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MENTAL HEALTH SERVICES IN AMERICAN JAILS:

A Survey of Innovative Practices

Suzanne M. Morris, M.A., Henry J. Steadman, Ph.D., and Bonita M. Veysey, Ph.D.

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Suzanne M. Morris, M.A., Henry J. Steadman, Ph.D., and Bonita M. Veysey, Ph.D. are with Policy Research Associates, Inc. Requests for reprints may be addressed to Suzanne M. Morris, M.A., Policy Research Associates, Inc., 262 Delaware Avenue, Delmar, New York 12054.

Abstract

This study uses a stratified sample designed to elicit information about policies and practices for managing detainees with mental illnesses in five sizes of jails. The research design involved three phases: (1) a mail survey to a random sampling of all U.S. jails, (2) a follow-up telephone survey to a stratified sample of 100 of the mail survey respondents, and (3) site visits to 10 jails during the final phase of the study. Findings indicate much emphasis in U.S. jails' mental health services on: screening, evaluation and suicide prevention. Also, despite numerous barriers faced by jails in providing treatment for detainees with mental illnesses, many have designed and implemented innovative programs and policies to maximize care to this group using the limited resources available. The observed innovative programs and policies are divided into five core areas so that other jails, using the information provided, can begin to develop a mental health service strategy within their resources.

Introduction

American jail populations are exploding. From 1980 to 1992, the number of persons in jail on any given day in the United States increased from 158,394 to 444,584 (Bureau of Justice Statistics, 1993). In the twelve month period preceding June 1990, there were approximately 10.1 million admissions and 9.9 million releases from jails across the country (Bureau of Justice Statistics, 1991).

Compounding the crowded conditions in American jails is the fact that jail populations include more persons with mental illnesses than ever before. Recent literature emphasizes the increasing reliance of communities on jails as alternatives for inadequate community-based mental health services (Teplin & Pruett, 1992; Torrey, et al., 1992). Most jails, however, are not equipped to appropriately handle the influx of citizens with mental health needs into their facilities. The negative impact of inappropriately incarcerating the mentally ill in facilities which offer inadequate mental health services affects everyone: mentally ill detainees, correctional officers and administrators and the members of the community from which they come and to which they inevitably will return.

There have been many attempts to estimate the prevalence of mental illnesses in jail settings over the past twenty years. In the 18 studies reviewed by Teplin (1990) prevalence rates vary from 5 percent to 63 percent. Not surprisingly, the studies using samples of persons referred for mental health evaluation had the highest incidence, while random samples of detainees tended to reveal lower estimates. In the most carefully designed study of prevalence of mental illnesses among jail detainees, Teplin (1990) found, in a random sample of male jail admissions in Cook County, IL, that 6.1 percent had a current psychotic illness and were in need

of treatment services (L.A. Teplin, personal communication,1993). Among female Cook County detainees, the estimates of mental illness were even higher. As many as 12 percent of the female detainees had current symptoms of schizophrenia or affective disorder (Teplin, personal communication, 1993). On a national level, this would indicate that approximately 700,000 admissions annually to U.S. jails are individuals with acute and severe mental illnesses.

Whether the impetus for providing mental health care to jail detainees stems from a humanitarian or a correctional management viewpoint, jails do have a substantial constitutional obligation to provide minimum care. Custodial facilities have both the duty to protect and the duty to treat a serious medical or psychiatric condition. Case law in this area has defined the extent of these duties as they affect persons with mental illnesses. In addition to cases such as *Estelle v. Gamble, and Bowring v. Godwin* that establish the standards of medical and mental health care, *Langley v. Coughlin* actually provides a list of the specific claims, that, in conjunction with deliberate indifference, indicate constitutionally inadequate mental health care (Cohen & Dvoskin, 1992):

1. Failure to take a complete medical (or psychiatric) record
2. Failure to keep adequate records
3. Failure to respond to inmates' psychiatric history
4. Failure to at least observe inmates suffering a mental health crisis
5. Failure to properly diagnose mental conditions
6. Failure to properly prescribe medications
7. Failure to provide meaningful treatment other than drugs
8. Failure to explain treatment refusal, diagnosis and ending of treatment
9. Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed
10. Personnel doing things for which they are not trained (p.344)[715 F. Supp. at 540-41.]

Clearly, the provision of mental health services to persons with mental illnesses who come into contact with the criminal justice system is not an option, but a constitutional necessity.

Further, the *Langley* checklist indicates that minimum care is quite extensive, requiring screening and identification of serious mental disorders; crisis care; on-going mental health treatment, including the availability of physicians, good record keeping and a range of treatment options; and staff training.

Despite this duty, a study of mental health services in U.S. jails with rated capacities of 50 or more detainees indicated that, while most jails offered at least one mental health service, few jails provided a comprehensive range of services (Steadman, Steadman, & Dennis, in press). More than half of all U.S. jails provided intake screening, nearly half provided mental health evaluations, while only 35 percent provided crisis intervention services, and only 26 percent provided discharge planning. These figures are alarming in light of the clear constitutional obligation of jails to provide a minimum standard of care.

One reason for the shortage of comprehensive services in our nation's jails may be due to a general lack of understanding about how to organize, develop and implement mental health services. The study reported here examined innovative practices used by jails across the U.S. to provide mental health services. These jails varied in size and in the characteristics of the communities to which they belong, and correspondingly, have developed different strategies to provide mental health services. Information gleaned from these innovative policies and procedures may help other jails begin to develop a mental health service strategy within their resources. In this way, U.S. jails may be able to more effectively respond to the needs of the approximately 700,000 individuals admitted each year who suffer from acute and severe mental illnesses.

Methodology

The 1992 National Institute of Justice (NIJ) Research Plan requested proposals for "a national assessment of information, programs, and practices on the management and supervision of mentally disabled offenders by the correctional system." NIJ was particularly interested in discovering the specific special management needs of mentally ill offenders in U.S. jails, the types of programs being used to serve them, the implementation of any policies for supervising this population, and the associated allocation of resources.

In response to that request, this study used a stratified sample designed to elicit information about policies and practices for managing detainees with mental illnesses in five sizes of jails, based on an assumption that jails of different sizes also have different demands, resources, capabilities and strategies for managing detainees with mental illnesses. This is an important distinction, because large jails are more likely to contract for services and to use highly formalized methods of management. In contrast, small jails operating with limited supports often utilize innovative "natural" resources in their communities, such as clergy, volunteer organizations and families.

Our research design involved three phases. The first was a nationwide mail survey to a random sampling of all U.S. jails to determine the percentage of detainees receiving mental health services, the particular services available to these detainees, and the self-rated effectiveness of the jail's mental health services. The second phase of the study was a follow-up telephone survey to a stratified sample of 100 of the mail survey respondents who had assessed their mental health services as "very effective." Based on the mail and telephone data, 10 jails were selected for site visits during the final phase of the study.

The purpose of the mail survey was twofold: (1) to enumerate and describe basic components of jail mental health services, and (2) to identify jail programs from which a sample could be drawn for telephone interviews. For purposes of this study, jails with rated capacities between 20 and 50 were surveyed. Data for larger jails were obtained from a concurrent study using a similar methodology to assess jail diversion programs for the mentally ill in all U.S. jails with rated capacities of 50 or more (Steadman, et al., in press). Since sections of the mail surveys describing basic components of jail mental health services were virtually identical in the two studies, information was drawn from the "diversion" data set and combined with the new survey data from this study.

The mail survey was a one-page document which included items dealing with overall jail mental health program effectiveness, the types of mental health services available, and descriptive characteristics of the jails. The survey was distributed to 1706 jails. The diversion study mailed the survey to all jails with a rated capacity of 50 or more (N=1106) with a return rate of 62 percent. The 600 jails who received the survey through this study were randomly selected from the remaining 2400 jails listed in the American Jail Association's Directory of Jail Administrators, Who's Who in Jail Management (1991) with a return rate of 61 percent. Overall, we received responses from 1053 jails for a 62 percent response rate.

The second phase of the study was a follow-up telephone survey to a stratified sample of 100 of the combined mail survey respondents. Because the primary objective of this study was to identify successful or innovative strategies, the sampling frame for the telephone interviews included only those jails that assessed their mental health services as "very effective." As displayed in Table 1, a stratified sample was drawn from the 149 jails that rated their services

as very effective in order to represent all-sized jails.

Insert Table 1 Here

Data were collected on community linkages, other services available in the community, and any special policies or practices the jails had with the local police, the courts, and/or the local mental health centers. In addition, we asked for overall estimates of how many persons who require mental health services in the community actually get services, and the quality of those services.

All of the 100 jails selected for telephone interviews were contacted. Eighty-seven interviews were successfully completed for a response rate of 87 percent.

Based on the mail and telephone data, jails were stratified by size and 10 were selected as having particularly noteworthy practices, policies or procedures in their management, supervision and treatment of detainees with mental illnesses. Some of the key features we considered to be important reflected core concepts which appeared many times during the course of our telephone interviews, such as "cooperation," "communication," "linkages," "information-sharing," "coordination," "liaison," and "boundary spanners."

All 10 jails, two small (rated capacity of less than 99), two medium (rated capacity of 100-249), three large (rated capacity 250-999), and three mega (rated capacity 1000 and over), were contacted and agreed to participate in the study. Each site visit began with a comprehensive

jail tour followed by interviews with each of the key people involved with the programs and policies which we were investigating. The mean number of interviews we conducted in each facility was seven.

Although we originally set out to investigate an average of three innovative program elements or policies at each site, once there, we found a number of additional program components that warranted study. In all, we examined 49 program elements over the ten sites.

Table 2 lists, with their rated capacities, the ten jails included in the site visits.

Insert Table 2 Here

Results

Responses to the mail survey were received from each of the 51 jurisdictions (50 states and Washington, D.C.) surveyed. A description of the jails surveyed is included in Table 3. The rated capacities of the jails ranged from 13 to 15,592, and the annual bookings ranged from 8 to 250,451. The average percentage of persons receiving mental health services at the time of the survey was estimated to be 7.0 percent. Roughly 84 percent of the jails responding indicated that 10 percent or less of their inmates were receiving mental health services. Fourteen percent of the respondents rated their jail's mental health services as "very effective."

Insert Table 3 Here

One section of the mail survey focused on the availability of specific mental health services to the jail's detainees. The data indicated that there is much emphasis in U.S. jails' mental health services on:

- **Initial Screening** for mental health treatment needs (88% of the respondent jails provided this);
- **Follow-up Evaluations** (provided by 69% of the jails); and,
- **Suicide Prevention** Services (found in 79% of the jails).

Table 4 displays the services provided in the jails according to size. Crisis intervention and psychotropic medications were found to be commonly used methods of treating and managing detainees with mental illnesses -- especially in the larger jails. Overall, more than 50 percent of the jails reported providing these two services. Less commonly used interventions are psychotherapy and special housing units for detainees with mental illnesses. Not surprisingly, this was found to be especially true in the smaller jails. Only 26 percent of the jails surveyed provided discharge planning, indicating a serious need in this area across all-sized jails.

Insert Table 4 Here

In conducting this survey, we were interested in discovering why the jail's mental health services had been rated "very effective." As a means of discovering innovative programs and practices for treating, managing and supervising mentally disordered offenders, telephone

respondents were asked whether or not they had a particularly effective policy or procedure for delivering each of their specific mental health services.

Although there are numerous barriers to providing treatment for detainees with mental illnesses in our nation's jails, we found that many jails have designed and implemented innovative programs and policies to maximize care to this group using the limited resources available. For clarity, we have divided the observed innovative programs and policies into the following core areas: (1) screening, evaluation and classification procedures, (2) crisis intervention and short-term treatment practices, (3) discharge planning mechanisms, (4) court liaison mechanisms, and (5) contracting procedures.

1. Screening, Evaluation and Classification Procedures

A critical first step in the identification of detainees with mental health treatment needs is the initial screening and assessment upon booking into the jail. The most thorough and cost-effective mental health screening process, models of which we found in eight of the 10 jails that we visited, is a **multi-tiered evaluation process**. This particular type of mental health screening and evaluation is that recommended by the American Psychiatric Association's Task Force on Psychiatric Services in Jails and Prisons (1989). It includes (1) initial screening done by the booking officer immediately upon booking into the jail to ascertain suicide potential, mental health history, and current medications, (2) intake mental health screening done by a member of the mental health staff within twenty-four hours of booking, and (3) mental health evaluation completed by appropriately trained mental health professionals in response to referrals made from the screening process, custodial staff, or the detainees themselves. Such evaluations should take place within twenty-four hours of referral.

Multi-tiered screening is both cost effective, because it utilizes line officers and nursing staff during routine activities for the initial stages, and comprehensive, insofar as it is able to identify a large proportion of individuals in need of mental health services who might otherwise be overlooked. A particularly good example of multi-tiered screening was found at the Summit County Jail in Akron, OH. This facility employed a three-tiered approach consisting of (1) an initial mental status exam given to all detainees by a booking officer, (2) a cognitive function exam administered by a mental health worker to all of those found to be in need of further assessment, and (3) a clinical evaluation of all those indicating further need performed by a clinical psychologist. This screening and evaluation procedure highlighted the importance of this stage in the process and was especially reflective of that particular facility's philosophy of making mental health care a "number one priority."

Ensuring an appropriate housing assignment through inmate classification is a continuation of the screening process and is another important area of initial identification and assessment. Although we did find a few programs with innovative classification systems for persons with mental illnesses, only one stressed the importance of ensuring that trained mental health staff are involved in classification decisions for those detainees with mental health treatment needs.

In the Fairfax County (VA) Jail, deputies in the classification department are specially trained in mental health issues and in identifying appropriate referrals to the forensics and substance abuse staffs. In this facility, classification relied on a formal, written policy which involved mental health providers in classification decisions. Responsibility for inmate classification was delegated to an Institutional Classification Committee (ICC). The committee consisted of one representative from each of the following departments in the jail: Diagnostic and

Treatment, Classification and Programs, Confinement, Medical, and Forensics. The committee assigned custody levels to inmates and effected changes in their custody level during confinement whenever necessary. This jail applied objective behavioral classification ideals to all inmates, including persons with mental illnesses. This process allowed persons receiving mental health services to be housed based on their behaviors and abilities, not on their illnesses. The involvement of mental health staff in the decision-making helped to ensure that inmates' mental health status is taken into account and helped immensely with communication.

2. Crisis Intervention and Short-Term Treatment Practices

The need for crisis intervention in the jail setting is quite clear. The manner in which it can best be provided is not. Guidelines for providing this service from the APA's Task Force on Psychiatric Services in Jails and Prisons (1989) include: (1) training to recognize crisis situations, (2) 24-hour availability of mental health professionals to provide evaluations, (3) a special housing area for those requiring medical supervision, and (4) 24-hour availability of a psychiatrist for clinical evaluations and to prescribe emergency medications.

In most of the jails we visited, a high priority was placed on providing crisis intervention services. Examples of what is being done effectively in this area overall were especially evident in three facilities. Two of these employed **crisis intervention specialists** and one had a **crisis intervention team**. All three facilities met or exceeded the APA guidelines. The primary goals of those charged with handling crisis intervention in these facilities, whether a single specialist or a team, was to assess, stabilize as quickly as possible, house appropriately (e.g. into a mental health or special housing unit), and to provide direct mental health services. Clients included

those who were actively psychotic, those at risk of committing suicide, and those under the influence of drugs or alcohol.

The Summit County Jail in Akron, OH reported that having a "Crisis Intervention Specialist" as part of the jail's staff enabled them to speed up the classification process for persons with mental illnesses and to more effectively bring the person's needs to the attention of the mental health staff. In the Jefferson County Jail in Louisville, KY, the "Crisis Intervention Team" received referrals from the corrections staff and helped the detainees cope through the development of problem solving skills. A technician, who was specially trained to intervene in crisis situations, served as the "Crisis Intervention Specialist" for the Shelby County Jail in Memphis, TN. This specialist worked closely with the jail's psychiatrist to provide a variety of mental health services. Having crisis intervention specialists in the jail frees corrections officers from handling difficult situations involving persons with mental health problems and allows for timely and appropriate solutions.

One of the more common crises that jails face in their day-to-day operations are inmate suicides and/or threats of suicide. The Jefferson County Jail in Louisville, KY, designed an innovative policy to respond to potential suicides, called the "Inmate Suicide Watch Program." This formal, written program was implemented, run and staffed by a private contractor, Correctional Medical Systems, in the jail. The program was described as a participatory suicide prevention program with the stated goals of assuring the ongoing safety and well-being of the jail's inmates and promoting teamwork, compassion and a sense of responsibility among the program's participants. Inmate participants assisted correctional officers in achieving the common goal of preventing inmate suicide or self-injury. In two-men teams, inmates

accompanied officers on their rounds each night from 10:30 p.m. to 7:00 a.m., monitoring all inmates, not only those known to be at risk.

The key players in the program were the correctional officers who supervised the inmate observers, the Correctional Medical Services' employee who selected and trained them, and the inmate observers themselves. These "watch inmates," who were volunteers, were selected through a process which was based in part on need in the areas with which they are most familiar (e.g., an inmate assigned to a 6th floor cell would be chosen to patrol the 6th floor). Inmates considered this a desirable position in the jail for which they were compensated with a minor stipend of $3.00 per week, a character reference for the court, and periodic special acts of appreciation and recognition by the jail administration. In preparation for participation in the program, inmates received "a couple of hours" of training on topics such as depression and cues or characteristics associated with suicide (e.g., time frames, etc.). An accompanying inmate handbook also described the program, listed behaviors to watch out for, actions to be taken when risky behavior is observed, and a list of rules entitled "DOs and DON'Ts." Again, this program helped corrections officers to perform their job more efficiently.

Each of the 10 sites visited reported that they were better able to manage and supervise mentally disabled offenders in their jails as a result of having specific positions responsible for handling crisis intervention and short-term treatment.

3. Discharge Planning Mechanisms

The weakest part of all jail programs for detainees with mental illnesses is discharge planning. Most of the programs we visited offered referrals upon release, but were not

aggressive and included little or no follow-up. We found only <u>one</u> especially innovative and comprehensive discharge planning program. The discharge planning at the Fairfax County (VA) Jail was special in that it not only linked detainees with mental health related services upon release, but it also concentrated on maintaining the detainee's family ties while incarcerated. This provided the individual with an additional system of support upon release and most likely contributed to his or her success after release. The services of this particular program were provided by Offender Aid and Restoration (OAR), a twenty-one year old private, non-profit organization located directly across the street from the jail and 90 percent funded by the county.

OAR's professional staff consisted of eight members, all of whom had at least a Bachelor's degree in criminal justice, psychology, or sociology and worked closely with the jail to provide services that would not ordinarily be available. The program's essential elements were:

- interface between the agency and the jail's mental health unit, including an excellent working relationship between the two staffs and weekly meetings with the jail's psychiatrist,
- good communication flow between the judge, the booking staff, the jail's forensic unit, and the agency,
- transportation and housing assistance to persons with mental illness upon release,
- emergency services for those without plans at release,
- volunteers trained to teach, mentor, and tutor educational classes in the facilities and to serve as "guides" at detainee's release,
- teachers - both professional and volunteer - to teach life skills, such as parenting

and preparation for release,

- group therapy for inmates and their families,
- support groups for families and close friends of inmates,
- emergency funds for families for food, clothing, etc. while their providers are in jail.

Discharge planning in this particular facility was provided for every individual. One special, and very important consideration was made for persons with mental illnesses; they worked with the same staff person, a professional, not a volunteer, from intake through discharge. This assumes that every person's special needs can be addressed, not only during incarceration, but afterward as well.

Clearly, discharge planning and follow-up are critical pieces of any jail mental health program. However, most jails believe that their job ends when the detainee leaves the jail. Good discharge planning will attempt to engage released individuals into programs that will help them remain in the community. It is important to realize when planning for more effective jail mental health services that the best programs start planning for discharge during the early stages of the detainee's incarceration and have specific follow-up procedures in place to ensure that any linkage provided upon release is maintained. In the long run, making the effort to provide comprehensive discharge planning will benefit not only the detainee, but the jail and the community as well.

4. Court Liaison Mechanisms

Jails have a symbiotic relationship with the courts. Their interdependence is particularly

relevant for offenders with mental illnesses. All of the sites visited as part of this project had developed, at a minimum, relatively routinized means for ad hoc interactions with the courts to respond to the special needs of detainees with mental illnesses. Furthermore, several had developed specific programs to facilitate interactions between the jails and local courts concerning this inmate population.

The Court Liaison Program in the Pinellas County Jail in Clearwater, FL was staffed by a director, who was based at the Department of Social Services, and a forensic social worker supervisor (Ph.D.), three forensic social workers (M.A.), and a secretary who were based in the jail. The Court Liaison program focused on mentally ill misdemeanants. Staff did not want to send such individuals to a psychiatric hospital as incompetent to stand trial (IST) or not guilty by reason of insanity (NGRI); dispositions which could result in long-term, but unnecessary hospitalization. These individuals may not have had any prior offenses and may have simply exhibited bizarre rather than harmful behavior.

In response, a cooperative agreement was worked out between the District Mental Health Board, the State's Attorney, the Public Defender, and the Judiciary. Under this agreement, the court liaison would go into the jail to identify likely candidates for civil commitment as an alternative to incarceration. After identification and evaluation, the court liaison submitted the inmate's name to the State's Attorney who reviewed the file and agreed to drop the charges if the person was eligible for civil commitment. Alternatively, the court liaison contacted the Public Defender's Office (also alerting the State's Attorney), who filed a motion for transportation to the civil commitment hearing. If the court granted the motion, a court order was written up. Next, the civil commitment hearing was held, arrangements were made for

subsequent placement, the inmate's release papers were processed, and transportation was arranged to bring the individual to the new placement. The court liaison personally walked the papers through the process to expedite matters, notified all relevant individuals, and arranged for continuity of care of these individuals after release.

This program appeared to be an effective response to what has been traditionally a relatively difficult problem for jail staff, namely, how to divert offenders with mental illnesses out of a criminal justice system poorly equipped to respond to mental health needs and into a civil system specifically prepared to address these needs. The use of a court liaison mechanism both facilitates and expedites the ability to move a detainee with mental illness from the jail into a more appropriate treatment setting. The positioning of the court liaison enables him or her to maintain contact with and gain the cooperation of a number of players vital to ensuring that these transfers occur smoothly, that individuals do not fall between the cracks, and that the provision of services is continuous and effective.

5. Contracting Procedures

One of the most commonly mentioned problems facing U.S. jails with regard to detainees with mental illnesses is the lack of adequate resources and staff. Several sites had innovative ways of gaining access to needed services with little or no resources. Two of the sites we visited, Summit County (Akron), OH and Henrico County (Richmond), VA, contracted for psychiatric services with the community psychiatry program at their local medical school. The local medical college's Community Psychiatry rotation included assignments at the county jail. It is important to note that the psychiatrists were not part of a forensic training program, but

rather a community psychiatry program; this implicitly acknowledged that detainees with mental illnesses are a community services responsibility. This type of service contract ensured that trained medical personnel were in the jail on a regular basis, even when the jail could not support a full-time, permanent physician.

We found three of the 10 jails we site visited were contracting for mental health services through a national private care provider such as Correctional Medical Services or Prison Health Services. For example, in the Pinellas County Jail, the private contractor provided the following: (1) mental health services, (2) minimum staffing requirements, (3) professional liability insurance, and (4) medications. A benefit for jails of the privatization model was that, due to the national scope and size of the provider company, resources were available to the jail that they would not otherwise have had. Two of the jails with these contracts also had a **contract monitor** who assured compliance with the terms of the contract, including making sure they maintained accreditation standards and the staffing patterns required by the contract. Overall, the methods we observed jails utilizing to contract for services ensured that needed services were available without having to create an entire program within the jail on limited resources.

Conclusion

No matter how effective mental health diversion of jail detainees may be, there will always be persons with mental illnesses in U.S. jails. Mental health litigation has established the legal right to treatment of individuals in custodial facilities. Mental health services are a constitutional right of pretrial detainees as well as sentenced jail inmates. Despite this fact, at least 20 percent of all U.S. jails have no mental health resources available (Torrey, et al., 1992).

Given that jails have a constitutional duty to provide mental health treatment, as well as the need to provide a secure and safe environment for both staff and inmates, it is in the best interest of all to stabilize and treat detainees with mental illnesses. It is important to underscore the fact that good mental health treatment can actually reduce security risks by minimizing the symptoms of mental illnesses, thereby decreasing potential disruptions to jail routines and procedures and injuries to staff and detainees.

Mental health treatment can involve a number of components and may be provided in several different contexts. The innovative practices examined through this research reflected the experiences of jails of different sizes and various communities. These jails are not the only ones that have developed innovative strategies. In fact, many jails have found unique and creative solutions to these difficult demands. The program components we have highlighted here seem to be widely generalizable and lend themselves to adaptations to local conditions.

Clearly, each jail has its own unique characteristics and needs. There is no <u>one</u> best way to provide mental health services. The policies and procedures utilized by the jails in this study represent promising strategies that can be adapted to individual communities to help all U.S. jails develop mental health services that meet constitutional standards and the needs of the individual jail, its detainees, and its community.

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TABLE 1

JAILS RATING THEIR MENTAL HEALTH SERVICES AS "VERY EFFECTIVE"

	RATED CAPACITY	FREQUENCY	% SELECTED	# SELECTED
"Very Small"	20 - 50	46	66%	30
"Small"	51 - 99	23	66%	15
"Medium"	100 - 249	29	66%	17
"Large"	250 - 999	37	66%	24
"Mega"	1,000 +	14	100%	14
Total		149		100

TABLE 2

DESCRIPTION OF JAILS INCLUDED IN SITE VISITS

JAIL	RATED CAPACITY
Shelby County (Memphis), TN	2,845
Hillsborough County (Tampa), FL	2,276
Pinellas County (Clearwater), FL	1,979
Jefferson County (Louisville), KY	823
Fairfax County (Fairfax), VA	614
Summit County (Akron), OH	402
Hampshire County (Northampton), MA	248
Henrico County (Richmond), VA	178
Page County (Clarinda), IA	29
Lee County (Leesburg), GA	23

TABLE 3

DESCRIPTION OF JAILS RESPONDING TO MAIL SURVEYS

	Size of Jail (Rated Capacity*)					
	Very Small N=295	Small N=265	Medium N=268	Large N=156	Mega N=43	Total N=1013
Current Census	24	66	160	506	2568	2572
Annual Bookings	1205	3294	5287	106730	41362	6296
Percent of Inmates Receiving Mental Health Services	3.6	5.7	8.9	11.1	11.5	7.0
Perceived Effectiveness (1=low 5=high)	3.422	3.233	3.399	3.703	4.024	3.359

***Rated Capacity:**

Very Small=20-50
Small=51-99
Medium=100-249
Large=250-999
Mega=1000+

TABLE 4

JAIL MENTAL HEALTH SERVICES BY SIZE OF JAIL

	Size of Jail*					
SERVICE	Very Small N=295	Small N=265	Medium N=268	Large N=156	Mega N=43	Total N=1013
Screening	74.9	91.1	93.9	96.8	97.7	88.3
Evaluation	47.1	63.6	80.8	91.7	97.7	69.0
Suicide Prevention	62.4	78.7	88.1	93.6	95.3	79.4
Crisis Intervention	32.2	43.0	57.9	76.9	83.7	50.6
Psychiatric Meds.	27.1	39.5	62.5	85.9	100.0	51.5
Inpatient Care In Jail	29.2	11.2	10.3	26.9	53.5	20.4
Outside Jail	52.9	36.8	39.1	52.6	46.5	44.9
Therapy/Counseling	18.3	23.6	35.2	57.7	83.7	32.9
Spec. Housing Area	22.0	42.2	49.4	73.1	93.0	45.1
Discharge Planning	12.2	19.6	26.9	50.6	67.4	26.1
Avg. Number of Services	3.8	4.5	5.5	7.1	8.2	4.0

***Rated Capacity:**
Very Small=20-50
Small=51-99
Medium=100-249
Large=250-999
Mega=1,000+