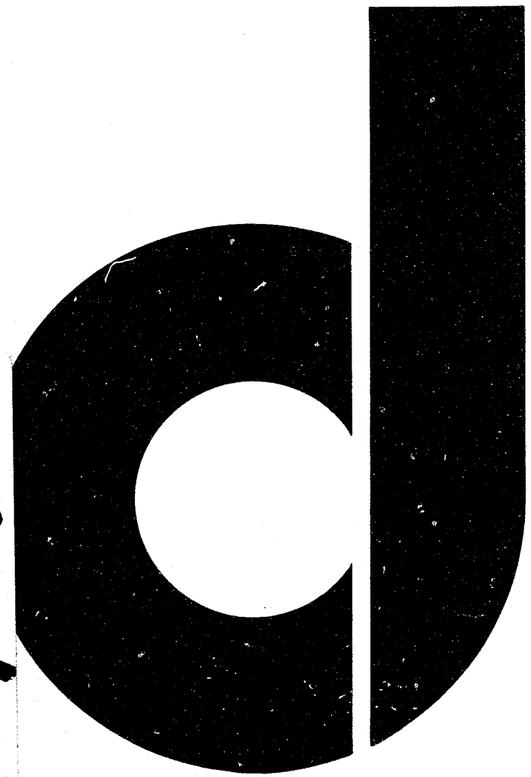
National Institute of Mental Health

Mental Health Services in Local Jails



Crime and Delinquency Issues

MENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

CRIME AND DELINQUENCY ISSUES:
A Monograph Series

MENTAL HEALTH SERVICES IN LOCAL JAILS:
Report of a Special National Workshop

Edited by

Christopher S. Dunn, Ph. D.
Center for Studies of Crime :d Delinquency
National Institute of Mental Health

and

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This monograph is one of a series on current issues and directions in the area of crime and delinquency. The series is sponsored by the Center for Studies of Crime and Delinquency, National Institute of Mental Health, to encourage the exchange of views, to promote in-depth analyses and recommendations, and to make these available to legislators, policymakers, program administrators, agency personnel, and concerned citizens.

This particular monograph in the series has also been sponsored by the National Institute of Justice and the National Institute of Corrections. It resulted from the efforts of the three Federal agencies that jointly sponsored the Special National Workshop on Mental Health Services in Local Jails.

The opinions expressed in this monograph are the views of the authors and do not necessarily reflect the official policy or positions of the National Institute of Justice, the National Institute of Corrections, the Department of Justice, the National Institute of Mental Health, or the Department of Health and Human Services.

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FOREWORD

In the fall of 1978, the National Institute of Corrections, the National Institute of Law Enforcement and Criminal Justice, and the National Institute of Mental Health invited a number of jail and correctional administrators and mental health personnel from across the country to a Special National Workshop on Mental Health Services in Local Jails. The purpose of this workshop was to develop recommendations for more effective attention to the mental health needs of persons confined in our Nation's jails. Mental health services to inmates of correctional institutions are usually meager and inadequate; the present overcrowding in many jails and the resulting additional stresses require even more attention. Moreover, courts are increasingly requiring that the traditional nonexistent or substandard health and mental health services in jails be markedly improved.

This monograph brings together the information presented at the workshop on several important topics: (1) the nature and extent of mental health needs in local jails; (2) assessment and intervention approaches for addressing these needs; (3) mental health service delivery systems and models that are currently in use; (4) legal issues, responsibilities, and constraints involved in providing mental health services in jails; and (5) needed future action, research, and training efforts.

It is our hope that this information will be of help to legislators, program administrators, policymakers, and service providers in their continuing efforts to make our jails safer and more humane environments for those who are confined there and for those who work there.

Moreover, we are pleased to note that the contribution of the National Workshop did not end with the meeting; the collaborative effort has been carried over into additional research and training activities sponsored by our respective agencies in the jails-mental health area.

We are pleased to make this product of our collaborative efforts available to a wide audience of criminal justice, legal, and mental health workers, as well as to other interested persons.

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CHAPTER 1

The Special National Workshop on Mental Health Services in Local Jails: Background and Development

Christopher S. Dunn, Ph. D.

introduction

This monograph brings together the papers that were prepared for the Special National Workshop on Mental Health Services in Local Jails. The workshop was organized and jointly sponsored by three Federal agencies—the National Institute of Mental Health (NIMH), the National Institute of Corrections (NIC), and the National Institute of Law Enforcement and Criminal Justice (NILECJ, now the National Institute of Justice)—to address a number of issues concerning mentally ill persons in local jails. These issues included the following:

1. How many such arrested and detained persons or sentenced offenders are there; what are their prior criminal and/or mental health histories; and what are their mental health problems?
2. What means are there for local jails to screen, identify, and provide needed services?
3. What are the nature of and variation in intervention or service delivery programs for the mentally ill offender in local jails, and how do these programs operate?
4. What are the legal requirements and duties concerning the provision of mental health services in local jails?

5. What are the needed improvements or knowledge that must be developed to address identified deficiencies or problems in regard to these issues?
6. What kinds of collaborative or cooperative arrangements exist between different government agencies, or across different levels of government, that can foster or promote program improvements?

This introductory chapter provides an overview of the development and joint sponsorship of the workshop by the three Federal agencies and focuses on specific contributions.

Collectively, these chapters represent one of the most comprehensive and detailed examinations of the problems and issues confronting local jails. Jails have long been neglected in terms of resources and program development, information collection, analysis and dissemination, and public scrutiny—as compared to other criminal justice agencies or areas (see, for example, Mattick and Aikman 1969; Burns 1971; Mattick 1974; Goldfarb 1975; and Matheny 1976). Consequently, any concerted attention to conditions in local jails, even in regard to specific issues such as mental health problems, must ultimately contend with the overall societal context. As the National Advisory Commission on Criminal Justice Standards and Goals (1973: 275–277) has indicated, that context has been one of "abominable physical condition," absent sanitary facilities, lack of program space, overcrowding (if urban), "lack of adequate staff," inadequate security management, reliance on "trusties," "unrelieved idleness," and substantial risk of physical violence to both inmates and staff.

But beyond simply addressing a long-standing need to know more about jails, the current collection represents a rather unique perspective about jails, viz, that the problems faced by local corrections are a shared responsibility not just of the criminal justice system but also of other public agencies (for example, health and mental health facilities) having the service delivery knowledge and skills that are sorely needed but often lacking in local jails. When such problems are perceived as shared responsibilities, possible improvements or solutions also become shared responsibilities, particularly in times of fiscal austerity when duplication and waste are obviously to be avoided. Moreover, the perspective of shared responsibility also provided the rationale for the three Federal agencies to collaborate in developing and sponsoring the workshop and other related activities.

Whereas much of the past literature depicted only the many serious problems characterizing local jails, the contributions in this report also attempt to document the kinds of existing programs

and to describe their essential features. It should not be inferred that the programs identified or features described represent "model" programs in the sense of having been rigorously evaluated and found to be effective and efficient in their operation. Rather, the dissemination of information about existing programs and needs is intended to respond to a different local need, viz, to learn what other jurisdictions around the country have done or are doing.[1] The presentation of such information, along with the comments and observations of contributing authors, is intended as a program development resource in its own right. Local officials can use this material in tailoring a program to suit their own jurisdiction's needs and circumstances.[2]

Nevertheless, as some of the contributing authors stress in detail, there are still impediments to program development that are not addressed simply by knowing what is going on around the country. Another objective of disseminating the current collection of papers is to identify the areas in which local program development could be much improved by even the simplest of "needs identification" or "program evaluation" research. As Steadman indicates, research can be used "as a means to *informed* action."

Being Jailed: Mental Health Implications

Being jailed following arrest for an alleged criminal offense is for many people an upsetting, threatening, and depressing experience. Life abruptly shifts gears, from patterns of daily social activities to patterns of custody and control; from self-chosen interactions to enforced ones; from familiar habits in satisfying personal needs to unfamiliar, unvaried, unchosen ones. Under the conditions that characterize most jails, real and self-imposed pressures are great; personal reactions are strong; and maladaptations abound. With the inability—real, apparent, or imagined—to cope with such powerful pressures comes the first development of mental disorders for some or the rekindling of existing mental problems for others.

The Special National Workshop was stimulated by the recognition that significant numbers of persons confined in jails have serious mental and emotional disorders; that the stresses of incarceration will often exacerbate the mental disorder and lead to a variety of management problems; and that jails typically lack the necessary resources to handle and to treat serious health and mental health problems. Thus, problems are often ignored until a crisis occurs. Or, the management efforts may be nothing more

than to restrain the very disturbed inmates or simply watch depressed and withdrawn inmates. Clearly, these are unsatisfactory interventions for dealing with the serious mental health problems.

In addition to the pain and suffering endured by the troubled inmates, mental health problems and crises cause other problems for local jails. The lack of capabilities to provide even the most basic care and treatment poses a troubling issue for many sheriffs and local jail administrators, especially since the jail is usually required to accept all persons ordered detained regardless of their past history or current problems. Moreover, courts have ruled that detained persons and sentenced prisoners cannot be denied access to necessary medical care, including care for psychiatric or mental health needs.[3]

Sheriff Jack Driscoll of Sherman, Tex., has shared his view of the commonly felt frustrations that sheriffs experience in confronting the ugliest of mental health problems in the jails, viz., the suicide. At the conclusion of a recent regional workshop, he wrote the following poem:

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Workshop Rationale and Development

Prior to 1978, there were few systematic attempts to measure the prevalence and incidence of mental disorders in jail populations or even systematic reports of programs providing diagnostic or treatment services. This situation was obviously part of the more general state of relative inattention to jails—in the field of corrections, by the research community, by State agencies, and also by the Federal agencies sponsoring programs of assistance for State and local criminal justice and/or mental health agencies. Nevertheless, it was evident from the sporadic research efforts, as well as from numerous anecdotal reports, that local jails held many inmates in acute need of mental health services.

In response to these reports and to inquiries made to the NIMH by local mental health officials (whose assistance had been requested by their local sheriffs), the Center for Studies of Crime and Delinquency convened a 1-day seminar attended by a few Federal, State, and local officials, as well as some knowledgeable persons from the field of corrections and mental health. At this seminar it was pointed out that, although State security hospitals and prison medical and mental health units provide services for their inmates, the inmates of local jails are probably in much greater need of attention.

A number of reasons were suggested for the above conclusion: (1) In some jurisdictions, court-ordered restrictions on State prison populations had begun to cause a serious backup of convicted felons in local jails, leading to severe crowding; (2) even though local courts may order the commitment of seriously mentally ill prisoners to security hospitals, the lack of hospital bedspace and complications of transfer logistics produce long delays; (3) local jails lack needed professional resources and staff for providing mental health services; and (4) with the significantly tightened standards for civil commitment, and the deinstitutionalization movement in mental health, many chronic mentally ill persons are placed in the community, and some of them are being arrested for minor crimes and appearing in jails.[4]

The discussions at the seminar led to the recommendation that the Federal agencies sponsor a national workshop in order to highlight the problems of mentally ill offenders in local jails, to stimulate further efforts at State and local levels between corrections

and mental health agencies, and to provide needed technical assistance.

It was also noted that the President's Commission on Mental Health had urged that special attention be given to the mental health service needs of various "unserved" and "underserved" groups in the population.[5] The Commission had also observed that "a high percentage of jail and prison inmates are mentally disturbed" and had recommended:

> Mentally disabled persons in detention or correctional institutions should have access to appropriate mental health services on a voluntary basis and such access should not be connected with release considerations. (p. 45)

In view of their obvious programmatic interests in the topic of mental health problems in jails, the National Institute of Corrections (NIC) and the National Institute of Justice (NIJ, formerly the National Institute of Law Enforcement and Criminal Justice), both in the U.S. Department of Justice, had representatives participate in the seminar. Further, these three Federal agencies (NIC, NIJ, and NIMH) agreed to collaborate in sponsoring the national workshop.

Jails are primarily the responsibility of local governments. State governments are involved to a lesser extent in some administrative, inspection, and related roles. The Federal agencies are concerned with these issues because, while the legislative mandates of the three agencies relate primarily to the support of research and training, there are also mandates for the provision of consultation and technical assistance to State and local agencies. Moreover, there is also the programmatic concern that, to be of maximum utility, research and training activities must be related to specific crime, delinquency, criminal justice, or mental health problems and needs. Thus, there is a clear responsibility for the Federal agencies to provide needed technical assistance and to assist State and local agencies in dealing with a problem of major concern. Indeed, such technical assistance efforts have been an important aspect of the particular program units of each of the three Federal agencies involved. For example, the NIMH Center for Studies of Crime and Delinquency was interested in creating a program development resource for local mental health centers to use in formulating their own screening, service delivery, and consultation and training programs with respect to mentally ill persons in jails and in developing more precise information about the interactions between prior mental health problems and the stresses of jail conditions which aggravate such problems and in causing mental health

crises such as suicide attempts and self-mutilations. Likewise, the Jail Center of the National Institute of Corrections was interested in identifying and evaluating mental health service delivery programs in local jails, so that other jails wanting to initiate or improve their own mental health service programs could profit from such information. Similarly, the Corrections Division of the National Institute of Justice was interested in discovering whether correctional populations were getting an increasing number of persons with prior mental health problems and/or mental health agency contact and in investigating the observation made by some jail officials that the existence of a mental health service program has a salutory effect on jail security and safety. Finally, the NIJ Office of Development, Testing, and Dissemination was interested in the workshop for its National Executive Training Program series, since the proposed workshop participants would consist in large measure of local criminal justice and mental health agency executives.

Preliminary discussions among the three agencies led to formulation of the major aims and objectives for the workshop, and procedures were developed for planning and organizing its specific content and logistics. It was agreed that: (1) The workshop should spotlight major mental health problems and needs of local jails and should sensitize policymakers to these major concerns; (2) it should be a product-oriented meeting of carefully selected persons representing key agencies and organizations; (3) it should provide a forum where useful information and ideas could be exchanged and shared by correctional, mental health, and related persons in local, State, and Federal agencies; (4) the invited local participants should have a major role in identifying and further stimulating recommended attention and action in regard to the information developed for the workshop. A conference report (this document) would facilitate such postconference efforts; (5) finally, it was agreed that the specific content, logistics, and list of invited participants should be developed by a small planning group comprised of local and Federal agency representatives and others with appropriate substantive expertise.[6] The planning group also included staff of the University Research Corporation, who provided both substantive input and organized the administrative and logistic aspects of the workshop.[7]

The planning group developed five major curriculum areas, identified experts in each of the areas, and commissioned them to prepare papers for the workshop.

The five curriculum areas were: (1) the nature of mental health problems in jails; (2) the assessment and intervention approaches

for addressing serious psychopathologies; (3) the nature of existing mental health service delivery programs in jails; (4) legal issues surrounding the provision of mental health services in jails; and (5) the identification of important and needed program development, research, and training in each of the foregoing areas.

These curriculum areas formed the basis for particular workshop sessions. The format for each session involved the presentation of a state-of-the-art paper, followed by formal comments and then general questions and comments. These were followed by small groups (each group having representatives of the various correctional, mental health, and research participants) which discussed in depth the issues addressed in the papers and formulated a set of recommended action and/or research needs.

After the workshop was held (in Baltimore, Md., in September 1978), the authors of the major papers were asked to revise their presentations in light of the comments and discussion provided by participants. Those authors who had attended the workshop as observers and commentators (Gottfredson, Steadman, and Rademacher) also prepared their papers after the workshop. The papers were then edited for publication, the first and last chapters being prepared during the editing period.

An Overview of the Contributions

A major area of uncertainty that initially confronted the workshop planning group was the lack of systematic and detailed information concerning the nature and extent of mental health problems of jail inmates. Nor was such information available about the existence, nature, and usefulness of programs for addressing such problems. Such basic information was obviously necessary and desirable for a number of reasons. For example, although it had been alleged in a number of local settings that the number and seriousness of problems caused by mentally ill persons in jails were increasing, the general accuracy or validity of such assertions on a nationwide basis was unknown. The available literature was sparse and did not address the issue of fluctuations across various jurisdictions. Moreover, when scrutinized more closely, the extant literature revealed broad variations concerning how, when, by what specific criteria, and by whom jail inmates had been identified as mentally ill. Furthermore, there was even less information concerning jail programs that attempted to identify, diagnose, refer, or provide various treatment services to mentally ill inmates.

Because basic epidemiological and program information concerning the mentally ill in jail had never been systematically ascertained, workshop planners agreed to begin consideration of service delivery improvement by compiling the available information about the above-mentioned needs. In chapter 2, Gibbs reviews studies concerning the prevalence of mental disorders among jail populations. He finds that despite many recordkeeping deficiencies and methodological problems, acute psychotic disorders have a fairly low prevalence in general jail populations (i.e., previously unscreened or unreferred); these rates are only slightly higher than similar prevalence rates for the general population. On the other hand, the prevalence estimates for less serious mental disorders may range anywhere from 15 to 85 percent of the jail populations studied. However, as Gibbs notes, confidence in generalizing from these few studies is reduced because many of the studies used previously referred or screened populations, and there were also other methodological problems. Thus, it is difficult to make any precise overall conclusions about the actual magnitude of the different types and seriousness of mental disorders among jail inmates. However, Gibbs is able to discuss with greater confidence and in more detail the information about two major mental health crises in jails, viz, suicides and self-mutilation.

As with basic epidemiological information about the prevalence of mental disorders, the same lack of precise information existed in regard to the various service delivery programs. The lack of relevant literature on the subject, however, did not imply that no such programs existed. In terms of the purpose and objectives of the workshop, it was important to develop better information about the various mental health programs in jails. Accordingly, Morgan was commissioned to develop such basic information (as reported in chapter 3), and, rather surprisingly, we learn that many jurisdictions have some type of program which they choose to call a mental health program. Although Morgan's survey raises many additional questions about the exact definitions and criteria used by the various jurisdictions to determine the mental disorders, related needs, and program usefulness, this work nevertheless represents the first such national overview of these programs. And, while a more detailed and systematic survey would be highly desirable, Morgan's work was useful in documenting, within a rather short period, the existence of local programs and in identifying the broad variation in their characteristics. Morgan also located what she refers to as program "models"; i.e., different jurisdictions have developed different types of programs based on their specific needs.

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Seven such programs are mentioned in chapter 3 and are described elsewhere in much greater detail (Morgan 1979).

The next three chapters (those by Singer, Megargee, and Brodsky) focus on specific issues in regard to mental health services in local jails. Singer (chapter 4) makes clear that jail inmates have a constitutional right to adequate medical care; this has been interpreted to include care for psychiatric and other mental health problems. Thus, it follows that there is a legal duty on the part of the responsible governing jurisdiction to provide mental health services to pretrial detainees and to sentenced prisoners. Correspondingly, there is also a legal duty on the part of the sheriff or jail official to provide detainees or prisoners *access* to such services. Singer examines in some detail the nature of that duty and its principal components, viz., an entrance examination and reasonable access to adequate treatment.

In chapter 5, Megargee discusses the applicability of some mental health screening or diagnostic assessment tools, including those that he has developed and applied in correctional settings.

In chapter 6, Brodsky identifies and describes mental health treatment intervention programs that have been used or suggested for jails. This chapter does not cover all forms of treatment programs; it points to programs that may be more useful in these correctional institutions. Brodsky also notes the importance of careful selection and training of jail staff. Also important is the removal of noxious jail conditions that aggravate or help to bring about acute stresses and psychological morbidity.

In the next two chapters, Rademacher and Gove discuss two special issues brought up at the workshop. In chapter 7, Rademacher notes that some juveniles are held in adult jails. He feels that, as a result, such youth are probably more vulnerable to severe emotional problems or other undesirable consequences. Research has shown (Lockwood 1980) that institutions in which youth and young adults are confined together have the highest rates of sexual assault, the younger inmates being the more likely victims. Rademacher offers suggestions for preventing emotional problems or violent victimizations in situations where the juveniles cannot simply be removed from adult jails.

In chapter 8, Gove discusses the societal reaction effects associated with the diagnosis and treatment of mental illness, for example, stigma, "secondary deviance," or inappropriate expectancy about future behavior. He notes that labeling theory does not offer much guidance in regard to mental illness in jails because of various practical issues in diagnosing mental disorders in the context of high-stress environments like jails. In situations where mental illness can be easily feigned, Gove points out that some persons may actively seek such a diagnosis in order to be transferred to less stressful environments. Paradoxically, unless their behavior is obviously bizarre, the more seriously disturbed or withdrawn inmates may be ignored until their illnesses reach crisis proportions.

The last three chapters address the many issues that were raised by the workshop itself. From a criminal justice perspective, Gottfredson notes in chapter 9 that a major impediment to understanding these specific issues, and thus to developing better programs and more accurately targeted services, has been the singular lack of precise information concerning most aspects of jail management, operations, and the effects of incarceration on the inmates—especially those who already have mental problems or are vulnerable to such problems. Gottfredson provides an overall outline for research on jails that should make it easier in the future to develop recommendations about specific desired improvements. In chapter 10, Steadman argues for improved attention to the overall mental health networks and support systems in various communities, and how these might be mobilized in support of or to directly assist jail mental health service delivery. Steadman views research as a *means to informed action* and calls for dual attention to the translation of research results into useful program applications and for careful assessment of ongoing service delivery programs to determine their effects and effectiveness. In the final chapter, Dunn and Baunach review the various issues, problems, and recommendations highlighted at the workshop and describe how the subsequent efforts and activities of the three sponsoring Federal agencies have been responsive to the workshop's findings and recommendations.

Conclusion

Throughout this introductory chapter, reference has been made to the comparative state of inattention to the many and even glaring problems of jails. This volume is an effort to fill the many gaps in our knowledge about the prevalence of mental disorders in jails, various mental health service delivery programs in use, and efforts to improve conditions in our Nation's jails. It does not purport to contain all the answers (nor is it reasonable to think that it could), but, the efforts of the Special National Workshop are to improve the capabilities and knowledge of the people most directly affected—local jail and mental health officials and staff, other agency executives, criminal justice officials, local politicians

and policymakers, and concerned citizens. There are, of course, no panaceas—only hard work, the need for creative thinking, the innovative application of knowledge and experience, and the allocation of needed resources. Given the generally low political and budgetary priority accorded to jails, close cooperation and collaboration among correctional and mental health agencies are necessary in order to stimulate and support such efforts.

Footnotes

1. One of the most frequent positive evaluative comments made by workshop participants was that the workshop made it possible to "learn what was going on around the country." Such comments implied a general absence of any effective forum for the communication and exchange of program information among the many local jurisdictions. As discussed below, the need to provide such a forum provided one important rationale for the sponsoring Federal agencies to develop this workshop.
2. Persons using this volume for information for program development purposes are encouraged to contact participants (listed in the appendix) whose jurisdictions or agencies might be geographically near or of relevance in other ways. The purpose of listing the workshop participants is to encourage the exchange of local program development or program assessment information.
3. In rare cases, jail officials are not required to accept prisoners, for example, when the persons are acutely ill or incapacitated by a life-threatening injury. But, once accepted, a constitutional right to adequate medical and mental health care applies. See Singer, chapter 4.
4. See, for example, Bassuk and Gerson, 1978.
5. See, for example, the conclusions of the President's Commission on Mental Health *Report* (hereafter PCMH *Report*) 1978:4,45, in regard to the nature of "underserved" and "unserved" population groups.
6. The Federal agency representatives were:

   Dr. Phyllis Jo Baunach, NILECJ/Corrections Division

   Mr. Craig Dobson, NIC/Jails Center Program

   Dr. Christopher S. Dunn, NIMH/Center for Studies of Crime and Delinquency

   Mr. Paul Estaver, NILECJ/Office of Development, Testing and Dissemination

   The non-Federal representatives were:

   Mr. Gordon Kamka, Warden, Baltimore, MD city jail

   Dr. Asher Pacht, Department of Psychology, University of Wisconsin, Madison, WI

   Mr. Richard Singer, Rutgers University Law School, Newark, NJ

   Dr. Alex Swan, Department of Sociology, Fisk University, Nashville, TN
7. Overall project leadership for the University Research Corporation was provided by Dr. Sheldon Steinberg, and for the National Criminal Justice Executive Training Programs by Mr. Martin Hodanish.

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CHAPTER 2

On "Demons" and "Gaols": A Summary and Review of Investigations Concerning the Psychological Problems of Jail Prisoners

John J. Gibbs, Ph. D.

Introduction

Jails have been depicted as "schools for crime," "dens of decadence," "hell holes," "tombs," and, more recently "ultimate ghettos." Journalistic descriptions of the physical and psychological impact of jails on their inhabitants are commensurate with the graphic portraits of jail environments.

The audiences of the social critic and the journalist demand that they paint their portraits in broad strokes. Their message is best conveyed by this medium. When one moves from the realm of the social critic or journalist to the world of the administrator and the researcher, however, the jail picture becomes less clear, and information demands change. "Hell hole" is not enough. If something is to be done, we must know more. What are the intensity and extent of the heat? Is there any information on the number and the dispositions of the devils? Does the hell in Tulsa look like the hell in Troy?

In the area of psychological and behavioral pathology in jail, we have not yet determined the shapes of the devil. Records are sparse and incomplete; systematic data collection efforts hover at the level of the well-intentioned hobbyist; and, when the demons stand up to be counted, the religion of the counter dictates their shape, and they can take a different form in every jail.

Observers of jails from Dostoyevsky (1959) to Goldfarb (1975) have made general observations about the debilitating effects of the jail and the debilitated state of jail prisoners, but there still remain a number of basic questions. One question is a variant of

the nature or nurture issue. Do jails pose problems that result in psychological difficulties for otherwise normal individuals, or do jails house large numbers of individuals who are predisposed to experiencing psychiatric or psychological problems? A third possibility is that there is an interaction effect between predisposing factors and certain elements of the jail environment. Before this issue can be broached, however, an even more basic question should be answered: What are the nature and extent of psychiatric difficulties or psychological problems in the jail setting?

Impediments to Accurate Estimation

A number of students of American jails note that these institutions house a large number of persons suffering from serious psychological difficulties, and it has been reported that institutional personnel ". . . consider psychiatric illness to be the single major health problem among inmates in metropolitan jails." (Petrich 1976: 1439) Information on the actual extent (the proportion of the population afflicted) and nature (specific types) of these difficulties is limited, however. There are three interrelated restrictions on the amount and quality of systematic information for estimating the nature and extent of psychological problems among jail inmates: records, responsibility, and reliability.

Hood and Sparks (1970) contend that the utility of agency collected data

> . . . depends entirely on the quality of information which is available about offenders; and at the moment this is very low, wherever research is based on administrative records routinely kept by correctional agencies. Almost invariably, such personal and social data as are available in these records are haphazardly recorded, and are thus likely to be missing or inaccurate for a high proportion of case. . . . (p. 185)

The experiences of researchers on mental illness in jail attest to the accuracy of the above statement.

A survey of Nebraska county jails (1968–1969) showed that less than one-third of the counties complied with a minimum statutory requirement that an annual report on the jail be submitted to the district court clerk (Arnot 1969). In the same survey, Arnot (1969, table XIV) notes that only 29 percent of the jails reported that records were kept on prisoner illness. Adams and Burdman (1957) report in their survey of California county jails that "in studying and evaluating the county jails, the existing records of jails were

found generally inadequate for evaluative or even descriptive purposes" (p. 93). One of the strongest indictments of jail recordkeeping practices was made by Mattick: "The American jail obtains very little information about the prisoners committed to its keeping, retains little of what is obtained in any usable form, and reports almost nothing of what is usable to higher authorities" (1974, p. 793).

Goldfarb reports:

> Because of the scanty available jail statistics, no one knows how many inmates suffer mental illness and need special health care as a result. Even as to the discrete group of self-identified disturbed inmates, no evidence is available to show the type and severity of their psychological problems or the lengths of time they spend incarcerated in local jails because of them (1975, p. 95).

In his study of incidents of self-injury in detention facilities, Gibbs (1978) discovered that the amount of missing data on men who had injured themselves while confined averaged approximately 40 percent and ranged from 8 percent for age to 57 percent for confinement history.

One reason for the dearth of valid data on psychological problems and their associated characteristics in jails is the lack of responsibility and perceived need for collecting such information, especially in detention settings. According to National Advisory Commission on Criminal Justice Standards and Goals:

> By tradition, the detention of unconvicted persons has fallen outside the jurisdiction of corrections, the courts, and police. Judges seldom order persons detained pending trial; they simply set bail. Prosecutors and defenders do not lock people up; they merely argue their recommendations to the court. Sheriffs and wardens make no detention decisions; they only act as custodians for those who fail to gain pretrial release. Taken altogether, these abdications relegate the pretrial process to the role of stepchild in the criminal justice system and explain why the problem remains so troublesome (1973, p. 98).

Within organizations, information is typically gathered for present and future decisionmaking and management purposes or for purposes of accountability. If one does not perceive oneself as a decisionmaker or as accountable, the need for data collection does not exist.

A related problem concerning responsibility for gathering information on mental health problems in jails is the scarcity of jail personnel (researchers, social workers, psychologists, psychiatrists,

etc.) who have an interest in mental health and who are willing to assume responsibility for data collection. Thus, a 1973 American Medical Association survey found that only 13 percent of the jails included as part of a national survey reported psychiatric services. (Petrich 1976:1439) Arnot reported that only 7 percent of Nebraska's 90 county jails hired a physician who routinely made calls; 4 percent reported no physician available to the jail; and 69 percent reported private physicians on call on a fee for service basis (1969:36). In 1957, Adams and Burdman found that 88 percent of California jails had no psychiatric services and that 95 percent reported no psychological services or social workers available. The Law Enforcement Assistance Administration's (LEAA) 1972 jail survey showed the following breakdown of professional employees in jails: medical doctor, 19 percent; nurse, 6 percent; psychiatrist, 3 percent; psychologist, 2 percent; social worker, 5 percent (U.S. Department of Justice 1975, Table 15).

In this regard, Goldfarb (1975) noted:

> Since few jails have regular arrangements to obtain psychiatric medical services, and since intensive psychological testing and evaluation is rarely a feature of the jail intake process, there is no accurate count of the incidence of various mental disorders among inmates (p. 103).

Even when estimates of the nature and extent of psychological problems do exist for individual institutions, there are difficulties in making comparisons among jails and aggregating information for a number of institutions.

One problem area is the low reliability or interrater consistency of estimates made by various institutional personnel. For example, Johnson (1976) interviewed a group of prison custodial personnel in New York State (n=81) and found not only wide variation in estimates of the proportion of inmates experiencing psychological problems (0–65 percent) but also considerable variability in definitions of what constituted a psychological problem. The reliability problem may not be solved by employing only the judgments of mental health professionals. There may be large variation in the diagnostic schemes used by such personnel, and, even when the same diagnostic catergories are used, the agreement among those making diagnoses may be low.

This section has provided a brief description of some of the problems involved in estimating the extent and nature of mental illness or psychological problems in jail populations. Subsequent sections will furnish information on (1) the number of individuals who enter jails who have existing psychological problems or histor-

ies of psychiatric difficulties, (2) the number of people who require psychiatric evaluation or treatment while confined, and (3) a review of the research on self-destructive behavior in jail.

Problems at the Entry Stage

Many commentators on the American jail believe that jails shoulder a disproportionate burden of the noncriminal social problems embodied in the undesirable, the unwanted, and the unattached of our society. Jails are characterized as repositories for those who are deemed unworthy of a place in the community, unqualified for a place in the more specialized institutional settings, or unfit for a quasi-institutional setting. Jails are the in-baskets of the criminal justice system where those who are awaiting decisions on a myriad of issues are placed tier upon tier, like so many pieces of paper. Counted among them are men and women who display symptoms of severe psychological disturbance.

Few observers describe jail populations without noting their diversity and the presence of the mentally ill. Consider the following two portraits of jail populations:

> The typical jail scence is bedlam; even to the untrained observer the atmosphere is stressful and the population contains individuals who show signs of mental illness. Some of these sick people contribute to the inhuman conditions in jails, others are victims of it; all ought to be somewhere else (Goldfarb 1975, p. 83).

> The jail is a major intake center not only for the entire criminal justice system, but also a place of first or last resort for a host of disguised health, welfare, and social problem cases. The latter consists, for the most part, of a large number of highly vulnerable or treatable cases for whose protection and improvement society may have expressed a deep concern, but for whom no other treatment facilities have been provided: drunks, drug abusers, the mentally disturbed, and the homeless indigent (Mattick 1974, p. 781).

If, as the jail experts quoted above agree, mentally ill persons are entering our jails, what proportion of the intake population do these people comprise? What is the nature of their illness? What are their characteristics?

Two studies (Swank and Winer 1976; Schuckit et al. 1977) present data which address these questions. As part of a larger program at the Denver County Jail, Swank and Winer conducted

clinical interviews with 100 newly admitted inmates who entered the jail in daily consignments and classified them into psychiatric diagnostic categories. The diagnostic categories reported in the study were: functional psychosis, organic psychosis, antisocial personality neurosis, alcoholism, drug addiction, transient situational disturbance, mental deficiency, and convulsive disorder. Definitions are not provided for the diagostic categories, nor is it indicated if more than one examiner evaluated the inmate for purposes of reliability.

The authors present data which show that 24 percent of the new arrivals reported a history of some type of psychiatric contact (evaluation, treatment, or hospitalization), 64 percent admitted no psychiatric history, and 12 percent were classified as undetermined. Of the 24 new admissions who reported psychiatric histories, 21 percent (n=5) were included in each of the following categories: evaluation only, outpatient/day care, and long-term inpatient care. The remaining 37 percent (n=9) had received short-term inpatient care (Swank and Winer 1976, table 1).

Swank and Winer report that 64 percent of the newly admitted prisoners fit one of several diagnostic categories. The antisocial personality and other personality disorder categories together accounted for 45 percent of those who received a diagnosis, and another 37 percent were either for alcoholism or drug addiction. None of the other diagnostic categories represented more than 5 percent of the prisoners who were classified (Swank and Winer 1976, table 2).

Schuckit et al. (1977) conducted structured personal interviews with 199 newly-admitted, white, male prisoners in the San Diego jail. These men were arrested for nondrug-related felonies and had no previous felony convictions. The restricted nature of this sample limits its utility for estimation purposes. The interviewees were classified by a psychiatrist into one of six categories, based on the psychiatric disorder which apppeared first chronologically. There is no mention in the study of a reliability check on the diagnostic classification. The six categories were: alcoholism, drug abuse, antisocial personality, affective disorder, organic brain syndrome, and no diagnosis.

The authors report that almost half (48 percent) of the interviewees met the criteria of one of the five diagnostic categories. Of those receiving a psychiatric diagnosis, 34 percent were classified as antisocial personalities, and 26 percent, 32 percent, 3 percent, and 5 percent were categorized as drug abusers, alcoholics, organic brain syndromes, and affective disorders, respectively. The authors considered that only 8 percent (those suffering from organic brain

syndrome or affective disorder) of those receiving a diagnosis, or 5 percent of the entire sample, were in need of immediate treatment. Their data also indicate that 44 percent of the sample had been hospitalized in a mental institution, 48 percent had reported having experienced depression for more than 2 weeks, and 24 percent reported histories of suicide attempts.

Obviously, there are some large discrepancies between the findings of Swank and Winer (1976) and Schuckit et al. (1977). For example, the authors of the ealier study report that 14 percent of their sample had been hospitalized, whereas Schuckit et al. indicate that 44 percent of the inmates they interviewed admitted pyschiatric hospitalization. Swank and Winer found that 64 percent of the newly arrived prisoners met the criteria of one of their diagnostic categories, while Schuckit et al. report that only 48 percent of their sample fit their diagnostic categories. Although these differences could reflect actual differences in the populations from which the samples were drawn, they could also be the result of differences in sampling designs or diagnostic schemes. Whatever the case, both studies suggest that a sizable proportion of the jail intake population can be considered as suffering from some form of mental illness.

Another indication of the persons who enter jails with psychological difficulties is the number of them who are confined for mental observation, who are awaiting transfer to a mental hospital, and who are not accused of a crime but are confined because they were engaging in bizarre behaviors which suggested mental illness. Referrals for mental observation should be viewed with caution, however. In some jurisdictions, persons accused of certain offenses (e.g., homicide) are invariably placed on mental observation status, independent of any psychiatric history or diagnosis.

Some of the jail surveys conducted in various States have collected relevant information in this area. Arnot's survey of Nebraska county jails during 1968 and 1969 suggests that approximately 2 percent of the State's county jail population were confined for a mental health hearing (1969, table IV, II). A National Council on Crime and Delinquency (NCCD) survey of 350 randomly selected cases at the Summit County jail in Akron, Ohio, showed that 7 percent of the sample were incarcerated for "suspicion of insanity" (NCCD 1962, table IV). Mattick and Sweet, in their 1967–1968 survey of Illinois jails, found that 2 percent of the jail population were being held for mental health authorities.

Once again, there is marked variation among the estimates. This could be due to actual differences among the jurisdictions, the

result of differences in survey methodologies, and/or counting rules.

There may also be a sizable group of people who enter jail relatively free of psychiatric symptoms but who react to situational pressures in a pathological fashion; or there may be a considerable number of psychotics in remission whose symptoms become active after spending some time in jail. (Some problems identified at the entry stage may well be responses to the situational pressures of arrest and/or the anticipatory anxiety about the prospects of detention.)

The next section surveys the findings on the proportion of the total jail population who experience psychological difficulties while confined. Findings reported in this section are also not without problems. In most studies, it is not possible to separate people who enter jails with problems (the topic of the present section) from those whose problems emerge during confinement.

At first glance, this chicken-or-egg dilemma may not appear to have great practical significance, since something has to be done for both groups. But, if one wishes to measure the impact of the jail environment on relatively well-functioning inmates (i.e., persons considered healthy when they enter the institution), or if one wishes to develop intervention or diversion programs for the two groups, information concerning the proportion of the population in each group and the nature of the problems becomes significant.

Problems in Jail Populations

The Swank and Winer study (1976) also contained an analysis of 445 prisoners who were referred to a psychiatrist or who requested to see one. If such contacts with a psychiatrist are considered a measure of the number of people suffering from psychological problems in the jail population, the rate of psychiatric illness in the Denver County jail during 1974 was 35 per 1,000 inmates (445/12,453). If we consider as ill only those of the referrals who received a diagnostic label (412), the rate becomes 33 per 1,000 inmates.

As mentioned above, 412 inmates (about 93 percent of the 445 referrals) received a diagnostic label. The functional psychoses category contained the greatest number of persons receiving a diagnosis (25 percent), followed by other personality disorders (22 percent), antisocial personality (16 percent), and alcoholism (13 percent). None of the other diagnostic categories (organic psychosis,

neurosis, drug addiction, transient situational disturbance, or mental deficiency) contained more than 10 percent of the sample. The Swank and Winer data suggest that inmates who are referred to jail mental health personnel have substantial problems. Approximately two-thirds of the inmates who were diagnosed were considered to be suffering from either psychotic or personality disorders.

Inmates who were referred were most likely to be: white (57.3 percent), single (38.9 percent), committed for a felony (41.4 percent), previously convinced (56.9 percent), and between the ages of 20 and 29 (52.9 percent). Almost three-fifths of the referred inmates reported psychiatric histories, and two-fifths had a history of psychiatric hospitalization.

When the referred group was compared with a nonrandom sample of newly arrived inmates (n=100), it was found that whites and men with psychiatric histories were overrepresented in the referral group, while those committed for a felony and those without prior convictons were underrepresented. (Swank and Winer 1976, table 1, p. 1132). Compared to the new admissions group, members of the referred group were more likely to receive psychiatric diagnoses (93 percent versus 64 percent) and were more likely to be classified as alcoholics (Swank and Winer 1976, table 2).

Petrich (1976) conducted a study of the inmates in King County jail (Seattle, Wash.) who were referred to the institutional psychiatrist during a 5-month period from September 1, 1973, to January 31, 1974. The staff psychiatrist examined 122 individuals of an estimated 200 individuals. (The author reports that a number of individuals were referred for treatment but were released from the jail prior to examination or were judged not to need psychiatric examination.) Based on the number of inmates examined and the estimated number of people booked into the jail during the study period (n=2,625), Petrich computed a psychiatric morbidity rate of 46 per 1,000 inmates.

The referral sample consisted of 102 males and 20 females. The male referrals differed from the general jail population in terms of age and ethnicity. The referred persons tended to be older and more likely to be members of a minority group. The modal picture of the referred inmate in Petrich's sample looks similar to that described by Swank and Winer (1976). The majority of both male and female referrals were single (never married, divorced or separated), confined on felony charges, had previously been arrested and confined, and reported psychiatric histories. Approximately one-third of the persons in the referred group reported that they had attempted suicide. (Petrich does not compare his referral

sample with the general jail population on any of the variables mentioned in the modal profile.)

There are also some similaries between the Swank and Winer and the Petrich studies in the distribution of the referred inmates among the diagnostic categories. (In the Swank and Winer study, the diagnostic categories, other than the convulsive disorder category which is not considered in this chapter, are mutually exclusive. In the Petrich study, a referred inmate could receive more than one diagnosis. The comparisons between the two studies referred to in this paper are between the percentage of persons in each Swank and Winer diagnostic category and the percentage of diagnoses in each of Petrich's diagnostic categories.) The functional psychosis category contained one-fourth of the cases in the Swank and Winer study and about one-fifth of the cases in the Petrich study (for the Petrich study, the mania and schizophrenia cases were combined to compute the functional psychosis percentage); the diagnosis of alcoholism accounted for approximately 13 percent of the diagnoses in each study; there was only a 2 percentage point difference with regard to persons classified as mental defectives and neurotics in the two studies, and antisocial personality was the diagnosis in 16 percent of the cases in the Swank and Winer study and 23 percent of the cases in the Petrich study. Drug dependency, however, was diagnosed in 24 percent of the Petrich cases and in only 9 percent of the Swank and Winer cases.

Some of the State jail surveys include estimates of the number of persons in the jail population who are experiencing psychological problems. A 1968 NCCD survey of the Wayne County Jail in Michigan found that over 8 percent of the jail population was receiving some type of medication for the treatment of psychotic and psychoneurotic disorders (NCCD 1968). Olds' (1956) survey of the Baltimore City Jail showed that approximately 19 percent of the inmates were suffering from some type of mental disorder. Mattick and Sweet (1970) reported on Illinois jails:

> Although survey statistics must depend on the estimates and judgements of jailers not trained in psychiatry, they are indicative. More than 60 percent of the county jails held from 10 to 50 of such persons (mentally ill) varying from a few hours to more than 48 hours (p. 12).

The studies reviewed to this point indicate the number of jail inmates recognized as suffering from psychiatric disorders on the basis of the visible nature of their illnesses. These inmates would typically be referred to the jail mental health or medical personnel by custodians and other jail employees. Persons who are trouble-

some or highly visible in other ways are probably overrepresented in this group. In contrast, those who suffer silently or whose symptoms take less overt forms often do not become part of the referral population. If their number were known and figured into the morbidity rate, the estimated rate of psychological problems among jail inmates would be considerably higher.

The Significance of Self-Injury

Self-injury is discussed separately from any of the traditional diagnostic categories because (1) self-destructive behavior is a frequent problem in jail, which has been investigated with and without the use of standard diagnostic categories, and (2) content-analyzed interviews with self-destructive prisoners have provided a richer picture of the problems experienced and the pressures faced by jail inmates than by persons in any diagnostic category.

Self-destructive behavior is an important measure of psychological disorder or breakdown for a number of other reasons:

1. Self-destructive behavior is not uncommon in jail. Toch (1975) reports on the extent of self-injury in jails and prison: ". . . with even the most conservative figures we can show that the problem of self-mutilation is endemic and that nothing commensurate occurs in other settings. If a problem even remotely similar were to arise in the outside world, it would provoke outrage and emergency intervention" (p. 127). Johnson (1976) notes that 41 percent of the inmate crisis situations described to him by prison staff members involved self-injury. The problem of self-injury also touches the lives of men who do not injure themselves. Inmates who report they are experiencing problems in confinement often provide information about suicidal thoughts to indicate the depth of their distress (Toch 1975).
2. Self-injury not only is statistically associated with a number of other indices of psychological stress (Johnson 1976) but also goes beyond these measures by representing a wider range of motives, symptoms, problems, and concerns (Toch 1975). Other measures of psychological breakdown, e.g., requests for protective segregation or commitment to a mental institution, may reflect a more limited set of concerns, such as fear or psychotic difficulties (Johnson 1976). Self-injury covers a broad spectrum of concerns.

3. Because self-inflicted injury is an act that typically requires medical attention, it is more likely to be reflected in institutional records than are some other actions that indicate psychological breakdown. Other behaviors that represent a wide range of psychological difficulties may be less visible, be handled informally, and therefore may never appear in official records.

Studies of Self-Injury

The available investigations of self-injury have been characterized by small sample size, restricted definitions of self-injury, emphasis on the method of self-injury, and analysis of demographic characteristics to construct a profile of inmates prone to engage in self-injury. Only three of the eight studies reviewed compare the self-injury group with a control sample drawn from the general jail population on the relevant variables. Most of the research reviewed is focused on the characteristics of the man who injures himself, and it tends to overlook system-individual interactions or transactions. Studies of self-injury share a common problem with other investigations of psychological difficulties among jail inmates, viz, the inquiries do not provide any concrete data on whether self-injury in jail is explained by the stresses of the jail environment, the susceptibilities of some persons incarcerated in jails, or some interaction between these two factors.

It appears that self-injury is a more serious problem in jail than in prison or in the community. In jails that contain both pretrial and sentenced inmates, the detainees (those awaiting trial) are more likely to injure themselves. Esparza (1973) reported a suicide rate of 57.5 per 100,000 in a sample of county jails in a midwestern State. He compares this with the suicide rate of 10.5 per 100,000 in Federal prisons (Rieger 1971) and with the rate of 16–17 per 100,000 reported for the general male population (Hendin 1967). Heilig (1973) found that, of the suicides committed in Los Angeles county jails in the years he sampled this population, 96 percent occurred in the pretrial detention setting. In New York City jails, 93 percent of the men who committed suicide between October, 1970, and September, 1971 did so in a detention setting (Martin 1971).

The incarceration time prior to the self-destructive act was found to be an important variable in some of the investigations. Danto (1973*a*) reports that 6 of the 10 suicides he studied occurred within

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30 days of incarceration. Esparza (1973) found that 67 percent of the suicides in his sample occurred within 90 days of confinement. Heilig (1973) reports that 19 of his 26 cases committed suicide within their first 24 hours of confinement. Fawcett and Marrs (1973) found that 52 percent of their combined suicide sample (attempted and successful cases) had committed their self-destructive acts within 30 days of confinement; 19 percent had injured themselves within the first 3 days of confinement. In 69 percent of the suicide group, the self-inflicted death had resulted within the first 30 days of incarceration. Beigel and Russell (1973) report that ". . . all the suicide attempts occurred in a period from the end of the first week to the end of the sixth week after placement in jail. None was found after six weeks, despite far longer stays in jail for many of the prisoners" (p. 110). Martin (1971) found that 62 percent of the suicides (n=13) had occurred within the first 10 days of jail confinement.

When samples which have comparable data and time intervals are combined, the samples of Danto (1973*a*), Heilig (1973), Fawcett and Marrs (1973), and Martin (1971) yield a total size of 70 cases. Three-fourths of this combined sample committed self-destructive acts within 30 days of their confinement.

The above findings suggest that some self-destructive inmates may experience "entry shock." In other words, they find the transition from the "streets" to confinement so disequilibrating that they experience psychological breakdowns. For some descriptions of the transitional problems related to confinement in jails, the "entry shock" explanation of jail self-injury seems plausible. For example, Irwin (1970) provides a vivid description of initial reactions to jail:

> . . . the disjointed experience of being suddenly extracted from a relatively orderly and familiar routine and cast into a completely unfamiliar and seemingly chaotic one where the ordering of events is completely out of his control has a shattering impact upon his personality structure. One's identity, one's personality system, one's coherent thinking about himself depend upon a relatively familiar, continuous, and predictable stream of events. In the kafkaesque world of the booking room, the jail cell, the interrogation room, and the visiting room, the boundaries of the self collapse (p. 39).

As previously mentioned, most of the studies reviewed do not include comparisons between self-injury samples and samples of the general jail population, but they do provide some data on the characteristics of those who injured themselves. Danto (1973*a*) reports that 6 of the 10 suicides he studied at the Wayne County jail were committed by prisoners charged with a violent felony.

Esparza (1973) found that 84 percent of the cases he reviewed (n=66) had a crime of personal violence appearing on their record. In their study of a Belgian jail, Wilmotte and Plat-Mendlewicz (1973) found that of the 137 crimes the self-injury group (n=84) were suspected of committing, there were 48 crimes of personal violence, 57 property crimes, and 18 drug offenses. Fawcett and Marrs (1973) discovered that 67 percent or 14 of the 21 prisoners who committed suicide or who made "high intent suicide attempts" were charged with violent personal crimes (including nine homicide charges). And, the data collected in New York City detention facilities by Gibbs (1978) indicate that men who injure themselves are more likely to have histories of arrest for violent offenses and violent offense charges pending than are members of a random sample of the general jail population.

In contrast to the above findings, Beigel and Russell (1973) in their study of attempted suicides in Arizona jails found that 50 percent of the control group was charged with a violent crime, as compared with 23 percent of the suicide attempters. Similarly, Heilig (1973) found that, of the 26 individuals who committed suicide, none was charged with a violent crime. And, Martin's (1971) analysis of 13 suicides in the City of New York Department of Corrections institutions between October 1970 and September 1971 indicates that the vast majority of these persons had not been charged with violent crimes.

Thus, although there is variation among the reported findings on violence and self-injury, the available evidence suggests that there may be a positive association between these two behaviors. Ethnicity also appears to be related to self-injury, since most studies show that whites represent a greater percentage of the self-injury population than blacks, and in jails that house a sizeable Puerto Rican population, these persons are more often included in the self-injury population than are blacks.

Gibbs (1978) found that, in comparison with the general jail population, the self-injury groups contained an underrepresentation of blacks (23 percentage points), and an overrepresentation of whites (13.7 percentage points) and Latins (11 percentage points). Similarly, Martin (1971) found that, although whites comprised only 10 percent of the New York City jail population, they accounted for 38.5 percent of the suicides; Puerto Ricans also represented 38.5 percent of the jail suicides, although they accounted for only 25 percent of the jail population. Blacks were underrepresented among the suicides; although blacks represented 65 percent of the jail population, they accounted for only 23.1 percent of the suicides. Esparza (1973) reported an ethnic breakdown for suicides and at-

tempted suicides of about 80 percent white and 20 percent black; Heilig (1973) found that the overwhelming majority of the cases in his study were white; Fawcett and Marrs (1973) reported that 52.4 percent of the cases studied were white, followed by 33 percent black and 14.3 percent Latins.

The findings of two studies diverge from the trend described above. Danto (1973*a*) reported that 6 of the 10 cases he studied were black. Beigel and Russell (1973) found, in Arizona jails, there were 17 percent more nonwhites (predominantly Mexican-Americans) among the suicide attempters than in the control group, although this difference was not statistically significant.

The review of studies on self-destructive behavior in jails suggests that there may be a link between mental illness and self-injury and between prior suicide attempts and self-injury. Danto (1973*a*) reported that 7 out of the 10 suicide cases he studied had a history of mental illness and that 4 of the 10 cases had a history of prior attempts. Esparza (1973) comments concerning his sample of suicide and attempted suicide cases that "these prisoners had also invariably received some type of psychiatric assessment and/or treatment since a high percentage of them had previously had a history of mental illness and previous attempts (sic) were known as 'mentals' to the jail authorities" (p. 35). Unfortunately, Esparza does not specify what he considers to be a "high percentage"; one also has to assume that "invariably" means that *all* the cases had received psychiatric evaluation or treatment.

The findings thus far suggest relationships between self-destructive behavior in jail and violence, ethnicity, and mental illness. However, because in most studies to date, the self-injury samples have not been compared with a random sample of the jail population, it is not possible to determine: (1) whether the self-injury sample differs from the general jail population with respect to these factors, and (2) the strength of the association between self-injury and other variables.

In the one study (Gibbs 1978) that made extensive comparisons between a jail self-injury population (415 cases) and a random sample of the jail population (1,188 unweighted cases and 1,537 weighted cases to reflect adolescent and adult populations), those who injured themselves were more likely to be older, married, and/or drug addicts. They were also more likely to have a history of previous arrest for a property, drug, or violent offense, previous incarceration experience in jail or prison, and a pending charge involving a violent crime (Gibbs 1978). All these differences were statistically significant at the .05 level, using chi square analyses. However, the strength of association (phi) between self-injury and

any of the above variables never reached a magnitude of .20. The low strengths of these relationships indicate that knowledge of these personal history variables associated with self-injury in jail is not of great assistance in identifying or predicting which inmates are likely to injure themselves.

What are the problems experienced by men who injure themselves while confined in jail? Danto (1973) notes guilt, hopelessness, and social isolation; Esparza (1973) mentions the shock of family separation; Fawcett and Marrs (1973) consider the self-destructive acts of inmates a "decisive and desperate action of control over the outcome of their lives . . ." (p. 86). These authors go on to note that:

> Feelings of isolation, helplessness and often hopelessness created by the inmate's isolation and loss of control over his situation make the experience of loss of support by significant others outside the jail especially intolerable (Fawcett and Marrs 1973, p. 94).
>
> . . . the pressure caused by the unknown future and lack of control of the inmate over his own life, as well as the possible presence of depressive features creates the conditions that militate toward suicidal behaviors (Fawcett and Marrs 1973, p. 100).

The only study to systematically explore motives for self-injurious behavior while in jail was conducted by Gibbs (1978). Part of the data analyzed in this study were 333 tape-recorded and transcribed clinical interviews with men who had injured themselves in jail (105) and prison (228). The interview content was classified by means of a typology constructed by Toch (1975). This classification was done by the interviewer and by an independent rater. Each interview was rated with regard to a primary or dominant theme and, in about half the cases, a secondary theme. Interrater agreement ranged from 85 to 90 percent on primary themes and 75 to 80 percent on secondary themes; in instances of disagreements between raters, a final classification was reached by consensus. [Readers interested in a full description of the typology used and its development should refer to Toch (1975), Johnson (1976), or Gibbs (1978). Those interested in a detailed description of self-destruction themes in jail compared with those in prison should review Gibbs (1978).]

Thematic analysis of the interviews revealed that the most common problem described by these self-destructive jail inmates was a crisis involving self-doubt or self-worth, especially in relation to significant others. The results of the analysis suggested that

imprisoned men need the support of significant others in the community for a number of reasons, such as contact with outside reality, contrast to the coldness of the institutional environment, and a sense of belonging to the world beyond confinement. Family and friends also become important for self-definition, in that when one is loved, one is worthy. When support is withdrawn or not offered, one may feel alone or unwanted. During the initial stage of confinement, support from significant others may help absorb the shock of incarceration and also provide necessary tangible benefits, such as bail, counsel, clothing, money, and other necessities.

Gibbs (1978) compared interviews of self-destructive jail inmates with those of prison self-mutilators and found statistically significant differences. Psychological breakdown among the jail inmates was more likely to relate to the need for support from significant others, whereas a greater proportion of the self-destructive prisoners reported problems involving fear for personal safety.

Conclusion

In 1974, Mattick wrote:

> It is possible to speak knowledgeably of the American jail because what information we have is so consistent: the jails everywhere are inadequate. Perhaps a few local variations have escaped our notice. But the student of jails quickly discovers that, historically, the "jail problem" has not been a subject of professional disagreement over the basic details of jail conditions, nor even of what to do about them; on the contrary, there has been remarkable agreement (Queen, 1920; Fishman, 1923; Robinson, 1944; Alexander, 1957). Modern survey techniques may make it possible to begin to objectify and quantify the conclusions reached long ago by personal experience and anecdotal evidence. It remains to be seen whether figures speak louder than rhetoric (1974, p. 782).

The studies reviewed here demonstrate that we are still not in a position to see ". . . whether figures speak louder than rhetoric." The primitive nature of the methodologies employed provides us with modal portraits of mentally ill and suicidal inmates, but we do not know how they differ from other members of the jail population. We have estimates of the rates of self-injury and psychological breakdown in jail, but these rates are seldom based on probability samples. Moreover, we do not know if differences between various

estimates are due to sampling errors, differences in definitions, or geographical or yearly variation in action rates.

There is a need for a survey of the populations of our Nation's jails based on scientific sampling techniques, consistent definitions across jurisdictions, and reliable assessment instruments. There is a need for specificity in our research questions, i.e., what impacts jail has on what people and under what circumstances. Above all, there is a need for accurate recordkeeping by jail personnel. Such basic information will enhance our ability to develop and implement programs to ameliorate the stresses of jail for vulnerable groups, and to identify and divert inmates whose chances of psychological survival would be better in another setting.

In some circles, a plea for additional research is considered trite, the banner of the actionless, or an excuse for lack of substance. In the area of psychological and behavioral pathology in jails, the call for additional research is not such a plea or defense. It is in fact a necessity. The "hell holes," as some have called jails, will be with us for quite some time. If we want to ameliorate the stress of these institutions for vulnerable groups and to enhance the chances of psycholollgical survival for susceptible men, we must know more about the problems and stresses they face. A first step should be to gather some basic and reliable information on the nature and extent of psychological and behavioral pathology in jails. Our initial action should be research.

> In the complex and costly business of social action we should not leave to chance any area of decisionmaking or any aspect of any situation that can be properly studied. By properly, we mean rigorously and powerfully and in such ways that other people may verify any results for themselves—in fact, we mean scientifically (Wilkins 1965, p. 4).

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CHAPTER 3

Service Delivery Models: A Summary of Examples

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Introduction

According to the 1977 *Sourcebook of Criminal Justice* statistics, there were 3,921 jails [1] in the United States, estimated to process annually from 1½ to 5½ million persons (Gibbs, chapter 2). Based on recent trends and projections, the average number incarcerated each year is expected to 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 that, in many observers' views, they are now considered a priority management and treatment problem. These observations and concerns are amply supported by both literature review and recent research reported in the presentations by Brodsky, Gibbs, Gove, Megargee, and Singer. Further, the jail populations also 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, a growing number of the mentally ill are appearing in jails because of their criminal arrests, albeit often for minor charges; it appears that arrest and booking are regarded as the most reliable way of securing involuntary detention of mentally disordered persons.

One reason for 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 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, p. 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 many individuals, almost inevitably perhaps, to encounters with the criminal justice system. 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 frequently being used as a disposal for both the mentally ill and the mentally retarded.[2]

In many jurisdictions, this use has deleterious effects for the incarcerated because jails usually lack adequate preparation, direction, or mental health support in the management and treatment of those most needing services. Consequently, today's jails are the storage place of last resort, allowing society to warehouse citizens who have manifested deviant or socially disruptive behavior. Moreover, despite the protestations of sheriffs and jail administrators about the inappropriateness of housing the mentally ill in jail, the situation seems unlikely to change in the foreseeable future.

There are at least two major factors which lead to the expectation of continued booking of mentally disordered or mentally retarded persons into the jails. One is the unlikelihood that the policies or procedures for State mental hospitalizations will drastically change. The resumption of vast psychiatric institutionalizing of mental patients is improbable because of the legal challenges to involuntary treatment, tightened commitment statutes, greater use of "less restrictive settings," patients' rights litigation, and related policy changes. The second factor is the growing public intolerance with criminal acts of mentally disturbed persons (e.g., chronic patients released from State hospitals) and with the recurrent nuisance behavior of some mentally retarded persons. Consequently, law enforcement intervention has been increasingly requested by the community to deal with and to remove these "problems."

The problems regarding the management and adequate treatment of mentally disordered persons confined in jails can be expected to continue, unless conditions and past professional relationships are changed. Although efforts have already been undertaken by jail professionals to reduce some of the management difficulties, the need for additional outside assistance with mental health treat-

ment for the jail's clients has been universally recognized. The link between jails and human service agencies has traditionally not been strong. Few community representatives have expressed interest in jail populations or offered services for them. Few jail managers have heretofore sought to cultivate outside agency involvements with their facilities. Whenever prior contacts were attempted between corrections/law enforcement and mental health/social service representatives, the experiences often were unsuccessful and reinforced existing stereotypes and antagonistic attitudes. Brodsky's explanation (chapter 6) of the consequences of the encounters between jail personnel and mental health staff indicates the nature of the process.

However, there has been concern demonstrated recently by jail personnel who are frustrated with present conditions and who understand that new methods for coping with the increasing mental health-jail problems are being 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.

While, as evident below, different modalities have been adopted to address these issues, solutions should involve the development and efficient use of resources and referrals. There must be local, regional, and national planning with well-coordinated communication and program implementation. Through coordinated and cooperative jail and human service endeavors, the most cost-effective strategies for the management and treatment of mentally disordered offenders can be provided.

Survey Design, Distribution, Response, and Program Screening

In recognition of this need for cooperation, as an initial step to facilitate local program development efforts, and in preparation for the Special National Workshop on Mental Health Services in Local Jails, one planning task was to conduct a state-of-the-art survey. This survey was intended to identify existing jail mental health service delivery programs, to assess the nature of jail mental health service delivery systems, and to identify replicable jail

mental health service delivery "models," that is, sets of necessary or characteristic program features. A further goal was to select a small set of programs whose features or characteristics could be described in case-study detail, so that the "program model" elements could be exemplified in operation. The programs eventually selected and visited (described in detail in Morgan 1979) are "models" in the sense that they represent different ways in which the constituent elements and features of service delivery programs (e.g., needs, development, screening, training, treatment, referral) are operationalized. They are *not* necessarily "exemplary" models in the sense of being rigorously evaluated and found to be eminently successful (although they seem to address needs specific to their jurisdictions). Instead, they are working models that have been screened in regard to having or illustrating a variety of criteria.

From the outset, a major obstacle limited the conduct and analysis of this survey. The lack of data at the national level reflects the generally low level of interdisciplinary communication. Many innovative programs undoubtedly exist throughout the Nation and need to be studied more systematically.[3] Because of the limited information that was available about individual jail mental health programs, this initial survey sample is not as comprehensive as might have been desired; the results are interesting but need further and more systematic followup and replication. In other words, identifying programs and describing characteristic features all in the same stage of research are not usually the preferred strategy, since some programs that are missed might contribute additional, different information in regard to the salient features. It needs to be remembered, however, that the survey was commissioned specifically as a workshop planning tool, and only when the number of programs that began to be located grew, was there a decision to move toward identifying program "models."

Another difficulty which affected the survey, specifically subjects' responses, was the apparent language barrier between mental health and criminal justice professionals. This problem surfaced repeatedly when program managers attempted to answer questions about their mental health services. A major source of their concern was the uncertain and imprecise definition of "mental health." For example, Beck (1978) noted:

> . . . 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 de-

fined" and that "available data are often inadequate or misleading."

Since the mental health professionals have evidently not agreed upon a uniform definition, it is little wonder that jail personnel and the public have problems with the imprecise concept. Nevertheless, because the intent of the survey was to acquire as much information as possible about what existed in the field, the interpretation of "mental health" was left open. Only services established exclusively for substance abusers were excluded.

Perhaps reflecting the definitional problems, estimates of the percentage of mentally ill persons in responding jails ranged between 0 to 60 percent.[4] Estimates for the mentally retarded in responding jails ranged between 0 to 25 percent.

Another type of problem was illustrated by the duplicate survey responses returned from four individual projects, one description having been completed by a mental health staff member and a second by a jail representative, apparently each unknown to the other. Although basically similar, the subjective emphasis and explanations in each half of the duplicate responses were both interesting and distinct. (Further discussion is provided in the Survey Data Summary section).

Consequently, because of these discrepancies, "mental health" programs were reviewed in light of each jail's statement of needs and objectives. They were also reviewed in terms of the following basic service components: intake/screening/classification, prevention, crisis intervention, ongoing treatment, and followup/referral. Also, discussions with the involved mental health and jail staff were required during the onsite evaluations for model service delivery selections.

Distribution and Response

Although it would have been ideal to contact each of the approximately 4,000 jails, time and budget constraints made it impossible. 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 methods for data collection included a review of available program literature and mail and telephone requests for program identification or referral. Letters were sent to State-level agencies or associations, past conference participants, and members of interested or involved affiliate organizations. Table 1 indicates the types of agencies or persons contacted and the response rate of each type. Personal or telephone inquiries

(see table 1) were essentially the most productive efforts with respect to program identification. The jail inspectors expressed the best sense of the problem and what was being done within the jails in their respective States. It should also be noted that everyone interviewed by phone responded fully to the questions and shared the opinion that the issue of mental health problems in local jails was an important concern.

On the basis of 845 initial inquiries, 193 programs for mental health services in local jails were identified, 160 from the sources shown in table 1. An additional 33 unduplicated programs were identified as LEAA-supported nonblock grant awards relating to mental health services in correctional institutions.

The second stage of inquiry involved requests (N=193) for written program descriptions. The 81 programs returning descriptions comprised the subgroup that were screened for selection as "example" programs and for which statistical summaries of program features and characteristics are presented below.

The screening process began by identifying the criteria shown in list form in table 2. Twenty programs, approximately 25 percent of the 81 responding programs, were selected for the purpose of site visiting to ascertain more fully the nature and operation of each. The selection of these 20 attempted to encompass as much variation across the screening criteria as possible. Once the visits had been conducted, six individual local programs and one statewide set of activities were selected as program "models." They were:

Table 1. Survey Response Rates by Type of Inquiry and Type of Respondent

Type of inquiry	Type of respondent	Number of inquiries	Responses	
			Number	Rate (in %)
Mail	State Agencies:			
	Mental Health Departments	49	30	61
	Mental Retardation Departments	52	27	52
	State Planning Agencies (i.e., SPA's) or Corrections Departments.	56	23	41
	Associations (e.g., Sheriffs)	30	9	30
	Subtotal	187	89	48
Mail	Directories or Participant Listings:			
	American Correctional Association.	53	20	38
	Criminal Justice Information Service.	21	8	38

Table 1. Survey Response Rates by Type of Inquiry and Type of Respondent—Continued

Type of inquiry	Type of respondent	Number of inquiries	Responses	
			Number	Rate (in %)
	Correctional Service Agency Division.	12	4	33
	1975 Symposium-Mentally Retarded Citizen and the Criminal Justice System.	87	14	16
	Subtotal	173	46	27
Mail	Referrals from above agencies	51	20	39
	Total	411	155	38
Phone	State Jail Inspectors	34	34	100
	Sheriffs, Jail Managers, or Jail Staff (from NIC Jail Center training sessions).	300	300	100
	Local agencies, associations, universities, research project staff.	100	100	100
	Total	434	434	100
Totals:				
Mail		411	155	38
Phone		434	434	100

- Alabama—Marengo County
- California—Los Angeles County
- California—Napa County
- Michigan—State Jail Mental Health Task Force
- New Jersey—Monmouth County
- Ohio—Cuyahoga County
- Washington—Whitman County

Officials of these programs were invited to participate on the Service Delivery Models panel of the workshop. They were asked to provide narrative descriptions of their programs, including all the topics that are listed in the appendix to this chapter. These narrative descriptions formed the basis for workshop presentations about each program. Summaries of the essential features and characteristics of each program are presented below, and the complete narrative descriptions are presented in Morgan (1979).

Many of the other programs visited in the course of arriving at seven programs invited to participate on the workshop panel deserve recognition for their program achievements. However, because of the need to illustrate a balanced sample of operations according to the criteria shown in table 2 (e.g., size of jail, region of the country, type of delivery system), some of these other programs could not be selected as panelists. Nevertheless, representatives from these other programs were invited to the workshop as participants and are also identified as resource contacts in Morgan (1979). And as with the representatives of the seven selected programs, use of the expertise of these other program officials is also encouraged.

Table 2. List of Screening Criteria for Selection of Example Jail Mental Health Programs (applied to 81 jails returning written program descriptions)

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. Apropriate 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

Finally, none of the service delivery system or program examples should be taken as the only way to solve jail mental health problems. The selected programs serve to illustrate the variety of ways

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in which responses to identified needs with appropriate and replicable services are indeed possible, feasible, and in operation. It is hoped that these examples of service delivery systems will offer jail managers and mental health sevice providers the opportuity to evaluate and extract useful program components.

Survey Data Summary

Because the intent of the survey design and distribution, as explained above, was of an exploratory nature, it is not possible to draw definite conclusions about mental health programs in jails based upon the data generated in this inquiry. It is possible, however, to make general and preliminary statements, based upon patterns that emerged from the program responses.

A total of 193 initial requests for program descriptions were sent (in April 1978) to jails identified as having mental health programs. A followup letter containing a second copy of the program description questionnaire was sent to all nonresponding institutions on May 18, 1978. Of these requests, 97 responses were received by August 1, 1978, after which date responses could not be included in the analysis prepared for the workshop. This 50 percent response rate compares favorably with the response rates of most mail surveys.

During preliminary analysis, 16 of the 97 respondents indicated that they had no program. This fact provides additional confirmation of the nature of 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, analysis was limited to the examination of frequency and contingency tables. Preliminary analysis suggested that two variables, "size of the jail," and "program budget," might account for some of the differences in the response rates. Contingency tables were thus constructed, using size of jail and program budget as "independent" variables. As the following analysis indicates, differences emerge from these comparisons.

The two "independent" variables first need to be defined. The variable, "size of the jail," refers to the size of the inmate population on the day the questionnaire was answered. In the initial contingency tables, this variable was broken into five categories (jails with fewer than 50 inmates; 50–149 inmates; 150–499 inmates; 500–999 inmates; and 1,000 or more inmates). 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: *small*—those with fewer than 50 inmates; *medium*—those with 50 to 499 inmates; and *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 in a jail with 50 inmates and one with 450 inmates, the data from this survey suggest that there is enough 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 identified as: (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. These interrelationships should be examined in any future research efforts.

Recognizing the limitations of the data detailed above, the analysis suggested first of all that the underlying basis of the programs is different when one controls for the size of the jail population. This was evident upon examination of the responses to the questions pertaining to litigation and program rationale. As might be expected, because of location and isolation from the reform activities usually centered in larger cities, the small jails report a lower incidence of litigation relating to health or mental health programs (33 percent) compared to medium (44 percent) and large (91 percent) jails. Thus, 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.

It is possible 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 supported by the differential responses to the question of how and why the program got started. It was found that 73 percent 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 40 percent of the jails with large budgets responding with similar statements. On the other hand, we find that 39 percent of the large jails initiated their programs because funding was provided, while only 18 percent of the small jails fell into this category. There seems to be some degree of association between involvement in litigation and rationale for beginning the program. Perhaps the litigation issue is related to the high correlation between jail size and program budget, indicating 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. To provide 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 program models described below.

Table 3. Estimated Percent of Jail Population Mentally Ill by Size of Jail

Question: What is the approximate percentage of the current jail population that is mentally ill?

Percent mentally ill	Size of jail			Total
	Less than 50	50 to 499	500 or more	
0				
Number	4	5	0	9
Percent	(40)	(14)	(0)	(16)
1–5				
Number	3	12	2	17
Percent	(30)	(33)	(20)	(30)
6–10				
Number	0	11	6	17
Percent	(0)	(31)	(60)	(30)
11+				
Number	3	8	2	13
Percent	(30)	(22)	(20)	(24)
Total:				
Number	10	36	10	56
Percent	(100)	(100)	(100)	(100)

An alternative course of action revealed by the data shows a greater tendency for the small jails to transfer those inmates judged to be mentally ill or retarded than for the medium and large jails. Although this conclusion may seem to rest on a tenuous base, since only about 10 percent 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 great substantive differences in the way jails *define* the mentally ill and mentally retarded, interesting patterns can be noted. In response to requests for an estimate of the percentage of mentally ill and mentally retarded inmates in the jail, 40 percent of the small jails stated that they had no mentally ill inmates at the time of the survey inquiry, while 80 percent of the larger jails said that more than 5 percent of their population were mentally ill (table 3). The same trend holds true for the mentally retarded, with 78 percent 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 percent mentally retarded inmates (table 4). 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?", suggest that perhaps there is a difference in transfer successes. Among the small jails, 64 percent report placing the mentally ill or retarded in alternative situations within 1 week. In comparison, only 42 percent of the medium-size 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 potential patterns that may warrant further examination.

Table 4. Estimated Percent of Jail Population Mentally Retarded by Size of Jail Population

Question: What is the approximate percentage of the current jail population that is mentally retarded?

Percent mentally retarded	Size of jail			Total
	Less than 50	50 to 499	500 or more	
0				
Number	7	7	1	15
Percent	(78)	(21)	(10)	(29)
1–5				
Number	1	21	8	30
Percent	(11)	(64)	(80)	(57)
6–10				
Number	1	4	0	5
Percent	(11)	(12)	(0)	(10)
11+				
Number	0	1	1	2
Percent	(0)	(3)	(10)	(4)
Total:				
Number	9	33	10	52
Percent	(100)	(100)	(100)	(100)

In conjunction with inspecting the comparative underrepresentation of the mentally ill in small jails, one might also examine the small jails' usage of State hospitals as alternative placements; however, 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 percent of the medium-size jails, and 27 percent of the large jails.

Responses regarding how the mentally ill are processed and treated, once they have been identified, show that little difference exists among the general treatment plans 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 are presented and discussed in aggregate form.

Table 5. Disposition of Those Identified as Mentally Ill

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

Type of processing	Number	Percent*
Segregation	15	23
Evaluation	27	42
Transfer	5	8
Other	18	28
No answer	16	
Total	81	101

*Excludes the "No answer" category.

Once identification of mental illness has been made, 42 percent 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 (table 5). Another 23 percent of the jails mentioned that they would first segregate the identified inmate, while 8 percent 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 indicated to the question of how they processed the mentally ill once identified (table 6). The first type of treatment mentioned by 62 percent of the responding programs consisted of counseling and/or evaluation of the inmates. Of considerably 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 understand the extent and types of medication used in jail settings and their effectiveness.

Table 6. Types of Services Provided to Mentally Ill Inmates in Jail

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

Type of service	First type		Second type	
	Number	Percent*	Number	Percent*
Counseling and 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

*Excludes the "No answer" category.

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 percent of the small jails said they would put a suicide attempt under observation, 29 percent of the medium-size jails and 33 percent of the large jails reported this procedure (not shown in tables). Upon examination of the influence of budget on the treatment of suicide attempts, this distinctive treatment strategy is further emphasized (table 7), tending to address the interrelationship between staffing patterns/facility limitations and program design/service provision.

Table 7. Treatment of Suicide Attempts by Size of Program Budget

Question: How are suicide attempts handled?

Type of treatment or handling	Size of program budget			Total
	Less than $50,000	$50,000 to $200,000	More than $200,000	
Observation:				
Number	4	6	6	16
Percent	(19)	(33)	(46)	(30)
Counseling:				
Number	4	4	2	10
Percent	(19)	(22)	(15)	(19)
Isolation:				
Number	2	1	2	5
Percent	(10)	(5)	(15)	(10)
Medication:				
Number	1	0	1	2
Percent	(5)	(0)	(8)	(4)
Transfer:				
Number	3	2	0	5
Percent	(14)	(11)	(0)	(10)
Other:				
Number	7	5	2	14
Percent	(33)	(28)	(15)	(27)
Total:				
Number	21	18	13	52
Percent	(100)	(99)	(99)	(100)

Responses regarding preventative program aspects show 51 percent of the jails saying that they identify potential mental health problems and refer to mental health workers for treatment (table 8). Another 28 percent 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-size 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.

Table 8. Treatment of Mental Health Problems by Size of Jail

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

Type of treatment or handling	Size of jail			
	Less than 50	50 to 499	500 or more	Total
Refer to mental health agency:				
Number	2	18	6	26
Percent	(25)	(53)	(67)	(51)
Counsel:				
Number	3	11	0	14
Percent	(38)	(32)	(0)	(27)
Transfer:				
Number	0	3	1	4
Percent	(0)	(9)	(11)	(8)
Other:				
Number	3	2	2	7
Percent	(38)	(6)	(22)	(14)
Total:				
Number	8	34	9	51
Percent	(101)	(100)	(100)	(100)

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 percent of the jails responded that the mental health program had affected 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. Administrators of large jails will also be encouraged to hear that it was the

larger jails that were more likely to have security positively affected by the mental health program. For instance, one 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 psychotropic medication. The number of commitments to psychiatric hospitals has 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 finding seems to contradict myths about security problems being 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 the more precise evaluation of tension and security-related issues in the jail. Further research is again recommended.

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. When provided the opportunity to indicate the types of problems experienced by their programs (viz, funding, staff shortage, support and cooperation, organizational, and other), however, only 7 percent of the respondents mentioned funding of the program as a problem. Furthermore, only 16 percent of the jails reported that a shortage of staff members was a problem. The large jails, with their large staffs, tended to report staff shortages as a problem. All of the responses from the small jails fall into the inclusive "other" category; this category additionally accounts for 49 percent 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 element 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 9, 10, and 11 present basic information about the jails surveyed. Table 9 presents the percentage of female custodial staff; table 10, the legal status of confined inmates; and table 11, the inmate racial distribution. This information is presented in order

to provide a general impression of some of the characteristics particular to the different size 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. According to 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.

Table 9. Percent Female Officers by Size of Jail

Question: What percentage of the custody officers are female?

Percent female officers	Size of jail			Total
	Less than 50	50 to 499	500 or more	
0				
Number	3	5	0	8
Percent	(38)	(15)	(0)	(17)
1–9				
Number	0	5	1	6
Percent	(0)	(15)	(14)	(12)
10–24				
Number	0	20	6	26
Percent	(0)	(59)	(86)	(53)
25–50				
Number	5	4	0	9
Percent	(63)	(12)	(0)	(18)
Total:				
Number	8	34	7	49
Percent	(101)	(101)	(100)	(100)

Table 10. Jail Population Legal Status by Size of Jail

Question: What is the percentage of current population sentenced?

Panel A. Percentage of Jail Population Sentenced

Percent sentenced	Size of jail			Total
	Less than 50	50 to 499	500 or more	
0				
Number	0	2	0	2
Percent	(0)	(5)	(0)	(3)
1–30				
Number	1	16	8	25
Percent	(9)	(42)	(50)	(38)
31–60				
Number	6	16	7	29
Percent	(55)	(42)	(44)	(45)
61+				
Number	4	4	1	9
Percent	(36)	(11)	(6)	(14)
Total:				
Number	11	38	16	65
Percent	(100)	(100)	(100)	(100)

Panel B. Percentage of Jail Population Awaiting Trial

Question: What is the percentage of current population pretrial?

Percent pre-trial	Size of jail			Total
	Less than 50	50 to 499	500 or more	
1–30				
Number	3	3	0	6
Percent	(27)	(8)	(0)	(9)
31–60				
Number	6	13	7	26
Percent	(55)	(33)	(41)	(39)
61+				
Number	2	23	10	35
Percent	(18)	(59)	(59)	(52)
Total:				
Number	11	39	17	67
Percent	(100)	(100)	(100)	(100)

Table 11. Racial Composition of Jail Population by Size of Jail

Question: What is the racial distribution of the current population?

Panel A. Percent White

Percent white	Size of jail			Total
	Less than 50	50 to 499	500 or more	
1–30				
Number	1	1	6	8
Percent	(11)	(3)	(38)	(14)
31–60				
Number	1	19	7	27
Percent	(11)	(59)	(44)	(47)
61+				
Number	7	12	3	22
Percent	(78)	(38)	(19)	(39)
Total:				
Number	9	32	16	57
Percent	(100)	(100)	(101)	(100)

Panel B. Percent Black

Percent black	Size of jail			Total
	Less than 50	50 to 499	500 or more	
0				
Number	5	4	1	10
Percent	(56)	(13)	(6)	(18)
1–30				
Number	3	11	5	19
Percent	(33)	(35)	(29)	(33)
31–60				
Number	0	13	4	17
Percent	(0)	(42)	(24)	(30)
61+				
Number	1	3	7	11
Percent	(11)	(10)	(41)	(19)
Total:				
Number	9	31	17	57
Percent	(100)	(100)	(100)	(100)

Although generalizations cannot be made from such a small sample, these four duplicate forms 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 responses indicate 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, rationales for the beginning of the program provided by the jail respondent and by the program respondent were different. Most noticeable were the vast differences in the inmate demographic data. In some instances, it was difficult to determine if indeed the same jail and program were being described.

Summary Remarks and Suggestions for Future Research

These exploratory findings suggest interesting research questions. 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. 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 established, some of the areas in which data should be collected are: (1) the program type (see table 13), 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 are important, but the extent to which these and other organizational variables affect program development is still uncertain. The use of alternative placements also appeared to affect 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 sequence in which various types of treatment are provided. Stressing the sequence would help to explain the priorities of the program and, in turn, allow for a more accurate assessment of the overall effectiveness of various strategies. The immediate question which arises, however, is how program effectiveness can be measured. Such evaluation might, for example, be accomplished by exploring the impact of the program on jail security, management, and overall environment.[5] Also, perhaps most directly, program evaluation might be accomplished by looking at the usefulness of the treatment interventions on the course, severity, and remission of the psychiatric disorders involved. 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.

In addition to the statistical summaries and research recommendations made possible through analyzing the survey responses, the following issues were raised as a result of site visits and interviews with program representatives. These are generic impressions and demand systemmatic investigation and validation. For example,

- What are the special mental health needs of female inmates, and how are these needs affected by the present relative lack of such programs?
- Should pretrial competency and criminal responsibility examinations be performed by persons other than those having treatment responsibilities?
- What are the desirable and optimal selection and assignment methods for officers working with mental health programs?

- An 18–36 month period appears to be required for the development of rapport between mental health personnel and security staff, and for service delivery programs to be accepted, at least with respect to the programs reviewed herein. Is that period typical of other programs or program types?
- What specific actions will help the mental health program staff to provide or prove their credibility or speed their integration into the jail environment?
- Does a cell without padding prevent self-injury more successfully than a padded cell, when used for isolating suicidal inmates?
- Is it true that when a "good" jail mental health program has been developed and "discovered," more and more individuals are sent to the program by law enforcement, courts, family referrals, etc., to the point where its resources become overused?
- What accounts for the typical reluctance of community mental health center staff to become involved in the delivery of jail services, and what can be done about it?

Seven Service Delivery Program Models

The most significant and substantial sources of information about mental health service programs in jails are the expanded program descriptions prepared by the officials of the seven programs selected as example programs. From the 20 site visits conducted in the late spring and summer of 1978, these seven programs (as indicated above) were chosen to prepare more lengthy descriptions containing information about each of the topics listed in the appendix to this chapter.

There were reasons for ultimately selecting the seven jail mental health service delivery programs as models. In essence, we looked for what appeared to be well-operating systems of varying sizes, resources, treatment philosophies, and management policies and procedures. It is again essential to emphasize that several other superior programs were also seen, but, because of the overall workshop size constraints, representatives from these other programs could not be invited to serve as panelists. Furthermore, there are undoubtedly many outstanding programs which were not considered in this overview research simply because knowledge of their existence was unavailable.

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The seven model service delivery programs have been described in much greater detail in Morgan's larger report (1979).[6] Each program narrative is constructed according to the appendix at the end of this chapter and is self-explanatory. The following information briefly summarizes these program descriptions and, since each narrative could not be reproduced here, emphasizes a few of the more salient program features.

Table 12. Population Characteristics of Six Selected Local Jails

	Population size	1977 annual bookings	Percent of population			
			Pretrial	Sentenced	Mentally ill	Mentally retarded
ALABAMA:						
Marengo	49	756	24.0	76.0	4.0	2.0
CALIFORNIA:						
Los Angeles (4 facilities)	9,560	210,000	43.0	57.0	35.0	2.5
Napa	62	2,175	47.0	53.0	25–50	1.0
NEW JERSEY:						
Monmouth	310	4,347	68.5	31.5	10–15	3.0
OHIO:						
Cuyahoga	700	7,500	86.6	12.4	18.0	3.4
WASHINGTON:						
Whitman	10	263	50.0	50.0	10–20	1.0

Tables 12 through 14 highlight several demographic characteristics and service delivery elements of the six local programs. Table 12 presents population size, 1977 bookings, percentage pretrial and sentenced, and estimated percentage mentally ill and mentally retarded. These are a few of the basic factors around which the type and extent of services required were assessed and the delivery system of each program was developed. That is, the development and orientation of service delivery programs are predicated upon answers to such questions as:

- Are there significant numbers of mentally ill or mentally retarded inmates who require specialized programing?
- Are crisis interventions services for pretrial inmates needed more than ongoing treatment for a predominantly sentenced population?
- Does the size of a jail's mentally ill population, in proportion to the annual number of bookings, suggest the need for a more effective screening/identification strategy?

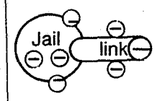
A system seeking to replicate one of the service delivery models should initially consider these program characteristics in regard to their own jurisdiction's similarities and realistic service needs.

Table 14 illustrates the program structure, staff accountability, and facility services of the six local programs. Five of the six jails are under the supervision and jurisdiction of a County Sheriff; the sixth, Napa County jail, operates under the direction of a County Department of Corrections. The typological categories presented in tables 13 and 14 are adapted from the National Jail Resources Study (Newman et al. 1976:257–279).

Table 13. A Typological Model for Mental Health Service Delivery in Jails

System	Model elements		
	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.	

Table 13. A Typological Model for Mental Health Service Delivery in Jails—Continued

System	Model elements		
	Primary focus of service delivery system	Description	Schema
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.	

Adapted from Newman, et al. 1976:257–279.
⊖Service component.

Table 14. Program Structure, Staff, and Service of Selected Jails by Type of Service Delivery Model

County	Type of model			
	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.	.....	

Table 14. Program Structure, Staff, and Service of Selected Jails by Type of Service Delivery Model—Continued

County	Type of model			
	Internal	Intersection	Adjunct	Combination
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.			

The following are some of the interesting program features of the six local programs that were represented. In Marengo County, Alabama, the program was created through the efforts of a community mental health center (CMHC) official who lobbied for and then occupied the combined position of jail administrator and mental health service provider. In Los Angeles, the custody program of the jail uses a behavior reward system for inmate management. In Napa County, California, the jail mental health program is an integrated program involving both male and female inmates and staff. In Monmouth County, New Jersey, the jail mental health program was initiated and implemented by the persistent efforts of the jail security officer. In Cuyahoga County (Cleveland), Ohio, screening for mental health problems occurs as part of the intake and classification process and results in placement in a psychiartic unit located on one floor of the jail, if serious illness is identified or

occurs during incarceration. In Whitman County, Washington, in-house mental health services are provided by an Offender Services Coordinator, with emergency services being available from the CMHC professionals. The Offender Services Coordinator also does rotations on the CMHC emergency shifts. Whitman County jail has a capacity of 35 inmates, a jail population of about 10 inmates, but has developed a complete inhouse or referral-for-service set of program alternatives.

The seventh program represented at the workshop was, in essence, a set of statewide activities that developed in the State of Michigan. Michigan's mental health code was extensively changed in 1974 (like those in many other States within the past 10 years) to focus on community treatment of the mentally ill and on more stringent requirements for involuntary commitment to State hospitals. As a result, a number of jail administrators came to believe that many people formerly treated in State hospitals were being arrested and held in jail without receiving adequate care for their mental health problems. Increased concern among both correctional and mental health officials, particularly concerning the problem of jail suicides, was the catalyst for the formation of a statewide jail mental health task force in May 1977. This task force conducted investigations and surveys about various aspects of jail mental health problems in the State. It made recommendations concerning mandated services to be provided through the Department of Corrections or the Department of Mental Health, including emergency care, mental health training for officers, the development of resource packages for local communities concerning where to obtain assistance, and the articulation of policies to assist law enforcement in admitting appropriate individuals to State hospitals rather than to jails. By 1979, some of these recommendations had been translated into a State law requiring local mental health agencies to provide assistance to jails, while others had been translated into proposed rule changes promulgated by the Department of Corrections for jails. (A more complete description of these changes is available in Morgan 1979, pp. 163–176). Thus, Michigan was chosen to represent the way in which a statewide task force could address the need for improved mental health services in local jails.

Conclusion

In its report in 1977, the Pennsylvania Governor's Task Force on Maximum Security Psychiatric Care made the following observation:

> 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 (p. 30).

Throughout the many discussions surrounding this survey, funding and facility/space limitations have been cited to justify the lack of jail mental health programs. From the example service delivery program descriptions and their institutional blueprints, we have observed that programs have been implemented despite the many obstacles. Thus, some of the traditional reasons for failing to make services available should become less acceptable.[7] Mental health care can be provided at no additional 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 or Whitman Counties. Moreover, none of the model programs operates within a facility that was satisfactorily designed to accommodate the current mental health care needs of the jail population. Yet, each program has been able to establish institutional services.

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

In sum, the existence of these model programs supports the conclusions drawn by another national survey:

> 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 p. 45).

Eighty-one successfully operating programs around the country have demonstrated that, in spite of fiscal, architectural, personnel, and other constraints, jail mental health management and treatment problems can be overcome with commitment, creativity, and cooperation. The features of these 81 programs are diverse, but the model programs clearly demonstrate that service delivery can be accomplished in a variety of responsive ways.

Footnotes

1. Jails are defined as locally administered adult institutions with authority to hold persons for longer than 48 hours.
2. "Mentally ill" and "mentally disordered" are used interchangeably and, when included with "mentally retarded," are considered "persons in need of mental health care."
3. A case in point is the Alabama program cited in Brodsky's paper (chapter 6). For whatever reasons, this seemingly sucessful relationship was not mentioned by the jail or mental health center in response to a program description request.
4. This would seem to agree with the disparate research studies which explain the extent and nature of the problem (see chapter 2 by Gibbs for a review of these studies).
5. For a model of how the jail environment can be evaluated, see "Utilization of the Berkshire Model in Changing the Environment of the County Jail," available from the National Institute of Corrections, Jail Programs Center, P.O. Box 9130, Boulder, CO 80301.
6. The narrative for the seventh model, the State of Michigan, essentially addresses the same issues, although a difference in presentation style was necessitated.
7. Additionally, courts have made it clear repeatedly in regard to the correlated inmate right to health care that the argument of insufficient funds can not justify inadequate care. See *Jackson* v. *Bishop* 404 F2d 571 (C. A. 8, 1968), and also *Bey et al.* v. *Pierce et al.*, No. 78-2621 (3d Cir., December 28, 1979).

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Appendix I

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?
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 females, number of males, 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 multicounty 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?

1. Sheriff's Department, Department of Corrections personnel? Mental Health Center personnel? Independent contracted personnel? (Please explain)
2. If contracted services, please include a copy of the contract.
3. 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 that 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 or training are provided?
D. How is this training accomplished? Classrooms? (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 8½" 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.

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CHAPTER 4

Providing Mental Health Services to Jail Inmates: Legal Perspectives

Richard G. Singer, J.D., LL.M., J.S.D.

Introduction

It scarcely seems possible that less than a decade ago the legal revolution in corrections began. In 1967, when Cohen prepared his report on the law of prisoners' rights for the President's Crime Commission,[1] virtually all his analysis was speculative. There was no major judicial decision on any aspect of corrections, and surely none concerning medical services for prisoners, much less for pretrial detainees. Today, of course, it is different; virtually no one would challenge the notion that a prisoner has a legal right—ultimately protected by the Constitution—to adequate medical care.[2] Not only courts, but independent interested organizations, such as the American Correctional Association, the American Medical Association, the American Bar Association, The National Sheriff's Association, and a host of others agree and have attempted to articulate more definitely the contours of such a right.[3]

The duty for the sheriff and State* to provide medical services generally would seem *a fortiori* to include mental health services. Yet, while the American Correctional Association spoke in depth about medical treatment in its 1966 Manual of Correctional Standards, its references to mental health services were fleeting.[4] Similarly, in 1975, when LEAA funded a nationwide study of correctional medical care, and then published it as a prescriptive package,[5] the authors themselves called attention to the fact that neither mental health nor dental services were considered, and they declared: "We hope that parallel studies in these areas will be undertaken soon."

*As used in this chapter "State" means the responsible government authority.

The first suit to seriously consider the broader ground of the sheriff's duty appears to have been *Jones* v. *Wittenberg*.[6] There, in what has now become a typical "jail case," inmates of the Lucas County, Ohio jail sued in a class action suit on conditions generally in the jail. In a sweeping order, which ranged from prescribing the kind of paint to be used on the walls to due process considerations, to mail, to nutrition, the court, in addition, ordered the sheriff to consider changes in the provision of mental health services.[7]

> Quarters for inmates who are too ill to remain safely as part of the general population of the prison, but not sufficiently ill to require hospitalization [shall] be made available.

From that very minor beginning, a stream of cases has spurted forth,[8] and today there is no doubt, either in the case law or in the standards, that the State must provide meaningful mental health services to pretrial detainees and prisoners. Much of the present effort is geared not toward establishing the legal duty of the State to provide such services but toward determining new and innovative methods of delivering such services.

This chapter explores the meaning of the legal requirements that a jail must provide mental health services, and the legal liabilities which may arise when the sheriff fails to provide such services. Aspects of funding and legal problems, which may arise in attempting to provide those services, are also discussed.

What Kinds of Services

If there is a legal duty on the part of the sheriff to provide access to medical and mental health services generally, how are his attempts to meet this duty to be assessed by the courts? What efforts, in short, must the sheriff undertake?

The Role of Standards

There is, of course, no easy and simple answer. But there are some useful guides. Ten years ago, about the only source to which anyone could turn to ascertain "the state of the art," the "standards of care" of the industry, was the American Correctional Association's Manual of Correctional Standards.[9] Today, in place of a paucity of standards, we find a deluge of standards.

First, there are standards relating to corrections in general, such as those put forward by the National Advisory Commission on

Criminal Justice Standards and Goals,[10] the President's Commission on Law Enforcement and Administration of Justice Task Force on Corrections,[11] the National Council on Crime and Delinquency,[12] the United Nations, [13] the Association of State Correctional Administrators,[14] and the American Bar Association.[15] These sets of standards, which are intended to cover all, or most, aspects of correctional life, spend little time on medical facilities as such. Thus, for example, the National Advisory Commission devoted only two pages to health care in over six hundred pages in its volume, which covered all issues ranging from sentencing and legislative reforms to parole to community release, etc.

A second set of standards, recommendations, guidelines, etc., is for jail administrators in general. Typical is the National Sheriff's Association Manual on Jail Administration,[16] later replaced by six smaller handbooks on specific areas. The Manual spent virtually no time on medical concerns as such. Similarly, we have the jail standards suggested by the Nebraska Bar Association Committee on Correctional Law and Practice,[17] the National Sheriff's Association Jail Security Classification and Discipline Standards,[18] and the U.S. Bureau of Prisons.[19] Additionally, there are the statewide jail standards applicable in some States, such as those in Illinois,[20] California,[21] Pennsylvania,[22] South Carolina,[23] and Oregon.[24] While these standards will obviously be more precise in terms of jail problems—which may be distinct and different from correctional problems, both generally and with regard to medical care in particular—again, they may not relate precisely either to medical care or mental health in general.

A third set of standards relates more closely to our precise issue—medical care in correctional facilities. Here, we would look to standards of the American Medical Association [25] and the American Public Health Association.[26] Again, however, these standards do not deal at length with mental health delivery systems or even mental health services generally. Thus, the American Public Health Association Standards has a separate section on mental health services which runs approximately one page of a roughly ten-page document. The American Medical Association standards are approximately as comprehensive, but neither of these sets of standards is as precise as our needs require.

Moreover, as one might expect, these standards conflict, do not cover the same ground, or approach the issue from different angles, thus leaving some question as to which standard, or set of standards, we should follow. As B. Jaye Anno has noted:

> The standards—developed by the various professional groups—are not comparable with respect to format and depth of content. What is emphasized in one set of standards may not be mentioned in another . . . no one set of standards has yet emerged as the definitive guide for health care delivery systems in jails or prisons, or both.[27]

Anno concludes that, until there is consistency, "institutions will be able to pick and choose the standards they like best among the various sets."

The conclusion is somewhat dubious, particularly if one talks about legal standards and the application of the standards in litigation. Doctors, of course, are already familiar with the role which standards, promulgated by private bodies, have played in the expansion of negligence. Although courts once followed the so-called "locality rule" in assessing malpractice,[28] that rule was abrogated in the famous case of *Darling* v. *Charleston Community Memorial Hospital,*[29] where the court held that, among other things, nationally promulgated standards could be used to determine the standard of care necessary. This decision spawned progeny throughout the country, which continued to rely upon nationally promulgated standards.[30] While it is certainly true that, so long as there are various standards, some more general than others, courts will be relatively free to select among the standards that are submitted to them as relevant, depending on what the precise facts of the case demonstrate and what the difficulties are that confront the court at the particular time, it is likely that, in the absence of any agreed-upon standard, the courts will look primarily to the ABA draft because these standards are drafted by lawyers rather than by interested groups who might, or might not, have a hidden agenda in mind. Let me add, hastily, that I do not believe that to be the case. In most instances, the AMA/ACA standards are at least as demanding as the ABA standards. But there are difficulties, nevertheless.

Still another problem with standards, or at least some of them, may be their inherent ambiguity. The use of words such "adequate," "available," "accessible," etc. may be so open-ended as to leave both correctional administrators and courts totally at sea with only very slight guidance.

Nevertheless, all these standards do agree to a remarkably substantial extent. Thus, for example, virtually all the standards agree that there is a requirement of providing medical care, that the State must pay for this medical care, that mental care services are included in the provision of medical care which the State must provide, and that there is an obligation on the part of the State

both to treat mental illness and, if possible, to prevent its occurrence. In short, all agree that there is an obligation to either provide medical services or unrestricted *access* to medical services.

One final point on the standards: They are not Pollyannaish. Recognizing that the size of jails varies considerably, there are no strict requirements that there be a specific number of doctors, nurses, licensed health professionals, etc. in the facility throughout a 24-hour period. Indeed, most of the standards do not require any such medical personnel to be on hand. Instead, the standards and the case law generally accept, as for example the ABA standards do, the various methods by which medical services are now provided to prisoners: (1) in-house doctors or other professionals; (2) on-call doctors; (3) arrangements with a nearby hospital either to visit the facility or to have ill prisoners taken there.

The standards, that is, do not focus on *form;* it is *content* that is paramount; and the essence of the content, in a single phrase, is "meaningful access to meaningful medical services as quickly as needed."

Particular Requirements of Access

Entrance Examination

In 1972, the American Medical Association conducted a self-answer study of American jails.[31] The results demonstrated a level of medical care so poor that it stunned even those familiar with jails generally. Of all the findings, however, perhaps none was so startling than the finding that intake medical examinations were given, as a matter of routine, only by 1.7 percent of all city jails, and 3.0 percent of all county jails. In another 50 percent of the jails, prisoners received examinations if something was "obviously" wrong, if they complained, or if they complained *and* something was obviously wrong. But a full 47.5 percent of all responding city jails and 48.5 percent of all responding county jails said that they gave *no* medical examination to *any* prisoner.

Virtually all the standards recognize the need for preliminary medical examination at the initial intake process, including examination for obvious mental illnesses.[32] But the standards are often unclear whether these preliminary examinations must be conducted by a licensed physician much less by a licensed mental health practitioner.[33]

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If a preliminary examination detects some mental illness, what should be done? Some standards would require that the jail *preclude* admittance and take the prisoner to a hospital.[34] That would probably be the most desirable course of action, since it would avoid any legal problems involving later transfer to a mental hospital, as discussed later. But State statutes may *require* the sheriff to accept all prisoners, whether he wants to or not. If so, what should he do?

Here, the standards are also in agreement. The AMA, for example, says that a person recognized as possibly mentally ill,[35]

> should be isolated in a cell of his own in restraints. . . . The individual should not be left in a cell by himself because he may thrash about, strike his head, or attempt to destroy himself.

And the National Sheriffs Association, in 1970, declared, in a standard not substantially changed since then: [36]

> Jail procedures should include instructions for the segregation, observation, and treatment of inmates who are suspected to be, or who have been declared, mentally ill.

Isolation of the prisoner from other prisoners does not mean that he should be left alone; this is obviously the worst possible course of action to take with a potential suicide. If the prisoner is to be isolated, care must be taken to assure that someone is watching him at all times, while arrangements are made to transfer him to a mental health facility.[37]

The courts have agreed virtually unanimously that preliminary medical examinations are required as a matter of law.[38] And, as discussed more fully later, the failure of a sheriff to protect against a person who, through the preliminary examination, indicates potential for suicide, has been viewed by several courts already as imposing liability on the sheriff, if the suicide actually occurs. In short, the law, as it now stands, supports the approach taken by the standard setters.

Reasonable Access to Reasonable Treatment

Every correctional facility, jail, or prison must, therefore, provide "reasonable access" to both emergency and nonemergency medical assistance, including mental health services. Critical for this process is daily sick call, required by both the standards and the case law.[39] But daily sick call is insufficient protection for the health of

the prisoner unless he can assure that, in fact, he *will* see the physician. This means that no correctional officer will determine that the prisoner is "malingering" and fail to forward the request for sick call and that every prisoner will indeed have access.[40] It also means that, in a conflict between the doctor's orders and those of the sheriff, the doctor must be given preference.[41]

Other conflicts, of course, arise:[42]

> Other examples of the impermissible influence of correctional concerns are decisions to delay needed operations because of the unavailability or cost of guards, decisions to limit all prescriptions to two daily doses because of guard shifts or population count requirements, or decisions not to transfer a sick inmate to the infirmary because he is confined to punitive segregation.

The access must be to qualified medical personnel. Hardly anyone will be surprised by the statement that:[43]

> "Traditionally, prisons have been where medicine's undesirables—foreign medical graduates, doctors with drinking or drug problems, older doctors—wind up treating society's undesirables. Pay has been low; benefits poor. Working conditions remain, at best, unattractive. Backup facilities are poor or nonexistent."

In many States, persons otherwise disallowed to practice medicine on "normal" civilians are allowed to practice in State institutions—jails, prisons, mental hospitals, nursing homes. As compared to the average $63,000 a year, prison doctors are drastically underpaid.[44]

The harshness of these facts is visited upon the prisoners. It is not surprising, therefore, to learn that one of the major complaints of the prisoners at Attica, as elsewhere in this country, concerned both the competence and the attitude of the prison doctor.[45]

Guards are not doctors. Virtually every national standard which has confronted the question of drug control in prison has provided that only a licensed physican should dispense drugs of any kind.[46] In some instances, the administration of the drug may be under the guidance of such a physician. The reasons are self-evident; there are probably more drugs, per capita, in prison than on the street and, almost certainly, more persons seeking to use them. Prison, as we hardly need to be told again, is a dreadful place; it encourages, if it does not actually foster, mental anxiety, boredom, etc. And drugs can provide at least one superficial response. Notwithstanding these reasons for careful control, most State Attorneys General, who have issued opinions, have disagreed, indicating

that nonmedical personnel may administer drugs, assuming they have been prescribed.[47] Presumably, the reason is economic; many small jails simply could not afford the kind of supervision required by the national standards.

Treatment means treatment, not pacification. It is generally acknowledged that, in all correctional institutions, especially jails, low-level, mind-affecting drugs are rather widely available to prisoners and, indeed, are often dispensed to prisoners—by doctors or others—to reduce the level of discontent and violence.[48]

This raises yet another question: Does the prisoner, assuming competence, have the right to refuse treatment, including, but obviously not limited to, drugs? I believe so, although there are some decisions which imply that there is no such right.[49] These cases, in my opinion, are clearly wrong. First, I believe, the sheriff and/or mental health professional is only obligated to provide *access* to medical services. If the prisoner refuses such service when proffered, the duty has been met (assuming, of course, that the services are not so clearly inadequate, etc., that the proffer cannot be viewed as bona fide). So from the viewpoint of legal liability, there is no need for the sheriff or others to press forward. Second, the prisoner's right to refuse treatment, based in part on his constitutional right to autonomy and privacy,[50] should be respected, and his body held inviolate, as it has been (except in emergencies) under the common law.[51]

Whether agreeing to treatment, or refusing it, of course, the prisoner must be competent and accepting treatment, must have given informed consent.[52] There is no magic formula for informed consent; some States have definitions which differ substantially, while most States have not even considered the problem legislatively. For our purposes, a good, solid definition of informed consent is that found in the California Code: [53]

> To constitute voluntary informed consent, the following information shall be given to the patient in a clear and explicit manner:
>
> (a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
>
> (b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
>
> (c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
>
> (d) The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how to and to what extent they may be controlled, if at all.
>
> (e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.
>
> (f) The reasonable alternative treatments, and why the physican is recommending this particular treatment.
>
> (g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

This brief survey of potential conflicts between security needs of the prison and medical needs of the prisoner has, I hope, at least given the flavor of the issue: When there is a clash, the medical needs win. But accommodation is desirable, if possible. As Professor Neisser wrote: [54]

> The third aspect of delivering prescribed health care is the utilization of effective procedures . . . that overcome the rigorous institutional structure and schedule of prison life . . . . The medical staff cannot reasonably expect work schedules or disciplinary procedures to be modified to facilitate delivery of medication to ambulatory patients, but inmates do not lose their constitutional rights to medical care because the prison adheres to strict working and disciplinary schedules. Thus, in the context of delivering prescribed care, the need for careful medical organization and administration becomes a constitutional imperative.

Where Should Treatment Occur?

Thus far, we have assumed that the provision of mental services will occur in the jail. But, ideally, treatment for mental illness should occur in a hospital, or other mental health facility, not in a jail.[55] Yet, there may be obstacles.

First, some State statutes may require a sheriff to accept every person brought to the jail or otherwise committed to him. This may preclude the most obvious way to deal with the new contact—simple refusal by the sheriff to accept him.

Second, State statutes may so define those subject to involuntary hospitalization that some persons deemed mentally ill may not qualify. For example, in some States (now a majority) it is a predicate for involuntary commitment that the person be both mentally

ill and dangerous to self or others.[56] Other States may require both a showing of mental illness and some other criterion; for example, New York requires that the patient be so disabled as to be unable to decide for himself.[57]

For those persons who cannot meet the second of these requirements, treatment in the jail may be the only alternative.[58]

Third, transfer to a mental hospital carries with it a potential additional stigma, a "grievous loss" which the prisoner may suffer if so transferred. Just 10 years ago, the United States Supreme Court held that, before a prisoner could be transferred to a mental hospital, the same processes that would be used to commit a nonprisoner must be followed.[59] Thus, prisoners who are thought to be mentally ill and in need of commitment must be given a hearing, etc. prior to (or in cases of an emergency, as soon as possible after) the transfer.[60] These hearings are at the heart of the concept of liberty in a free society; nevertheless, they are, admittedly, a burden on the jail and the psychiatrist, and it is not unreasonable to assume that in some instances persons in the process will select to avoid such a hearing by attempting treatment in the jail facility.

One possible solution to at least some of this dilemma is to do as California has done—allow any jail prisoner to voluntarily commit himself [61] (which does not require a hearing), if either a judge or the sheriff agrees and the mental health director agrees. On the other hand, such a solution may be overbroad and induce prosecutors to seek jail commitment, at least pretrial, in situations in which the defendant otherwise would have simply been released. California also provides that a jail inmate involuntarily transferred to a medical facility may, without anyone's permission, change to voluntary status [62] The experience of California is, at this point, so sketchy that it is difficult to know whether this concern is a realistic one; [63] nevertheless, it does exist.

A fourth problem—one which is difficult for the law to prove, much less wrestle with, yet which is undeniably present—is the fact that many of the prisoners who *might* be subject to transfer are likely to be the "troublemakers" in whatever institution they find themselves. Thus, the sheriff is anxious to transfer them to the mental health facilities in the area, while the director of such a facility is pressed, at least subconsciously, to find that the prisoner's mental illness has rapidly disappeared, and he may be returned to the jail. The arguably dangerous psychopathic prisoner thus becomes a ping-pong ball between the two departments. Moreover, the director may have substantial reason for rejecting such a transferee, since many local mental health centers are intended primarily for outpatient care or for inpatient care of the most

liberal kind. Consequently, there may be inadequate security to prevent the charged patient from escaping.[64] This, of course, is not a proper response, since there may well be—indeed almost assuredly will be—"free world" patients who need maximum security care and yet who should not be shipped off several hundred miles upstate to the "only" such facility. Yet, since the prisoner/patient must be near the site of his trial, such long distance transfers, as well as being undesirable from a humanitarian viewpoint, may well be invalid, as unduly restricting his access to counsel and the courts (at least prior to trial).

It is possible that statutory change in the process of transfers to mental hospitals, if the change expedited transfer, might reduce the number of suicides, but it is far from clear that such would be the result. In 1974, New York enacted legislation [65] for just that purpose, but as Christianson noted: [66]

> The law may help to alleviate some inmate anxiety over the status of their cases, but its effect on the level of inmate suicides may not be as great as some legislators have hoped. For one thing, most suicides occur almost immediately after entry into jail; for another self-injury rates in mental facilities are often just as steep as those in penal institutions, even though the former usually provides closer supervision.

Assuming, however, the possibility of transfer, or even of commitment, of a mentally ill jail inmate, several questions yet remain, at least in terms of who bears legal responsibility for the prisoner while he is in the mental health facility. For example, is the prisoner still, legally, in the custody of the sheriff, so that if the prisoner escapes, it is the sheriff's responsibility? If so, then perhaps the sheriff ought to be able to "forbid" transfer on the basis of his own legal responsibility. Yet, such an act would clearly be an interference with medical judgments, something we have already indicated is both wrong in principle and increasingly recognized as invalid as a matter of law. The same question remains on the other side: Should the mental hospital be able to refuse admission of the transferee on the grounds that it has inadequate security, etc.? [67]

The "solution," if I may call it that, is both simple and complex. It is that, in every county, there should be at least one State mental facility which has a reasonable number of high security wards, or beds, which allows the transfer to the facility. Legal responsibility for subsequent actions by the patient should be lodged on the director of the facility to which the prisoner is transferred; the responsibility is assumed as part of his job.[68]

CONTINUED

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A Note on Financing

The county, or other governmental unit responsible for the jail, is, of course, responsible for paying for medical services. There is, however, a possibility, circumscribed by legal questions not yet resolved, that these agencies could seek Federal help—Medicaid payments—to cover, or at least defray, these expenses. The issue is a murky one.

The pertinent Medicaid provisions declares that a person is not eligible if he is "an inmate of a public institution (*except as a patient* in a medical institution.)" [69] Several questions of definition then arise: (1) Who is an "inmate"?; (2) What is a "public institution"?; (3) What is a "medical institution?" We will deal with these in inverse order.

At first blush, it would seem that a prisoner in a hospital infirmary might be in a "medical institution" and that a prisoner in a nonprison hospital certainly is in a "medical institution." Current interpretation, however, is contrary to this commonsense reading of the statute. By regulation, a "medical institution" is defined as an institution which:

> (i) is organized to provide medical care, including nursing and convalescent care (and)
>
> (ii) has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards (and)
>
> (iii) is authorized under State law to provide medical care

and meets certain staffing needs.[70] According to DHHS interpretation, however, a jail infirmary is not itself an "institution," but rather part of a larger institution—the jail—which does not meet the definition of "institution." [71] Therefore, a jail infirmary is not a "medical institution" so that a prisoner in such an infirmary, if an "inmate of public institution," is not covered.

A prisoner transferred to a nonprison hospital, however, would surely seem to be in a medical institution" as defined by the regulation. However, again according to current interpretation, such a prisoner is not an inmate in that institution, since custody remains with the sheriff.[72] Therefore, prisoners transferred to a place which would otherwise qualify as a "medical institution" cannot qualify for Medicaid funds under this provision.

There is a reason for this interpretation: Since the State is under an obligation to provide such medical services, the Federal Government should not be under an obligation to pay the State for providing those services. It is, in short, a measure of economy. Given other interpretations noted below, however, this rule is a difficult one to sustain.

First, the Medicaid statute itself provides that a person under 21 receiving inpatient care in a psychiatric hospital is eligible for Medicaid payments, even if he is otherwise a jail inmate.[73] Thus, in at least this one instance, the Federal Government does provide payment for the services, even though the State also has an obligation to provide these services. Why psychiatric services should be different from other services is not clear; nevertheless, a constitutional argument would be difficult to frame here and would almost certainly be unavailing.

Second, current regulations of the Department of Health and Human Services (DHHS), previously DHEW, provide that Medicaid will pay for services, psychiatric and other, for persons otherwise eligible, "for the month in which an individual became an inmate of a public institution." [74] Thus, a jail inmate, even if not in a psychiatric hospital, receiving inpatient care, will qualify for Medicaid payments during the first "month" of his incarceration. There is some question whether "month" means "calendar month" or the "first 30 days," although the Congressional history indicates that the term should be limited to "calendar month," since the purpose is for billing purposes.[75] Thus, a prisoner who is incarcerated in jail on September 28 has only 2 days for eligibility, while one incarcerated on September 1 has 29 days eligibility.

These two exemptions—inpatient psychiatric care, and the "calendar month"—seriously undermine the notion that the Medicaid statute should continue to be construed as it now is, on the theory that the Federal Government should not pay the State for performing the State's duties.

Nevertheless, even given these interpretations, there is still one other serious question as to whether a pretrial detainee is an "inmate in a public institution." Clearly, the jail is a "public institution." Nevertheless, an individual is not an "inmate of a public institution" if he is "in a public institution for a temporary emergent period pending other arrangements appropriate to his needs." [76] One could argue that a pretrial detainee, whose presence in the jail is only because he cannot raise bail, is in the jail "for a temporary emergent period." What his "needs" would be are unclear, but it again could be argued that his "need" is freedom, contingent upon bail.[77]

In summary, then sheriffs may receive Medicaid reimbursement for services rendered:

1. to all jail inmates under 21 within the first "calendar month" of their incarceration;
2. to all inmates under 21 transferred to a psychiatric institution for inpatient care.

They may not receive Medicaid reimbursement for medical services rendered to inmates:[78]

1. over 21;
2. under 21, for services rendered after the first calendar month.

Substantial questions remain about the validity of these distinctions, particularly the "month" limitation. The "21" limitation is probably constitutional, for reasons we need not explore here. But, unquestionably, serious consideration should be given to seeking either departmental reinterpretation of the statute or an amendment to the statute. Moreover, under current interpretations, the jail should quickly determine whether the inmate should be transferred to inpatient psychiatric care, since, for all purposes, these expenses are reimbursable, assuming the inmate is otherwise eligible.

Liability and Defenses

The question of liability, on the part of either the sheriff or the mental health worker in the jail, is enormously complex. Here, I will simply try to sketch the legal doctrines.

Contempt and Fines

I have already indicated that some courts have ordered massive changes in jails, including changes in the delivery of medical and mental health services. Because these changes are usually the kind that involve expenditures of large sums of money, a sheriff cannot be held liable for not having attained these changes on the budget he has had in the past. But delay, or obstinacy, in carrying out the court's order, once issued, can, and on several occasions has, resulted in stiff fines against correctional officers for contempt of court.[79] Several months ago, the Director of the Department of Corrections of Rhode Island was fined $1,000 per day for every day he failed to implement a new classification scheme in the prison [80] even though

he had not been the director when the court order had initially been handed down. His responsibility, in other words, was institutional as much as personal.

Because, as discussed below, the likelihood of a substantial damage award against a sheriff, or mental health officer, for injury to an individual prisoner is not great, this aspect of liability must be seriously considered by all persons involved in the correctional system.

Individual Liability

A mentally ill prisoner, or a person injured by a mentally ill prisoner, or his survivors, may sue a sheriff or a mental health provider, either in State court or in Federal court. If the suit is in State court, the prisoner must prove that the defendant was negligent; [81] If in Federal court, the prisoner must show that the defendant was "deliberately indifferent" to his medical needs or intentionally refused to meet them.[82] Both these standards, particularly the Federal one, are difficult for the prisoner to meet, but it should be noted that the sheriff may be liable for such indifference or intent on the part of his guards, assuming he has hired them, even if he was not aware of their acts. Thus, if a guard were to refuse to allow a prisoner sick call and the prisoner suffered injury or died, the sheriff would be liable; the mental health care provider, not having been notified, has not been negligent and would not be liable.[83]

Even if the prisoner demonstrates that there is some possibility that the defendant could be liable under the relevant standard, both the sheriff and the mental health provider have a series of "defenses" to such actions, all of which basically hinge on the question of whether they were exercising a sound discretionary judgment, although ultimately proved wrong. If so, according to both State courts [84] and the United States Supreme Court,[85] the prisoner will not be allowed to collect. Moreover, if a mental patient injures himself or another, the sheriff can avoid liability by demonstrating that he did not know, or have cause to know, of the mental illness of the prisoner. The mental health care provider, of course, will have the same defense, but, since he has the expertise to diagnose mental illness, his defense will not be so readily available.

Of course, the "rules" are easily stated, but their application is not always simple. To explore the issue a bit more deeply, let us

deal with an illustrative—and the most relevant—example: jail suicides.

Jail Suicides

In the last few years, an entire field of study—suicidology—appears to have become established, and there is no dearth of material generally on the issue of suicide. Nevertheless, there are few studies dealing directly with the question of jail suicides. A collection of materials on the subject can be found in "Jailhouse Blues." [86] But even the studies in this collection differ on their findings, as might be expected in different jails. Thus, in one study, the suicide rate reported was 57.4 per 100,000 in a sample of the county jails in a midwestern State.[87] Fawcett and Marrs, however, found a rate of approximately 16 per 100,000 in the Cook County Jail,[88] and Heilig found a rate of approximately 8, or 2 per 100,000, depending on the year.[89] Henden found a similar rate of 16–17 per 100,000.[90] Almost all studies on jail suicides agree that the suicides occur relatively early in the incarceration, although there is disagreement as to how early. Danto reports that 60 percent of the suicides occurred within 30 days of incarceration.[91] Esparza found that 67 percent of the suicides in his sample occurred within 90 days of confinement,[92] and Heilig found that 76 percent of suicides he studied occurred within their first 24 hours of confinement.[93] Fawcett and Marrs found that 52 percent of their cases committed their self-destructive act within 30 days, with 19 percent injuring themselves within the first 3 days of institutionalization; [94] Beigel and Russell report that all their suicides occurred within the first 6 weeks of placement in jails,[95] and Martin found that 62 percent of the suicides occurred within the first 10 days of jail confinement.[96]

Such findings make clear the imperative nature of the intake mental examination: Most potentially suicidal inmates could be detected, if ever, at that point, while waiting even 14 days for such an indepth interview would seriously jeopardize a number of potential suicides.

Attempting to draw some connection between suicides and mental illness, which is the focus of this study, is even more difficult. Farberow, for example, concludes that there is relatively little connection: [97]

> There was surprising (and fairly strong) evidence . . . that suicide did not occur in schizophrenics in response to impulsive delusional thoughts or hallucinations but rather that self-destruction occurred in a somewhat planned and organized attempt at extrication from intolerably stressful life situations.

Leonard also suggests the problems involved in drawing correlations: [98]

> Figures given (for the percentages of suicides for the mentally ill) rest largely on the definition of mental illness, however, and therefore run the gamut from as low as 20% to as high as 90 to 100%. Such a wide variation reflects the difficulty of defining and categorizing mental illness in the first place and the relative independence of suicide and present day psychiatric nosology.

Greenberg concludes from this: [99]

> The mere fact that a suicide attempt (occurs) . . . cannot by any means be taken as conclusory evidence for the presence of mental illness especially if by mental illness one means an inability to perceive reality accurately, to reason logically, and to make plans and carry them out in an organized fashion.

On the other extreme, there are a number of authorities who argue that virtually all suicides occur from mental illness.[100]

In those instances where mental illness can be said to be involved in the suicide, theoretically both the mental health expert and the sheriff might potentially be liable for having failed to prevent it, if it was clear that the victim was inclined toward such an action. In those instances, however, where there is no necessary link of mental illness and suicide, the sheriff alone might be liable under current standards. The difficulty, of course, with that approach is that the sheriff may be less able than the doctor to diagnose suicidal tendencies, even those not necessarily caused by mental illness, and it seems harsh to put that burden on the shoulders of the sheriff. On the other hand, given what we do know about the importance of prison conditions and threats against life in giving impetus to suicides, the sheriff might be deemed more of an expert in some instances than even the mental health expert. The balance is a difficult one to draw and, in most instances, would be drawn not by "the law" but by the jury using its good commonsense as guided by the instructions from the court.

With that preface, then, let us see how the law thus far has treated liability for jail suicides.

The Law of Jail Suicides

The most obvious possible point of negligence in jail suicide is the weakest link—when the prisoner is first admitted to the jail. We have already seen that the sheriff and the State are under duty to conduct at least a preliminary examination at that time. It is not surprising, therefore, that many of the cases finding liability essentially find negligence in not having conducted such an examination. In *DeZort* v. *Hinsdale,*[101] for example, the "prisoner" voluntarily sought jail commitment, indicating that he was concerned about his strong suicidal tendencies. Nevertheless, there was no physical or mental examination by the admitting guard. The court held that it was a jury question as to whether the jailer had been negligent. Similarly, in *State ex. rel. Hayes* v. *Billings,*[102] deceased had been incarcerated by a sheriff who, according to the allegations, knew that he was without his mental capacity. When he fell from the upstairs hallway of the jail to the concrete floor below, the court held that the question of negligence was for the jury. Similar findings arise when the sheriff has good cause to know of the mental illness.[103]

Just as a sheriff may be liable for failing to properly ascertain at booking, or at some later point, the suicidal tendencies of his prisoner, he may become liable when the prisoner or someone else informs him of the suicide potential of a charge.

The court's willingness to hold sheriffs in such situations is in some contrast to the general position of the law of torts to suicides and those who "cause" them. Traditional tort theories dictated no liability for persons who "cause" others to commit suicide, either on the theory that the "cause" had not been sufficiently proved or that the victim's intervening act of self-destruction "broke" the causal chain.[104] Only when the victim acts from an "uncontrollable impulse" spurred by the defendant's action has there even been the possibility of liability, and then only recently.[105]

On the other hand, the vast majority of cases, particularly those which have dealt with treatment of those known or suspected to be suicidal, have not resulted in liability on the part of either the doctor, or, if also present, the jailer. The crux of these cases, whether in State or Federal court, has been the "discretionary" or "partial immunity" concept, based in part upon the difficulty of diagnosing mental illness,[106] and in part on the notion that the purpose of treatment requires risk taking in the general population.[107]

Yet, there are cases which go the other way. In *Dinnerstein* v. *United States,*[108] for example, the trial court found negligence and was upheld on appeal, where a patient, admitted because of suicidal tendencies, was placed on a ward without restrictions and, within 24 hours, leaped to his death from a seventh floor unsecured window. The court quoted with approval the lower court view that "At the least, for the first few days . . . his movements should have been restricted so that he could be closely watched." And, as far as suicidal tendencies were concerned, the lower court said: "His own denial upon admission of suicidal ideation and even Dr. Gottlieb's belief that he was not imminently suicidal, cannot excuse the complete absence of precautions to insure the safety of a patient with a suicidal gesture in his past. . . ." As to the "open door" policy, the court declared: "While we must accept some calculated risks in order to insure the patient's legal rights and provide him with the most efficient therapy, we must also admit that errors in judgment do occur, and that when they do, medical authorities must assume their rightful share of the responsibility."

These cases—and their conflicting results—demonstrate the tension in which the law, reflecting the real world, finds itself. On the one hand, there is the duty of the sheriff to examine persons both upon initial examination and at later points. A failure to do this, or to follow the directions of a mental health professional when mental illiness is detected, will result in liability.[109] There is, consistent with this view, some tendency for the courts to suggest that where the evidence is dubious, the duty is to confine closely until a further diagnosis can be made. This would clearly be in accord with current penological standards.[110]

On the other hand is the recognition that accurately diagnosing mental illness is difficult and that general propositions of freedom, as well as due process, rebel at the notion of capricious close confinement in the absense of rather conclusive evidence: The "open door" policy is almost dictated by a democratic risk-taking society. Moreover, the notion of "discretionary" immunity seems readymade for this precise situation, so that the prisoner's survivors will collect only if there has been, in effect, abuse of discretion.

Summary

In brief, the law prior to the 1970s virtually never seriously considered the possibility that a jailer or a mental health profes-

sional might be liable for the suicide of a person incarcerated in an institution.

Although that rule is now changing and the law recognizes the possibility, it is likely that, in the absence of overwhelming evidence of suicidal tendencies, the sheriff is not likely to be held liable. He is likely to be even more secure if he relies upon the expertise of the mental health professional. And that professional, in turn, because of the tenuous nature of definitions in the profession, will be essentially immune from liability, except in the most extreme cases.

If, therefore, there is an impetus to prevent suicide in the jail, it will not come from a deterrent effect of tort law but from the desire of the sheriff to operate a calm jail and from his desire to serve humanitarian ends.

An Epilog on Liability

The rules of liability of the individual sheriff, or of the mental health professional in the jail, are probably right, or nearly right. To mulct an individual for conditions, environment, structure, etc., over which he has minimal control, can only be characterized as vindictive; where the individual precludes access to necessary medical care or negligently conducts the treatment, matters over which there is control, liability should obtain, given always the remembrance that we want to take as many chances in favor of liberty as we can.

But that does not deal with the issue of whether the government, as an entity, regardless of the liability of its individual officers, should nevertheless pay for injuries sustained because it has incarcerated persons—albeit justifiably—in such institutions. A jail without substantial visiting hours, for example, is much more oppressive than a prison with meager visiting hours, since in prisons, at least, there are numerous "rehabilitational" activities not present in jails. If the lack of such activity "causes" mental illness, then perhaps the State should be liable, without respect to fault. If the budget will not allow for the proper training in mental illness detection as well as in first aid, the State should, as a cost of this decision, reap the consequences.

The government, after all, does this now in large part. It pays for all attorneys' fees for most State correctional employees and indemnifies them for most charges of liability found by the jury. If, instead, of the negligence concept, a workers' compensation concept, akin to the notion that the prisoner is in a "work place" over

which he has little or no control, were instituted, those payments could be avoided and that money used to compensate, on a set scale, all prisoners who suffer from the lack of protection, medical care, proper safety devices, and the rest. This solution would clearly be much more equitable than the present system which requires so much fine-line drawing in a situation in which the State holds—both literally and figuratively—all the knives.

Conclusion

The law is beginning to recognize the duty of the State and the sheriff to provide mental health services to prisoners who need them. In accord with national standards and evolving case law, this means that there must be sufficient personnel, trained in both the detection and treatment of mental illness, present in the jails at all times. Otherwise, liability of the sheriff will surely result, if the prisoner injures himself or others. Given the present law, in which the government generally refuses to accept responsibility for such injuries, this is probably the best solution. But far preferable is a legal system which would (1) allow temporary transfers to mental health centers as soon as mental illness is diagnosed; (2) impose upon the government, as the ultimately responsibile authority, liability for those injuries which do occur as a result of the failure of fallible persons, attempting to do their jobs in a forthright and professional manner, without the necessity of having to demonstrate negligence. Persons do not seek the stress of jail, even those who voluntarily commit crimes, and the legal system should respond, in affirmative and remedial ways, to solve that dilemma.

Footnotes

1. F. Cohen, *The Legal Challenge to Corrections* (1967).
2. See, e.g., South Carolina Department of Corrections, *The Emerging Rights of the Confined* (1972): The United States Supreme Court has agreed, *Estelle* v. *Gamble,* 429 U.S. 97 (1976). The literature, and case law, is enormous. Of these, only a few really deserve mention. In the literature: Neisser, Is there a doctor in the joint, 63 *Va. L. Rev.* 921 (1977) (hereafter Neisser); Plotkin, Enforcing prisoners' rights to medical treatment, 9 *Crim. L. Bull.* 159. (1973); Comment, Eighth amendment medical care and protection from the violence of fellow inmates, 49 *Not. Dam. Law.* 454 (1973).
3. These and other standards are discussed infra, pp. 70–73.
4. American Correctional Association, *Manual of Correctional Standards* (3rd Ed. 1966). (hereafter *ACA Manual*).

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5. Bresher and Della Penna, *Health Care in Correctional Institutions* (1975).
6. 330 F. Supp. 707 (W.D. Ohio 1971).
7. Id. at 718.
8. See, e.g., *Campbell* v. *McGruder,* 416 F. Supp. 100 (D.D.C. 1975); *Baines* v. *Government of the Virgin Islands,* 415 F. Supp. 1218 (D.V.I. 1976); *Leaman* v. *Helgemoe,* 437 F. Supp. 268 (D.N.H. 1977). Most important is *Bowring* v. *Godwin,* 551 F. 2d 44, 47, 49 (4th Cir. 1977):

   > We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart. . . . We therefore hold that Bowring (or any other prison inmate) is entitled to psychological or psychiatric treatment if a physician or other health care provider . . . concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial. . . . The starting point . . . is an evidentiary hearing . . . to determine if the prisoner is indeed suffering from a "qualified" mental illness. . . . If the answer is in the affirmative, the court shall order that appropriate action be taken by the prison authorities.

9. *ACA Manual,* supra, n. 4.
10. National Advisory Commission on Criminal Justice Standards and Goals: *Corrections* (1973) (hereafter *NAC*).
11. President's Commission on Law Enforcement and the Administration of Justice, *Task Force Report: Corrections* (1967) (hereafter *1967 Report*).
12. National Council on Crime and Delinquency, *Model Act for the Protection of the Rights of Prisoners* (1972) (hereafter *NCCD*).
13. Fourth United Nations Congress on Prevention of Crime and Treatment of Offenders, *Standard Minimum Rules for the Treatment of Prisoners* (rev. ed. 1970) (hereafter *U.N. Rules*).
14. Association of State Correctional Administrators, *Uniform Correctional Policies and Procedures* (1972) (hereafter *ASCA*).
15. American Bar Association, Report of the Special Committee on the legal status of prisoners, reprinted in 14 *Amer. Crim. L. Rev.* 377 (1977) (hereafter *ABA*).
16. National Sheriffs Association, *Manual on Jail Administration* (1970) (hereafter *NSA Manual*).
17. Nebraska State Bar Association Committee on Correctional Law and Practice, *Jail Standards* (1977) (hereafter *Neb. Jail Standards*).
18. National Sheriff's Association, *Jail Security, Classification and Discipline Standards* (1974).
19. United States Bureau of Prisons, The Jail, Its Operation and Management (1970).
20. Illinois County Jail Standards, Ch. 14 (1972) in American Bar Association and American Medical Association, *Medical and Health Care in Jails, Prisons, and other Correctional Facilities* (hereafter *ABA/AMA Compilation*). 49 (1973).
21. California State Board of Corrections, Regulations applying to jails and other local detention facilities, Title 15 (1973) in *ABA/AMA Compilation,* supra n. 20 at 53.
22. Pennsylvania Dept. of Corr., *Minimum Standards and Operating Procedures for Pennsylvania County Prisons* (1976).
23. South Carolina Dept. of Corrections, *Standards for County Jails* (1970) in ABA/AMA Compilation, supra n. 20, at 58.

24. Dept. of Human Resources, *Jail Standards and Guidelines for Operation of Local Correctional Facilities* (1973).
25. American Medical Association, *Standards for the Accreditation of Medical Care and Health Services in Correctional Institutions* (1978) (hereafter *AMA*). Since a draft form of these standards were adopted virtually verbatim by the American Correctional Association's manual of standards for adult local detention facilities (1977), by which the ACA will assess jails for purposes of accreditation, they are probably the most important set of standards.
26. American Public Health Association, *Standards for Health Services in Correctional Institutions.*
27. Anno., Standards for health care in correctional institutions in *Health Care in Correctional Institutions* 35 (University Research Corporation, 1977).
28. See, e.g., *Weintraub* v. *Rosen,* 93 F.2d 344 (7th Cir. 1931); *Mason* v. *Geddes* 258 Mass. 40,154 N.E. 519 (1926).
29. 33 Ill. 2d 326, 211 N.E. 2d 253 (1965).
30. See, e.g., *Purcell* v. *Zimbleman,* 18 Ariz. App. 75, 500 P.2d 335 (1972); *Kakligian* v. *Henry Ford Hosp.,* 48 Mich. App. 325, 210 N.W. 2d 463 (1973); *Fiorentino* v. *Wenger,* 19 N.Y. 2d 407, 227 N.E.2d 296, 280 N.Y.S. 2d 373 (1967). See generally, Dornette, The legal impact on voluntary standards in civil actions against the health care provider, 22 *N.Y. L. Rev.* 925 (1977).
31. American Medical Association, *Medical Care in U.S. Jails* (1972) (hereafter *AMA Jail Study*).
32. Thus, for example, the AMA, *The Recognition of Jail Inmates with Mental Illness, their Special Problems and Needs for Care* (1977) (hereafter *AMA, Recognition*) declares at page 7:

    > Recognition of psychiatric disorder should begin with an initial screening at the time of booking. This screening should be part of the overall medical screening and include questions directed toward previous psychiatric care, psychiatric hospitalizations, use of "nerve" medicines, and the present emotional state of the inmate.

    The *NSA Manual,* supra n. 16, rule 20, paragraph 10, states that:

    > A mental health staff should be available for the examination and diagnosis of every prisoner and treatment of prisoners who are not sufficiently disturbed to be committed as psychotic.

    AMA, supra n. 25. Standard 1024 provides that "written standards (should) exist for screening, referral and care of mentally ill and retarded inmates"; the *ASCA* rules, supra, n. 14, provides:

    > Upon admission, the admitting officer should determine whether the person being admitted should receive immediate medical attention. Immediate attention should be provided for any individual who is suspected of being ill, physically injured, emotionally disturbed.

    It is clear, however, that this is not the current practice. A study in California in 1976 found that "More than 75% of the inmates diagnosed as mentally disordered received no mental health service. None of the studied counties performed systematic screening of inmates by people skilled in diagnosis." Arthur Bolton Associates, *A Study of the Need and Availability of Mental Health Services for Mentally Disordered Jail Inmates and Juveniles in Detention Facilities* (1976).
33. The American Medical Association Standards are clear: There is no such requirement. *AMA,* supra n. 25, Sec. 1011. Similarly, the American Bar Association standards, while requiring a preliminary examination, are strangely silent on the issue of who should conduct them. *ABA*, supra n. 15, Sec. 5.4. Other standards either expressly agree that nonmedical persons may conduct

these examinations, or are silent on the point, thus implying acquiescence. Again, it should be recalled that these standards may be silent *not* because there will never be a requirement that the examination be conducted by a physician, or even by a person trained in recognizing mental illness, but because these standards are written for a national audience and, therefore, only establish that it is not always required that the examination be so conducted. Thus, for example, while a small jail in mid-Montana, whose typical population is six, might well avoid the necessity of hiring a psychiatrist to perform such examination, major urban jails, such as those in New York, San Francisco, Chicago, Los Angeles, Houston, etc., might be so required.

34. *UN Rules*, supra n. 13, expressly provides for special rules dealing with insane or mentally abnormal prisoners: 82(1). Persons who are found to be insane shall not be detained in prisons, and arrangements shall be made to remove them to mental institutions as soon as possible. The United States Bureau of Prisons, in *The Jail—Its Operation and Management*, provides that persons who are in need of medical treatment should be refused admission. Similarly, *AMA*, supra n. 25, Standard 1024 says: "Admission to appropriate health care facilities in lieu of detention, should be sought for all suspected mentally ill or retarded inmates," which suggests that admission should be initially refused. Accord, *Pa. Standards*, supra n. 22.
35. *AMA, Recognition,* supra n. 32 at p. 5.
36. *NSA Manual,* supra n. 16, Stan. XI 4.
37. Thus, the *AMA, Recognition,* supra n. 32, at 7, suggests that:

> While awaiting transfer to another institution there should be adequate observation by trained staff to protect the patient from injury, either self-inflicted or by others, and to monitor the effects of medication which may have been given.

38. See *Hamilton* v. *Landrieu,* 351 F. Supp. 549 (E.D. La. 1972); *Smith* v. *Hongisto,* No. C 70-1244 RHS (N.D. Cal. 1973); *Collins* v. *Schoonfield,* 344 F. Supp. 257, 277 (D. Md. 1972), *Hamilton* v. *Love,* 328 F. Supp. 1182, 1186 (E.D. Ark. 1971).
39. *ABA,* supra n. 15 Sec. 5.2; U.S. Bureau of Prisons, *Medical Standards* 37602, p. 17 (6/12/67); *UN Rules,* supra n. 13, at Sec. 25: *NSA Manual,* supra n. 16, Sec. 3; 15 *Cal. Adm. Code* Sec. 1161; *AMA* supra n. 25, Standard 1016, intriguingly, varies the requirement of sick call according to the size of the population. Unfortunately, there is no discussion as to how that approach was reached. For case law in sick call, see *Wayne County Jail Inmates* v. *Wayne County Board of Commissioners* (Wayne County, Mich., Cir. Ct., May 17, 1971) at 161; *Hamilton* v. *Love,* 328 F. Supp. 1132. (E.D. Ark. 1971) (weekly, by stipulation). Some standards will allow sick call by a nonphysician, but the case law is more stringent. For cases holding that screening even by a nurse is deficient in terms of sick call, see *Todaro* v. *Ward,* 431 F. Supp. 1129 (S.D.N.Y. 1976), aff'd ——— F.2d ———(2d Cir. 1977); *Dillard* v. *Pitchess,* 399 F. Supp. 1225 (C.D. Cal. 1975).
40. According to all the standards of the correctional profession, this conflict is not really present. The American Correctional Association declared, a dozen years ago, that "To achieve quality medical care, any incompatibility between medical and prison rules must be resolved in the former's favor." *ACA Manual,* supra n. 4. Similarly, the National Advisory Commission on Criminal Justice Standards and Goals stated, in 1972: "Correctional personnel should not be authorized or allowed to inhibit an offender's access to medical personnel or to interfere with medical treatment." *NAC,* supra n. 10, Section 2.6. Accord, *ABA,* supra n. 15, Section 5.2(iii). Indeed, the American Medical Association's *Standards for the Accreditation of Medical Care and Health Services in Jails* appears to have taken an unnecessarily reticent position on this issue. In its last draft before final adoption, the Association provided, in Section 5161, that "The physician has no restrictions imposed on him by the facility administration regarding the practice of medicine." A comment to that section declared: "Security regulations applicable to facility personel should also apply to the medical personnel." In the final Standards, however, the language of the comment was raised to the level of the Standard and became the second clause. See *AMA,* supra n. 25, Section 1002. This change may be insignificant, in fact; but it augurs ill for those who seek to establish that, where there is conflict,the medical judgment must always dominate.

See, e.g., *Battle* v. *Anderson,* 376 F. Supp. 402 (D. Okla. 1974): "No individual member of the staff or inmate population who is not a fully qualified health professional or paraprofessional shall inhibit, present, or obstruct any inmate from call." Accord, *Smith* v. *Hongisto,* No. C-70-1244 RHS (N.D. Cal. 1973). Many prison regulations are also in accord. See, e.g., *Medical Standards of the U.S. Bureau of Prisons,* at 37602, p. 20, June 12, 1967. The first substantive Standard of the new AMA Standards provides: "The physician has no restrictions imposed upon him by the facility administration regarding the practice of medicine."

Examples of guard interference with access to the doctor include *Freeman* v. *Lockhardt,* 503 F.2d 1016 (8th Cir. 1974)—inmate denied access after eye infection diagnosed; *Campbell* v. *Beto,* 460 F.2d 765 (5th Cir. 1972)—cardiac patient denied access to physician for 13 days while on restricted diet; *Wood* v. *Maryland Casualty Co.,* 322 F. Supp. 436 (W. Dist. La., 1971)—burn victim denied access after return from hospital; *Redding* v. *Pate,* 220 F. Supp. 124 (N. Dist. Ill., 1963)—epileptic denied access after onset of new symptoms.

41. In *Sawyer* v. *Sigler,* 370 F. Supp. 690 (D. Neb. 1970), for example, the warden had issued an order that all drug medication would be taken in liquid form so as to avoid possible subterfuge and drug selling by prisoners. Sawyer, armed with an order from the prison doctor that he could not take the drug in those forms and should be allowed to take the drug in pill form, sought relief in Federal court under the Civil Rights Act, which he obtained. The Eighth Circuit affirmed the lower court order upholding the prisoner's position, 445 F.2d 813 (8th Cir. 1971). The order of the prison doctor was essential to Sawyer's victory, since other inmates in the same case complained about the same practice but had no doctor's order that they receive the drug in the pill form. Both courts denied relief to these prisoners. See also *United States ex rel. Hyde* v. *McGinnis,* 429 F.2d 864 (2d Cir. 1970), in which the court upheld a rule by the prison doctor that the prisoner take his medicine in liquid form. For other cases in which the prison doctor and the warden clashed, see *Campbell* v. *Beto,* 460 F.2d 765 (5th Cir. 1972); *Mitchell* v. *Chester County Farms Prison,* 426 F. Supp. 271 (E.D. Pa. 1976). Several courts have required prison administrators to yield in assigning work to prisoners whom the doctor has rated as unable to do the work. *Black* v. *Ciccone,* 324 F. Supp. 129 (W.D. No. 1970); *Woolsey* v. *Beto,* 450 F.2d 321 (5th Cir. 1971); *Martinez* v. *Mancusi,* 443 F.2d 921 (2d Cir. 1970); *Silborn* v. *Hutto,* 509 F.2d 621 (8th Cir. 1973); *Campbell* v. *Beto,* 460 F.2d 765 (5th Cir. 1972).
42. Neisser, supra n. 2, at 959–60.
43. Cost—Prison health care: part of the punishment?, 25 *New Physician* 29–33 (April 1976). See *AMA,* supra n. 25, Section 1005 (requiring licensure).

44. Neisser, supra n. 2 at 926, declares that "prison medical staffs are clearly underpaid by prevailing medical standards" citing the *ABA/AMA Compilation* (3d ed., 1974) at 95, and the report of the medical panel concerning Menard Correctional Center at 5, 27, 29 filed in *Lightfoot* v. *Walker,* 73-238-E (E.B. Ill. November 18, 1976).
45. See New York Special Commission on Attica, *Report: Attica,* pp. 63-66.
46. *ASCA,* supra n. 14, at 41: "The prescription, dispensing and administration of medication should be under strict medical supervision. The medical director should designate who, among appropriate health service staff, should be responsible for these functions;" *ABA,* supra note 15, Section 5.6; *AMA,* supra note 25, Section 1029 (physician orders; person trained by physician administers); *Neb. Jail Standards,* supra note 17, Sections 12-1 and 12-8 (staff may administer as ordered by physician).
47. Twenty-one Attorneys General responded to a letter requesting information on official opinions as to drug dispensing in correctional facilities. Of these, fourteen had not issued such an opinion. Of the remaining seven, five (Alaska, Kentucky, Minnesota, Georgia, and Wisconsin) allow someone other than a physician to administer the drugs. Pennsylvania agrees, if the drugs have been distributed by a pharmacist. One court has held that *only* licensed doctors or nurses may dispense drugs, under State law. *Newman* v. *Alabama,* 349 F.Supp. 278 (M.D. Ala.) aff'd 503 F.2d 1370 (1974), cert. den. 421 U.S. 948 (1975). Recently, Judge Johnson refused a petition to modify that order with regard to drugs prescribed by a doctor and maintained in the original package. Letter from Young Dempsay, Assistant Attorney General of Alabama to the author, May 1, 1978.
48. See the dissent of Mr. Justice Stevens in *Estelle* v. *Gamble,* arguing that the allegations there could be read as indicating "that an overworked, undermanned medical staff in a crowded prison is following the expedient course of prescribing nothing more than pain killers." At 110.
49. See, e.g., *Peek* v. *Ciccone,* 288 F. Supp. 329 (W.D. No. 1968).
50. Schwartz, Deprivation of privacy as a "functional prerequisite": the case of the prison, 63 *Crim. L., Crim. & Pol. Sci.* 229 (1972); Singer, Privacy, autonomy and dignity in the prison: a preliminary inquiry concerning constitutional aspects of the degradation process in our prisons, 21 *Buff. L. Rev.* 669 (1972).
51. See W. Prosser, *Torts* Section 9 (4th ed. 1971).
52. The *AMA,* supra n. 25, standard 1008 deals exclusively with informed consent: "All examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, the informed consent of parent, guardian, or legal custodian applies where required by law."
53. Cal. Welf. & Inst. Code, Section 5326.2 (1976).
54. Neisser, op. cit. supra n. 2, at 971.
55. See letter from William Reid, Mentally Ill Offender specialist, Mental Health Program, Calif. Health & Welfare Agency, to author, 2/28/78: "Most mental health professionals who head jail units in county programs . . . are opposed to the concept of providing any involuntary medication or other involuntary therapy inside the jail (except for) emergency intervention in order to remove an individual to a treatment facility."
56. See Developments-Civil commitment of the mentally ill, 87 *Harv. L. Rev.* 1190, 1202-04 (1974).
57. New York Mental Hygiene Law Section 31.01 (Supp. 1972).

58. A good example of the problem was found by the *Bolton Study* of the California system, supra note 32 at pp. 431-432. The study found that, of the inmates identified as mentally disordered, only about 60 percent were considered appropriate for transfer to a mental institution under the present legal standards and, indeed, that only 15 percent were considered appropriate for such transfer under the involuntary transfer provision. Thus, at least 40 percent, and perhaps as much as 85 percent, of the persons in jail who had mental disorders of a substantial nature—not personality disorders—were, at least in the view of the *Bolton Study,* not eligible to be transferred to a mental institution because of the definition of mental illness, which the legislature had passed in order to protect the civil liberties of persons who otherwise were to be committed. This tension obviously must be resolved.
59. *Baxstrom* v. *Herold,* 383 U.S. 107 (1968). The court currently has before it a case asking whether due process requires such a hearing, *Vitek* v. *Miller,* 46 L.W. 3484 (1978). Even if the court follows the narrow decisions in *Haymes* v. *Montayne,* 427 U.S. 236 (1976) and *Meachum* v. *Fano,* 427 U.S. 215 (1976), both of which held that interprison transfers do not require due process, *Baxstrom* would remain to require a hearing if the State required one for civil commitment. Since most States do so require, the impact of *Vitek* is likely to be minimal.
60. *Baxstrom* involved a transfer of a prisoner whose term was ending; thus, the transfer was really more like a commitment. But it was soon applied to prisoners whose sentence had much time to run. *United States ex rel. Schuster* v. *Herold,* 410 F.2d 1071 (2d Cir.), cert. den., 396 U.S. 847 (1969). It is possible, however, that the courts could view both *Schuster* and *Baxstrom,* and the cases which have followed them, as involving virtual commitment to the mental health system, rather than temporary transfer. If so, it is possible that less due process would be required, for example, for a short period for purposes of diagnosis. This would both follow the general concepts of the requirements for medical treatment generally (i.e., a hearing is not required before a prisoner is transferred to a hospital for an appendectomy) and perhaps be more realistic.
61. Cal. Penal Code, Section 4011.8 (1975).
62. Cal. Penal Code, Section 4011.6 (1975).
63. Cal. Welfare & Inst. Code, Section 5403 (1978) requires a 5-year study of the efficacy of the program.
64. Thus, the *Bolton Study,* supra note 32 at 445, found: "There is an acute shortage of appropriate secure local treatment facilities for mentally disordered offenders throughout the state. County jail facilities seldom provide an environment conducive to mental health treatment, and local psychiatric treatment facilities generally lack the security capability necessary to protect the public from offenders who may be dangerous, or escape risks. *Because of the lack of secure local treatment facilities, diversion of mentally disordered offenders from jails to local mental health facilities is limited to non-dangerous inmates who pose little risk."*

    Indeed, a 1972 survey found only 19 security hospitals, one of whose major functions was to provide comprehensive treatment for mentally disordered offenders, 23 mental health facilities, including facilities expressly for sex offenders, and 26 correctional institutions which had a comprehensive treatment program for mentally disordered offenders. Eckerman, *A Nationwide Survey of Mental Health and Correctional Institutions for Adult Mentally Disordered Offenders,* DHEW Pub. No. (HSM) 73-9018 (1972). Although the survey did *not* include mental hospitals which, as a matter of general treat-

ment, also treated mentally ill offenders, and did not include facilities which did not treat "offenders," but detainees, the paucity of available institutions is nevertheless of great concern.

65. New York Corr. Law, Section 402.
66. Christianson, In prison: Contagion of suicide, *The Nation* 243 (Sept. 21, 1974).
67. Cal. Penal Code, Section 4011.8 effectively allows the mental health director to refuse to admit jail prisoners who seek to have themselves voluntarily committed, but does not articulate a reason for this power. The Model Penal Code allows the director of the Department of Mental Hygiene to withhold his agreement to a suggested transfer. Sec. 3.03.3(4). Of course, it might be argued that the mental health facility always had de facto power to reject a patient it does not want by the sheer expedient of declaring that he is not metally ill within the meaning of the relevant statutes which define their scope. There is, unhappily, good reason to believe that this occurs with some frequency. If the legal doctrines enunciated infra were applied, however, there might be less eagerness to apply at least this ploy, since failure to properly diagnose serious mental illness could lead to liability when the patient harms himself or others.
68. Still another possible solution, where staff and members of the respective departments are not, as is all too often the case, at loggerheads over a number of issues, is to have the State department responsible for prison (and jail?) policy reach an agreement with the department responsible for mental health care generally. See, e.g., Memorandum of Understanding Between North Carolina Department of Correction and North Carolina Department of Human Resources (Nov. 29, 1977). See Kiel, Mental health intervention for jail inmates (paper delivered at the National Jail Conference sponsored by the American Medical Association, August 21, 1977) at page 3. Such an agreement would, and should, cover issues of control, reimbursement, authority, etc. and would at least provide a point from which further exploration of interagency cooperation could redound to the benefit of the clients.
69. 42 U.S.C. Section 139d(a)(A).
70. 45 C.F.R. Section 248.60(5).
71. 45 C.F.R. Section 248.60(1).
72. See Letter from Borge Varmer, Regional Attorney of the Department of Health, Education and Welfare, to Congressman Edward Koch, June 30, 1977, accord. *Policy Information Release* No. 53 (H.E.W. Welfare Administration, Bureau of Family Services, April 26, 1967). See also Op. A.G. (Nev.) No. 64, Mar. 13, 1972, in *CCH Medicare and Medicaid New Developments,* paragraph 26,454 (1972).
73. 42 U.S.C. Section 139(a)(16).
74. 45 C.F.R. 248.60(a)(3)(i).
75. See S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 82 (1965).
76. 45 C.F.K. 248.60(a)(4)(ii).
77. With the renewal of the death penalty in many States, such no-bail detainees may occur. Nevertheless, the vast majority of detainees remain in jail only because of inability to post bond, and there would appear to be little reason to exclude them from Medicaid payments to which (assuming other eligibility) they would be entitled but for their poverty. Moreover, the "invidious discrimination" problem posed in the text should *not* be conclusive, since the no-bail statutes themselves do not cross that line.
78. Intriguingly, it is not only national Medicare and Medicaid that discriminate against prisoners who need mental treatment. According to the *Bolton Study,* supra note 32, at page 12, the California system (Medi-Cal) also denies benefits to persons diverted to community treatment programs under provisions of the California Penal Code. Thus, a potential major source of Federal funding for community alternatives to jails is not used.

79. *Jackson* v. *Hendrick,* No. 2437, Feb. Term (Phil. Ct. of Common Pleas, December 1, 1977) ($250,000 fine). Cf. *Hamilton* v. *Love,* 361 F.Supp. 1235 (E.D. Ark. 1973) (vacating order of contempt upon sheriff's compliance with order).
80. *Palmigiano* v. *Garraty,* 443 F.Supp. 956, 23 CR.L. 2106 (D.R.I. March 28, 1978).
81. See *Upchurch* v. *State,* 51 Haw 150, 454 P. 2d 112 (1964); Isele, Constitutional issue of the prisoner's right to health care 9 (*AMA,* 1976).
82. *Estelle* v. *Gamble,* 429 U.S. 97 (1976).
83. Thus, sheriffs have been held liable, or at least subject to liability, where they, or their guards, negligently failed to protect a prisoner in protective custody from an attack by other prisoners, *Upchurch* v. *State,* supra. n. 81; where the plaintiff was exposed to other prisoners who the sheriff knew, or should have known, were drunk, *Glover* v. *Hazelwood,* 387 S.W. 2d 600 (Ky. 1964); *Honeycutt* v. *Bass,* 187 So. 848 (La. App. 1939); *Daniels* v. *Anderson,* 195 Neb. 95, 237 N.W. 2d 397 (1975); mentally disturbed, *St. Julian* v. *Stata,* 82 So. 2d 85 (La. App. 1955); or otherwise dangerous, *Breaux* v. *Stata,* 314 So. 2d 449 (La. App. 1975); or exposed to a "kangaroo court," *Ratliff* v. *Stanley,* 224 Ky. 819, 7 S.W. 2d 230 (1928). Recently, courts have been willing to sustain possible causes of action for homosexual rape as well, *Van Horn* v. *Lurchard,* 392 F. Supp. 384 (E.D. Va. 1975).
84. *Haino* v. *Stata,* 61 N.J. 585, 297 A. 2d 561 (1972); *Travis* v. *Pinto,* 37 N.J. Super. 263, 298, A. 2d 828 (1965).
85. *Procunier* v. *Navaretta,* 98 S.Ct. 855 (1978); *Wood* v. *Strickland,* 420 U.S. 308 (1975).
86. *Jailhouse Blues,* (Danto, ed. 1973) (hereafter *Blues).*
87. Esparza, Attempted and committed suicides in county jails, in *Blues,* supra n. 86, at p. 27.
88. Fawcett and Marrs, Suicide at the county jail, in *Blues,* supra n. 86, pp. 84, 86.
89. Heilig, Suicide in jails, a preliminary study in Los Angeles County, in *Blues,* supra n. 86, at p. 47.
90. Henden, Psychiatric emergencies, in *Comprehensive Textbook of Psychiatry* 1170 (A. Freedman and H. Kaplan, eds. 1967).
91. Danto, Suicide in the Wayne County Jail: 1967–70, in *Blues,* supra n. 86, p. 3.
92. *Esparza,* supra n. 87.
93. *Heilig,* supra n. 89.
94. *Fawcett and Marrs,* supra n. 88.
95. Suicidal behavior in jail: Prognostic consideration, in *Blues,* supra n. 86, p. 107.
96. Martin, Prison Suicide Study, Interdepartmental Memorandum, City of New York Health Services Administration (1971).
97. Farberow, Schneidman, and Leonard, Suicide among schizophrenic mental hospital patients, in *The Cry for Help* 78, 91 (N. L. Farberow and E. S. Schneidman, eds. 1965).
98. C. Leonard, *Understanding and Preventing Suicide* 273 (1967).
99. Greenberg, Involuntary psychiatric commitments to prevent suicide, 49 *N.Y.U. L. Rev.* 227, 236 (1974).
100. Bergler, Suicide: psychoanalytic and medicolegal aspects, 8 *LA. L. Rev.* 504 (1958); A. Brill, *Fundamental Conceptions of Psychoanalysis* 262 (1921); D. Henderson and R. Gillespie, *Textbook of Psychiatry* 69 (10th ed. 1969). See also

Havens, Recognition of suicidal risks through the pyschological examination, 276 *N. Eng. J. Med.* 210 (1967).

101. 35 Ill. App. 3d 703, 42 N.E. 2d 468 (1976).
102. 240 N.C. 78, 81 S.E. 2d 150 (1954).
103. Thus, in *Porter* v. *County of Cook,* 42 Ill. App. 3d 287, 355 N.E. 2d 561 (1976), the prisoner complained that he was "hearing voices." The doctor's certificate indicated the need for immediate hospitalization, but this did not occur. To drive away the voices, the prisoner set fire to his mattress, sustaining severe injuries, and nearly dying. A judgment award of damages was upheld. See also *LaVigne* v. *Allen,* 36 App. Div. 2d 981, 321 N.Y.S. 2d 179 (1971); *Gioia* v. *State,* 22 App. Div. 2d 181, 254 N.Y.S. 2d 384 (1964); cf., *Thomas* v. *Williams,* 105 Ga. App. 321, 124 S.E. 2d 409 (1962) (drunk prisoner not sufficiently protected).
104. *Scheffer* v. *R.R. Co.,* 105 U.S. 249 (1882); *Salsedo* v. *Palmer, 278 F. 2d 92 (2d Cir. 1921).*
105. *Richardson* v. *Edgeworth,* 214 So. 2d 579 (1969); *Tate* v. *Canonica,* 180 Cal. App. 2d 898, 5 Cal. Rptr. 28 (1960); *Fuller* v. *Preis,* 35 N.Y. 2d 425, 322 N.E. 2d 263 (1974). See generally Schwartz, Civil liability for causing suicide: A synthesis of law and psychiatry, 24 *Vand. L. Rev.* 217 (1971).
106. Schwartz, supra n. 105 at 236:

> Although the so-called "thin skull" rule in cases involving physical injury might provide some support allowing recovery in cases involving pre-existing instability, it is submitted that an imposition of such liability would be wholly out of proportion to the hazard risked in many cases of negligently inflicted injury. In other words, in the mental illness field, because no one can reasonably expect a person to be mentally ill and to do bizarre things from small slights, they should not be liable under the skull rule.

Several cases have denied liability for jail suicides on various grounds. Thus, in *Kendrick* v. *Adamson,* 51 Ga. App. 402, 180 S.E. 647 (1935), the court viewed the drunken prisoner's act of suicide as superseding cause. In *Griffis* v. *Travelers Ins. Co.,* 273 So. 2d 523 (La. 1973), the court found, as a matter of fact, no negligence on the part of the jail officers, who had removed from the prisoner all matches before placing him in a cell; the prisoner then received matches from a neighboring cell and began a fire which resulted in third-degree burns. Finally, in *Thompson* v. *State,* 30 App. Div. 2d 914, 292 N.Y.S. 2d 491 (1968), the court again found no negligence.

These latter two cases, then, agreed that there was a duty to the prisoner to protect him from his own folly but found that the duty had been nonnegligently carried out. In contrast in the most important adverse case in this area—*Lucas* v. *Long Beach,* 60 Cal. App. 3d 341, 131 Cal. Rptr. 470 (1976)—the court challenged that very premise. Lucas involved a 17-year old who had been booked for disorderly conduct when he was unable to pass basic tests for sobriety. Although he had been swaying, a breathalyzer test showed no significant amount of alcohol in his body, the officers thereby concluding that he was on drugs. Three hours after being placed in the cell, the juvenile was found hanging by his neck in a noose constructed of a strip of cloth torn from a mattress cover. The court found no liability, denying even a duty to examine.

107. *Baker* v. *United States,* 226 F. Supp. 129 (D. Iowa 1964), *aff'd.* 343 F. 2d 222 (8th Cir. 1965). *Accord, Gregory* v. *Robinson,* 338 So. 2d 288 (Mo. 1960); *White* v. *United States,* 224 F. Supp. 127, 129 (E.D. Va. 1965), *aff'd,* 359 F. 2d 989 (4th Cir. 1966).
108. 486. F. 2d 34 (2d Cir. 1973). In *Lucy Webb Eayes National School* v. *Perotti,* 419 F. 2d 704 (D.C. Cir. 1969), plaintiff's decedent had been admitted to the hospital for purposes of observation. The day after his arrival, he slipped out of the maximum security ward and jumped through a window. Plaintiff had two theories of negligence: (1) The hospital was negligent for not having stronger glass in the window; (2) the hospital was negligent for allowing the decedent to escape from the maximum security ward. On the first point, Bazelon, J., for the court, declared that "since the emphasis in the new ward was to be upon therapy rather than confinement, they wished to create an open, pleasant atmosphere to the fullest extent possible." Therefore, using regular glass to achieve this end was not negligent. On the other point, the court held that there was a possibility of negligence, and the jury verdict was allowed to stand. See also *Harper* v. *Cserr,* 544 F. 2d 1121 (1st Cir. 1976).
109. In *Adams* v. *State,* 71 Wash. 2d 14, 429 P. 2d 109 (1967), for example, the doctors clearly recognized the patient's suicidal tendencies. Due to negligence on the part of the staff, however, the patient simply walked out of the hospital, past two security posts left vacant by their occupants, in time to leap in front of an oncoming car. The court affirmed the judgment against the State. Obviously, the parallel for the jail cases is clear—while the psychiatrist may be safe from damages if the proper diagnosis and warnings are present, the sheriff and/or his staff may be liable if they carry out these warnings in a negligent manner.
110. *U.S. Bureau of Prisons,* supra n. 19: "When a prisoner's disruptive or self-destructive behavior cannot be controlled by locking him up, it may be necessary to restrict his ability to move. If a mentally disturbed prisoner bangs his head against the wall or floor, it may be necessary to immobilize [him] . . . ."

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CHAPTER 5

Psychological Assessment in Jails: Implementation of the Standards Recommended by the National Advisory Commission on Criminal Justice Standards

Edwin I. Megargee, Ph. D.

In its 1973 Report on Corrections, the National Advisory Commission on Criminal Justice Standards and Goals made recommendations concerning the diagnostic, classification, and treatment programs that should be available in local adult correctional institutions. The purpose of this chapter is to discuss the assessment techniques required to implement the *Standards* with respect to each of the several functions local jails are expected to perform. The practical and ethical problems faced by the psychologist at such stage of the recommended assessment process will be discussed, and policies, techniques, and tools will be recommended, along with suggestions for needed research.

The Role of Diagnosis and Assessment in a Jail Setting

The Functions of Local Adult Institutions

The National Advisory Commission recommended that the local jail should evolve into a community correctional center which would coordinate all community correctional services. It would serve as a focal point for referrals to diversionary mental health, alcohol, drug, and other community services and would provide direct services and supervision to offenders on both an inpatient and an outpatient basis. It would provide a secure residential facility for the detention of accused persons awaiting trial and the incarceration of convicted offenders and also function as a prerelease center for incarcerated offenders returning to the community from State and Federal institutions.

Although the coordinated community correctional center is at best a dream in most jurisdictions, many of its functions are presently being performed by local adult facilities, and more will be included as communities attempt to implement the 1973 *Standards.* This multiplicity of functions that the jail is expected to perform is one of the major problems and challenges confronting psychologists providing assessment services in such settings.

First, local adult institutions are expected to serve as clearinghouses and referral sources for arrested individuals. Those suffering from physical illnesses or wounds, major mental illnesses, alcholism, or addictions must be identified and referred to appropriate facilities (Standards 9.4.1 and 9.7.1). Intake workers are also expected to determine who is likely to be a menace to society or to flee to avoid prosecution, so that such a person can be maintained in secure facilities. Those who are not dangerous and who can be trusted to return for court are to be released (Standard 9.4). All of these functions involve assessment.

The second function of the jail is to provide for the secure detention of individuals who are considered dangerous or likely to abscond. Additional assessment is necessary for these individuals, first, to determine where and with whom they should be placed and, second, to determine the services and programs they should be afforded while awaiting trial. As we shall see, the latter task is complicated by the fact that, although the *Standards* specify that a full range of programs should be made available to pretrial detainees (Standard 4.9), they also prohibit any attempts to "rehabilitate" as-yet-unconvicted individuals (Standard 4.8.4.a). In pretrial detention, the jail operates strictly as a warehouse, and, like any warehouse, it is expected to return the "merchandise" in the same condition as it was when received, no worse and no better. (Unfortunately, it is much easier to store tables and chairs and return them unchanged than it is human beings.)

A third function of the local adult institution is to serve as a correctional facility for those convicted of misdemeanors who are sentenced to periods of confinement. Society simultaneously seems to require jails to punish, rehabilitate, and incapacitate offenders, while deterring other would-be offenders, a melange of demands that are often mutually exclusive. While this process of punishment, rehabilitation, incapacitation, and deterrence is proceeding, the jail is also responsible for the physical and mental health and well-being of the inmates and for providing programs designed to

foster positive change. At this stage, assessment is required to assist in both management and in programing.

The coordinated community correctional center envisioned in the *Standards* would also assume some of the functions now provided by probation and parole and by half-way houses, including the provision of supervision and services to offenders residing in the community and prerelease programs for offenders returning from State and Federal institutions. When this comes to pass, additional diagnostic and assessment services will be required to assist in initial program planning as well as ongoing consultation with field supervisors. Since these functions are not presently included in the typical jail's mission, they are not discussed in this chapter.

Thus, the functions of the local adult facility and the types of assessment required vary according to the legal status of the offenders and the stage of the criminal justice process in which they find themselves.

Problems of Assessment in Jail Settings

The National Advisory Commission's *Report on Corrections* stated, "The most striking inadequacy of jails is their abominable physical condition" (1973, p. 275), and the deficiencies of the space, staff, and resources found in most jails are too well known to bear repeating. Suffice it to say that most jails and lockups range on a continuum from appalling to inadequate, and today, as in the past, much of the thrust of jail reform rightly focuses on correcting these physical conditions. A person who resides in the most deprived, depraved, vice-ridden, violent, scabrous pit of iniquity should be able to go to jail secure in the knowledge that at least conditions will be no worse in the "slam" than they were in the slum. Yet, as Morris points out,[1] some jails fail to meet even this dismal standard. In such settings, simply insuring the physical and mental survival of the population must take precedence over any other reform.

But, even in the best local facilities, those which meet the highest physical standards, problems peculiar to the role and functions of jails in our society will confront the psychologist. According to the *Report on Corrections,* "Because of their multiple uses, jails house a population more diverse than any other correctional institutions. The 1970 jail census found that of 160,863 persons held on the census date, 27,460 had not been arraigned, 8,688 were awaiting some post-conviction legal action, 69,096 were serving sentences

(10,496 for more than a year), and 7,800 were juveniles" (1973, p. 274).

Offenders entering jails from the street may be sick, wounded, acutely psychotic, intoxicated, and/or addicted to drugs and/or alcohol. They come from all walks of life; some are society's affluent, more represent the effluent. Their academic and reading skills are often minimal or nonexistent, and, although they speak a variety of languages, English is not always one of them.

As if dealing with such a heterogeneous array of people is not problem enough, the diagnostician must also cope with the fact that being jailed often engenders stress that makes it difficult or impossible to administer the usual psychometric measures or to obtain adequate data regarding everyday functioning in the community. Over time, the acute anxiety usually diminishes, but initial decisions regarding diversion and detention must be made quickly, within 3 days according to Standard 9.4.1.

The vast volume of cases that must be processed through many jails also poses a considerable problem for the diagnostician; 7,984,547 people were taken into custody in 1975 (Gottfredson et al. 1978). For individuals arrested, a decision must be made as to whether or not they are suffering from a condition that requires referral to a hospital, mental health, detoxification, substance addiction, or other community facility. If not, it must be determined if their release would pose a serious threat to the community and whether they are likely to require detention in order to ensure their presence in court. The sheer number of such cases and the limited time in which the decisions must be made preclude anything remotely approaching a full professional workup on each person, even though the decisions to be made are of the utmost importance to the individual offender, his family, employer, and society in general. Even if psychological science were so advanced that a psychologist could make a complete and accurate assessment of each arrested individual simply by shaking his or her hand, there still would not be enough professional time available for each accused offender to receive that handshake. Professional time must be husbanded frugally, and its optimal allocation is a major problem for mental health professionals in jail settings.

Another general problem is the lack of mental health professionals equipped by experience or training to work in local correctional facilities (Ingram 1974; Spielberger et al. 1973). A general rule of thumb in many criminal justice agencies is that it takes about a year for conventionally trained clinical psychologists or psychiatrists to be worth their salt in criminal justice settings, since the nature of the clientele, the legal and administrative procedures

required, and the type of problems and decisions encountered differ so greatly from those found in conventional mental health settings. A few clinical training programs, such as those at Florida State University and the University of Alabama, include criminal justice training and experience in their curricula, but, until more programs do likewise, there will be a serious dearth of appropriately trained professionals for jails to call upon. For the time being, on-the-job training will continue to be the rule rather than the exception, so jail administrators should allow time for their mental health staff to obtain necessary supervision or consultation and to attend training sessions and workshops.

Mental health professionals, accustomed to dealing with people who seek their services voluntarily, often find it difficult to adapt to the legal and ethical strictures that govern jail inmates, especially during the pretrial phase. They must adjust to the fact that the jail rather than the individual inmate is their client and that absolute confidentiality cannot be maintained, if they are to do their diagnostic tasks. It is essential that psychologists, whether serving as consultants or employees, clearly define their roles with their employers at the outset and redefine them as administrations change. It is best if this is done in writing so there is no possbility of confusion when the inevitable conflicts and crises occur.

Generally, the attitude of the administration will be that no information obtained from the inmate in the context of diagnosis and classification can be considered privileged or confidential, especially during the pretrial phase. If the accused individual confesses, reveals the names of coparticipants, or discloses the location of damaging evidence, the sheriff's department (which typically operates the jail and employs the psychologist) usually wants to be informed. Even if incriminating evidence is not obtained, the psychological examination influences whether the defendant will be detained or set free while awaiting trial.

The limits regarding confidentiality, especially with respect to incriminating information and the possible outcomes of the assessment, must clearly be communicated to those being evaluated so they can decide whether or not to cooperate with the assessment procedures. I inform a jailed individual who I am, whom I am working for, why I am evaluating the individual, and the possible outcomes of that evaluation, including who is likely to be privy to the information I obtain. When I am employed by the court or a law enforcement agency, I give individuals in the pretrial phase a Miranda-type warning with respect to their rights and the possible consequences of relinquishing them. If the accused does not wish to cooperate or wants to have counsel present during the evaluation,

these wishes are respected. (Most clients assume that everyone in the jail is working for the police and prosecution so these admonitions are less constraining and inhibiting than psychologists unused to legal settings might suppose.)

The issue of confidentiality is closely linked to coercion. One should avoid situations in which release from detention is contingent upon a "clean bill of health" from the mental health worker. They would lead to a coercive "Catch 22" dilemma in which the accused would be locked up until trial if he chose to exercise his right to remain silent or not take tests.

Among convicted offenders being examined for programing, the issue of guilt has already been decided, and there are fewer constraints on the diagnostic process. Nevertheless, there are also limits on confidentiality in this situation which must be negotiated with the administration and communicated to the offender. In virtually all instances, the psychologist is expected to pass on information regarding events that might result in harm to others, such as a planned escape or assault. Jail administrations vary on whether other data obtained in diagnostic or counseling sessions, such as references to undetected crimes, are expected to be transmitted. In any case, it is essential that the administration, the mental health professional, and the individual offender all have a clear understanding of the limits on confidentiality (Lane and Kling in press).

As part of the assessment process, the psychologist may be expected to help in program planning, not only for convicted offenders but also for pretrial detainees. Detainees often need mental health services, but Standard 4.8.4.a clearly states that it is inappropriate to attempt to "rehabilitate" or change an unconvicted person detained awaiting trial. Nevertheless, Standards 4.9.1.a, b, and c dictate that educational, vocational, recreational, treatment, and counseling programs should be available for pretrial detainees who wish to participate in them on a voluntary basis, with the records of such participation being kept confidential. The diagnostician called on to plan an individual's program may find it difficult to avoid rehabilitation while providing access to suitable helping programs.

A major problem facing diagnosticians is the fact that so little empirical research has been done on assessment in jail settings. The bulk of the assessment literature is focused on college students and psychiatric patients, populations that differ from jail populations in a number of respects, not the least of which is the motivational set that they bring to the examination. Of the mental health personnel available, the psychologist is usually the only one who has received received specific research training. If research is to

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progress beyond the vague speculations and statements of faith that I offer in place of scientific knowledge in this chapter, it is essential that psychologists in jail settings undertake research to test the validity of their diagnostic decisions and to devise techniques that will improve their validity while reducing their cost in time, professional personnel, and, not the least, dollars. Yet the sheer demands for service are likely to exceed vastly the time available. In their initial bargaining with jail administrators, psychologists should insist that time and resources be set aside for research aimed at validating and improving the diagnostic process in jail settings and that this time remain inviolate. Once embroiled in the chronic urgency that characterizes most jails, the psychologist has difficulty obtaining research time if it means a reduction in inmate services.

The problems thus far identified of inadequate resources, heterogeneous clientele, multiplicity of functions, volume of cases, ethical conflicts, and a paucity of research pervade the diagnostic process at all stages.

Assessment in Stage I: Initial Screening

Decisions To Be Made and Services Required in Stage I

Once an individual has been arrested, the complex people-processing apparatus of the criminal justice system is activated. Law enforcement personnel are involved in obtaining data regarding guilt or innocence of the specific charges and investigating possible involvement in other offenses, both locally and in other jurisdictions. From these data the district or State's attorney must decide whether the evidence warrants prosecution and, if so, at what level. The judiciary is concerned with protecting the rights of the individual and, later, determining his guilt or innocence.

At this stage, the community correctional agency must determine (1) whether the accused individual can or should be diverted from the criminal justice system to some alternative form of intervention and (2) whether pretrial detention will be required to insure the individual's presence at trial or to protect the community.

These functions are spelled out succinctly in Standard 9.4 on adult intake services:

> Each jurisdiction should immediately take action, including the pursuit of enabling legislation where necessary, to establish centrally coordinated and directed adult intake services to:
>
> 1. Perform investigative service for pretrial intake screening. Such services should be conducted within 3 days and provide data for decisions regarding appropriateness of summons release, release on recognizance, community bail, conditional pretrial release, or other forms of pretrial release. Persons should not be placed in detention solely for the purpose of facilitating such services.
>
> 2. Emphasize diversion of alleged offenders from the criminal justice system and referral to alternative community-based programs (halfway houses, drug treatment programs, and other residential and nonresidential adult programs). The principal task is identifying the need and matching community services to it. . . .
>
> 5. . . . Most alleged offenders awaiting trial should be diverted to release programs, and the remaining population should be only those who represent a serious threat to the safety of others (*Report on Corrections* 1973, p. 296).

The *Standards* further specify that "Social inventory and offender classification should be a significant component of intake services" and that psychiatrists, clinical psychologists, social workers, interviewers, and education specialists should be available for intake service programs, either as staff members or on a contract basis. Administratively, it is recommended that intake processing should be a function of the judiciary.

Role of Diagnosis at Stage I

In Stage I, several major decisions must be made, often with minimal data, at a time of crisis for the accused. The intake staff must be concerned with protecting the rights of the accused on the one hand and preserving the safety of the community on the other.

The first step in screening is to identify those who are mentally or physically ill, those who are addicted to alcohol or drugs, and those who are potentially suicidal or self-mutilative so they can be directed toward facilities or programs more appropriate for their particular needs. The second is to identify candidates for diversion to community programs designed to cope with their behavior outside the criminal justice system. The third is to screen the remainder to determine which individuals should be detained and which should be released pending judicial processing of their case.

Problems of Diagnosis at Stage I

The decisions made at the time of initial screening probably have more far-reaching importance for the accused and society than those at any other stage, yet they must be made in the shortest time and with the least amount of data. Because of the volume of cases at Stage I, individual interviewing and assessment by professional mental health personnel are out of the question in most jurisdictions, yet the emotional and physical state [2] of the accused often precludes the administration of tests or other structured assessment devices.

The need to protect the civil rights of these as-yet-unconvicted individuals further compounds the problem of assessment. It will be recalled that 17 percent of the people confined on the day of the 1970 National Jail Census had not yet been arraigned, much less convicted. Arrested individuals have a right to privacy, and one must be very conservative with regard to collecting psychological data or administering tests so as to avoid unnecessary intrusion into people's lives, even with their informed consent. The security of their psychological dossiers must be maintained, and this writer believes that data collected on those not eventually adjudicated guilty should be destroyed.

Thus, the dilemmas are clearly drawn: All arrested individuals except ". . . those who represent a serious threat to the safety of others" have a right to the ". . . least restrictive alternative that will give reasonable assurance that the person will present for trial" (Standards 4.8.4.b and 9.4.5), but the community has a right to be protected from further depredations on the part of already apprehended individuals. The accused has a right to remain silent and a right to minimal intrusion into his private affairs and personality functioning, yet the psychologists assisting the screening process require the maximum amount of valid information on which to base their assessment.

Recommended Procedures and Techniques for Pretrial Screening

The ethical and practical constraints delineated above mitigate against the routine administration of psychometric assessment devices to all arrested individuals. Moreover, in most jurisdictions the volume of cases will make individual clinical interviews by psychiatrists or psychologists prohibitive. How, then, is intake screening to be carried out?

Standard 4.5.2 dictates that the following procedures should begin upon arrest:

> When a law enforcement agency decides to take a person accused of crime into custody, it should immediately notify the appropriate judicial officer or agency designated by him. An investigation should commence immediately to gather information relevant to the pretrial release or detention decision. The nature of the investigation should be flexible and generally exploratory in nature and should provide information about the accused including:
>
> a. Current employment status and employment history.
> b. Present residence and length of stay at such address.
> c. Extent and nature of family relationships.
> d. General reputation and character references.
> e. Present charges against the accused and penalties possible upon conviction.
> f. Likelihood of guilt or weight of evidence against the accused.
> g. Prior criminal record.
> h. Prior record of compliance with or violation of pretrial release conditions.
> i. Other facts relevant to the likelihood that he will appear for trial.
>
> (*Report on Corrections 1973, p. 123).*

The most efficient use of professional time would be for mental health professionals and physicians to undertake extensive training of these intake investigators, teaching them to recognize the basic signs suggesting that the arrested individual might be mentally or physically ill, suicidal, or addicted. Custodial personnel must also be alert for signs of emotional or mental instability as well as physical illness. (For example, it is essential that they be able to discriminate a diabetic coma from a drunken stupor.) If these front line personnel, who routinely must evaluate and supervise all arrested individuals, feel that there is cause for concern, then they should make a referral to the appropriate professional personnel, detailing the nature of their concern (i.e., suicide potential or psychosis) and the behavioral cues that suggested this possibility.

Those individuals referred by the intake screening or custodial staff should then be evaluated by the mental health professionals. Processing of the referral will be expedited if the intake or custodial staff have been trained by the psychologist to administer the Minnesota Multiphasic Personality Inventory (MMPI). An audiotaped version will be required for those with low literacy levels, and Spanish or other locally common language versions should be

available. The MMPI can be scored and profiled by clerical staff or computer. If the MMPI and an initial diagnostic interview, along with basic office tests of orientation, sensorium, and the like, indicate that there is indeed cause for concern, then the case should be referred to an appropriate community mental health facility. Since such a facility usually has its own intake procedures, there may be no need for a more extensive psychological workup at the jail.

In most cases, such as those showing "soft" signs of a schizophrenic or paranoid reaction or suicidal potential, a more extensive professional evaluation may be required. The battery used should be adapted to the needs of the specific case and the training of the diagnostician. Among the tools that may be used are clinical interviews with the individual and, if permitted, family members, along with tests such as the MMPI, the Wechsler Adult Intelligence Scale, the Bender Visual Motor Gestalt, the Rorschach Test, and the Thematic Apperception Test.

Many cases require little diagnostic effort. An admitted addict with extensive needlemarks on his arms, arrested for possession of narcotics, who begins exhibiting withdrawal symptoms several hours after his arrest, obviously needs to be transferred to an appropriate drug-detoxification facility.

If the combination of specially trained intake and custodial personnel backed up by professional psychologists and/or psychiatrists is to work, a strong interdependent relationship with regular communication must be established. The mental health professional will find that some workers fail to refer appropriate cases, while others refer inappropriate ones. Regular feedback and consultation with the referral sources will serve a valuable training function.

Over time the screening effort will improve if systematic followups are made. The mental health professional and the screening team should review diagnostic errors in an effort to determine what signs were missed, what behavior was misinterpreted, or what data proved to be erroneous, with the goal of eliminating or minimizing these sources of error in the future. This should include not only the overlooked cases, such as an undetected suicide, but also individuals predicted to be assaultive or disturbed who were not.

Turning from the identification of individuals with mental health and other problems requiring referral or diversion, the second basic decision is whether an individual is dangerous to the community and/or likely to flee to avoid prosecution if released. Considerable data have been accumulated with respect to the accuracy of predictions of dangerousness by mental health personnel (Megargee 1976). It is well established that, unless there is a chronic pattern of repetitive violence, dangerous behavior cannot be predicted with any degree of accuracy in the individual case. Kozol et al. (1972), who have had extensive experience in the evaluation of potential violence, have flatly stated, "No one can predict dangerour behavior in an individual with no history of dangerous acting out." Even in those who had been violent, Kozol and his colleagues could achieve no better than 35 percent accuracy after a 3-month period of extensive and intensive evaluation.

The major problem in the prediction of dangerous behavior is the high false-positive rate, that is, the large number of nondangerous individuals who are wrongly assessed as dangerous. This is less of a problem in pretrial screening than it is in some situations because the consequences of falsely being labeled as dangerous are somewhat less adverse; the typical outcome is temporary detention while awaiting trial, whereas in the mental health system the consequence is commitment until such time as the patient is no longer deemed dangerous.

In assessing potential danger, the intake staff should place their primary reliance on the individual's previous behavior and the situation to which he or she will be returning if released. Obviously, the greater the history of violence, the greater the risk of violence in the future. If a husband arrested for beating his wife is immediately released without a cooling-off period or some counseling, his natural inclination might be to return and beat her again for getting him into trouble.

The undercontrolled, assaultive individual is the easiest to recognize because of his long history of past violence. The overcontrolled assaultive person (Megargee 1966) poses more problems. If there is an elevation over a T-score of 8 on the MMPI *O–H* Scale (Megargee et al. 1967; Megargee 1973), further evaluation might identify a potentially assaultive, overcontrolled individual; however, it is likely that such a person will slip through Stage I screening. The acutely psychotic assaultive person should be recognized by the procedures already delineated. However, a chronic psychosis, especially a paranoid state, might be missed. Routine testing with the MMPI might help, but at Stage I this is generally impractical and, as already noted, poses some ethical and legal problems.

It should be noted that detention until trial is not necessarily the only way of coping with potentially dangerous individuals. Some may require only temporary detention until the situation has eased somewhat. Others, whose anger is directed toward a given individual, might be released on a peace bond that will automatically result in their being jailed if they approach or harass the threatened party.

The nature of the charges, community ties, employment record, criminal history, and similar data collected upon intake are probably more predictive of whether an individual will surrender himself for trial than any psychological tests (*Report on Corrections* 1973, p. 109). Indeed, the writer is not aware of any data on using such tests to identify those likely to jump bail. Successful actuarial tables have been devised, but they must be used with discretion. Obviously, releasing individuals, such as Edward Metesky, New York City's "madbomber," or David Berkowitz, the "Son of Sam" would have been inappropriate, despite the fact that both were first offenders and had stable employment histories.

It is possible that research would show that testing could supply data that would be predictive. The MMPI *Pd* scale, which Elion and Megargee (1975) found to be valid for blacks as well as whites might be useful, and so might the California Psychological Inventory's Socialization, Responsibility and Self-Control Scales (Megargee 1972*a*). However, there are no data to support these speculations, and, until the necessary research is performed, detention of individuals on the basis of unvalidated test patterns would undoubtedly lead to serious legal and ethical questions.

Along with the topic of testing individuals at the first stage, the disposition of psychological test data collected during intake screening should be discussed. No matter how efficient the police department is, not everyone who is arrested is guilty of a crime. Whether a jurisdiction opts for a broad program of psychological testing or the more restrained approach advocated in this chapter, some important civil liberty questions are raised by law enforcement agencies collecting and preserving psychological dossiers on innocent individuals. If every arrested individual were tested, almost 8 million psychological case folders would be opened annually. There are many ways such files could be misused. As data accumulated, it would be tempting to review the available case files to attempt to identify suspects for various crimes, particularly those with a bizarre flavor. Potential employers might also seek access to such files. This writer would recommend that, as a matter of policy, psychological test files on individuals who are not subsequently adjudicated as guilty be destroyed. The only exception would be in the context of using such data for research purposes, and in such cases stringent safeguards would have to be taken to protect the confidentiality of the subjects. Such research projects would have to be approved by a disinterested peer review committee to ensure that the precautions are adequate.

Research Needed in Stage I

A number of research needs can be identified with respect to screening arrested individuals. Norms for the full MMPI with recently arrested individuals need to be developed. The burden of test administration on staff and on clients would be eased considerably if one of the short forms of the MMPI was found to be as valid as the full MMPI when used with this population for the purposes outlined. However, the data thus far on the correctional application of short-form MMPIs are discouraging (Moorhead 1979). Investigations need to be undertaken on using psychological tests to predict absconding on bail. The effects of the stress engendered by arrest on test scores also needs to be determined.

Assessment in Stage II: Pretrial Detention

Decisions To Be Made and Services Required

After the judiciary acts upon the recommendations made by the intake staff in Stage I, with due consideration of viewpoints of the prosecuting and defense attorneys at the time of arraignment, some arrested individuals are detained, pending trials. If the *Standards* have been followed, this consists of ". . . those who represent a serious threat to the safety of others" (Standard 9.4.5) and those for whom ". . . the judicial officer finds substantial evidence that confinement or restrictive conditions are necessary to insure the presence of the accused for trial" (Standard 4.5.3.b).

The first decision is where to house the individual. The *Standards* require that, "Persons awaiting trial should be kept separate and apart from the convicted and sentenced offenders" (Standard 4.8.4.c). They further state, "Prisoners who suffer from various disabilities should have separate housing and close supervision to prevent mistreatment by other inmates. Any potential suicide risk should be under careful supervision. Epileptics, diabetics and persons with other special problems should be treated as recommended by the staff physician. Beyond segregating these groups, serious and multiple offenders should be kept separate from those whose charge or conviction is for a first or minor offense" (Standard 9.7.1.d & e). Gender and age must also be considered. All of these diverse guidelines are aimed at the preservation of the lives and health of the inmates. In addition, the staff are interested in know-

ing which inmates are the most likely to be disruptive or to attempt escaping from the facility.

In addition to the above mentioned management decisions, the institution has an obligation to provide pretrial detainees with a full range of voluntary programs:

1. Persons awaiting trial in detention should not be *required* to participate in any program of work, treatment, or rehabilitation. The following programs and services should be *available* on a voluntary basis for persons awaiting trial:
   a. Educational, vocational, and recreational programs.
   b. Treatment programs for problems associated with alcoholism, drug addiction, and mental or physical disease or defects.
   c. Counseling programs for problems arising from marital, employment, financial, or social responsibilities (Standard 4.9.1).

The Role of Diagnosis in Stage II

Generally, there are fewer problems involved in assessment in Stage II than there were in Stage I. In Stage II, there are more data available on which decisions can be based, and there is less urgency for immediate decisions. The volume of cases should be considerably smaller. This allows time for more thorough data collection and rapport building. Nevertheless, some of the same problems remain. Chief among these is the fact that one is still dealing with unconvicted defendants who have a right to minimal intrusion in their lives, consistent with the operation of the institution. As in Stage I, the writer recommends that data collected on individuals not subsequently adjudicated guilty be destroyed, unless kept for research with suitable safeguards.

Program planning for pretrial detainees is made difficult by the fact that one must refrain from attempts at rehabilitation (Standard 4.8.4.a); all program participation must be on a voluntary basis, and any coercion or appearance of coercion must be avoided. Planning is further complicated by the unpredictability of court dates, so that it is often difficult or impossible to foresee accurately how long the period of detention will be.

Recommended Procedures and Techniques for Stage II

Standard 9.5 specifies in considerable detail the admission procedures that should be followed for those remanded to pretrial detention. They include the collection of basic record data, a private interview with a counselor, social worker, or program staff member, and a thorough medical examination by a physician. All of these data, plus the data collected during the initial Stage I screening, should be available to assist in the Stage II assessment.

In addition to these data, the writer would recommend that the MMPI be administered routinely, after the purpose of the test and how it will be used have been explained. This can be done individually by the intake interviewer or on a group basis under the supervision of a trained custodial officer. Appropriate conditions should be provided for the testing. Those taking the test should be in a separate area, free from noise and distractions. As noted above, an audiotaped version should be available for nonreaders and foreign language editions for those who do not read or speak English. To minimize invalid or random responding, it is suggested that the answer sheets be inspected for signs of pattern responding (i.e., five true, five false) and respondents asked to indicate how they answered five or six items chosen randomly. If they are unable to do so, or if an obvious random pattern has been used, they should be asked to take the test again.

The MMPIs may be scored by clerical personnel or sent for computerized scoring services. Computerized interpretation should not be used except as an advisory input to a licensed clinical psychologist who has the final responsibility for MMPI interpretation (Eichman 1972; Rodgers 1972). The psychologist should be familiar with the jail population and with MMPI norms for such populations, including the data regarding the performance of various ethnic or racial groups. At the time of interpretation, the psychologist should also have the basic information regarding the case before him; as Rodgers (1972) points out, a "normal" MMPI profile with no signs of anxiety or depression from an individual known to have committed rape and murder is a sign of pathology. (This is one reason why computerized interpretations which cannot take such facts into account are not recommended.)

The intake interviewer, the examining physician, and the trained custodial staff mentioned in Stage I, with the addition of the MMPI, should serve as an adequate "DEW line" for the identification of emotionally disturbed or potentially suicidal individuals. As in Stage I, such individuals should be referred to the psychologist or psychiatrist for closer scrutiny, using psychometric instruments designed to assess focal questions with greater validity than the more general screening devices.

The MMPI can also be used to assist in the assignment of custody level and living area. The *Standards* mandate that all correc-

tional agencies, whether community or institutional, should adopt comprehensive classification systems using clearly delineated categories and internally consistent groupings (Standard 6.1). Such a system has been devised for adult male offenders based on the MMPI (Megargee and Bohn with Meyer and Sink 1979). Edinger (1979) and Nichols (1979) have reported favorably on its application to State offenders. Sink (1979) has determined it is applicable to women, and Cassady (1979) has found that it can be used successfully with jail inmates. One advantage of the system is that it is based entirely on a uniform, easily obtained data base, namely the MMPI, and the bulk of the classification can be done by computer, thus facilitating its implementation in larger systems in which classification according to more complex systems, requiring more extensive data, might be impractical.

The writer's MMPI-based classification system has recently been implemented as a guide to quarters assignments at the Federal Correctional Institution in Tallahassee, Fla., where, in conjunction with a consideration of such factors as known history of violence and physical size, it is used to sort inmates into those who are likely to be initiators of violence (about 15 percent), those who are likely to be recipients of violence (about 15 percent), and the average group at neither extreme (about 70 percent). After assigning the predators and the prey to different dormitories, Bohn (1978, 1979) reported a significant decrease in the level of violence in the institution, with no assaults occurring in the dormitory reserved for the average offenders.

Other classification systems which provide useful data with respect to management and treatment are the Interpersonal Maturity Level (I-Level) system devised by Warren and Palmer (Warren 1969) and the four-fold classification system devised by Quay (1974). One disadvantage of the I-level system is the fact that it requires extensive clinical interviewing by a person trained in I-level theory, although tests have been devised which purport to give accurate I-level classifications. A more serious drawback to its use in jails is that the research thus far has focused primarily on juvenile delinquents; it remains to be determined how applicable the I-level system would be to the adult offenders found in jail settings.

The Quay system, which has been recently extended to adult populations (Quay 1974), depends on a behavior checklist filled out by a custodial officer and a case-history checklist filled out by a caseworker. One drawback might be the lack of time for the officers who fill out the behavior checklist to become acquainted with the inmates. Bohn (1978) noted some difficulties with the reliability

of behavior ratings made after only 2 weeks of observation. A good case history is also required. If the time and resources exist to allow good Quay ratings to be made, the system might prove useful in jail settings.

Another potentially useful technique is the State-Trait Anxiety Inventory (Spielberger, et al. 1970). A unique feature of this instrument is that it is designed to be readministered so that changes in mood over time can be tracked. This might be useful in evaluating emotional stress as the trial date approaches.

Thus far we have discussed assessment during Stage II to identify possible problem cases which require further scrutiny and as an aid to management, specifically quarters assignment. In addition, the psychologist in a jail setting may also be asked to help determine competency to stand trial. To be incompetent to stand trial, a defendant has to have such a degree of emotional or cognitive impairment that he or she is unable to understand or participate in the legal proceedings or help his or her attorney in the preparation of a defense. Interviews focused specifically on the nature of the charges and proceedings, observations of everyday interactions with other inmates and staff, and individual intelligence and personality tests currently provide the best data base for such determinations. Lipsitt et al. (1971) devised a "Competency Screening Test" which Rumreich (1973) has shown to have some validity in a mental hospital setting. If further research (cf. McGarry et al. 1973) continues to demonstrate the test's reliability and validity, it could prove quite useful in jail settings.

It is questionable how much testing can or should be done with respect to program planning for pretrial detainees. The voluntary nature of the programing, the constraints against testing, and the uncertainty regarding the amount of time for which the detainee will be in jail, all operate against effective or extensive assessment for program planning in Stage II. If such assessment is implemented, the procedures to be outlined for this purpose in Stage III are recommended.

Research Needed in Stage II

Considerable research is needed on the application of classification systems as aids to jail management among pretrial detainees; in particular, the adequacy and cost-effectiveness of the writer's MMPI-based system and Quay's adult classification system need to be determined.

Other studies need to chart the typical course of behavior over the pretrial detention period. How much anxiety is normal? How much is cause for concern? It may be that some individuals deteriorate markedly as trial approaches; if so, can ways be devised to identify such individuals at the outset so that some form of intervention can be planned? The State-Trait Anxiety Inventory could be helpful in such research.

Finally, as in all assessment studies, the validity of the initial predictions needs to be determined. How many of the referred individuals did, indeed, appear disturbed on closer scrutiny? How well did those who appeared on the verge of a breakdown withstand the stress of the pretrial period? How applicable, reliable, valid, or useful are the various assessment techniques mentioned when applied to the population and problems typically found in a jail setting?

Assessment in Stage III: Postconviction Incarceration

Decisions To Be Made and Services Required

After trial and conviction, some offenders are sentenced to local adult institutions for periods of incarceration ranging from a few days to a year or more. Some of those entering the jail as convicted misdemeanants are individuals who were detained prior to trial; others are entering the jail for the first time. Both groups, however, require an intake evaluation, and management and programing decisions similar to those in Stage II have to be made. Those who are mentally or physically ill or who have other special needs must be identified, each individual must be classified according to a comprehensive classification scheme, management decisions have to be made, and, as in Stage II, programing plans need to be formulated. Unlike Stage II, the posttrial offender can be assigned to programs, and offender rehabilitation is now a legitimate objective.

Role of Diagnosis in Stage III

The role of diagnosis and assessment in Stage III is much the same as in Stage II, except that, in dealing with convicted offenders who will be in residence for specified lengths of time, more

emphasis can be placed on program planning. Moreover, more diversified programs including work and study release can be considered, since the population, unlike that in Stage II, will no longer consist solely of those who are escape risks and/or dangerous to society.

Problems Associated With Assessment in Stage III

Society expects incarceration to accomplish a number of goals, not all of which are mutually compatible. Assessment is not relevant to such goals as punishment, deterrence, or incapacitation; an offender is sent to jail *as* punishment, not *for* punishment, so there is no need for "punishment planning." But whatever the reason for sentencing a person to a term in jail, it obviously benefits society if rehabilitation takes place. For this reason, the *Standards* require that potentially rehabilitative programs be provided (Standard 9.8) and that assessment and classification systems be instituted to assist in program planning (Standards 6.1.b, 9.7 and 9.8)

During incarceration, the institution is responsible for the health and welfare of all the inmates, making screening necessary to identify potential problem cases. This process has the same problems, such as lack of an adequate research basis, listed in Stages I and II; the major difference is that in Stage III we are dealing with convicted rather than unconvicted offenders, and a more thorough evaluation is possible.

Recommended Procedures and Techniques for Stage III

A substantial proportion of those sentenced to periods of incarceration in local adult facilities will be entering jail for the first time if the *Standards'* injunctions with respect to pretrial detention are implemented. Whether or not they are detained prior to trial, a new intake classification should be carried out upon entrance as a sentenced offender.

The same basic initial screening procedure outlined in Stage II should be adopted for Stage III, except that an intake interview with a psychologist or psychiatrist should be added to the intake officer interview, case-history collection, physical examination, and MMPI. As in the previous stages, if any of these routine intake procedures suggests that the offender is likely to have serious

mental health or adjustment problems, a more extensive individual assessment should be made.

Convicted offenders have to be housed separately from pretrial detainees, and management classification decisions must be made. The writer would recommend the adoption of either his own MMPI-based system or the Quay adult system described in Stage II. Fowler (1979) recently reported that success or failure in a Mississippi Restitution Center was closely associated with MMPI type, and Cassady (1979) found that the MMPI-based system was a useful tool for the assignment of sentenced jail inmates to work release programs. Bohn's success in reducing the level of violence in a prison setting through management classification based on MMPI type has already been noted.

Special assessment procedures should be undertaken with respect to program planning. Standard 9.8 requires, "Educational programing which relates to the needs of the client and contributes to his ability to cope with community living is needed in local correctional facilities. . . . Educational programing should be geared to the variety of educational attainment levels, more advanced age levels and diversity of individual programs. . . . Vocational deficiencies and training needs should be determined on the basis of thorough aptitude and skill testing." Assessment techniques must be adopted to meet these requirements.

The MMPI, which should be administered as part of the intake screening and management classification process, also provides information relevant to the need for, and probable response to, counseling or therapy. In addition, the California Psychological Inventory (CPI), a personality assessment device which concentrates on the normal range of functioning, including assessment of achievement motivation, interpersonal relations, and socialization (Gough 1960; Megargee 1972*a*), would be useful.

Intellectual ability should also be assessed. Few jails have the mental health resources needed for individualized intelligence tests, such as the Wechsler Adult Intelligence Scale (WAIS). The revised Beta Examination, which does not depend on reading ability, has proved useful in adult correctional settings serving offenders from a variety of ethnic backgrounds. The California Short-Form Test of Mental Maturity (CTMMSF), which is available in grade levels from 1 through 16, requires 45 minutes to adminster and is "among the best" group measures of verbal intelligence (Goldman 1972). The Quick Word Test, which is also available in levels ranging from Grade 4 through college and professional adults, can be used to give a reasonably accurate verbal IQ in 15 to 20 minutes of group testing time, but it is probably less valid than

the CTMMSF (Nunnally 1972). Both the CTMMSF and Quick Test probably underestimate the intelligence of minority group members, especially bilinguals, although they may accurately forecast their functioning level in typical English-speaking classes.

An educational achievement measure should also be adopted for high school and grade school dropouts for whom a GED program might be desirable. By far the best is the Stanford Achievement Test (SAT) (Merenda 1965), but it requires several lengthy testing sessions and good reading ability which make it impractical in most jail settings. The individually administered Wide Range Achievement Test (WRAT) gives grade-level estimates in arithmetic, spelling, and reading, but its validity is questionable (Thorndike 1972). Some jurisdictions might choose to screen new inmates with the WRAT and, if the WRAT scores suggest deficiencies, follow up with the SAT. The CPI has several scales predictive of educational achievement in high school and college (Megargee 1972*a*), and our MMPI types have been found to differ in their educational progress in a prison setting (Megargee et al. 1979).

Finally, a vocational interest inventory would be useful. The Strong Vocational Interest Blanks (SVIB) for men and women are among the oldest and most respected of such instruments (Campbell 1971). However, many of the occupations that they cover are beyond the abilities and educational levels of most jail clients. The Minnesota Vocational Interest Inventory (Clark 1961), is geared more toward blue-collar, semiskilled, and skilled occupations requiring no more than a high school education. More research is needed on the MVII (Westbrook 1972), and the present writer has encountered difficulties applying the MVII in correctional settings.

These assessment devices, in conjunction with social history and interview data and the inmates' own expressed desires and aspirations, should provide a good basis for programing. Obviously, such factors as custody level and anticipated length of stay will also need to be considered; it is foolish to place someone serving 30 days into a GED program or to recommend work release for a high escape risk.

According to the *Standards,* the actual program plans should be formulated by a team including institutional staff members and representatives from community agencies that might be involved, such as mental health, vocational rehabilitation, and the like. A job-placement expert is especially needed so that vocational training has some relation to job availability.

In addition to initial program planning, further assessment may be needed to monitor progress and adjustment over the course of confinement and to assist in release planning. It is desirable to

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maintain records of adjustment and progress on a monthly basis to assist the treatment team in evaluating each individual's progress. The Megargee Interpersonal Adjustment Rating form, which is filled out by a custodial officer who has regular contact with the offender, and the Megargee Work Performance Rating form, which is compiled by the work crew supervisor, might be helpful in this process (Fowler and Megargee 1976; Megargee 1972*b*).

As always, the correctional psychologist should continue to be available to consult with and take referrals from staff members involved with supervision and treatment of the offender.

Research Needed in Stage III

Studies relating intake data on jail clients to the attainment of program goals are virtually nonexistent, as are studies on the relation of goal attainment (i.e., GED) to subsequent adjustment or recidivism. Both are needed. Few of the tests listed have been used on jail populations, and research is needed to determine their reliability, validity, and appropriate norms, especially when applied to minority groups.

Summary

Implementation of the National Advisory Commission on Criminal Justice Standards and Goals' recommendations for the operation of local adult correctional facilities poses a number of challenges to psychologists and mental health professionals and requires diagnosis and assessment of jail inmates at three distinct stages, each of which presents its own problems and requires its own procedures.

Certain general problems confront the diagnostician working in a jail setting. In addition to the limitations on staff, space, and resources, the psychologist is confronted with a facility that is expected to perform different social functions and with an extremely heterogeneous and voluminous population, many of whom are unable or unwilling to participate in conventional psychometric assessment. Policies with respect to confidentiality differ considerably from those found in private practice or mental health settings, and it is essential that the psychologist, the administration, and the inmates all have a clear understanding of the limits regarding the confidentiality. Jail assessment is further hampered by a dearth of mental health professionals with criminal justice training and by the general lack of empirical research on assessment among jail populations.

The first stage at which assessment takes place is initial screening after arrests. At this point, decisions are necessary regarding who should be diverted to noncriminal justice community programs and which of the remaining defendants need to be detained pending trial. The volume of cases, the brief time allotted, and practical and ethical constraints against testing arrested individuals all argue against routine direct assessment by mental health professionals. Instead, the mental health professional should train intake and custodial personnel to recognize cases that appear to require mental health intervention and refer them for professional evaluation.

Pretrial detention is the second stage at which assessment is required to identify inmates with special problems, to assist in management classification, and to help in programing. In addition to the intake procedures recommended in the *Standards,* routine administration of the MMPI is recommended. The intake data and personnel can be used to identify cases requiring a more thorough evaluation. The MMPI can also serve as the basis for the offender classification system devised by Megargee and his associates. If resources permit, the Quay adult classification system is another alternative.

The assessment of convicted offenders sentenced for periods of confinement is similar to that in Stage II, except that greater emphasis can be placed on program planning. Personality, ability, achievement, and vocational interest tests are suggested to assist in classification and programing designed to meet the needs of each individual offender.

Research is needed at all three stages to test the validity of the procedures and instruments recommended and to devise and test techniques better suited to the special needs of local adult institutions in the future.

Footnotes

1 Morris, Norval. Personal communication, October 28, 1976.

2 Those who are physically ill or wounded will be diverted to appropriate medical facilities, but many of the remaining individuals will be intoxicated, exhausted, acutely anxious, or otherwise debilitated.

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CHAPTER 6

Intervention Models for Mental Health Services in Jails

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Introduction

The written history of jails in America reads like a gothic horror story, with its foul forces and tragic consequences. It has been observed that "If verbal condemnation alone could do the work, the jail as an institution would have crumbled long ago. No penal institution, in fact no social institution of any kind, has been more scathingly denounced . . .". (Robinson 1944, p. iii).

Our task is not to reiterate all of the problems in jails. Yet, mental health problems always occur in context, and the context in jails has been that of abominable physical conditions, sanitary and health inadequacies, untrained and insufficient staff, ineffective screening, unrelieved idleness, and the pervasive threat of violence (National Advisory Commission on Criminal Justice Standards and Goals 1973). These problems are intimately identified with the jail as emotional stressors and with subsequent psychological strains of the confined persons. These noxious conditions and events, and ways to ameliorate them, are not discussed here, as we examine the more narrow topic of mental health intervention models; however, they are acknowledged as central difficulties that call for priority actions.

A definition of jails must be undertaken. We agree with Mattick (1974) that the term "jail" encompasses a variety of disparate facilities, ranging from a three-cell detention area in the sheriff's offices of a rural county to a thousand-bed, complex prison typical of major urban centers. Both settings have in common the holding of arrested citizens for more than 48 hours and serving as intake point for the local criminal justice system.

With such diversity, the issues of mental health needs and services are more than a matter of scale. The smallest jails have been recommended for elimination because they cannot offer appropri-

ate services of all sorts, and they would be replaced by regional community correctional centers. Similarly, the single large metropolitan jail has been criticized: ". . . with its inclusion of all functions in a single facility, (it) creates an unnatural physical and psychological environment" (National Advisory Commission on Criminal Justice Standards and Goals 1973, p. 282). The recommended alternate is ". . . a network of dispersed facilities and services geographically located to perform their functions best" (p. 282). The development of more regional centers and more flexibility in metropolitan jails are assumed in the present discussion of needs, standards, and models.

Needs

Determining the nature of mental health services needed in a jail setting is dependent upon understanding the nature of individuals confined in jails. The key question that should be raised is: What is the incidence of serious mental disorder of jail residents? The information that is available is contradictory.

On the one hand, Kal (1977), using the American Psychiatric Diagnostic and Statistical Manual II (DSM–II), with a random sample of a county jail population, reports an overall morbidity rate of 50 percent DSM–II diagnoses among female inmates and 63 percent DSM–II diagnoses among the male inmates. He attributes these findings to "the uniquely heterogeneous nature of a county jail population compared to state or federal prisons and to indicate that florid psychotics represent the tip of the iceberg of mental health needs in a county jail. Even this segment is unlikely to be totally recognized by the jail authorities" (p. 483).

In contrast, Petrich (1976) reports a much smaller incidence of seriously disturbed individuals in a jail setting. Of 18,000 persons confined in the King County jail of Seattle, Washington, and the Seattle City jail over a 1-year period, 539 individuals, or about 3 percent, were referred to the professional staff for assessment or services. Most of these individuals were either described as manifestly disorded (24 percent) or violent (26 percent). The Petrich description of the psychopathology was in reaction to the jail incarceration. He observed, "Many jailed inmates undergo an initial reaction of shock, feelings of helplessness, and finally adaptation as they are booked into jail" (p. 414).

Two other investigations of incidence of psychiatric disorder in jails report findings somewhere between the Kal high estimates of

50 to 63 percent psychopathology and the 3 percent estimates from the Petrich study in King county. Swank and Winer (1976) evaluated 545 inmates in Denver County, Col. Of these prisoners, 22 percent were diagnosed as psychotic, and 23 percent had a history of either long-term or mutliple hospitalizations. One additional study of 199 male prisoners without prior felony convictions, interviewed within 1 day after their arrests, concluded that 46 percent met psychiatric diagnostic criteria, but that only 5 percent needed acute treatment (Schuckit, Herrman, and Schuckit 1977).

These diverse findings agree with our own summaries of studies of psychiatric evaluations of offenders (Brodsky 1973). Studies of felons were found to have reported ranges of psychological disturbance ranging from 15 percent up to 85 percent of the offender sample. The range of psychotic illnesses in nine such studies was quite narrow, running between 1 and 2 percent of the populations investigated. We concluded at that time, "It is neither reasonable nor appropriate to administer clinical services to justice clients in general. . . . It is suggested that there may be a high potential inherent in the utilization of clinical services directed toward selected clientele within the justice system. There are, indeed, psychologically troubled offenders, in addition to those who develop impairments after their incrimination. Both are in need of psychological assistance. However . . . the presumption of client homogeneity is incongruent with our knowledge" (pp. 66-67).

If, indeed, selected prisoners and perhaps up to half of all citizens entering jails are suffering from substantial mental disturbances, a need exists for major inhouse programs for mental health service delivery. Such programs would be based on this perspective of the jail as a final filter to identify and aid the mentally disturbed. Thus, Mattick (1974) states, "In short, the jail is a major intake center not only for the entire criminal justice system, but also a place of first or last resort for a host of disguised health, welfare, and social problem cases. The latter consist for the most part of a large number vulnerable or treatable cases. . ." (p. 781). Since so many jail inmates stay such brief periods of time, if the jail is to function as a behavioral intake center of last resort, then the disguised social problems should be uncovered and intense, brief, crisis-oriented services delivered by professional staff.

The alternative perspective must also be considered, namely, that the number of disturbed individuals in jail is equal to or less than the proportion in the general population. If this assumption is true, then it is a waste of time and services to be involved in careful screening and major service delivery in the institutions. An observer concerned with cost-effectiveness might assert that consumer utilization of mental health services is a monster with an unlimited appetite; to the extent that services are available, demand will follow supply, individuals will seek out help, and services will be used. If the number of psychotic individuals does range between 1 and 3 percent, as indicated by the aforementioned Petrich (1976) and Brodsky (1977) reports, a general screening followed by a quick referral of the few seriously disturbed individuals to other settings should be routinely undertaken. The treatment efforts within the jail should be extended only by line staff for ongoing institutional adjustment problems.

With this background of incidence identified, we move now to specific models for mental health services and intervention. The first one to be considered is the most common pattern, that of drawing on the local hospital or community mental health center.

Emergency Services at the Hospital or Mental Health Center

When confined persons become delusional, violent, incoherent, or otherwise seriously mentally disordered, they may be taken to a local hospital or mental health center. Many jails shackle the prisoners, and two guards accompany each prisoner to the emergency room or intake unit. After a sometimes long wait, the prisoners are seen and assessed, and some action is taken. The action may include holding the persons for observation, hospitalizing them, providing medication, referring them, or returning them to the jail without treatment. This last option occurs often and is the source of much dispute between treatment and jail personnel.

The dispute arises because the disturbed behaviors seen in the jail frequently diminish or disappear by the time prisoners are seen in the emergency room. As the prisoners are moved from the physically unpleasant and symbolically punitive environment, the immediate sources that prompted and sustained the psychopathology are no longer present. The emergency room physicians find no disorder, and the two guards and prisoner are sent back empty-handed, only to have the same behaviors reemerge at the jail. The guards and jail personnel are frustrated by this sequence of events. They have had a management problem, a crazy person who does not belong in jail, and they cannot get the appropriate mental health professionals to assume their responsibilities. On the other hand, the mental health professionals see a coherent, apparently adequately adjusted person and, in good conscience, cannot act to

hospitalize or medicate. A parallel dilemma arises in the case of violent and disordered persons: Neither agency wants such persons in its care. The hospital is frightened by the violence and does not have secure facilities. The jail is frightened by the severity of the psychopathology and does not have staff or facilities appropriate to deal with psychotic prisoners. It is not unusual for reciprocal blame and ill will to be generated by the agency interactions about these prisoners.

This model involves the hospital or other outside agency providing jail mental health services at the hospital's physical location. Although this is a common practice, it is usually unsatisfactory to both parties. Different expectations and objectives for the collaboration produce poor communication and resentments. Both agencies feel imposed upon, view the working contact negatively, and enter it reluctantly: for these reasons, it is a minimal contact, activated only at times of serious crisis.

Jail Counseling and Psychotherapy

A widespread model for psychological intervention in the jail setting is a collaborative arrangement between the community mental health center and the jail administration. The typical arrangement consists of a single mental health professional visiting the county jail and seeing inmates on a referral basis from the jail staff. This therapist extends short-term counseling for emotional problems and offers from 4 hours to 20 or 30 hours per week of professional time.

Thus, the Greene County Guidance Center (Jail Counseling Project 1978) of Xenia, Ohio developed its program in direct response to the awkwardness of having two guards bring an inmate to the mental health center for evaluation or services. A psychiatric social worker spends 4 or 5 hours a week seeing referred inmates in a "safe, secure and private area" and providing consultation on specific cases and problems to the jail officials.

An alternate approach is to target specific jail subpopulations for psychotherapeutic services. These populations may include psychotic individuals, alcoholics, individuals with drug problems, youthful offenders, depressed or presuicidal individuals, and so on. Thus, in the Tuscaloosa County jail (Alabama), McCarter, Colwick, and Goodwin (1978) report the development of a group therapy program. Each week, the staff members of a local mental health center offer a 90-minute group therapy meeting for inmates with

drug and alcohol abuse problems. Inmates with histories of violent crimes or escape charges are not permitted to take part in the group. The nature of the treatment is "primarily one of confrontation of irrational thinking, over-reliance upon maladaptive defense mechanisms, and maladaptive behavior for whatever reason" (p. 3). Although participation is totally voluntary, it is reported that 100 percent of the enrolled members attend. Furthermore, after discharge, approximately 45 percent of the individuals who had been involved in the group sessions continued at the mental health center to pursue the same treatment they began in jail.

Therapeutic Communities

Several jails have introduced therapeutic communities, in which staff and inmates join in an intensive, full-time, reciprocal-helping program. In the therapeutic communities within jails, the residents live in a single area and engage daily or more often in a group meeting, and each individual assumes some responsibility for influencing the behaviors of fellow residents in positive and constructive ways.

Two such programs exist at the Baltimore City jail. One program is called CASH—an acronym for Confined Addicts Seeking Help. It is housed in an old gymnasium on the fourth floor of the jail, converted into living quarters for the 35 participants. The program description claims that "The CASH program operates on the theory that a change in behavior will prompt a corresponding change in attitude. Through constant peer group confrontation, negative behavior is dragged out in the open and examined. Positive patterns fill the void as old ways are discarded. It is a delicate process: accepting a person, but rejecting his values. It is a process that can occur only in open atmosphere, where trust is accepted without question" (CASH brochure). An entire floor was set aside as well for a larger therapeutic community called Eager Village. Three hundred inmates in the Baltimore City jail with a variety of social needs are participating in this program in community helping within the jail.

Therapeutic communities don't lend themselves to all jail settings because of limitations of physical structures and insufficiently trained staff to organize and maintain such a community. Nevertheless, it offers an attractive alternative for citizens who are kept in jail settings for a long time. In the absence of diverting persons into the free community, the intense involvement and activity of

such a therapeutic community provide an alternative to idleness, offer regular and orderly social contacts, and provide normative standards and values toward law-abiding behavior. There is no reason to believe that, for individuals spending 6 hours or indeed even 48 hours in a jail, staying in a therapeutic community would make a difference or be appropriate. Nor is there evidence suggesting that it would not make a difference or be inappropriate. In any case, a substantial minority of jail inmates do spend long periods in jail, and the therapeutic community model offers the promise of affirmative environments and personal growth.

The One-Stop Social Service Center

One solution to the multiple goals and clinical service needs in jails has been proposed by Goldfarb (1975). He suggests that jails should be divided into three fully autonomous wings. One wing would be a pretrial detention unit serving exclusively to prevent flight or further crime. Goldfarb points out that the exclusive function could be achieved through reform that would eliminate the use of money bail. The second wing would consist of dormitories for community correctional program offenders, for offenders in work-release programs, half-way houses, on furloughs, and those who are providing restitution services to the community. The third wing is the unit of interest to the present discussion. Goldfarb calls it an "intake classification and referral agency for special cases. . . . A one-stop center for social services" (p. 437). The purpose of such a center would be to concentrate professional skills in a single location.

We have assumed that no children whatsoever would be held in jail, and there has been discussion only of the needs of jailed adults. Goldfarb states that all the children in jail would be held in a specialized children's section within the wing; they would live, dine, and have their recreation in this section. However, they would have the shared staff for medical and professional services with the rest of the wing. This wing would serve to offer pretrial residential care for the youth, insuring that the childen are not placed in unsuitable homes or returned to unsuitable homes awaiting trial. The goal is to set up a neutral place for the children to remain until a guardian or parent arrives; for other children, it would serve the purpose of "diagnostic custody." For up to 48 hours they would remain in the section, be screened, and then would have their hearings and be released.

A second target group is mentally and physically disordered defendants. The purpose of the wing for this group would be to concentrate high-quality diagnostic services. Individuals would be identified who needed preventive or corrective psychological care. Again, beginning with the departure point of holding only those defendants who are dangerous and have a risk of flight, all such disordered individuals would take a short psychological test battery and then begin what Goldfarb terms a "good diversion effort."

The referral element is a key process in such a center. Alternate treatment programs and diversion placement would be a major target of this diagnostic and referral process.

Goldfarb suggests that there would be specific treatment offered within this center. However, such treatment would be only short term and crisis oriented and would include detoxification and treatment activities for alcoholics and narcotic addicts. Goldfarb asserts "Any modern detention facility must be designed, staffed, and programed to identify and assist arrested narcotic addicts" (p. 441). He further reports that most detoxification care for jailed alcoholics is insufficient. The detoxification process he proposes would include 5 to 7 days of care in an alcoholic ward, for a complete detoxification process. Following that period, the inmates would be subjected to a psychological assessment and referral.

The advantages of such a program are that professional services would be concentrated, that separate living facilities would be organized just for disordered defendants, and that special services and living quarters for youths would be provided isolated from the rest of the jail's function. The emphasis on referral is a particularly praiseworthy one, since it realistically suggests that only a modest amount of professional services can be gathered, even in such a centralized intake and referral wing.

A disadvantage is the issue of screening into the pretrial detention wing. That is, who would go into the pretrial detention wing, and who would go into the intake classification and referral wing? Furthermore, some mental health dilemmas in jails generally may well continue in the pretrial detention wing and, without major design changes, in the community correctional wing as well.

There is a more serious hazard. In spite of Goldfarb's assertion that only genuinely dangerous and high-risk individuals would be kept in the one-stop social services wing, it seems very likely that the jail population would balloon. The existence of such an intake wing would probably cause many people to be sent to the jail for assessment and referral who would otherwise not be confined.

Life-Skills Enhancement

One alternative in mental health service delivery is not to try to change well-established behavior patterns and pathology. Rather, life-skills enhancement is directed toward improving specific skills and knowledge. Such programs typically are offered in an academic curriculum model, with a duration of 4 to 40 hours of organized instruction, both didactic and experiential. These program are time limited and problem oriented. At the end of such programs, participants often receive certificates of completion and have the achievement formally entered in their institutional records.

Many specific skills are taught in correctional life-skills enhancement. The skills range from transcendental meditation instruction (Abrams and Seigel 1978), to instruction and skill in dealing with insomnia (Toler 1978), to a variety of techniques to improve interpersonal and social skills and listening techniques. At both the Lompoc Federal Correctional Institution (Calif.) and the Federal Prison Treatment Facility in Lexington, Ky., human resource centers have been organized on just such a model. The model further offers the potential for especially talented and interested graduates to receive further training and become continuing instructors.

The potential advantages for life-skills enhancement in a jail setting include the fact that it is not psychopathology oriented and that it is time limited and appropriate for so many of the short-term confinees. Individuals who complete it and who become trainers can offer continuity to the program and have the second-level skill of training others. Furthermore, it is a sufficiently time-intensive experience which aids in combatting the serious problems of idleness in jails.

Suicide Prevention Programs in the Jail

> The prisoner was admitted to the jail during the evening watch. He had been charged with child molesting and it was his first arrest. He was middle aged, well dressed, and well known in the community. He was employed at a white-collar job and had a wife and two daughters, aged 8 and 12. When admitted, he would not talk to the admitting officer, and identifying information had to be taken from his personal papers. He did not want to call his wife or attorney. In the shower and while changing to jail clothing, he began to cry, but said nothing. When placed in a cell, he sat in the corner and talked to himself and cried. He would not talk to the jailer and turned his face to the wall. Later that evening, he tried to cut his wrists with a piece of wire he had taken from the bed. (Pappas 1970, pp. 91–92)

Successful suicides are among the most dramatic, tragic, and galvanizing events within jails. They sharply focus the public's attention on the psychological trauma of imprisonment and the actual experience of living within jail. Virtually every medium-size or large jail has reported suicides of adults and teenage youth with subsequent serious but short-lived reform efforts directed at jail conditions.

In the Danto book, *Jailhouse Blues* (1973), five studies of suicidal behavior in jails are reported. Danto, for example, reported that there had been 10 successful suicides in the period 1967 to 1970 at the Wayne County jail, which had a typical census of 1,000. In a report by Esparza (1973), there were 60 attempted and 6 successful suicides in six county jails, with a total population of 248, over a 5 year period. Esparza notes that this was five times the rate of suicides in Federal prisons and three times the rate of suicide in the general population. Fawcett and Marrs (1973) additionally report a 1 month "epidemic" of three suicides and one attempted suicide in the Cook County jail of Illinois.

These authors have identified a number of reasons underlying attempted and successful suicides in jails. They note that for some confined persons there is a sense of disgrace and embarrassment and for others there is a growing sense of hopelessness over time (Danto 1973). It is further suggested that the authoritarian environment itself and the dehumanizing quality of life in the institution strongly contribute to suicidal intentions.

Several obvious steps may be taken. Pappas (1970), for example, states "The jailer's best precautions against suicides are close supervision, ability to evaluate prisoners, knowledge of first aid, and established emergency procedures" (p. 94). Wilkerson (1973) urges recreational facilities, hiring of professionals, and a sophisticated reception-diagnostic center as key elements in preventing and dealing with suicide. Danto (1973) encourages jailers to take suicide threats seriously, to not place potentially suicidal individuals in isolation, to have immediate medical treatment available, to encourage phone calls to relatives and attorneys, and to promote good listening by the guards.

We offer five recommendations for suicide prevention programs in jails.

Program Identity. The identification of a suicide prevention program in a jail setting by itself acknowledges explicitly that the problem is serious, that it occurs with sufficient frequency to merit

the development of a program, and that there is a core of knowledge, skills, and reponses which all staff should master. Thus, a first recommendation is the explicit commitment to and staff identification of a suicide prevention program. Information about the program should be made available to newly arrived prisoners.

Use of Inmate Resources. Jails confine large numbers of persons with some talents, interpersonal skills, with much available time, and with little to do. Selecting and training the best among these individuals to assume responsible roles in suicide prevention, as well as other helping roles, are key and important actions. Their roles in suicide prevention would be with respect to careful observation and immediate crisis intervention and counseling. Danto specifically urges the establishment of:

> An experimental program which would train inmate trustees to form rescue patrols to be available at night, to talk with the lonely prisoners, and to spot those attempting to hang themselves. Assigning groups of depressed and suicidal patients into ward structures with sensitive staff might also help to reduce the numbers of those who commit suicide. (pp. 10–11)

In a similar vein, Pappas asserts, "It is a great help to the jailer if prisoners can be trusted to keep an eye on the potential suicide" (p. 94).

Assumptions. It is suggested that jail staff consider all new prisoners at risk, unless there is compelling evidence to the contrary.

Accountability. One of the successes of the industrial "Zero Defects" program has been for each person to feel specifically accountable for the final product. In the same sense, at many public institutions, the large signs identifying the number of days at work without accident and the United Fund percent-achieved "thermometers" are ways of heightening public accountability for shared goals. These educational and information dissemination vehicles can promote a sense of generalized accountability with regard to suicides, self-mutilations, and other injuries. It is further suggested that specific overall responsibility be assigned to certain staff members with regard to suicide prevention in the jail.

Expediting Help. Assuming that many prisoners in jail settings are sorely hurting, every effort should be made to expedite help for confined persons in a variety of ways. While we are describing it here in the context of suicide prevention, the basic approach also applies to prevention of violence and psychological deterioration. It is suggested that 24-hour access to "hot lines" or other telephone services be made available and that around-the-clock helping services with specifically accountable and designated helpers be communicated and provided.

Mental Health Services by and for Jail Custodians

Time . . . moves slowly to him whose whole employment is to watch its flight (Samual Johnson, *The Idler*).

There is a great deal of stereotyping of police officers and correctional personnel. Of this stereotyping, that of the jail guard as hostile, brutal, and insensitive is among the most widespread and enduring. We believe that jail correctional officers should not be assigned any such single stereotype. To some extent, the officer may be considered a victim of the particular environment and of role demands of the job, much like the jail prisoner. The jail officer suffers, is blamed, and at the same time represents the key employee who makes a difference in the lives of confined persons in jail. Hawkins (1976) puts the current state of knowledge very accurately:

> One of the most curious features of the whole history of modern imprisonment is the way in which the custodial officer, the key figure in the penal equation, the man on whom the whole edifice of the penitentiary system depends, has with astonishing consistency, either been ignored or traduced or idealized but almost never considered seriously (p. 105).

Our knowledge of the jail guard comes from our knowledge of correctional personnel in general. In a hearing before Congress, Barney Apfel, the Secretary-Treasurer of the California State Correctional Officers Division of the Teamsters Union, stated:

> Correctional officers work under the most trying and dangerous conditions prevailing in America today. They are abused, threatened, maligned, and killed while performing work which is essential to our society. Risks and hazards of their job, the ever-present feeling of crisis, the total unpleasantness of the work environment are all rewarded with insufficient staffing, inadequate safety measures, poor working conditions, and criticism of the efforts of the correctional officer (Apfel 1971).

We propose two directions in considering the jail guard. The first direction is caring for and providing services to the officer. The second direction is improving services that the officers can perform and roles that they can assume.

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Officers who are appropriate for the position need to be selected. Furthermore, they need to be trained in roles and issues relating to their work. Officers need to have the same services which have been discussed for the citizen confined in jails. That is, officers themselves go through a variety of personal and occupational crises. No specific information is available on suicide rates in jail guards, but suicide and general health morbidity rates have been reported for police officers in a publication of the National Institute for Occupational Safety and Health (Kroes and Hurrell 1975). In this document, Richard and Fell (1975) reported that the annual suicide rate of police officers in Tennessee was 69.1 per 100,000 per year, a rate that was third out of 23 occupational groups. The suicide rate in a collection of miscellaneous occupations in Tennessee, with a sample of 363 suicides, was 20.6 suicides per 100,000. Similarly, the premature death rate for police officers (exclusive of homicides) was significantly high; also, police were admitted to medical hospitals at a significantly higher rate than most other occupations, often with circulatory and digestive system problems.

The antecedent conditions that lead to these physical and psychological effects include some stressors specific to police work and some shared with other occupations. The conditions include role conflict in which officers are caught between discrepant expectations, the territoriality stressors of working in an alien environment, excessive responsibility for the lives and welfare of other individuals, role ambiguity, a negative public image (Hurrell and Kores 1975). Programs have been developed which allow law enforcement personnel to receive helping services and to participate actively in changing their work environment and roles. In offering consultation to criminal justice personnel in general, Brodsky (1977) described the relationship of such line personnel to the consultation process as highly ambivalent, both wanting assistance, but, because of reasons of distrust of the outside consultant, showing reluctance to receive help.

An alternate method has been proposed by Herrick (1975) who offers structural principles that apply to any organization. He suggests that stressors arise to the extent that:

> The quality of an organization's work life (i.e., the degree to which workers experience security, equity, individuation and participation) is low. Improvements in the quality of work life are hypothesized to reduce occupational strain (i.e., improve satisfaction, health and behavior) (p. 203).

Herrick reports in a number of industrial settings that the establishment of a quality of work life (QWL) committee allowed the assessment of the quality of work in any setting, the development of a QWL plan, and the remediation of the major fears regarding security, physical harm and want, and inequities in both pay and work. Further QWL goals are individuation, feedback, variety, and growth in learning. Although developed in industrial settings, the QWL method has direct applications to the work of jailers. Both organizational and personal satisfaction may be improved, and thus the ability to relate successfully to prisoners will be enhanced. The training officer at a large southern jail put it well recently when he declared: "We are not going to treat prisoners right until our troops are confident in themselves so they don't have to stand and yell and argue with the prisoners."

In the second stage of the role of officers in mental health services, we must consider services offered by, rather than for, the jail guards. What is it that guards should do? What should they be like as people and as helpers? Some information is available on this topic in the Glaser (1964) studies of five Federal prisons. The most frequent reason the inmate-subjects reported they disliked an officer was "his manner of expressing himself toward inmates, rather than specific things he did." It is no surprise that the inmates who were most positively influenced by the prison staff said that these staff were individuals who acted toward them in friendly and considerate manners and voice and who treated them with fairness and predictability. Hawkins (1976) echoes this theme:

> A hostile, superior, contemptuous, or dismissive attitude on the part of a staff member constitutes an attack on the prisoner's self-esteem and inspires resentment both against the staff member and against the values and standards which he symbolizes. Such an approach might almost be designed to cause prisoners to identify with criminal attitudes and values. By contrast a pleasant, friendly approach which allows prisoners to preserve some self-respect, while it is unlikely to inspire instant conversion of criminals to noncriminals, is at least unlikely to be positively damaging (p. 92).

Surely friendliness and fairness are obvious and straightforward objectives of training. Such attitudes may then be employed in the delivery of diagnostic and counseling services. Correctional personnel with positive attitudes and training may engage in identifying presuicidal, seriously depressed, prepsychotic, and retarded individuals.

Elsewhere we suggested that a bill of rights is in order for correctional officers (Brodsky 1974). The same list of occupational rights applies to jail guards, who should have "a piece of the action," that is, to be heard in one's work. The list includes the

right to have a sense of personal and professional growth in one's work in order to look back and see and know that some vocational growth has occurred. It includes the right to make a difference, so that one's life and work offer a genuine contribution. It includes the right to look forward to continued recognition and improvement in one's work.

In the context of community perspectives, Heller and Monahan (1977) suggest that, as long as jail guards, among other helping regulators, experience much strain in the way they perceive their clients, little change is likely to occur, and much misunderstanding and estrangement will result. A systematic plan of constructive exposure is suggested that will remove the clients from the role of an alienated minority to the helpers. Heller and Monahan additionally advise that it is important that persons such as jail guards (although they do not discuss jail guards per se) be able to increase their options for constructive action. Rather than having limited and overly defined roles, such increased options can come from a variety of planning conferences, and the complementing of naturally occurring community change mechanisms from the courts, from community officials, and public interest groups.

A caution must be extended about these programmatic recommendations for correctional officers. In the context of an unchanging and oppressive environment, the suggested changes would have no more impact than trying to use a canoe paddle to change the course of a river. Nevertheless, the daily responsibilities for improvement are those of officers in the jail and only modestly those of psychologists and other mental health professionals on the outside. In a directly related vein, writing about consultation to human service organizations, Heller and Monahan (1977) assert:

> Very few problems in real life are exclusively psychological in nature. The most troubling problems are those with complex determinants, of which the psychological component, while significant, is just one among many. There is little gain when clients with difficulties in living are 'taken over' by personnel in the mental health sphere. . . . The mental health professions do not control the tangible real-life reinforcements necessary for changing individual or corporate behavior in our society. By themselves, they do not possess the leverage to effect our social contingencies impinging upon individuals. (p. 260)

Prevention Strategies

In the wide acceptance of community psychiatry and community mental health ideologies, the term prevention has been used with great frequency and with little precision. It has been pointed out that it is far easier to describe what prevention is not than what it is (Heller and Monahan 1977). It is not, for example, the development of new treatment programs, the extension of existing mental health services to new populations, or training paraprofessionals to take the place of mental health professionals. Rather, prevention in mental health services is most clearly seen in efforts to prevent mental disorders from occuring, to reduce their incidence, and to offer services at the earliest possible time in order to minimize the duration and seriousness of such disorders. So-called tertiary prevention, to deal with the continuing effects of existing disorders, should not be considered a true prevention concept.

There are major methodological problems in understanding the extent to which jail living represents stressful life events and in learning precise cause-and-effect relationships of those events on subsequent psychological disorder. As Dohrenwend and Dohrenwend (1978) point out ". . . reactions to stressful life events can not be understood without taking into account the contextual factors of amount of previous experience with an event, amount of social support available, degree of anticipation and the degree of control over the occurrence of an event" (p. 14). Furthermore, most life events cannot readily be kept distinct in jail settings. Dohrenwend and Dohrenwend (1978) note that these events are those "confounded with the psychiatric condition of the subject," those events "consisting of physical illnesses and injuries to the subject," and finally those events "whose occurrences are independent of either the subject's physical health or his psychiatric condition" (p. 10).

Given these cautions, the influence of jail confinement does appear iatrogenic in nature. Beyond the conditions that individuals bring into the jail setting, many disorders fall in the third category, viz., being precipitated by the event of being in jail. Furthermore, there are specific kinds of jail experiences, which may or may not apply to all individuals in a given jail setting, which appear to promote greater levels of disorder. Some of these are physiological as well as psychological in nature, but ". . . it is a basic proposition of psychosomatic medicine that physical disorders are accompanied by some degree of emotional disturbance and

emotional disorders by some degree of somatic disturbance" (Dohrenwend and Dohrenwend 1978, p. 10).

D'Atri and Ostfeld (1975) reported a study of systolic and diastolic blood pressures in inmates housed in an institution holding both pretrial and posttrial (sentenced) individuals. No subject group differences were present on age, height, and weight, all of which might otherwise account for blood-pressure differences. The mean systolic blood-pressure level of the individuals in single occupancy cells was 109.6, while that of inmates in dormitories was 133.6. The mean diastolic blood-pressure level of single occupancy cell inmates was 67.8, while that of dormitory inmates was 79.3. Tests of both differences were significant beyond the .01 level of probability. In similar cross-sectional analyses of two other correctional institutions, the same pattern was found. Furthermore, after the first 30 days of confinement there was a pattern of continuing rise in blood-pressure level. After cautioning that this cross-sectional study limits causal inferences, D'Atri and Ostfeld suggest that one of the health implications of their finding is "it may be better to limit or eliminate dormitories in future prison design and construction" (p. 565).

While there is a wealth of prevention strategies, at least two others are discussed here: (1) the reduction of noise within the jail as one environmental factor (many others might be noted); and (2) the prevention of severely psychologically disordered persons being held even temporarily in the jail pending commitment.

The National Clearinghouse for Criminal Justice Planning and Architecture (1977) reported an investigation of jail noise in the Manhattan House of Detention (The Tombs). After observing that the level of noise in which regular conversation can occur must be 55 to 60 decibels (dBA) and that one has to shout to be understood if the ambient noise level is 85 dBA, the National Clearinghouse described noise measurements in the Manhattan House of Detention. Average noise levels on one floor were 80 dBA, peaking at 94 dBA. The Clearinghouse reported:

> The noise levels on the eighth and tenth floors of The Tombs depict a situation in which telephone use is nearly impossible, inmate and guard communication is exceedingly difficult, and sleep, rest and/or study is not possible for inmates who desire such during lock-out hours. And, during lock-in, the radio is played at nearly the same volume as the television's. In short, the noise levels clearly were major contributing factors to the stress and anxiety experienced by the inmates (p. 3).

The National Clearinghouse observed that the noise levels were found by Federal District Judge Lasker (1974) to be intolerable and to represent a "gross tax (on the inmates') mental health" (p. 3).

The next strategy is the prevention of psychologically disordered individuals, who are not law violators, being jailed until they can be committed or until some other action can be taken about them. Paul and Turner (1976) described the way in which a behaviorally oriented community mental health center in Huntsville, Ala. offered a 24-hour crisis service which was able to reduce length and frequency of jailing of emotionally disordered indivduals. They assumed "the jailing of an emotionally disturbed individual was not therapeutic and potentially counter-therapeutic [and that] . . . there would be a need to organize a variety of services to take care of immediate crises and needs." After these programs were organized, the jailings of psychologically disordered individuals decreased from 74 people jailed for 514 days in 1970 to 13 people jailed for 67 days in 1972 and then to 7 individuals jailed for only 17 days in 1974. The few people who still were jailed were felt to be extremely violent or there was insufficient information to justify hospitalization at that time. This very small number of people actually jailed in such a large urban area indicated that the minimum number is less than would be anticipated in most jail settings.

An extensive shopping list could be developed of needed preventive services. The ones discussed attend primarily to individual jails and problems of disordered offenders. On a much broader scale, Mattick (1974) asserts "if jail reform is to be effective, it must transcend the individual jail and must be conceived in a broader, most systematic manner, which sees the jail problem as an integral part of the entire criminal justice system" (p. 822). Thus, Mattick urged that alcoholics, narcotic users, sex offenders, and many other defined criminals should be decriminalized and many persons in present jail populations diverted. Second, he urged State and Federal participation in local jail administration, supervision, control, and financial support, and, if necessary, reorganizing and restructuring local government with regard to control of the jails.

Standards

Many standards have been issued relating to jail services (American Bar Association 1974); the most recent standards that encompass mental health care have been prepared by the National Advi-

sory Commission on Criminal Justice Standards and Goals (1973) and by the Commission on Accreditation for Corrections (1977) of the American Correctional Association. Both commissions address the needs for housing the mentally ill, addicts, and alcoholics elsewhere; when such individuals are jailed with criminal charges, the standards call for segregating them and offering special treatment and supervision. The National Advisory Commission recommends for immediate adoption that:

> The mentally ill should not be housed in a detention facility (Standard 9.7 1.a.) and since local correctional facilities are not equipped to treat addicts, they should be diverted to narcotic treatment centers. When drug users are admitted to the facility because of criminal charges not related to their drug use, immediate medical attention and treatment should be administered by a physician (*Standard* 9.7 1.b). For alcoholics, *all such offenders* should be diverted to a detoxification center (emphasis ours).

Similarly, the Commission on Accreditation in Corrections (1977), in its *Manual of Standards for Adult Local Detention Facilities* describes special programs for such inmates. Thus it recommends as essential that an individual treatment plan be developed for the mentally ill, the alcoholic, and the drug dependent, and

> When not provided in a community health facility, detoxification from alcohol, opiates, barbituates, and similar drugs is performed at the facility under medical supervision (*Standard* 5180, p. 37).

While both sets of standards call for jail counseling programs, contracting for mental health services, and suicide prevention efforts, they do not specify the nature or patterns of such service delivery. The full range of services and models discussed lie within the broad dicta of both sets of standards. The standards do not offer guidelines but rather minimum criteria for program concerns and goals.

Directions for Research

Followup Research on Confined Citizens. Baseline data are needed on the impact of the jail experience on confined citizens. Individuals who are seriously disturbed or violent or who have flamboyant psychopathology come to the attention of jail authorities; however, the psychiatric problems of the hundreds of thousands of citizens who pass through "uneventfully" remain unknown. Research is needed into the several categories of psychological effects of jail confinement on incarcerated citizens. Such research should be directed at the traumatic aspects of the jail confinement, the aspects of confinement that have no impact, and the categories of individuals who are most and least vulnerable to such effects. Just as jail traumas should be examined, so should possible jail strens. *Stren* comes from the word strength and is a community psychology term for an experience that has a lasting positive impact on an individual's behavior and life. A trauma, on the other hand, may be defined as an event that has a lasting negative impact on a person's behavior and life.

Research on Jailers. For all practical purposes, no useful scholarly information is available on jail personnel. The first step in such research should be an analysis of tasks and job performance of officers. The second step should be an analysis of characteristics of bad and good officers in different types of jail settings. The third step would be an investigation of jail stressors and patterns of jailer strains, with exploration of stress-reduction techniques and knowledge. The final area of necessary investigation is a longitudinal study of jailers over time. The psychological and physical changes that occur, ranging from blood pressure to cynicism and occupational socialization, should be investigated.

Establishing the Research Demonstration, Mental Health Unit Within the Jail. Mental health service delivery within jails is rarely subjected to any kind of evaluation, and services typically are offered in response to individual and organizational crises. A program of establishing research and demonstration units for mental health services within several selected jails would allow the study of differential effectiveness of mental health intervention techniques. Life skills models, group therapy, professional versus paraprofessional staff, therapeutic communities, classification and screening techniques, and other mental health practices could be evaluated within an explicit research mission.

Violence and Suicide Research. Jail settings have reported high rates of suicides, suicide attempts, threats, and violence. While some preliminary information on suicide rates and attempts in jails is available, relatively little information is available about threats of violence and actual violence. Information should be gathered with regard to physical structures, milieu, size, staffing, and program patterns associated with high and low suicide and violence rates.

Preventive Research. Both primary and secondary prevention of mental disorders in jails are important areas in program development and research. Research needs to be conducted into the effec-

tiveness of keeping mentally ill individuals out of jails, dealing with psychological disorders at the time that they arise, educational programs for prevention, and the use of community resources for primary and secondary prevention. Prevention research of all kinds is difficult to conceptualize and to implement. Nevertheless, the difficulty and sometimes diffuseness of such research should not discourage the search for promising methodologies in assessment of community diversions and related programs; such programs may reduce the incidence, duration, or severity of mental disorders in jails.

Conclusion

> In the old days, before the discovery of eruptions, the lava had to be carried by hand down the mountain and thrown on the sleeping villagers. This took a lot of time. (Clarence Brown)

Just as there were in fact no old days in the case of "discovery of eruptions," there have been no old days in jail programs. The problems and psychological sequelae have existed for essentially the full history of jails. The traumatic and harmful effects of jail confinement (the functional equivalent of hot lava) have poured unabated on the lives and well-being of confined citizens. The potential solutions are complex, possibly expensive, and require fresh research data and program development in jail settings. Nevertheless, it is only out of this serious commitment to dealing with the mentally ill that we can hope to combat the pervasive, iatrogenic effects of jail imprisonment.

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CHAPTER 7

Juveniles in Jail: Special Issues for a Population Subgroup

Donald A. Rademacher

Introduction

This chapter deals only with some selected issues relating to juveniles in jail. The complexity of this subject makes it impossible to cover all, or even most, of the many important topics relating to this long-neglected issue. Some juveniles in jail are confined with or near adult inmates and/or have regular contact with adult inmates; some juveniles are physically and sexually assaulted. Exposed to undesirable adult behavior, labeled "criminal," cut off from family and peers, some of these young persons are pushed into further antisocial and illegal behavior. Their trust of adults is shaken by their daily contacts. The topics to be discussed here represent basic problems and needs that are essential to the elimination of the confinement of juveniles in adult detention facilities.

Mental health and mental health services were not defined for purposes of this workshop, permitting a considerable variation in participant responses to the subjects covered. An open discussion of mental health is probably necessary in early consideration of such a subject. Mental health was approached both from the standpoint of specific mental problems and illnesses and from the broader range of personal problems which today fall under the mental health services umbrella. These latter services include those provided by community mental health agencies and other agenices. Specific mental health problems, mental illness, and mental retardation are the primary concerns of this chapter, but the broader community-based mental health services will have a definite role for juveniles once they are in the community.

For many years the mental health needs of persons confined in jails were not recognized. Jail operations, both planned and accidental, often caused and/or compounded the mental health problems of inmates. When the mental health needs of these inmates

began to be recognized in the latter half of the 19th century, it appeared to be the beginning of a major change in care. However, mental health services for these persons were not developed. Inmate mental health needs were slowly acknowledged during the 20th century, but the general and almost universal neglect of jails kept special services from being developed, except in isolated facilities. This workshop brought mental health services for jail inmates to the surface once more.

The workshop focused on jails authorized to hold inmates for periods in excess of 48 hours. These are jails that house sentenced offenders in addition to those awaiting release on bond or personal recognizance, arraignments trial, transfer, or related actions. For the most part, they are operated by counties. Basically they represent the same group included in the 1970 *National Jail Census* (LEAA 1971). The census included the 4,037 locally administered jails located in 47 States and the District of Columbia in 1970.

The jails included in the census represent only about 25 percent of the adult detention facilities in the United States. The remaining detention facilities include 12,000 or more lock-ups, which in most communities are operated by city law enforcement agencies. These facilities serve the same general function as the jails, except that they do not hold sentenced offenders and they can only hold persons for periods up to 48 hours. The lock-ups are locked and secure facilities. Many resemble county jails except in size; a few are large. Some lock-ups resemble locked offices with beds instead of desks. The presence of lock-ups was mentioned during the workshop, but their needs for or role in providing mental health services was not considered.

When studying jails or planning services for secure detention, it is essential that lock-ups as well as jails be included. Most lock-ups only house a small number of inmates at any one time. However, the number of lock-ups, the constant flow of inmates, and the limited jail staffing tend to make these facilities potentially more threatening to the physical and mental health of inmates than the larger and frequently better staffed jails.

Inmate self-inflicted injuries, attempted and actual suicides, and the services required to prevent or control such acts were frequently mentioned during the workshop as a priority jail mental health concern. It was pointed out in the discussions that many, and maybe most, of inmate self-inflicted injuries occur during the first 30 hours of confinement, with the act often taking place within a few hours of admission. Since lock-ups can hold inmates for up to 48 hours, they house large numbers of persons during the period when self-inflicted injuries often occur. Any plan to develop mental health services to deal with this specific problem must, therefore, include lock-ups.

The exact number of lock-ups in the United States and their locations are not known, nor is the size of the population they serve. This large gap in resource information concerning the protection and care of estimated hundreds of thousands of confined people can no longer be overlooked by criminal justice or mental health agencies or the public. Obviously, more information about jails and lock-ups, and the problems and backgrounds of the people detained in these facilities, must be known before realistic correctional and mental health services can be planned and implemented.

The need for obtaining better information and data about all criminal justice agencies and the persons they deal with is not new. The Wickersham Commission made a major recommendation about this need in its 1932 report. Since that time, every major study commission and/or criminal justice special conference has also cited the need for usable resource information. The President's Commission on Law Enforcement and Administration of Justice said:

> There are no national and almost no state or local statistics at all in a number of important areas: the courts, probation, sentencing and the jails. . . . In short, the United States is today in the era of the high speed computer, trying to keep track of crime and criminals with a system that was less than adequate in the days of the horse and buggy (1967, p. 123).

A number of important subjects were touched on in the workshop. Some participants expressed concern for special groups of inmates and wanted to know if the needs of these groups were to be discussed. Women and juveniles were mentioned several times. The overall focus of the workshop considered all inmates without regard to special mental health problems, and this point of view was probably all that could be considered in the available time. However, various inmate groups and subgroups are different and have special needs. The mental health needs of women, juveniles, mentally retarded inmates, to name but a few, must be considered independently to assure that their needs are not submerged in programs designed for the predominantly adult male population.

Juveniles in Jail

Long before the rights of juveniles were seriously considered, Wines (1895) called for the removal of juveniles from adult facilities. Wines emphasized that "The toleration of children in penal institutions of any description is an outrage to which no government, national, state or municipal should under any circumstances give its consent" (p. 302). This comment, made in 1895, preceded the birth of the juvenile court movement and was made years before the first juvenile detention unit appeared. In 1943, almost 50 years after the above comment, Casey (1943) reported that there were no reliable data on how many children go to jail each year, but he estimated that detention cases alone ran into the tens of thousands (p. 176).

About the same time, Deutsch (1950), commenting on the myth of jail therapy, took communities to task when he said, "It is disgraceful for any community to be forced to say it sends children to jail because it has no better detention facilities" (p. 238). Deutsch went on to add, "In so many communities the jailing of children continues because it is believed, in . . . The myth that to jail is to reform has a firm grip on some authorities and on large segments of the population" (p. 239). The myth persists today.

Over the years, many agencies and organizations, including major criminal justice bodies, have supported the removal of juveniles from adult detention facilities. Citizen organizations have joined in this appeal. While complete documentation of what happens to juveniles in adult jails is not available, it is clear that they may be more vulnerable to the influences and abuses of adult jails and lock-ups. For example, Lockwood (1980) reports that, while both the targets and aggressors of prison sexual violence tend to be young, targets are also typically younger than aggressors. And he notes that, where adolescents are confined with young adults, rates of sexual violence are the highest. In view of such age-related vulnerabilities, there is certainly reason to question the practice of detaining youth in adult jails or even to advocate for their removal from such facilities.

Legislation is essential if jailing of juveniles is to be stopped. A few States now have laws that prohibit or greatly restrict this practice. Some States have moved to tighten their laws and regulations but have not made jail detention illegal. Probably many jail administrators and law enforcement officials would support a workable plan. Legislation probably will not be passed until research assessing the impact of jails on juveniles is available or

information and data on jails and their populations is known. Unfortunately, legislators need more resource material than the occasional jail-abuse story which reaches the media.

National composite jail and lock-up information must be outlined, designed, collected, and tabulated on a monthly and annual basis. This will require both State and local participation. Since the information was more readily available 20 years ago, it can, with adequate planning, technical assistance, and the involvement of persons knowledgable about juveniles and jails, certainly be retrieved today.

While national and State data are not available, studies fortunately are available that include data on juveniles in jail. While these studies cover various periods and geographic areas and do not seek the same information, they do nevertheless provide a basis for estimates and suggest some jailing trends. The National Assessment of Juvenile Correction's report, *Under Lock and Key—Juveniles in Jail and Detention* (Sarri 1974), estimates that up to 500,000 juveniles are processed through local jails each year in the United States (p. 5). When this figure is compared to the estimated 87,951 juveniles detained in jails, as reported in *Corrections in the United States* (NCCD 1967, p. 15), the rapid increase in jail detention is evident. Based on these figures, the number of juveniles in jail increased by over 400 percent in just 13 years.

Other studies and reports including data on juveniles in jail show that 10,320 juveniles were held in jail in Illinois (Mattick and Sweet 1969, p. 59), 7,235 were held in Oklahoma (Oklahoma Crime Commission 1971, p. 11–13), 2,502 were held in Michigan (Preadmore 1973), 6,000 were held in jails in Virginia (John Howard Association 1974 p. 26), 10,688 were held in Wisconsin (Wisconsin 1976).

The Wisconsin study demonstrates what can be learned when verified data are available. The 10,688 juveniles were held in jails during 1974. By comparing the number of jails to the child population under the age of 18 years (which includes infants), it was learned that 9 percent of all children were jailed during that year. This 1-year detention rate was probably the highest ever in the United States. Fortunately, such information caused Wisconsin to take action to control jail intake (Special Study Committee 1975, pp. 50–59.).

From a mental health perspective, the removal of juveniles from jails could pay long-term benefits; and, when such a change is based on sound plans, it would offer no threat to the community. It is often assumed that juveniles are placed in jail because they have committed aggressive or violent acts and are dangerous. However,

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in the Children's Defense Fund study (1977) that included onsite visits to 449 jails and lock-up in nine States, *only* 11.7 percent of the juveniles in jail on the day of the site visit were charged with serious offenses against the person (FBI Index Violent Crimes). Another 17.9 percent were held for status offenses, and 4.3 percent were held for protective custody. Based on the types of offense alone, it could be said that over 88 percent of the jailed juveniles evidently were *not* being held because they were considered to be dangerous.

It should also be noted that the preceding study found more children detained in lock-ups than in census jails; also, there was a substantial use of jails in counties with special juvenile detention units.

Criteria for Detention

The workshop did not discuss the court's role in detention control. The courts, with few exceptions, have responsibility for controlling detention. Actual screening responsibility is usually delegated to intake personnel. The report on *Standards and Goals for Juvenile Justice* (NAC no date) supports court control of intake and establishes criteria for pre-adjudication detention. The intake criteria state that detention should be considered *as a last resort* when no other reasonable alternative is available; that detention should only be used when the juvenile has no parents, guardians, custodians, or other persons able to provide supervision and care for him and able to assure his presence for subsequent judicial hearing; that detention decisions should be made only by court or intake personnel, not by police officers; that, prior to first judicial hearing, the juvenile ordinarily should not be detained longer than overnight; and that juveniles should not be detained in jails, lock-ups, or other facilities used for adults.

Detention standards call for passage of legislation which prohibits juveniles from being detained in facilities housing adults accused or convicted of crimes. It is also urged that responsibility for detention decisions should be placed solely with court and intake personnel; the standards also cover when a child should be detained and the length of the first detention. The actual detention standards cover two points, the prevention of detention in adult facilities and detention, if imposed, to be in a facility used only for housing juveniles who have committed acts that would be criminal if committed by an adult.

Thus, the focus has been on removal of juveniles from jails. That is the essential action that is needed. However, experience has shown that even concerted efforts to bring about even minor changes take an exceptionally long time. Juveniles must be protected during the interim period. To provide the necessary protection, States and courts should establish criteria covering jail detention. Such criteria should, at least, include the following:

1. Admission of juveniles to jails and lock-ups should only be allowed on order of the court or by court intake personnel.
2. Only juveniles charged with offenses that would be crimes if committed by adults should be detained in jail.
3. No child should be detained if a suitable alternative method of supervision is available.
4. Jails and lock-ups housing juveniles should have adequate admission screening services, both correctional and physical/mental health. Adequate physical/mental health screening requires that examinations are made by physicians and other qualified staff.
5. Juveniles placed in jail should be housed in facilities separated from adult inmates in such a way as to prevent both visual and vocal contact. Inmates, including trustees, should not be permitted to contact juveniles.
6. In all units housing juveniles, jail staff should be assigned on a 24-hour-per-day basis, and staff should have direct sight contact with all juveniles.
7. Complete records, including identifying and demographic information and health-mental health records, should be kept for all juveniles admitted to the facility. The records should include the date and time the juvenile was admitted and the name, title, address, and telephone number of the person who placed the child.
8. No juvenile should be admitted to the jail or lock-up unless the nature of the charged offense is known.

These are only a few of the necessary criteria. Others should be added. If a jail or lock-up cannot meet these criteria, that facility should be prohibited by special court order from holding juveniles.

Closing Statement

Specific mental health problems of juveniles have not been covered in this chapter, but it dealt with a vital mental health issue by presenting policy problems that must be dealt with before spe-

cific mental health services can properly be developed. Lock-ups must be included in plans. Information and data must be made available by all detention facilities and a comprehensive national detention facility data retrieval system must be developed. The problem of juveniles in jail is serious and seems to be getting worse. If the items suggested in this chapter are acted upon, available community mental health services may be able to respond to the problems of many of these juveniles, without having to develop new residential facilities and programs.

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CHAPTER 8

The Labeling and Treatment of Mental Illness in Jails: A Theoretical Discussion [1]

Walter R. Gove, Ph. D.

Introduction

Within our society, there are two sets of large, formal institutional arrangements for dealing with two different types of deviance: criminal behavior and mental illness. Their interaction raises a number of questions because the judicial processing system is based on the assumption that a person's actions are essentially the product of rational thought, and, in contrast, the psychiatric perspective is based on the premise that human behavior is basically a product of irrational processes. Because human behavior has both rational and irrational components, perhaps inevitably these two institutional systems are in constant contact even though they rest on fundamentally different conceptions of human nature. For example, a decision on whether or not to hospitalize or jail a mentally disturbed individual who has committed criminal acts is a frequent dilemma for the police. Similarly, psychiatry is involved in a variety of determinations in the legal process, such as: (1) competency to stand trial; (2) criminal responsibility and the defense of insanity; (3) presentence evaluations; and (4) court testimony. Also, the mentally ill in jails and prisons not only need but have a legal right to treatment (Schwitzgebel 1979).

This issue, the treatment of the mentally ill in jail, is the focus of this chapter. Understanding fully the issues involved in the treatment of the mentally ill in jails requires an appreciation of the theoretical and pragmatic dynamics between the psychiatric perspective and the assumptions of the judicial processing system. Such an appreciation is often lacking.

A review of the literature indicates that relatively little is known about the occurrence of mental illness among inmates in jails. Outside the jails, the police are called not only when someone has

clearly committed a crime but also when someone creates a serious disturbance and/or is perceived as a serious threat to others. Essentially, the police have three courses of action. They can attempt to calm down the individuals by talking to them, isolating them, acting as mediators, etc. or, on the basis of what they see and hear, the police may decide an individual is mentally ill and play an official role in the initiation of commitment to a mental hospital. Alternatively, the police may arrest the individual who has created a disturbance on a variety of charges, a procedure which generally leads to the individual being placed in jail.

A review of the literature also indicates that there are relatively little data on the factors affecting a particular choice of action or the frequency with which particular choices are made by the police (but see, e.g., Bittner 1967). The choice of action probably involves a complex set of factors, including the behavior and demeanor of the individual, the behavior and demeanor of the complainants, the nature of the acts perceived by the police and alleged to them, the ease of initiation to mental hospitalization, the perceived quality of the hospital, the condition and facilities available at the local jail, the established routine within the police department for dealing with such individuals, and the particular characteristics of the policemen involved. This is a long list of factors which probably affect the choice made by the police, and it seems reasonable that there are wide variations among different jurisdictions in the extent to which police route mentally ill individuals into jail. The variations caused by these factors may at least partially account for the wide differences in the proportion of persons in jail who are mentally ill (Petrich 1976; Guze et al. 1962; Cloninger and Guze 1970; Swank and Winer 1976).

Although we may anticipate wide variations in the extent to which mentally ill individuals are to be found in jails, we may assume for several reasons that virtually every jail contains some mentally ill persons. First, even when mental hospitalization is a readily available alternative, the police are apt to route severely disruptive individuals into jail, particularly if they are perceived as violent and likely to commit serious criminal acts. Second, some persons who have committed criminal acts are also mentally ill. Third, both the process of being jailed and the environment within the jail are extremely stressful for some individuals and, at least occasionally, trigger the onset of mental illness (e.g., Toch, 1975). In short, virtually every jail confronts the issue of how to deal with the mentally ill, although the magnitude of the problem varies among jails.

Recent revolutionary changes in psychiatric treatment and changes in the law are claimed to have substantially increased the number of mentally ill individuals in jails. From 1955 to 1971, there was an increase each year in the number of patients admitted to public mental hospitals; since then, the admission rates leveled off and began to decline slightly. In spite of the increased admission rate, the resident population has declined every year since 1955, this reduction brought about by a sharp decrease in the length of hospitalization. There has been a shift away from treatment in mental hospitals to treatment centers more closely tied to the community. From 1955 to 1975, the rate of inpatient hospitalizations remained relatively constant, but there was a marked change in the place of treatment, with more persons receiving inpatient treatment in general hospitals, community mental health centers, and, to a lesser extent, Veterans Administration (VA) hospitals.

In all settings the length of treatment is now relatively brief. In 1975, the median length of inpatient care in public mental hospitals was 26 days, in private mental hospitals 20 days, in community mental health centers 13 days, in VA hospitals (psychiatric admissions only) 18 days, and in general hospitals (psychiatric admissions only) 12 days. The most striking characteristic of psychiatric treatment was the tremendous increase in the number of patients who received care in outpatient psychiatric clinics (Gove 1980*a*).

In 1971, in the case of *Wyatt* v. *Stickney*, the Federal District Court in Alabama held that involuntarily committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition," and this case appears to have become the accepted standard for all hospitals. In 1975, in *O'Connor* v. *Donaldson,* the U.S. Supreme Court ruled that "a state cannot constitutionally confine a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends" (Crane et al. 1977*b*, p. 827).

A systematic review of involuntary patients at specified periods is becoming standard practice in public mental hospitals; however, a number of States had review boards long before this time (e.g., see Kerlins and Knudsen 1976). Other States have set up systematic procedures to insure that the rights of patients are protected. For example, in Michigan all patients are notified of their rights, as specified by a new mental health code, and each institution has a special person designated as a rights adviser who investigates complaints (Coye and Clifford 1978).

Subsequently, on April 30, 1979, in *Addington* v. *Texas,* the Supreme Court made a ruling that more clearly delineates the requirements for commitment: Persons can be committed only if they are presently both mentally ill and dangerous to either themselves or others; the evidence supporting this finding must be "clear and convincing." While this standard of proof is not as stringent as that required in criminal cases, where the standard is "beyond a reasonable doubt," the ruling clearly indicates that the prescribed commitment standard is more stringent than the earlier "preponderance of the evidence." Furthermore, 14 States already had laws requiring the standard used in criminal case (see *Addington* v. *Texas*). Also, the Supreme Court has imposed stringent limits on how long defendants found incompetent to stand trial can be hospitalized (Steadman 1979). Although Scheff argued in 1966 that mental hospitals routinely accept voluntary patients, there is by now substantial evidence that this is no longer the case (Rose et al. 1977; Feigelson et al. 1978; Morrissey 1979). On the average, a voluntary applicant has about a 50 percent chance of being admitted. With the recent tightening of procedures, as Morrissey (1979) makes clear, some persons who would benefit from hospitalization apparently cannot get admitted. In summary, the abuse of patient rights that had earlier been raised by the labeling theorists is now much less of an issue.

With the deinstitutionalization of mental patients, it is clear that many persons who had formerly been institutionalized are living under even more undesirable conditions in the community (e.g. Lamb 1979). Furthermore, it is obvious that many of these former mental patients not only need maintenance therapy but also that a substantial number of patients are not receiving psychiatric treatment (Davis 1975; McCraine and Mizell 1978; Hansell 1978; Winston et al. 1977).

In summary, it is now possible to treat with a brief hospitalization many persons who are severely mentally ill. But a considerable number of mentally ill individuals have chronic problems, and, although their acute symptoms can relatively quickly be treated in a mental hospital, upon release some of them are disruptive and may violate criminal laws. It should thus be anticipated that a proportion of these individuals will end up in jail where, because their problems are different from those of the average inmate, they are apt to disrupt normal institutional procedures and to create serious problems.

Labeling Theory and the Treatment of the Mentally Ill in Jails

Jails have probably always been faced with the problem of mentally ill inmates. However, as noted, recent court rulings, as well as numerous changes in the law, have reportedly resulted in a substantial influx into jails of persons who are mentally ill. Furthermore, jails are now legally required to provide treatment for mentally ill inmates, which, historically, they have been ill equipped to do. It is thus not surprising that jail administrators responsible for the treatment of mentally ill inmates have been looking for guidelines on how to recognize and treat inmates who are mentally ill.

Labeling theory, sometimes known as the societal reaction perspective, focuses on the dynamics of how and why persons are labeled and on the short- and long-range consequences of labeling someone deviant (in this case mentally ill); this perspective pays particular attention to social processes which are not part of more formal aspects of treatment. Labeling theory has for almost two decades (Gibbs and Erickson 1975; Cole 1975; Gove 1980*b*) been the dominant theory in the area of deviance in sociology and has been popular in some of its sister disciplines, particularly psychology. It would thus seem to follow that (1) labeling theory has a great deal to say that could be useful, and (2) persons responsible for the treatment of mentally ill inmates could turn to labeling theory for guidance. As labeling is such a prominent perspective, its merger with the psychiatric perspective could also be useful in identifying and treating the mentally ill in jails. Unfortunately, such a conclusion would be inaccurate, for labeling theory was developed as an alternative to traditional explanations of deviant behavior, not as a complement to them. Thus, it is virtually impossible to take labeling theory as it exists and merge it with the psychiatric perspective. This is unfortunate, since the symbolic interactionist's perspective, out of which labeling theory evolved, is one that has the potential for sensitizing individuals to many of the problematic issues involved in identifying persons as mentally ill while they are in jail.

Because persons concerned with the diagnosis and treatment of mentally ill persons in jail may seek guidance from the labeling theory perspective, I review why, despite its popularity, this theory may not provide that guidance. I then describe a number of processes involved in the treatment of the mentally ill in jails in order to sensitize persons to problematic aspects of the task, which (although not indicative of labeling theory's points) nevertheless ex-

emplify some basic issues conceptualized in the symbolic interaction perspective.

Labeling theory has evolved out of the symbolic interaction perspective which considers "reality" almost entirely socially defined. It considers whether or not behavior is defined as deviant in relative terms, and at the same time, it almost totally ignores the biological aspects of human nature. Labeling theory provides a general theoretical explanation of deviant behavior, not a specific explanation of a particular behavior. It is used to explain a wide variety of deviant behaviors because it focuses on general *social processes* that are presumed to be basic to the development of most forms of stabilized deviant behavior. Labeling theory focuses first on the actions of the audience, when looking at imposition of a deviant label on a particular actor, and then on the consequences for the actor of the deviant label that has been imposed.

A fundamental distinction made by labeling theorists is between *primary deviance* (i.e., the behavior which may cause someone to be labeled a deviant) and *secondary deviance* (i.e., the behavior produced by being placed in a deviant role). Regarding primary and secondary deviance, Lemert (1967:17) says:

> Primary deviation is assumed to arise in a wide variety of social, cultural, and psychological contexts, and at best has only marginal implication for the psychic structure of the individual; it does not lead to symbolic reorganization at the level of self-regarding attitudes and social roles. Secondary deviation is deviant behavior or social roles based upon it, which becomes a means of defense, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation.

The labeling theorists do not appear to attach significance to an act of primary deviance, except insofar as others react toward the commission of the act. To them, deviance is not a quality of an act but, instead, is produced in the interaction between a person who commits an act and those who respond to it (Becker 1963:14). As Erikson (1962:11) says:

> Deviance is not a property *inherent in* certain forms of behavior; it is a property *conferred upon* these forms by the audiences which directly or indirectly witness them. The critical variable in the study of deviance, then, is the social audience rather than the individual actor, since it is the audience which eventually determines whether or not any episode of behavior or any class of episodes is labeled deviant.

Similarly, Becker (1963:9) states:

> Social groups create deviance by making rules whose infractions constitute deviance, and by applying those rule to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an "offender". The deviant is one to whom the label has successfully been applied; deviant behavior is behavior that people so label.

Becker goes on to emphasize the distinction between rulebreaking and deviance, noting that many persons who commit rulebreaking acts do not receive a deviant label, while others who have not broken rules may, by mistake, be labeled deviant.

What concern societal reaction theorists have with an individual's personal and social attributes is focused on how these affect the way *others* (e.g., jail personnel or mental health personnel working in jails) respond to an act of primary deviance. Thus, these theorists are not concerned with whether a particular societal attribute is related to the likelihood that an individual will commit a deviant act, but with whether the societal attribute facilitated or impedes that individual's ability to avoid the imposition of a deviant label.

According to this perspective, the most crucial step in the development of a stable pattern of deviant behavior is usually the experience of being caught and publicly labeled as a deviant. Whether or not this happens to a person "depends not so much on what he does as on what other people do" (Becker 1963:31). Erikson (1962:311), writing about the public labeling process, states:

> The community's decision to bring deviant sanctions against the individual . . . is a sharp rite of transition at once moving him out of his normal position in society and transferring him into a distinctive deviant role. The ceremonies which accomplish this change of status, ordinarily, have three related phases. They provide a formal confrontation between the deviant suspect and representatives of his community (as in the criminal trial or psychiatric case conference); they announce some judgment about the nature of his deviancy (a verdict or diagnosis for example), and they perform an act of social placement, assigning him to a special role (like that of a prisoner or patient) which redefines his position in society.

Erikson (1962:311) goes on to state: "An important feature of these ceremonies in our culture is that they are almost irreversible." Why might this be the case? According to the labeling theorists, the status of *deviant* is a master status which overrides all other statuses in determining how others will act toward the

person (Becker 1963:33). Once a person is stigmatized by being labeled a deviant, a self-fulfilling prophecy is initiated, with others perceiving and responding to the person as a deviant (Becker 1963:34; Erikson 1962:311). Furthermore, once persons are publicly processed as deviants, they are usually forced into a deviant group (often by being placed in an institution). As Becker notes (1963:38), such groups have one thing in common—their deviance. They have a common fate; they face the same problems; and, because of this, they develop a deviant subculture. This subculture combines a perspective on the world with a set of routine activities. According to Becker (1963:38), "Membership in such a group solidifies a deviant identity"' and leads to rationalization of their position. According to the labeling theorists, once labeling has occurred, it is extremely difficult for the person to break out of the deviant status.

In summary, the labeling theorists focused on the societal attributes of those who react and those who are reacted against, in order to explain why some persons and not others become labeled as deviant. They argue that, once a person has been labeled a deviant, and particularly if that person has passed through a "degradation ceremony" and been forced to become a member of a deviant group, the person has experienced a profound and frequently irreversible socialization process. He or she not only acquires an inferior status but also develops a deviant world view and the particular knowledge and skills that go with it. And, perhaps equally important, he or she develops a deviant self-image based upon the image of himself or herself received through the actions of others.

In discussing societal reactions, it is useful to distinguish between labeling as a dependent and as an independent variable (e.g., Orcutt 1973). In viewing labeling as a dependent variable the concern is explaining why certain people—and not others—come to be labeled deviant.

The traditional view is that persons are labeled criminals because of the commission of criminal acts; they are labeled mentally ill because they are mentally ill and behave accordingly; or, they are labeled physically disabled because they have a physical disability.

The societal reaction view is that persons are labeled as deviant primarily as a consequence of societal characteristics, particularly the power or resources of the individuals, the social distance between the labeler and the persons labeled, the tolerance level in the community, and the visibility of the individuals' deviant behavior (e.g., Scheff 1966:100). The attribute which has received by far the most attention in the literature is the resources and power of

the individual; it is argued that persons with few resources and little power are the ones most likely to have a deviant label imposed upon them.

As is indicated by Becker (1963, 1967), Lofland (1969), Lemert (1951:394-97), Sagarin (1975), Rubington and Weinberg (1971), Gove (1975), Gibbs (1966), the labeling theorists side with the underdog, and they apparently equate the underdog with those on the margin of society who, because of their societal attributes, are ill-equipped to prevent the imposition of a deviant label. Thus, the labeling perspective provides an explanation for why those on the margin, for example the poor and the black, are particularly likely to be labeled deviant. In summary, when labeling is treated as a dependent variable, labeling theory hypothesizes that the main cause of being labeled a deviant is the individual's marginal status in society.

Once persons have been labeled deviants, the labeling theorists argue that reacting to persons as if they were deviants is the major cause of deviant identities and lifestyles. It is assumed that, without a societal reaction, most deviant behaviors would be transitory. In contrast, if the individual is reacted to as a deviant, it is assumed that the deviant status will become more or less permanent. Further, it is argued that deviant status will act as a master status; that is, this particular status determines how others will act toward the person across the range of social interaction. This perspective also hypothesizes that persons labeled as "deviants" are cut off from interaction with "normals" and channeled into contact with similar deviants. It is also presumed that, once this happens, it becomes very difficult for the individual to return to a normal status.

Labeling theory focuses largely on processes characteristic of the macroenvironment, for example, why certain persons in society are labeled deviant, and those so labeled tend to establish deviant careers. Although labeling theory has been popular among social scientists, particularly sociologists, it has not withstood empirical analysis well (for review of the evidence in the areas of crime and mental illness, see Gove 1975, 1980*a*, 1980*b*; Tittle 1975; Wellford 1975; Hagan 1974; Hirschi 1975, 1980). In particular, the data consistently indicate that persons are labeled deviant primarily because they have committed deviant acts; also, typically, a career of deviance is well established before an individual officially acquires a deviant label. The fact that labeling theory does not explain most deviant behavior, however, is not cause for ignoring it. There is considerable evidence to suggest that labeling theorists are focusing on some real social processes. Thus, the problem is not that the

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processes being described do not exist but that labeling theorists have grossly overstated the importance of these processes.

In view of its characteristics and basic focus, labeling theory is difficult to apply to the diagnosis and treatment of the mentally ill among jail inmates. First, labeling theory as it is formulated applies to general societal processes, whereas the jail is a comprehensive institutional setting where social interactions occur within a unique microenvironment. Second, inmates in jail have already gone through some if not all of the processes of being labeled criminals and thus, according to labeling theorists, have already acquired a deviant master status which will make it difficult for them to function later as normal adults. Thus, the issue of diagnosing and treating (i.e. labeling) certain inmates in jail as mentally ill is not a process that fits well into the paradigm developed by labeling theory, although the processes do have a number of things in common. How these may be problematic aspects of providing mental health services in jails is described in the next section.

Intrinsic Points of Tension Involved in the Treatment of Mentally Ill Inmates

There are at least three major points of tension between psychiatrists and jailors in the treatment of the mentally ill inmate. The first has to do with the effectiveness of treatment, in situations where jail inmates are transferred to a mental hospital. As noted in the introduction, in a hospital setting psychiatrists are capable of routinely providing effective treatments for the severe symptoms of mental illness. Once this has been done, from the hospital's and the psychiatrist's point of view, there appears to be no justification for retaining the inmate in the hospital. In many cases inmates who are sent to mental hospitals for treatment are returned to the jails after a short time. However, if the conditions of incarceration play an important role in the etiology of becoming mentally ill, the inmates may again relapse into a state of illness. Thus, the inmates may once again be sent to a mental hospital, only to be treated and shortly returned to jail. This cycle can be repetitious because the hospital may not be able to treat the inmates so that they can function adequately in jail; and, the hospital is not in a position to solve the problem the inmates pose for the jailor by keeping them hospitalized for a prolonged period. From the point of view of the jailor, the continued failure of the hospital to treat the inmate "effectively" is a constant irritation. Similarly, the hospital is also

likely to find the constant recycling of inmates a source of irritation.

A second problem has to do with the location of treatment. The mental hospitals of today are open institutions; patients' stays are short; the patients are generally voluntary; and hospitals almost invariably practice some form of milieu therapy, a basic premise being that patients be given as much freedom and responsibility as possible in order to enhance their level of functioning, self-esteem, and self-image. The placement of an inmate in such a hospital setting is invariably problematic because of security issues. If the hospital provides sufficient security to prevent escape by the inmates, the whole treatment program of the hospital is apt to be disrupted; without such security the inmates could escape. The obvious alternative, of course, is to treat the inmate in jail, but, except for a few large jails, there are not the necessary medical facilities in which appropriate treatment can take place. Nevertheless, treatment is often attempted in such settings, even though it is apt to be unsatisfactory to the psychiatrists, the inmates, and the jailors.

A third potential source of friction is directly tied to labeling theory. If labeling theory is correct, the inmate may have acquired the master status of criminal. The psychiatrists may see this label as the dominant characteristic of the inmate, and it may affect the psychiatrist's willingness and/or ability to perceive and define the inmate as also mentally ill. Beside the general social psychological processes discussed by the labeling theorists, there seem to be additional reasons for psychiatrists to be reluctant to define inmates as mentally ill. For example, the psychiatrists may believe the inmate is feigning mental illness in order to serve less time, and few psychiatrists may like to spend their time on such individuals. In summary, there are a number of reasons for an inmate's master status of criminal affecting adversely the treatment the inmate receives from a psychiatrist: To this extent, this adverse reaction is apt to be irritating to the jailor (and inmate) and to cause a strain between the psychiatric and judicial systems.

Insights From the Symbolic Interaction Perspective

The interactionist perspective, out of which labeling theory developed, provides important insights into the problematic nature of the process and consequences of labeling inmates as mentally ill.

The institutional setting of jails and prisons is set up specifically to contain persons charged with or convicted of crimes and to control disruptive behavior. Disruptive behavior on the part of inmates often occurs; it may be perceived as a normal, if troublesome, aspect of inmate behavior. To a large extent, the degree to which inmates receive attention from the staff is directly related to the extent to which they are troublesome, and this attention is typically directed at containing such behavior. This interaction in jails between inmates and staff appears to affect greatly the identification of mentally ill inmates. First, disruptive behavior, which in the community often identifies a person as mentally ill, may be viewed as normal or expected behavior in a jail setting and may lead merely to implementation of procedures which control or contain the behavior. In most jails, only when the disruptive behavior takes on persistent and/or bizarre forms, is it apt to lead to a person being viewed as mentally ill. Furthermore, persons whose mental illness is characterized by depression and withdrawal are not apt to be troublesome to the staff and thus are not as likely to be identified as mentally ill. The exception to this, of course, is an inmate's serious suicide attempt. In summary, the control procedures characteristic of jails work against identification of inmates who are not acutely mentally ill; the overtly disruptive rather than the withdrawn, passive, and depressed are apt to be identified as mentally ill.

For inmates there are advantages, or at least perceived advantages, in being labeled mentally ill. In many jails, this label may lead to preferential treatment, ranging from being placed in a hospital to being released from work duties, and generally being able to do "easy time." As a consequence, unlike the situation in the community where the vast majority of people wish to avoid the label of mental illness, in jails some inmates may actively seek it. In psychiatry, one of the key indications of mental illness is a person seeking or at least accepting the need for psychiatric treatment. However, this indicator is less reliable in jails where staff must distinguish those who are really mentally ill from those who are feigning mental illness. We know that mental illness is fairly easily feigned (Rosenhan 1973) and that psychiatrists can be deceived. In summary, in jails there are advantages to inmates for feigning mental illness, and the task of distinguishing those who are truly mentally ill from those who are not is extremely difficult, except in clear-cut cases.

For the reasons discussed above, it is reasonable to assume that the staff of jails are relatively unconcerned with mental illness except for for those episodes that are life-threatening or lead to

acute psychotic crises. This lack of attention is also reinforced by the absence of resources necessary to provide effective psychiatric care. In at least one respect, however, jails may provide a superior setting for psychiatric counseling, especially for the typical inmate who may experience some form of life crisis but not necessarily a psychotic episode. Persons in jail tend to view their incarceration as a critical and demeaning life experience. They also tend to be anxious and uncertain about their future. These characteristics, in fact, are exactly those which predispose someone to make basic life changes and to be receptive to psychotherapy (Gordon 1977). For many inmates who are not acutely mentally ill, a brief and carefully structured framework which forces them to confront their life's course and demonstrates plausible alternatives for returning to normal society has potential value.

Implications

1. The underlying issue of labeling theory as it has been developed and applied has focused on (1) the initial application of a deviant label on an individual, and (2) the consequences for the individual so labeled. In contrast, the issue here is the consequence of labeling an individual mentally ill who has already been labeled a criminal by virtue of arrest and incarceration in a jail. The processes by which jail inmates come to be labeled mentally ill and the consequences of the label are more complex issues than that usually dealt with by labeling theorists; hence, we can only make informed guesses. The process of attaching a new or additional deviant label on someone already labeled as a deviant presumably affects the consequences of the initial label. As this process is obviously a continuing one involving changing reactions and conflicting interpretations, probably the individuals who have the most insight are those actually involved, both those doing the labeling and those being labeled. Thus, a systematic investigation focusing on the insights of these individuals would likely be the best place to start obtaining information on these processes.

2. Previous research has produced disparate estimates of the proportion of persons in jails who are mentally ill. In fact, I think we have little idea of the prevalence of mental illness in jails, especially the factors which produce variations in such prevalence rates.

3. Research is needed on the judicial system in general and on the police in particular to determine among those mentally ill who are arrested why some get routed into jail, and what are their characteristics compared to those who are dealt with in other ways. Furthermore, there are substantial grounds for assuming that incarceration in jail produces mental illness in some individuals, but we know little about what distinguishes individuals who become mentally ill in reaction to incarceration and those who do not. Also, we do not know what the most problematic features of incarceration are in terms of precipitating mental illness.

4. The diagnosis of mental illness has always been somewhat problematic. However, in communities the task has at least been simplified by the fact that most persons do not seek psychiatric care (and thus the label of mental illness) unless they have a serious emotional disturbance. Furthermore, in the community prospective patients often initially understate many of their difficulties. However, in jails a number of people may wish to be labeled and treated as mentally ill, a situation further complicating the problem of correct diagnosis. Among the large number of issues with respect to psychiatric diagnosis in jail situations that require research, I would like to note two specifically. It is important to ascertain, first, if under these conditions there is a greater tendency to diagnose a person as *not* mentally ill, and, second, what role the informal inmate network plays in assisting the diagnosis. It may be that other inmates have a more accurate "reading" of the individual and probably know whether the inmate is pretending to be ill.

5. A great deal has been written about how the label of mental illness affects persons when they return to the community. Although there appears to be a readjustment process that involves a number of problems, in general, there seem to be few long-term negative effects to having been a mental patient (e.g., Gove 1975, 1980c). As far as I know, there has been no research on the consequences for criminals who have also been labeled mentally ill, consequences which include both the reaction of the inmates during the period when the individual is still incarcerated and the reaction of the community when the criminal who has been labeled mentally ill is eventually released.

6. Most inmates in jails are there for a brief time. For most of them it is a time of crisis, and at such times, persons tend to be particularly anxious and susceptible to change. This is indicated in the research on psychotherapy and also in terms of the factors which produce abstention among alcoholics and drug addicts (e.g., McAuliffe 1975). It may be important to see whether, and under

what specific forms of psychotherapeutic interventions, the negative aspects of the incarceration experience could be used to facilitate a change in lifestyle for jail inmates.

Footnote

1. *Editor's Note:* The different perspectives concerning the origin and seriousness of mental illness of jail inmates (i.e., are they "bad" or "sick?") allegedly held by jail staff and mental health personnel working in jails create role conflict and administrative problems in the management of the jail. In that regard, the workshop planning group considered the issue of screening and diagnosing jail inmates as mentally ill to have more ramifications than simply identifying an individual in need of mental health services. One body of knowledge relevant to these additional ramifications is the sociological perspective known as the societal reaction perspective of deviant behavior and its most familiar expression in labeling theory. As an expert on the societal reaction perspective and labeling theory concerning both crime and mental illness, Gove was asked to address the issue of the additional ramifications of mental illness diagnosis in jails, in the context of labeling theory, in order to shed light on the possible sources of conflict and administrative issues between custody and service delivery roles.

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CHAPTER 9

Jails and Mental Health: Suggestions Toward a Research Agenda

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During the Special National Workshop on Mental Health Services in Jails, one theme occurred repeatedly, regardless of the specific topics under discussion. This was the complaint of lack of knowledge: absence of data, insufficient information, and plausible but untested hypotheses. The last item on the conference agenda was the identification of research needs to assist in a general plan for study of mental health services in jails. This position for the discussion of research was reasonable because the conference planners had realized the earlier discussions would highlight such needs. But in any criminal justice agency planning or administrative meeting, usually research is last on the agenda; and the short shrift ordinarily given to research needs continues to result in complaints about the lack of information. To address this need, research must be moved up on the agenda to a higher priority position. Managers desire action, but if they desire *informed* action and more rational decisionmaking, an increased emphasis must be given to information needs.

In both the criminal justice and mental health areas, the topic of jails similarly has been given a low ranking. That is, jails, too, usually are last on the agenda of criminal justice, mental health, and funding agencies. In corrections, which consists mainly of programs of jails, probation, prison, and parole, the investment of research efforts has been the opposite of that expected, if the sheer numbers of persons involved were the major criterion for the selection of focus. Thus, a good deal of study has been done of parole from prisons, affecting a relatively small number of persons; perhaps somewhat fewer studies have been made of prisons, which involve many more individuals; and very few studies of jail—affecting a much larger number of persons—are to be found. (The investment is, apparently, inversely proportional to the numbers of persons affected.) Within jails, perhaps more persons are held in custo-

dy awaiting adjudication than are confined to serve sentences; and yet few studies of them are available.

If research on mental health problems in jails is to be given a higher priority, a general strategy for study is also needed. This chapter suggests a framework for such research. Four general categories of information needs are discussed. These are interrelated, and if pursued simultaneously, they can provide an integrated program for producing knowledge that can improve practice in this neglected area.

The four areas of need concern improvements in *conceptualization, measurement, classification,* and *program evaluation.* All are necessary to the proposed general strategy which must address both national and local needs for information critical to rational planning and management.

Improved Conceptualization

At the most general level of conceptualization, a question repeatedly asked at this conference was "What are jails for?" This seemingly simple question received complex answers from diverse perspectives. To the variety of views resulting from differing mental health orientations is added the fact that jails are imbedded in the context of the criminal justice system, where differing perspectives of justice obtain as well. Thus, there are divergent, often conflicting views on the purposes of jails, from both mental health and justice perspectives. And, any general effort toward improving programs must face the need for greater clarity of the theoretical bases for mental health programs in jails.

The usual demand for action and for practicality, not theory, may be expected; but nothing is so impractical as beginning or attempting to administer programs—or seeking to evaluate them—without a clear conception of what the program is designed to achieve.

The views of mental health professionals tend to be derived from divergent viewpoints in psychiatry and psychology, from different social theories, or from innovations in clinical practice. Clinical practice may be derived, implicitly at least, from the psychoanalytic perspective, from behaviorism, or from phenomenological psychology—orientations fundamentally in conflict. The labeling theories discussed in the workshop provide another markedly different frame of reference (Gove, chapter 8). And, an example of another distinct set of conceptions, also discussed in the workshop, is given

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by the therapeutic community concept (Jones 1953). These theoretical conceptions implicitly or explicitly guide the implementation of programs to provide mental health services in jails; and if we are to learn how such programs succeed or fail it is imperative that their theoretical framework be spelled out.

The theoretical perspectives of correctional administrators also are apt to conflict, although these are rarely specified in advance of program planning. There is little unanimity on the basic purposes of jails.

Consider, first, that portion of jail populations serving sentences imposed by the court. An analysis of current controversies concerning sentencing shows that there are two general camps, each with subdivisions (O'Leary et al. 1975). Each has a long history of philosophical underpinnings and debate. On the one hand, there are advocates of utilitarian purposes, including treatment (rehabilitation), incapacitation, or general deterrence. Their aims are pragmatic; all are aimed at crime reduction. On the other hand, there are proponents of a retributive or desert perspective who perceive the imposition of penalties commensurate with the seriousness of the offense of conviction to be the means to the fundamental purpose of just desert.

Second, the often larger portion of the jailed populace, those awaiting trial, are not in jail for punishment or even *as* punishment; they have not been convicted of crime. Operationally, however, the circumstances of confinement are indistinguishable from those of persons ostensibly being punished. Debate in this conference revolved around issues of the traditional presumption of innocence, the concept of preventive detention, and the constitutionality of pretrial detention for any reason other than assurance of appearance for trial.

A first agendum for a practically useful research program is thus a call for better theory. There is a need for improved integration of the theoretical bases for mental health practice; but, in addition, these bases need to be integrated within better articulated (and better agreed upon) criminal justice theory. Improved conceptualization is essential to bring order to research; it is equally essential to sound institutional management.

Improved Measurement

Once there are increased agreements and specifications of what mental health services in jails are intended to do and how they are

to do it, the need for improved measurement becomes clear. Lord Kelvin (Pearson 1924) often expressed this fundamental need:

> When you can measure what you are speaking about and can express it in numbers you know something about it, but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meager and unsatisfactory kind (p. viii).

Only a decade ago, the President's Commission on Law Enforcement and Criminal Justice completed its work (President's Commission 1967). In the course of its study, the Commission found that no one knew how many jails there were in the United States, how many persons were confined, or how many had serious mental health problems before, during, or after jail. Many people are still startled to learn that, as recently as 1967, a Presidential Commission had to request a special survey even to estimate the number of jails. We still lack even rudimentary information on the nature and extent of mental health problems in jails and on needs for or delivery of mental health services to people in jails.

How many jails are there now? One source (M. Gottfredson et al. 1978) indicates that there are 3,921. Another (Goldfarb 1975) asserted there are more than 5,000. How many persons are jailed? Gibbs (chapter 2) cites estimates (not counts) per year of "between one and a half million and five and a half million persons." Not only do we lack solid information on the incidence and prevalence of mental health problems in jails, but also we lack systematic procedures for keeping track of how many jails there are and how many persons are put in them. A basic need is improved recordkeeping, on both national and local levels, to provide adequate statistical systems yielding descriptive data on the scope and nature of the problems. Such data systems need not be complex or even unduly expensive. Yet, the information they could provide is essential for rational management, and it can provide data fundamental to a variety of research purposes.

Unfortunately, another quotation on the topic of measurement may be required to give balance to Lord Kelvin's admonition. The first Director of the National Institute of Law Enforcement and Criminal Justice (Siu 1968) cited St. Augustine:

> For so it is, oh Lord my God, I measure it;
> but what it is that I measure, I do not know (p. 3).

The problems of reliability and validity of measurement discussed by Gibbs (chapter 2) and others at the workshop attest to the need for attention to these measurement concerns. The related

issue of definitions of concepts to be measured is of course an integral part of the need for improved conceptualization.

Besides reliable recordkeeping systems, there are basic measurement development problems that need attention. These complex research problems, deserving of attention in their own right, include the problems of improved measurement of person variables, whether derived from individual histories, personality measures, or nosological categorization; better measures of any treatments (interventions); and more adequate measures of outcomes.

"Better measures" of person variables require an integration with the improved conceptualization already claimed to be needed, with the operational definition of key theoretical concepts to be used. They require, also, attention to problems of reliability and validity of information inserted into case-history records (such as presentence investigations) and to data extracted from such files.

"Better measures" of treatments require data not only regarding whether or not persons are placed in, volunteer for, or seek but do not find treatments; they require development of means for assessing the *extent* or *strength* of the treatment. This is analogous to the matter of dosage. Was the person given a little or a lot of the prescription? There is another, equally important but often ignored issue which has to do with the *quality* of the treatment or intervention in terms of the theoretical formulation guiding the program.

"Better measures" of outcomes must include not only measures of "recidivism," although these are needed, but also improved measures of personal and social adjustment. The latter measures should be derived from or related to the statements of specific program objectives.

Other measurement development problems, repeatedly emphasized by workshop participants, include more adequate attention to measurements of *staff* variables as well as those focused on inmates. The workshop discussion called attention to a variety of additional problems, including definition and measurement of diverse concepts such as *stress, social climate, overcrowding, physical structure* of jails, and *program patterns.* Much discussion was focused on the concept of stress and the perception that the social climates of jails may be modified to reduce stress and hence behavior disorders. How are such concepts to be measured or assessed?

The concept, stress, apparently was used in the workshop with a variety of meanings. For example, it was used to refer to "entry shock" as that term was employed by Gibbs (chapter 2) or to refer to noxious environmental conditions and events (Brodsky, chapter 6), i.e., to environmental "press" (Murray 1938). Others used the concept more generally, referring to a situation and environment

placing the person (i.e., the human organism) under great strain. This conception is similar to that of Selye (1950) whose concept of "general adaptation syndrome" encompasses physiological as well as psychological adaptions to stress. There was, in any case, an apparent consensus in discussions that concepts of stress are important to further studies of the effects of jails. Examples of the questions raised included:

1. How do already disturbed persons respond to the stress of jail? How are existing mental health problems exacerbated by stress?
2. How are normal persons affected by jail stress, and what mental health problems are aggravated?
3. How do jail staff cope with jail stress, and what training or mental health services are needed to assist them?
4. How can jail stress be reduced?
5. How does overcrowding contribute to stress?
6. What are the empirical relations between stress and jail behavior such as suicide, assaultive behavior, or escape?
7. What classifications of persons exhibit differential adaptations to jail stress?

Improved Classification

A third area of basic need is improved classification. In correctional work, the word, "classification," usually refers to assignment of persons to particular programs or housing units. As used here, however, it refers to the research process of developing ways of categorizing or grouping people as similar on variables, with the resultant groupings related to some purpose. There are three critical problems of mental health services in jails that require attention to classification issues: *screening issues, prediction problems,* and *differential treatment.*

Classification for Screening

Among the critical problems of screening at intake to jails is the early, accurate identification of potential suicide victims—a requisite to development of intervention programs. Another screening problem is quick recognition of inmates in need of protection, including those who are particularly at risk of victimization, including sexual abuse. Also, improved classification for custody (se-

curity) purposes, including identification of potentially assaultive or escape-prone persons, is important.

Classification for Prediction

The problem of prediction was implicit in many of the workshops discussions; it is essentially one of classification (Gottfredson 1975). Issues concerning the setting of money bail, release on recognizance, or pretrial diversion involve at least the problem of prediction of appearance for trial and, often, apparently, that of criminal behavior. The need for risk-screening procedures such as those aimed at reduction of suicide, self-harm, escape, and victimization targets also points to prediction problems. In addition, the problem of classification for treatment may involve the problem of differential predictions of outcomes for various classes of inmates, given assignments to different treatments. Besides these needs for prediction methods to provide assistance in program assignment, prediction methods can be useful in program planning and in program evaluations (Gottfredson 1971).

Classification for Differential Treatment

A major challenge to the corrections field generally, which applies equally to the more specific issues of providing improved mental health services in jails, is to determine what kinds of treatment services are helpful to what kinds of offenders. Jail populations are extremely heterogeneous, and ardent advocates of a variety of mental health services may be found. The challenge is to determine what works for whom, and with respect to what specific objectives. The naive question "what works?" may not, if it ignores this variety of both persons and treatments, be reasonably expected to be useful in guiding either research or practice.

Improved Program Evaluation

Needs for better program evaluations are not unique to jails, and they are not confined to mental health programs therein. Nevertheless, they must be proposed as a third general need. This requirement is, of course, interrelated with the others. Most mental health programs should include procedures to provide feedback to help guide administrators' efforts as programs are developed and

changed. These programs should also include systematic procedures that can give unbiased estimates of the degree to which the programs are attaining their objectives (Glaser 1973). The problem of program evaluation has been neglected in respect to jails (McCrea and Gottfredson 1974); and evaluations of mental health services in jails have been almost wholly lacking.

This lack was apparent in most of the specialized programs reviewed in this workshop (Morgan, chapter 3) and in related jail programs (Brodsky, chapter 6). In even the most promising programs, there is an absence of evaluation plans to permit later determinations of the effectiveness of the programs. As noted by Morgan (chapter 3), such evaluations are needed not only to assess the degree to which long-range goals, such as recidivism reduction, are achieved but also to determine how goals, such as decreased assaults, disruptive behavior, and jail disturbances, may be attained. The general need for program evaluation is well recognized, and it need not be belabored; nevertheless, the importance of evaluation studies to improved planning, effective management, and more rational and humane handling of persons in jail can hardly be overemphasized.

A General Strategy for Study

The conference papers and discussion called attention to national and local needs for improved information for management of jails in general as well as for improved handling and treatment of those confined and in need of mental health services. Further, they suggested that basic research on the measurement of key concepts and on classification issues, including problems of prediction, has been neglected. Such research could contribute also to program evaluations which, in turn, can be more helpful if the theory underlying the program development can be clarified, better articulated, and specified. These seemingly diverse needs can be integrated into a broad framework for research in this field, because all the needs are interrelated. Progress in one sector can enhance the probability of gain in another.

1. A concerted effort toward an increased agreement on aims is called for. The purposes of programs should be described in specific, measurable terms. Program methods, by which it is expected that these aims will be met, must also be identified.

2. A national program providing minimal statistical data on jails, who is in them, why, and with what mental health problems, and

also providing data on followup outcomes is essential. A small core of basic data about the individuals jailed and what happens to them is required for both national planning and local management.

3. Jail managers need an extension to this basic core of data in order to keep track of offenders and to keep score on program results in ways idiosyncratic to local needs and programs, not only for a minimal accountability system but also for further program development.

4. Management information systems can provide a base of information from which the measurement and classification studies can be accomplished more efficiently.

5. They can and should also provide a basis for the program evaluation studies. Various evaluation methods, with differing degrees of rigor, may be possible, including some opportunities for experimental designs, for quasi-experimental methods, and for systematic studies of natural variation in inmates, programs, and outcomes. All can contribute to decreasing the present ignorance of what kinds of procedures are apparently helpful with various categories of problems. Programs of "quality control" are needed to assess the quality and strength of the treatment provided and to ensure its integrity in terms of a specifiable, theoretical frame of reference.

6. In every aspect of these steps, attention should be given not only to recordkeeping and analysis of offenders or alleged offenders, their treatment, and their subsequent careers, but also to the staff of the institutions. Here, the two aims mentioned by Brodsky should be recalled—purposes of assistance *to* staff and purposes of inmate assistance *through* staff (Brodsky, chapter 6).

7. Specialized, basic research such as the measurement of stress and the impact of jail environments on mental health is needed to augment this framework. A theme repeated throughout the workshop was how little is known of the potential negative impact of jail (on inmates and staff). Some inmates are seriously disturbed *before* they are jailed. Others are disturbed *while* they are jailed. Others are disturbed *as a result* of jail. These widely held beliefs are poorly documented, but they deserve further, detailed study.

8. Similarly, the research needs cited by Brodsky (chapter 6) provide examples of areas for study that could build on the proposed framework, for example:

- followup research on confined citizens to determine the harmful, neutral, or positive impacts of jail confinement
- research on jailers, to include task analyses, job performance, differences between bad and good officers in different types of settings, investigations of jail stress and stress-reduction techniques, and longitudinal studies of jail personnel
- establishment of research demonstration mental health units in jails
- specialized studies of violence and suicide, including information on "physical structures, milieu, size, staffing and program patterns associated with high and low suicide and violence rates"
- prevention research, including studies of effectiveness of programs of diversion of mentally ill from jails and other programs aimed at both primary and secondary prevention of mental disorders

The research needs identified by Megargee (chapter 5) at each "stage of assessment" can be incorporated in the general scheme. These provide specific suggestions of needs in the measurement and classification areas.

The general strategy offered may seem a somewhat grandiose or overly ambitious conception, but the research neglect of jails, the dearth of systematic knowledge of the role of jails in mental health, and the extent of misery calling out to be reduced demand a plea for a major effort.

There is a story of the Emperor of an eastern country centuries ago who was wandering in the woods. He came upon a beautiful oak and thought how it would be for his people if that oak could be in the center of his palace garden. When he returned to the palace, he called his advisors together and told them of his plan. Silently, they looked at him in amazement until one ventured to ask, "Emperor, do you know that it takes centuries to grow a magnificent oak like that?" He replied, "Then we had better plant it right away."

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CHAPTER 10

A Research Agenda for Mental Health Services in Local Jails

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There are few program areas in either the criminal justice or mental health systems that have less information available to planners and practitioners than mental health services to jails. This workshop indicated that the three Federal agencies involved, recognizing this lack of information, are willing to commit resources to developing adequate knowledge. This agenda is developed from a mental health research perspective: In reviewing the material presented and from participating in the workshop discussions, it was clear that the conceptualization of jail mental health service problems and their solutions was narrow because of an inadequate understanding of the operation of the State and local mental health systems beyond those few segments that have come into direct contact with the jails. Thus, it would be profitable to look more broadly at the issues involved in what to do with the mentally ill person in jail and what to do about the jail stress that results in psychiatric symptomatology and suicidal behavior.

Why Research?

One sheriff at the workshop noted, "I don't want research. I want action." But this is exactly what research should be about—helping to inform action through a systematic collection and analysis of client, agency, or program information. Applied to programmatic questions, research is simply a mechanism to provide the administrator and frontline service provider with the information needed to more effectively and intelligently carry out their jobs. When a proper collaboration between practitioner and researcher occurs, the products are exactly of the "show me" quality referred to by that sheriff. That is, when a problem is identified and framed into a researchable question, when the appropriate information is gathered and analyzed in regard to both the programmatic con-

cerns of the staff and the conceptual issues of interest to the researcher, the result is to increase an agency's capabilities for informed action.

A second major reason for research is to obtain program funds. It is difficult to approach a State or county legislature or municipal government to request funds for mental health programs without answers to the basic questions on the number and types of problems. The crush of routine jail business does not foster even basic recordkeeping systems. A standard reason for refusing requested funds is that they are not sufficiently justified. With current recordkeeping systems, documented justifications are often impossible. Without research or other systematic program evaluation, legislators or fiscal officers are often provided ready excuses for not developing mental health programs for jails.

Jail personnel need to be better equipped to undertake informed action for mental health program development and administration. Mental health services cannot be effectively set up without new funds or the strategic reallocation of existing funds, both of which options may require documentation of almost all phases of jail operations. A research program could pave the way for action by aiding in funding and developing programs geared to actual needs.

Research Content

Relationships Between Mental Health Services and Local Jails

The observation by Morgan, "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" (chapter 3) summarizes the views offered by many conference participants. Similar assumptions, made consistently during the workshop deliberations, concerned the changing relationships between the mental health and criminal justice systems, and the rapid and fundamental changes that have occurred in the standards for involuntary civil commitment in many jurisdictions. More persons are supposedly being placed in jail who formerly would have been in State mental hospitals where they were seen as still belonging.

There are serious questions as to the validity of these perceptions and how such observations coincide with those of mental health

service providers. Sorting out the complexities of these issues and developing precise data concerning these interrelationships, both currently and historically, is the first step in a research strategy: We have recently compiled data that are relevant to this issue.

As part of a project to ascertain the arrest rates of former mental patients in New York State, random samples of all patients released from New York State mental hospitals in 1968 and 1975 were followed. It was found that ex-patients were arrested more often than the general population. This difference resulted from the high arrest rate of those released patients with two or more arrests *prior* to their hospitalizations (Steadman et al. 1978; Cocozza et al. 1978). Mental patients with no arrests prior to hospitalization were arrested about as often as the general population. It was also determined that the rates of arrest for ex-patients had increased between 1968 and 1975. For our purposes, the key finding was one which compared our results with a similar study done in the late 1940s in New York State (Brill and Malzberg 1954).

First, it was apparent that, just as there had been an increase in rates of arrest of ex-mental patients between 1968 and 1975, so too had there been a substantial increase between 1948 and 1968. Also, in the Brill and Malzberg sample, those patients with no prior arrests were arrested less often or about as often as the general population. Again, the patients with *multiple prior* arrests produced the large differences between the mental patient and general population overall arrest rates. In attempting to explain why the arrest rates of ex-patients had increased so dramatically from 1946 to 1975, we found that the number of male patients (there were no females in the Brill and Malzberg study) in State mental hospitals who had previously been arrested had nearly tripled in the 30-year period. In 1946, 15 percent of all male patients in New York State mental hospitals had been arrested at some time prior to hospitalization. By 1968, this figure had risen to 32 percent, and by 1975, to 40 percent. Given the relationship between prior and subsequent arrest in any population, it was not surprising that the overall arrest rate of ex-patients had risen.

The more difficult question concerned why the proportion of male patients with arrests had greatly increased. Our hypothesis was that persons who formerly would have gone to jail were now being passed on to State mental hospitals, in part because of the increasing overcrowding of prisons and jails, while the deinstitutionalization of State mental hospitals was making more beds available there. This hypothesis appears to conflict directly with most of the observations expressed at the workshop about the current relationships between jails and mental hospitals.

Put another way, when I hear the repeated claim that jails have more mental health problems to contend with and that mental health service providers increasingly avoid the treatment of persons charged with or convicted of crimes, I wonder how this can be true if more and more persons in mental hospitals have previously been arrested. But it is not enough for the corrections person to say "Believe me, I know".

There is little, if any, information on which to assess how it is that different trends perceived by each system's personnel are occuring. Are more mental patients criminals and more criminals mentally ill because of some consistent fundamental reason? Who are the people who pingpong back and forth between the two systems? How are the processes of transfer or refused transfer between the criminal justice and mental health systems operating? These difficult and unwieldy questions require substantial specification in order to become manageable research projects. Nevertheless, clarification of the interrelationships between the criminal justice and mental health systems on local, State, and regional levels is badly needed for a basic understanding of recurring problems and shifting responsibilities between the two systems.

The Impact of Changing Mental Health Legislation on Jails

One of the dominant topics in the deliberations of this workshop was the impact on the local jail of more restrictive involuntary civil commitment standards. Since the landmark 1969 revision of the California mental health code, most revisions of mental health commitment statutes have been more restrictive and more dependent on explicit demonstrations of a person's dangerousness to self or others. Arguably, the result is that more mentally ill persons who display nuisance behavior are being booked and detained in jail. The corrections staff feel these persons are in need of treatment and belong in a mental hospital; they disturb the jail's routine and, perhaps, further exacerbate their own mental problems (Abramson 1972). A contrary view has also been argued; Monahan (1973) notes that many deviant acts which were simply nuisance behavior had for many years resulted in *inappropriate* mental hospitalizations for persons without serious or treatable mental illness because mental institutions were the easiest way to remove the persons from the community. The criminal procedures provided more adequate due process protections and led to jail detention.

Those views again represent at least two different ideas of evolving relationships between the mental health and criminal justice system, each with a different interpretation of the impact of recent legal changes on the jail and its programs. In fact, little is known about the actual impact of the various legal changes either on the mental health or the criminal justice systems and their various policies and programs. In some useful analyses (e.g., Kittrie 1971), statutory histories are traced, but precise data on changes within the two systems are sketchy. Research in a variety of settings would elucidate what happens in local jails as a result of mental health and criminal statutory changes. Their impact on huge metropolitan areas, such as New York City or Los Angeles, are probably not the same as in less populous urban areas or in rural locales. Even within the same State, there may be remarkable differences.

The Impact of Judicial Rulings and National Health Standards

Another area relating to the overall relationships between the criminal justice system and mental health services is the impact of various Federal and State court rulings and the development of national standards for health services in jails. A conference discussion led by Harris (1978) examined the impact of judicial decisions in four jurisdictions. She concluded that the main direct effects were decreased jail brutality and less inappropriate punishment. However, she felt that the experience in these four jurisdictions provided no support for the belief that the courts could be expected to be sources of needed social change. These findings are similar to those of Leaf (1976) on the impact of the *Wyatt* v. *Stickney* decision on State mental hospitals in Alabama. Leaf concluded that the few improvements were more limited than might have been anticipated by the comprehensiveness and specificity of the judicial guidelines. Thus, the actual impact on mental health services in jails that local and Federal court decisions may have had remains unclear; it has been more limited than often presumed. It becomes important, then, to determine the circumstances in which greater or lesser changes occur and what these changes are.

Another type of promulgation whose effects on mental health service remain unknown are the quality-of-care standards, such as those pertaining to mental health services prepared by the American Medical Association. Such standards are often closely related to judicial decisions, since the courts may rely upon existing stand-

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ards established by various professional groups (at least until *Bell* v. *Wolfish*). The development of such guidelines are thought to be beneficial since jails may then have standards which provide a rationale for program development and related fiscal resources. Because little is known about the real effects of such standards in any context, the use of such standards in litigation by mental health advocates may ultimately result in as much aggravation to the jails as benefit. Of course, the jail's personnel could encourage challenges by various legal aid groups to force the development of programs. Regardless, with the variety of possible positive and negative effects that judicial interventions and national program standards may have, it would be productive to begin developing precise data on the various impacts on jail programs.

Referral Process

A third research question on the relationships between the mental health and criminal justice systems relates to understanding the entry and exit processes between the two systems. There is no systematic information available about the volume or types of referrals. Equally important is the compilation of information on who is rejected for mental health services or jail detention, under what circumstances, and for what reasons. Surely, inmates who attempt suicide merit mental health service responses. It is also clear that many, if not most, mental health facilities are reluctant, or explicitly refuse, to accept persons with outstanding criminal charges. Documentation of actual referral and refusal patterns in various jurisdictions is needed, along with specification of the characteristics of the inmates accepted and refused, the characteristics of the agencies involved, and the dynamics of decisionmaking at these key points.

A central focus of any research on referral processes must be the police officer. Despite assertions to the contrary by some conference participants, little is known about police decisions in the street and shortly after arrest which result in a person being taken to a mental health facility rather than jail. Although Bittner (1967), Rock (1968), and Snibbe (1973) provided data about the relationship between the police and mental health services, there has yet to be systematic information on the patrol officer's day-to-day decisionmaking about the use or nonuse of mental health services or diversions for the arrestee or the potential arrestee. There is a need for systematic knowledge about the processes by which the

patrol officer reaches decisions about the handling of various types of violent, bizarre, or nuisance persons (believed to be mentally ill) in varying jurisdictions and under different conditions. Too little attention is paid to the needs and requirements of the criminal justice system and of its components, viz., jails, and the working definitions of the key gatekeepers; the attention has been concentrated on the problems of persons already being processed in the system. Until research also undertakes a comprehensive analysis of the key decisions made by the police officer on the street, the formulation of coherent policies and practices will necessarily be delayed.

Correction Officer Practices and Needs

Brodsky (chapter 6) noted that "for all practical purposes no useful scholarly information is available on jail personnel." Such a gap is a critical one, given the importance jail personnel have for identifying mental health service needs, as well as causing or exacerbating these needs. That the jail environment may produce stress associated with conditions requiring mental health interventions is well accepted. It is surprising that so little attention has been devoted to the possible negative effects of this same environment as a work setting for jail personnel. If the jail's impact on the inmate brings out latent problems, why should it not *also* be expected to do the same for those for whom it is a work environment?

For whom, under what circumstances, and to what degree are jails bad work environments? These issues become crucial when addressing policy concerns about the selection and training of correctional officers. The majority opinion at this workshop seemed to be that the selection process was more crucial than training, since no amount of training leads to a significant improvement in persons who were fundamentally ill-equipped to be correction officers. However, as Brodsky noted in his discussion, the question of selection comes down to: "We want a good ———— for correction officers," but we do not know how to fill in the blank. Also, because little research exists about jailer selection, such criteria cannot be adequately formulated, and indicators of successful job performance are also insufficiently developed. Brodsky (chapter 6) offers a number of specific suggestions for research in this area which would be positive first steps. As one workship participant suggested, maybe "non-normals" make the best correction officers. If this were the case, tests that screen out marginal personalities of one type or another might actually provide disservice to the mental

health of both inmates and correction officers. In any event, research priorities should be focused on the selection of correction officers, with only secondary emphasis given to designing and implementing training programs.

Goals/Effects of Mental Health Treatment in Jails

Various depictions of the functions of jails were offered during this workshop, such as "the jail as a public health outpost" and "jails providing what [services] the community does not." Mental health services to jails were seen as ranging from simply "meeting the needs of inmates" to "inmate management through mental health services."

A fundamental research need is to determine what the various groups see as the responsibilities of jails and the manner in which mental health services can be absorbed into the various models that communities may have for their jails. In other words, before anyone can assess the effectiveness of a jail program, mental health or otherwise, the criteria for a successful program must be specified. It may be that the goals of jails vary from place to place; similarly, what is defined as "mental health service needs" may also vary. On the other hand, the development of national standards alluded to above suggests that there may be some basic service obligations that any inmate population can expect in any jail.

An examination of community attitudes toward jails might provide indications of which mental health programs are likely to receive community support and the methods by which such programs might be sold to the public. The issue of community resistances was raised during this conference, for example, the question, "how much service is owed to inmates?" Depending on the notion of the purpose and goals of jails, differing responses would result.

In essence, it is one thing to bring together a group of respected correctional and mental health professionals and to suggest what mental health programs are needed. It is quite another matter to implement these programs in the face of frequent public opposition and outright hostility emanating from the community perception that convicted offenders are getting more services than the public at large. Survey information on the attitudes of the public, professionals, correctional practitioners, and politicians would help to address these difficult issues.

Another research issue concerns the role of jail mental health services in the reduction of later violence and other crimes. Newman and Price observed that "jails hold those who society

fears most (whether realistically or not), and jails are expected to return them as less fearsome" (1977:502). Similarly, there appears to be an expectation on the part of jail personnel that mental health services help decrease violence in jails. Petrich (1976) reported that almost one-quarter of all referrals for mental health services were for individuals described as violent. Likewise, Brodsky (chapter 6) observed that "when confined persons become delusional, *violent,* incoherent, or *otherwise seriously mentally disordered,* they may be taken to a local hospital or mental health center" [emphasis added]. The implicit link here between perceived need for mental health services and the reduction of violence in the jail and in the community is clear.

The public looks to jails and other correctional facilities to reduce the probability of future crime, especially violent crime; similarly, jailers look to mental health services to help reduce violence in jails. At this time, neither expectation has much basis in fact. First, psychiatric interventions do not treat criminal recidivism or violence per se. Rather, treatment is geared to specific psychiatric symptomatology which may not be related to criminal recidivism or which may actually increase it. For example, if an inmate is habitually involved in crimes of economic gain, through mental health treatment he may become a better functioning person and thereby a more competent criminal who is arrested less often and thus precipitates more crime. In short, the relationships between mental illness and mental health treatment in jails as far as reducing either violence in the jails or violent or other criminal recidivism are unclear, requiring much research.

The Dynamics of Program Development

The final content area of this research agenda focuses on the processes by which mental health service programs are developed and implemented: What works, for whom, under what circumstances, and how is it set up? To assess what works or how well something works, there must be some criterion against which success can be measured. Assuming the possibility of some consensus on what good programs are, research could determine how such programs are set up, made operational, and effectively maintained. These issues focus on questions of organizational development and administration. While Megargee (chapter 5) and Brodsky (chapter 6), for example, discuss programs that might be profitably implemented in any jail, systematic information about which programs would be useful for which types of communities and how locales

with varying needs and resources can go about establishing these and other programs is still lacking. There may be a wealth of sound advice available, as indicated by the workshop panel on "Service Delivery Models," but it has yet to be systematically collected and distilled. Such data are essential to prevent the continual reinvention of the wheel. Also, many worthwhile programs are established, run their course, and are terminated, some by choice, others by exigencies. Research should be geared to the development processes and to the maintenance and termination processes.

Role of Volunteers

One specific question about program development and maintenance that repeatedly arose during this conference was the role of volunteers in jail mental health programs. Although many successful programs rely heavily on volunteers, there is no systematic information abut the types of programs which make use of volunteers, the types of persons who provide specific types of services, and the costs and benefits of each type of service provision.

The Location of Services

Related to program implementation and development are questions about the optimum location of mental health programs intramurally, extramurally, or in what combination. On one side, are those such as Dr. Alan Stone, past President of the American Psychiatric Association, who recommended that " . . . prisoners should be given Medicaid and allowed to seek whatever medical help that they want outside the institution" (1978:8). On the other side, there are the programs described at this conference in which a full range of mental health services have been developed *within* the jail system, such as in the massive jails in New York City and Los Angeles. The research questions should determine what are the most efficacious and cost-effective programs, for what types of facilities, and under what conditions. As yet there is minimum information about what programs exist, although Morgan's work (chapter 3) is a giant first step. However, there are no systematic analyses about optimum arrangements for various types of jails.

Needs Assessments

In part, the answers to the above questions demand more information of the type reviewed by Gibbs (chapter 2), Brodsky (chapter 6), and Gove (chapter 8). This information focuses on the kinds and distributions of mental health problems of jail inmates. The available knowledge about the mental health needs of jail inmates is so rudimentary that it is difficult to develop suitable program models. A crucial first step in this area is further research on the distribution of specific psychiatric symptomatologies and on broader mental health problems, such as the impact of the jail environment on inmate and staff functioning. One outcome of comprehensive and detailed needs assessments may be an increased realization of the limited number of jail problems that mental health services can actually be expected to ameliorate.

Impact of Mental Health Services on Jail Organization

Another area of program development characterized by inadequate information is the uncertain effect of mental health programs on jail organization. That is, in what ways is the day-to-day routine of jails affected by the presence of mental health service programs? Clearly, when such programs are developed, different personnel are involved, and the usual routines of the jail are affected. If comprehensive service programs are developed within the jail, inmates who might previously have been transferred to medical or psychiatric inpatient facilities will remain in the jail's general or special population sections. On the other hand, the development of mental health services may result in the referral of inmates, either on an outpatient or inpatient basis, to mental health services outside the jail, thus removing them from the jail population. We lack knowledge about the impact such changes in jail personnel and inmate populations may have on the operations of these facilities.

Effects on Receiving Mental Health Services

Another important aspect of the effects of mental health treatment is at the individual level: What is the impact on the inmate of being labeled mentally ill or receiving psychiatric treatment? First, what is the effect on the inmate's day-to-day interactions with other inmates and correction officers, and how might the changes in the interactions have an impact on his/her mental

health? Second, what is the impact of being so labeled on the term of incarceration? While these questions have been looked at in the circumstance of pretrial incompetency diversions (Steadman 1979), there is no information on whether receiving mental health treatment in jails actually increases or decreases detention time. Specifically, what kinds of treatments seem to work best for which inmates and in which types of jails?

Some hypotheses about being labeled mentally ill in jail flow directly from the labeling theory discussed by Gove (chapter 8). In addition, there may be other considerations crucial to an inmate who is trying to make decisions about whether to participate in a treatment program. The inmate may wish to know what consequences his involvement in treatment will have on the time he spends in jail. At present there is no clear answer to such questions.

Research Methodologies

Cohort Studies

A general strategy that is especially adapted both to the questions of the overall relationships between the jails and mental health services and to the effects of mental health treatment programs in jails is that of cohort studies. Large groups of persons are selected for study, and their paths through the criminal justice and mental health systems are tracked for many years, either prospectively or retrospectively. Both strategies would be productive, the retrospective analysis being able to generate more quickly working data about the flow of inmates back and forth between mental health and jail facilities.

Currently, it is unclear what the careers of jail inmates are in terms of receiving voluntarily or involuntarily mental health treatment, particularly in State mental hospitals or outpatient programs, and how these experiences relate to their patterns of criminal activity and incarceration histories. To begin demarcating the working relationships and changing responsibilities of mental health and correctional agencies, it is essential that longitudinal studies of large groups of different types of inmates in different types of environments be undertaken. Less is gained by selecting a group of inmates at a specific time and describing what percentage have formerly received treatment and how many have been in State mental hospitals, thus concluding that many inmates are

appropriate candidates for mental hospitalization. It is necessary to know all those persons who have been at one time or other in the various detention and treatment programs, why some stay in, filter out, or circulate back and forth, and why and how these phenomena occur. Cohort studies are a primary way of obtaining the answers.

Control Groups

A second research endeavor is the use of control groups. For example, when a study of attempted or successful suicides shows that two-thirds were actively using alcohol or drugs on admission, and three-quarters were between the ages of 21 and 30, an inclination might be to institute some type of special precautions for persons admitted to the jail who fall into this group. However, if two-thirds of the entire inmate population are abusing alcohol or drugs on admission and if three-quarters of all inmates are between 21 and 30, then the characteristics of the suicidal group are not at all indicative of any tendencies toward suicide, and any suicide watch program instituted on such criteria would be wasteful.

In studies to ascertain the characteristics of any high- or low-risk groups for any types of special screening or related programs, it is essential to have control groups with which the inmates of potential programmatic concern may be compared. Without such comparative data, much program money is wasted.

A Major Research Limitation

Regardless of the research methods chosen or the issues being studied, a major consideration in any research agenda for jails is the Federal and other guidelines on the use of human subjects in research. Prisoners have been designated as a "special" group, viz., as being vulnerable to exploitation. There has been concern about possible abuses centering on the use of prison inmates for drug studies. Jails, per se, have not been mentioned in the critical reviews of research practices in penal facilities. Nevertheless, the current regulations, restricting the types of research and detailing the guidelines that must be followed, place certain restrictions on the kinds of research programs that may be conducted. For example, it is essential to obtain the informed consent of the research

subjects, to avoid coercive influences, and to safeguard confidentiality (see, e.g., Code of Federal Regulations 1978).

A key distinction is that between research and program evaluation. Generally, program evaluation is the collection of systematic data for administrative decisionmaking about the operation of an ongoing or pilot program. As long as such data collection is geared toward developing an information base about program operations for direct decisionmaking, most proposed or current Federal research regulations do not apply. However, when data collection is set up for its own merit, without direct feedback into regularized administrative decisionmaking, it may be defined as research. When this occurs, a series of regulations pertaining to informed consent and voluntary participation must be adhered to. Persons considering the development of any research program should clearly define the work to be done in the context of existing and proposed Federal research and privacy regulations, lest ethical and legal liability and problems arise.

Conclusion

The research agenda outlined here is intended to provide program administrators with basic information to develop appropriate mental health programs. The first step is to determine the actual relationships between the criminal justice and mental health systems. It is then possible to move toward framing and answering the other questions about mental health service to jails.

After this first matter of business, the other issues surrounding needed information about jail staff (i.e., selection, training, and program needs), the goals and effects of jail mental health services, and the processes of effective program development and implementation, can be addressed appropriately. Among the more productive ways in which they may be addressed are cohort studies, whether the cohorts be composed of inmates being processed through the respective systems or of jail mental health programs. The use of control groups in the research designs is another important need.

In laying out these priority areas for research, the focus has been on large problem areas rather than specific questions. It would seem more beneficial to establish priority areas, within which the interests of individual researchers and the needs of given agencies or regions could be merged, and to establish specific projects which would offer mutual benefit. In this manner, projects would be developed which would have the "show me" and "we want action"

components alluded to above. From the vantage point of the Federal agencies, then, it seems advisable to list generic problem areas that suggest high yield as guidelines for practitioners and researchers, leaving to them the specification of particular research questions.

While the information presented in this workshop by jail administrators and by mental health service providers offered a convincing case for the need for innovative mental health services, more information is needed before one can realistically expect public or legislative support. Also, more effort, such as this workshop, is needed to build a sound data base for rational program development that avoids past errors and is cost effective. The research agenda proposed here is geared to such goals. On the one hand, the crisis atmosphere communicated persuasively at the workshop may be nothing more than a cry for minor reorganization of existing programs and statutes. On the other hand, this crisis may require broad modifications of jails and community and State mental health services in order to deal with the many individuals who need, but are not receiving, mental health services. To address these important needs, the jailer, the researcher, and the Federal funding agencies must work in close collaboration.

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CHAPTER 11

Workshop Themes and Subsequent Activities

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Issues and Recommendations Generated by the Workshop

The papers contributed to the Special National Workshop agree that there is much to be done to improve mental health services in local jails and, more generally, to improve conditions surrounding pretrial confinement and short-term sentences. Specifically, it was noted that:

1. Regularized and systematic key information about jail inmates, staff, and programs is sorely needed.
2. Some jails have surmounted the customary fiscal and personnel constraints to initiate and maintain mental health service delivery programs.
3. Where such programs exist, process and outcome evaluations are rarely pursued.
4. Such program evaluation information is highly desirable, not simply to ascertain and improve program effectiveness but also to provide technical assistance to others seeking to develop or to improve similar programs.

The above points of fundamental agreement should not overshadow some major tensions and inconsistencies that also surfaced at the workshop. Among the major sources of tension reflected in participant comments were some basic differences in views and perspectives about such roles as:

1. Government level—Federal/State/Local.
2. Academic/Practitioner.
3. Corrections/Mental Health.
4. Research/Action.
5. Constitutional Rights/Agency Procedure/Professional Duty.

Such differing perspectives and tensions are valuable insofar as they help to raise important issues, clarify differing perspectives on

major needs and problems, and lead toward resolution of the differences. Typically, however, such tensions and conflicts tend to inhibit successful program development. Nevertheless, the Special National Workshop moved beyond mere descriptions of the forces inhibiting cooperation and progressed to an understanding of the issues and even some positive resolution of differences.

What follows is a summary of some of the major outcomes and recommendations resulting from this workshop. Consensus regarding conclusions or future actions was generally apparent in the following areas: (1) local communication and information sharing; (2) jail mental health program teams; (3) training roles; (4) interagency cooperation; and (5) research needs.

Local Communication and Information Sharing

A major goal of the workshop was simply to bring together persons from different professions, disciplines, and agency affiliations in order to share information, to clarify issues, and to identify feasible next steps. This goal was most satisfactorily achieved. In fact, a frequent comment in the open-ended section of the workshop evaluation was that the interaction with other professionals and the opportunity to learn about what was going on around the country were among the most valued activities of the workshop. In particular, representatives from the seven programs identified by Morgan were beseiged with requests for additional information about their programs. This, in turn, led some to suggest that the service delivery programs should have been offered as the very first or principal agenda item and that the other topics could have been integrated into the agenda as responses to these programs. In any event, the information about the evolution and operation of specific service delivery programs was in demand, addressed an important need, and was well received.

Jail Mental Health Program Teams

An important suggestion was to use the experiences of the seven specific programs described by Morgan and of others that came to light. It was recommended that regional workshops, similar to the Special National Workshop, be held in other parts of the country. It was also recommended that future workshops should include teams of community members representing the jail, the mental health agency, and local government managers, executives, or judicial officials. Subsequent experience with regional workshops (see

pp. 209–210) indicated that the team concept is an important component for developing local action plans and for initiating or improving mental health services in jails.

The team concept was important in three respects. First, it facilitated communication among team members from the same community and among similar professionals across communities. Second, it helped keep specific issues in sharp focus, since team members contributed first-hand information about different approaches or procedures, and other members were their own best critics. Moreover, articulation of perspectives on specific needs or issues brought out agreement or disagreement. Although agreement does not necessarily create solutions, it does foster a working consensus about operationalizing major program objectives. Where disagreements exist, they, too, are important as an indication of differing information and/or perspectives, rather than simply differences of opinion. Third, an interdisciplinary team can probably be formed in many communities without adding new positions or budgeting additional personnel funds. Instead, reallocations or contributions of time to specific mental health training or service delivery functions in the jail may be enough to initiate a program. Although this strategy has the problem of robbing Peter to pay Paul, it nevertheless reflects a practical solution to inevitably difficult trade-offs that increasingly occur in regard to scarce or even shrinking public funds.

Training Roles

Depending upon a jurisdiction's specific needs, the provision of training to jail personnel by mental health professionals can significantly increase the jail staff's resources for improving the adequacy of mental health services. Teams such as described above can develop training for jail staff to recognize emotional disturbances, screen and evaluate jail admissions, communicate relevant information to mental health professionals, handle emergency situations like suicide or self-mutilation attempts, and deal humanely with severely disturbed or violent persons.

Additionally, mental health professionals on such teams may also assist in identifying those specific conditions within a jail that appear to contribute to the tension and stress felt by inmates and staff alike. Where some of these conditions (for example, crowding, noise) may be impossible for jail officials to control, the mental health professionals and agencies can be effective allies and partners for improving them (for example, providing testimony about

the mental health ramifications of such conditions). Where conditions in the jail can be controlled (for example, social isolation, lack of meaningful activity, sanitary and nutritional problems, access to sick call and to legal case status information, etc.), the mental health professionals may be able to identify and suggest *prevention-oriented* changes that help to reduce tensions and stresses without compromising security.

It is important to note that none of the above-mentioned activities necessarily entails new positions or direct service delivery by mental health professionals. Thus, there are a number of activities that multiprofession teams can accomplish without requiring positions or additional funds.

Interagency Cooperation

Another issue raised at the workshop was the difficulty of initiating and sustaining cooperation among mental health and correctional agencies. Traditionally, these linkages have been difficult to develop. However, as indicated by the effective collaboration of the three Federal agencies (representing criminal justice, corrections, and mental health perspectives) in planning and sponsoring the workshop, such collaboration is possible. Further, as indicated by one of the seven programs highlighted by Morgan (chapter 3), cooperative activity has been developed by State-level departments of mental health and corrections in Michigan. More recently, similar activity has been taking place in Pennsylvania and in Oregon; other local programs, in addition to those identified by Morgan, have also been initiated.

Since the level of cooperation at all these levels of government may ebb and flow with the passage of time, with changes in available resources, or with changes in key public officials, once initiated, cooperative activity should not be left to chance or to gentlemen's agreements. Instead, the operation of cooperative programs is facilitated by formalized agreements on the overall principles of the joint activity as well as operating policies and procedures. These latter specifics are necessary because, in all but the smallest communities, the persons responsible for developing the broad parameters of the cooperative agreements are not typically the ones who carry out the many day-to-day tasks and activities (e.g., screening, training, emergency treatment, or transfer). And, since occupational practices and perspectives tend to differ between mental health and corrections, forethought and specific guidance in regard to operational problems are both necessary and beneficial.

Two other insights concerning team activity and formal agreements emerged from the discussions and recommendations. Programs which seemed, at least in the views of their advocates, to be most successful were those implemented from the top down. In other words, the commitment of agency or organizational leaders to the cooperative programs needed to be present and clearly communiciated throughout the organizations involved. Another insight was the influence, particularly in smaller jurisdictions, that a single individual could have in identifying areas of cooperative activity and in launching a program. Often, the key support for such cooperative programs is alleged to rest with local judges who have control over bail or other pretrial release decisions, and over emergency or involutary commitment proceedings or transfer hearings. Another example regarding the key role of certain individuals is that the initial stimulus for the development of at least three of the seven programs described by Morgan came from energetic and concerned local or State officials.

Research Directions

The workshop also emphasized a need for more reliable, detailed, and rigorously compiled information about jail mental health needs, program operations, and program effects. Although Gottfredson and Steadman attribute this need to the absence of research on jails per se and on community mental health systems, there are three additional themes that emerged in regard to research: (1) clearer conceptualization; (2) basic epidemiological information; and (3) program evaluation.

The first theme is the importance of *clear conceptualization* of the problem. Participants throughout the workshop used differing definitions of terms, such as "mental health" or "mental health problems." There was general agreement, especially among the researchers, that unless there were a clear conceptualization and understanding of the nature of the problem, it would not be possible to do an adequate job of defining variables of interest, devising appropriate data collection instruments, conducting meaningful research, or devising appropriate programs. Practitioners, however, considered the definitions of mental health and the diagnosis of mental disorders as less important than information designed to aid program development. Yet, how one defines the issues and estimates their magnitude influences decisions regarding program development. Therefore, conflicting definitions from various professional perspectives serve to sharpen differences in operations both

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within and among programs. Lack of consistent definitions of mental health needs by criminal justice and mental health practitioners may lead to inappropriate, inefficient, and ineffective services for clients.

On the other hand, the looseness of definitions has various implications for research. First, variation in definitions and perspectives implies variation in underlying conditions and operation of mental health service programs in jails. The sources and consequences of that variation have important research and program implications. Why, for example, is program A best suited to jurisdiction X, whereas program B is best suited to jurisdiction Y? Would jurisdiction Z be better off if it adopted program C rather than D? The same variation also implies that standardization, in the sense of uniformly applied mental health definitions, classifications, and service program evaluation criteria, is extraordinarily difficult to implement. Researchers, for example, would be unable to provide step-by-step rules or criteria for the development and implementation of mental health service delivery models applicable to a wide range of communities and programs.

A second research theme which emerged from the workshop was the importance of obtaining *basic epidemiological information* on factors such as the extent of mental health problems and the persons included in the target population. Workshop participants generally held divergent views on who requires services and the types of services needed. For example, the panel describing intervention models noted that few services are provided for jailed women. However, some practitioners argued that all services provided for men are available to women as well. This discrepancy means that additional basic data must be obtained which indicate the extent and types of problems faced by incarcerated offenders of both sexes. At a minimum, additional data must be collected regarding the proportion of jailed populations of both sexes that is suicidal, depressed, or dangerously mentally ill, and the types of service needed.

The third research theme was the importance of *evaluation research.* Workshop participants acknowledged a need to conduct careful assessments of programs already in operation. Researchers further indicated a need to set up experimental programs, monitor them closely, and determine their efficiency and effectiveness over time. For example, many participants suggested that it may be impossible for small rural jails to expend limited resources on elaborate mental health programs. However, training programs which enable staff to learn to screen and identify mental health problems themselves could more feasibly be established, implemented, and evaluated in selected jurisdictions. Although local agency participants preferred the experiential aspects of the workshop to the theoretical (as might well be expected), these same participants were among the first to support the crucial role that even simple facts and figures about program operations and their role in jail management played in supporting and justifying future efforts. With respect to this last point, as Steadman pointed out, *research* then becomes a vehicle for *informed action* and thus has meaning and value for both practitioners and researchers. Researchers obtain clearer insights and understanding about the nature and extent of mental health problems of jailed offenders; practitioners learn more about the conditions under which certain types of programs may benefit certain offender groups over others. In the long run, this knowledge assists in the development of more effective and efficient mental health services.

All in all, the definition and importance of research issues were sharpened and focused by the interactions and reflections of participants. The Gottfredson and Steadman chapters ably highlight specific issues. But equally as important, the workshop interactions led to reinforcing (as one planning group member wrote on debriefing) "the concern that researchers must be sensitive to the needs of the local jail planners and practitioners in their efforts. The way in which research in jails is conducted must be structured carefully. Researchers should attempt to involve local practitioners in the process and to provide research results periodically which will assist jail personnel in their day-to-day operations."[1]

Summary

The Special National Workshop occurred during a period when momentum for improving jails and local mental health systems was sparked by broader events. In 1977, the National Institute of Corrections (NIC) opened its Jail Programs Center in Boulder, Colo., to provide technical assistance to State and local officials. NIC also identified six jails around the country as regional Area Resource Center jails, at which technical assistance was provided to local officials. (By 1981, the number had grown to 12.) The President's Commission on Mental Health was created in 1978 and began its broad series of investigations into all facets of mental health services in the country. The National Coalition for Jail Reform, a broad-based group of 28 national organizations, was formed to lobby for the improvement of local jails; the Coalition articulated a policy preference for removing the mentally ill from

jail. And the General Accounting Office (GAO) undertook companion studies to investigate the Federal role in providing assistance for mental health problems in prisons and in local jails. Not all of these events preceded the workshop, but they did form the general climate in which the workshop was developed and in which various followup activities specifically related to the workshop occurred.

Although none of the events mentioned above, including the workshop, has dramatically changed the overall characterization of jail conditions as described throughout this monograph, their momentum has stimulated additional Federally sponsored activities. Before describing these activities in the next section, it is important to point out that the three sponsoring agencies were able to formulate them within the context of the consensus achieved in the areas discussed above. For example, the identification of research needs was valuable because, first, the workshop discussions and interchange clarified specific issues for further research development and support. Two such issues are: (1) What is the relationship between prior mental health system and/or justice system contact and the current contact? and (2) what effect does the existence or implementation of a jail mental health program have on jail security issues or on the institutional climate? Second, since a variety of disciplines contributed to the identification of issues, the funding agencies and research users (i.e., local jail and mental health agency officials) could then have have more confidence in the direct relevance of subsequently sponsored research.

Another important result in guiding the direction of the followup activities was the compilation of pragmatic "how-to" information regarding the actual operation of various programs. By accumulating such knowledge about existing service delivery programs, it is possible to develop new program models. That is, selected elements from one or more programs may be combined or integrated into program models which seem most appropriate for other populations or settings. These models may also be tested, refined, and disseminated on a larger scale. In addition, such program information also serves to defuse arguments that "it can't be done" or "it can't be done here." If resistance persists despite the positive experiences in other jurisdictions, it may indicate that jail or community conditions are not primarily responsible for continued inaction.

In sum, the sponsoring agencies have benefited from the workshop by the development and refinement of those issues that are sufficiently important and relevant to warrant the expense of more rigorous scientific inquiry. At the same time, the more immediate program development needs can be modestly addressed by pointing to a number of programs that have developed in spite of or in

response to the usually articulated reasons for not having such programs.

Subsequent Activities

One of the major recommendations of the workshop was to have regional meetings presenting a curriculum similar to the workshop but involving teams of participants representing local jurisdictions. This recommendation was based on evidence of the need for local interagency cooperation and collaboration in developing mental health services. Under sponsorship of the National Institute of Corrections, Morgan developed and conducted a training project entitled "Initiating and Improving Mental Health Services in Local Jails." Three 3-day training programs were conducted in the fall of 1979 in different regions of the country (Georgia, Massachusetts, and Colorado). Each training workshop involved teams of participants from several jurisdictions representing the jail, the community mental health agency, and municipal government or judiciary. In all, 36 local jurisdictions were represented by approximately 100 participants. The only condition of participation was that a jurisdiction's team members had to have met at least once before the training program and to have toured each other's facilities to learn about the respective programs. The regional meetings involved lectures and discussions from some of the Special National Workshop participants and other training materials. Small group sessions were also included to identify and examine the sources of existing and potential differences, such as those identified earlier in this chapter. The final day was devoted entirely to the development and criticism of team action agendas for initiating or improving mental health services in each of the local jurisdictions represented. These action agendas were plans which the team members agreed to implement over the next 12-month period.

Federal collaboration was continued in regard to the regional training program. The NIMH Center for Studies of Crime and Delinquency contributed staff time to provide technical assistance to the training program and to develop and implement the initial phase of an evaluation design regarding implementation of team action agendas. One of the co-authors (Dunn) attended the three regional programs and administered a baseline instrument designed to (1) elicit participant attitudes and opinions regarding correctional policy, correctional change, and mental health; and (2) record participant and jurisdictional background data. A first anal-

ysis of these Time I data has been prepared and presented.[2] Further implementation of the evaluation design (i.e., community followup to ascertain implementation of the action agendas) is currently in progress.[3] Finally, the NIMH Center for Studies of Crime and Delinquency is sponsoring research to continue jail/mental health agency investigations in 32 local jurisdictions that participated in the regional workshops, as well as in a comparison sample of communities who did not.[4]

Related research has been independently supported by the National Institute of Justice. Two projects are specifically concerned with the movement of corrections populations between the mental health and correctional systems. Interest in this issue arose in part from the observations by many local agencies that an increasing number of people coming into jails have histories of prior mental hospitalization or treatment for mental disorders. It is typically alleged that these individuals have been released from mental hospitals and returned to the community where treatment gains made in the institution are lost, relapses occur, and various socially deviant and other problem behaviors result. Consequently, these persons are often arrested for "nuisance" behaviors that may constitute minor offenses.

While nationwide trends of decreasing State mental hospital populations and increasing jail and prison populations lend some support to these general observations, more conclusive evidence will become available once two NIJ-sponsored research projects are completed. In one study, Steadman and Monahan[5] are conducting a national survey of the volume and characteristics of prison-mental health system transfer; compiling a more complete record of the confinement careers of a sample of inmates and mental patients in six States between 1968 and 1978; describing the dynamics of the prison-mental health movement of populations in these six States; describing the related movement of quasi-criminal populations (e.g., pretrial incompetent defendants, insanity defense acquittals); and conducting a legal and policy analysis of key statutes and case law developments with special attention to the six States.

In the other study, Schuerman, Kobrin, and Fry[6] are examining population transfer rates between the mental health and correctional systems for Los Angeles County for the period 1975 to 1978. Their analysis will focus on the proportion of persons in each system with a prior record in the other; trends in the number of individuals in various states of transfer status between one system and the other; policies regarding termination of transfer status; rates of recidivism by offense type for terminated outpatients from

the mental health system; rates of rejection of transferees by the receiving system; policies related to the decriminalization of various offenses and the effect of these on population transfer; and the effect of determinate sentencing statutes on the treatment of a population served simultaneously or alternately by the correctional or mental health system.

A third and related NIJ-sponsored project is examining the current use of psychiatric and psychological assessments by criminal court judges in an effort to determine what kind of mental health information is required by judges to assist in making appropriate judicial decisions. Thus, the Forensic Science Foundation will identify the types of cases in which special psychiatric or psychological assessments are most often requested to help judges make informed decisions; identify those factors that influence judges' decisions to request special psychiatric or psychological case assessments; evaluate the currently used methods of communicating psychiatric information to the court; and determine the extent to which these reports are comprehended and used by judges.[7]

Conclusion

The activities described in this monograph reflect some of the recent efforts by persons in three Federal agencies, in State and local correctional and mental health agencies, and by various concerned citizens to address the serious mental health problems in local jails. At the Federal level, the "next steps" described above are endeavors to identify the size and shape of these basic issues; hence, some of these endeavors involve further research efforts. Other efforts involve continued support to identify and resolve common problems.

The importance of this cooperative and collaborative endeavor is obvious but bears repeating: Not only do we stand to gain a great deal from learning about these important but frequently ignored issues, but also we may gain a great deal in the process of sharing knowledge and resources among agencies at all levels of government. In particular, problems and issues may be assessed from diverse perspectives leading to the development of joint or cooperative initiatives that can provide workable, efficient, and nonduplicative solutions to these major needs.

The modest collaborative effort by the sponsoring Federal agencies will, it is hoped, have a ripple effect on State and local agencies in further efforts to improve mental health services for correc-

tional clients and staff, and to improve those conditions in penal institutions that are psychologically debilitating to both inmates and staff.

This task is neither simple nor easy. It is, nevertheless, an important task for government agencies and concerned citizens. If one mark of a civilized society is the conditions under which wrongdoers are punished, then conditions in this Nation's jails indicate that there is considerably more civilizing to be done.

Footnotes

1. Phyllis Jo Baunach, "The Research Panel, Research and Evaluation Issues; Mental Health Services for Jailed Offenders Conference, Friday, September 29, 1978," Memorandum to Acting Director, NILECJ, October 4, 1978.
2. Dunn, C. S., and Ainslie, S. E. "Strategies for Correctional Reform" Presented at the American Society of Criminology, Philadelphia, Pa., November 1979.
3. The National Institute of Mental Health and the National Institute of Corrections shared equally in the costs of supporting an extension to Carole Morgan's training grant. The extension was for the purpose of (1) providing technical assistance in implementing the team action agendas and (2) providing for an independent evaluation of the implementation activities. That evaluation is being conducted by the Bureau of Special Projects Research, New York State Department of Mental Hygiene, Henry J. Steadman, Ph. D., Director.
4. NIMH Research grant No. 1 R01 MH35241, "Interfacing Local Jails with the Mental Health System," to the New York State Department of Mental Hygiene commenced in January, 1981. This project is a detailed analysis of community support activities associated with mental health service delivery to local jails. The study is being directed by Henry J. Steadman and expands on evaluation work being conducted by Steadman on the initial action plan implementation of the 36 communities that participated in Morgan's training program.
5. Steadman, Henry J. and Monahan, John, *The Movement of Correctional Offender Populations Between Mental Health and Correctional Facilities,* NIJ research grant No. 79-NIAX-0126, Albany, New York: Research Foundation for Mental Hygiene, Inc. 1979
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