illustrates personal or telephone inquiries. These were essentially the most productive efforts with respect to data collected. The jail inspectors expressed the best sense of the problem and what was being done within the jails of their respective states. It should also be noted that I did not talk with anyone who did not share the opinion that this was a primary area of concern.

Table 4 illustrates the specific number of programs which were identified as a result of the inquiries made or identified from the Law Enforcement Assistance Administration's print-out sheets for programs funded during the past five years.

Table 1

Distribution: Letter I (Attachment A)

# Sent		# Replies
	State Agencies	
49	Mental Health Departments	30
52	Mental Retardation Departments	27
56	State Planning Agencies (Departments of Corrections)	23
30	Associations (Sheriffs, etc.)	9
187		89*

Table 2

Distribution: Letter II (Attachment B)

	Directories/Participant Lists	
53	American Corrections Association membership	20
21	Criminal Justice Information Service	8
12	Division Corrections Service Agency	4
87	1975 Symposium "Mentally Retarded Citizen & the C.J. System"	14
173		46*
51	Referrals for further information received from correspondence*	20

411--Total Written Requests Total Rec'd. from Written Requests--155

Table 3

Personal or Telephone Inquiries

34	Jail Inspectors (State Regulatory Agencies)
300	Sheriffs, Jail Managers, or Staff Representatives (Contacts at training sessions addressed approximately 12 @ 25 participants: WICHE, MSU, OSU, NIC-SIS-LEGAL ISSUES, WOMEN IN JAILS, ETC.)
100	Representatives from agencies, associations, universities, research projects (including, but not limited to: American Bar Association, American Medical Association, John Howard Assoc., National Council for Crime and Delinquency, National Institute of Mental Health, National Institute of Corrections, National Clearinghouse, National Assoc. of Corrections, Offenders Aid and Restoration, National Sheriffs Association, Assoc. for Programs for Women Offenders, Battelle, National Assoc. of State Mental Health Directors, National Assoc. of Community Mental Health Centers, American Justice Institute, American Corrections Assoc., VERA Institute of Justice, Rand Corp., President's Commission of Mental Retardation, Fortune Society, Project Share, Americans for Effective Law Enforcement, various state health departments, forensic services, probation diversion projects, police departments, etc.)
845	Total inquiries made: Tables 1, 2, and 3.

Table 4

Specific Programs Identified

160 Resulted from above sources (Tables 1, 2, and 3).

Letter (Attachment C) and a Program Description Request (Attachment E) were sent to either the sheriff or contact person named for the program

33 The FY 1973-78 printout for non-block awards relating to mental health services in correctional institutions was reviewed and 47 jail-related programs were identified. Fourteen of the 47 were duplicate referrals identified from the above sources. Letter III was sent with a Program Description Request (Attachment F)

193 Total Program Descriptions requested

Table 5 illustrates the program request distribution and response rate according to the jurisdictional regions of the United States Circuit Courts (see Attachment G map).

Table 5

	Region										Row Total
	I	II	III	IV	V	VI	VII	VIII	IX	X	
Requests Sent	14	11	18	11	22	20	12	22	42	21	193
Program Description Response	3	3	6	6	11	7	4	7	23	11	81
No Program Response	1	0	1	2	3	2	1	2	4	0	16
Total	4	3	7	8	14	9	5	9	27	11	97
Response Rate	29%	27%	39%	73%	64%	45%	42%	41%	64%	52%	50%

Table 6 lists the criteria considered for the screening and ultimate selection of the exemplary programs. Basically, the 81 positively responding programs noted above comprised the category for screening and the statistical analysis forthcoming in Part II.

SCREENING/SELECTION:

Table 6

Screening and Selection Criteria

1. Geographic location
   - A. Regional distribution
   - B. Community characteristics
2. Jail
   - A. Population characteristics
   - B. Facility
   - C. Management
3. Program
   - A. Objectives/rationale
   - B. Resources available and utilization proportionate to services rendered
   - C. Length of time operational and how initiated
   - D. Stage of development of service delivery system
   - E. Type of service provision
4. Program staff
   - A. Number ratio to jail size
   - B. Professional credentials
   - C. Appropriate for program objectives
   - D. Mental health/Jail authority and accountability
5. Program budget
   - A. Ratio to jail size
   - B. Replication feasibility
   - C. Appropriate for program objectives
6. Program components/specific services delivered
   - A. Screening/classification
   - B. Prevention/recognition of potential problems
   - C. Crisis intervention
   - D. Ongoing treatment in jail
   - E. Follow-up/referral
7. Training
   - A. Stage of development
   - B. Attitude/behavior integration

Twenty programs, or approximately 25 percent of the 81 responding programs were visited on site. Six individual systems were eventually selected for Workshop presentation as model mental health-jail service delivery programs:

- Alabama - Marengo County
- California - Los Angeles County
  Napa County
- New Jersey - Monmouth County
- Ohio - Cuyahoga County
- Washington - Whitman County

The State of Michigan was chosen as the seventh model to demonstrate a comprehensive statewide approach to the problem. Narrative explanations of each program will be included in Part III of this report.

Many of the programs visited deserve recognition for their outstanding services and may not have been selected only because of the need to recommend a balanced sample of operations according to size, region, system, etc. Representatives from several of these programs will be in attendance at the Workshop as participants and faculty. They will be identified as resource contacts in the final report and utilization of their expertise is strongly encouraged.

Finally, none of the exemplary service delivery systems herein proposed should be taken as the only way to solve the mental health-jail problem. These programs are being recommended for the variety of ways they responded to their needs with appropriate and replicable services. It is hoped that these examples of service delivery systems offer jail managers and mental health providers the opportunity to evaluate and extract acceptable program components. Specific policies and procedures information will be provided with each narrative for beginning implementation consideration.

Naturally, because of the unique needs of each facility's structural design, population, resource availability, and financial support, modification of programs will vary. This is precisely why interdisciplinary communication and integrated professional efforts are needed to guide, direct, and supervise staff in achieving competence to successfully perform the task.

Control as the primary tool used for the management of individuals in need of mental health care must be replaced by more sophisticated treatment and program strategies.

The establishment of centralized information networks, identification of cross-professional resources, and the provision of shared expertise through technical assistance can reinforce and support rather than frustrate this program development.

Parts II and III of this paper will include the model program descriptions, compiled survey data, statistical analysis, and research impressions. The final report will be distributed prior to the Workshop Panel on "Service Delivery Models" in Baltimore.

We the willing,

led by the unknown,

are doing the impossible for the ungrateful.

We have done so much,

for so long,

with so little,

we are now qualified to do anything with nothing.

Part II: Survey Analysis

SURVEY STATISTICS

It must be emphasized again that the intent of the survey design and distribution explained in this paper was of an exploratory nature. Although desirable, it is not possible, to make any definitive statement about mental health programs in jails based upon the data generated in this inquiry. It is, however, possible to make some very general and preliminary statements and hypotheses based upon trends that emerged from the program responses. The most salient results will be briefly discussed in this section.

Table 5 in Section I indicates that 193 initial requests for program descriptions were forwarded to jails identified as having mental health programs. Of these requests, mailed in April, 1978, 97 responses were received by August 1, 1978, after which point responses were not included in the analysis. This 50% response rate compares favorably with the response rates of most mail surveys. One follow-up letter containing a second copy of the program description questionnaire was sent to all non-responding institutions on May 18, 1978. (Attachment D)

It was interesting to note during preliminary analysis that sixteen of the ninety-seven respondents indicated that they had no program. This data additionally reveals the information gap that exists with regard to the nation's jails. (These jails had, after all, been specifically recommended by a person or agency within the same state who thought the jail had a mental health program.)

Due to the exploratory nature of the survey and to the type of data available, data analysis was limited to the examination of frequency and contingency tables. Preliminary analysis of the frequency distribution suggested that several variables, primarily size of the jail and program budget, might account for some of the differences in the response rates. Contingency tables were then run using size of jail and program budget as the independent or casual variable. As the following analysis will indicate, certain trends did emerge from this strategy.

Before proceeding with the analysis, the two independent variables need to be defined. The variable, size of the jail, refers to the inmate population on the day the questionnaire was answered. In the initial contingency tables, this variable was broken into 5 categories (jails under 50 inmates, those with 50 - 149; 150 - 499; 500 to 999; and 1000 or more). Analysis of responses indicated that these categories could be further collapsed as the responses to several of the categories were quite similar. In the final analysis, jails were separated into the following three categories based upon their inmate populations: 1) Small--those with fewer than 50 inmates; 2) Medium--those with 50 to 499 inmates; and 3) Large--those with 500 or more inmates.

Although it can be argued that there is a large difference between the types of problems and general administration procedures occurring in a jail with 50 inmates and one with 450 inmates, the data from this survey suggest that there is enough significant comparability to allow the inclusion of both in the same category.

The other variable which seemed to influence response patterns was the program budget. Once again, these categories were identifiable:

1) Programs with less than a $50,000 annual mental health budget;

2) Those with $50,000 to $200,000 annual budget; and

3) Those with more than $200,000 appropriated to the mental health program. Although there is a high correlation between these two independent variables (r = .72), each one seems to be tapping a slightly different dimension. This would be something to continue to examine in any future research efforts.

Recognizing the limitations of the data detailed above, analysis of the information is now possible. First of all, as suggested above, the data seem to indicate that the underlying basis of the programs is different when one controls for the size of the jail population. This can be seen from examination of the responses to the questions pertaining to litigation and program rationale. (Tables 7A, 7B, and 8) As might be expected, due to location and isolation from the reform activities usually centered in larger cities, the small jails report a lower incidence of health or mental health program litigation. In addressing this very issue, the respondent for the Los Angeles County Jail wrote that "because Los Angeles is the hub of activity and the major population center in Southern California, the Los Angeles County Jail system bears the brunt of attempted reforms brought about by class action suits." This is not to say that conditions with regard to inmate well-being are any better in the smaller jails, but merely suggests that the larger city jails are likely to be under closer scrutiny by such watchdog groups as the American Civil Liberties Union. Additionally, inmates have greater access to and more knowledge about the use of legal assistance from Legal Aid Services, federally funded legal assistance projects, National Lawyers Guild, and the Public Defender's Office.

A logical deduction from this point would suggest that there is a good possibility that a considerable number of the larger jails established programs in response to court orders or as outcomes of the litigation brought against the jails. This line of reasoning is provided support by the differential responses to the question of how and why the program got started. As revealed in Table 8, 73% of the programs with budgets under $50,000 stated that a need or a desire for a program was the major reason for starting the program. This compares with only 46% of the jails having large budgets responding with similar statements. On the other hand, we find that 39% of the large jails initiated their programs because funding was provided while only 18% of the small jails fell into this category. It can be seen, then, in the response patterns found in Tables 7A, 7B, and 8 that there is some degree of association between the involvement in litigation and the rationale for beginning the program. Perhaps related to the judicial intervention issue is the high correlation between jail size and program budget which indicates that the large jails have more money allotted to their mental health programs. Aside from the obvious implication that this allows employment of a larger, specialized staff, it also has implications for the type and diversity of services made available within the jail. In order to provide the institutional services, however, some small jails compensate for their restricted budgets by contracting services from a local mental health center or other community agency. Both methods for providing treatment have been successfully demonstrated by the model programs in Part III.

An alternative course of action revealed by the data shows a greater tendency for the smaller jails to transfer those inmates judged to be mentally ill or retarded than the medium and large jails. Although this conclusion may seem to rest on a tenuous base since only 10% of all the jails responding to the survey mentioned that they transferred the mentally ill rather than treating them in the jail, the responses to several additional questions indicate that the smaller jails do indeed more frequently refer the mentally ill and retarded out of the jail and into some alternative form of placement. Assuming that there are no significantly substantive differences in the way jails define the mentally ill and mentally retarded, some interesting trends can be noted. In response to requests for an estimate of the percentage of mentally ill and mentally retarded inmates in the jail, 40% of the small jails stated that they have no mentally ill inmates at the time of the survey inquiry, while 80% of the larger jails said that more than 5% of their population was mentally ill. (Table 9). The same trend holds true for the mentally retarded, with 78% of the small jails attesting that there were no mentally retarded inmates in their jail population. Eighty percent of the large jails, however, reported that their population contained from 1% to 5% mentally retarded inmates. (Table 10) The issue of whether or not such differences can be attributed to definitional problems or to differential screening processes or whether they are actually reflective of successful methods for alternative inmate placements remains unresolved. However, the responses to the question, "How long does it take for an alternative placement?" which are reported in Table 11 suggest that perhaps there is a difference in transfer successes. Among the small jails, 64% report placing the mentally ill or retarded in alternative situations within

one week. In comparison to this, only 42% of the medium and large jails reported the same efficiency in securing alternative housing. At this point, it must again be cautioned that these data are of an exploratory nature and can really only serve to introduce certain trends that may warrant further examination.

In conjunction with inspecting the comparative under-representation of the mentally ill in small jails, one might also examine the small jails' usage of state hospitals as alternative placements. It is significant to note, however, that the jail is still used as the intervening process agent to get an individual into the hospital. (Sixty-four percent of small jails mention the state hospital as the most frequently used alternative placement, compared to 33% of the medium sized jails, and 27% of the large jails.)

Responses regarding how the mentally ill are processed and treated once they have been identified show little difference exists between the general treatment plan followed by the various jails. Neither the inmate population nor the program budget seemed to significantly influence the treatment program strategies. Consequently, the data pertaining to the treatment approaches will be presented and discussed in aggregate form.

Once identification of mental illness has been made, 40% of the responding jails reported that they would first counsel the inmate or conduct an evaluation to determine which type of treatment would be best suited to that particular person. Another 20% of the jails mentioned that they would first segregate the identified inmate while, as reported earlier, 10% of the jails attempted to immediately transfer the individual.

Responses regarding the type of services and treatment provided the mentally ill and retarded in the jail show slightly more respondents providing counseling and/or evaluation than they said they did in response to the question of how they processed the mentally ill once they had been identified. The first type of treatment mentioned by 62% of the responding programs consisted of counseling and/or evaluation of the inmates. Of considerable more interest, however, is examination of the responses listed for the second type of treatment used. Forty-six percent of the programs stated that some sort of medication was the second method chosen to treat the mentally ill. This latter finding is one that could be investigated further to better understand the extent and types of medication proving most effective for jail mental health treatment.[5/]

Responses regarding the type of action taken following a suicide attempt allow discussion of the different strategies in accord with the size of the inmate population. While only 10% of the small jails said they would put a suicide attempt under observation, 29% of the medium sized jails and 33% of the large jails reported this procedure. Upon examination of the influence of budget on the treatment of suicide attempts, this distinctive treatment strategy is further emphasized. (Table 14). This tends to address the inter-relationship between staffing patterns/ facility limitations and program design/service provision.

Responses regarding preventative program aspects show 51% of the jails saying that they identify potential mental health problems and

5. During site visits and discussions with the various staff representatives who prescribe the drugs, the most commonly preferred medication cited was Prolixin. It was also unanimously stressed that few, if any, tranquilizers (Valium, Librium) were dispensed.

refer to mental health workers for treatment. Another 28% say that they counsel inmates identified as potential mental health problems. There was a slight tendency for the larger jails to say that they referred inmates while the smaller and medium sized jails were more prone to counsel the inmates. These observations, combined with the responses to whether or not the correctional staff is trained to identify and treat the mentally ill, lead one to wonder if it is the correctional staff that provides the counseling in these jails. Future inquiry is necessary to examine and clarify this question.

Sheriffs and jail managers who are concerned about the effects a mental health program might have upon security at their jail can be somewhat relieved by the following responses. When asked to address this issue, 45% of the jails responded that the mental health program had effected security, with two-thirds of that group stating that the program had the effect of reducing tension in the jail. Only one jail reported an increase in the tension. (Table 16A and 16B) Administrators of large jails will also be encouraged to hear that it was the larger jails that were more likely to have security positively effected by the mental health program. For instance, the Monmouth County respondent wrote, "The program has reduced tension between inmates, between inmates and staff, and educated the officers as to recognizing and handling emotionally disturbed people. Also, many crises are now avoided with early diagnosis and the use of psychotopic medication. The number of commitments to psychiatric hospitals had been reduced by 50%. There is less aggressive interaction between the officers and inmates with the presence of the mental health team. . . ." Although not as emphatically,

most of the responding programs made similar statements. This seems to dispell some of the myths that security problems are increased with the introduction of treatment programs into the jail. One problem, though, is that these responses are based mostly on perceived effect of the program and not on actual data measuring tension and security related issues in the jail. Subsequent research is again recommended in this area.

Another issue of particular interest to administrators is that of program funding. One often hears that budgets will simply not allow for program development and the expansion of jail services. However, when provided the opportunity to express the types of problems experienced by their program, only 7% of the respondents mentioned funding of the program as a problem. (Table 17) Furthermore, only 16% of the jails reported that a shortage of staff members was a problem. Interestingly enough, it was the large jails, with their large staffs, that tended to report staff shortages being a problem. Table 17 also reveals another interesting trend in that all of the responses from the small jails fall into the inclusive "other" category. This category additionally accounts for 49% of all responses - strongly suggesting the uniqueness of each program and its attendant problems. Thus, while it is possible to suggest certain trends in the data according to common features, there remains a large degree of uniqueness and variability. This is an important consideration to note for jails wishing to implement a program. While one of the model systems described in the following section may serve as a prototype, modifications must be anticipated to meet the specific needs of each jail.

Tables 18 to 20B appear at the conclusion of this section and represent some basic information about the jails surveyed; percentage of female custodial staff, percentage of sentenced and pre-trial inmates, and the inmate racial breakdown. These tables are presented in order to provide a general impression of some of the characteristics particular to the different sized facilities, and to indicate that this survey sample does not differ significantly from the comparable demographic characteristics available for the nation's jails.

DUPLICATE PROGRAMS:

For one reason or another, more than one response was received from four jails. In each case, one response to the program description was completed by jail personnel, while another was completed by a representative of the mental health community. Based upon comparison of the primary demographic data and the different responses to questions about the program, these forms were evidently completed independent of one another. That is, there appears to have been no collaborative effort by the jail and mental health personnel to share information despite their mutual involvement in the program.

Generalizations cannot be made from such a small sample but these four duplicate forms do serve to highlight some of the problems encountered when attempting to gather data on American jails. First, there is the lack of local, regional, and national communication between systems, which results in the subsequent problems encountered when trying to identify individual programs.

These duplicate forms stress that the apparent lack of communication filters down, or perhaps begins, within each jail. That is, there appears to be little communication between the security personnel and the separate mental health program staff. For instance, in all four cases, different rationales for the beginning of the program were provided by the jail respondent and by the program respondent. Most noticeable were the vast differences in the inmate demographic data. In some instances, it was difficult to determine if the same jail and program were indeed being described.

Associated with the lack of communication is a lack of understanding of each other's role in the jail. Perhaps with greater communication this problem might be alleviated, although there appears to be a deliberate attempt in some instances to perpetuate the separate perceptions. The sheriff of one Nebraska jail, for instance, made the following statement in response to most of the questions pertaining to the program in his jail: "This could be better answered by doctors who handle mental problems." Likewise, in a Kansas jail, although the jail respondent felt the program had effected security by relieving the tension level, the court psychologist did not think that security had been effected.

SUMMARY REMARKS AND SUGGESTIONS FOR FUTURE RESEARCH:

Given the previous summarizations of the data collected from the survey of mental health programs in the nation's jails, an attempt will now be made to isolate researchable ideas based upon these exploratory findings. It must be emphasized again that first and foremost, there

has to be a uniform definition of mental health. A review of the definitions provided by the seven model programs might provide a base from which to begin. A uniform definition would help to alleviate some of the confusion in discussing a program and its client population. In terms of research, the researcher could have a greater sense of security that the respondents were addressing the same issue and the differential responses would be more apt to indicate real differences in programs rather than merely definitional differences.

Once a common research definition has been set forth, some of the areas in which data should be collected are: 1) The program typology i.e. internal, intersectional, adjunct, or combination service delivery system; 2) The characteristics of the jail that seem to determine the most suitable type of program; 3) More exploratory research into different available treatment strategies; and 4) Documentation of the effect of the program on security and jail management. By focusing on these issues, greater knowledge could be gathered as to the relative effectiveness of programs, both in terms of providing humane treatment and the cost-benefits of various strategies.

The responses to this survey suggested that for some jails, and not exclusively the small ones, it was more effective to have an intersectional or combined program than it was to have an internal operation. The particular jail and community characteristics which might indicate the advisability of one approach over another need to be documented. This survey further suggested that inmate population and program budget have some impact, but to what extents these and other variables effect program development are still uncertain. The use of alternative placements also

appeared to effect the distribution of mentally ill inmates in the jail, as the jail and mental hospital populations have been proposed to vary inversely with one another. Subsequent exploration into the type and extent of alternative placements used by jails would help to clarify this issue.

Some of the problems encountered in this survey were attributed to the lack of a common definition of mental health and the failure to specify a term sequence in which the various types of treatment are enacted. Stressing the sequence would help to better explain the priorities of the program. This would, in turn, allow for a more accurate assessment of the overall effectiveness of various strategies. The immediate question which arises, however, is how can program effectiveness be measured. It might be accomplished in several ways: 1) As was attempted in this survey, by exploring the impact of the program on jail security, management and overall environment, or 2) By examining recidivism data for inmates serviced by the program. Although, given the attendant problems associated with recidivism data, the former method would be preferable. Moreover, in addition to requesting perceived impact on security and management, documentation of the number of fights between inmates, assaults on staff, escapes, disruptive behavior, vandalism, and general jail disturbances might be documented over several years to determine if the program had any real impact on such jail activities. Finally, further efforts could be made to determine the influence, if any, that the program has on the jail environment, especially in terms of security and jail management implications. For a model of how the jail enviornment can be evaluated, consult "Utilization of the Berkshire Mode in Changing the Environment of the County Jail: An Evaluation" available through the Nat. Inst. of Corrections - Jail Center.

In addition to the statistical analyses and research recommendations made possible through the survey responses, the following issues are raised as a result of site visits and personal discussions with program representatives. They are generic impressions and demand systematic investigation and validation. They will only be cited here and discussed more extensively at the Workshop.

1. Special mental health needs of female inmates and the current, relative lack of programs which include women.
2. Recommended staff separation of competency/sanity evaluation responsibility from treatment responsibility.
3. Selection and assignment methods for officers working with mental health programs.
4. An 18-36 month period required for mental health - security staff rapport to develop and the program to be accepted.
5. Sheriff/jail manager's support essential for a program to operate, but mental health program staff must expend the efforts to prove credibility, change attitudes, and integrate into the jail's system.
6. A cell without padding more successfully prevents self-injury than a padded cell when used for isolating suicidal inmates.
7. When a "good" jail - mental health program has been developed and discovered, more individuals are sent to the program by law enforcement, courts, family referrals, etc.
8. The importance and degree of influence exerted by a single person to initiate/implement a program.
9. The typical reluctance of mental health centers/staff to become involved in jail services.

QUESTION: Is the jail now or has it been involved in litigation because of medical or mental health problems?

Table 7A

Litigation Issue

Size of Jail	Yes	No	Row Total
Less than 50	3 (33%)	6 (67%)	9 (100%) 15%*
50 to 499	17 (44%)	22 (56%)	39 (100%) 66%
500 +	10 (91%)	1 (9%)	11 (100%) 19%
Column Total	30 51%**	29 49%	59

*Represents row percentage (9 divided by 59 equals 15%)

**Represents column percentage (30 divided by 59 equals 51%)

Table 7B

Litigation Issue

Program Budget	Yes	No	Row Total
Less than $50,000	8 (40%)	12 (60%)	20 (100%) 44%
$50,000 to $200,000	12 (75%)	4 (25%)	16 (100%) 35%
$200,000 +	8 (80%)	2 (20%)	10 (100%) 22%
Column Total	28 61%	18 39%	46

QUESTION: What is the approximate program budget?

Table 8

Program Rationale by Program Budget

Program Budget	Funding Provided	Need or Desire	Other	Row Total
Less than $50,000	4 (18%)	16 (73%)	2 (9%)	22 (100%) 42%
$50,000 to $200,000	4 (22%)	6 (33%)	8 (44%)	18 (100%) 34%
$200,000 +	5 (39%)	6 (40%)	2 (15%)	13 (100%) 25%
Column Total	13 25%	28 53%	12 23%	53

QUESTION: Approximate percentage of current jail population mentally ill?

Table 9

Mentally Ill Population by Size of Jail

Size of Jail	0%	1 - 5%	6 - 10%	10% +	Row Total
Less than 50	4 (40%)	3 (30%)	0 (0%)	3 (30%)	10 (100%) 18%
50 - 499	5 (14%)	12 (33%)	11 (31%)	8 (22%)	36 (100%) 64%
500 +	0 (0%)	2 (20%)	6 (60%)	2 (20%)	10 (100%) 18%
Column Total	9 16%	17 30%	17 30%	13 23%	56

QUESTION: Approximate percentage of current jail population mentally retarded?

Table 10

Mentally Retarded by Size of Jail

Size of Jail	0%	1 - 5%	6 -10%	10% +	Row Total
Less than 50	7 (78%)	1 (11%)	1 (11%)	0 (0%)	9 (100%) 17%
50 - 499	7 (21%)	21 (64%)	4 (12%)	1 (3%)	33 (100%) 63%
500 +	1 (10%)	8 (80%)	0 (0%)	1 (10%)	10 (100%) 19%
Column Total	15 29%	30 58%	5 10%	2 4%	52

QUESTION: How long does it take for an alternative placement?

Table 11

Time of Alternative Placement by Size of Jail

Size of Jail	Less than 1 Week	1-3 Weeks	More than 3 Weeks	Other	Row Total
Less than 50	7 (64%)	1 (9%)	2 (18%)	1 (9%)	11 (100%) 22%
50 - 499	11 (42%)	6 (23%)	2 (8%)	7 (27%)	26 (100%) 53%
500 +	5 (42%)	3 (25%)	1 (8%)	3 (25%)	12 (100%) 24%
Column Total	23 47%	10 20%	5 10%	11 22%	48

QUESTION: Are the mentally ill or retarded identified before housing? How are they processed after this identification?

Table 12

Processing of Mentally Ill

Process	Number	Adjusted* Percentage
Segregation	15	23%
Evaluation	27	42%
Transfer	5	8%
Other	18	28%
No Answer	16	--
Total	81	101%

* Percentage excludes the "No Answer" category.

QUESTION: Do you provide services for the mentally ill or mentally retarded while they are in jail? What are the services?

Table 13

Treatment of Mentally Ill

First Type of Treatment	No.	Adj. %	Second type	No.	Adj. %
Counseling & Evaluation	44	62%		9	17%
Medication	5	7%		25	46%
Therapy	7	10%		7	13%
Referral	6	9%		6	11%
Other	9	13%		7	13%
No Answer	10	--		27	--
Total	81	101%		81	100%

QUESTION: How are suicide attempts handled?

Table 14

Treatment of Suicide Attempts by Program Budget

Program Budget	Observation	Counseling	Isolation	Medication	Transfer	Other	Row Total
Less than $50,000	4 (19%)	4 (19%)	2 (10%)	1 (5%)	3 (14%)	7 (33%)	21 (100%) 40%
$50,000 to $200,000	6 (33%)	4 (22%)	1 (6%)	0 (0%)	2 (11%)	5 (28%)	18 (100%) 35%
$200,000 +	6 (46%)	2 (15%)	2 (15%)	1 (8%)	0 (0%)	2 (15%)	13 (100%) 25%
Column Total	16 31%	10 19%	5 10%	2 4%	5 10%	14 27%	52

QUESTION: Do you identify and treat potential mental health problems? How?

Table 15

Treatment of Mental Health Problems by Size of Jail

Size of Jail	Refer to MH	Counsel	Transfer	Other	Row Total
Less than 50	2 (25%)	3 (38%)	0 (0%)	3 (38%)	8 (100%) 16%
50 - 499	18 (53%)	11 (32%)	3 (9%)	2 (6%)	34 (100%) 67%
500 +	6 (67%)	0 (0%)	1 (11%)	2 (22%)	9 (100%) 18%
Column Total	26 51%	14 28%	4 8%	7 14%	51

QUESTION: Has the program affected security?

Table 16A

Security Issue

Size of Jail	Yes	No	Total
Less than 50	1 (11%)	8 (89%)	9 (100%) 16%
50 - 499	16 (46%)	19 (54%)	35 (100%) 64%
500 +	8 (73%)	3 (27%)	11 (100%) 20%
Total	25 45%	30 55%	55

QUESTION: How has the program affected security?

Table 16B

Security Issue

	Number Replies	Adjusted Percent
Reduce Tension	19	63%
Increase Tension	1	3%
Other	10	33%
No Answer	51	--
Total	81	99%

QUESTION: What particular problems have existed or still exist with the program?

Table 17

Problems

Size of Jail	Funding	Staff Shortage	Support & Cooperation	Organi-zational	Other	Total
Less than 50	0 (0%)	0 (0%)	0 (0%)	0 (0%)	9 (100%)	9 (100%) 16%
50 - 499	3 (9%)	4 (12%)	6 (18%)	6 (18%)	14 (42%)	33 (100%) 60%
500 +	1 (8%)	5 (38%)	2 (15%)	1 (8%)	4 (31%	13 (100%) 24%
Column Total	4 7%	9 16%	8 15%	7 13%	27 49%	55

QUESTION: What percentage of the custody officers are female?

Table 18

Female Officers

Size of Jail	Less than 10%	10% to 24%	25% to 50%	0%	Row Total
Less than 50	0 (0%)	0 (0%)	5 (63%)	3 (38%)	8 (100%) 16%
50 - 499	5 (15%)	20 (59%)	4 (12%)	5 (15%)	34 (100%) 69%
500 +	1 (14%)	6 (86%)	0 (0%)	0 (0%)	7 (100%) 14%
Column Total	6 12%	26 53%	9 18%	8 16%	49

QUESTION: Percentage of current population sentenced?

Table 19A

Percentage Sentenced by Size of Jail

Size of Jail	0%	1 - 30%	31 - 60%	60% +	Row Total
Less than 50	0 (0%)	1 (9%)	6 (55%)	4 (36%)	11 (100%) 17%
50 - 499	2 (5%)	16 (42%)	16 (42%)	4 (11%)	38 (100%) 59%
500 +	0 (0%)	8 (50%)	7 (44%)	1 (6%)	16 (100%) 25%
Column Total	2 3%	25 39%	29 45%	9 14%	65

QUESTION: Percentage of current population pre-trial?

Table 19B

Percentage Pre-Trial by Size of Jail

Size of Jail	1 - 30%	31 - 60%	60% +	Row Total
Less than 50	3 (27%)	6 (55%)	2 (18%)	11 (100%) 16%
50 - 499	3 (8%)	13 (33%)	23 (59%)	39 (100%) 58%
500 +	0 (0%)	7 (41%)	10 (59%)	17 (100%) 25%
Column Total	6 9%	26 39%	35 52%	67

QUESTION: Racial distribution of current population?

Table 20A

Racial Distribution by Size of Jail - White

Size of Jail	1 - 30%	31 - 60%	60% +	Row Total
Less than 50	1 (11%)	1 (11%)	7 (78%)	9 (100%) 16%
50 - 499	1 (3%)	19 (59%)	12 (38%)	32 (100%) 56%
500 +	6 (38%)	7 (44%)	3 (19%)	16 (100%) 28%
Column Total	8 14%	27 47%	22 39%	57

Table 20B

Racial Distribution by Size of Jail - Black

Size of Jail	0%	1 - 30%	31 - 60%	60% +	Row Total
Less than 50	5 (56%)	3 (33%)	0 (0%)	1 (11%)	9 (100%) 16%
50 - 499	4 (13%)	11 (35%)	13 (42%)	3 (10%)	31 (100%) 54%
500 +	1 (6%)	5 (29%)	4 (24%)	7 (41%)	17 (100%) 28%
Column Total	10 18%	19 33%	17 30%	11 19%	57

"In sum, America's system of criminal justice is over-crowded and overworked, undermanned, underfinanced, and very often misunderstood.

It needs more information and more knowledge.

It needs more technical resources.

It needs more coordination among its many parts.

It needs more public support.

It needs the help of community programs and institutions in dealing with offenders and potential offenders.

It needs, above all, the willingness to re-examine old ways of doing things and to reform itself and to experiment, to run risks, to dare.

It needs vision."

(Monahan 1976: 290)

Part III: Seven Service Delivery Models

SEVEN MODEL PROGRAMS:

The most significant and substantial portions of this survey report are the attached narrative program descriptions. As noted in Part I of this paper, there were a myriad of reasons for ultimately selecting these mental health - jail service delivery models. They represent operating systems of varying sizes, resources, treatment philosophies and management policies and procedures.

It is again imperative to emphasize that several other superior programs were seen, but because of total selection criteria their representatives were not selected to serve as workshop panelists. A few of the particularly impressive operations have been included in this report along with brief site-visit commentary. (See Attachment H).

Furthermore, there are undoubtedly many outstanding programs which were not considered in this research simply because knowledge of their existence was limited and not easily ascertained. These systems are especially urged to bring their work forward by contacting the National Institute of Corrections - Jail Center for evaluation and inclusion in the resource information data bank and communications network.

Six of the model service delivery program descriptions have been delineated to afford narrative consistency, comprehensiveness, and comparability.[6/] The organizational structure and content guidelines are included for reference at the beginning of the program descriptions.

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6. The narrative for the seventh model, the State of Michigan, essentially addresses the same issues although a difference in presentation style was necessitated.

Each program narrative is self-explanatory and needs little interpretation. The information which follows is offered to briefly introduce and emphasize a few of the more salient issues.

The next two tables are given to facilitate preliminary program identification and applicability by highlighting several fundamental demographic and service delivery elements.

Table 21 illustrates population size, 1977 bookings, percentage pre-trial and sentenced and percentage mentally ill and mentally retarded. These are a few of the basic factors which imply the type and extent of services required and the delivery system to be developed within each unique jail setting. For example, each service delivery program is predicated upon the answers to such questions as:

- Are there significant numbers of mentally ill or mentally retarded who require specialized programming?
- Are crisis intervention services for pre-trial inmates needed more than institutional on-going treatment for a predominantly sentenced population?
- Does the size of the jail's mentally ill population vis-a-vis the annual number of bookings suggest the need for a more effective screening/identification and diversion strategy?

A system seeking to replicate one of the service delivery models should initially consider these inherent program characteristics for similarities and realistic service imitation.

Table 21

Jail Population Characteristics

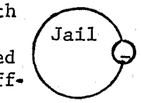
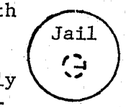
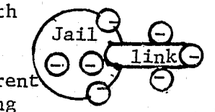
	Population Size	1977 Annual Bookings	% of Population			
			Pre-Trial	Sentenced	Mentally Ill	Mentally Retarded
ALABAMA: Marengo	49	756	24%	76%	4%	2%
CALIFORNIA: Los Angeles (4 facilities)	9,560	210,000	43%	57%	35%	2.5%
Napa	62	2,175	47%	53%	25-50%	1%
NEW JERSEY: Monmouth	310	4,347	68.5%	31.5%	10-15%	3%
OHIO: Cuyahoga	700	7,500	86.6%	12.4%	18%	3.4%
WASHINGTON: Whitman	10	263	50%	50%	10-20%	1%

Tables 22A and 22B illustrate program structures, program staff accountability and facility services. Five of the jails are under the jurisdiction of the County Sheriff. The sixth, Napa County Jail, operates under the direction of a County Department of Corrections. The typological categories are adapted from the National Jail Resources Study, Pennsylvania State University.

Table 22A

A Typological Model

For Mental Health - Jail Service Delivery

System	Primary Focus of Service Delivery System	Description	Schema
INTERNAL	Treatment while incarcerated, brokerage arrangements and referral post-release.	Jail autonomous. Service is administered and provided by sheriff's personnel.	
INTERSECTION	Treatment while incarcerated, brokerage arrangements and follow-up post-release.	Jail interacts with outside agencies. Service is provided by a separate staff-organization and integrated into jail operations.	
ADJUNCT	Treatment while incarcerated, brokerage arrangements and referral post-release.	Jail interacts with adjunct unit. Service is contracted exclusively for jail and integrated into operations.	
COMBINATION	Type varies depending on systems.	Jail interacts with several providers concurrently. Two or more different conduits, including jail staff, outside resources, and brokerage arrangements provide services to inmates.	

⊖ Service component

Table 22B

Program Structure, Staff and Service

INTERNAL	INTERSECTION	ADJUNCT	COMBINATION
MARENGO	(1975) LEAA grant to Mental Health Center. Service staff also serves as Jail Administrator		
LOS ANGELES		(1972) Forensic Mental Health Unit as autonomous jail division with state Health Dept. contracted staff. Coordinated operation with separate Medical and Custody treatment units.	
NAPA			(1977) "Bootlegged" mental health center staff, informally contracted with Liaison positions assigned to criminal justice system.
MONMOUTH	(1974) Formal contract with mental health center for part-time staff services.		
CUYAHOGA		(1977) Class action suit resulted in Institutional Supportive Services, formally contracted directly under Commissioners.	
WHITMAN	(1976) LEAA grant for Offender Services Coordinator, serves as non-commissioned Sheriff's Department staff and mental health professional on-call to community.		

Table 23 lists interesting program aspects or activities observed during site visits or presented in service descriptions and discussions. They represent impressive or innovative features which are recommended for further inquiry and elucidation.

Table 23

Unique Program Features

MARENGO:	Combined position of mental health service provider and jail administrator.
LOS ANGELES:	Custody Program with behavior reward system.
NAPA :	Mental health programs operationally integrated male/female staff and inmates.
MONMOUTH:	Initiation and implementation of mental health programs by jail security officer.
CUYAHOGA:	Screening/classification system and specific program plans for mentally retarded offenders.
WHITMAN:	Sheriff's jail staff on-call as Mental Health Professional for community services.

COMMENTARY:

> "From a realistic and pragmatic point of view it is not likely that our society will reorder its priorities in the immediate future and devote a significantly larger portion of its resources to care and treatment of the mentally ill offender. Neither the professionals currently working in the field, nor the offenders or their families, have any great influence on our legislators, and certainly no lobbies are working on a federal or state level to increase spending in this area. We must, then, within the field itself, devote our first efforts to the more efficient utilization of existing staff and facilities." (Pennsylvania; 1977: 30)

Throughout much of the survey research, funding and facility/space limitations have been typically cited to justify the lack of mental health - jail programs. It can be noted from these exemplary service delivery descriptions and institutional blueprints that programs have been implemented despite the admitted obstacles. As these programs are reviewed, the excuses for failing to make services available should become less acceptable.[7/] Mental health care can be provided, for example, at no cost to the jail or mental health center, as demonstrated by Napa County; or supplemental grant budgets can be secured to initiate programs, as demonstrated by the Sheriffs of Marengo and Whitman Counties.

Moreover, none of the model programs operates within a facility that was satisfactorily designed to accommodate the current jail - mental health care needs. Yet, each program has been able to establish institutional services in spite of the structural restrictions.

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7. Additionally, the courts have made it clear repeatedly, with regard to the correlated inmate right to health care, that the argument of "insufficient funds" can not justify inadequate care, i.e. (Jackson v. Bishop 404 F2d 571 C.A. 8, 1968).

Finally, the lack of personnel has been frequently proposed as a major impediment to providing mental health treatment within the jails. Again, the exemplary programs challenge the validity of this assertion by illustrating a variety of means for finding and keeping professional staff. Even more cogent is the utilization of a Custody Program in a system as impersonal as Los Angeles. The deputies working with mental health housing units in the main jail are successfully and independently serving as treatment staff by improving inmate behavior and achieving the reintegration of "problem" individuals into the general jail population.

Therefore, the existence of these model programs supports the conclusions drawn by another mental health - corrections national survey in refuting the most commonly heard service objections.

> "The success or failure of any program, which has as its objectives a change of human behavior, is dependent more upon the personalities of the staff and the quality of the relationship between the changer and those to be changed than upon the numbers of staff members or the condition or location of a facility...
>
> This is not to suggest that handicaps, such as overcrowding, understaffing, and shortage of program equipment do not affect the outcome of the program. However, too often these factors become excuses..." (Santamour and West 1977: 45)

Eighty-one successfully operating programs around the country have demonstrated that in spite of fiscal, architectural, and personnel restraints, mental health - jail management and treatment problems can be overcome with commitment, creativity and cooperation.

In conclusion, it is hoped that the following program descriptions will encourage the reassessment of jail - community mental health services and lead to integrated action planning. Informational questions or requests for assistance regarding this survey report can be directed to the sheriff or program representative for the specific system; the National Institute of Corrections - Jail Center, P.O. Box 9130, Boulder, Colorado 80301, (303) 443-7050, Resource Information Center, (303) 441-1101; or Carole Morgan, Criminal Justice Consultant, Western Interstate Commission for Higher Education, P.O. Drawer P, Boulder, Colorado 80302, (303) 492-8232.

CONTENT GUIDELINES FOR
EXEMPLARY PROGRAM DESCRIPTION

I. PROGRAM INTRODUCTION

A. How is "mental health" defined as it relates to the provision of mental health services in your jail?

B. How did your program get started? Date when it got started?

C. What are the program's objectives?

D. If the personalities currently involved in the service delivery change, what linkages exist to insure the continuation/institutionalization of mental health-jail services?

II. DEMOGRAPHICS

Give current statistics unless they do not accurately represent the population. In such a case, give "average" population statistics and specify the differences.

A. Current jail population: number of female, number of male, number maximum capacity.

B. Racial distribution of current population: percentage Anglo, percentage Black, percentage Mexican-American, percentage other.

C. Approximate percentage of current population mentally ill. (Using other than I-A definition?)

D. Approximate percentage of current population mentally retarded. (How has this been determined?)

E. Percentage of current population pretrial. Percentage of current population sentenced.

F. How many people were booked into your facility last year?

G. Budget

1. Approximate annual expenditure for total jail operations.

2. Approximate annual expenditure from jail budget for mental health services.

3. Source of funding and approximate annual appropriations for mental health-jail services if not jail budget.

H. Community

1. County size and characteristics (population/geography). City size if relevant to jail.

2. County government (city structure if relevant to jail).

3. Program/personnel resources (i.e., universities, senior citizens, etc.).

4. Unique residential or industrial influence.

5. Jail population includes multi-county jurisdictions? (List other counties and agreements.)

6. Jail population/problems/successes reflective of any particular community attitudes/characteristics?

III. SERVICES

A. Who provides the mental health-jail services?

Sheriff's Department, Department of Corrections personnel?
Mental Health Center personnel?
Independent contracted personnel? (Please explain)

If contracted services, please include a copy of the contract.

Total number of mental health service delivery staff?
(List only those providing direct service to jail population; i.e., not entire backup mental health center personnel.)

B. How is someone identified to be in need of mental health-jail services? (Using other than I-A definition?)

C. What happens to the person who has been identified in need of mental health services? (Please be specific in terms of policies and procedures step-by-step for crisis intervention, treatment, and referral.)

IV. TRAINING

A. Which jail staff are trained to identify and/or work with mental health problems?

B. Who provides this training?

C. How many hours of training are provided?

D. How is this training accomplished? Classroom? (please include curriculum) OJT? Other?

V. MANAGEMENT

A. How has the mental health-jail program affected security and jail operation?

B. How has the program affected personnel and inmate safety?

C. Based upon the successful experiences of your program, what recommendations would you make for replication?

D. Based upon the negative experiences of your program, what problems can you identify and what recommendations would you make for lessening or avoiding these difficulties?

VI. FACILITY

A. How old is your jail?

B. How does the physical design promote or inhibit the delivery of mental health services?

Please include a facility blueprint which shows specifically where mental health services are provided. A simple sketch would be sufficient if a jail blueprint is impractical, since it must be reducible to 8 1/2" by 11" paper.

VII. ATTACHMENTS

Please include the following:

A. Your state's mental health code.

B. A copy of the last jail inspection report for your facility. (Please note if you are not state inspected, but under review from another agency.)

C. State jail standards and enforceability.

D. Court orders resulting from litigation specifically mandating mental health and related services in your jail.

SERVICE DELIVERY MODEL

Marengo County Jail, Linden, Alabama

I. PROGRAM INTRODUCTION

A. Mental Health refers to any jail programs or services designed to meet the needs of inmates. This includes programs designed to treat acute or chronic mental disorders as well as to provide habilitative opportunities for motivated inmates.

B. The program began in August of 1975 at the initiation of the Sheriff of Marengo County and as a result of a cooperative agreement with the West Alabama Mental Health Center.

Motivation for developing the program was:

1. No inmate services were available in the jail and the Sheriff felt that many of the inmates could habilitate themselves if services were offered.
2. The Sheriff's desire for the jail to become more than just a detention facility.
3. The Federal Court Order against the Alabama prison system which caused a backlog of state inmates in all Alabama county jails, including Marengo County.

C. The program's objectives are:

1. To offer an alternative to traditional incarceration for motivated inmates.
2. To provide motivated inmates guidance in changing their life styles through counseling and other mental health services.
3. To provide classification and evaluation services to assist in selecting inmates to participate in the Work Release program.
4. To provide appropriate mental health services in the jail for inmates with acute or chronic mental health disorders.
5. To develop more appropriate techniques of inmate management.

D. If present personalities involved in the delivery of services were to change, the program likely would continue because:

1. The mental health services in the jail have become an established service program in the organization and funding of the West Alabama Mental Health Center.
2. The programs have so changed the entire structure and philosophy of the jail so that jail management has been simplified and a new Sheriff probably would continue the programs in order to simplify his job and to alleviate traditional problems of jail management.
3. The County Commission fully supports the jail program and would insist on its continuance.
4. New jail standards being issued may make such programs mandatory.

II. DEMOGRAPHICS

A. Current jail population (8-30-78)
Female none
Male 49
Maximum Capacity 52

B. Racial Distribution
Anglo 5 inmates = 10.2%
Black 44 inmates = 89.8%

C. Percentage mentally ill: .04% (2 inmates)
Both of these inmates have been diagnosed as Schizophrenic and are maintained on psychotropic medications as prescribed by a physician.

D. Percentage mentally retarded: .02% (1 inmate)
Determined by psychological testing. Inmate to be transferred in near future to Vocational Rehabilitation Service residential center in Montgomery.

E. Percentage pre-trial: 24%
Percentage sentenced: 76%

F. Number booked into jail in 1977: 756

G. Budget

1. Jail - $82,000.00 (including salaries)
2. Sheriff's Department - $125,000.00 (including salaries)
3. Mental Health Services are not in jail budget. They are contracted for with money received in a LEAA grant- $12,000.00 (10-01-77 thru 9-30-78)

H. Community

1. Marengo County has a population of approximately 27,500, with a total land area of 978 square miles. The topography is gently rolling and the Tombigbee River is the western boundary. Elevations range from 50 to 320 feet. Primary industries are cattle, timber, and farming. Demopolis, 8,500 population, is largest city. Linden, county seat, 2,500 population is only other town of more than 1,000 population.

2. There is a County Commission form of government. Each of the four elected Commissioners represents a district of the county. The elected Commission President presides.

3. Primary resources for jail programs:

a. West Alabama Mental Health Center is only county resource agency. A comprehensive community mental health serving five counties, the main office is in Marengo County, 16 miles from the jail. The following services are available to the jail:

1. Psychiatric consultation
2. Psychological testing
3. Mental Retardation services
4. Day treatment services
5. Psychological counseling
6. Indigent drug program
7. Drug and alcohol services (detoxification and rehabilitation)
8. Medical consultation

b. Alabama Vocational Rehabilitation Service - located in Selma, Alabama, 50 miles to the east, this office provides service for any inmate referred to them.

c. Veteran's Administration Hospital - located in Tuscaloosa, Alabama, 70 miles to the northeast. A community team from the hospital will visit and work with any inmate who is eligible for VA service.

d. Community volunteers - church and civic groups provide services to inmates

e. No other resources are available in this rural area.

4. Unique residential or industrial influences - Other than cattle, farming, and timber industries, there is a large cement plant, a large paper mill, and two garment factories in the county. The proposed Tennessee-Tombigbee Waterway forms the western boundary of the county.

5. The jail population is unique only in that it includes an inordinate amount of inmates sentenced to the state prison system. Fifty-seven percent of the jail inmates are state sentenced. The average length of sentence in the Marengo County Jail is 25.15 years.

6. The community attitude toward the services being offered in the jail is positive. At this time, there are more community requests for Work Release employees than we can fill. In addition, citizens have responded very well to requests for volunteer assistance. There has been no negative reaction from the community.

III. SERVICES

A. Mental Health services are provided in the jail by a psychologist from West Alabama Mental Health Center. His services are funded by the Sheriff's Department on a contractual basis with funds received in an LEAA grant.

The Mental Health psychologist provides most of the services and utilizes all available resources from the mental health center (i.e. testing, consultations, etc.)

Excluding back-up resources, the total number of mental health service-delivery staff is only one.

B. Identification of inmates in need of mental health service:

1. In an acute case, tentative identification of the need is made by the arresting officer or the jailer who then makes the appropriate contact with mental health.
2. In less obvious cases, identification is made by the contractual psychologist during his daily service at the jail. If warranted, he then arranges for psychological testing or psychiatric consultation to confirm his original diagnosis.

C. Procedure for provision of mental health services:

1. Initial identification as stated above.
2. If appropriate, medical consultation for medication.
3. In an acute case, a mental health staff member is on call at all times and will assist with provision of emergency service. This service is secured by the arresting officer or the jailer who calls the 24 hour emergency service number.
4. In a non-emergency situation, the contractual psychologist arranges for necessary services. He arranges for treatment utilizing the resources available through the mental health center. If a referral is to made, he does that also.

IV. TRAINING

A. No formal training has been offered to any of the jail staff. The contractual psychologist (36 hours per week) is the only member of the jail staff trained to identify and/or work with mental health problems.

B. N/A

C. N/A

D. Informal training is offered as a result of the contractual psychologist working daily in the jail with the staff.

V. MANAGEMENT

A. The mental health-jail program has not harmed the security of the jail. If anything, it has made it more secure due to the fact that inmates are doing constructive things and have an incentive to demonstrate good behavior so that they might be allowed to participate in certain aspects of the program. During the three years that the program has been operating, there has not been one case of serious inmate vandalism (destruction of plumbing, etc.) in the jail.

B. During the same three year period there has not been one attack upon jail personnel or any serious attack upon any inmate (excluding normal fisticuffs).

C. Replication of our program would be a positive experience for any small county jail. It is beneficial not only to inmates but also to law enforcement personnel.

D. Fortunately, as of this date, there have been no negative experiences.

VI. FACILITY

A. The Marengo County Jail is 16 years old.

B. Physical design inhibits the delivery of any type of jail services. The jail was built for a short-term detention facility only with no provision for inmate service programs. All service programs are performed in spite of the facility.

VII. ATTACHMENTS

A. Mental Health Code - attached

B. Jail inspection reports - attached

C. Alabama does not have state jail standards

D. Court orders - attached

E. Diagram of jail facility - attached

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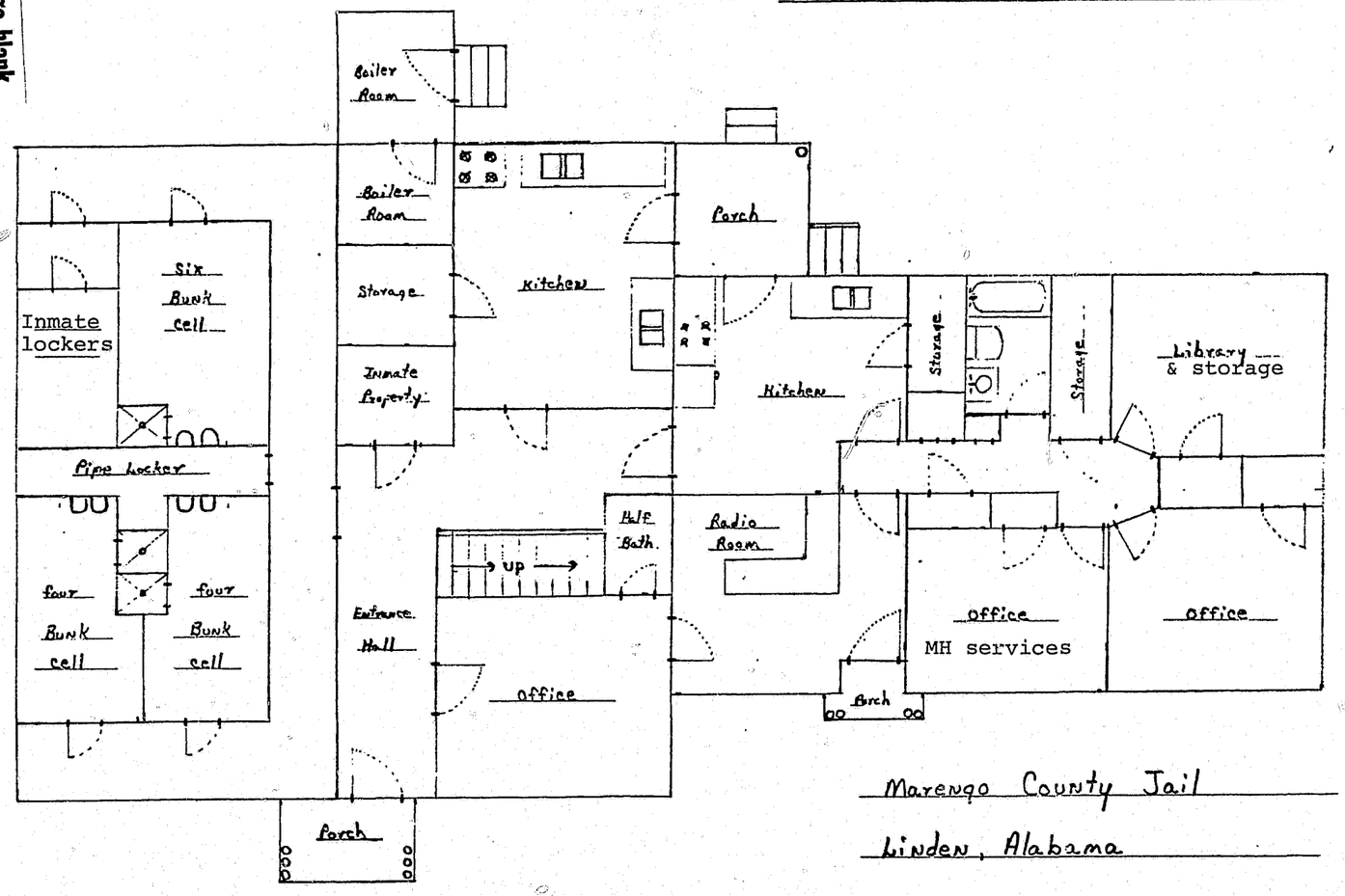
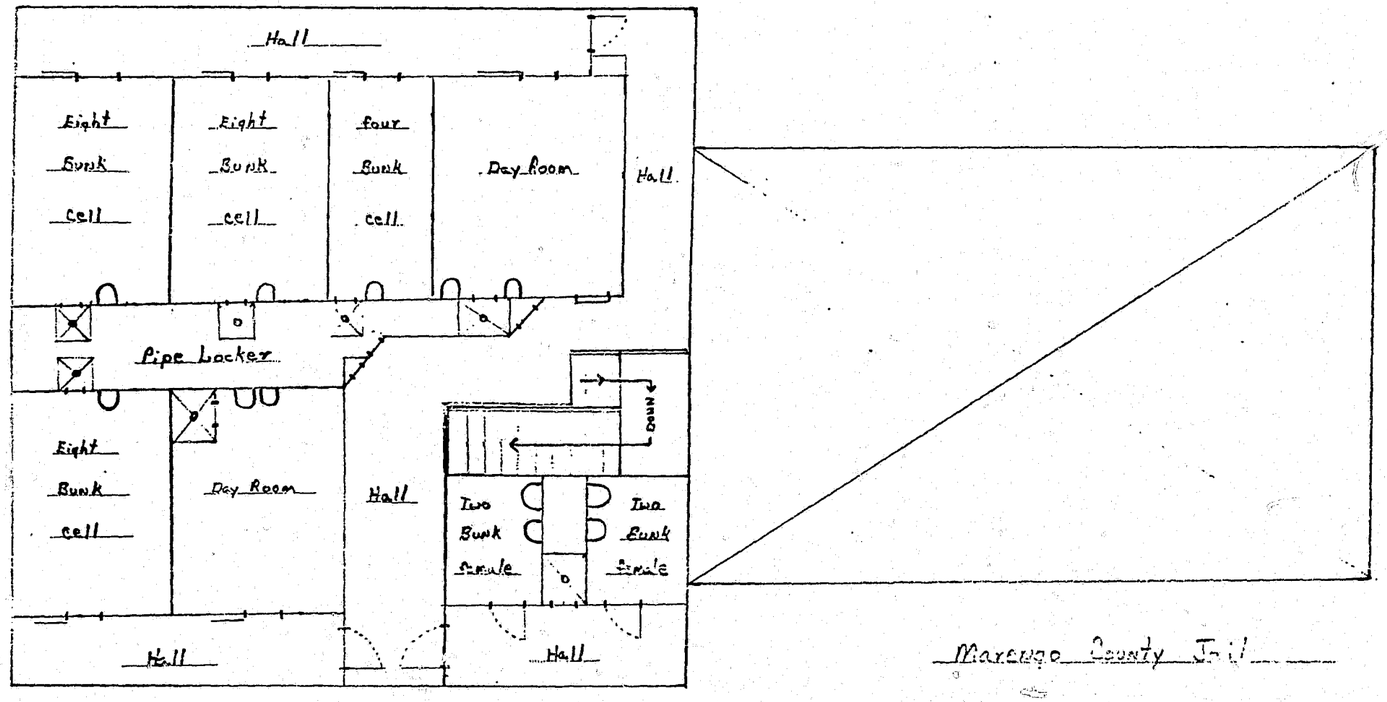
Main floor



Marengo County Jail

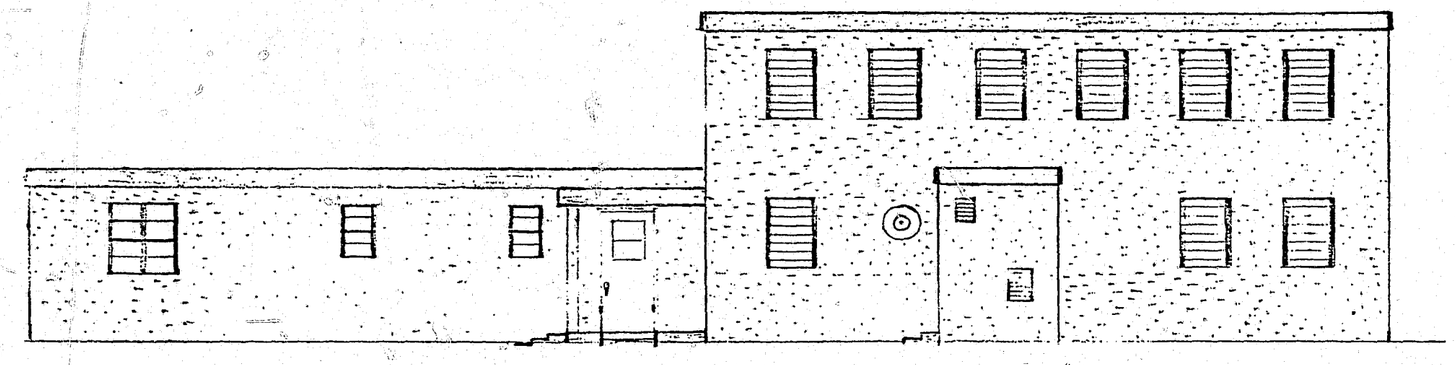
Linden, Alabama

Second floor

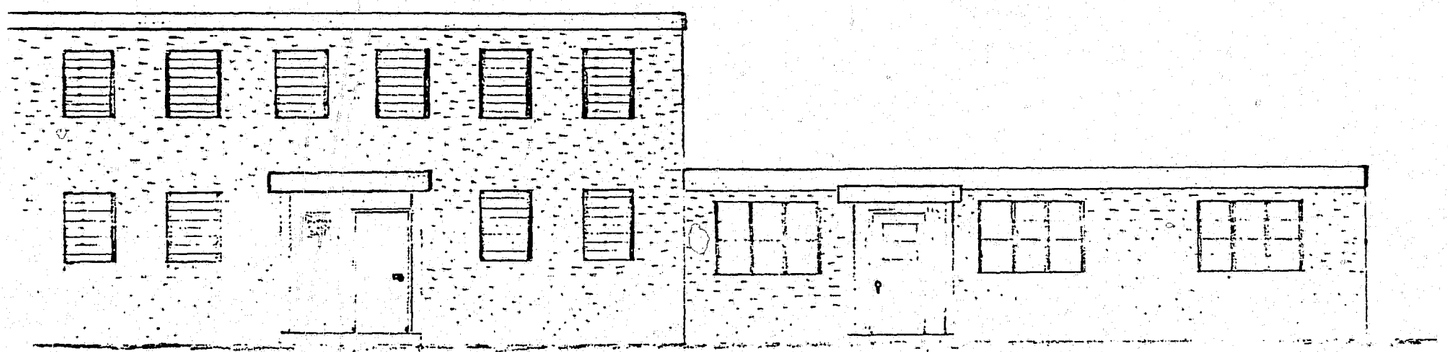


Marengo County Jail

Linden, Alabama

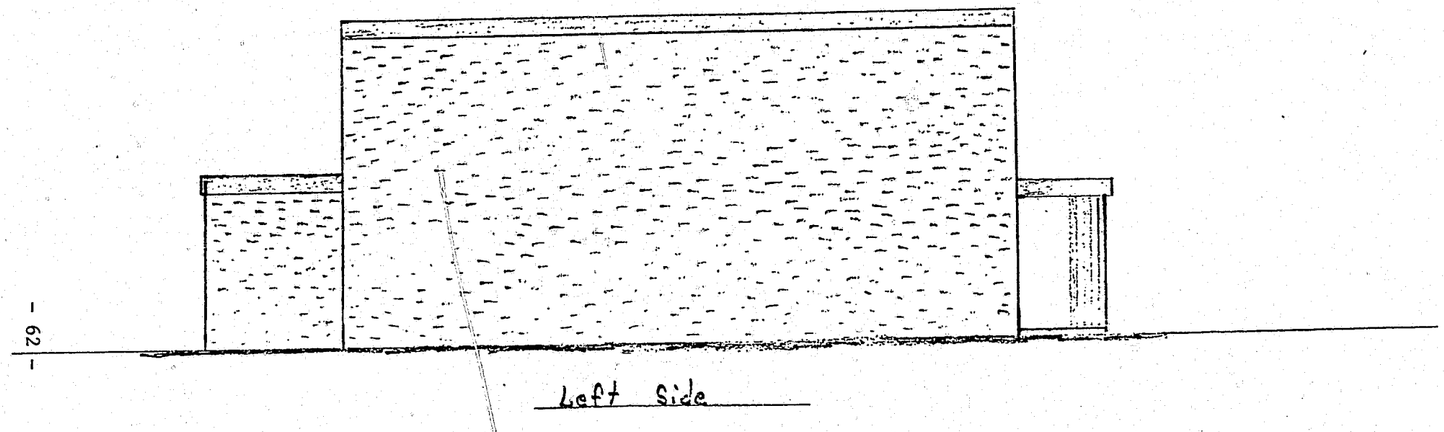


Rear View

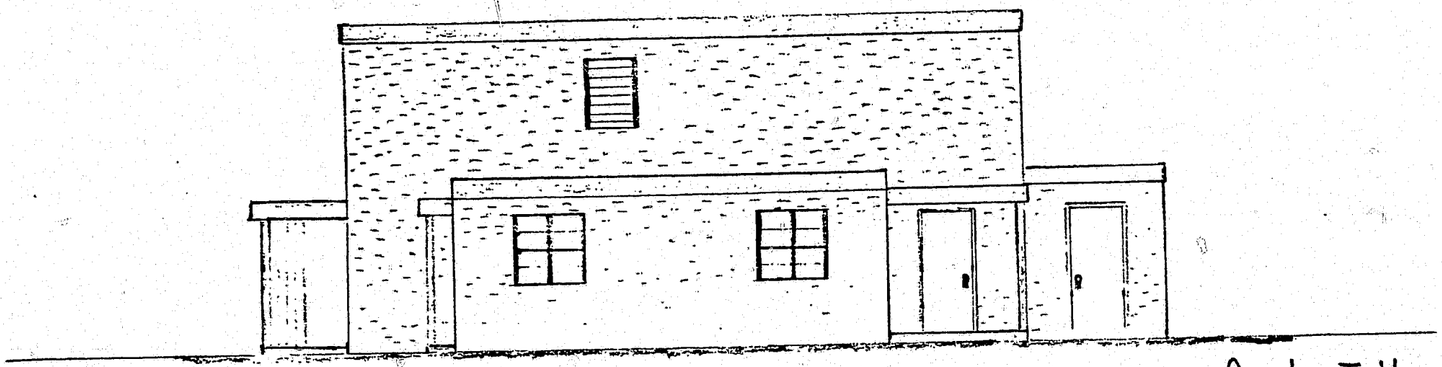


Front View

Marengo County Jail



Left Side



Right Side

Marengo County Jail

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE

DISTRICT OF ALABAMA, NORTHERN DIVISION

JEAN P. LYNCH, individually and on behalf of all persons similarly situated,	)	
Plaintiffs,	)	
JESSE M. HUGHES,	)	
Intervening Plaintiff,	)	
v.	)	CIVIL ACTION NO. 74-89-N
WILLIAM J. BAXLEY, individually and as Attorney General of the State of Alabama; PERRY HOOPER, individually and as Probate Judge of Montgomery, Alabama, and as a representative of all other Alabama Probate Judges; TAYLOR HARDIN, individually and as Commissioner of Mental Health for the State of Alabama; FRED L. HUGGINS, individually and in his official capacity as Probate Judge of Clarke County, Alabama,	)	
Defendants.	)	

JUDGMENT

Pursuant to the Memorandum Opinion made and entered in this cause this date, it is the ORDER, JUDGMENT and DECREE of this Court that:

1. Title 15, § 432 and Title 45, § 210 of the Alabama Code (1958 Recomp.) be and each is hereby DECLARED void as being violative of the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the Constitution of the United States.

2. Plaintiff Lynch and all other members of the class whom she represents that are presently confined in Bryce and Searcy hospitals pursuant to involuntary commitment orders issued under the authority of Title 15, § 432 or Title 45, § 210 are, and each is hereby DECLARED to be, incarcerated in violation of the Fourteenth Amendment to the Constitution of the United States. Each such person is ORDERED to be discharged, transferred to a custodial facility appropriate for the care and treatment of his particular disabilities, or newly committed in accordance with the standards set forth herein within 180 days of the date of this Judgment.

3. The defendants and the members of the class whom they represent are permanently RESTRAINED and ENJOINED from involuntarily committing any person to or at Bryce or Searcy hospital, or any other hospital maintained by the State of Alabama, except pursuant to and in accordance with the minimum standards set forth hereunder and in the Memorandum Opinion rendered and filed in this cause this date.

4. This Court will appoint one or more persons licensed to practice law in the State of Alabama as guardian ad litem for the purpose of protecting the legal rights of the persons affected by this Judgment. Reasonable fees for the performance of such services shall be determined by this Court and taxed as costs against defendants. Such guardian(s) shall function as adversarial representative(s), shall have full access to all records of the persons affected by this Judgment, and shall be empowered to take any and all actions deemed advisable to protect the legal rights of the persons affected by this Judgment.

5. Discharge of persons now unlawfully confined, where considered appropriate, is ORDERED to take place at the earliest possible time.

6. The defendant Commissioner of Mental Health is ORDERED to take all necessary steps to ensure that adequate and appropriate transitional services are provided to each person released from confinement pursuant to this Judgment. Such services shall include, but not be limited to:

(a) Assistance in locating a suitable home;

(b) Assistance in procuring employment and/or job training, where feasible;

(c) Assistance in securing available benefits through federal and state sources, such as welfare, Social Security, Medicare, and Medicaid;

(d) Out-patient care;

(e) Post-discharge counseling; and

(f) Such other services as are necessary and appropriate in facilitating reintegration into the community.

7. Each patient who expresses the desire to be voluntarily recommitted and who is deemed competent to make such a decision by his guardian and by the hospital's Human Rights Committee, after appropriate inquiry, shall be permitted to sign voluntary recommitment papers.

8. Any person who expresses the desire to be voluntarily recommitted but who is deemed incompetent to make such a decision by either his guardian or by the Human Rights Committee shall become the subject of an involuntary commitment proceeding as provided herein.

9. If any person now unlawfully confined and over whom the state has thus assumed a significant custodial relationship knowingly and intelligently elects to remain at the hospital after being informed of the options available, he shall not be denied the right to remain there solely because his present mental condition would not warrant involuntary commitment under the standards set forth in this Memorandum Opinion and Judgment.

10. If any person now unlawfully confined in Bryce or Searcy hospital does not elect to remain there and is unable by reason of age, physical infirmity or mental condition to properly care for himself, but is not committable under the standards set forth herein, the defendant Commissioner of Mental Health is ORDERED to transfer such person to custodial facilities appropriate for the care and treatment of his particular disabilities.

11. Prior to any recommitments being sought, the staff of each hospital shall, for each of its patients heretofore involuntarily committed, if it has not already done so:

(a) Evaluate the condition and progress of such person using appropriate psychiatric, psychological, and social work personnel;

(b) Assist such person in contacting his nearest relative or relatives, his guardian ad litem, and/or other legal counsel; and

(c) Develop a treatment program for such person suggesting all feasible, less restrictive means of treatment, and discuss same with him and with interested members of his family.

12. No new involuntary commitment of a person now confined shall be sought without the staff first exploring with the patient and his family whether a voluntary arrangement including the minimum restraint considered necessary by the hospital is acceptable to the patient. This arrangement may include voluntary recommitment to the hospital or such informal relationships as are mutually agreeable. Each patient shall be fully advised of all available alternatives, both medical and legal. All discussions and interviews between patient and staff shall be kept as free from undue influence and coercion as possible.

13. In those cases in which involuntary recommitment is sought by the appropriate official(s), a full hearing shall be held within a reasonable time, but in no event sooner than will allow adequate preparation of the case by the guardian ad litem or later than 180 days from the date of this Order.

14. Each involuntary recommitment hearing shall be presided over by the probate judge of the county wherein the patient resides or resided prior to commitment, pursuant to the probate court's power "[t]o amend and control its process and orders so as to make them conformable to law and justice." ALA. CODE, tit. 13, § 4.

Recommitment hearings involving patients presently confined in Bryce hospital may be presided over by either the Probate Judge of Tuscaloosa County or the probate judge of the county of the patient's residence. ALA. CODE, tit. 45, § 220 (1958).

15. The defendant judges of probate, Mental Health Commissioner, Attorney General, and their representatives and successors be, and each is hereby ORDERED to take the necessary steps to ensure that any new involuntary commitment or recommitment proceedings are conducted in accordance with the following minimum constitutional standards:

(a) Adequate notice of the hearing and its purpose shall be given sufficiently in advance of the scheduled proceedings to permit a reasonable opportunity to prepare therefor.

(b) The person proposed to be committed or recommitted shall have the right to attend the hearing unless the Court, after appropriate inquiry, determines that he is so mentally or physically ill as to be incapable of attendance.

(c) The subject of the hearing shall be informed of his right to counsel and to the appointment of counsel if indigent. Where the re-commitment of a presently confined patient is sought, a guardian ad litem who is an attorney shall be appointed.

(d) Any person now unlawfully confined shall be entitled to independent expert examination and assistance in preparation for the hearing, by means of court appointment where he cannot afford to retain such services.

(e) If recommitment hearings are to be conducted on the hospital premises, they shall take place in surroundings as non-coercive as possible. In no event shall such hearings be held in patients' quarters. Appropriate street dress shall be made available to each subject, if not already available to him.

(f) No person shall be committed or recommitted unless the probate judge finds:

(i) That he is mentally ill;

(ii) That he poses a real and present threat of substantial harm to himself or to others;

(iii) That the danger has been evidenced by a recent overt act of the individual.

(iv) That there is treatment available for the illness diagnosed or that confinement of the dangerous but untreatable individual is necessary for his and the community's safety and well-being; and

(v) That commitment or recommitment is the least restrictive alternative necessary and available for treatment of the person's illness.

(g) The necessity for commitment or recommitment must be proved by evidence which is clear, unequivocal, and convincing.

(h) At the hearing, the subject shall have the right to offer evidence, to be confronted with the witnesses against him and to cross-examine them, and the privilege against self-incrimination. The rules of evidence applicable in other judicial proceedings in this state shall be followed in involuntary commitment proceedings.

(i) A full record of the proceedings, including findings adequate for review, shall be compiled and retained by the probate court.

(j) Nothing contained in this Order shall be construed to limit the power of the guardian ad litem to waive any of his client's rights when, in his judgment and in the judgment of the probate judge after appropriate findings of fact, waiver is in the best interests of his client.

16. No guardian ad litem shall be subject to civil litigation or liability, in any form, for any action or inaction in the discharge of

his duties or functions as guardian, except that any party in interest may at any time petition to have the guardian substituted, removed or the guardianship terminated.

17. The parties shall attempt to provide final relief in accordance with this Order for all persons presently confined in Bryce and Searcy hospitals pursuant to involuntary civil commitment orders as expeditiously as possible. The Mental Health Commissioner shall file with this Court a progress report on the disposition of such persons 120 days from the date of this Order and shall file a final report 180 days from the date of this Order.

It is further ORDERED that the costs incurred in this proceeding be and they are hereby taxed against the defendants.

Done this the 14th day of December, 1974.

Robert T. Rives
UNITED STATES CIRCUIT JUDGE

UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT JUDGE

SERVICE DELIVERY MODEL

Los Angeles County Jail

I. PROGRAM INTRODUCTION

A. How is "mental health" defined as it relates to the provision of mental health services in your jail?

"Mental health," (as it relates to the provision of mental health services in Central Jail), is considered to be present in an individual if he has good contact with reality, is effective in coping with life's demands, maintains positive interpersonal relationships, and does not display symptoms indicating a psychiatric problem.

B. How did your program get started? Date when it got started?

1. FMHU Program - The Forensic Mental Health Unit (FMHU) is a mental health treatment team which functions in the Los Angeles County Jail system supplying mental health services to the jail population. It originated in November 1972 through cooperation of various County agencies including the Sheriff's Department, Mental Health Services, the Grand Jury, and the Board of Supervisors. The team has increased in size from an initial psychiatrist in November 1972 to a full-time professional staff of 22 persons with clerical back-up which results in a highly efficient and functional team.

2. Custody Program - The sworn personnel program originated as a mutual agreement for need by jail and medical administration. It was started September of 1977.

C. What are the program's objectives?

1. FMHU Program - The team functions by screening, evaluating, treating when indicated, and offering continuing care including post-release planning to inmates who are currently in custody in the Los Angeles County Jail system. It operates within four of the six major Los Angeles County Jail facilities, the Central Men's Jail, the Hall of Justice Jail, the Wayside Honor Rancho, and the Sybil Brand Institute for Women. The team operates to a large extent as if it were a community mental health center in its delivery of services which include individual and group counseling, prescribing appropriate medications when indicated, arranging for transportation to Metropolitan

State Hospital when in-patient psychiatric treatment is needed, and arranging for follow-up treatment following the inmates' release from jail.

2. Custody Program - This program operates within Central Jail only. Its main purpose is the promotion of efficiency and harmony between custody, and medical and psychiatric staffs.

D. If the personalities currently involved in the service-delivery change, what linkages exist to insure the continuation/institutionalization of mental health - jail services?

A linkage is obtained by a cross training of personnel which provides a backup structure and continuity with our system of jail services. There does exist established policy and procedures although written directives are currently being developed, in order to make this linkage more concrete.

II. DEMOGRAPHICS

Give <u>current</u> statistics unless they don't accurately represent the population. In such a case, give "average" population statistics and specify the differences.

A. Current Jail Population:

Male: 8,722; Female: 838; Maximum Capacity: 10,800

B. Racial Distribution of Current Population:

25% Anglo; 45% Black; 30% Mexican-American and other.

C. Approximate Percentage of Current Population Mentally Ill:

35% (all types); 8% (psychotic)

D. Approximate Percentage of Current Population Mentally Retarded:

2.54%

E. Percentage of Current Population Pre-trial: 43%
Percentage of Current Population Sentenced: 57%

F. How many people were booked into your facility last year:

Approximately 210,000 were booked through Inmate Reception Center into Central Jail.

G. Budget:

1. The approximate annual expenditure for total jail operations at Central Jail is $24,000,000.

2. The approximate annual expenditure from the budget for mental health services is as follows:

Jail budget: $300,000
Medical Services budget: $250,000

3. The source of funding and approximate annual appropriations for the Mental Health Unit (FMHU) are as follows:

a. Source of funding - 90% State; 10% Los Angeles County.

b. FMHU In-house budget - $483,504.

c. Outside contract agencies - $876,000

Gateway Satellite - $396,000
Hope Mental Health - $240,000
Community Care Service - $240,000

H. Community

1. County size and characteristics:

The population of the County of Los Angeles is approximately 7 million. This figure represents 33% of the population of the State of California. The County is comprised of 4,000 square miles of drastically varying climates and geography ranging from semi-desert and mountainous areas to coastal lowlands.

2. County Government:

The County Government consists of a Board of Supervisors with a Chairman seated annually on a rotation basis.

3. Program/personnel resources (i.e. universities, senior citizens, etc.).

There are numerous major universities and innumerable community colleges within the Los Angeles County, many of which foster programs relating to jails and prisoners. Community groups exist at every level and include church, civic and ethnic organizations. Family counselors, mental health counselors, and job counselors are involved with helping prisoners and their families deal with problems that evolve from incarceration.

4. Unique residential or industrial influences:

The County of Los Angeles is comprised of 80 cities with each having their own city government. There are, however, 32 cities that contract for their law enforcement with the Sheriff's Department.

Within the County there is a tremendous amount of truck farming and seasoned crop work. These factors combined with the temperate climate and the close proximity to Mexico draws a large number of itinerant workers and illegal aliens into the County. The County also borders on the Pacific Ocean and is a port of entry which affords additional opportunity for the entry of legal and illegal aliens.

The aero space industry, oil refining and light industry along with extensive heavy industries are found throughout the County drawing a wide spectrum of workers. Economic conditions, however, change drastically in this area and cause wide unemployment at various times throughout the county.

5. Jail population includes multi-County jurisdictions:

The major counties having reciprical agreements with Los Angeles County are Ventura County and Riverside County. There are similar but fewer contacts with Orange, San Bernardino and Kern Counties.

The Sheriff's Department would accept prisoners from other counties for any of the following reasons:

a. Change of venue cases;

b. where the safety of the inmate must be provided for in unique instances;

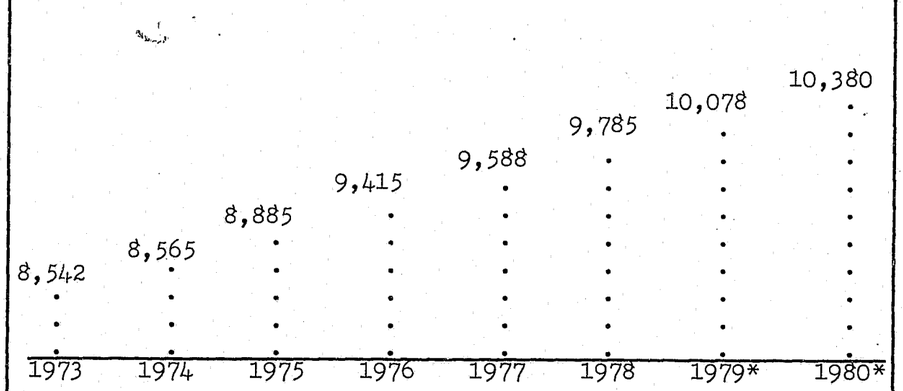
c. psychiatric evaluations and special medical appointments;

d. overcrowding or inadequate facilities.

We also contract with the Federal Government to house federal prisoners, in order to make them accessible to the Federal Courts located in Los Angeles County.

6. Jail population/problems/successes reflective of any particular community attitudes/characteristics?

This chart graphically shows the actual and projected increases in jail population in Los Angeles County.



* Projected jail population

a. Problems?

1. Because Los Angeles is the hub of activity and the major population center in Southern California, the Los Angeles County Jail system bears the brunt of attempted reforms brought about by class action suits. Problems other jails face once or twice a year, we deal with daily. (i.e., the housing of homosexuals, informants, pro pers, juveniles, plus prison and community gang members, etc.).

2. There are also a large number of non-English speaking persons within the community and the jail populations.

3. The size of our facility, the number of prisoners we house and the daily dispersal of 1,000 prisoners to 23 court locations are additional problems.

4. Also because of the size of the jail change can not always be brought about as rapidly as the courts and the community might desire.

b. Successes

1. Because of our size and the amount of people we deal with, we are able to provide schooling and other activities as well as counseling services beyond the scope of most local detention facilities.

2. A program based solely on a reward system has been implemented by the custodial staff, whereby, unacceptable prisoner behavior stemming from mental problems is modified. In a very short time literally hundreds of prisoners have progressed through the program and have been returned to the main stream of jail life. Recidivism to unacceptable behavior has generally been under 10%.

III. SERVICES

A. Who provides the mental health - jail services?

1. Sheriff's Custody Division
2. Medical Health Services Bureau
3. Forensic Mental Health Unit

B. Numerous contracts exist with outside agencies, such as:

1. Hope Mental Health
2. Gateway Satellite
3. Community Care Service Section

Although copies of the contracts are not immediately available, additional information and specifics of these contracts will be available upon request to:

Don Verin, M.D.
Chief Psychiatrist
Central Jail
441 Bauchet Street
Los Angeles, California 90012

C. The total number of mental health service-delivery staff are as follows:

1. Custody Program

1 Sergeant
1 Deputy
15 Additional deputies working throughout the hospital area.

2. Medical Services Bureau

15 Nursing staff on hospital ward.
15 Nursing staff in clinic area.
2 Medical doctors

3. FMHU Program

3 Psychiatrists - M.D.
4 Psychologists - Ph.D - two years post-doctoral experience
4 Mental Health Counselors, RN - B.S. degree and post-graduate psychiatric experience and training
5 Psychiatric Technicians - formal training and State License
1 Occupational Therapist - B.A. degrees and experience

3. Cont.

1 Social Worker - Master's degree - psychiatric social worker
1 Mental Health Services Coordinator - Master's degree PSW experience and training
1 Health Services Educator
1 Mental Health Counselor, Volunteer
1 Regional Center representative
6 Psychology interns

D. How is someone identified to be in need of mental health jail services?

Non-psychiatric registered nurses screen all inmates coming into the system. Due to the large number of inmate admissions daily, these nurses do not have time to do more than a very superficial mental health screening. For this reason, many mentally ill inmates in need of treatment are housed in the general population and fail to be scheduled for evaluation by a mental health specialist unless their abnormal behavior comes to the attention of custodial or nursing personnel. Also the jail classification unit exercises an effort to identify the mentally ill before housing.

E. What happens to the person who has been identified in need of mental health services?

They are interviewed by custody and medical personnel and are housed in specific areas provided for the mentally ill and/or mentally retarded, away from the general jail population. They, and others who have intermittant psychiatric problems are contacted by the FMHU and the following procedures are initiated:

1. Intake interviews for screening and evaluation.
2. Formulation of treatment plan and its implementation which may include any or all of the following:

   a. On-going individual counseling and psychiatric therapy.
   b. Group psycho-therapy.
   c. Referral to psychiatrist for psychiatric and medical evaluation.
   d. Diversion of inmate to state mental hospital.
   e. Referral of inmate to outside contract agencies for post release planning.

When a person has been identified in need of mental health services, the nursing staff administers 24-hour a day nursing care. They also deliver all medications prescribed by FMHU doctoral staff and perform any recurrent screening of these patients.

IV. TRAINING

A. Which jail staff are trained to identify and/or work with mental health problems?

All sworn personnel have a basic training to identify extreme cases of mental health. Approximately 5% of these personnel have received specialized training and work directly with the mentally ill.

B. Who provides this training?

The Sheriff's Department Custody Division and the Medical Liaison Personnel provide training as scheduling permits. Additional in-depth training is in the development stages.

C. How many hours of training are provided?

Approximately 8 to 20 hours.

D. How is this training accomplished?

The jail staff receives their training through briefings, procedural handouts and on-the-job training under the supervision of nursing and FMHU staffs.

V. MANAGEMENT

A. How has the mental health-jail program affected security and jail operations?

More civilian personnel have access to the jail facilities. By cooperation between the Sheriff's Department, Medical Health Services and FMHU, procedures have been developed that meet the mutual needs of each department for the care of the mentally ill inmate.

B. How has the program affected personnel and inmate safety?

This program has greatly upgraded the segregation of potentially violent prisoners. The identification, segregation and treatment of these prisoners has significantly lowered the number of physical altercations. Also, close supervision of suicide prone inmates has reduced the number of suicides.

C. Based upon the successful experiences of your program, what recommendations would you make for replication?

Initiating and maintaining a working relationship between custody, FMHU and the nursing staff. It is valuable to have an "in house" psychiatric unit which would be staffed with individuals from various professional disciplines. (i.e. nurses, psychologists, psychiatrists, technicians, etc.). It is also important to foster the development of post release treatment with outside agencies. Emulation of the behavior modification system alluded to earlier should meet with similar successes and is cost effective.

D. Based upon the negative experiences of your program, what problems can you identify and what recommendations would you make for lessening or avoiding these difficulties?

1. Insufficient staff - Gains have been made but personnel levels could be increased to better deal with inmates' mental health needs. Funding constraints are in inhibiting factor.

   a. To screen all incoming inmates for psychological/psychiatric problems.
   b. To fill needs for post-release and follow-up procedures.
   c. To provide pre-booking disposition of cases.

2. Physical space - Necessary for group and individual counseling and therapy sessions. (Space availability has increased but could be increased further if funds were available).

3. Inaccessibility of patients - Current practice allows reasonable access. There has been a significant increase of agencies and living facilities obtained for FMHU use.

4. Limited Budget - For in-service training of sworn personnel medical and FMHU staff in the handling of the mentally ill. Additional staff is also needed.

5. Procedural relationships with the courts are in need of improvement due to the fragmentation of the judicial system and the lack of a liaison.

6. Insufficient security housing availability at state hospitals.

Greater coordination, communication, inter-reactions between the Sheriff's Department's Medical, Custody, Classification, and FMHU have made these problems less of a factor.

VI. FACILITY

A. How old is your jail?

Central Jail located at 441 Bauchet Street, Los Angeles, California was constructed in 1963 with the new addition completed in 1977.

B. How does the physical design promote or inhibit the delivery of mental health services?

There is a lack of space in order to allow for more psychiatric hospital beds and interview and testing areas for the mental health personnel.

There are approximately 30 California Codes, most of which contain references to the care and handling of the mentally ill. The major portions of California law relating to this area, however, are found in the Welfare and Institutions Code and the Health and Safety Code.

CONTINUED

1 OF 3

TABLE I

PRE-TRIAL CLASSIFICATION
INTERVIEW AND POINT SYSTEM

POINTS	AREA OF ASSESSMENT	
3	Present job 1 year or more or full-time student	EMPLOYMENT POINTS
2	Present job 4 months or present and prior job 6 months	
1	Presently employed or receiving financial assistance	
0	Unemployed	
2	Present residence 1 year or more	RESIDENCE POINTS
1	Present residence 6 months or present & prior 1 year	
0	Less than 6 months at present residence	
2	Lives with family and weekly contact with other family members	FAMILY TIES POINTS
1	Lives with family or weekly contact with family	
0	Lives with non-family	
2	No convictions	PRIOR RECORD POINTS
1	1 misdemeanor conviction	
0	2 misdemeanor convictions or 1 felony conviction	
-1	More than 3 misdemeanor convictions or more than 2 felony convictions	
3	$1,875 or less	BAIL AMOUNT POINTS
2	$1,876 - $3,500	
1	$3,501 - $5,000	
0	$5,001 - $10,000	
-1	$10,001 - any bail	
-2	No Bail	
3	Part II property/all other misdemeanors	CURRENT CHARGE POINTS
2	Part II person/drug, alcohol offenses	
1	Part I property/heroin	
0	Part I person/CCW w/prior Part I conviction	
3	Positive identification (fingerprints)	IDENTIFICATION POINTS
2	Confirmed identification (known, court papers, prior record matches, etc.)	
1	Tentative identification (phone call verification)	
0	Unconfirmed identification	

TABLE II

SECURITY LEVELS

PRE-TRIAL INMATES AT CENTRAL JAIL

POINTS		
12 +	Minimum	Qualifies for dorm No escort
10 - 11	Low Moderate	Relatively free movement in cellblock Open dayroom if possible No escort
7 - 9	Moderate	Cellblock with constant access to freeway (possibly new modules w/dayroom in cellblock) No escort
2 - 6	High Moderate	Cellblock with constant access to freeway (not necessarily daily or unlimited use of dayroom) No escort
0 - 1	Maximum	Cellblock with access to freeway on limited basis only (i.e., required exercise time) Must be escorted

COUNTY OF LOS ANGELES—SHERIFF'S DEPARTMENT
INMATE INTERVIEW & PLACEMENT RECORD

DATE JAN 1978

NAME | BOOKING NO.

RESIDENCE ADDRESS | CITY | ZIP CODE

HOW LONG RESIDED IN L.A. COUNTY? | HOW LONG RESIDED IN CALIF.? | MARITAL STATUS: MARRIED ( ) DIVORCED ( ) SEPARATED ( ) SINGLE ( ) WIDOWED ( ) NUMBER OF DEPENDENT CHILDREN

SEX | RACE | HAIR | EYES | HEIGHT | WEIGHT | D.O.B. | AGE | BIRTHPLACE

EDUCATIONAL BACKGROUND 1 2 3 4 5 6 7 8 9 10 11 12 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) | COLLEGE 1 2 3 4 ( ) ( ) ( ) ( ) | TECHNICAL OR TRADE

WERE YOU EMPLOYED AT TIME OF ARREST? YES ( ) NO ( ) | IF YES, HOW LONG? | EMPLOYER'S NAME & ADDRESS

JOB TITLE AND/OR SPECIFIC DUTIES | DO YOU NEED WORK WHEN RELEASED YES ( ) NO ( )

HOBBIES, SPECIAL INTERESTS OR SKILLS | DO YOU WANT WORK WHILE IN JAIL YES ( ) NO ( ) | WHAT KIND OF WORK

KITCHEN SERVICE ( ) FACILITY SERVICE ( ) EXTERNAL FACILITY SERVICE ( )
STAFF SERVICE ( ) HOSPITAL/HEALTH ( ) INMATE PERSONNEL SERVICE ( )

IN EMERGENCY NOTIFY | RELATIONSHIP | HOME PHONE

RESIDENCE ADDRESS | CITY ZIP CODE | BUS. PHONE

PRESENT CHARGE | BAIL | SENTENCE | PAROLE YES( ) NO( ) | PROBATION YES( ) NO( ) | HOLDS

	COURT	CHARGE	DATE	COURT	CHARGE	DATE
PENDING COURT APPEARANCES						
	COURT	CHARGE	DATE	COURT	CHARGE	DATE
PRIOR ARRESTS	WHERE & CHARGE		WHEN	WHERE & CHARGE		WHEN
	WHERE & CHARGE		WHEN	WHERE & CHARGE		WHEN
PREVIOUS TIME SERVED	WHERE		WHEN	WHERE		WHEN
	WHERE		WHEN	WHERE		WHEN

HAVE YOU EVER ESCAPED FROM A PENAL INSTITUTION? WHERE | WHEN

HAVE YOU EVER BEEN IN A MENTAL INSTITUTION? WHERE | WHEN

WOULD YOU CLASSIFY AS ANY OF THE FOLLOWING? NARCO ( ) HOMO ( ) SEX OFFENDER ( ) EPILEPTIC ( ) DIABETIC ( ) ALCOHOLIC ( )

DO YOU NOW OR DID YOU EVER HAVE ANY OF THE FOLLOWING DISEASES? TB ( ) VD ( ) HEPATITIS ( ) ASTHMA ( ) JAUNDICE ( ) WHEN? _____

ANY OTHER? _____ MEDICATION _____

REMARKS

THIS INMATE WAS [illegible] THAT HE WILL [illegible] TO WORK PURSUANT TO PENAL CODE SECTION 4017 AND GOVERNMENT CODE SECTION 25359.

EMPLOYMENT RESIDENCE
FAMILY TIES PRIOR RECORD
BAIL AMOUNT CURRENT CHARGE
IDENTIFICATION POINT TOTAL

SECURITY LEVEL
MIN. ( )
L. MOD. ( )
MOD. ( )
H. MOD. ( )
MAX. ( )
MIN. DISQ. ( )

DID YOU OR WOULD YOU PARTICIPATE IN ANY PROGRAM? YES ( ) NO ( )
SCHOOL ( ) ALCOHOL ( ) DRUG ( ) OTHER ( )

INTERVIEWING OFFICER | APPROVED BY

761340C-SH-CORR.33-PS 4-77

ASSIGNMENT & TRANSFER RECORD			NAME	
DATE	TRANSFERRED TO	REASON	WORK ASSIGNMENT	REMARKS
JAN 1978				

DISCIPLINE SUMMARY

DATE	FILE No.	VIOLATION	DISPOSITION

1041. Inmate Records. Each facility administrator shall maintain individual inmate records which shall include but not be limited to personal property receipts, commitment papers, court orders, reports of disciplinary actions taken, and medical orders issued by the jail physician.

1042. Fiscal Records. Each facility administrator shall maintain fiscal records which will clearly indicate the costs for his detention facility according to generally accepted accounting principles. Such records shall include feeding and clothing outlay and other program costs.

1043. Incident Reports. Each facility administrator shall maintain a written record of all incidents which result in physical harm, or serious threat of physical harm to an employee or inmate of a detention facility or other person. Such records shall include the names of the persons involved, a description of the incident, the actions taken, and the date and time of the occurrence. Such a written record shall be prepared and submitted to the facility manager within 24 hours of the event of an incident.

Article 6. Segregation

1050. Communicable Diseases. Each facility manager shall segregate all inmates with communicable diseases. To determine if such segregation shall be made, in the absence of medically trained personnel at the time of booking, an inquiry shall be made of the person being booked as to whether or not he/she has or has had tuberculosis, has hepatitis, a venereal disease or other special medical problem. The response shall be noted on the booking form.

History: 1. Amendment filed 1-2-76; effective thirtieth day thereafter (Register 76, No. 1).

1051. Mentally Disordered Persons. Each facility manager shall segregate all mentally disordered inmates. If a physician's opinion is not readily available, an inmate shall be considered mentally disordered for the purpose of this section if he or she appears to be a danger to himself or others or if he appears gravely disabled. A physician's opinion shall be secured within 24 hours of such segregation or at the next daily sick call, whichever is earliest. If practical and feasible, such a mentally disordered inmate shall be transferred to a medical facility designated by the county and approved by the State Department of Health for diagnosis, treatment, and evaluation of such suspected mental disorder, according to Penal Code Section 4011.6.

History: 1. Amendment filed 6-21-73 as an emergency; effective upon filing (Register 73, No. 25).
2. Certificate of Compliance filed 8-31-73 (Register 73, No. 35).

1052. Administrative Segregation. Each facility administrator/manager shall provide for the administrative segregation of inmates who are determined to be homosexual, mentally deficient, prone to escape, prone to assault staff or other inmates, or likely to need protection from other inmates, if such administrative segregation is determined to be necessary in order to obtain the objective of protecting the welfare of inmates and staff. Administrative segregation shall consist of separate and secure housing but shall not involve any other deprivation of privileges than are necessary to obtain the objective of protecting the inmates and staff.

1053. Use of Safety Cell. The safety cell described in Article 9, Section 1081(c), of those regulations shall be used for the housing of only those inmates who fall under the provisions of Section 1051 of these regulations and/or those inmates who display bizarre behavior which results in the destruction of cell furnishings or reveal an intent to cause self-inflicted physical harm. Such a prisoner shall be placed in a safety cell only with the approval of the facility manager or the watch commander and continued retention in such a cell shall be reviewed a minimum of every eight hours. A medical opinion on placement and retention shall be secured within 24 hours of placement in such a cell or at the next daily sick call, whichever is earliest, and the inmate shall be medically cleared for continued retention every 24 hours thereafter. Intermittent visual supervision shall be provided at least every half hour.

History: 1. Amendment filed 6-21-73 as an emergency; effective upon filing (Register 73, No. 25).
2. Certificate of Compliance filed 8-31-73 (Register 73, No. 35).

Article 7. Public Information

1060. Public Information Plan. Each facility administrator shall develop a plan for the dissemination of information to the public, to other government agencies, and to the news media. The public and inmates shall have ready access to the following printed material: (a) The State Board of Corrections publications, *Guidelines for the Establishment and Operation of Local Detention Facilities, California Laws Pertaining to County and City Adult Detention Facilities,* and these regulations; (b) facility rules and procedures affecting inmates as specified in Sections 1030, 1060, 1130, 1140, 1150, 1151, 1152, 1153, 1154, 1170, 1171, 1172, and 1173 of these regulations.

History: 1. Amendment filed 6-21-73 as an emergency; effective upon filing (Register 73, No. 25).
2. Certificate of Compliance filed 8-31-73 (Register 73, No. 35).
3. Amendment filed 8-31-73; effective thirtieth day thereafter (Register 73, No. 35).

Obtaining Mental Health Treatment for Mentally Disordered Jail Inmates and Juvenile Detainees

A Handbook for Criminal Justice and Mental Health Professionals

State of California
Health & Welfare Agency

Department of Health
714-744 P Street
Sacramento, CA 95814

August 1977

TABLE OF CONTENTS

Prepared by Christopher Walt (B.A., M.A. 1973 Stanford University)
under contract to the State Department of Health.

INTRODUCTION

Most jails and juvenile detention facilities contain mentally disordered persons. A recent study of five counties found that 16% of adult jail inmates and 23.5% of juveniles in detention facilities suffered from mental disorders.[1] Left untreated, mentally ill prisoners disrupt the normal custodial routine of the jail and may decompensate to the point that long-term institutional treatment is required. The criminal or juvenile charges against them are often minor, yet contribute to the clogging of the courts.

Sections 4011.6 and 4011.8 of the Penal Code allow referral of certain mentally disordered persons from jails or detention facilities into the community mental health system.

Referral works to the advantage of all parties concerned. It enables the staff to remove a mentally disordered prisoner[2] who disturbs the jail with bizarre or aggressive behavior. It allows a mentally ill prisoner to be evaluated and receive treatment for his disorder, often in a therapeutic setting outside the jail. Finally, it relieves the workload of the courts by giving the courts and prosecuting attorney the option of dismissing criminal proceedings once the mentally disordered prisoner has received necessary mental health treatment, particularly if the offense charged is minor.

Referral is currently used successfully by many California counties, including Los Angeles County where over 700 county jail inmates are treated outside the jail annually. Many of these have all pending criminal charges against them dropped once they enter mental health treatment.

The purpose of this handbook is to facilitate referral by providing judges, attorneys, jail staff, and mental health professionals with a concise explanation of the laws authorizing referral and by answering some typical questions concerning referral. The handbook *does not* discuss laws governing persons found incompetent to stand trial, not guilty by reason of insanity, or mentally disordered sex offenders.

Since 1974 the State Department of Health has maintained a specialist in Sacramento to deal with services to mentally ill offenders. Specific questions not answered by this handbook may be directed to:

California Department of Health
Specialist for Mentally Ill Offender Services
744 P Street
Sacramento, California 95814
(916) 920-6754

1 Arthur Bolton Associates, "A Study of the Need For and Availability of Mental Health Services for Mentally Disordered Jail Inmates and Juveniles in Detention Facilities", prepared for the California Department of Health, October 1976.

2 It must be emphasized that provisions of Section 4011.6 apply to juveniles in detention facilities as well as to jail inmates. However, in the interest of brevity, "prisoner" is used here to include both adults and juveniles, and "jail" to include juvenile detention facilities.

HISTORY OF PENAL CODE SECTIONS 4011.6 AND 4011.8[3]

Penal Code Section 4011.6 permits a judge or person in charge of the jail (jailer) to transfer a mentally disordered prisoner to a local mental health facility for evaluation and possible involuntary treatment. However, it does not authorize the judge or jailer to require *admission* to the facility. The staff at the facility can refuse to admit any prisoner who is not a danger to himself or to others, or gravely disabled, just as the staff can refuse to admit for involuntary treatment *any* person who is not dangerous to himself or others, or gravely disabled.[4]

Section 4011.6 was enacted in 1963 to permit initiation of civil commitment proceedings for mentally disordered jail inmates. Prior to that time, some local authorities believed that an inmate could not be subject to commitment unless he was first released from the status of prisoner. As originally enacted, Section 4011.6 allowed the person in charge of the jail to have a mentally ill prisoner examined by a physician in the jail. If the physician believed the prisoner to be mentally ill, the jailer could file a petition for commitment of the prisoner to a state hospital. This procedure could be completed while the prisoner remained under the custody of jail authorities.

In 1968, after passage of the Lanterman-Petris-Short Act, which ended indefinite commitment of the mentally ill, Section 4011.6 was amended to allow initiation of involuntary treatment proceedings for mentally disordered jail inmates pursuant to the provisions of the Lanterman-Petris-Short Act.

Subsequent amendments gave judges the authority to initiate referrals under Section 4011.6, required confidential reports upon referral of a prisoner, permitted jail inmates to be placed under mental health conservatorships, and made Section 4011.6 applicable to juveniles in detention facilities.

In 1975 the Legislature added Section 4011.8 to allow jail inmates to receive mental health treatment on a voluntary basis. The intent of the Legislature in enacting this section was to facilitate treatment of mentally disordered inmates who were not eligible for involuntary treatment under Section 4011.6 because they were not dangerous to themselves, dangerous to others, or gravely disabled.

Section 4011.8 requires approval of a judge or jailer if the prisoner is to receive treatment outside the jail and, unlike Section 4011.6, also requires consent of the local mental health director. Section 4011.8 is *not* applicable to juveniles in detention facilities.

3 For a detailed legislative history, see Appendix I

4 For a definition of terms used in the Laterman-Petris-Short Act, see Appendix III.

TEXT OF PENAL CODE SECTION 4011.6

Section 4011.6 allows for referral of a mentally disordered prisoner to a mental health facility for *involuntary treatment* under the provisions of the Lanterman-Petris-Short Act.

Initiation by judge or jailer

4011.6 In any case in which it appears to the person in charge of a county jail, city jail, or juvenile detention facility, or to any judge of a court in the county in which the jail or juvenile detention facility is located

Mental disorder

that a person in custody in such a jail or juvenile detention facility may be mentally disordered,

Referral for evaluation

he may cause such a prisoner to be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and he shall inform the facility in writing which shall be confidential, of the reasons that such person is being taken to the facility.

Examination by local mental health director

The local mental health director or his designee may examine the prisoner prior to transfer to a facility for treatment and evaluation.

Mental health provisions applicable

Thereupon, the provisions of Article 1 (commencing with Section 5150), Article 4 (commencing with Section 5250), Article 4.5 (commencing with Section 5260), Article 5 (commencing with Section 5275), Article 6 (commencing with Section 5300), and Article 7 (commencing with Section 5325) of Chapter 2 and Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code shall apply to the prisoner.

Notice requirements

Where the court causes the prisoner to be transferred to a 72-hour facility, the court shall forthwith notify the local mental health director or his designee, the prosecuting attorney, and counsel for the prisoner in the criminal or juvenile proceedings about such transfer. Where the person in charge of the jail or juvenile detention facility causes the transfer of the prisoner to a 72-hour facility the person shall immediately notify the local mental health director or his designee and each court within the county where the prisoner has a pending proceeding about such transfer; upon notification by the person in charge of the jail or juvenile detention facility the court shall forthwith notify counsel for the prisoner and the prosecuting attorney in the criminal or juvenile proceedings about such transfer.

Confidential report to judge or jailer

If a prisoner is detained in, or remanded to, a facility pursuant to such articles of the Welfare and Institutions Code, the facility shall transmit a report, which shall be confidential, to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility and to the local mental health director or his designee, concerning the condition of the prisoner. A new report shall be transmitted at the end of each period of confinement provided for in such articles, upon conversion to voluntary status, and upon filing of temporary letter of conservatorship.

Conversion to voluntary status

A prisoner who has been transferred to an inpatient facility pursuant to this section, may convert to voluntary inpatient status without obtaining the consent of the court, the person in charge of the jail or juvenile detention facility, or the local mental health director. At the beginning of such conversion to voluntary status, the person in charge of the facility shall transmit a report to the

person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility, counsel for the prisoner, prosecuting attorney, and local mental health director or his designee.

If the prisoner is detained in, or remanded to, a facility pursuant to such articles of the Welfare and Institutions Code, the time passed therein shall count as part of the prisoner's sentence.

Credit for time served

When the prisoner is so detained or remanded, the person in charge of the jail or juvenile detention facility shall advise the professional person in charge of the facility of the expiration date of the prisoner's sentence. If the prisoner is to be released from the facility before such expiration date, the professional person in charge shall notify the local mental health director or his designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail or juvenile detention facility, who shall send for, take, and receive the prisoner back into the jail or juvenile detention facility.

Expiration of sentence

A defendant, either charged with or convicted of a criminal offense, or a minor alleged to be within the jurisdiction of the juvenile court may be concurrently subject to the provisions of the Lanterman-Petris-Short Act (Division 5, Part I, Welfare and Institutions Code).

Concurrent mental health proceedings

If a prisoner is detained in a facility pursuant to such articles of the Welfare and Institutions Code and if the person in charge of such facility determines that arraignment or trial would be detrimental to the well-being of the prisoner, the time spent therein shall not be computed in any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings. Otherwise, nothing contained herein shall affect any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings.

Statutory time requirements

For purposes of this section, the term "juvenile detention facility" includes any state, county, or private home or institution in which wards or dependent children of the juvenile court or persons awaiting a hearing before the juvenile court are detained.

Juvenile detention facility

2—76547

ANALYSIS OF PENAL CODE SECTION 4011.6

The following narrative is intended to illustrate the major provisions of Section 4011.6. A more detailed explanation, in the form of questions and answers, follows. Although the narrative concerns a jail inmate, provisions of Section 4011.6 are equally applicable to juveniles in juvenile detention facilities.

X has been arrested on a charge of disturbing the peace. He was arrested while standing on a street corner shouting bizarre and obscene comments to passersby. In jail his behavior has continued unabated and creates a disturbance by antagonizing other prisoners. The jail staff bring X's behavior to the attention of the person in charge of the jail, the jail captain.

In any case in which it appears to the person in charge of a county jail, city jail, or juvenile detention facility . . .

X is brought before a judge for arraignment. He continues his bizarre behavior in court.

Or to any judge of a court in the county in which the jail or juvenile detention facility is loca l . . .

On the basis of X's conduct, either the jail captain or the judge may conclude that X is mentally disordered. They need not be certain of their determination. They need only believe that X *may be* mentally disordered.

That a person in custody in such jail or juvenile detention facility may be mentally disordered . . .

The jail captain or judge directs a jail staff person to take X to the nearest mental health facility which has been designated by the county as a 72-hour treatment and evaluation facility. If the location of such a facility is not immediately known, it can be determined by phoning the local mental health director.

He may cause such prisoner to be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code . . .

Along with X, the judge or jail captain sends a written statement of the reasons

And he shall inform the facility in writing which

X is being sent to the facility. The statement need only include a description of X's behavior and the judge or jail captain's belief that X may be mentally disordered.*

shall be confidential, o the reasons that th person is being taken t the facility.

The judge or jail captain may request the local mental health director to examine X before he is transferred to the 72-hour facility. Such an examination is not required, and the local mental health director is not obliged to perform an examination. However, some county mental health programs have established jail treatment teams to evaluate prisoners who may require treatment outside the jail or to treat prisoners inside the jail when possible.

The local mental health director or his designee may examine the prisoner prior to transfer to a facility for treatment and evaluation.

After being taken to the 72-hour facility, X is evaluated by the facility staff to determine whether he is eligible for involuntary treatment under the provisions of the Lanterman-Petris-Short Act. If the staff concludes X is, as the result of a mental disorder, a danger to others or to himself, or is gravely disabled, X may be detained for 72 hours of treatment and evaluation. He may also be held for an additional 14 days of intensive treatment if he has not recovered by the end of the initial 72 hours. If X is believed by the staff to be imminently dangerous to others, he can be held for an additional 90 days after a specified court procedure. Finally, if X is found to be gravely disabled (defined as unable to provide for his personal needs for food, clothing, or shelter), he can be placed under a one-year mental health "conservatorship" after a court hearing.

Thereupon, the provisions of Article 1 (Commencing with Section 5150), Article 4 (Commencing with Section 5250), Article 4.5 (Commencing with Section 5260), Article 5 (Commencing with Section 5275), Article 6 (Commencing with Section 5300), and Article 7 (Commencing with Section 5325) of Chapter 2 and Chapter 3 (Commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code shall apply to the prisoner.

* For sample form, see Appendix II.

If the *judge* causes X to be taken to the 72-hour facility, the judge must notify

1. the local mental health director or the person designated by the director to receive such notification ("designee").
2. the prosecuting attorney.
3. X's attorney.

If the *jail captain* causes X to be taken to the 72-hour facility, the captain must immediately notify

1. the local mental health director or his designee.
2. each court within the county in which proceedings against X are pending.

Each court in which proceedings are pending must then notify

1. X's attorney.
2. the prosecuting attorney.

The notice may be oral or written and is intended to notify all concerned parties of X's transfer from the jail to a mental health facility.

If X is admitted to the facility, the facility must send a confidential report on X's condition to

1. the judge or jailer who referred X to the facility.
2. the local mental health director or his designee.

Where the court causes the prisoner to be transferred to a 72-hour facility, the court shall forthwith notify the local mental health director or his designee, the prosecuting attorney, and counsel for the prisoner in the criminal or juvenile proceedings about such transfer.

Where the person in charge of the jail or juvenile detention facility causes the transfer of a prisoner to a 72-hour facility the person shall immediately notify the local mental health director or his designee and each court within the county where the prisoner has a pending proceeding about such transfer; upon notification by the person in charge of the jail or juvenile detention facility the court shall forthwith notify counsel for the prisoner and the prosecuting attorney in the criminal or juvenile proceedings about such transfer.

If a prisoner is detained in, or remanded to, a facility pursuant to such articles of the Welfare and Institutions Code, the facility shall transmit a report, which shall be confidential, to the person in charge of the

A new report must be sent at the end of each period of involuntary treatment, upon X's conversion to voluntary status, and upon the filing of a temporary conservatorship over X.

If X is admitted to the facility, he may subsequently decide to accept treatment in the facility on a voluntary basis. X may do so by signing an application for admission to the facility and need not obtain the consent of the judge or jail captain who originally referred him to the 72-hour facility.

If X does convert to voluntary status, the *person in charge of the facility* must notify

1. the judge or jail captain who referred X to the facility.
2. X's attorney.
3. the prosecuting attorney.
4. the local mental health director or his designee.

jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility and to the local mental health director or his designee, concerning the condition of the prisoner. A new report shall be transmitted at the end of each period of confinement provided for in such articles, upon conversion to voluntary status, and upon filing of temporary letter of conservatorship.

A prisoner who has been transferred to an inpatient facility pursuant to this section, may convert to voluntary inpatient status without obtaining the consent of the court, the person in charge of the jail or juvenile detention facility, or the local mental health director.

At the beginning of such conversion to voluntary status, the person in charge of the facility shall transmit a report to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility, counsel for the prisoner, prosecuting attorney, and the local mental health director or his designee.

Any time X spends in the treatment facility will count as part of his sentence. This is true whether X is sentenced or unsentenced at the time of his referral under Section 4011.6.

If X is a sentenced prisoner, the jail captain must notify the person in charge of the facility to which X has been referred of the expiration date of X's sentence.

If the facility decides to release X prior to the expiration of X's sentence (because, for example, he is no longer a danger to himself or others, or gravely disabled, and refuses to accept treatment voluntarily), the *person in charge of the facility* must notify

1. the local mental health director or his designee.
2. X's attorney.
3. the prosecuting attorney.
4. the jail captain.

The jail captain will then return X to jail for the duration of his sentence.

Even though criminal charges are pending against X, he may nevertheless be treated under the applicable provisions of the Lanterman-Petris-Short Act, including 72-hour evaluation, 14-day certification for intensive treatment, 90-day post-certification for imminently dangerous persons, and one-year conservatorship for gravely

If the prisoner is detained in, or remanded to, a facility pursuant to such articles of the Welfare and Institutions Code, the time spent therein shall count as part of the prisoner's sentence.

When the prisoner is so detained or remanded, the person in charge of the jail or juvenile detention facility shall advise the professional person in charge of the facility of the expiration date of the prisoner's sentence.

If the prisoner is to be released from the facility before such expiration date, the professional person in charge shall notify the local mental health director or his designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail or juvenile detention facility, who shall send for, take, and receive the prisoner back into the jail or juvenile detention facility.

A defendant, either charged with or convicted of a criminal offense, or a minor alleged to be within the jurisdiction of the juvenile court may be concurrently subject to the provisions of the

disabled persons. The fact that X is eligible to receive treatment for his mental disorder may lead the court or prosecutor to terminate the criminal proceedings against X.

If the court chooses not to dismiss the pending criminal proceedings, X must be arraigned and brought to trial within certain time periods. If the time requirements are not met, the court must dismiss the action against X.

However, if X is admitted to the facility and the person in charge believes that arraignment or trial would be detrimental to X's well-being, the time X spends in treatment is *not counted* for the purposes of the statutory time requirements governing arraignment and trial. Otherwise, any time spent in treatment under Section 4011.6 will be counted.

If X is a juvenile rather than an adult, the provisions of Section 4011.6 apply to him if he is being held in a state, county, or private facility in which wards or dependent children of the juvenile court, or persons awaiting hearing before the juvenile court, are detained.

Lanterman-Petris-Short Act (Division 5, Part 1, Welfare and Institutions Code).

If a prisoner is detained in a facility pursuant to such articles of the Welfare and Institutions Code and if the person in charge of the facility determines that arraignment or trial would be detrimental to the well-being of the prisoner, the time spent therein shall not be computed in any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings. Otherwise, nothing contained herein shall affect any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings.

For the purposes of this section, the term "juvenile detention facility" includes any state, county, or private home or institution in which wards or dependent children of the juvenile court or persons awaiting a hearing before the juvenile court are detained.

QUESTIONS AND ANSWERS REGARDING PENAL CODE SECTION 4011.6

Initiation of a PC 4011.6 Referral

Q: Can a PC 4011.6 referral be initiated by someone other than a judge or jailer?

A: Technically, no. The statute authorizes only judges and jail authorities to make a PC 4011.6 referral. However, other parties (such as a prisoner's attorney, family, or friends) may bring the prisoner's mental condition to the attention of a judge or jail authorities, who can then make a proper referral under PC 4011.6.

Q: Can the jailer delegate his authority to make referrals under PC 4011.6?

A: The statute does not explicitly authorize or prohibit such delegation of authority. In some counties, the Sheriff (who operates the county jail) delegates the authority to make referrals to a jail treatment team. Sometimes the delegation is absolute — the jail team's recommendation that a prisoner be removed from the jail under PC 4011.6 is always approved by the jail captain or commander. In other cases, the jail captain must approve the actual removal of a prisoner from the jail after considering such factors as the crime charged against the prisoner and the prisoner's propensity for escape.

Q: Can a judge or jailer refuse to allow removal of a mentally disordered inmate under PC 4011.6?

A: Yes. Even if an inmate is clearly mentally disordered (having been so diagnosed by a jail treatment team, for example), the judge or jailer may refuse to allow the prisoner to be taken from the jail. Such refusal may be based on the prisoner's propensity for violence or escape, or on the gravity of the pending charges.

Q. Can a judge order a PC 4011.6 referral for a prisoner whom the jailer has refused to release?

A: Yes. The authority of a judge to make referrals under Section 4011.6 is not contingent upon the approval of the person in charge of the jail. The statute allows either the jailer *or* any judge of the county in which the jail is located to make a referral. The judge can exercise independent discretion as to whether a prisoner should be removed from the jail for treatment under Section 4011.6.

Q: Can mental health treatment be given to a prisoner in jail if the prisoner is not referred to a facility under PC 4011.6?

A: PC 4011.6 neither authorizes nor prohibits treatment of mentally disordered prisoners in jail (unless a unit of the jail has been designated a 72-hour treatment facility, in which case the provisions of 4011.6 apply). If a prisoner held in jail agrees to accept mental health treatment voluntarily, the prisoner may receive such treatment under the provisions of Section 4011.8. If the prisoner is unable or unwilling to consent to treatment, 4011.6 does not authorize involuntary treatment in the jail; it only authorizes referral of a mentally disordered prisoner to a 72-hour facility for evaluation and treatment.[5]

Q: Can a judge order a PC 4011.6 referral for someone who has been released on bail or on the person's own recognizance (O.R.)?

A: No. PC 4011.6 applies only to persons "in custody", which by definition excludes anyone who has been released from custody on bail or O.R. A court may impose conditions on a person who is released O.R. under the implicit grant of authority in Section 1318.4 of the Penal Code. One such condition might be that the person seek and submit to mental health treatment. However, the authority to impose mental health treatment as a condition of release O.R. is not derived from Section 4011.6.

Mental Disorder

Q: What evidence of mental disorder must a judge or jailer have before making a referral under PC 4011.6?

A: Section 4011.6 requires only that a person in custody "appear" to be mentally disordered. In most cases a prisoner's behavior will be the

[5] At the time of writing, legislation has been introduced in the 1977-78 Session of the California Legislature which would require that prisoners retained in jail for mental health treatment give informed consent to such treatment if psychotropic drugs are to be used. If the prisoner is incapable of giving consent, the legislation requires an independent psychiatric and judicial review before medication can be used beyond a 72-hour period of emergency care. (AB 1627, Alatorre, as amended May 17, 1977).

principal evidence upon which a judge or jailer bases a determination that the prisoner may be mentally disordered. The judge or jailer may request the local mental health director or his designee to examine the prisoner in jail and determine whether the prisoner meets the criteria for involuntary treatment under the Lanterman-Petris-Short Act — dangerous to self or others, or gravely disabled. However, such examination is *not* required for referral to a 72-hour facility outside the jail.

Q: **Must the judge or jailer have "probable cause" to believe that the prisoner is a danger to others or to himself, or gravely disabled?**

A: Yes, although the statute is not explicit on this point. Section 4011.6 allows referral of a prisoner to a 72-hour facility "pursuant to Section 5150 of the Welfare and Institutions Code". Section 5150, in turn, authorizes a peace officer (or designated mental health professional) to take a person to a 72-hour facility if he has "probable cause" to believe that the person is, as a result of mental disorder, a danger to himself or others, or gravely disabled.

A judge or jailer making a referral under PC 4011.6 should follow the probable cause standard for three reasons. First, 4011.6 clearly states that referral of a jail inmate to a 72-hour facility is made "pursuant to Section 5150", and Section 5150 requires probable cause. Second, under 4011.6 the same provisions of the Lanterman-Petris-Short Act which apply to the civil population, including Section 5150, also apply to inmates referred to treatment under PC 4011.6. Finally, to use a standard for referral of a jail inmate for involuntary mental health treatment which is less strict than the standard used for referral of the general population might violate the constitutional requirement of equal protection of the law.

Referral for Evaluation

Q: **Can a prisoner be referred under PC 4011.6 to any mental health facility?**

A: No. A prisoner can only be referred to a facility which has been designated by the county and approved by the State Department of Health as a facility for 72-hour treatment and evaluation. Most 72-hour facilities are hospitals. The local mental health director or the State Department of Health can provide the location of designated 72-hour facilities within the county.

Q: **Is the 72-hour facility required to admit a prisoner referred under PC 4011.6?**

A: No. Section 4011.6 is simply a mechanism for transporting a prisoner to a 72-hour facility for evaluation and treatment. The staff at the facility must determine whether the prisoner is mentally disordered and meets the criteria set forth in the Lanterman-Petris-Short Act for involuntary treatment, i.e., dangerous to self or others, or gravely disabled. If the prisoner does not meet one of the three criteria he cannot be admitted to the facility unless he agrees to accept treatment voluntarily and signs a voluntary admission form. The same is true for any member of the community who is taken to a 72-hour facility for evaluation and treatment.

Therefore, a judge or jailer cannot order a prisoner admitted to the 72-hour facility under the aegis of 4011.6, but can only order a referral to the facility for evaluation.

Q: **Must a written document be sent to the facility by the judge or jailer?**

A: Yes. The judge or jailer must inform the facility in a confidential writing of the reasons for the prisoner's referral under 4011.6. The document need only state, for instance, that a prisoner appears to be mentally disordered because of certain behavior, and include a description of the behavior.

Examination by the Local Mental Health Director

Q: **Is an examination by the local mental health director required for a PC 4011.6 referral?**

A: No. As originally enacted, Section 4011.6 did require an examination by a "physician" who would determine whether the prisoner was mentally ill; after such a determination, the person in charge of the jail could file a petition for commitment of the prisoner to a state hospital. The current version of 4011.6 clearly states that the examination by the local mental health director is permissive, not mandatory. The language regarding the examination legitimizes the operation of jail treatment teams operated by some county mental health programs which screen prisoners before they are taken outside the jail to a treatment facility.

Q: **Can an examination by the local mental health director take the place of the evaluation by staff at the 72-hour facility?**

A: There is nothing in the statute to authorize or prohibit a county from adopting a policy that prisoners examined in the jail and found to meet the criteria for involuntary treatment will be automatically admitted to a 72-hour facility. In most counties, both the staff at the 72-hour facility and the jail treatment team are county mental health employees. As long as the prisoner is examined by mental health staff and found to be a danger to others or to himself, or gravely disabled, where the examination is performed is of no relevance to the purposes of 4011.6. The decision to adopt such a policy, however, is an administrative one and is not compelled by the language of 4011.6.

Applicable Mental Health Provisions

Q: **Which provisions of the Lanterman-Petris-Short Act are applicable to prisoners referred under PC 4011.6?**

A: After a prisoner has been referred to a facility under 4011.6, the following provisions of the Lanterman-Petris-Short Act apply:

Chapter 2 (commencing with Section 5150)

Article 1	Detention for Evaluation and Treatment (72 hours)
Article 4	Certification for Intensive Treatment (14 days)
Article 4.5	Subsumed under Article 4
Article 5	Judicial Review
Article 6	Post-certification for Imminently Dangerous Persons (90 days)
Article 7	Legal and Civil Rights of Involuntarily Detained Persons

Chapter 3 (commencing with Section 5350) Conservatorship for Gravely Disabled Persons (1 year)

Prior to 1975, when Chapter 3 was added to the applicable provisions, prisoners referred under PC 4011.6 could be treated for a maximum of 90 days. Now the full range of treatment provisions, including conservatorship for gravely disabled prisoners, is available. Similarly, all of the legal protections of the Lanterman-Petris-Short Act apply to prisoners who receive treatment after referral under 4011.6.[6]

Notice

Q: **Who must be notified when a judge or jailer makes a PC 4011.6 referral?**

A: If a *judge* makes the referral, the judge must notify the local mental health director (or his designee), the prosecuting attorney, and counsel for the prisoner. If the *jailer* makes the referral, the jailer must notify the local mental health director (or his designee) and each court of the county in which a proceeding against the prisoner is pending. *Each court* must then notify counsel for the prisoner and the prosecuting attorney.

Q: **What form of notice must be given?**

A: Although the statute does not specifically require written notice, it is sound policy for the court or jailer to provide a written record of the notice given.

Conversion to Voluntary Status

Q: **What is meant by "conversion to voluntary status"?**

A: Conversion to voluntary status occurs when a person who entered treatment involuntarily chooses to accept further treatment voluntarily. When this happens, the person generally signs a request for voluntary admission and the involuntary "hold" on the person is terminated. The Lanterman-Petris-Short Act specifically requires that treatment staff seek the agreement of an involuntary patient to accept further treatment voluntarily. This provision simply reaffirms the right of a prisoner referred for involuntary treatment to accept additional treatment voluntarily.

6 For a summary of the applicable provisions of the Lanterman-Petris-Short Act, see Appendix III.

Q: Can a prisoner who has converted to voluntary status leave the facility at any time?

A: This depends upon the status of the criminal proceedings. If the prisoner has been *sentenced* and requests to leave the facility prior to the expiration date of the sentence, the facility must notify the jailer, who will return the prisoner to jail. If the prisoner is *unsentenced* and the criminal proceedings are still pending, the criminal court will generally issue a "court hold" on the prisoner directing that he be returned to court on a specific date for arraignment or trial. If such a prisoner chooses to terminate his voluntary treatment and requests to leave the facility, the person in charge of the facility should notify the jailer and have the prisoner returned to jail. (Alternatively, the treatment staff could reinstitute a 72-hour evaluation if the prisoner remains a danger to himself or others, or gravely disabled.)

If the prisoner has no criminal charges pending and is not under a sentence, he is, for purposes of the mental health system, no longer a prisoner at all and must be treated no differently from any other voluntary patient. A voluntary patient who requests to be released must be released unless he is eligible for involuntary treatment.

Credit for Time Spent in Treatment

Q: Must both sentenced and unsentenced prisoners be given credit for time spent in treatment after referral under PC 4011.6?

A: Yes. Sentenced prisoners clearly fall within the language of this provision. Under Section 2900.5 of the Penal Code, as amended in 1976, an unsentenced defendant who has been charged with a felony or misdemeanor must be given credit against his sentence for any time spent in "a jail, camp, work furlough facility, halfway house, rehabilitation facility, *hospital*, prison, or similar institution . . . ." (emphasis added). The broad language of Section 2900.5 would seem to cover treatment in a mental health facility so long as that treatment is given while the defendant is in custody.

Expiration of Sentence

Q: What happens to a sentenced prisoner who must be released from treatment before expiration of the sentence?

A: If a sentenced prisoner is to be released from prison before the expiration date of his sentence, the person in charge of the treatment facility must first notify

1. the local mental health director or his designee.
2. counsel for the prisoner.
3. the prosecuting attorney.
4. the person in charge of the jail.

Upon receiving such notice, the person in charge of the jail will take the prisoner from the facility and return him to jail for the duration of the sentence.

Q: Must a prisoner whose sentence expires while he is in treatment be released from treatment immediately?

A: No. If the prisoner is being treated *involuntarily*, he can be treated beyond the expiration of the sentence so long as he continues to meet the criteria for involuntary treatment. For example, if a prisoner is being treated under a 90-day post-certification when the prisoner's sentence expires, he can continue to be treated for the duration of the post-certification period. A prisoner whose sentence has expired, in short, is treated in the same manner as any other person who is held for involuntary treatment.

If, however, the prisoner is receiving treatment on a *voluntary* basis when the sentence expires, the prisoner must be released upon request unless he remains dangerous to himself or others, or gravely disabled. In this case, involuntary treatment proceedings (beginning with another 72-hour evaluation) should be reinstituted.

Concurrent Mental Health Proceedings

Q: What is meant by the statement that a prisoner "may be concurrently subject to the provisions of the Lanterman-Petris-Short Act"?

A: This language clarifies that criminal proceedings and proceedings under the Lanterman-Petris-Short Act can run simultaneously.

Q: Do criminal proceedings take precedence over mental health proceedings?

A: Yes, although this is not explicit in the statute. Section 4011.6 was never intended to preempt criminal proceedings. It is a procedure for referring mentally disordered offenders into the mental health system for treatment pending outcome of the criminal proceedings. Since the court retains jurisdiction over an unsentenced prisoner and the jailer retains jurisdiction over a sentenced prisoner, staff of the mental health treatment facility must comply with orders for return of the prisoner to court or jail.

Statutory Time Requirements

Q: Do statutory time requirements for arraignment and trial apply to prisoners referred to mental health treatment under Section 4011.6?

A: Yes, unless the person in charge of the mental health facility determines that arraignment or trial would be detrimental to the well-being of the prisoner, in which case time spent in treatment is *not counted* in any time requirements for arraignment or trial. The intent is to ensure that unsentenced prisoners referred to treatment under 4011.6 are not able to avoid pending criminal proceedings by receiving treatment which "uses up" the time requirements for arraignment and trial. Thus, any time spent in treatment after the person in charge of the mental health facility determines that arraignment or trial would be detrimental to the prisoner is not counted for the purposes of the time requirements.

It is not clear from the statute how the person in charge of the facility communicates his opinion to the court. In some counties every prisoner is sent to court for arraignment or trial and it is left to the judge to re-refer the prisoner to the facility under 4011.6 or initiate proceedings under Section 1368 of the Penal Code (incompetence to stand trial).

TEXT OF PENAL CODE SECTION 4011.8

Section 4011.8 allows a jail inmate (not a juvenile in a detention facility) to make application for *voluntary* mental health services.

Initiation by prisoner

4011.8. A person in custody who has been charged with or convicted of a criminal offense may make voluntary application for inpatient or outpatient mental health services in accordance with Section 5003 of the Welfare and Institutions Code.

Absence from jail

If such services require absence from the jail premises, consent from the person in charge of the jail or from any judge of a court in the county in which the jail is located, and from the director of the county mental health program in which services are to be rendered, shall be obtained. The local mental health director or his designee may examine the prisoner prior to transfer from the jail.

Notice requirements

Where the court approves voluntary treatment for a jail inmate for whom criminal proceedings are pending, the court shall forthwith notify counsel for the prisoner and the prosecuting attorney about such approval. Where the person in charge of the jail approves voluntary treatment for a prisoner for whom criminal proceedings are pending, the person in charge of the jail shall immediately notify each court within the county where the prisoner has a pending proceeding about such approval; upon notification by the jailer the court shall forthwith notify the prosecuting attorney and counsel for the prisoner in the criminal proceedings about such transfer.

Credit for time served

If the prisoner voluntarily obtains treatment in a facility or is placed on outpatient treatment pursuant to Section 5003 of the Welfare and Institutions Code, the time passed therein shall count as part of the prisoner's sentence.

When the prisoner is permitted absence from the jail for voluntary treatment, the person in charge of the jail shall advise the professional person in charge of the facility of the expiration date of the prisoner's sentence. If the prisoner is to be released from the facility before such expiration date, the professional person in charge shall notify the local mental health director or his designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail, who shall send for, take, and receive the prisoner back into the jail.

Expiration of sentence

A denial of an application for voluntary mental health services shall be reviewable only by mandamus.

Judicial review

ANALYSIS OF PENAL CODE SECTION 4011.8

The following narrative is intended to illustrate the major provisions of Section 4011.8. A more detailed analysis, in the form of questions and answers, follows.

X is an inmate in county jail awaiting trial on charges of breaking and entering. He is unable to post bail and is not considered a good risk for release on his own recognizance. Because of personal problems and the jail experience, X is profoundly depressed, but is not suicidal. X tells a guard that he wants to see a psychiatrist.

A person in custody who has been charged with or convicted of a criminal offense may make voluntary application for inpatient or outpatient mental health services in accordance with Section 5003 of the Welfare and Institutions Code.

The jail in which X is being held has an agreement with the local mental health director whereby a psychiatrist visits the jail daily to see prisoners who request or require mental health treatment. The psychiatrist examines X and determines that he should receive treatment outside the jail for his depression. Since absence from the jail is required, the psychiatrist requests approval from the jail captain or a judge to treat X in an outpatient or inpatient facility outside the jail. (If there is no such arrangement with the local mental health director, the consent of the director would have to be obtained by the judge or jailer who approves the prisoner's request for voluntary mental health services.)

If such services require absence from the jail premises, consent from the person in charge of the jail or from any judge or a court in the county in which the jail is located, and from the director of the county mental health program in which the services are to be rendered, shall be obtained. The local mental health director or his designee may examine the prisoner prior to transfer from the jail.

If the *judge* approves X's request for voluntary mental health services, the judge must notify X's counsel and the prosecuting attorney about such approval.

Where the court approves voluntary treatment for a jail inmate for whom criminal proceedings are pending, the court shall forthwith notify counsel

If the *jail captain* approves X's request, he must notify each court within the county in which X has a criminal proceeding pending.

Each court must then notify the prosecuting attorney and X's attorney about X's transfer to a mental health facility for voluntary treatment.

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Any time which X spends in treatment under 4011.8 will be credited against his sentence. This is true even though X is unsentenced at the time he receives treatment.

If X is a sentenced prisoner and is permitted to receive treatment outside the jail, the jail captain must notify the person in charge of the facility of the expiration date of X's sentence.

for the prisoner and the prosecuting attorney about such approval.

Where the person in charge of the jail approves voluntary treatment for a prisoner for whom criminal charges are pending, the person in charge of the jail shall immediately notify each court within the county where the prisoner has a pending proceeding about such approval; upon notification by the jailer the court shall forthwith notify the prosecuting attorney and counsel for the prisoner in the criminal proceedings about such transfer.

If the prisoner voluntarily obtains treatment in a facility or is placed on outpatient treatment pursuant to Section 5003 of the Welfare and Institutions Code, the time passed therein shall count as part of the prisoner's sentence.

When the prisoner is permitted absence from the jail for voluntary treatment, the person in charge of the jail shall advise the professional

Should the facility decide to release X before the expiration of his sentence because, for example, X refuses to cooperate or has received maximum benefit from treatment, the person in charge of the facility must notify

1. the local mental health director or his designee.
2. X's attorney.
3. the prosecuting attorney.
4. the jail captain.

The jail captain must then return X to jail for the duration of his sentence.

If X's request for voluntary mental health services is denied either by the jail captain or the local mental health director, X can obtain judicial review by a writ of mandate pursuant to Section 1085 et seq. of the Code of Civil Procedure.

person in charge of the facility of the expiration date of the prisoner's sentence.

If the prisoner is to be released from the facility before such expiration date, the professional person in charge shall notify the local mental health director or his designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail, who shall send for, take, and receive the prisoner back into the jail.

A denial of an application for voluntary mental health services shall be reviewable only by mandamus.

QUESTIONS AND ANSWERS REGARDING PENAL CODE SECTION 4011.8

Initiation

Q: Does PC 4011.8 apply to juveniles in juvenile detention facilities?

A: No. It applies only to persons "charged with or convicted of a criminal offense".

Q: Does PC 4011.8 apply to both sentenced and unsentenced prisoners?

A: Yes.

Q: Can a prisoner receive voluntary outpatient services under 4011.8?

A: Yes, subject to the approval of the local mental health director *and* a judge or jailer. (See discussion below)

Q: Must a prisoner meet any specified criteria regarding severity of mental disorder in order to receive treatment under 4011.8?

A: No. However, there is nothing in 4011.8 which limits the authority of the local mental health director to refuse treatment to a prisoner whom the director believes is not mentally disordered.

Q: What does Section 5003 of the Welfare and Institutions Code provide?

A: Section 5003 states that nothing in the Lanterman-Petris-Short Act "shall be construed in any way as limiting the right of any person to make voluntary application at any time . . . for mental health services . . . ." Section 5003 reflects the philosophy of the Lanterman-Petris-Short Act—that people should be encouraged to accept mental health treatment voluntarily whenever possible.

Absence from Jail

Q: Who must give consent before a prisoner can receive voluntary mental health services?

A: If the treatment requires the prisoner's absence from the jail, the local mental health director and the jailer or a judge must approve the prisoner's request for treatment. Presumably, if the prisoner is to be treated in the jail, the consent of the mental health director, judge, or jailer is not required.

Examination by Local Mental Health Director

Q: Is an examination by the local mental health director required for treatment under PC 4011.8?

A: No. But if treatment requires absence from the jail, the consent of the local mental health director must be obtained. (See above)

Notice

Q: Who must be notified when a judge or jailer approves voluntary treatment for a prisoner under PC 4011.8?

A: If a *judge* approves the treatment, the judge must notify the prisoner's attorney and the prosecuting attorney. If the *jailer* approves the treatment, the jailer must notify each court within the county in which the prisoner has a pending criminal proceeding. *Each court* must then notify the prosecuting attorney and counsel for the prisoner.

Q: Do the notice requirements apply only to prisoners who are to be removed from the jail for voluntary mental health services?

A: This is unclear. The statute does not explicitly limit the requirements for notification to cases in which the prisoner is treated outside the jail. However, there is a reference to the court's responsibility to notify the prosecuting attorney and counsel for the prisoner "about such transfer," which suggests that notice is required only when the prisoner is removed from the jail. The reference may have been an unintentional carryover from the language of Section 4011.6, after which the notice requirements of 4011.8 are patterned.

In light of the ambiguity, it would be advisable for judges and jailers to provide notice whenever they approve voluntary mental health services, whether such services are to be provided inside or outside the jail.

(N.B. Some counties use 4011.8 only when a prisoner needs treatment outside the jail. Prisoners who cannot be removed from the jail but who are willing to accept treatment voluntarily are simply treated in the jail without provisions of 4011.8 being invoked. As noted in the earlier discussion of Section 4011.6 (p. 15) there is no explicit statutory authority for providing mental health services to jail inmates except under the provisions of Section 4011.6 and 4011.8.)

Q: **What form of notice must be given?**

A: Although the statute does not specifically require written notice, it is sound policy for the court or jailer to provide a written record of the notice given.

Credit for Time Spent in Treatment

Q: **Must both sentenced and unsentenced prisoners be given credit for time spent in treatment under PC 4011.8?**

A: Yes. (See discussion on page 20).

Expiration of Sentence

Q: **Must voluntary mental health treatment cease when the prisoner refuses to accept further treatment?**

A: Yes. Voluntary treatment cannot continue after the prisoner has expressed a desire to terminate treatment.

Q: **What must a facility do with a prisoner who refuses to accept further treatment?**

A: This depends on the status of the prisoner. If the prisoner is *unsentenced* and charges are still pending, he must be returned to court or jail for further criminal proceedings.

If the prisoner is *sentenced* and the sentence has not yet expired, the facility must notify the jailer, who will return the prisoner to jail.

If the prisoner's sentence has expired or the criminal proceedings have been dismissed, the prisoner must be released from the facility

when he refuses to accept further treatment unless he can be held under the involuntary treatment provisions of the Lanterman-Petris-Short Act as a danger to himself or others, or gravely disabled. A prisoner on whom the criminal "hold" has been terminated must be treated the same as any other person in the mental health system.

Judicial Review

Q: **How may a prisoner obtain judicial review of a denial of voluntary mental health services?**

A: If a prisoner's application for voluntary mental health services is denied, the prisoner may obtain judicial review by filing a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure. The writ can be used "to compel the admission of a party to the use and enjoyment of a right . . .to which he is entitled, and from which he has been unlawfully precluded by such inferior tribunal, corporation, board, or person."

OTHER ASPECTS OF REFERRAL — REFERRAL PRIOR TO ARREST

Although the primary focus of this handbook has been on referral of prisoners from jails and detention facilities into mental health treatment, referral can occur even before an arrest is made.

Peace officers occasionally come in contact with a person who has committed a criminal offense and who appears also to be mentally disordered. Often the person's offense is minor or grows out of a family dispute, yet an officer may feel compelled to intervene. The officer may arrest the person on the criminal violation, or he may decide to take the person to a facility for treatment and evaluation under the Lanterman-Petris-Short Act.

Section 5150 of the Welfare and Institutions Code provides a peace officer with an alternative to the immediate arrest of a mentally disordered person who has committed a crime. It allows the officer, in effect, to delay any decision to arrest a mentally disordered person until after the person has been evaluated at a 72-hour facility.

Section 5150 authorizes a peace officer to take to a 72-hour facility any person whom the officer has probable cause to believe is, as the result of a mental disorder, dangerous to himself or others, or gravely disabled.

The major provisions of Section 5150 are as follows:

1. The officer must have "probable cause" to believe that the person is, as the result of a mental disorder, a danger to others or to himself, or gravely disabled.

2. The officer must submit in writing an application stating (a) the circumstances under which the person's behavior was called to the officer's attention, and (b) that the officer has probable cause to believe the person is a danger to others or to himself, or is gravely disabled.

Staff at the 72-hour facility will examine the person to determine whether the person meets the criteria for involuntary treatment. If he meets the criteria, he will be treated according to the provisions of the Lanterman-Petris-Short Act. If the person does not meet the criteria and refuses to accept treatment voluntarily, the facility cannot detain him further.

An officer making a referral under Section 5150 may request and receive notification from the facility if the person is detained for less than the full 72 hours, provided that (a) the officer requests such notification at the time he submits the required application, and (b) the officer states in writing that the person has been referred under circumstances in which a criminal charge might be filed (Section 5152.1).

Each law enforcement agency within a county must arrange with the county mental health director a method for giving prompt notification to officers (Section 5152.2).

Sections 5152.1 and 5152.2 assure an officer that if the person cannot be held for treatment, he will be notified so that the person can be processed through the criminal justice system.

Some confusion has surrounded two amendments made to Section 5150 in 1975: substitution of "probable cause" for "reasonable cause" and deletion of the requirement that an officer's belief that the person is mentally disordered be based on the officer's "personal observation".

The substitution of "probable cause" for "reasonable cause" was intended to provide peace officers with a standard with which they are familiar, since all arrests without a warrant must be based on probable cause. The elimination of "personal observation" was intended to allow an officer who did not witness the person's behavior or act to rely on information provided by witnesses.[7]

[7] For a discussion of the legislative intent concerning the 1975 amendments, see Final Report of the Assembly Select Committee on Mentally Disordered Criminal Offenders (1973-74), Honorable Frank Lanterman, Chairman.

APPENDIX I

Legislative History of Section 4011.6

Enacted by Stats. 1963, Chapter 1731	Allowed jailer to have prisoner examined by physician. If prisoner found to be mentally ill, permitted jailer to file petition for commitment of prisoner to state hospital.
Amended by Stats. 1968, Chapter 1374	Allowed jailer to petition for court-ordered evaluation of prisoner under provisions of Lanterman-Petris-Short Act. Permitted treatment for 72 hours, 14 days, and 90 days.
Amended by Stats. 1970, Chapter 1627	Allowed jailer to refer prisoner to facility for 72-hour evaluation and made certain provisions of LPS applicable to such prisoner.
Amended by Stats. 1971, Chapter 1117	Allowed any judge of the county in which jail is located to initiate referral under 4011.6.
Amended by Stats. 1974, Chapter 22	Required confidential report from judge or jailer of reasons for referral of prisoner under 4011.6. Also required confidential report from facility on prisoner's condition at end of each period of confinement.
Amended by Stats. 1975, Chapter 1258	Allowed establishment of conservatorships for prisoners referred under 4011.6. Required notification of specified parties upon referral under 4011.6. Allowed prisoner to convert to voluntary status.
Amended by Stats. 1976, Chapter 445	Made 4011.6 applicable to juveniles in juvenile detention facilities, as defined.

Legislative History of Section 4011.8

Enacted by Stats. 1975, Chapter 1258	Allowed prisoner to make application for voluntary mental health services.

APPENDIX II

This appendix contains sample forms which a county may wish to utilize for referrals under Penal Code Sections 4011.6 and 4011.8. The forms contain more information than is required by law, but such information has been found useful in counties which currently use Sections 4011.6 and 4011.8.

SAMPLE FORM A

This form may be used for referrals under Section 4011.6 which are initiated by the *court.*

SAMPLE FORM B

This form may be used for referrals under Section 4011.6 which are initiated by the *person in charge of the jail.*

SAMPLE FORM C

This form may be used for voluntary treatment under Section 4011.8 which requires absence from the jail. If an inmate is to receive voluntary treatment in the jail, a simple statement of consent to treatment would be sufficient.

The sample forms may be modified to suit the needs of individual counties.

SAMPLE FORM A

COURT-ORDERED
REFERRAL FOR MENTAL HEALTH EVALUATION
PURSUANT TO P.C. SECTION 4011.6

County Superior Court	Department
County Municipal Court	Division
Address	Telephone
In re: Defendant	Booking Number
Criminal Charge	Case Number
Prosecuting Attorney	Defense Attorney
Address	Address
Telephone	Telephone
Court where next hearing is scheduled	Date of hearing (if known)

IT IS HEREBY ORDERED that, pursuant to Section 4011.6 of the Penal Code, the above-named defendant be transported directly to the _____ (name of facility), a designated 72-hour treatment and evaluation facility, located at _____, so that such facility may determine whether defendant is, as a result of mental disorder, a danger to others or to himself, or gravely disabled pursuant to Section 5150 of the Welfare and Institutions Code.

The court has probable cause to believe that defendant is, as a result of mental disorder:

- ☐ a danger to others
- ☐ a danger to himself
- ☐ gravely disabled (unable to provide for his personal needs for food, clothing, or shelter)

The court's belief is based upon the following observed behavior and/or information received:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Page 1 of 3

INSTRUCTIONS FOR FACILITY

DEFENDANT IS A SENTENCED PRISONER ☐ Sentence expires on _____

If the facility is to release defendant prior to the expiration date of sentence, the facility SHALL NOTIFY:

a. The local mental health director or designee

Name _____
Address _____
Phone _____

b. Counsel for defendant

c. Prosecuting attorney

d. Person in charge of the jail

Name _____
Address _____
Phone _____, who shall send for, take, and receive defendant back into jail to be held there pending expiration of sentence.

If the facility is to release defendant after the expiration date of sentence, the facility may discharge defendant directly into the community.

DEFENDANT IS AN UNSENTENCED PRISONER ☐

Court in which proceedings are pending _____

☐ HOLD FOR RETURN TO CUSTODY

Case is continued to _____ (date) at _____ (time) in the above-named court.

If the facility is to release defendant before the above-mentioned date, the facility SHALL NOTIFY:

The person in charge of the jail

Name _____
Address _____
Phone _____, who shall send for, take, and receive defendant back into jail to be held there for further order of the above court.

If the person in charge of the facility determines that arraignment or trial would be detrimental to the well-being of defendant, the person in charge shall communicate his opinion to the above-named court, defendant's counsel, and the prosecuting attorney.

☐ COURT RETURN – RELEASE ON OWN RECOGNIZANCE

If the facility is to release defendant before the above-mentioned date, defendant is to be on his own recognizance and is to report to the court named above within three (3) days after release. The facility shall notify the court of defendant's release.

Page 2 of 3

☐ NO COURT HOLD – DISMISSAL

The court hereby determines that defendant can be more appropriately handled according to California's civil mental health laws than in the criminal justice system. As a result of this determination and in the interest of justice, the criminal charge(s) indicated above shall be dismissed pursuant to Section 1385 of the Penal Code upon evaluation of defendant pursuant to Section 5150 of the Welfare and Institutions Code.

REPORTS

The facility shall forward a report on the condition of defendant at the end of 72-hour evaluation and each subsequent period of treatment, upon conversion to voluntary status, and upon filing of temporary letter of conservatorship to the following parties:

a. The above-named court
b. The local mental health director or designee

NOTICE

Notice of this order shall be provided to:

a. The local mental health director or designee
   Name _____
   Address _____
   Phone _____
b. Counsel for defendant
c. Prosecuting attorney

DISTRIBUTION

Original to be transmitted with defendant to facility

Dated: _____ JUDGE: _____

SAMPLE FORM B

JAIL–INITIATED
REFERRAL FOR MENTAL HEALTH EVALUATION
PURSUANT TO P.C. SECTION 4011.6

In Re: , Defendant	Booking Number
Criminal Charge	Case Number
Prosecuting Attorney	Defense Attorney
Address	Address
Phone	Phone
Court where next hearing is scheduled:	Date of hearing (if known):

I, _____ (person in charge of jail), direct that, pursuant to Section 4011.6 of the Penal Code, the above-named defendant be transported to the _____ (name of facility) located at _____, so that such facility may determine whether defendant is, as a result of mental disorder, a danger to others or to himself, or gravely disabled pursuant to Section 5150 of the Welfare and Institutions Code.

I have probable cause to believe that defendant is, as a result of mental disorder:

☐ a danger to others
☐ a danger to himself
☐ gravely disabled (unable to provide for his personal needs for food, clothing, or shelter)

My belief is based upon the following observed behavior and/or information received:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

INSTRUCTIONS FOR FACILITY

DEFENDANT IS A SENTENCED PRISONER ☐ Sentence expires on _____

If the facility is to release defendant prior to the expiration date of sentence, the facility SHALL NOTIFY:

a. The local mental health director or designee

Name _____

Address _____

Phone _____

b. Counsel for defendant

c. Prosecuting attorney

d. Person in charge of the jail

Name _____

Address _____

Phone _____, who shall send for, take, and receive defendant back into jail to be held there pending expiration of sentence.

If the facility is to release defendant after the expiration date of sentence, the facility may discharge defendant directly into the community.

DEFENDANT IS AN UNSENTENCED PRISONER ☐

Court in which proceedings are pending _____

If the facility is to release defendant, the facility SHALL NOTIFY:

a. The local mental health director or designee

Name _____

Address _____

Phone _____

b. Counsel for defendant (If unknown, send in care of court)

c. Prosecuting attorney

d. Person in charge of the jail

Name _____

Address _____

Phone _____, who shall send for, take, and receive the defendant back into the jail to be held there for further order of the above court.

REPORTS

The facility shall forward a report on the condition of defendant at the end of 72-hour evaluation and each subsequent period of treatment, upon conversion to voluntary status, and upon filing of temporary letter of conservatorship to the following parties:

a. The above-named court

b. The local mental health director or designee

NOTICE

Notice of defendant's transportation to the facility shall be provided to:

a. The local mental health director or designee

Name _____

Address _____

Phone _____

b. The above-named court and any other court within the county where defendant has a pending proceeding

DISTRIBUTION

Original to be transmitted with defendant to facility.

Dated: _____ Signed: _____
(person in charge of jail)

SAMPLE FORM C

APPLICATION FOR VOLUNTARY TREATMENT
PURSUANT TO P.C. SECTION 4011.8

In re:	Booking Number
Criminal charge	Case Number
Prosecuting Attorney	Defense Attorney
Address	Address
Phone	Phone
Court where next hearing is scheduled	Date of next hearing (if known)

APPROVAL AND TRANSPORTATION

The local mental health director (or designee) and

The person (or designee) in charge of the jail ☐ (if initiated by the JAIL) or Judge _____ (if initiated by the COURT) has approved voluntary mental health treatment for the above-named defendant at:

☐ 24-hour facility
☐ Day treatment (inpatient) facility
☐ Outpatient treatment facility

pursuant to P.C. Section 4011.8. The defendant is referred to _____ (name of facility),

located at _____.

Transportation is to be arranged as follows: ☐ Sheriff ☐ Private ☐ Public

Signed _____ (jail commander or designee) Title _____ Date _____

INSTRUCTIONS FOR FACILITY

DEFENDANT IS AN UNSENTENCED PRISONER ☐

Court in which proceedings are pending _____

If the facility is to release defendant, the facility SHALL NOTIFY:

a. The local mental health director or designee
   Name _____
   Address _____
   Phone _____
b. Counsel for defendant (If unknown, send in care of court)
c. Prosecuting attorney
d. Person in charge of the jail
   Name _____
   Address _____
   Phone _____, who shall send for, take,

and receive the defendant back into the jail to be held there for further order of the above court.

DEFENDANT IS A SENTENCED PRISONER ☐

Sentence expires on _____

If the facility is to release defendant prior to the expiration date of sentence, the facility SHALL NOTIFY:

a. The local mental health director or designee
   Name _____
   Address _____
   Phone _____
b. Counsel for defendant
c. Prosecuting attorney
d. Person in charge of the jail
   Name _____
   Address _____
   Phone _____, who shall send for, take,

and receive the defendant back into jail to be held there pending expiration of sentence.

SHOULD PROCEEDINGS AGAINST DEFENDANT BE DISMISSED OR DEFENDANT'S SENTENCE EXPIRE WHILE IN THE FACILITY, DEFENDANT MAY BE DISCHARGED DIRECTLY.

NOTICE REQUIRED

If treatment is approved by the PERSON IN CHARGE OF THE JAIL, notice must be sent to:

a. Each court in which proceedings against the defendant are pending

If treatment is approved by a JUDGE, notice must be given to:

a. Counsel for defendant
b. Prosecuting attorney

DISTRIBUTION

a. Original to be transmitted with defendant to facility
b. Copy to be sent to each court in which proceedings against defendant are pending

APPENDIX III

Provisions of the Lanterman-Petris-Short Act Applicable to Prisoners Referred Under PC 4011.6

The Lanterman-Petris-Short Act (LPS) ended the indeterminate judicial commitment of the mentally ill in California. The Act substituted specific criteria which must be met before a person can be treated against his will and established fixed periods of involuntary treatment ranging from 72 hours to one year.

To be held for involuntary treatment under LPS, a person must be, as the result of a mental disorder, impairment by chronic alcoholism, or addiction to narcotics, either

- A danger to others
- A danger to himself

or

- Gravely disabled

(Grave disability is defined as a condition in which a person is unable to provide for his basic personal needs for food, clothing, or shelter.[1])

The following provisions of the Act apply to prisoners referred to treatment under Section 4011.6:

Article 1 (commencing with Section 5150) **Detention for Evaluation and Treatment**

Any person referred to a mental health facility by a peace officer or designated member of an attending staff may be evaluated and treated for up to 72 hours if the treatment staff determine that the person is a danger to himself or others or gravely disabled.

If the person is *not* a danger to himself or others or gravely disabled, he must be released from the facility unless he is willing to accept treatment voluntarily.

[1] The definition of grave disability was amended in 1974 to include persons who have been found incompetent to stand trial under Section 1370 of the Penal Code and who have been charged with a crime involving harm or the threat of harm to another person. This provision affects relatively few persons.

A court hearing need not be held in order to detain a person for 72-hour evaluation and treatment.

Article 4 (commencing with Section 5250) **Certification for Intensive Treatment**

If a person held for 72 hours has not sufficiently recovered for release, remains a danger to himself or others or gravely disabled, and refuses to accept treatment voluntarily, the facility may "certify" him for up to 14 days of intensive treatment.

No court hearing is required, but the person must be informed of his right to obtain judicial review by writ of habeas corpus.

If the person has threatened or attempted suicide (either before or during treatment) and presents an imminent threat of taking his own life, he can be held for an additional 14 days, a total of 28 days beyond the 72-hour evaluation.

Article 5 (commencing with Section 5275) **Judicial Review**

Any person involuntarily detained for 14-day certification has the right to obtain a court hearing for release from treatment by writ of habeas corpus. Failure of any staff person to communicate a patient's request for release to the superior court is a misdemeanor.

Article 6 (commencing with Section 5300) **Post-Certification Procedures for Imminently Dangerous Persons**

If a person who has been treated for 14 days has threatened, attempted to inflict, or inflicted physical harm on another person (either before or during treatment) and presents an imminent threat of substantial physical harm to others, he may be treated for up to 90 days.

A hearing is required, at which the person has the right to be represented by counsel and to a jury trial. In order for the person to be held for post-certification, the jury must unanimously find that the person presents an imminent threat of substantial physical harm to others.

Napa County Department of Corrections

NAPA COUNTY

DEPARTMENT OF CORRECTIONS

1125 THIRD STREET • NAPA, CALIFORNIA 94558
AREA CODE 707/253-4401

BRENDA HIPPARD
DIRECTOR

SPECIAL NATIONAL WORKSHOP ON MENTAL HEALTH SERVICES IN JAILS

I. The Napa County Community Mental Health Department recognizes as its responsibility, service to the entire community, especially to those segments of the community considered "high risk". It has been well documented and generally recognized by jail administrators that a large percentage of people incarcerated in correctional facilities have severe mental health problems.

The Napa County Department of Corrections is a local agency charged solely with jail management. Under the California State Government Code, Section 23013, the Board of Supervisors, by resolution, established a county department of corrections on June 10, 1975. At the time and until October 1, 1978, Napa County has the only county jail administered and staffed entirely by non-sworn, non-law enforcement personnel.

Napa County established a policy of humane inmate treatment, including comprehensive mental health services as the foundation philosophy of the Department of Corrections. At the inception of procedures for the new jail, the County Mental Health Department provided mental health staff, specifically crisis response workers, to attend to the needs of the inmate population. Through development of procedures based on the recognition of existing needs, the service to the jail has become more formalized culminating in a direct multi-service approach which pivots on a liaison staff person assigned directly to the criminal justice system.

Since October 3, 1977, the program has included:

Staff	Assignments
Two Mental Health Liaisons	Screening, consultation, crisis counseling, liaison, coordination of services
Outpatient psychotherapists	Individual and group therapy

Psychiatrist	Consultation, evaluations for medications
Crisis Service	24 hour crisis intervention, consultation, evaluations for involuntary hospitalizations

The intent of the Community Services Division of the Napa Mental Health Department is to upgrade the skills of people in the community in order to deal effectively on a daily basis with the client population, to, in fact, upgrade the general mental health of the community. Through consultative services to and training for the jail correctional personnel, the intent is to create within the jail a more healthy milieu, a place to identify new problem people and to follow up on previous clients. In addition, by having a liaison consistently present in the jail, some persons who would not otherwise seek the help offered in the community have an opportunity of a positive encounter with the mental health services.

Presently, through cooperative efforts of the administration of both the mental health and corrections departments, there is a move to institutionalize this program. With continued strong administrative support, in another year the program may develop its own verity. Policy and procedures manuals are being developed by both agencies incorporating mental health services to the jail as top priority with other specialized services and needs. It is also hoped that in the future specific county funding will insure the program's continued existence. County officials often demonstrate acknowledgement and acceptance of programs through the budget process.

It must be acknowledged however, at this moment, that the fine service that inmates of the Napa County Jail receive is by courtesy and cooperation of individuals employed throughout the Napa County administration, Napa's criminal justice system, the Mental Health Department and several private service agencies. Should some of these individuals withdraw, the program may be hard put to continue.

II. Demographics

A. Current Jail Population: Capacity 60

Male	Female
58	4

B. Racial Distribution

Anglo	Black	Mexican-American	Other (Am. Indian)
82%	2%	13%	3%

C. Mentally Ill

Approximately one-fourth of the current jail population is in therapy. At least one-half have been identified and have had contact with mental health staff. All mentally ill inmates are held in the jail unless code criteria is met (harmful to self, harmful to others, gravely disabled).

D. Mentally Retarded

Less than one percent normally. None today. The arresting agencies provide identification procedures and screening of their own and seldom bring what they determine as mentally retarded offenders to jail. They primarily commit mentally retarded offenders to the state hospital.

E. Pretrial Population: 29

Sentenced Population: 33

F. Total Bookings 1977/78: Approximately 2,175

G. Budget

1. Jail Operations: FY 1977/78: $797,866.00
   FY 1978/79: (proposed) $701,332.00
2. Jail monies for Mental Health: $ 0.00

3. Source of funding: Mental Health staff of liaison, psychiatrist, two counselors and crisis staff time is "bootlegged" from the Mental Health Community Services budget. As job descriptions and task analyses are developed with the Mental Health Department, a portion is considered as "service to the jail". No specific grant funding has been received from the state, although applications are now in progress.

The Mental Health Department administration, through coordination and program management, has so far been able to provide the needed services without expanding personnel and budget.

H. Community

Napa County, situated in the northern part of the San Francisco Bay Area, is 758 square miles. Its most prominent geographic feature is the Napa Valley, which contains the county's four incorporated cities surrounded almost exclusively by vineyards. The mountain ranges surrounding the Napa Valley have elevations up to 4,400 feet and are a major recreational resource for the entire San Francisco Bay Area. Lake Berryessa, in the northeast portion of the county, is the single most significant recreational attraction.

Through the Napa Valley, north-south, runs a single highway which bears the major source of valley traffic, both locals and tourists. The jail population's nearly one-half drunk driving offenders may be attributed to several law enforcement agencies (State Highway Patrol, Sheriff's Office, three police departments) converging responsibilities.

Although Napa County is the least populated of the nine Bay Area counties (91,700), its total population increased by 12,560 or 15.9% between 1970 and 1977, making it the third fastest growing county in the area. The City of Napa posted the largest absolute population increase: 12,422 or 34.5%.

Napa's community is primarily caucasian with Spanish/American persons making up the largest minority population. The jail population reflects the racial mix of the countyproportionately. The jail is rather new, only two and one-half years old, and was built small to enhance the community's interest in developing viable alternatives to incarceration. There is also an active attempt in this community to consolidate services with the elimination of overlaps through official encouragement of cooperation among agencies. Especially important is the focus on the cooperation of all the criminal justice agencies toward more efficient and effective service.

III. Services

A. Mental Health personnel, corrections personnel, probation officers and private counselors all provide mental

health services to the jail population. A Corrections Resource Team was created to provide staffing for multi-problem inmates. The Team includes, at its nucleus, the Mental Health Liaison, a correctional officer, a jail nurse, two probation officers (assigned to the jail), a representative from a private alcohol counseling program (N-CAP), the director of the Community Justice Program (Volunteer Bureau), and a representative from a private community drug rehabilitation program. The Team receives referrals from any of its members.

Formalized and traditional mental health services are provided by Mental Health professionals. Additionally, corrections officers are expected to identify needs and problems in inmates, discuss and plan treatment with the professionals and carry out appropriate "treatments". Treatment plans and housing classifications are used whenever possible to replace chemical therapies. Counseling and therapy is provided in groups or individually and occasionally by outside professionals through special contact visitations.

Besides the six core mental health professionals, and the several private representatives, the twenty correctional officers are the providers. Thefacility's policy of integrating male and female staff and male and female inmates in and of itself is considered a direct mental health service with creditable results.

B.&C. Procedure

1. Crisis Intervention: Any nurse or officer who identifies an inmate as needing mental health counseling will notify the Supervising Correctional Officer. Any inmate may bring mental health service attention to himself/herself by request. The Supervising Correctional Officer will be responsible for determining if the situation is an emergency such that the Crisis Service should be contacted immediately; e.g., possible Napa State Hospital commitment, suicide, extreme agitation, depression. Cases determined not an emergency will be referred daily to the liaison for contact at 2:00 p.m. Only the Supervising Correctional Officer on duty, or their designee, should call the Crisis Service. Any time the Crisis Service is called, the Supervising Correctional Officer must log it in the medical log, make an incident report, and be sure a copy is distributed to the nursing staff. Calls to Crisis Service should include some identifying data about the situation requiring attention by Crisis Service staff.

2. Consultation: The liaison's major role is consulation and education. When the Crisis Service is called by the Supervising Correctional Officer, part of their responsibility will be to consult with the referring Supervising Correctional Officer. This interaction will then be logged. A plan is developed by staff and logged. The next morning the liaison will be informed of this interaction. Continued contact will be coordinated by the liaison.

3. Individual Therapy: This will be provided on a limited basis. Referrals should be made through the liaison. The basic approach will be short term psychotherapy, to include drug counseling.

Crisis Counseling: The liaison will accept all referrals for crisis counseling. This approach is six session counseling provided to people in an actual life crisis by liaison.

Group Therapy: Referrals for either group can be made through the liaison or directly to the group workers.

Men and Women's Group: Wednesdays, 10:00 a.m. to 11:30 a.m. The focus of the group is to provide a supportive environment in which participants can air any subject of concern; i.e., stress of incarceration, separation anxiety, depression, future goals, substance abuse, etc.

Women's Group: Thursdays, 9:45 a.m. to 11:00 a.m. Open to all women inmates. Focus of the group will be to confront issues unique to incarcerated women.

4. Person may be referred to Resource Team for multi-problem staffing.

5. Psychotropic Medications: Referrals should be made to the psychiatrist through the liaison or nursing staff. Many symptomatic problems are the result of incarceration; i.e., loss of sleep, anxiety, etc. and are to be expected. However, if there is concern regarding a particular person's behavior, please make the referral. The psychiatrist will determine which people are appropriate for medications.

IV. Training

All jail staff are trained to identify and work with mental health problems. There is a fairly new staff/psychiatrist group once a week which provides the opportunity for individual officers to consult directly with a psychiatrist regarding concerns of clients. Other than this one and one-half hour session, training takes place in an on-the-job informal manner through daily contacts with the liaison. More formalized training will be provided in the future as funding becomes available and as appropriate training curriculum is developed.

V. Management

The mental health-jail program has enhanced jail and jail personnel security and has facilitated many parts of jail operation. Although the jail is considered a maximum security facility, it is operated in an "open" manner. It is policy to encourage all supportive social service programs to make use of the time the inmate-clients spend in jail. Therefore, counselors, both public and privately employed, are welcome on a daily scheduled basis after an initial security background verification. The primary goal of the "open" program is to service the minimum needs of the inmates in the Maslovian manner allowing inmate energy to be available to focus on rehabilitation activities. In this manner, volunteers make outside contacts for concerned inmates, the facility provides modern jail comfort, the officers treat the inmates with a dignified and respectful attitute (generally reciprocated) and by the time counselors begin their therapy, the inmate usually can find the energy to pay attention and participate. The jail, in turn, benefits from all this by having to manage much calmer, less angry inmates. In our two and one-half years, we have had virtually no jail destruction and very minor and infrequent inmate violence. We find occasional minor drug contraband (marijuana, home brew, pills), but very much less than might be expected with so many non-jail personnel coming in and out daily. Since we also run work furlough and outside trusty programs out of the jail, it becomes astonishing that we have so very little contraband.

There are problems, however, in time management. Scheduling becomes a major problem so that programs do not overlap or that major jail operations such as meals and court movements are not interfered with. The facility, too, was not designed with such an open program in mind. There is virtually no counseling area available so that mental health counselors most often meet clients in the multi-purpose room, where other sessions may also be in progress.

Confidentiality is based on an honor system and is managed by the least obnoxious proximity.

Another problem experienced by the jail personnel is that a great deal of energy is necessarily expended by them toward counseling and non-violent behavior control for which they have not been adequately trained. They are asked to exhibit great patience and presence of mind when dealing with unruly inmates. There are very few immediate rewards for exemplary behavior. In the long run, the pay-offs are there in that no staff has been injured or that inmates later become easily handled. Staff education and training, as well as screening for hiring, become extremely important. There is an added necessity of diverting persons who want to develop traditional law enforcement careers away from a department that is solely detention.

Mental health services are meeting with correctional staff now in an effort to train the corrections officer in the needed counseling and crisis intervention techniques. Training money from both Mental Health and Corrections will be applied to hire trainers if necessary. However, the existing mental health staff will, as a priority, be used first.

VI. Facility Description

This facility was opened for inmate housing and as a new department on February 6, 1976. The Law Enforcement building was built to house the Sheriff's Office on the first floor, the Municipal Court, District Attorney and Probation on the second floor, and the 60-bed jail on the third floor.

The jail was designed to provide the maximum number of individual cells possible. The inmate housing units are situated on the building perimeter and are provided with security windows for access of natural light. Throughout the facility, the wall paint varies through several pastel shades and most floors (hallways, dining room and office) are carpeted to reduce noise level.

Indoor recreation, meals, library and counseling takes place in the multipurpose room. There is a folding wall that enables the room to be cut in half so that more than one group activity can take place at one time. There are movable tables and chairs throughout the room which may be arranged to suit the activities.

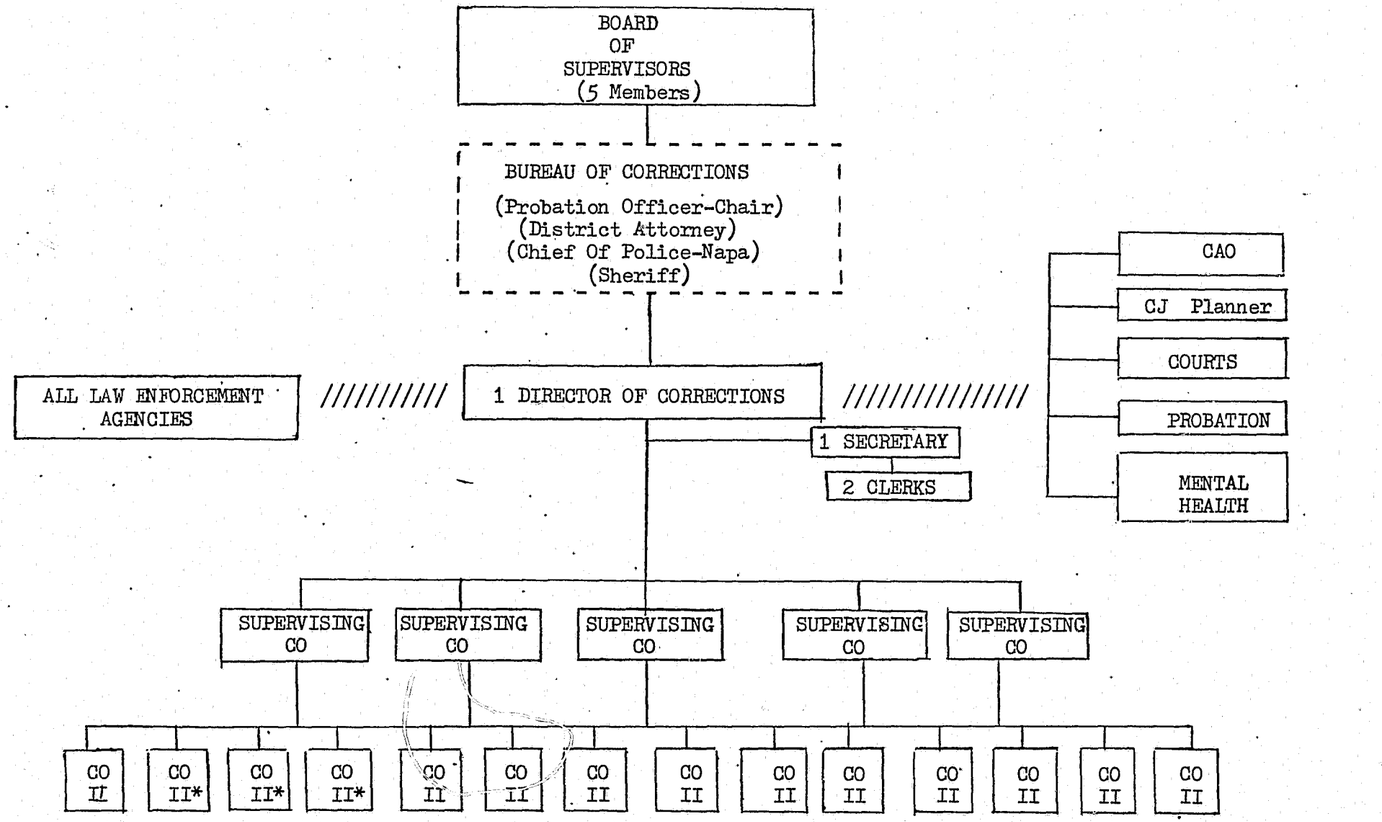
Within the basic facility design, no housing area is really much different than any other in the traditional jail

sense for segregation, for discipline or protective custody. An added burden is placed on the jail operations and prisoner management to be creative and flexible and to work with counseling rather than force. This we see as both an advantage and a disadvantage that make mental health services to both inmates and staff essential to our program.

BMH/dh

DEPARTMENT OF CORRECTIONS

(ORGANIZATIONAL CHART
AND AGENCY RELATIONSHIPS)



COI will qualify as COII
during FY 78/79

LEGEND:
DIRECT AUTHORITY= _____
ADVISORY = - - - - - -
COORDINATION = ////////

IND.
IND.
IND.
IND.
ISOLATION
4 Beds
8 man Day Room
4 BEDS
4 BEDS
8 man Day Room
4 BEDS
IND
Day Rm
IND
IND
8 man
Day Room
IND
IND
IND
IND
8 man
Day Room
Multi-Purpose
Visiting
Public Lobby
Visiting
Exercise Yard
(outdoors)
Dining
Office
FEMALE
DAY Rm
IN
IN
IN
IN
Day Rm
IN
IN
8 man
Day Room
IND
IND
IND
IND
Kitchen
ADMINISTRATION
Jail ELEV
Booking
Safety Cell
School Room
JAIL
Infirmary
8 man
Day Room
IND
IND
IND
IND
Holding
Holding
Laundry + Storage
MEDICAL EXAM.

SERVICE DELIVERY MODEL

Monmouth County Correctional Institution
Freehold, New Jersey

I. Program Introduction

A. A definition of "mental health" in our jail includes but is not limited to the following:

1. Continuity of care with community agencies. A mental health aid to give us the capability of planning medical, psychological, and social services for most of the inmates that the team serves.

2. Markedly decrease the incidence of delirium tremens.

3. See that psychiatric medications are used more effectively.

4. Training of jail correction and nursing staff.

5. Decrease the incidence of acting out in the jail among inmates treated by the mental health team.

6. Standardize procedures for transfer and return of inmates to and from State psychiatric hospitals, and develop a liaison system for sharing of information.

7. Help improve classification procedures for inmates (housing, work, etc.) served by the team.

B. Several studies and evaluations of the jail population as early as 1970 proved that the acquisition of psychiatric service for the jail of a design incorporating and involving correctional personnel (training, support, consultation, etc.) would enhance staff interest, skill, and, it is hoped, attitude, ultimately conditioning more humane treatment and greater institutional rehabilitative properties.

On June 1, 1971, the Board of Chosen Freeholders of the County of Monmouth designated the State Marlboro Psychiatric Hospital as the hospital to which a Municipal or County Judge may commit a person for observation, examination, or treatment. My membership to the Professional Advisory Committee (P.A.C.) of the County Mental Health Board (M.H.B.) in 1973 enabled me to regularly attend monthly meetings with other professional members and educate them as to the mental health needs of the confined offenders. After developing a rapport with the Community Mental Health Center and the County administrator in charge of funding, a budget was established to develop a mental health program at the jail.

During 1974 the Freeholders provided $25,000 to the County Mental Health Board who in turn would fund the Community Mental Health Center to provide service to the jail. On November 1, 1974, the psychiatrist and a psychiatric social worker began working at the jail on a regular basis. Two years later, 1977, the budget was increased to $35,000 and a third member (mental health aide) was added to the team.

C. Program Objectives

1. The appropriate provision of psychotropic medications to prisoners.

2. Aiding the jail physician in the management of difficult psychiatric cases, including transfer to a State Psychiatric Hospital.

3. Increase correction officers' skills in the recognition and management of emotionally troubled inmates.

4. Establish a continuous system of care for men and women served by the program, one that will enable efficient and effective use of community mental health and social service agencies during and after their incarceration.

5. Intervene clinically to prevent or limit severe emotional disturbance in the jail population.

6. Crisis intervention work with inmates and officers.

7. Group therapy
   a. An aftercare group for inmates with psychotic diagnosis.
   b. An insight-oriented group for men who have had trouble controlling violent and self-destructive impulses.
   c. A community meeting group for the female prisoners in the jail.

D. The Community Mental Health Center is responsible for hiring members of the team. Also, they have the option to add to the staff members not requiring additional salary (i.e., interns, community agency workers, etc.).

II. Demographics

A. Jail Population (8-30-78)

Female	30	40 (maximum capacity)
Male	280	285 (" ")
Total	310	325 (" ")

B. Racial Distribution

Anglo	45%
Black	53%
Mexican American	0
Other	2%

C. Current Jail Population Mentally Ill: 10-15%

D. Current Jail Population Mentally Retarded: 3%

The health team gets data for items C and D from continuous evaluation of the jail population.

E. Pretrial Population: 68.5%
Sentenced Population: 31.5%

F. There were 4,347 people booked into the jail during 1977.

G. Budget

1. Total jail budget for 1978	$512,225
2. Jail expenditures for M.H. (RN's 1/3 time)	3,810
3. Board of Chosen Freeholders fund M.H. (1978)	35,000

H. Community

1. Monmouth County population 1978, approximately 531,950 (35 boroughs, 2 cities, 15 townships, and 1 village, primarily suburban-rural with 26 miles of coastline).

2. County government consists of five elected Freeholders.

3. Program volunteers consist of church men and women and community agencies.

4. Seashore vacation county with a large recent influx of year-round single family units. (Some light industry).

5. Commitment contracts with U.S. Army (females), federal prisoners, immigration, postal authorities, and females from an adjoining county.

6. The major jail problem is the youthful offenders (18-25 years) and the social problems this group brings with them into the criminal justice system. Overcrowding is also a slight problem in that inmates find it difficult to adjust when tension rises. Community social service agencies have become more receptive to providing service to inmates now than they were several years ago.

III. Services

A. Sheriff's Department: one nurse (RN), approximately 1/3 time
Mental Health Center: psychiatrist, psychologist, mental health aide
Human Service provides at no cost a social worker (MSW)

B. Correction officers have been trained to recognize and refer on a Mental Health Observation Report inmates in need of service. Referrals are also accepted from family, friends, lawyers, physicians, and in some cases referrals come from judges, police, and community agencies. The inmate may also request to see someone from the team.

C. Once a referral has been made, a written observation report is forwarded to:

1. Correction officer coordinator for review and completeness.

2. The next step is to the psychologist who reviews and determines who of the team will handle the case. Crisis cases are reclassified immediately and the physician notified.

3. Treatment could be medication, individual or group counseling, or a change of living quarters.

4. Referrals would include a community mental health center after release, also, the involvement of the family who may be part of the emotional problem.

5. Suicide possibilities receive mental health counseling, medication prescribed if indicated, notification to the correction administration for reclassification. Suicide precautions are taken which consist of 15-minute checks and the inmate dressed in hospital gown when needed.

6. Commitment to a State Psychiatric Hospital if necessary. This step is decided by two doctors and a judge.

IV. Training

A. All correction officers receive mental health training as part of their inservice training. There are two officers who work in the medical wing daily and they are used for crisis intervention situations. Also, the booking officers are trained to recognize and refer new admissions in need of assistance.

B. Training is provided by the Consultation and Education staff member of the Community Mental Health Center. Also, the jail team members do OJT whenever possible.

C. Two two-hour intensive training sessions are held each year.

D. A spring and fall seven-week inservice training session provides all officers the opportunity to attend our formal classroom setting. Mental health is one of the seven classes offered the students.

V. Management

A. The program has reduced tension between inmates, among inmates and staff, and educated the officers to recognize and handle emotionally disturbed people. Many crises are now avoided with early diagnosis and use of psychotropic medication. The number of commitments to psychiatric hospitals has been reduced by 50 percent. There is less aggressive interaction between the officers and inmates with the presence of the mental health team, an age-old problem of jails.

B. The staff now can turn to the team and request assistance in handling aggressive situations. Inmates also can now request early intervention into their problem, thus avoiding conflict with staff. Early detection has been the keynote to the proper handling of security cases.

C. Positive Aspects

1. Carefully select a ranking officer to train and become the coordinator of the mental health program.

2. Encourage the coordinator to become involved in community mental health endeavors and project the corrections point of view to others.

3. Evaluate your jail population as to its specific unique mental health needs. Do not rely on other studies or statistics.

4. Educate both the officer staff and inmates that it is their program. Prove a strong position of confidentiality.

5. Include judges that program is in-house and gain their support.

6. Support for the program must come from the top down.

7. Begin the program small and slowly increase the service as experience is gained. Avoid as much paperwork as possible.

D. Negative Aspects

1. Training of the officers was first conducted by members of the mental health team. This proved a mistake--the staff challenged every point and used personal daily negative experiences as examples. It proved more successful to bring in qualified C & E instructors from the mental health center who do not have daily contact with the staff and therefore avoid personality conflicts during the classroom presentation.

2. Printed information was not codified for the inmates at the start of the program. The inmates had many questions and some apprehension about the validity of the program until a handbook was printed explaining the positive aspects of their mental health program.

VI. Facility

A. The jail is eight years old.

B. As this facility is fairly new, many cells and medical rooms were provided for us to develop both medical and mental health programs. There are 16 cells which are used for the mentally ill and for reclassification of emotionally disturbed inmates who otherwise would have to live with their stress in general population. It should be noted, however, that a mental health program can function in most jails regardless of the age of the facility. There is always at least one cell or room which serves as a place to speak with inmates or to separate by classification. Also, training of the corrections staff could be conducted away from the jail and their training used when handling the prisoner in the jail or during transportation.

VII. Attachments

A. State mental health code - not available

B. Jail inspection - enclosed

C. Jail standards - not available

D. Court orders from litigations - case still pending

E. Regarding "IV - Training" - enclosed

Conclusion

It is imperative when developing a mental health team to select a dedicated ranking officer from within the correctional staff. As security is the prime concern of all jails, the coordinating officer can control the direction the mental health team takes and avoid many of the conflicts and problems with both the inmates and jail administration. Also, a ranking officer has enough influence to work with community service agencies, county officials, and his own jail administration.

Nelson F. Stiles
Deputy Warden
Monmouth County Correctional Institution
Waterworks Road
Freehold, NJ 07728

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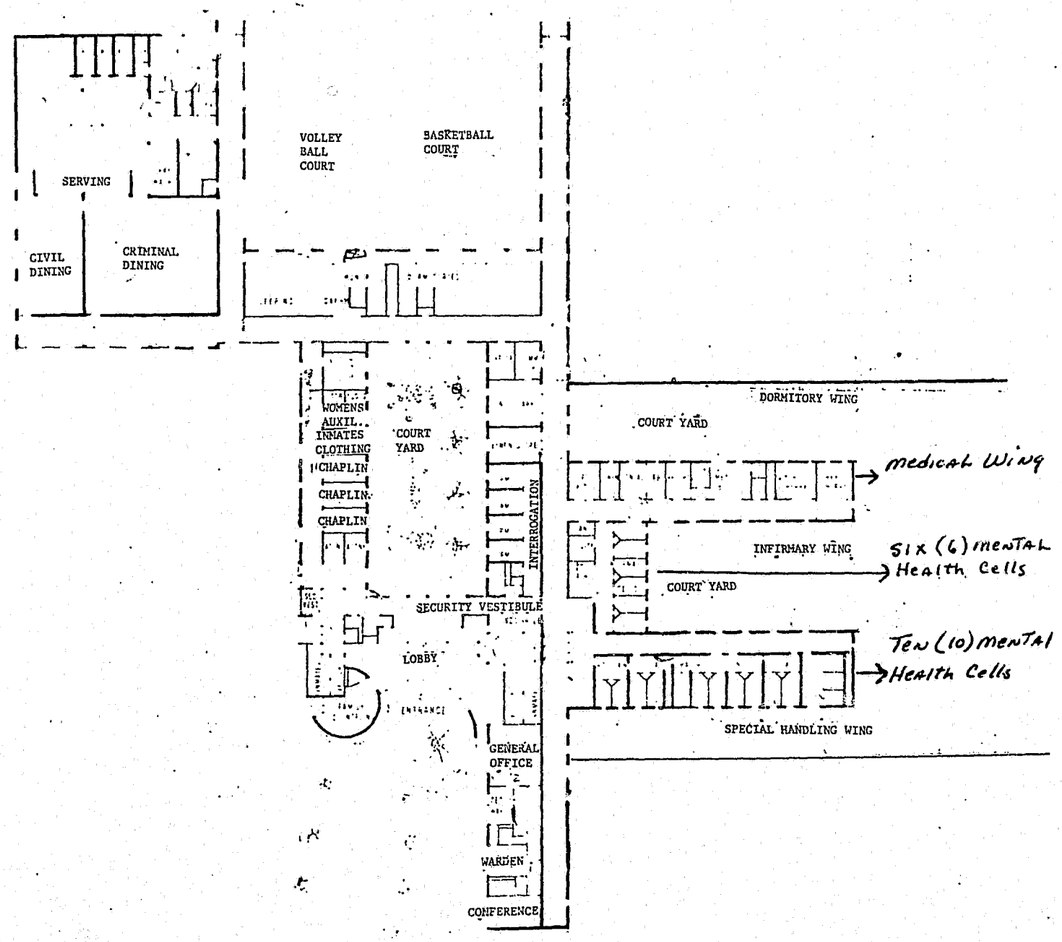


COMMUNITY MENTAL HEALTH CENTER

FITKIN HOSPITAL

1945 Corlies Avenue / Neptune / New Jersey 07753 / TELEPHONE / AREA CODE 201 / 775-5500

August 14, 1978

Deputy Warden Nelson F. Stiles
Monmouth County Correctional Institution
Waterworks Road
Freehold, New Jersey 07728

Dear Nelson,

What follows is an outline of the material I presented at April and May training sessions for correction officers of your facility. Each session was two hours in length.

I The Assessment - Management of the Suicidal Inmate
- A. Significant facts concerning suicide (rates, numbers of, common forms of)
- B. The relationship of suicidal behaviors to other life crises
- C. Commonly held myths about suicide
- D. Primary motivations in suicidal behavior
  1. Communication
  2. Ambivalence about life and death
  3. Intended effects on others
- E. Managing the crisis workers' own feelings
- F. Assessing the crisis
  1. Immediate steps to establish rapport and manage one's own feelings
  2. Factors influencing suicidal potential
     - a. Age and sex
     - b. Suicide plan
     - c. Precipitants of stress
     - d. Psychiatric symptoms
     - e. Available resources
     - f. Life style
     - g. Communication pattern
     - h. Reactions of significant others
     - i. Medical status
  3. Ranking factors

G. Managing the Crisis
   1. Gaining entry
   2. Ensuring safety
   3. Establishing rapport
   4. Offering help
   5. Mobilizing available supports
   6. The crisis workers' emotional "presentation of self"
   7. Making basic prognostic judgments

II The Assessment and Management of Inmates who are Seriously Mentally Ill
   A. Recognizing basic symptoms of severe mental illness (with emphasis in a county jail setting),
      1. Changes in observable behavior
      2. Disturbances in orientation
      3. Paranoid and grandiose behaviors
      4. Psychosomatic delusions
      5. Hallucinatory Behavior
      6. Dangerousness and Fear
   B. Organic versus functional psychotic behavior
   C. Handling disturbed and/or violent inmates
      1. Timing
      2. Involving significant others
      3. Maintaining your self-composure
      4. Avoiding undue excitement
      5. The pitfalls of coercion and lying to clients
      6. Posture, tone of voice, body language

I hope that we will be able to expand the content and format of the presentation and gear it toward training a cadre of crisis intervention specialists at the Monmouth County Correctional Institution.

If I can provide further information or an interview for the study, please let me know.

Sincerely,

Marc H. Levin, M.S.W., A.C.S.W.
Director, Consultation & Education

MHL:bem

SERVICE DELIVERY MODEL

Cuyahoga County Jail, Cleveland, Ohio

I. PROGRAM INTRODUCTION

A. How is "mental health" defined as it relates to the provision of mental health services in your jail?

Those psychotic and disturbed individuals who are delusional, hallucinatory or so severely depressed that they are in need of specialized care.

B. How did your program get started? Date when it got started?

1. The mental health program in Cuyahoga County is a direct result of a Federal class action suit, Sykes vs. Kreiger. The Federal mandate was as follows:
   a. An area shall be set aside within the County Jail for a psychiatric ward.
   b. Psychiatric screening of all inmates shall be conducted on a continuing basis.
   c. Observation and treatment of inmates of the Psychiatric Ward shall be governed by a written plan.
   d. The training of jail security personnel in the detection, observation and handling of psychiatric inmates shall be governed by a written plan.

2. The total program started with our move into our new Corrections Center in July of 1977.

C. What are the program's objectives?

The program's objectives include the following:

1. To facilitate the due process of the psychiatrically disturbed inmate. To stabilize the individual's functioning so that he can more speedily continue said due process.
2. To reduce the number of negative incidents that harm the welfare of the incarcerated mentally disturbed individual.
3. To reduce tension within the entire corrections facility by identifying and separating psychiatrically ill inmates from the remainder of the population.

D. If the personalities currently involved in the service-delivery change, what linkages exist to insure the continuation/institutionalization of mental health -- jail services?

The continuation of mental health services in this institution is assured for two reasons -- first, having to do with the Commissioners' involvement for the establishment of these services as part of the agency, Institutional Supportive Services, which was duly created and resolved to deliver mental health services among others. Secondly, is the fact of our mandated Federal court order.

II DEMOGRAPHICS

A. Current jail population: Number of female; Number of male; Number maximum capacity.

Our current jail population as of August 28, 1978 was a total of 692. This total consisted of 48 females, 640 males and 4 juveniles. The maximum capacity of this institution is 770. The total capacity is 890 which includes 120 holding cells for the City of Cleveland, thus leaving a capacity of 770 for county

inmates. The total, 692 is for county inmates. The city holding area fluctuates greatly each day.

B. Racial distribution of current population -- percentage of:

As of 8-28-78 -- Anglo .. 34%, Black .. 64%, Other .. 1%.

C. Approximate percentage of current population mentally ill?

Averages at 18%.

D. Approximate percentage of current population mentally retarded?

3.4% would be identified as percentage of current population mentally retarded. This percentage is determined through our screening process. It should be noted that a more specific program of identifying retarded persons is to be implemented in early 1979. A complete battery of tests will be given to those inmates who are "flagged" through our screening process. This information will serve as a base line for both the Court of Common Pleas, the Probation Department and the Board of Retardation to determine diversification placement of these individuals in the community.

E. Percentage of current population pre-trial? Percentage of current population sentenced?

Pre-trial -- 86.6% Sentenced -- 12.4%

F. How many people were booked into your facility last year?

7500

G. Budget:

1. Approximate annual expenditure for total jail operations -- $7½ million.
2. Not applicable.
3. $175,000 LEAA grant and general county funds.

H. Community:

1. Cuyahoga County is the largest county in Ohio with a population of 1.7 million -- the largest city is Cleveland with a population of approximately 600,000. It is a large urban industrial city experiencing inner-city blight and problems.
2. County government is run by a three man Board of County Commissioners elected to four year terms. The primary appointed official is the County Administrator. The county has an overall budget of $500 million.
3. Being a large urban county, we have universities with which we are involved, primarily for the use of student placements -- social work and psychology interns. We are presently involved in the operation of a program called "Street Academy" in which we utilize the volunteer services of a variety of agencies coming into the institution leading classes in areas related to jobs, health, etc. We have a senior citizen group assisting the social service department with social service requests primarily making phone calls.
4. See #1.
5. We have no formalized agreement with other counties. We do trade inmates with several neighboring counties depending on individual situations.

6. No unusual problems other than what one would expect in a general jail population. Our particular program as stated earlier came into being from a federal court order. We receive good support from our County Commissioners, but it would be difficult to assess the community attitude. We are experiencing positive attitudes from the community agencies with which we are interfaced.

III SERVICES

A. Who provides the mental health - jail services?

An independent agency under the Board of County Commissioners, Institutional Supportive Services consists of the Medical Department, Social Service Department and the Psychiatric Department. There is a great deal of overlap, but specifically, the present numbers of staff delivering mental health services in our jail are --

one part-time psychiatrist, and a full-time staff consisting of:
one psychologist
two psychiatric social workers
two mental health screeners
two Registered Nurses (RN's)
three LPN's
one physician's aide
one arts and crafts therapist

B. How is someone identified to be in need of mental health - jail services?

The identification of mental health problems occurs in two ways -- the initial procedure is through our screening process. After booking and processing, an individual is given a medical examination by a physician's assistant and then interviewed by our mental health screener. During this interview, a social history and mental health questionnaire are utilized as a guide in identifying any mentally disturbed individuals. Our classification system would identify these individuals as P1 or P2 (for psychiatric) and they would be seen by our psychologist or psychiatrist for determination of placement into one of our psychiatric units or for continued observation and counselling in other parts of the jail. The second major avenue of identification and referral is through our social service department by their daily coverage of the living units within the jail. In identifying an individual who is regressing or having difficulty and they are not able to counsel, referral for further determination of this individual will be made. Corrections Officers also make a number of referrals.

C. Refer to B. In addition, those with serious psychiatric disorders are immediately placed in the Psychiatric Unit. Others are placed on a waiting list or are assigned to areas of the population where they may be more closely observed.

IV TRAINING

A. Which jail staff are trained to identify and/or work with mental health problems?

All incoming Corrections Officers are given 4-6 hours of general classroom instruction on recognition and handling of the mentally ill. Corrections Officers in psychiatric units and staff are involved in weekly staff development and case conferences.

B. Who provides this training?

The psychologist on staff.

C. How many hours of training are provided?

See above.

D. How is this training accomplished?

Our Corrections Center has a training officer and assistant who run orientation programs for all new workers. We are included within this training program. There is no written curriculum.

V MANAGEMENT

A. How has the mental health - jail program affected security and jail operation?

Although it is difficult to be specific given the lack of base data in this area, it is very clear among the administrators of the jail that our program has a very positive effect regarding security in jail operation, primarily related to the reduction of tension, having previously had these individuals in general jail population. The knowledge of our presence for immediate referral and possible placement in our unit serves as a very relieving factor for the corrections staff.

B. How has the program affected personnel and inmate safety?

Again, the lack of base data does not allow us to give specific factors on the regularity of difficulties, fights, etc. that occur within a jail. We are presently assisting the Sheriff's Department in keeping weekly, monthly and yearly statistics on incidents within the jail. It is the impression of the older Corrections Officers that there has been a dramatic decline in incidents since our presence.

C. Based upon the successful experience of your program, what recommendations would you make for replication?

We would firstly recommend our classification system. Our experience to date is that it works, period. Its simplicity is effective in proper placement of inmates throughout our institution. Secondly, is the positive aspect of what we feel has been effective in our psychiatric services. The following is a brief description of our goals and services in the psychiatric area. I believe that this points out the major experience we have had and what we would maintain is realistic in primarily dealing with pre-trial detainees.

The goals of the psychiatric staff are limited and realistic. That which is of primary importance is two-fold: (1) to help the psychiatrically disturbed inmate to become sufficiently stable in order that (2) he may receive his due process. The inmates' homeostasis is accomplished by chemo-therapy and by the continual daily contact on the part of nurses, aides, correctional officers, and most especially, by two psychiatric social workers whose constant endeavor is to make sense to the inmate the enigmatic maze of the criminal justice system. These kinds of personal, one-on-one interventions utilize the one piece of reality available to the psychotic inmate. From this, all other parts of reality begin to come into focus. Energy is not

expended in "curing" the inmate, but instead directed toward stabilization and due process. These are the specific needs of the inmate and are the only aspects of their life presently with which they wish to deal.

Program and activity is also part of the Psychiatric Unit's daily schedule. Arts, crafts and recreation are an important part of the unit's daily routine.

For those who are retarded, whether in need of mental health service or not, a psychologist from a community agency spends an afternoon a week working with specific retarded inmates in a therapeutic mode. He also does testing when necessary in order to determine an I.Q. level as well as a level of functional skills. Here, too, the social workers serve as advisors to attorneys and the court in recommending and finding appropriate placement alternatives in the community for specific inmates. The social history questionnaire used as a tool in classifying all inmates contain specific "flag" indicators used to investigate further possible retardation and the level thereof. As previously stated, some retarded inmates are separated from the general population. This particular part of the screening process supplies us with more concrete evidence in determining how best to manage and house mentally retarded offenders. It also serves as base-line information for other aspects of the criminal justice system, namely the Probation Department and the Court of Common Pleas. Since incarceration of the mentally retarded offender provides unique problems for the Institution, the initial identification of such population will also serve as essential information for the establishment of Group Homes in the community for this special population, the plans of which are already in progress.

D. Based upon the negative experiences of your program, what problems can you identify and what recommendations would you make for lessening or avoiding these difficulties?

One of the major problems which we are still fighting is the role definition of the nursing staff and Corrections Officers as to who controls "the living unit". This was a very major problem for the staff in the beginning and still continues although not as a major obstacle. Another major difficulty but one without any recommendation for improving is the reality of the daily jail routines which our program must yield to such as visitation, court appearances, psychiatric evaluation by the Forensic Center of the court and outside others, etc.

VI FACILITY

How old is your jail?

Our move into the Cuyahoga County Corrections Center took place in July, 1977.

How does the physical design promote or inhibit the delivery of mental health services?

The physical design of the 4th floor booking area used for the screening process is excellent and the 24-72 hour holding area on the same floor enriches our classification system. Our psychiatric units are difficult to comment on in that the original designated areas (note MB and MC) were very inadequate since they have much smaller day room space than the regular housing pods of our institution. We now use regular housing pods and they have been adequate.

Enclosed is a diagram of the 6th floor, medical/psychiatric.

VII ATTACHMENTS

A. State mental health code.

Ohio has no specific state mental health code. We have Boards of Mental Health and Retardation which respond to state mandates and assist in the placement or mental health services and serve as a conduit for state, county and federal funds. One of our generalized mandates is to see that services are provided in the criminal justice area for the mentally ill, but as of this date, we receive no funds from them.

B. Jail inspection report.

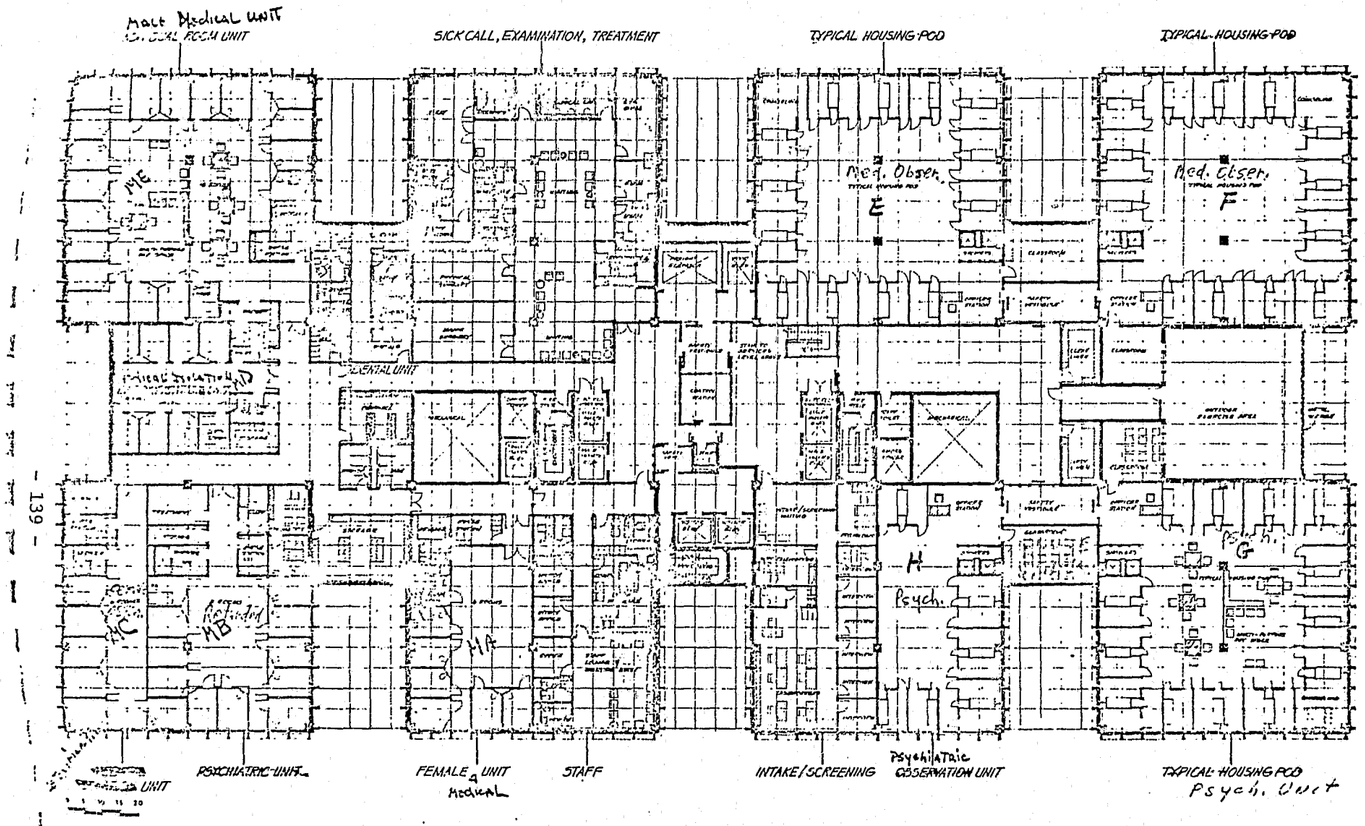
We have no official agency performing a jail inspection. Our Corrections Center developed its own jail inspection report by merely making questions out of the mandated court order requirements for the jail. See attachment #1.

C. State jail standards and enforceability.

State of Ohio, Department of Corrections last year assigned several individuals to inspect jails and came out with a standards manual. This has moved very slowly and to my knowledge still have no enforceability attached to their function.

D. Court orders resulting from litigation.

The Sykes vs. Kreiger litigation is attachment #1, merely changed to questions.



CORRECTIONS CENTER - LEVEL 4

CUYAHOGA COUNTY JUSTICE CENTER

PRINDLE, PATRICK and PARTNERS
ARCHITECTS : ENGINEERS : PLANNERS
STANDARD BUILDING 1370 ONTARIO STREET - CLEVELAND OHIO

46/54

CIMS/77127

CUYAHOGA COUNTY SHERIFF'S DEPARTMENT
GERALD T. MCFAUL, SHERIFF

NAME _____ SO# _____

A. STATUS	SENTENCE / NON-SENTENCE		JUV. / MALE FEMALE	FEMALE / MALE
B. SECURITY	S 1	S 2	S 3	S 4
C. MEDICAL	M 1	M 2	M 3	M 4
D. PSYCHIATRIC	P 1	P 2	P 3	P 4

REASONS WHY: _____

CLASSIFICATION/RECLASSIFICATION	POD DESIGNATION/DATE	APPROVED CLASSIFICATION OFFICER

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NAME_____ DATE_____ INTERVIEWER_____

CUYAHOGA COUNTY SHERIFF'S DEPARTMENT
GERALD T. MCFAUL, SHERIFF

MENTAL HEALTH QUESTIONAIRE

I HAVE:

	In past 2 years	More than 2 yrs. ago	Never
Taken medication for nerves			
Had severe headaches or dizzy spells			
Gotten in trouble because of my drinking			
Gotten along well with my Father			
Trouble getting along with other people			
Been addicted to drugs			
Gotten along well with my Mother			
Purposely hurt myself			
Thought I was going crazy			
Had trouble keeping my mind on things			
Gotten in trouble because of my sexual behavior			
Been on methadone			
Had a nervous breakdown			
Trouble controlling my temper			
Had treatment for alcholism			
Been in mental hospital			
Had fainting spells, seizures, blackouts, DT's			
Tried to kill myself			
Felt someone was controlling my thoughts or what I was doing			
Been in a drug treatment program			
Had periods of feeling very depressed			
Had people tell me they thought I was crazy			

P-1

IMMEDIATE PLACEMENT IN ACUTE PSYCHIATRIC UNIT

... Overt psychotic behavior; i.e., delusional, hallucinatory, thought disorder, severe depression.

P-2

CONSIDERATION FOR PLACEMENT IN PSYCHIATRIC UNIT

... Returnee from Lima

... When appropriate, inmates with prior hospitalization or institutional history (mental or retarded)

... Needing further protected evaluation:

1. Suicidal
2. Depression
3. Questionable diagnosis

P-3

CONSIDERATION FOR COUNSELING SERVICE

... Anxiety (anxious)
... Fearful
... First offender
... Withdrawn
... Behavioral problems

P-4

NO PSYCHIATRIC CONSIDERATION

AREA DESIGNATE MEDICAL

M 1	Needs immediate hospitalization
M 2	Hospitalization recommended or placement in med. pod
M 3	Medical consideration or observation recommended Ongoing medical involvement, not impairing general population placement or maximum placement
M 4	No medical consideration

CLASSIFICATIONS SECURITY

MAXIMUM CUSTODY

S-1

1. Extreme escape risk, has escaped from custody before, has voiced such threats.
2. Extremely assaultive, has assaulted officers and/or inmates before.
3. Extremely belligerent, very likely to be assaultive or aggressively homosexual.
4. Extreme agitator or conniver endowed with leadership qualities who has caused trouble with various groups before. Has organized inmate demonstrations in the past.
5. Extreme homicide risk.
6. Has one or more detainers lodged against him/her.
7. Evidenced emotional instability.
8. Has committed a legally chargeable offense within the institution.

CONTINUED

2 OF 3

CLASSIFICATIONS SECURITY

MEDIUM CUSTODY

S-2

1. Assaultive on occasions.
2. Unstable background - no family ties.
3. Poor work record.
4. Second or Third offender - felony offenses.
5. Chronic supervisory problem -- commits felonies. Offenses: stealing, fighting, etc.
6. Possible escape risk.

CLASSIFICATIONS SECURITY

MEDIUM

S-3

1. Very weak and submissive.
2. Very fearful of bodily harm.
3. Chronic supervision problem -- commits nuisance offenses.
4. History of repeated offenses -- misdemeanor offenses.
5. Unstable background -- poor family relation and history of migratory.
6. Chronic follower of inmate leader and causes.

CLASSIFICATION SECURITY

MINIMUM

S-4

1. First offense - non violent crime.
2. Naive and non-sophisticated.
3. Stable background -- family and work history.
4. Able to work as a trustee, with apparent strong ties to family and community.
5. Not an apparent escape risk.
6. Not an apparent homicide risk.
7. Evidenced emotional stability.
8. Prior good behavior record while incarcerated.

GTMC/77130

S. ____
A. ____
MC. ____

SCREENING QUESTIONNAIRE

R. ____

1. NAME: _____

   ALIAS (OTHER NAMES USED): _____

2. ADDRESS: _____ CITY: _____

3. DATE OF BIRTH: _____ CITY OF BIRTH: _____

4. PHONE NUMBER: _____ SOCIAL SECURITY NO.: _____

5. MARITAL STATUS: (check one) MARRIED ____ DIVORCED ____ COMMON LAW ____ SINGLE ____ SEPARATED ____

6. NUMBER OF CHILDREN YOU HAVE: _____

7. HOW LONG HAVE YOU LIVED IN CLEVELAND? _____

8. DO YOU LIVE WITH YOUR FAMILY NOW? YES _____ NO _____

9. IF YOU HAVE A FAMILY, ARE YOU SUPPORTING THEM NOW? YES ____ NO ____
   (IF "YES", HOW MUCH ARE YOU SUPPORTING THEM? COMPLETELY ____ PARTLY ____)

10. IF YOU HAVE A FAMILY, ARE YOU NOW SUPPORTED BY THEM? YES ____ NO ____
    (IF "YES", HOW MUCH ARE THEY SUPPORTING YOU? COMPLETELY ____ PARTLY ____)

EDUCATION:

11. ARE YOU GOING TO SCHOOL NOW? YES _____ NO _____
    (IF "YES", CHECK ONE: FULL-TIME _____ PART-TIME _____)

12. DID YOU GRADUATE FROM HIGH SCHOOL? YES _____ NO _____

13. WHAT WAS THE HIGHEST GRADE IN SCHOOL THAT YOU FINISHED? _____

14. WHAT IS THE NAME AND LOCATION OF THE LAST SCHOOL YOU ATTENDED? _____

    _____

WORK:

15. DID YOU HAVE A REGULAR JOB WHEN YOU WERE ARRESTED? YES ____ NO ____
    (IF "YES", CHECK ONE: FULL-TIME _____ PART-TIME ____)

16. HOW LONG DID YOU WORK AT YOUR LAST JOB? _____

17. WHAT IS THE NAME AND ADDRESS OF YOUR LAST EMPLOYER? _____

    _____

FAMILY:

18. HOW OLD WERE YOU WHEN YOU LEFT HOME? _____

19. WERE YOU LIVING WITH YOUR REAL PARENTS BEFORE LEAVING HOME? YES ____ NO ____

20. HAVE YOU LIVED IN ANY PLACES BESIDES HOME (E.G., FOSTER HOMES, GROUP HOMES, DETENTION HOMES, PRISONS, HALF-WAY HOUSES)? YES ____ NO ____
    (IF "YES", WHERE AND FOR HOW LONG?): _____

    _____

    _____

21. WHY DID YOU LEAVE HOME?

SELF:

22. ARE YOU IN GOOD HEALTH? YES ____ NO ____

23. HAVE YOU HAD ANY OPERATIONS, SICKNESSES, OR SERIOUS ACCIDENTS IN THE PAST FIVE (5) YEARS? YES ____ NO ____

24. HAVE YOU EVER BEEN SHOT OR STABBED? YES ____ NO ____

25. HAVE YOU EVER BEEN SERIOUSLY HURT IN A FIGHT? YES ____ NO ____

26. HAVE YOU EVER BEEN IN MILITARY SERVICE (E.G., ARMY, NAVY)? YES ____ NO ____
(IF "YES", PLEASE TELL
1. WHEN: _____
2. FOR HOW LONG: _____
3. WHAT KIND OF DISCHARGE YOU RECEIVED: _____)

27. DID YOU DO TIME AS A JUVENILE? YES ____ NO ____
(IF "YES", PLEASE SAY WHERE & FOR HOW LONG: _____)

28. HAVE YOU DONE TIME AS AN ADULT? YES ____ NO ____
(IF "YES", PLEASE SAY WHERE & FOR HOW LONG: _____)

29. ARE YOU NOW ON PROBATION OR PAROLE? YES ____ NO ____
(IF "YES", CHECK ONE: PROBATION ____ PAROLE ____
(IF "YES", PLEASE GIVE P.O.'S NAME: _____)

30. WHAT ARE YOU CHARGED WITH NOW? _____

31. DO YOU EXPECT TO BE OUT OF JAIL SOON (WITHIN 2 WEEKS)? YES ____ NO ____
(IF "YES", PLEASE CHECK HOW: ON BOND ____ CASE DISMISSED ____
SENTENCE COMPLETED ____
SENT SOMEWHERE ELSE _____)

32. DO YOU HAVE A LAWYER? YES ____ NO ____
(IF "YES", PLEASE GIVE HIS NAME: _____)

33. WHAT IS YOUR BOND? _____

34. HOW DID YOU GET ARRESTED THIS TIME?

SERVICE DELIVERY MODEL

Whitman County Jail

SPECIAL NATIONAL WORKSHOP
ON MENTAL HEALTH SERVICES IN JAILS

Exemplary Program Description
Offender Services Coordinator
Whitman County, Washington

I. Program Introduction

A. The working definition of mental health in the Whitman County Jail is the absence of current psychotic or severe neurotic symptoms. Thus, the determination of the need for mental health services is based on observable behavioral signs of mental illness. (Appendix A, taken from the "Jail Health Care Policy and Procedures Manual" developed by the Offender Services Coordinator, lists symptoms and procedures for the jail staff.)

B. The need for more readily available rehabilitative and mental health services for jail inmates was recognized as a priority by the Regional Law & Justice Advisory Committee. The Sheriff developed a grant proposal to LEAA, and that proposal was approved in 1976. The program began actual operations on November 8, 1976, the date the coordinator was hired.

C. Grant support for the program ends October 31, 1978. At that time, the county will begin to fund 100% of the program budget, as an integral part of the Sheriff's Office jail budget. Also, at that time, the position will be converted to an administrative civil service position. Although this is no guarantee, it should aid the continuation of the program beyond the tenure of the current Sheriff and OSC.

II. Demographics

A. Current jail population: 10 male, 0 female, 35 maximum capacity.

B. Racial distribution of current population: 100% Anglo. Racial distribution of average population: 86% Anglo, 7% Black, 2% Mexican-American, and 5% Other (primarily Native American). The difference between the current population and the average is primarily coincidence; however, most of the non-Anglo population is drawn from Washington State University, which is presently not in session.

C. Using the above definition, 10% (one inmate) of the current population is mentally ill. As estimate of the average population would be slightly higher, perhaps 15-20%.

D. Percentage of current population mentally retarded: 0%. No formal screening has been done on current population. However, all were able to read and understand the intake questionnaire used by the OSC. One was considered in need of further assessment. The average percentage mentally retarded would be very low - less than 1%. Only two cases in two years have spent any significant time in this jail.

E. Percentage of current population pre-trial: 20%. Percentage of current population sentenced: 80%. Estimate of the average distribution

pre-trial vs. sentenced inmates: 50% - 50%. The distribution fluctuates greatly and the average is a rough estimate.

F. From September 1, 1977 to August 31, 1978, 263 persons were booked into Whitman County Jail.

G. Budget:

1. The 1978 budget for jail operations, is $26,056. This figure includes the OSC program budget for November and December only. It does not include the salaries of the dispatchers, who perform booking duties, or the deputies, who perform jailer duties, or the chief of services, who serves as the jail administrator, because the jail is only a small part of their responsibilities.

2. The OSC program budget for November - December 1978 is approximately $3,000. Another $3,000 is appropriated for all other professional services including medical and psychiatric services. Estimating one-third of this latter budget to be spent on mental health-related services, the approximate annual expenditure for mental health services is $4,000.

3. LEAA funding for the OSC program for the first year provided $26,000 and $20,000 in the second year.

H. Community:

1. Whitman County is a primarily agricultural county with a population of approximately 41,900. Almost half of that population is connected directly to Washington State University (WSU), a school of 16,000 students set in a small town of 4,000 year-round residents (Pullman). Other than that population concentration, the county is sparsely populated, having an area of almost 4,000 square miles.

2. County government, located in the county seat of Colfax, is headed by a three-member board of county commissioners. The Sheriff is directly responsible to the commissioners for the operation of the jail. He has two chief deputies under him, a chief of operations and a chief of services, who is also the jail administrator.

3. The following agencies are most closely relied on for referrals and assistance for clients: Whitman County Mental Health Center, Whitman County Alcoholism Center, C.E.T.A. Center, and Eastern State Hospital. To a lesser extent, many other agencies, including the following, have been used: WSU Human Relations Center, private psychologists, local ministers, Drug Abuse Treatment Coordinator, Spokane Community College, WSU Alcohol Studies Program, numerous residential treatment centers outside of Whitman County. (The OSC is currently applying for a grant which would establish a multi-disciplinary residential treatment center within the county).

4. The lack of major industries or vocational-technical schools in the area has been a negative influence on the total jail program. However, the lack of an urban atmosphere which usually accompanies such industries has been a positive influence.

5. The jail does house the long-term (30 days or more) sentenced prisoners from Asotin and Garfield Counties. These counties are even more rural and more remote than Whitman. A formal contract does not exist at this time, but the other counties do reimburse Whitman County on a per diem basis for inmates held in the jail. There is no difference in the services offered to out-of-county inmates other than the lack of otherwise available direct follow-up services.

6. The existence of a major university within the county no doubt has an influence on the community attitudes necessary to support a program of this type. The jail population, although certainly not free of "hard-core" cases, is relatively easy to work with. It is of a size which makes it possible to know each inmate personally and to keep abreast of any interactional problems that may develop. The small-town flavor of most of the county contributes to the ability to deal on a personal basis with employers, agencies, and significant others in a client's life. However, it also makes the problem of overcoming one's image as "bad" or "mad" a bit more difficult.

III. Services

A. Direct, in-house services are provided entirely by the Offender Services Coordinator, who is a non-commissioned member of the Sheriff's Office staff, under the supervision of the Chief of Services. A one-person operation is possible because it is operated on a "brokerage" basis, referrals being made to outside agencies for further treatment.

The exception to this is that 24-hour emergency service is provided to the jail (and the rest of the county) by the Whitman County Mental Health Center. Their mental health professionals (MHP's) are trained to identify and deal with mental health emergencies, particularly attempted suicides and psychotic episodes. They are also empowered to involuntarily commit a person to an evaluation and treatment facility for up to 72 hours under certain very specific circumstances. (The present OSC is also an MHP, providing these crisis intervention services to the county on a rotating on-call basis. Three other MHP's are on the mental health center staff.)

B. Mental health screening is first done by the booking officer as part of an initial intake health screening. (See Appendix B) Anyone suspected to be in need of immediate services is referred directly to the MHP on call. Others are referred to the OSC on the next working day, by either the booking or arresting officer, or anyone who suspects the need for services (such as probation officers, prosecutors, defense attorneys, etc.) Finally, everyone who spends approximately seven days in the jail goes through an extensive intake interview with the OSC to determine rehabilitative needs, including mental health. After the initial interview, participation in the program is voluntary.

C. Appendix A describes the process of referral to mental health services in detail. Often the procedure may be somewhat complicated by the need for security for certain individuals. Individual cases require certain different procedures. For example, a person who is clearly dangerous to himself or others as a result of a mental illness is normally immediately transferred to Eastern State Hospital by an MHP. However, if a person is

in need of non-emergency treatment and still has charges to face, the process may be more involved. The OSC may provide counseling on a regular basis, cooperating with the jail physician and a local psychiatrist on the supervision of possible medication. Meanwhile he may be working with the pre-sentence investigator to see if he can recommend further treatment as a condition of probation. Finally, and sometimes only with the approval of the Superior Court, a referral to an appropriate agency may be made.

IV. Training

A. All staff members are required to read the jail health care policy and procedures manual semi-annually and to attend semi-annual training programs in the identification and handling of mental health problems.

B. The OSC provided the first session of this training in cooperation with a local psychiatrist and the Whitman County Alcoholism Center. The second session, planned for this month, will be taught by programmed learning manuals provided by the Washington State Medical Association (WSMA). The Washington State Criminal Justice Training Commission also provides training of this nature, but to date no staff members have attended. A new grant program has established a regional training coordinator, who may be able to bring such training closer to this area.

C. The first session of the training offered 3 hours of instruction. It is not known how long the programmed learning manuals will take to complete.

D. The first session was a 3-hour classroom training period video-taped for those unable to attend either of the 2 sessions. The programmed materials may have to be supplemented by some classroom training.

V. Management

A. Although it is difficult to document, it seems that the existence of the OSC program has improved the security and the overall operation of the jail. Attempting to meet the legitimate needs of inmates has hopefully reduced their attempts to meet those needs by illegitimate or dangerous means (e.g., suicide threats, technical rules violations for attention, etc.)

B. No data are available for comparison, but one successful and one serious suicide attempt have occurred in the jail since the program began almost 2 years ago. The successful attempt was a man who did not appear depressed to either of the arresting officers, but who committed suicide within a few hours of booking. The man who made the serious attempt had been identified as in need of treatment and had undergone two previous admissions at Eastern State Hospital. He is now back there receiving extensive inpatient treatment.

C. A one-person program can be successfully operated in a small jail (i.e., less than 25 average daily population, which accounts for 75% of this country's jails) by using a "brokerage" system. The position must be sufficiently structured to allow for routine screening of all inmates and individualized care for those who cannot be immediately referred out. At the same time, it must be flexible enough to accommodate the differences

in the treatment needs of individual inmates. Having the service provider as a member of the Sheriff's Office (or Department of Corrections) allows him/her to overcome many of the built-in prejudices and obstacles to access for prisoners. Good relationships with referral agencies are absolutely essential.

The support of the administration and personnel of the jail is absolutely essential to the success of this type of program. A major "selling point" of the program is the protection from liability in cases of suicide, illness, or injury within the jail. A well-run, relatively inexpensive program can save a jurisdiction a great deal of money as well as provide more humane treatment for inmates.

D. One problem with a one-person agency is that that person has no one with whom to discuss individual treatment plans. Soem consultation arrangements should be made at an early date with a local psychiatrist or some professional person able to advise the coordinator on individual cases and overall program problems and development. Being a participant at the local mental health center's case conference might also meet this need.

Another problem likely to befall a one-person program is becoming over-extended. A clear delineation of what needs to be done and what the coordinator can and cannot do is essential. However, this delineation may have to be renegotiated as the needs of the jail and its inmates change.

VI. Facility

A. The Whitman County Jail was built in 1927. It was remodeled in 1975 by taking out one of the two cell-blocks and replacing it with a dormitory-style work-release section.

B. The remodeling made it possible to provide group counseling and education in a relatively secure and confidential setting. It also made work, school, and treatment releases possible without necessitating additional staff. An adequate individual counseling room does not exist in the more secure section of the jail. The room presently used is shared with the patrol sargeants and could provide an atmosphere more conducive to a good counseling relationship.

A sketch of the jail facility is included as Appendix C.

VII. Attachments

A. Appendix A is a copy of the "Procedures for Suspected Mentally Ill Inmates" taken from the Jail Health Care Manual.

B. Appendix B is a copy of the receiving screening form completed on each inmate at booking.

C. Appendix C is a sketch of the Whitman County Jail showing where mental health services are provided.

D. Appendix D is a copy of the state of Washington's mental health code.

E. Appendix E is a copy of the most recent State Jail Commission Inspection Report. This inspection was done on a standard-by-standard basis, so that the standards themselves are also included in this appendix. At this time the Jail Commission has no particular powers to enforce its standards, but two avenues are likely to develop for it to do so in the 1978 session of the legislature. First, legislation already exists authorizing the state to fund the construction of new jails, but only jails that meet the physical plant and the custodial care standards developed by the Jail Commission. The 1979 legislature will review the plans submitted and approved by the Jail Commission and possibly allocate funds to begin this process. Secondly, the Jail Commission may be empowered to close jails that do not come into substantial compliance with the standards within a specified period of time.

F. No litigation has been filed against Whitman County regarding the operation of its jail.

APPENDIX A

PROCEDURES FOR SUSPECTED MENTALLY ILL INMATES

(1) A referral to the Whitman County Mental Health Center should be considered any time that you have probable cause to believe that a person being booked into the jail is mentally ill. The procedures for this referral are as follows:

A.) If the Offender Services Coordinator (O.S.C.) is available, contact him to handle the referral. He will determine past history of psychiatric treatment and other relevant data, secure the necessary releases of information and attempt to make the best possible referral.

B.) If the Offender Services Coordinator is not available, and immediate treatment does not seem necessary, call the Whitman County Mental Health Center at 564-5193, and refer the person yourself.

C.) If you feel that immediate treatment is necessary, particularly if you feel that the person may be (1) a danger to himself, (2) a danger to others, or (3) gravely disabled, contact the Mental Health Professional (M.H.P.) on call. This can be done by calling Pullman Hospital (2nd floor) at 332-2541. They will be able to call or page an M.H.P. 24 hours a day. The M.H.P. will determine the least restrictive treatment alternative necessary to get treatment for the person. If necessary, he is empowered to involuntarily commit someone to an evaluation and treatment facility for up to 72 hours.

D.) In an extreme emergency, any peace officer may transport a person to Eastern State Hospital (E.S.H.) for involuntary treatment if, and only if, he has probable cause to believe that as a result of a mental disorder, that person is (1) a danger to himself, (2) a danger to others, or (3) gravely disabled. In this instance, however, the peace officer must remain at Eastern State Hospital until an M.H.P. from Spokane County can evaluate the mental status of the person.

(2) The following list of symptoms may serve as a guide for you to determine if a mental disorder is present:

A.) Hallucinations - e.g., hearing voices, seeing visions, perceiving something that isn't there.

B.) Illusions - misperceiving something that is there - e.g., thinking you are someone else, seeing an object as something it isn't.

C.) Delusions - strange beliefs or ideas, often overly religious or grandiose. - e.g., people being out to get someone, belief that thoughts can control others.

D.) Extreme Hyperactivity - constant moving, talking, inability to sleep for long periods of time.

E.) Withdrawal - very little activity, refusal to eat, speak, or get out of bed

F.) Obsessions - persistent thoughts that the person feels he cannot get out of his mind - e.g., thoughts of suicide, harming someone else, etc.

G.) Compulsions - repeated actions, person feels forced to act in a certain way, e.g., washing hands over and over.

H.) Phobias - severe, unrealistic fears - person may have increased pulse rate, hyperventilation, sweating, etc. in the face of a situation not normally frightening.

I.) Catatonia - unusual, rigid posturing - e.g., person stands with arms and legs in a particular position for hours at a time.

J.) Flight of Ideas - strange speech, stringing together unrelated topics and thought without apparent order.

(3) In any referral of this type, explore the recent and past history of drug and alcohol use and abuse. Alcohol, drugs and withdrawal from either can cause many of the same symptoms.

INITIAL INTAKE MEDICAL HISTORY FORM

FILE NUMBER_____ NAME_____ DATE OF BIRTH_____

SEX_____ DATE_____ TIME_____ a.m. / p.m.

YES____ NO____ Current illness or injury? If yes, describe_____

_____

YES____ NO____ Now under a doctor's care? DR._____

Dr. Address:_____

YES____ NO____ Special diet? Describe:_____

YES____ NO____ Physical handicap? Describe:_____

YES____ NO____ Diabetes?

YES____ NO____ Epilepsy?

YES____ NO____ Heart problems? Describe:_____

YES____ NO____ NEEDS TO SEE A DOCTOR! Action taken:_____

YES____ NO____ Allergies? WHAT?_____

YES____ NO____ Mentally disoriented? M.H.P. Called?_____

_____

YES____ NO____ Now taking medication? TYPE:_____ How often:_____

_____

YES____ NO____ Presently covered by any kind of health insurance, including welfare assistance? If yes, describe:_____

YES____ NO____ Any bruises, trauma markings, infestations, etc.? Describe:_____

_____

GENERAL PHYSICAL DESCRIPTION AND OTHER COMMENTS:_____

_____

_____

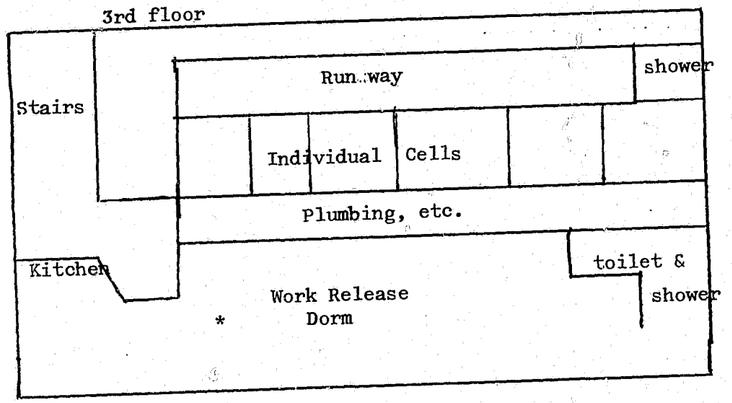
_____

Necessary medical care will not be denied to any inmate due to inability to pay. However, I understand that I am responsible for the costs of any medical care rendered to me while an inmate in the Whitman County Jail, except for routine treatment which can be provided by the jail physician. I hereby authorize the Whitman County Sheriff's Office to provide copies of my jail medical record to attending physicians and/or other institucions to which I may be transferred.

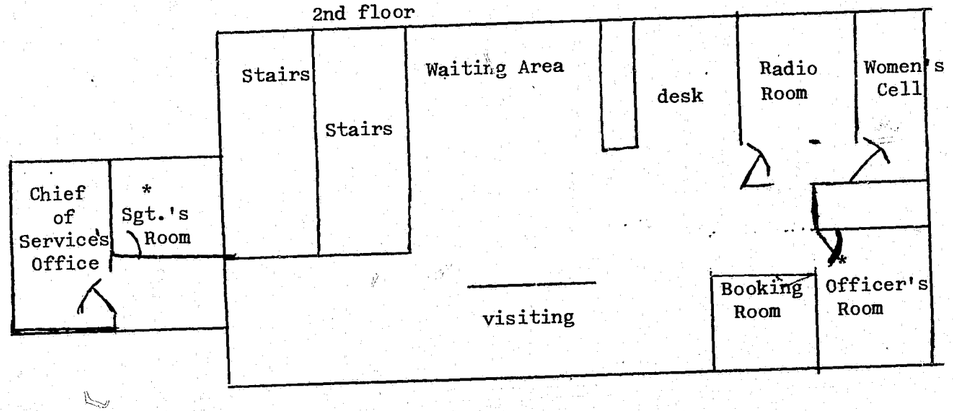
SIGNATURE:_____

WITNESS:_____
(Booking Officer)

APPENDIX C



* Group seating for counseling, classes, etc.



* Individual counseling intake interviews, etc.

OSC office is in adjacent building (county courthouse) in the prosecutor's office.

SERVICE DELIVERY MODEL - State of Michigan

Michigan's mental health code of 1974 dramatically changed the emphasis of treatment regarding emotionally disturbed individuals. Rather than the use of the large state mental hospitals, the first line of defense and treatment for mental illness switched to the many local community mental health centers that were established in Michigan communities. The code imposed more stringent requirements than ever before, regarding involuntary admission to the state mental hospitals. Although these stringent requirements have promoted the concept of community-based treatment for the mentally ill, many jail administrators believe these requirements to be a major cause of one of the most critical dilemmas in Michigan jails today - emotionally disturbed individuals incarcerated in jails, receiving no or inadequate mental health care.

Increased concern among correctional and mental health professionals regarding this problem formed the catalyst for initiating steps to provide adequate mental health care in jails, on a statewide basis. In May, 1977, a jail/mental health task force was formed consisting of six experienced and recognized professionals representing community mental health, jail rehabilitation, probation and parole, the Michigan Sheriff's Association, the Michigan Department of Mental Health, and the Michigan Department of Corrections. The ultimate responsibility of the task force was to make recommendations that would have statewide impact, in an attempt to provide adequate mental health care to appropriate individuals lodged in Michigan jails.

Initial goals were established by the task force, for the purpose of attempting to clearly define its role and promote continuity among the six members. These goals included:

1. Assess and document needs, services available, and services utilized in jails regarding professional emergency and continuing mental health care.

2. Assess and document county jail staff's training regarding the recognizing and dealing with psychiatric and/or behavioral problems in jails.

3. Assess and document problems experienced between county jails and the Center for Forensic Psychiatry.

4. Recommend provisions whereas every jail in Michigan has access to, and utilizes professional emergency and continuing mental health services to the appropriate inmate population.

5. Recommend provisions whereas all correctional staff in Michigan jails be trained and qualified to recognize and adequately deal with psychiatric and/or behavioral problems in jails.

6. Recommend provisions to alleviate problems identified between county jails and the Center for Forensic Psychiatry.

After initial goals had been established, the next step taken by the task force was to assess and document on a statewide basis, all factors the goals designated be covered. This massive information gathering process was initiated through extensive meetings with Sheriffs, jail staff, jail inmates, judges, mental health professionals, and local citizenry throughout the state. In addition, three comprehensive statewide surveys and one detailed study were enacted by the task force. These included:

1. A survey of all jail administrators, (with the exception of Wayne County), regarding the assessment issues stated in the task force's initial goals.

2. A survey of all state probation and parole agencies regarding mental health issues for probationers and parolees. (It was felt by the task force that mental health issues relating to probationers and parolees may have a direct effect upon the number of mentally ill persons booked in jail.)

3. A survey of all community mental boards regarding the type of services they offer, and their present involvement in providing those services in the jails.

4. A detailed study of suicidal behavior in Michigan jails throughout the past five years, specifically noting rising trends.

The results of this assessment were surprising only in regard to the high degree in which professional mental health services were needed in jails, and not adequately provided. The assessment regarding training also revealed a need for more intensive training on a statewide basis. In addition, a definite feeling of confusion and disenchantment existed among jail staff concerning the Center for Forensic Psychiatry and its role in the criminal justice system. This lack of knowledge regarding Michigan's mental health/criminal justice field was also evident in jail staff's questions regarding the relatively new verdict in Michigan - Guilty But Mentally Ill.* This was disturbing in that jails play a major role in the Forensic Center's responsibility regarding evaluations of jail inmates in relation to Michigan's mental health/criminal justice system. The task force's findings were documented and clearly demonstrated a tremendous problem in Michigan jails today. The importance of adequately documenting needs was recognized and it was felt to be necessary if recommendations for legislative or departmental policy changes were to be made.

- -

*Guilty But Mentally Ill - a verdict given when an individual is judged in a legal court of law to have committed a crime, and although the guilty person was determined to have been or is psychotic (mentally ill), he/she was able to understand and comprehend the seriousness of the crime. A person convicted of a felon and found to be Guilty But Mentally Ill is sentenced to the Michigan Department of Corrections and must serve out his/her time in the correctional setting. He/she however, is given psychiatric treatment, under the guidance of the Department of Corrections. One of the reasons for the creation of this verdict was an attempt to eliminate what some legislators believed, a loophole in the courts created by the Not Guilty By Reason of Insanity verdict.

Based on this information, the task force's desire was to formulate recommendations that would have the most impact on a statewide basis. Consequently, the focus of the recommendations was centered around the State Departments of Mental Health and Corrections. The basis for this decision was due to the state's ability to advise and regulate local mental health centers and jails throughout the state: The Department of Mental Health through its funding responsibilities and administrative code for all mental health centers; and the Department of Corrections through its authority given to them by law, to promulgate rules for all jails in the state.

The recommendations made to the Department of Mental Health mandated such things as:

1. The availability of emergency and continuing mental health care to every jail, lockup, and holding center in the State of Michigan.

2. The responsibilities for the delivery of emergency and continuing mental health care to every jail, lockup, and holding center in the State of Michigan.

3. The development of a policy to assist law enforcement personnel in admitting appropriate individuals to state mental hospitals rather than jails.

4. The development of a training program for any mental health professional working in a jail. Such topics as jail and security procedures, correctional and forensic issues, etc., shall be covered.

5. The exploration of alternative funding sources in addition to funding from the Department of Mental Health for community mental health programming in jails.

6. The development of an informational/educational package to be distributed among community mental health professionals and criminal justice personnel, regarding the Center for Forensic Psychiatry, forensic issues and the state's mental health/criminal justice system.

The task force's recommendations have not been taken lightly. The Department of Corrections for example, has proposed revisions of its promulgated rules for jails in Michigan. The following review of a few of these proposed rule changes for jails indicates both the type of recommendations made to the Department of Corrections by the task force, and the department's willingness to provide their cooperation in this endeavor.

Rule 791.___. MENTAL HEALTH SERVICES

Rule ___. (1) The administrator and the governing entity shall provide mental health services to inmates.

(2) A written agreement between the governing entity and the provider of mental health services or the administrator and the provider of mental health

services shall be established to provide:

(a) 24-hour crisis intervention and emergency services which include:

(i) Diagnosis and evaluation.
(ii) Treatment.
(iii) Location of treatment.
(iv) Provider of treatment.

(b) Continuing care which includes:

(i) Diagnosis and evaluation to determine those inmates who may be mentally ill, mentally retarded, or whose adaptation to the detention environment is significantly impaired.
(ii) Provision of treatment consistent with the continuing nature of the problem and expected length of stay.
(iii) Location of treatment.
(iv) Provider of treatment.

(3) The administrator, in conjunction with the responsible medical authority shall develop and implement written policies and procedures which will ensure the day-to-day provision of mental health services established in subrule (2) of this rule. These policies and procedures shall include but not limited to:

(a) Definition of psychiatric emergencies.
(b) Designation of contact person in case of a psychiatric emergency.
(c) 24-hour location of the provider of emergency services.
(d) Referral system for continuing mental health care and criteria for referral.

(6) Upon request, staff from the Office of Facility Services shall be available for consultation or advisory services to meet the requirements of this rule.

Rule 791.603. Staff training.

Rule 603. (1) The administrator shall develop and implement a continuing orientation and inservice training program for all facility personnel having direct contact with inmates.

(2) Training for facility personnel having direct contact with inmates shall include:

(a) Crisis intervention and control.
(b) Recognition of suicide prong behavior.
(c) Recognition of mental illness and retardation.
(d) Recognition of emotional disturbances.
(e) Basic first aid skills or equivalent.
(f) Cardiopulmonary resuscitation (CPR) and basic life support and recognition of symptoms of illnesses most common to the facility.
(g) Intake medical screening.
(h) Administering medication.
(i) Identifying and responding to medical, dental and psychiatric emergencies.

The recommendations made by the task force were approved by key administrative members of the Departments of Mental Health, Corrections, and Management and Budget. They have requested that the task force constitute a base membership of a new subcommittee called the "Subcommittee on Mental Health Care for Jail Populations." The charge given to this new subcommittee is to develop program models in various regions of the state for providing mental health care to jail populations. This new subcommittee scheduled its first meeting in September, 1978, and hopefully will begin actualizing recommendations made by the jail/mental health task force. In addition to support and positive action taken by top administrators of the departments, indications are that key members of the Michigan legislature are supportive of the recommendations made. A key official of an organization called the Michigan Jail Rehabilitation Services Association is also a top administrative aid to the Chairman of the Corrections Committee, Michigan House of Representatives. She is a strong supporter of the task force's work and indicates any legislative action regarding the improvement of mental health services in jails would be prioritized highly.

Although this writing has dealt specifically with the work of the task force, it is not meant to infer that other agencies and individuals have not made commendable strides in combating this problem. Some individual clinics and jails throughout the state have formed excellent relationships with one another in an attempt to provide mental health services to individuals incarcerated in jails. Sheriffs and jail administrators throughout the state have flooded the Department of Corrections with requests for training their jail staff regarding the recognizing and dealing with emotional disorders in the jail. The Office of Facility Services, Department of Corrections, has developed an extensive training program for correctional officers in jails. The program covers pertinent issues as suicidal behavior, mental illness, depression, drug and alcohol abuse, deviant sexual behavior, behavioral emergencies, and the psychopathic personality. The program is unique as it was specifically designed for correctional officers in city and county jails. The fact that this program has been received with enthusiasm by jail staff in Michigan speaks highly of jail administrators and their correctional staff's willingness to improve their own professionalism and potential to adequately deal with this problem.

The State of Michigan has recognized the dilemma of mentally ill people, incarcerated in local jails, with no or inadequate mental health care. Through a conscientious and cooperative effort between the many disciplines involved, it does not seem unrealistic to expect proper and efficient mental health care be given to any jail inmate in Michigan, in need of such service.

REPORT TO THE JOINT PLANNING COMMITTEE
ON THE NEED FOR MENTAL HEALTH SERVICES
IN COUNTY JAILS, AND RECOMMENDATIONS

APPENDIX 1

DEFINITION OF TERMS USED IN THIS REPORT

AFTERCARE
Services obtained from a mental health agency or other human service agency following release from jail. Assistance and/or referral will be required for locating and receiving aftercare services.

CENTER FOR FORENSIC PSYCHIATRY
An agency maintained under the jurisdiction of the Department of Mental Health created by legislation with the passage of Act 266 of 1966 and currently receiving its authority from Act 258 of 1974. The Center performs services as required by law, including evaluations regarding competency to stand trial, criminal responsibility, and evaluations following an acquittal by reason of insanity. Additionally, the Forensic Center provides treatment to individuals found incompetent to stand trial and individuals found to be in need of mental health services as well as other services including research that pertains to mental health and the criminal law.

CONTINUING MENTAL HEALTH CARE
Mental Health services that are provided on a regular and continuing basis by a mental health professional to anyone who needs such care in a jail.

EMERGENCY MENTAL HEALTH CARE
Immediate access to mental health services by a mental health professional for anyone who is experiencing an emergency mental dysfunction in a jail or lockup.

JAIL
A facility operated by a unit of local government for the physical detention and correction of persons charged with or convicted of criminal offenses.

JAIL ADMINISTRATOR
Sheriff, facility administrator, or other duly authorized person responsible for the operation of a facility.

JOINT PLANNING COMMITTEE
The Joint Planning Committee is a committee of senior staff from the Departments of Management and Budget, Corrections, and Mental Health who developed a report on "Policy Decisions for Programming for Forensic Patients and Prisoners with Mental Health Needs" in 1976. The Jail Committee is a sub-committee of this group.

LOCKUP
A facility operated by a unit of local government used to detain persons charged with or convicted of criminal offenses for a period of less than 48 hours.

MENTAL HEALTH PROFESSIONAL
Rule 1200 of the Department of Mental Health's Administrative Rules states that a "mental health professional" within a licensed hospital means a psychiatrist as defined in Chapter 4 of the Act (258), a psychologist, a certified social worker, or a registered nurse:

(e) "Psychologist" means a person certified as a consulting psychologist, psychologist or psychological examiner pursuant to Act No. 257 of the Public Acts of 1959, as amended, being . . . of the Michigan Compiled Laws.

(f) "Certified Social Worker", "Social Worker", or "Social Work Technician" means a person certified by the Board of Examiners of Social Work . . .

(g) "Mental Health Counselor" means a person with specific training in mental health from an accredited university whose counseling program has been approved by the Association for Counselor Education and Supervision or the American Psychological Association.

From Chapter 4, Section 400:

(i) "Psychiatrist" means a physician who devotes a substantial portion of his time to the practice of psychiatry and who has practiced psychiatry for one year immediately preceding his certification of any individual under this chapter.

MENTAL HEALTH SERVICE (COUNTY OPERATED)
A service operated within a county program shall be directed to at least one of the five following mental health areas: mental illness, mental retardation, organic brain and other neurological impairment or disease, alcoholism, or substance abuse. Priority shall be given to the areas of mental illness and mental retardation. A service is any of the following:

MENTAL HEALTH CODE (330.1208)

(a) Prevention, consultation, collaboration, educational or information service

(b) Diagnostic service

(c) Emergency service

(d) Inpatient service

(e) Outpatient service

(f) Partial hospitalization service

(g) Residential, sheltered, or protective care service

(h) Habilitation or rehabilitation service

(i) Any other service approved by the department

Rule 2005 of the Department of Mental Health Administrative Rules states:

"A community mental health board shall insure that the following minimum types and scopes of mental health services are provided to all age groups either directly by the board, by contract, or by formal agreement with public or private agencies or individuals:

(a) 24-hour intervention
(b) Prevention services
(c) Outpatient services
(d) Aftercare services
(e) Day program and activity services
(f) Public information services"

OFFICE OF FACILITY SERVICES, DEPARTMENT OF CORRECTIONS
The Office of Facility Services is a section of the Bureau of Correctional Facilities. This office is primarily responsible for the inspection and performance auditing of state-operated felony institutions, county and municipal jails and lockups, to assert compliance with statute, administrative rules and Department of Corrections policies. To provide technician assistance and consultation services to county sheriffs, county and municipal governments and the Bureau of Correctional Facilities with reference to planning, programming, construction and operation of correctional facilities, jails and lockups. To provide jailer training assistance.

24 HOUR EMERGENCY INTERVENTION SERVICES
24-hour emergency intervention services are defined as any type of emergency service which is available 24 hours. Emergency service may include a "hotline telephone" which is defined as a telephone service by which mental health professionals or trained mental health workers evaluate client defined emergencies and provide counseling or react accordingly to ensure rapid provision of appropriate intervention.

PREADMISSION SCREENING
Includes assistance to courts and other public agencies in screening residents of the service area who are being considered for referral to a state mental health facility for inpatient treatment to determine if they should be referred community-based resources as an alternative to inpatient treatment.

The following questions were asked in the county jails surveyed throughout the state. From these questions, the task force was hopeful that some valid insight could be obtained concerning mental health in the county jails.

(1) How many inmates are presently incarcerated?

(2) How many of these inmates are in need of immediate or long term mental health care? (excluding substance abuse)

(3) How many of those inmates are receiving any type of professional mental health care?

(4) How many inmates are in need of substance abuse counseling?

(5) Who is your local mental health clinic liaison?

(6) Is there a mental health professional "on call" 24 hours for emergency situations?

(7) Have your corrections officers received the training from Office of Facility Services regarding mental health (Recognizing and Handling of Abnormal Behavior in the Correctional Setting)?

(8) Have you had difficulty with the present Mental Health Code? If so, explain.

(9) Have you had difficulty with the Forensic Center in Ann Arbor? If so, explain.

FINDINGS

The total number of inmates in the 77 counties surveyed was 4,198. Out of this number, it was noted by jail administrators throughout the state that 850, or slightly over 20 percent needed some type of mental health care. Out of this 850, only 152, or approximately 18 percent were receiving any type of mental health care at all. Almost 44 percent (or 1,837) in the jail administrators' opinion, needed some type of substance abuse counseling.

PROBATION & PAROLE SURVEY

A survey was conducted of probation agents from the circuit court jurisdiction throughout the state. Some of the probation agents serve as parole agents as well. The survey requested information on the availability and use of mental health services. Answers fell into three categories:

A. Having a complete range of mental health services available in or to the jail, cooperative mental health agency services to inmates in the jail rated more than adequate to good.

B. Services of mental health professionals available, but limited quality, reluctance to be cooperative or become involved, slower service, generally average to poor quality.

C. Defined as either (1) services available but for various reasons inadequate and generally unused, or (2) public mental health services available but never used, either because of inferior service or total refusal of agencies to deal with jail inmates.

Results show that 20 percent of the counties which responded have no mental health services. Of the responding counties, 50 percent have services ranging from good to excellent.

The conclusion of the two committee members who conducted the survey is that "in those areas where human services including crisis intervention, suicide prevention, ongoing mental health professional services of a psychological and psychiatric nature are wanted and are deemed acceptable to those in authority, that those services are essentially available."[1]

[1] Report to Jail Committee on Probation and Parole Survey, July 1977, Claire Sterner, Probation and Parole; and Steve Newman, Allegan County Jail.

APPENDIX 4

COMMUNITY MENTAL HEALTH SURVEY

In July 1977, a survey questionnaire was sent to each of the Department of Mental Health's regional offices, with one questionnaire provided for each county. A phone survey was conducted by most of the regions.

The purpose of the questionnaire was threefold:

(1) to find out if mental health services were provided to the jail

(2) to inquire as to the availability of consultation to local police

(3) to inquire if mental health services were provided to ex-offenders

Results of this survey are provided in the following pages by community mental health board. A map showing each community mental health board and its respective region follows this explanation.

APPENDIX 5

MODEL JAIL PROGRAM

The purpose of this section will be twofold:

1. present a potential jail program, employing various components of service from the community and state and
2. give examples of staffing ratios and types of staff involved with a jail program.

An ideal jail program could potentially utilize the following service components:

1. mental health services
2. jail rehabilitation services
3. educational programs
4. substance abuse counseling
5. vocational education services (adult education)
6. testing and evaluative services (both psychological & educational)
7. recreational programs
8. follow-up or ex-offender program or referral process
9. other specialized programs.

Much of the information regarding the above types of programs were obtained from the Livingston County Re-Entry Program, Sheriff Hards, Sheriff and Mark Coulter, Director.

Program Statement

This jail program has been designed to assist jail inmates on a voluntary basis through a "total spectrum" of services. Various integrated programs shall be designed to aid an inmate with emergency or continuing mental health problems, habilitation or adjustment problems, the re-entry process to the community and to assist the individual through follow-up contact, subsequent to jail release.

Responsibility

All programs, with the exception of work release or follow-up programs shall be housed within the jail. The sheriff, by compliance with Rule 523 of the Rules for Jails, Lockups and Security Camps, shall insure confidentiality and security of all treatment areas.

If programs have not been previously located within or contracted with by the jail, the sheriff or designee shall establish a contract with the local community mental health office or another suitable and appropriate mental health agency for delivery of emergency and continuing care within the jail.

If the contract is developed with the community mental health program, the contract and a request for funding shall be presented to the Department of Mental Health in the usual budget request format.

Staff Required

Since the number of inmates incarcerated in the jail fluctuates daily, all staff ratios will be approximated figures.

Emergency & Continuing Care Services

Number of Inmates	Number of CMH Staff
less than 15	.5
16-30	1
31-50	1.5
51-70	2
71-100	2.5
101-150	3
151-200	3.5
201- +	4

For an inmate population of 40 or more, other suggested staff would include rehabilitation staff: one educational coordinator, one substance abuse counselor, one follow-up coordinator, three-seven part time teachers or adult education teachers, .5 to one recreational coordinator, and X number of volunteers.

These positions may be filled through federal grants, state positions, CETA positions, student placements from universities, community colleges or private institutions, volunteers, intermediate school districts or through a variety of other ways.

Any problems which arise that may require outside consultation shall be directed to the Office of Facility Services, Department of Corrections. The Office of Facility Services shall notify and may involve the Department of Mental Health regional office as appropriate.

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ATTACHMENT A

P. O. Drawer P, Boulder, Colorado 80302 • (303) [redacted] 492-8232

WICHE

Western Interstate Commission for Higher Education

affirmative action/equal opportunity employer

The National Institutes of Mental Health (NIMH), Law Enforcement Assistance Administration (LEAA), and National Institute of Corrections (NIC) will cooperatively sponsor a Special National Workshop on "Mental Health Services for Persons in Jails" in September 1978.

My project component is to identify and evaluate current mental health - jail programs which can be presented as model operations.

I would sincerely appreciate any information you can provide about the efforts in this area which exist in your state. While many programs may have been successful with only one facet of service such as diversion, screening and classification, crisis intervention, staff training, etc., I am interested in all referrals.

If you are unfamiliar with specific mental health - jail programs, perhaps you can suggest other resources and individuals more directly involved or knowledgeable.

Since this issue has been historically ignored, locating exemplary programs is extremely difficult. Therefore, any recommendations you can offer would be of tremendous value.

Thank you for your immediate attention and assistance.

Very truly yours,

Carole Morgan
Corrections Consultant

CM:cn

I can be contacted at (303) 492-8232.

ATTACHMENT B

P. O. Drawer P, Boulder, Colorado 80302 • (303) [redacted] 492-8232

WICHE

Western Interstate Commission for Higher Education

affirmative action/equal opportunity employer

The National Institutes of Mental Health (NIMH), Law Enforcement Assistance Administration (LEAA), and National Institute of Corrections (NIC) will cooperatively sponsor a Special National Workshop on "Mental Health Services for Persons in Jail" in September 1978.

My project component is to identify and evaluate existing mental health - jail programs which can be presented as model operations.

Since this area has been historically ignored, I realize that very little specific information may be available. However, the issues may be indirectly discussed within more generic categories; i.e., inmate health; jail screening criteria; crisis intervention and staff training; etc.

I would appreciate any relevant material you can recommend as well as any existing programs that provide mental health services to jail inmates with which you might be familiar. Please let me know the costs involved.

Thank you very much for your immediate attention and assistance.

Very truly yours,

Carole Morgan
Corrections Consultant

CM:cn

ATTACHMENT C

P. O. Drawer P, Boulder, Colorado 80302 • (303) 492-8232

WICHE

Western Interstate Commission for Higher Education

an equal opportunity employer

April 12, 1978

MEMORANDUM

TO: Sheriff

FROM: Carole Morgan, Corrections Management Consultant

SUBJECT: Mental Health Services in Jails

The National Institutes of Mental Health (NIMH), Law Enforcement Assistance Administration (LEAA), and National Institute of Corrections (NIC) will cooperatively sponsor a Special National Workshop on "Mental Health Services in Jails" in September 1978.

My project component is to identify and evaluate current mental health - jail programs which can be presented as model operations.

Your program has been recommended as a possible model for service - delivery in your state.

Since I am unable to site visit every program which is being preliminarily considered, I hope you will assist me in the selection process by completing the attached "Program Description."

Responses should be received before April 28, 1978. Returned information will be reviewed and the outstanding programs nationally will be contacted for further assessment.

Please accept my congratulations for the work you have accomplished in this traditionally neglected service area, and best wishes for your continued success.

Thank you for your cooperation and immediate attention.

CM:bc

Enclosures

Please accept my sincere apology for this form letter but because of time constraints there was no alternative.
Carole Morgan

ATTACHMENT D

P. O. Drawer P, Boulder, Colorado 80302 • (303) 492-8232

WICHE

Western Interstate Commission for Higher Education

affirmative action/equal opportunity employer

May 18, 1978

MEMORANDUM

TO:

FROM: Carole Morgan, Corrections Management Consultant

SUBJECT: Mental Health Services in Jails

Just a reminder to let you know that we have not received your completed "Mental Health Services in Jails" Program Description.

I am sure your efforts in this area deserve greater recognition and hope you will take the time to provide the information needed for further program consideration.

If your response has already been returned, please let me know as soon as possible.

I sincerely appreciate your cooperation and look forward to hearing from you.

CM:bc

ATTACHMENT E

MENTAL HEALTH IN JAILS

Program Description

NAME:_____

POSITION:_____

DATE:_____

LOCATION OF JAIL: CITY_____ COUNTY_____ STATE_____

CURRENT JAIL POPULATION: MALE_____ FEMALE_____ MAX. CAPACITY_____

RACIAL DISTRIBUTION OF CURRENT POPULATION:_____

APPROXIMATE PERCENTAGE OF CURRENT JAIL POPULATION MENTALLY ILL:_____

MENTALLY RETARDED:_____

PERCENTAGE OF CURRENT POPULATION PRE-TRIAL:_____ SENTENCED:_____

NAME OF PROGRAM:_____

AGENCIES INVOLVED:_____

DATE WHEN PROGRAM BEGAN:_____

I. RATIONALE

A. HOW DID THE PROGRAM GET STARTED?_____

_____

B. WHAT ARE THE PURPOSES/OBJECTIVES OF THE PROGRAM?_____

_____

C. IS THE JAIL NOW OR HAS IT BEEN INVOLVED IN LITIGATION BECAUSE OF MEDICAL OR MENTAL HEALTH PROBLEMS?

_____

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E. FOLLOW-UP:

1. DO YOU PROVIDE FOLLOW-UP TREATMENT OR COMMUNITY REFERRALS FOR THE MENTALLY ILL OR MENTALLY RETARDED?_____ HOW?_____

_____

IV. WHAT PARTICULAR PROBLEMS HAVE EXISTED OR STILL EXIST WITH THE PROGRAM?

_____

_____

V. WHAT PARTICULAR SUCCESSES HAVE RESULTED FROM THE PROGRAM?_____

_____

_____

VI. WHAT HAS BEEN AND IS THE RELATIONSHIP BETWEEN MENTAL HEALTH PROGRAM STAFF AND THE JAIL'S CUSTODY PERSONNEL?_____

_____

VII. DO THE CUSTODY OFFICERS RECEIVE SPECIAL TRAINING TO IDENTIFY AND TREAT THE MENTALLY ILL OR MENTALLY RETARDED?_____ WHO PROVIDES THIS TRAINING?_____

VIII. WHAT PERCENTAGE OF THE CUSTODY OFFICERS ARE FEMALE?_____

ARE THEY ASSIGNED TO MALE HOUSING UNITS?_____

HOW HAS JAIL MANAGEMENT BEEN AFFECTED BY THE PRESENCE OF WOMEN STAFF?

_____

IX. WHAT HAVE YOU LEARNED FROM YOUR PROGRAM EXPERIENCE THAT YOU WOULD RECOMMEND TO OTHER SHERIFFS/MENTAL HEALTH DIRECTORS TO IMITATE?

_____

_____

_____

_____

X. ADDITIONAL COMMENTS: (Please identify Program Director if other than person answering questions.)

_____

_____

_____

_____

_____

_____

ATTACHMENT F

P. O. Drawer P, Boulder, Colorado 80302 • (303) 492-8232

WICHE

Western Interstate Commission for Higher Education

affirmative action/equal opportunity employer

April 26, 1978

M E M O R A N D U M

TO: Project Director

FROM: Carole Morgan, Corrections Management Consultant

SUBJECT: LEAA Funded Project for Mental Health Services in Jail

The National Institute of Mental Health (NIMH), Law Enforcement Assistance Administration (LEAA), and National Institute of Corrections (NIC) will cooperatively sponsor a Special National Workshop on "Mental Health Services for Persons in Jails" in September 1978.

My project component is to identify and evaluate current mental health - jail programs which can be presented as model operations.

The 1973-78 LEAA printout for "Subgrant awards relating to mental health services in correctional institutions" described services possibly offered at one time to jail inmates.

Since this issue has been traditionally ignored, it is extremely difficult to locate specific data regarding existing or past programs. Therefore, any information you can offer would be of tremendous value.

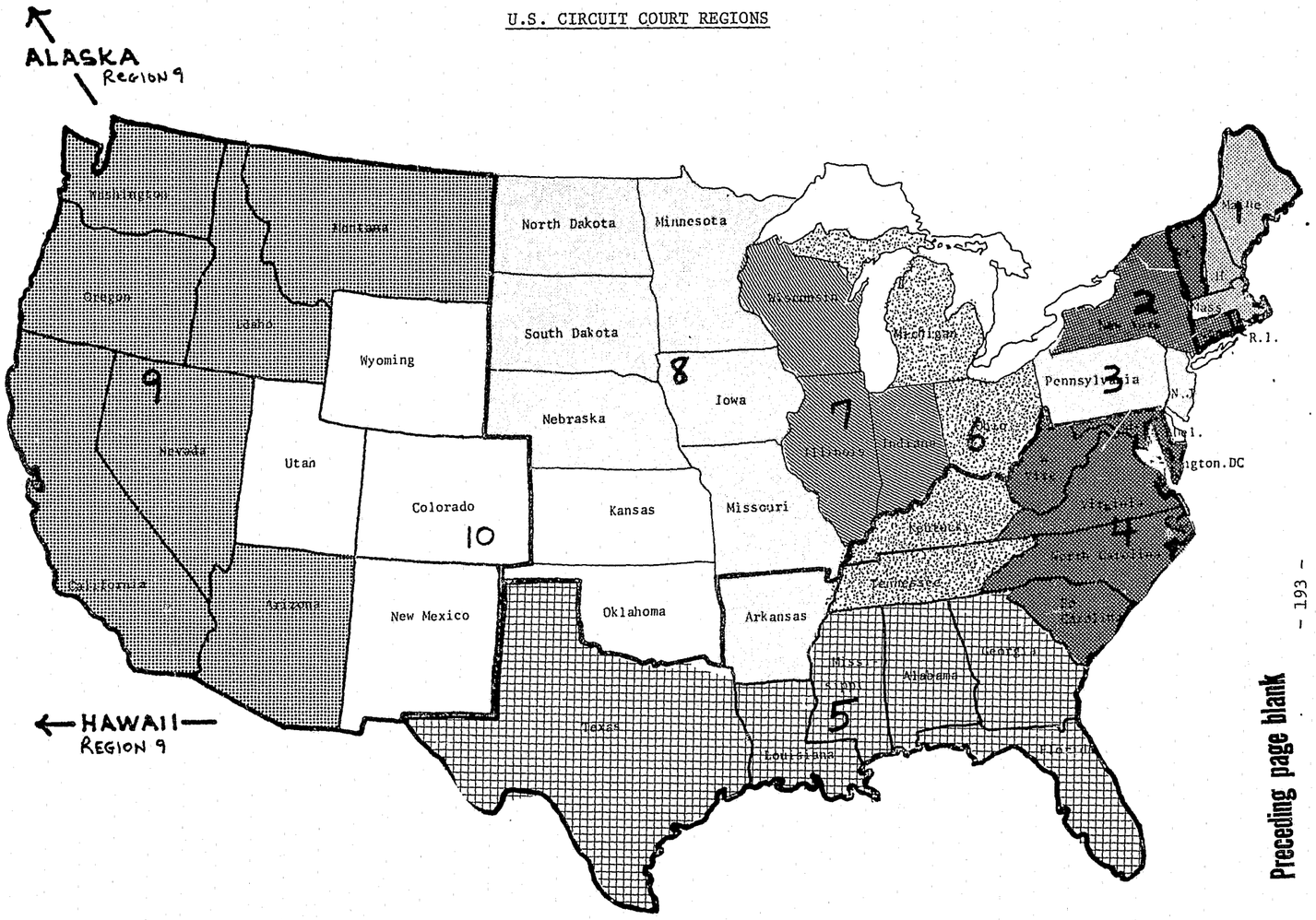
If mental health services for the mentally ill or mentally retarded jail population exist, please complete the yellow "PROGRAM DESCRIPTION." If services did operate but are no longer available, please return the explanatory white memo.

I hope to site visit those operations which have been successful in providing such services as diversion, screening and classification, crisis intervention, staff training or community follow-up referrals in order to finally select the workshop participants. Consequently, time is limited and your response before May 5, 1978 would be sincerely appreciated.

Thank you for your cooperation and immediate attention.

ATTACHMENT G

U.S. CIRCUIT COURT REGIONS



ATTACHMENT H

The following programs provide commendable mental health - jail services and are recommended for consideration. Salient program aspects or impressive activities observed during site visits, presented in service descriptions or discussions have been included.

MARYLAND: Baltimore City, Baltimore

Warden: Gordon Kamka

A. Therapeutic communities.

B. "Least repressive" jail atmosphere and amiable security officers - psychologist interactions (especially notable due to size of jail population).

MICHIGAN: Wayne County Jail, Detroit

Sheriff William Lucas

A. Reception diagnostic center concept.

B. Sophisticated triage mental health referral process.

UTAH: Salt Lake County Jail, Salt Lake City

Jail Administrator: Gary DeLand

A. Court screening intake services in jail/diversion and bonding alternatives.

B. Mental health staff research with environmental jail effects.

C. Associated mental health center staff research with identification/screening criteria for selecting successful performance custody officers.

FLORIDA: Alachua County Jail, Alachua County Department of Corrections, Gainsville

Director: Donald Cabana

A. Screening and diversionary programs.

B. Classification/testing and evaluation system.

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