TEN JAIL CASE STUDY AND ANALYSIS

American Medical Association's
Program to Improve Medical Care and Health Services
in Jails

June 1979

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PART ONE: OVERVIEW OF THE STUDY

I. INTRODUCTION

In June of 1975, the American Medical Association (AMA) received a grant from the Law Enforcement Assistance Administration (LEAA) to conduct a program to improve health care in the nation's jails. The AMA, in turn, sent out a Request for a Proposal to all interested state medical societies and subsequently selected six of these to serve as subgrantees. The successful applicants included medical societies in three mid-Western states (Indiana, Michigan, and Wisconsin), one Southern state (Georgia), one on the East Coast (Maryland) and one on the West Coast (Washington).

Each of these six state medical societies selected from three to seven jails to serve as pilot sites. In all, a total of thirty pilot sites were selected. A pre-profile of these selected jails and their existing health care delivery systems was developed during the first program year.[1/] This pre-profile initially served to identify health care deficiencies in each of the pilot jails. The state medical societies then utilized this information to develop model health care delivery systems to correct these deficiencies. In addition, the pre-profile data served as a baseline from which subsequent changes in the health care delivery systems could be measured.

A post-profile, conducted toward the end of the second program year, indicated that significant changes had occurred in the health

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1/ See, Anno, B. Jaye, Analysis of Jail Pre-Profile Data: American Medical Association's Program to Improve Medical Care and Health Services in Jails, Washington, D.C.: Blackstone Associates, (June 1977).

care delivery systems of the twenty-seven pilot jails[2/] remaining in the program.[3/] Some of the most important changes indicated by this post-profile were:

- An increase from fifteen jails where chronic and convalescent care was available pre-program to twenty-one jails at the end of Year Two where it was not only available, but adequate;
- An increase from seven to twenty jails meeting the definition of adequacy with respect to in-house clinics;
- An increase from ten jails which provided some type of physical exams to some inmates pre-program to fifteen jails which fully complied with the AMA's requirement to provide all inmates with complete health appraisals within fourteen days of admission (four other jails were in nearly full compliance with this standard at the end of the second year);
- An increase from twelve to twenty-two jails providing regular sick call to inmates;
- An increase from seven to twenty-two jails offering detoxification for both alcohol and drug abusers;
- An increase from sixteen to twenty-three jails providing special diets to inmates;
- An increase from sixteen to twenty-two jails offering routine mental health services;
- An increase from two to eleven jails providing some type of routine dental services; and

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2/ For more complete information on the reasons why three sites were dropped, see B. Jaye Anno, Final Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Two), Silver Spring, Maryland: B. Jaye Anno Associates (June 6, 1978). Suffice it to say here that the basic reason was a lack of cooperation from the jails' correctional staff or medical staff or both.

3/ See, B. Jaye Anno and Allen H. Lang, Analysis of Pilot Jail Post-Profile Data, American Medical Association's Program to Improve Medical Care and Health Services in Jails, Silver Spring, Maryland: B. Jaye Anno Associates (April 1978).

- An increase from nine jails having any written policies and procedures pre-program to twenty-two jails at the end of the second year which had written policies and procedures to govern all aspects of their health care delivery systems.

In addition, other improvements occurred, including:

- Changes in the policies and procedures governing the storing, handling and distribution of medications;
- The initiation of receiving screening in nineteen of the pilot jails;
- A reduction in the number of deaths occurring at the pilot jails;
- Changes in both "management information" and "inmate/patient treatment" record-keeping systems to bring them into compliance with the AMA standards in these two areas; and
- Increases in the number of medical personnel serving the jails as well as increases in the frequency and extent of coverage offered.[4/]

In addition to the "Jail Pre/Post Profiles," a second major data collection activity was undertaken during the first two program years, namely an "Inmate/Patient Profile."[5/] Whereas the Jail Pre/Post-Profile was designed to elicit information regarding deficiencies and subsequent changes in the thirty pilot jails' health care delivery systems, the Inmate/Patient Profile (I/PP) was designed to determine what consequences these deficiencies had on the health status of inmates and what impact the AMA program had on improving inmates' health status. Some of the more significant changes, as measured by the I/PP data, which occurred in the pilot sites between Year One and

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4/ Ibid., pp. 76-77.

5/ See B. Jaye Anno, Analysis of Inmate/Patient Profile Data--Year Two, Silver Spring, Maryland: B. Jaye Anno Associates (May 1978).

and Year Two included the following:

- Significant reductions in the proportion of inmates in accredited jails who stated they never had seen a dentist;
- Significant reductions in the proportion of inmates in accredited jails who stated they never had their eyes examined;
- Significant reductions in the proportion of abnormalities not previously identified and/or treated in the accredited jails that were picked up in four laboratory tests administered as part of the Inmate/Patient Profiles;
- Significant reductions in the proportion of body abnormalities not previously identified and/or treated in the accredited jails that were picked up during the physical examinations conducted as part of the I/PPs;
- Significant increases in the number of inmates in accredited jails who reported receiving physical exams upon admission, medical care other than an admission physical, and mental health care;
- Significantly fewer inmates in accredited jails versus the nonaccredited jails who reported being barred from obtaining medical services; and
- Significantly more inmates in accredited jails who had positive assessments of the attitude of the health care personnel treating them.6/

From the findings of the Jail Pre-Post Profile study, and the Inmate/Patient Profile study, it became apparent that the AMA's program had definitely had a positive impact on improving health care in jails. Some changes did occur in most of the pilot jails during the first two program years, but these changes were especially marked in those facilities which received AMA accreditation.

In spite of overall program success, however, some of the 30 pilot

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6/ Ibid., pp. 122-124.

sites demonstrated little or no improvement in their health care delivery systems and three of the original pilot sites were dropped from the program altogether.[7/] As the program expanded into a third year of operation, and grew from the original six state medical societies working with fewer than fifty facilities to sixteen state medical societies working with nearly one hundred and fifty jails, it became clear that more information was needed on the reasons why some jails failed to make the necessary changes and improvements required for AMA accreditation. In addition, more information was desired on the impact of the program at the local jail level.

In order to fulfill the need for this additional information, a case study of ten jails was undertaken during Program Year Three. The next chapter describes the methodology used to select the ten participant facilities and the techniques used to collect the data. The methodology section along with the introduction comprise Part I of the report. Part II will take a close look at the political, economic, and medical environments at each of the ten jails and suggest reasons why individual jails achieved or failed to achieve accreditation during Year Three. Part III will attempt to assess the impact of the program at each of the jails. This assessment will involve not only comparing changes in the level of medical services being provided at each of the ten jails, but also will encompass assessments of changes in inmate and booking officer attitudes, the

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7/ See page 9 of Analysis of the Pilot Jail Post-Profile Data, supra at note 3.

extent of transportation requirements for health care delivery, the effects of receiving screening, and an analysis of health care costs. The summary and conclusions are presented in Part IV along with the Appendices.

II. METHODOLOGY AND LIMITATIONS OF DATA COLLECTED

A. Types and Methods of Data Collected

1. Introduction

The development of the tools and resources necessary to conduct the Ten Jail Case Study and Analysis (T.J.S.)[8/] began in February 1978 and continued through July of that year. At the time the evaluation design was proposed and during the development of the form used to select the ten jails for participation in the study, input regarding the type and extent of data to be collected was solicited from the AMA national program and leadership staff, as well as LEAA representatives. In addition, the medical staffs at two Maryland jails and a limited number of residents at a Maryland pre-release center were utilized during May and June of 1978 in the development and pre-testing of certain data collection forms and questionnaires. After changes and refinements, the instruments were finalized.

It should be kept in mind from the start that the purpose of the T.J.S. was twofold in nature. The first and primary purpose was to determine the reasons why some jails are able to improve their health care delivery systems sufficiently to receive AMA accreditation while other jails cannot. The second purpose was to study the effect or impact of involvement in the AMA program on improving jail health care delivery systems as well as the costs of such improvements. At times, the study design had to compromise the optimum

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8/ In this report, this study will also be referred to as the Ten Jail Study or T.J.S. for short.

achievement of the second purpose in order to adequately insure the realization of the first. This need for compromise will be discussed further under the limitations section of this chapter.

2. Participant Jail Selection

The ten jails which participated in this study were selected in August 1978 from a pool of sixty-five facilities that had entered the third year AMA program. Originally it was anticipated that this pool would total approximately one hundred jails in fifteen states and the District of Columbia by the end of June.[9/] However, by the end of July, delays in project start-up in some of the ten newly added states and difficulties in adding new jails to the program in several of the six original states, substantially reduced the expected number of facilities from which the ten participants could be selected.[10/] Consequently, fewer jails were available which ideally met the pre-established set of selection criteria.

Nevertheless, for several reasons it was felt to be counter-productive to further delay site selection beyond August, while awaiting a larger and more ideal pool of third year jails. First, valuable time needed for data collection was being lost. Second, substantive changes were beginning to take place at several of the

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9/ The District of Columbia will also be spoken of as a "state" in this report.

10/ For more information on the problems encountered in getting jails involved in the third year program, see B. Jaye Anno and Allen H. Lang, Interim Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Three), Silver Spring, Maryland: B. Jaye Anno Associates, (December 8, 1978), pp. 16-22 & 38-44.

third year facilities already in the program, which would have biased the results of this study if these jails were chosen. Third, there was no definite way of determining when the number of third year facilities in the program would approach one hundred. Hence, the selection of the ten participant jails was conducted in August of 1978.

There were two primary and two secondary criteria used to select the ten jails. The primary criteria were: 1) jail size, as determined by average daily (inmate) population (ADP), and 2) the status of each jail's health care delivery system, as determined by each facility's responses to a number of questions on the AMA's Jail Application and Screening Form.[11/] The secondary criteria were: 1) that the ten jails be located in no more than three states and in close proximity to one another in order to hold travel costs to within the prescribed budget; and 2) that the jail staff demonstrate an apparent enthusiasm for and commitment to participating in the study.

Of the ten jails, five were to be small, with an ADP under fifty; three were to be medium-sized with an ADP between fifty and two-hundred; and two were to be large with an ADP of two-hundred or more. This breakdown by size roughly reflects the overall proportion of small, medium and large jails as they occur in the general population.[12/]

11/ See Appendix B for a copy of this form which is officially entitled "Application for Accreditation of Medical Care and Health Services in Jails."

12/ Law Enforcement Assistance Administration, "Survey of Inmates of Local Jails: Advance Report," Washington, D.C.: U.S. Department of Justice, National Criminal Justice Information and Statistics Service (1972), p. 13.

For comparative purposes, all ten sites were to be at approximately the same level in terms of the status of their health care delivery systems at the start of the study. Ideally, this level would place the ten facilities somewhere in the middle range, where accreditation was possible to achieve during the period of the study, but not guaranteed. In other words, real substantive changes would be necessary for each facility to attain accreditation, but these changes would not be obviously beyond the capability of any jail to accomplish within the given time period.

From the "Jail Application and Screening Form," the responses to ten questions were used as determinants of the status of the health care delivery system at each of the sixty-five third year jails available for possible participation in the study. These ten determinant questions were:

1) Was there a physician responsible for providing medical care to the inmates of the jail?

2) Was regular sick call being held at the jail?

3) If regular sick call was being held, was it being conducted by trained medical personnel?

4) Were inmates routinely screened for medical problems when they initially entered the jail?

5) If inmates were routinely screened, was this screening being performed by trained medical personnel?

6) Did the jail provide on-going medical services beyond emergency medical treatment?

7) Did the jail provide on-going mental health services beyond emergency mental health treatment?

8) Did the jail provide on-going dental services beyond emergency dental treatment?

9) Did the jail offer medically supervised alcohol detoxification?

10) Did the jail offer medically supervised drug detoxification?

From the responses to these ten questions, it was felt that those facilities that fell in the range suitable for participation in the study should: 1) already have a physician responsible for medical services; and 2) show positive responses to at least three but not more than five of the remaining nine determinant questions. Jails without a physician were not thought to be suitable for the study because experience from previous years indicated that such facilities face an obvious barrier to accreditation. In some cases, it has been shown that finding a physician is the most difficult aspect in a jail's efforts to improve its health care delivery system. It was also felt that facilities that answered positively to fewer than three of the remaining nine questions had too far to go to reach accreditation in the given time period. Likewise, jails with more than five positive responses were too close to accreditation because few, if any, substantive changes were needed. Therefore, the jails in the middle range were chosen as the best possible candidates for the study.

Table I presents a breakdown of the number of jails that fell into this middle range by jail size. It can be seen from this table that as jail size progresses from small to medium to large, the number of positive responses also increases with the overall average number of positive responses for the sixty-five jails equal to 4.12.

Table I

Number of Jails in the Middle Range of Health Care Services by Size

Jail Size	Total # of Jails in Program as of August 1978	# Having Physicians	# Having 3-5 Positive Responses On Jail Screening Form	Average # of Positive Responses to Nine Determinant Questions
Small (less than 50 ADP)	28	12	10	2.39
Medium (50-200 ADP)	25	23	8	5.00
Large (more than 200 ADP)	12	12	4	6.33
Totals	65	47	22	4.12

As the table indicates, forty-seven of the jails had a physician responsible for the delivery of their medical services in August 1978, but only twenty-two facilities fell in the desired middle range with three to five positive responses to the other nine determinant questions.

When the secondary criteria were considered, it became clear that few of the sixteen project states contained more than two of the twenty-two candidate jails. For the most part, they were fairly evenly scattered around the country. Therefore, in order to keep the participant jails in as close a proximity as possible, two facilities ultimately were selected that fell slightly outside the bounds of the primary criteria. In one case, the jail had positive responses to six of the nine questions and in the other case, the jail also had six positive responses, but no physician. In this latter facility, the hospital emergency room or the inmate's private physician were used when it was felt medical services were needed.

In addition to these minor selection criteria compromises noted above, it was also necessary to choose jails in four states instead of three (although two of these states did end up being contiguous to each other). Two jails were located in a Northeastern state, four in a mid-Atlantic state, and four in two Midwestern states. For reasons of confidentiality with regard to the participating jails, their names and the names of the states in which they are located are not mentioned in this report.

Prior to final site selection, feedback was obtained from the

project directors in five states regarding the possible participation of jails from their states. The project directors were asked to inform the jails about the study and alert them to the fact that they were being considered for participation. Eleven jails were subsequently contacted by the study investigators, first by letter and then by phone. From these contacts and further communications with the state project directors, ten sites were finally selected. The care and deliberation taken in selecting the facilities were rewarded by a much higher level of cooperation and enthusiasm than was originally envisioned. For the most part, the ten facilities provided the data requested of them in a prompt and accurate manner. Without their assistance, this study would not have been possible.

3. Forms and Procedures Used

a. Intensive interview schedules

In order to accomplish the primary objective of this study--namely an investigation of the reasons why some jails are able to attain AMA accreditation while others are not--in-depth structured interviews[13/] were conducted with key people at each of the ten facilities, both at the beginning and at the end of the study time period. These key people included administrative and health care staff at each jail, as well as community resource controllers who were involved in jail budgetary decisions.

Table II presents the titles of the key people that were interviewed at each of the ten facilities. At all ten sites, the person

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13/ See Appendix C for examples of the instruments used in the pre- and post-interviews.

Table II

Title of Key Staff People Interviewed at
Each of the Ten Facilities

Jail Code	Key Administrative Staff	Key Health Care Providers	Community Resource Controllers
6-1 1	1. sheriff (a) 2. chief jailer (c) 3. administrative assistant (b)	1. jail physician (b) 2. jail nurse (c*)	1. chief county executive (a)
6-2 2	1. sheriff (b) 2. jail program officer (c)	1. jail physician (a) 2. jail nurse (a)	1. chairman of county board (b)
6-3 3	1. sheriff (b) 2. chief jailor (a) 3. jail transition co-ordinator (c*)	1. jail nurse (c*) 2. county medical society executive director (part time) (b)	1. chief county executive (b)
7-1 4	1. jail director (a) 2. assistant jail director (a)	1. jail physician (a) 2. jail nurse (a)	1. chairman of county board (b)
9-1 5	1. sheriff (a) 2. jail deputy master (a)	1. jail physician (a) 2. jail medical director (a) 3. jail nurse (a) 4. jail nurse (a)	1. chairman of county commission (a)

Continued on next page--

Table II, Title of Key Staff People Interviewed at Each of the Two Facilities, continued

Jail Code	Key Administrative Staff	Key Health Care Providers	Community Resource Controllers
9-2 6	1. sheriff (a) 2. jail deputy master (a) 3. human services coordinator (a)	1. jail physician (b) 2. jail medical director (a) 3. jail nurse (a)	1. chairman of county commission (b)
13-1 7	1. warden (a) 2. deputy warden (a)	1. jail physician (a) 2. jail nurse (b) 3. jail nurse (c*) 4. director of nurses, county nursing home (c*)	1. president of county prison board (b)
13-2 8	1. jail administrator (a)	1. jail physician (a)	1. chairman of county commission (a)
13-3 9	1. sheriff (a)	1. jail physician (b)	1. chairman of county commission (b)
13-4 10	1. warden (a) 2. deputy warden (a)	1. jail physician (a) 2. jail health care secretary (b)	1. chairman of county commission (a)
Total Number Interviewed	21	22	10

a - both pre and post study interviews were conducted
b - only pre study interviews were conducted
c - only post study interviews were conducted
* - indicates that the individual was not associated with the jail during one of the interview periods

responsible for the administrative operation of the jail was interviewed as well as any assistant administrators if appropriate. In four instances, the person legally responsible for the jail was not the person who actually ran the jail. In all but one such instance, these individuals were also interviewed.

The key health care providers intensively interviewed included the responsible physician at nine facilities, medical directors at the two largest jails, jail nurses at those facilities that employed them, one administrative aid to a jail physician, and two people who were not directly involved with the delivery of medical services within a jail.

Nine chief county fiscal officers and the president of a county prison board were also interviewed as representatives of the community resource controllers for the ten jails.

The investigators intensively interviewed a total of fifty-three individuals. In thirty-one instances, both initial and follow-up interviews were conducted. In those instances where only one interview occurred, it was because: 1) the person was not associated with the jail during one of the site visits; 2) the person was unavailable during one of the site visits; or 3) a follow-up interview was not deemed beneficial because of the marginal involvement of the individual with the jail, the accreditation effort, or both.

In addition to the intensive interviews, the investigators spoke with numerous other personnel at the ten jails as part of the data collection process. Periodic phone consultations with various jail

personnel were also conducted during and after the study period as situations warranted. In all instances, the state project directors were kept informed of developments at each facility and they, in turn, assisted the investigators whenever asked to do so. Their assistance and advice helped facilitate the T.J.S. at all ten sites, not only with regard to initial site selection, but also throughout the study period.

b. Statistics regarding jail populations, transportation needs, and delivery of health care services

During the six month study period (September 1, 1978 to February 28, 1979) each of the ten participant jails was asked to maintain three statistical forms and one information sheet. The first form dealt with jail population characteristics, e.g. length of stay and daily population figures. The second form dealt with the need for transporting inmates outside of the jail for health care reasons, while the third asked the jails to record the number of various health care services provided to inmates. In addition, each jail was asked to report any changes in its health care delivery system on a separate sheet.

At the time of the initial on-site visits, these forms were given to jail administrators, along with both verbal and written instructions for completing them. The forms were designed to be kept on a daily and weekly basis and were to be submitted to the investigators monthly. Specifically, the package of data collection forms left with each facility consisted of:

a) a detailed set of instructions;

b) a form for recording daily jail population statistics (Form A);

c) a form for recording the daily transportation of inmates outside of the jail for health care reasons (Form B);

d) a form for recording the number of health care services delivered to inmates of the jail each week (Form C);

e) a sheet for recording changes in the jail's health care delivery system (Form D).[14/]

The forms were arranged in a folder and labeled by the month in which they were to be utilized.

c. Serious incident reporting

The staff at each participant jail was asked to supply the investigators with a report on the nature and frequency of the serious medical incidents that occurred during two time periods: January 1, 1975 to August 31, 1978 and September 1, 1978 to February 28, 1979. For each incident reported, the jail staff was asked to furnish information on the type of incident and the length of time the inmate had been incarcerated when the incident occurred.

The purpose of the serious incident report was to compare the frequency and severity of incidents prior to and after the jail's involvement in the AMA program. A serious incident was defined as a life threatening or potentially life threatening occurrence that required immediate emergency medical attention.

It was hoped that by collecting information on serious incidents for a period of several years, an "average" profile baseline statistic could be computed for use in comparing the frequency of similar

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14/ See Appendix D for a copy of these forms and the instructions which accompanied them.

incidents during the study period. Because serious medical incidents are a relatively rare phenomenon in most jails, especially those with small inmate populations, it was hoped that by going back in time for several years, a reliable average could be gauged for the occurrence of such incidents.

Although each of the ten facilities maintained data on serious incidents, many did not have a filing system which made for easy retrieval of this information. In most cases, the needed information was filed with the individual inmate's record, and the time needed to search each record was prohibitive. This was especially true in the medium and large jails that processed several thousand inmates each year. Therefore, in those facilities where no reasonable alternative existed, jail staff relied on their memories to create the "baseline" serious incident data. Such data collection methods are not very reliable and in all instances, probably resulted in fewer incidents being reported than actually occurred.[15/] Naturally, caution must be exercised in any interpretation of such data.

d. Transportation for medical reasons

The staff at each participant jail was also asked to supply the investigators with a report of the number of trips incurred for medical reasons for the six month period from September 1, 1977 to February 28, 1978. This time period was considered to be equivalent to the six month study period and should allow a rough comparison of

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15/ For further information on the problems inherent in incident recall, refer to Roger Hood and Richard Sparks, Key Issues in Criminology, New York: McGraw-Hill Book Company (1970), pp. 25-33.

the transportation needs of a jail prior to entering the program with its needs while in the program. Although each jail maintained some form of log which recorded when an inmate left the facility, these logs were not always suitable for retrieving the needed information. Therefore, only a few jails--mostly the smaller ones--were able to supply the requested information. The usefulness of this data for comparative purposes will be discussed again later. Suffice it to say here that because the data for the initial time period were obtained in a manner different from that for the study period, and because these initial data were not available from most of the jails, data reliability only allows a crude descriptive comparison.

e. Inmate questionnaires

A questionnaire was developed during May and June of 1978 that was designed to be both a descriptive indicator of inmates' attitudes toward the health care delivery system at the jail in which they were incarcerated and a rough measure of changes in attitudes that might occur as a jail's health care delivery system improved. The questionnaire was only meant to be a rough preliminary measuring device. It was not intended to be a highly controlled study nor a definitive statement on inmates' attitudes.

The questionnaire was pretested and extensively reviewed by twelve inmates divided into three discussion groups. Nine of the inmates were men and three were women. All were awaiting final release from jail at a Maryland pre-release center. Their criticisms and suggestions greatly influenced the final content, wording, and

selection of the questions used. The finalized questionnaire probed into three areas:

1) the availability and adequacy of jail health care services;

2) the accessibility of jail health care services; and

3) the feelings of inmates toward jail health care personnel.[16/]

Because the questionnaire was only meant as a preliminary descriptive indicator and a rough measure of possible change, it was administered by the investigators to no more than twenty inmates at each jail--ten during the initial on-site visit and ten during the follow-up visit. In the small jails that housed fewer than ten inmates on the day of either on-site visit, it was possible to give the questionnaire to all of the inmates available who were willing to complete it. At the larger facilities, however, a different sampling process had to be used.

Jail staffs were asked to select a cross section of their inmate population. In selecting this cross section, the jail staffs were also asked to choose inmates who were both literate and who would probably remain at the jail for several more months. Because these selection restrictions greatly reduced the number of qualified inmates, the nature of the study did not seem to warrant the use of random sampling techniques. Except at the two largest facilities, only a small percentage of the inmate population (i.e. fifteen to twenty) met the selection criteria.

In most instances, the questionnaires were administered to

16/ See Appendix E for a copy of the inmate questionnaire.

groups of from three to five inmates at a time, although in some cases, an individual interview was conducted. By way of introduction, the inmates were told the nature of the study, that their participation was strictly voluntary, that their individual responses would remain confidential, and that the jail would only receive an aggregate summary of all inmates' responses. Those inmates who completed the initial questionnaires were asked if they would be willing to complete a similar questionnaire the day before they were released. If the inmate responded positively, a second questionnaire was left with the jail staff to be given to the inmate at the appropriate time. This second questionnaire contained instructions to the inmate on mailing the questionnaire to the investigators using an attached self-addressed stamped envelope. This was done in order to maintain the inmate's confidentiality.[17/] Except for the last question and final mailing instructions, the pre- and post- inmate questionnaires were identical.

Any changes in inmates' attitudes during the time-frame of the study were to be measured in two ways, using a pre-post design method. First, the initial group of inmates was to complete the questionnaire at the beginning of the study in September 1978 and again one day prior to their release. In this way, their first responses could be compared to their second and any changes in responses noted. Second, a follow-up group of inmates was to complete the questionnaires at the conclusion of the study period in February 1979, and their responses

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17/ See the last page of Appendix E for the mailing instructions given to inmates.

were to be compared with the initial ones of the first group.

f. Booking officer questionnaire

A second questionnaire was also developed during May and June 1978. It was designed to measure several characteristics of booking officers and any changes in these characteristics during the time of the study. Like the inmate questionnaire, the booking officer questionnaire was not designed to be more than a rough descriptive indicator and measuring device.

This questionnaire was initially pretested by five health care staff at a large Maryland jail, after which the investigators and the staff at a second Maryland jail reviewed the pretest results and made needed changes. The assistance of the health care staffs at the two facilities was most beneficial in the selection of the questions which were ultimately used and in the writing of the medical situations used in part B of the questionnaire.

In part A of the questionnaire, booking officers were asked their opinion about:

1) the jail's health care delivery system; and

2) prisoner health care needs.

Part B presented six situations that might possibly occur at the jail during booking. After reading each situation, the booking officers were asked to indicate whether a medical problem existed, and if so, to describe the nature of the medical problem, and what action s/he would take if confronted with the given situation.

Questionnaires were given directly to the booking officers at

each jail or through a senior staff person at the time of both on-site visits. They were instructed to complete the questionnaires on their own and return them directly to the investigators. By comparing the responses on the first questionnaires with those on the second, changes in responses could be noted. Except for question A-15 which appeared on the follow-up questionnaire only and asked if any changes in the jail's health care delivery system had been noted since September, the two questionnaires were identical.[18/]

g. Jail health care costs

By studying the costs of maintaining the health care delivery system at each of the participant jails, the investigators hoped that a baseline figure could be developed which would give other jails a comparative measuring tool to use in estimating the costs and/or savings of implementing the AMA's standards. Such a study is often fraught with difficulties due to the complexity of most jail health care delivery systems, inadequate record keeping systems, and the multitude of ways in which different parts of a system may be reimbursed.

The ten participant jails were asked to supply the investigators with numerous types of health care cost data. This involved indicating the extent of health care services being provided as well as the agencies providing and paying for each service. The jails were asked to supply cost figures for the eight month period immediately preceeding the beginning of the study as well as the six month period of the study itself. In this way, it was hoped that some cost figures

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18/ See Appendix F for a copy of the booking officer questionnaire.

related to implementing the AMA standards could be developed.

The eight different areas for which health care cost data were sought included:

1) The costs of primary medical care providers (e.g. jail physician and medical staff including trained correction officers);

2) The costs of maintaining the medical facilities in the jail;

3) The costs of medical services provided to inmates of the jail by outside resources (e.g. hospitals, clinics, dental offices, outside consultants, psychiatrists, laboratories, etc.);

4) The costs of training jail staff in such areas as first aid, Cardiopulminary Resuscitation, emergency medical training, continued medical education, etc.

5) The costs of transporting inmates for medical reasons (e.g. manpower, vehicle maintenance, etc.);

6) The costs of security personnel while medical services were being delivered (e.g. while transporting inmates, during sick call, during hospitalizations, etc.);

7) The costs of drugs, medications, and renewable supplies; and

8) Legal costs resulting from inmate suits alleging poor medical care.

The ten jails were able to supply the requested information with only varying degrees of success, due in part to the various time-frames of their fiscal calendars and the manner in which their accounting systems operated. Some jails were able to supply summary copies of their budget expenses, while others supplied individual receipts for health care costs. Nevertheless, many health care costs could not be broken down into their component parts and had to be estimated either by the jail staff or the supplier of the service. In some

cases, neither actual cost data nor estimates were available for certain areas. Although the cost data obtained are considered fairly reliable, especially where actual cost figures are concerned, much cost information was still missing. While it would be an error to overextend any findings based on these data, by utilizing other types of data supplied by the jails in conjunction with the available cost information, some comparisons can be drawn between jails and some tentative statements made about health care costs.

B. Limitations of Data Collected

Before proceeding to an analysis of the Ten Jail Study findings, a brief discussion of the limitations of the data collected is warranted. As with any other research endeavor, questions regarding the reliability and validity of the data obtained influence the confidence one can place in the results.[19/]

As indicated previously, the T.J.S. was designed to serve two objectives. First, it was to be an investigation into the reasons why some jails are able to improve their health care delivery systems sufficiently to receive AMA accreditation while other jails cannot; and second, it was to be a study of the effect of an improved health care delivery system on a jail's environment. To insure a fair comparison of jails in order to adequately study the first objective, facilities were chosen whose health care delivery systems were at about the same level of development with regard to the availability

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19/ See e.g., Donald T. Campbell and Julian C. Stanley, Experimental and Quasi-Experimental Designs for Research, Chicago: Rand McNally College Publishing Co. (1966), especially pp. 1-6.

of physician and medical services. This meant that the participant jails already had a physician (except in one case) and were already providing some but not all of the health care services called for in the AMA standards. Because of this, visible changes in their health care delivery systems were not as dramatic as might have occurred if jails without health care staff and with few if any services had been selected. Therefore, it could be said that the accomplishment of objective two was somewhat compromised in order to insure that objective one was fairly and completely met.

In order to accomplish objective one, a case study analysis approach was used involving intensive structured interviews. The case study approach lacks many of the objective controls that are present in other types of analysis because individual investigator bias cannot be as stringently controlled. However, certain precautions were taken in order to limit investigator bias as much as possible. The structured interview schedules were closely reviewed prior to their use for content, purpose, and intent. In addition, only two investigators were used during the course of the study and each investigator was assigned total responsibility for conducting both the pre- and post- interviews at each jail. Therefore inter-investigator bias with regard to the case study analysis of each facility was minimized, although some degree of bias undoubtedly exists when all ten jails are considered together.

There were also problems associated with the data utilized to study objective two, many of which have already been mentioned in

reviewing the various forms used. Suffice it to say that the investigators were unable to obtain all of the data requested from individual jails for various reasons and data could not always be collected in a uniform fashion. In addition, the reliability of the data supplied could not always be verified except through the use of internal checks of consistency. Where these problems occurred, they will be further discussed in the interpretation of results.

Before turning to the results in Parts Two and Three, one final caveat should be mentioned. While the official data collecting time frame for the T.J.S. was the six month period from September 1, 1978 through February 28, 1979, some exceptions had to be made in gathering post-program data. All of the pre-program data were collected during September at all ten sites. However, some follow-up data were collected as early as mid-February at some jails and at others, as late as April. This meant that the jails which were reviewed last had an advantage in that they had more time in which to make improvements. Although not all data were affected by this time differential, measures with respect to standards attainment were. Hence, the reader should be aware of this potential for bias when reviewing the results sections dealing with standards.

In reviewing the pages which follow, the reader should keep all of these general limitations in mind. They have an effect both upon the degree to which comparisons can be drawn between the ten jails and on the degree to which generalizations can be made to other jails beyond these ten facilities.

PART TWO: CASE ANALYSIS

III. DESCRIPTION OF THE JAILS AND THEIR PROGRESS

A. Introduction

This section of the report follows a case study approach and looks at the ten jails in turn and the progress each made in complying with the AMA standards during the course of the study. Each case analysis begins with a general description of the jail and the health care system in place at the beginning of the study period. This is followed by the investigators' assessment of the medical, political, and economic environments in which a jail is located, since these may become contributory factors in the approach a jail takes in attempting to achieve accreditation of its health care delivery system.

After establishing the initial setting and environments at each jail, the case analyses look at the changes which occurred during the course of the study and point to what the investigators found as the primary factors contributing to the differing extent of progress made at each facility.

Table III (see next page) presents a summary breakdown of the standards met by each jail at the time of the investigators' initial on-site visits in September and again shortly after their follow-up visits in February and March. The determination of compliance was made based on a self-survey questionnaire completed by each jail or the state medical society project director as part of the jail's participation in the larger AMA jail health care program.

Table III summarizes compliance with the forty-two AMA standards broken down into three categories: service standards, of which there

TABLE III

RESULTS OF THE INITIAL AND FOLLOW-UP SELF-SURVEYS
COMPLETED BY THE TEN JAILS INDICATING THEIR COMPLIANCE WITH
THE THREE CATEGORIES OF STANDARDS: SERVICE, PROCEDURAL AND ENVIRONMENTAL

Jail Number	Jail Size[1/]	Compliance with 13 Service Standards		Compliance with 21 Procedural Standards		Compliance with 8 Environmental Standards		Compliance with all 42 Standards	
		Initial #	Follow-up #	Initial #	Follow-up #	Initial #	Follow-up	Initial #/%	Follow-up#/%
One	Small	6.45	12.67	6.54	20.67	6.00	8.00	18.99/45%	41.34/98%
Two	Small	6.89	12.67	11.56	20.01	7.00	7.00	25.45/61%	39.68/94%
Three	Med.	5.50	12.50	6.17	19.92	6.00	6.00	17.67/42%	38.42/91%
Four	Med.	8.75	12.50	15.52	19.37	6.60	6.60	30.87/74%	38.47/92%
Five	Large	11.04	13.00	12.88	21.00	6.00	8.00	29.92/71%	42.00/100%
Six	Large	10.25	12.67	14.79	19.47	8.00	8.00	33.04/79%	40.14/96%
Seven	Med.	10.67	11.88	11.45	14.25	7.60	7.60	29.72/71%	33.73/80%
Eight	Small	7.09	8.09	6.06	7.08*	8.00	8.00	21.15/53%	23.17/58%
Nine	Small	4.17	4.84	4.55	4.72**	8.00	8.00	16.72/43%	17.56/45%
Ten	Small	9.70	11.76	11.87	13.54***	8.00	8.00	29.57/72%	33.30/81%

*Two procedural standards were not applicable in this jail.
**Three procedural standards were not applicable in this jail.
***One procedural standard was not applicable in this jail.

1/ Small=less than 50 inmates; Medium=50-200 inmates; Large-more than 200 inmates (on an average daily basis)

were thirteen; procedural standards, of which there were twenty-one; and environmental standards, of which there were eight.[20/] The service standards were concerned with the direct delivery of medical services to the inmates of a jail. The procedural standards dealt with formalizing jail health care delivery components into a unified system, while the environmental standards were concerned with those aspects of jail living conditions which could directly affect the health of an inmate.

It should be pointed out that the grouping of the AMA standards into these three categories was for purposes of discussion only and that all forty-two standards did not necessarily fit neatly into this breakdown. In some cases, overlap between categories existed within an individual standard because it consisted of more than one requirement. Where that occurred, a jail could be in partial compliance with a given part of the standard without being in full compliance with the entire standard. As Table III and Appendix G indicate, this was often the case.

Further discussion of the results indicated in Table III will occur as each jail is individually analyzed in sections B-K which follow. At this point, however, it is worth noting that while all of the jails started at the middle range in terms of standards compliance (i.e. 42 to 79% initial compliance), there were two distinct clusters. Jails One, Two, Three, Eight and Nine tended to be at the lower end (42-61% compliance) whereas the remaining jails were at the higher end (71-79%

20/ See Appendix G for a listing of a jail's compliance with the individual standards and a copy of the self-survey questionnaire used by the AMA program and this study.

compliance). For the most part, these latter five jails tended to be the larger facilities. This is consistent with the positive correlation between jail size and pre-program status of health care delivery noted in previous reports.[21/] Notice, though, that by the time of the follow-up results, these differences by size of facility tended to disappear. This has been a consistent effect of the AMA's program as demonstrated here and in results from previous studies.[22/]

21/ See supra, note 3.

22/ Ibid.

B. Jail One (#6-1)

The initial site visit to this facility occurred on September 18, 1978. Primary informants regarding the jail's operations and environment included the sheriff, the chief jailer, a local physician providing some services to the jail and the chief county executive.

1. Pre-program Picture

a. General characteristics

This jail is located in a small rural community of 11,500 people in a mid-western state. There are an additional 6,800 students in residence at a local university who are not included in the population totals. The jail serves a county-wide population of 30,000.

The facility was built in 1963. It has a rated capacity of twenty-four inmates, although the average daily population is usually about half that figure. It is staffed by eight full-time deputy/dispatchers consisting of four men and four women, with one man and one woman on each shift. The women jailers are expected to prepare meals for the inmates in addition to their other duties. The staff is supplemented by four part-time deputy/dispatchers consisting of two men and two women. There is no state jailer training requirement at this time.

One of the drawbacks to the staffing pattern noted above is that the inmates remain fairly isolated. Since the primary duty of the jail deputies is to serve as dispatchers and the women also double as cooks, even with two staff per shift, the time available to check on inmate needs is somewhat limited. Perhaps it is for this reason that most inmates are not housed in single cells, even though space may be available.

Living conditions at the jail appear to be adequate. It is not over-crowded, is in good repair, and is kept clean. While there is a sense of order and precision in how the facility is run, it still retains a friendly atmosphere. The sheriff's concern for the welfare of the inmates was evident as was the respect of the staff for him.

b. Description of "pre" health care system and medical environment

At the time of the investigator's initial visit, there were no medical facilities or services available within the jail itself. There was no receiving screening, no sick call, no routine health appraisal, no routine psychiatric evaluation, no regular dental care and few in-house visits by medical providers. Only one of the twelve deputy/dispatchers had first aid and cardiopulmonary resuscitation (CPR) training.

For the most part, medical care was delivered on an "emergency" or "as needed" basis. Inmates were transported to the hospital emergency room or to the local clinic for services--both of which are nearby. Although neither of these relationships were formalized, one of the local physicians was utilized more than the other twelve because of his willingness to work with the jail.

Detoxification from alcohol and drugs was provided on a regular basis and counseling services for these addictions were available as well. However, other mental health services were less readily available.

Dental services for inmates were virtually non-existent. There were no routine examinations given nor was preventive dentistry a policy. If emergency treatment was required, any one of the eleven local dentists

might be called. Treatment, however, was most often limited to extractions.

A local pharmacy was used to obtain over-the-counter and prescription items. The deputies distributed medications as needed and kept records in individual inmate files. They did not have any training from the physician or the sheriff regarding performing this function, however.

A glance at Table III indicates that this jail had a long way to go to achieve accreditation of its health care delivery system. Its initial compliance level was only 45%. Nevertheless, neither the sheriff nor the chief jailer anticipated any problems in getting the medical community to support the program or provide services. The sheriff indicated that the jail had good relationships with various medical resource groups and was confident that they would prove cooperative. He also stated that finding a physician to accept responsibility for the jail's health care system would not be difficult, since the physician most often utilized had agreed to consider serving in this capacity.

When interviewed by the investigator, however, this physician did not match the sheriff's enthusiasm. He felt that the existing level of care provided to the inmates was more than adequate, and he did not believe the AMA program would bring improvements other than increased documentation of existing services. The time involved in writing up policies and procedures and in on-going record-keeping was seen as a disadvantage.

Further, this physician was not receptive to some of the standards such as the ones requiring all inmates to have physical exams within fourteen days and dental exams within ninety days. On the other hand, he felt receiving screening was important and stated that communicable disease screening should be performed on admission.

While the physician's attitude was not totally negative, neither was it overwhelmingly supportive. He did express some concern that, although currently voluntary, the program would become in the future "just one more attempt by government to regulate health care." Perhaps his attitude can best be characterized as one of reluctant agreement. He stated he would be willing to supervise the health care program, but did not want to be the primary provider. Thus, while somewhat skeptical regarding the potential benefits of the AMA program, the physician was willing to help out. The sheriff was his friend, and if he wanted his jail accredited, the physician would go along.

c. Description of "pre" political environment

All of the informants described the jail as enjoying good relationships with the press, local government and county officials. This is probably due, in part, to the sheriff's personal style. He is friendly, funny, and somewhat flamboyant. He is also energetic, as evidenced by his active participation in a number of community service groups as well as state professional associations.

Neither the sheriff nor the chief jailer anticipated any problems in gaining the support and cooperation of local government officials. This was borne out by the chief county executive who stated that he

felt the program would benefit both the inmates and the community. He also believed that the general public would support the program, if they thought it constituted "reasonable care."

The sheriff and chief jailer were less convinced of the public's good will toward such a program, however. The community was described as somewhat conservative, or to quote the sheriff, "They think I'm coddling the prisoners when I feed them three times a day." Still, they did not anticipate any active resistance from the public. The sheriff stated that if any developed, he would "appear before every civic organization in the county to sell the program and convince them of its worth." In addition, the support of local government officials was seen as more important and that had been assured by the county executive.

Staff resistance within the jail was not anticipated either, even though many of the needed changes would directly affect operational policies and procedures and increase the amount of paperwork required. When asked what he would do to overcome staff resistance if it developed, the sheriff stated, "There won't be any or they won't have a job." This tough-guy posture seemed to be just that, since the sheriff already appeared to have the respect and cooperation of his staff.

d. Description of "pre" economic environment

The county board is the primary funding source for the jail, although federal monies are occasionally available for specific programs. The board has a five-member subcommittee called the Law Enforcement Committee which meets monthly and approves all expenditures for the

jail. In general, the board was described as being fairly receptive to the jail's needs. The sheriff had contacted the Law Enforcement Committee prior to the investigator's initial visit, and stated he did not anticipate any problems in obtaining additional resources to make necessary changes in the health care delivery system.

While the county executive indicated that the board's willingness to provide additional monies would depend upon how extensive the funding would have to be, he also stated that the Board would "certainly listen to any proposal." He described the community as having "a strong sense of civil justice" and felt that the county would provide whatever was needed to ensure good health care for inmates.

The sheriff was asked what he would do if more monies were needed to make improvements and the county board refused to allocate it. He stated he would "just go ahead and spend it anyway and the county would have to cover it."

2. Progress Made in Attaining Standards

As indicated previously, Jail One was at the low end of compliance with the standards (i.e., only 45%) when it entered the program. From Table III, it can be seen that this jail met fewer than half of the thirteen service standards, less than a third of the twenty-one procedural standards, and six of the eight environmental standards initially. By the time of its follow-up self-survey, this situation had changed dramatically. The jail was in almost total (i.e. 98%) compliance with all forty-two standards.

Probably the most significant substantive changes occurred in the

service area, and the most important of these was the addition of a nurse in January to provide on-going services. She is a county public health nurse who comes to the jail two or three times a week to hold sick call, provide communicable disease screening, treat minor illnesses and injuries, and make referrals when other health care services are needed.[23/] In addition, the jail initiated receiving screening, began providing better dental and mental health care and improved its system of medication distribution.

Other important changes were made in the procedural area. Policies and procedures affecting health care were written up, arrangements with local providers were formalized, the medical record system was improved and necessary training was provided to jail staff on various health care topics.

While the jail was not accredited by the end of the study period, sufficient changes had occurred by April for the jail to apply for an on-site survey. This survey has now been completed and from the evidence at hand, it appears that this facility will receive accreditation of its health care delivery system in June.

3. Factors Contributing to the Extent of Progress Made

By all accounts, it seems evident that the primary factor influencing the extent of changes which occurred in this jail's health care system was the sheriff's driving interest to attain accreditation. His principal motivation was to seek approval of his system from a prestigious

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23/ While there is still no medical facility at this jail. the attorney's room doubles for this purpose, since it offers needed privacy. Minimal supplies and equipment have also been obtained.

national organization (namely the AMA) and thereby increase protection for the county, himself and his staff with regard to potential law suits in the medical area. The sheriff recognized that doing this would also mean better coverage for the inmates which he agreed with as well.

Obviously, the sheriff's interest in working toward accreditation was made easier by the fact that he did not encounter opposition from any quarter. The medical community agreed to new arrangements for providing services and in spite of his initial skepticism, the physician designated to supervise the jail's health care system proved fully cooperative. On a follow-up interview, this physician stated that he had no problems with the AMA program as it was currently administered, although he was still concerned about the possibility of future government interference. To date, though, he had agreed to all that was asked of him by the sheriff.

The sheriff indicated that whereas he had encountered some resistance from about a third of his staff regarding the additional paperwork required, no active objections were raised. He has tried to convince them of the worth of the program and how it can protect them as well as the inmates. According to the sheriff, one of the secondary gains of the program has been an increase in communication between inmates and the staff.

The Law Enforcement Committee of the county board was kept appraised of changes occurring at the jail and the sheriff found this body "100% supportive." On follow-up, the county administrator stated that he felt the program "represented a step forward by picking up the jail as a

part of the community." According to him, the public's reaction to the program was generally favorable, especially considering that the county tended to be a conservative area.

This positive political support for the program may have been due, at least in part, to the fact that no additional expenditures were required to make needed changes. Some of the money which previously may have gone to the local hospital or clinic is now used to pay the nurse.[24/] Neither the sheriff nor the county administrator anticipated a need for increased funding in the future, even though new services were being provided.

In summary, then, the sheriff's interest in accreditation and his willingness to push for it were probably most responsible for the dramatic increase in the standards attained at this facility. The sheriff's success, however, was contingent upon the cooperation and support of the medical community which was received. Other potential stumbling blocks such as active resistance from jail staff, local government officials or the general public did not materialize, and since additional funding was not required, economic constraints did not become an issue.

One final factor influencing the extent of progress made was undoubtedly the support and assistance provided by state medical society personnel. At least three on-site visits were made to provide technical assistance and regular phone contact was maintained. These individuals were said to be most helpful in interpreting the requirements

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24/ A more detailed cost analysis for each jail may be found in Part III of this report.

of the standards and in providing examples and advice regarding procedural arrangements.

C. Jail Two (#6-2)

This facility was visited initially by the investigator on September 19, 1978. Primary informants regarding the jail's operations and environment included the sheriff, the day shift jailer/dispatcher, the chairman of the county board, a county public health nurse and one of the two physicians serving the town.

1. Pre-program Picture

a. General characteristics

This jail is located in a small rural community of 2,000 inhabitants in a mid-western state. The town serves as the county seat largely because of its central location. While fairly large in area, the county-wide population is only 30,000. The major industry in the county is agricultural.

The jail itself was built in 1968 and is adjacent to the court house, which also contains many of the county offices. It has a design rated capacity of thirty-two prisoners, although the daily population is usually less than ten inmates. The jail is staffed by five full-time male jailer/dispatchers, which is sufficient to provide round-the-clock coverage by one officer per shift. A woman is available only when needed to book female offenders--an event which rarely occurs.

The size of the staff and the fact that the jailers double as dispatchers present potential problems for the jail with respect to medical emergencies. This is especially true of the evening and night shift, since the one jailer/dispatcher on duty is usually the only staff on the premises. The officer on duty is tied to the communication system for the sheriff's department as a whole, and does not always

have time to make regular checks of the inmates. The prisoners are physically isolated from the communications control center and must use whatever mechanisms may be available to gain the officer's attention to their needs.

The sheriff seemed aware of this potential problem, however, and it is perhaps for this reason that he requires his jailer/dispatcher to go through the same recruitment training program as the road crew--even though the state only mandates this training for the latter group. This means that all five jail officers have had first aid and CPR training.[25/] While this does not solve the problem of inmate isolation, it does increase the probability of an adequate response should a medical emergency occur.

The sheriff's emphasis on professionalism manifested itself in other ways. This was one of the few jails visited where the officers were regularly assigned to jail duty and where they were paid a salary equivalent to the road crew.

The atmosphere at the jail was friendly and fairly informal as befits that of a small town where the inmates and staff are likely to know each other already. Living conditions appeared adequate in that the jail was clean, reasonably comfortable and not overcrowded. The sheriff seemed proud of his jail and expressed a strong desire to provide well for its inmates. He felt the jail's involvement in the AMA program would make the inmates healthier and happier. It would afford him an opportunity to "keep closer tabs on the health of the prisoners

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25/ Three of these officers had also completed an advanced first aid course.

and prevent the spread of disease," while at the same time providing better protection for the jail. The sheriff recognized that his facility was "wide open for the possibility of a suit" and he wanted to avoid that by providing the necessary on-going care.

b. Description of "pre" health care system and medical environment

Like Jail One, there were no medical facilities or services available within the jail itself at the time of the investigator's first visit. Neither receiving screening, nor sick call, nor physical examinations, nor communicable disease screening, nor psychiatric evaluations, nor dental care were available on a routine basis. Instead, health care services were provided only when an immediate need arose.

The jail did have an advantage, however, in that it enjoyed good, on-going relationships with both of the physicians in town. One was used more than the other, in part because his office is only a block from the jail. While the physician would visit the jail when asked, the usual pattern was for one of the road crew to transport the inmate to the doctor's office. The willingness of the physicians to provide services to inmates was crucial, since there is no hospital in town and the nearest ones are both thirteen miles away. Interestingly, one of these hospitals is in a neighboring state, but it was used most often because the sheriff believes it provides better care.

Detoxification from alcohol and drugs was provided even though the facility used most often is in a neighboring county some forty miles away. Addiction counseling was sometimes furnished, although

other types of mental health care were less readily available. The lack of mental health resources in the county and the traveling distance to the nearest ones generally meant that only emergency psychiatric services were provided.

When it entered the program, Jail Two was not meeting any of the requirements of the dental standard. Emergency care was provided by any of the three dentists in town, but preventive and restorative services were not. The sheriff indicated that supplying routine dental care might prove to be difficult, because all three of the dentists were heavily booked. Community residents usually have to wait six weeks or longer for an appointment unless it is an emergency.

Deficiencies also existed in the way medications were stored, distributed and recorded. Further, the medical record-keeping system needed to be improved as did the documentation of other areas. More staff training with respect to health care policies and procedures was needed.

As discussed above and as indicated in Table III, Jail Two had a number of improvements to make before accreditation was possible.[26/] Nevertheless, the sheriff was confident that the necessary changes could be made rather quickly. As soon as he entered the program he had contacted the local physicians and been assured of their cooperation. He had also spoken with the county public health agency regarding the possibility of using its nursing staff to provide on-going services to inmates.

In addition, the sheriff had discussed his plans with the "Law

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[26/] Its initial compliance level was 61%.

Enforcement Committee" of the county board which reacted favorably. Further, the "Health Care Committee" of the county board approved the use of the county public health nurse in the jail. Obviously, from the sheriff's perspective, the necessary support from the medical community had been obtained.

Interviews with the primary jail physician and one of the county nurses confirmed the sheriff's position. Both were enthusiastic and supportive regarding the jail's participation in the AMA program. The physician did not foresee any problems in achieving any of the AMA standards. He felt the additional services could be provided, was interested in assuming responsibility for overseeing the jail's health care system, and was willing to undertake the paperwork necessary.

As one of the two physicians serving the community, he was already extremely busy, yet he was willing to assume the additional responsibility because he believed it would be beneficial. He stated the community "wanted to be up with the times" and he felt this program would help it avoid a lot of problems. His warmth and concern for the welfare of the townspeople--including inmates--were evident.

The county nurse interviewed was excited about the prospects of providing on-going care to a previously neglected segment of the population. She stated that services to the jail would be provided as part of the public health department's responsibility and that duties at the jail would be rotated among the three county nurses. The increased workload was seen as a disadvantage, but she felt the potential benefits outweighed this. The only problem anticipated was locating

a lab to do the serologies for syphilis screening, since there is no laboratory nearby. However, the nurse indicated that arrangements could probably be made with the State laboratory. In summary, she was strongly supportive of the proposed program and indicated a willingness to cooperate in any way possible.

c. Description of "pre" political environment

Both the sheriff and the day shift jailer reported that the jail enjoyed good relationships with the press, the community and the local government. Neither anticipated problems with any of these bodies regarding the jail's participation in the AMA program. The chairman of the county board indicated that this group would support the program if the members believed it would be beneficial. Since the health subcommittee had already approved some of the expected changes (e.g. the use of the public health nurse without charge to the jail) and the law enforcement subcommittee had raised no objections, cooperation from local government officials seemed assured.

The sheriff also felt that the public would support improving health services for inmates unless they believed that the care to be offered was "too good." If any objections regarding proposed changes were raised by the public, the sheriff planned to undertake a public education campaign to convince them of the need for and expected benefits of involvement in the AMA's program.

Attitudes of the jail staff were expected to be favorable. The day shift jailer approved of the proposed changes and appeared confident that the others would also. He stated that additional training

for the jail staff might be difficult to accomplish logistically, but there would be no objections to the requirement. Better documentation was seen as an advantage, even though it meant more paperwork. Aside from the obvious benefits to the inmates, he saw the program as affording better protection to the jail and the staff as well.

d. Description of "pre" economic environment

The county board has the primary fiduciary responsibility for the jail. Funding requests are brought first to the five-member law enforcement subcommittee which reviews proposals and makes recommendations to the full board. In general, the sheriff stated that the county board had always been very receptive to the jail's needs in the past. As noted above, he had already received the tacit approval of his subcommittee for the jail to become involved in the AMA program. Additional funds had not been requested, however.

The sheriff did not believe that implementing the AMA program would result in increased costs. In fact, he sold the proposal to the "Law Enforcement Committee" partially on the basis that this program would mean a cost-savings in the long run by avoiding potential litigation. While the sheriff's primary motivation for becoming involved in this program was said to be the personal satisfaction he would derive from "doing a good job and running a healthy jail," the chairman of the county board seemed most persuaded by the economic arguments.

2. Progress Made in Attaining Standards

Prior to entering this program in September, Jail Two was meeting

61% of the AMA's health care standards. It was in compliance with a little more than half of both the service and procedural standards and all but one of the eight environmental standards (see Table III). By the time of the investigator's follow-up visit in February, the jail had raised its compliance level to 94%. In fact, the on-site survey for accreditation had already taken place. This becomes even more significant when it is recognized that Jail Two was the only one of the ten facilities which made sufficient progress to request an official survey during the study period itself, albeit several others did so in the next two months.[27/]

As with Jail One, the most significant substantive improvements occurred in the service area. The addition of the public health nurse in January meant that Jail Two could now provide communicable disease screening, regular sick call, and on-going treatment and referral. The physician now comes to the jail to give inmates routine physical examinations and to provide treatment beyond the nurse's skill level.[28/] Receiving screening by trained jailers was initiated and the extent of dental and mental health care were increased.

27/ At its March meeting, the AMA's National Advisory Committee decided to defer an award of two year accreditation to this jail for sixty days, pending additional evidence that its newly enacted policies and procedures were being carried out fully. A re-survey showed that the jail continued to be in compliance and it is currently the only one of the ten studied to have been awarded full accreditation, although more expect accreditation in June.

28/ Like the previous jail, the attorneys' room doubles as the medical treatment facility. If more extensive care is needed than what can be provided at the jail itself, formal arrangements have been made to utilize community health care facilities.

Significant improvements also occurred in procedural matters. A new policy and procedure manual was developed, training was provided to jail staff, a medical record system was initiated, better controls were developed for the medication distribution system, and arrangements with a variety of community health care providers were formalized.

3. Factors Contributing to the Extent of Progress Made

Probably the most significant factor contributing to the attainment of accreditation at this jail was the support and enthusiasm demonstrated by the health care providers. The sheriff's interest in accreditation was obviously important, but it would have been insufficient to motivate change without the strong support from the medical community.

The agreement of the public health department to provide services, the health subcommittee's approval of this arrangement, the willingness of the nurses to perform "extra duty," and the physician's readiness to assume responsibility for the jail's health care system were all necessary ingredients. Further, the cooperation of one of the local dentists, other health care providers acceptance of formalized arrangements and the involvement of the county medical society were contributory reasons for what was accomplished.

As with the first jail, the foremost secondary influence undoubtedly was the lack of any active opposition to the program from other segments of the community. While some of the jail staff objected to the additional paperwork at first, the jail's program officer reported

that they were "coming around." In follow-up interviews, both the doctor and the nurse indicated that the jail staff was extremely co-operative and that the program seemed to be well-accepted.

The law enforcement subcommittee was kept informed regarding the proposed changes and approved all of the new policies and procedures which were developed to govern the jail's health care system. Again, the fact that the standards could be implemented without the necessity of requesting additional funds was probably an important determinant of the ready approval given by this body.

When respondents were asked on the follow-up visit what the primary factors were which aided the jail in achieving accreditation, the names of the doctor, the nurse, the sheriff and the program officer kept cropping up. There was also general agreement, though, that the contribution of the project director at the state medical society had been considerable. In fact, the jail program officer stated that this individual's assistance was the most important reason that the jail was able to attain accreditation so quickly.

Since on-going relationships with the medical community had already been established, much of what remained to be done involved formalizing and documenting various aspects of the delivery system. The state project director was said to be extremely helpful in assisting the jail with the necessary paperwork. Aside from supplying the jail with examples of forms, training manuals, and other resource materials, a number of on-site visits were made by the state project director to provide direct technical assistance. This enabled the

jail to avoid "having to reinvent the wheel" and thus, considerably reduced the time involved in formalizing its health care system.

D. Jail Three (#6-3)

The initial visit to this jail occurred on September 14. At that time, the sheriff, the chief jailer, the county executive and an attorney who served as the part-time secretary/treasurer for the county medical society were interviewed and served as the key informants regarding the jail and community environments. The officer who had assumed the newly-created post of "Jail Transition Coordinator" also proved useful.[29/]

1. Pre-program Picture

a. General characteristics

Jail Three is located in a good-sized community of about 100,000 people. The total county population served by the jail is approximately twice that figure. To some extent, this county serves as a "bedroom community" for the major metropolitan area in the state, which is about thirty miles from the county seat where the jail is situated. The area supports a large agricultural business as well as other industries, however, so it is not dependent upon the city in any way for its well-being. The county was described as being rich economically, but politically and fiscally conservative.

The present jail facility is located on the eighth, ninth and tenth floors of the county courthouse, which was built in 1931. The eighth floor houses the jail's administrative offices as well as adult female prisoners. Regular male inmates reside on the ninth floor, while work release prisoners occupy the tenth. The eleventh floor serves as the juvenile detention facility, but it is adminis-

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29/ The county is building a new jail and this administrative position was created to facilitate the transition between the two locations.

tratively separate from the jail. The sheriff's department is located in the basement of the courthouse building.

The facility has a design rated capacity of 118 inmates and averages about 100 prisoners on a daily basis. While the jail does not appear to be overcrowded, these figures are somewhat misleading for two reasons. First, while the average population figure over the course of a year may be 100, on any given day the population may soar well above that number. Second, the staffing problems at the jail as well as state requirements that women and work release prisoners be housed separately, mean that the majority of the inmates reside on the ninth floor, and this area is often overcrowded.

The jail seems inadequately staffed given its physical layout and the number of prisoners it holds. The clerk-typists double as booking officers on the day and evening shifts and matrons are available as needed to supervise female inmates. Aside from the presence of the chief jailer and the transition officer during the day though, there are only two officers per shift to cover the rest of the jail.

This staffing pattern and the physical layout of the jail present major problems in providing adequate supervision of the inmates as well as sufficient communication between inmates and staff. In addition, the jail appeared cluttered and very much in need of repairs. Construction has begun on a new facility though, which is across the street from the courthouse, and it is expected to be ready for occupancy toward the end of this year.

b. Description of "pre" health care system and medical environment

Of all the facilities involved in the TJS, Jail Three had the lowest initial compliance with the AMA standards (i.e., only 42%). It offered no health care services in-house, and few in the community, which was all the more startling because of the size of this facility.[30/] Basically, the only services provided consisted of medical, dental and mental health care of an emergency nature. An on-going treatment and referral system was nonexistent, no detoxification was available for inmates undergoing alcohol and/or drug withdrawal, and the jail had no formal arrangements with any community health care providers. In fact, it was the only one of the ten jails in the study which could not identify a physician who was already providing some services and might be willing to assume overall responsibility for the jail's health care system.

Jail Three also had the most inefficient and the least cost-effective delivery system initially. When an inmate had a medical complaint, s/he first had to get the attention of a jailer. The jailer would then call the sheriff's department and request that one of the road deputies transport the inmate to the local hospital and provide security while the individual was being treated. When a car and a deputy were free, they would be dispatched to the jail for this purpose.[31/]

30/ As indicated previously (see page 12 and note 21, supra), there has generally been a strong positive correlation between the size of a jail and the number of services offered pre-program.

31/ In a visually apparent emergency, an ambulance would be called, but security by the road crew had to be provided in these instances as well.

Because the jail had no standing arrangements with community health care providers, inmates were taken to the hospital emergency room for care in almost every instance. Thus, instead of the $15 to $20 that a physician or a clinic might charge for out-patient services, the jail was paying triple that fee for emergency room treatment.[32/]

Both the sheriff and the chief jailer were well-aware of the high cost and potential hazards of the jail's existing method of delivering health care. When asked why they continued this practice, the response was that they had no choice. Officials had tried on numerous occasions in the past to locate a physician willing to provide services to the jail, but without result. The most recent attempt had occurred a few months previously, shortly after the present sheriff took office. He wrote to the county medical society requesting assistance in finding a physician to serve the jail. When a response was finally received from this organization, it indicated that none of the membership was interested.

Other attempts to improve the health care system had also proved futile. A proposal that interns working in a local hospital "moonlight" at the jail two times a week for pay was turned down by the medical school's administration. The city health department was asked to provide communicable disease screening and other laboratory testing to inmates, but this office also declined. Finally, the county's visiting nurse agency was approached regarding extending its services to the jail, but again the response was negative.

32/ There are some obvious dangers to this type of system, including the lack of continuity of care. For example, different physicians often prescribed different medications for the same inmate, since they were unaware of each other.

There are a number of legitimate reasons which could account for this lack of support from the medical community, of course, and the specifics regarding these refusals to help the inmates are not known. Perhaps the proposals by the jail were not forcefully made or were ineffectively argued. Perhaps the money offered was insufficient. Nevertheless, it seems fair to say that active interest from the medical community regarding improving the jail's health care was definitely lacking.

This position was reinforced when the investigator attempted to interview a local attorney who served as the part-time executive for the county medical society. While he agreed to see the investigator, his attitude was suspicious to say the least. He demanded to be shown identification and credentials and insisted on calling the AMA to verify the investigator's legitimacy before agreeing to speak with her. Once these assurances were received, though, he relaxed considerably.

He indicated he had not heard of the AMA's program, and he was sure the members of the medical society were not aware of it either. When asked if he thought the physicians would be interested in such a program, he said he thought they would be receptive to hearing about it and some might be supportive, especially since it was being sponsored by the AMA. He further stated that finding someone to serve as the responsible physician might prove difficult, but not impossible; and that this task would be easier to accomplish if local government officials supported the program as well.[33]

33/ It should be noted that this attorney is the son of the chief county executive.

c. Description of "pre" political environment

Both the sheriff and the chief jailer indicated that their facility enjoyed reasonable relationships with the press and with county government officials. Neither of them was sure that they could generate support for health care improvements from this latter group, however, in view of the politically and fiscally conservative nature of the county. Of the two factors, both respondents felt that cost would be the primary determinant in gaining the approval of the local government. Somewhat the reverse was true with respect to public opinion though. The chief jailer stated he was not sure how the community would respond to the notion of improving health services for inmates, since "the public's usual attitude is 'Hang the bastards!'"

The expected attitudes of jail staff were also a source of concern to both respondents, but especially to the chief jailer. He stated that his facility was already understaffed and the people there were overworked as it was. He did not think they would take kindly to any proposal which meant additional duties and more paperwork. Finding time for training was also expected to be a problem.

The chief jailer's administrative difficulties are compounded by the fact that few of the jail staff are assigned there permanently. At present, new recruits in the sheriff's department are placed at the jail during their probationary period. Most stay only six to nine months and then transfer to the road crew. While the pay scale for both jobs is the same, working at the jail is not perceived as being as desirable as being a road deputy--in part, because working

conditions at the jail are not good and in part because the deputies there have a "junior" status.

While both the chief jailer and the sheriff seemed committed to the idea of improving the jail's health care, the expected resistance of the staff represented another potential roadblock to effective implementation of the AMA standards. When asked how he would attempt to overcome such resistance if it did materialize, the chief jailer indicated he would "just order them to do it."

d. Description of "pre" economic environment

As noted earlier, this county was reported to be relatively wealthy, albeit fiscally restrained. The primary funding authority for the jail is the county board which is composed of thirty-two supervisors. A legal services subcommittee has the most direct contact with the jail, while the chief county executive has veto power over the full board.

The law enforcement officials interviewed stated that the county board had not been particularly receptive to the needs of the jail in the past. For example, requests for additional personnel were routinely denied. While the community had approved building a new jail, funds to adequately staff and equip the new facility were not allocated. This was true for the medical section as well. Space for a screening room, an examination room and a dental office were planned, but monies for health care personnel and equipment were not authorized.

The county executive stated that the jail was "usually not too

popular with the citizens" and that they would resent additional expenditures beyond those already appropriated for the new facility. Still, he indicated that if the health care could be improved and "the cost was not too much more," the county government would probably go along with it. The possibility that a different delivery system might result in better services at a cost-savings to the county intrigued him.

2. Progress Made in Attaining Standards

Initially, Jail Three only complied with 42% of the AMA's standards (see Table III). It met fewer than half of the thirteen service standards, less than a third of the twenty-one procedural standards and six of the eight environmental. By the time of the investigator's follow-up visit at the end of March, significant gains had been made in all but the last category.

The changes which had occurred in the organization and delivery of health care services were nothing short of remarkable. Foremost among these was the addition of staff to provide services in-house. The jail's booking room now doubles as the medical treatment room, and a licensed practical nurse has been hired to provide screening and routine medical services. She holds sick call several times a week and makes referrals to community health care providers as needed.

The nurse's activities are supplemented by a physician assistant who comes in a couple of nights a week to provide physical examinations and by a physician who has agreed to oversee the jail's health care system. Arrangements were formalized with other health care

providers and routine dental care, detoxification services and increased mental health care are now available to inmates.

Minimum supplies, equipment and stock medications were purchased for the medical treatment room. A medical records system was initiated as was a new medication distribution system. Receiving screening was implemented and jail staff were trained to perform this task at booking. A policy and procedure manual was developed, standing and direct orders were written and various forms were devised to assist in the documentation of the new system.

Clearly, a number of improvements had been made in a relatively short period of time. The new system was expected to become fully operational as of April first and the jail had requested an official accreditation site survey for later that month. Information from the jail's self-survey (which is reflected in Table III) shows that this facility was meeting 91% of the AMA standards by the end of March. Unless the official survey turns up some unexpected deficiency, Jail Three is likely to receive accreditation in June.

3. Factors Contributing to the Extent of Progress Made

The changes which occurred at Jail Three were all the more dramatic when considered in light of its pre-program medical, political and economic environments--each of which contained potential obstacles for effective implementation of the AMA program. Of all the facilities studied, not only did Jail Three have the lowest initial compliance with health care standards, it also appeared to have the greatest probability of active community and staff resistance. There-

fore, it becomes even more important to try to ascertain why this jail was able to accomplish what it did.

The primary obstacle which the jail's administration had to overcome was to convince the medical community to become involved in providing on-going services, even though its previous attempts to do this had failed. It also needed to persuade the county officials that there was a more efficient and effective way to provide health care, and to encourage jail staff to support the program.

From the evidence at hand, it appears as though there were two principal factors accounting for the jail's success. First, the fact that the program was sponsored by the American Medical Association and involved the state medical society made all the difference to the local physicians. Letters about the program from these organizations were sent to the county medical society, which then held a meeting to discuss it. Once the scope of the program was known, a number of physicians became interested in supporting it and a few volunteered to provide more direct assistance. Reportedly, the fact that the AMA standards rely heavily on the use of allied health personnel was a strong selling point for the physicians.

The second factor which facilitated change was a demonstration project, which the jail undertook to prove to the county board that the old delivery system was inefficient and costly. The jail received approval to hire a nurse for two months to provide screening, routine treatment and referral services. At the end of the trial period, the jail was able to prove to the county board that the new

system would enable the jail to provide better services to inmates and more protection for the county at a lower cost. The county board fell in line. The existing appropriations for the jail were reallocated and all of the planned changes regarding personnel and procedures were approved.

Once support had been demonstrated by the local physicians and the county board, the jail experienced little difficulty in finding interested staff or gaining the cooperation of other community health care providers. Locating a physician who would agree to supervise the new system was said to be the most difficult standard to meet, but that, too, was accomplished.

While some resistance did materialize from the jail deputies as expected, the transition officer stated that they do comply with the new paperwork and procedural requirements, "even if they don't always like to." Further, the nurse reported that while the cooperation from the deputies was not always ideal, she felt they were getting more used to the idea and she was sure she could work with them. Apparently, approval and enthusiasm from the security staff is not nearly as crucial to the program's success as other factors such as strong motivation on the part of the jail's administrative staff and cooperation from the medical community.

The latter seems to be the key determinant for successful implementation of the AMA standards. Both the chief jailer and the transition officer felt they owed a debt of gratitude to the state medical society for the assistance given. When asked specifically what the

contributions of this organization had been, the chief jailer indicated that "most assuredly, they got the local physicians to take interest." In addition, the state project director was said to have been very helpful in providing resource materials (including examples of forms, policies and procedures) as well as on-site technical assistance and regular telephone communication.

One final point regarding this jail's progress should be noted. When Jail Three entered the program initially, the administrative staff did not believe they would be able to make any significant progress until they moved to their new facility. Because conditions at the old jail were poor, neither the sheriff nor the chief jailer believed the jail could get accredited at its present location. Since the AMA standards are service-based rather than facility-based, though--i.e. the emphasis is on the types of services which must be provided somewhere, but not necessarily at the jail itself--this jail was able to make significant improvements in its health care system, even given its present facility. As an added benefit, the structure of the AMA standards will allow Jail Three to transfer its present delivery system to the new location, virtually without interruption of services to inmates.

E. Jail Four (#7-1)

The investigator first visited this facility on September 12 and 13. At that time, the director (i.e., the chief administrator), the assistant director, the jail nurse, the jail physician and the chairman of the county board were interviewed among others. These five individuals were the primary informants regarding the operation of the jail and its existing health care system as well as the political and economic climate of the community.

1. Pre-program Picture

a. General characteristics

Jail Four is located in a fair-sized town in a mid-western state. The county served by this facility has approximately 280,000 residents. The county seat is about forty miles from the heart of the state's major metropolitan area and a number of the county's residents commute to the city to work. Agriculture and other industries are the mainstay of the county's economy, however.

The jail facility was built in 1975. It is modern in design and bright--almost cheery--in appearance. Administrative offices are carpeted, corridors are well-lit and painted colorfully instead of the usual drab-grey of concrete, and huge blow-ups of photographs adorn the walls. It gives the appearance of being clean, efficient and well-managed.

Unlike other jails across the country, space is not currently at a premium. The jail has a design rated capacity of 102 beds and averages eighty inmates on any given day. In addition to sufficient

bed space to meet current needs, the jail has a well-stocked library, a small auditorium which doubles as a chapel, an exercise room, a medical area, and several offices which serve as classrooms, meeting rooms and treatment facilities of various kinds.

While the sheriff retains legal responsibility for the jail, he is not very involved in its day-to-day operations. Instead, the jail is managed by a professional administrator who holds the title of director. He has an assistant who also serves as the training officer for jail staff. Neither of these individuals mentioned a problem with security staffing patterns, so presumably correction officer coverage is sufficient. Both mentioned that the staff had a sense of pride regarding working in a "model correctional facility" and stated that professionalism among staff was consistently stressed.

b. Description of "pre" health care system and medical environment

When Jail Four entered the AMA program, it already had a good, working health care system. A number of routine services were provided in-house by a nurse who came to the jail five times a week for five or six hours per day. The nurse was employed by a physician group which had a contract with the jail to provide basic health care services such as regular sick call, communicable disease screening, and abbreviated medical examinations. If more extensive care was required, inmates were referred to this physician group or to other community resources on a fee-for-service basis.

Detoxification from alcohol was provided as needed, although

similar services were not available for inmates suffering drug withdrawal. Some mental health care was available through a counseling and referral program and dental care not limited to extractions was given when inmates complained.

One of the physicians from the group under contract with the jail served as the spokesman. He indicated his office had been providing services to the jail for about eighteen years. When the new facility was built, he set up the jail's health care system and was obviously proud of it. He indicated he had put a lot of time and effort into developing the medical system at the jail, and he wanted the personal recognition that accreditation might bring.

The physician further stated that most of what needed to be done to attain accreditation involved formalizing relationships with other community health care providers and improving the documentation of existing services. Although not eager, he was more than willing to undertake the necessary paperwork to see that these tasks were accomplished.

Since the nurse was employed by his medical group and he was already overseeing her work, he indicated there would be no problems in gaining her cooperation in any operational changes that might be required. When the nurse was interviewed, she affirmed the positive working relationship between herself and the physician group and communicated her willingness to work toward accreditation. She stated she had been working at the jail for some time and that the attitude of the physician group and the jail's administrative staff had always

been one of wanting to provide the best care possible. She, too, was interested in "doing things right" and wanted to be proud of what she does. Like the physician, she believed that accreditation would be tangible evidence of a job well-done.

Both the physician and the nurse stated that the jail enjoyed good relationships with other health care providers. Neither anticipated any problems in gaining cooperation from the medical community. The area enjoyed an abundance of health care resources, so providing additional services was not expected to prove difficult either. In addition, the county medical society was actively interested in and supportive of the jail's efforts to achieve accreditation of its health care system.

c. Description of "pre" political environment

Both the director and the assistant director indicated that they expected the jail staff to be "100% cooperative" with the medical staff in any procedural changes which might be required. The director stated that his jail had already achieved national recognition when it first opened as an "exemplary adult correctional facility" so his staff was used to being inspected. This sense of professionalism among the staff was expected to carry over to any medically-related duties they might be asked to undertake.

The assistant director was enthusiastic about providing additional training to jail staff and appeared confident that the correction officers' response would be supportive as well. Although not actively involved, the sheriff was said to be committed to the idea of accredi-

tation and interested in the jail's working to attain it. Both the physician and the nurse confirmed these statements regarding the attitudes of the sheriff, the administrators and the correctional staff.

No resistance was anticipated from the general community, the press, or the local government either. Relationships with all of these bodies were said to be good and the responses from individuals who had been contacted about the program were said to have been favorable. Negative reactions from any of these groups were anticipated only if implementing the standards proved to be too costly.

d. Description of "pre" economic environment

As is usual with facilities of this type, a county board has fiscal authority over the jail. Its most direct contact with the board is through a corrections and rehabilitation subcommittee. While additional monies and services are sometimes available through grants and various organizations, 98% of the jail's funding was said to come from the county. The director described the board as having been very receptive to the jail's needs in the past. This was evident from the facility itself and the types of services already being provided to inmates. Since the county is relatively wealthy and the local government prides itself on being progressive, jail officials were able to obtain most of the resources they requested.

When the chairman of the county board was interviewed, he appeared supportive of the jail's efforts to improve its health care system.

He felt that the present level of care offered at the jail was good, but indicated that if it could be improved for about the same amount of money, the county board would endorse such a program. When asked about the willingness of the county to provide additional resources if needed, the chairman stated that if the benefits of accreditation were clearly demonstratable, more money would be allocated.

2. Progress Made in Attaining Standards

Jail Four had one of the highest initial levels of compliance with the AMA standards (i.e., 74%). Table III indicates that the jail was meeting two-thirds of the service standards, about three-fourths of the procedural standards, and most of the eight environmental standards before it became involved in the AMA program. By mid-February, Jail Four was in compliance with all but one or two standards in each category and had raised its overall compliance level to 92%.

Because Jail Four was already providing basic health care, changes which were made in the service area were not as dramatic as those described for the three previous jails. Still, important improvements did occur. For example, a more complete receiving screening program was initiated, the types of health appraisal data collected were expanded, dental screening and hygiene services were started, and detoxification as well as mental health services were increased.

A number of changes also occurred in the procedural area. The physician devoted considerable time and effort to writing up policies and procedures and to activities associated with improving the docu-

mentation of services provided. Relationships with community health care providers were formalized and the nurse's coverage at the jail was increased. Further, first aid kits were purchased and jail staff received training in first aid, CPR, receiving screening and handling mentally ill inmates.

While it was not accredited during the study period, Jail Four had requested that an official on-site survey be conducted. This survey took place in mid-March, and from the survey team's report, it appears highly probable that this facility will receive accreditation when the AMA's Advisory Committee meets in June.

3. Factors Contributing to the Extent of Progress Made

As with the previous three jails, the most significant factor contributing to the extent of progress made seemed to be related to the cooperation received from the medical community. All of those interviewed on follow-up stated that it was the physician who was pushing for accreditation and that he was the one who had done most of the work. Obviously, the nurse played a key role in seeing that procedural directives from the physician were carried out. Further, support and interest on the part of the jail's administrative staff was a necessary--although not sufficient--condition for change to occur.

Improvements in the health care system at Jail Four were facilitated by the cooperation received from the jail's correctional staff. Booking officers were said to have adapted well to the changes in admission procedures and training efforts were said to have been well received. The election of a new sheriff mid-way through the

study was said not to have affected the program one way or the other.

The physician did go before the county board to request an increase in his contract with the jail for the next year, but he stated that the additional monies required were not related to implementing the AMA standards. Nevertheless, the county board approved the new contract.

At this jail then, not only was there no opposition to improving the health care delivery system, there was active support for it from all the key groups. The physician's interest in accreditation and his willingness to devote the necessary time to it was undoubtedly the key factor influencing the progress made. The lack of political and economic constraints coupled with the progressive nature of the community and the professional pride of the nurse and the jail staff made the physician's job in bringing about change that much easier.

The assistance provided by the state medical society's project director (SPD) was also said to have been of benefit. This individual met with the director, the nurse and the physician to go over the standards and ensure that the meaning of compliance for each standard was fully understood. In addition, the SPD provided a variety of materials to assist Jail Four in formalizing its health care system and maintained regular contact with the physician. According to the personnel interviewed on follow-up, the SPD served as "a useful resource person" and gave technical assistance whenever asked.

F. Jail Five (#9-1)

The initial on-site visit to Jail Five took place on September 25 and 26, 1978. At that time the following individuals were intensively interviewed: the sheriff who is legally responsible for the jail, the deputy master who is in charge of jail operations, the jail's medical director, the primary jail physician, the two full-time jail nurses, and one of the county commissioners.

1. Pre-program Picture

a. General characteristics

Jail Five is located in a large urban environment and serves a county that has the largest population concentration in that region of the state--approximately one half million people. It is a large facility built in 1888 with a capacity to house 276 inmates. The main cell block area is three tiers high and divided into small individual cells. The jail was scheduled to undergo a major physical renovation, which was being substantially funded by a federal grant.

Although the jail is large and soundly constructed, the physical characteristics of the facility created some disadvantages. The individual cells were small by currently accepted standards and the locks had to be manually turned. A lot of the administration and daily functioning of the jail took place in a large rotunda area outside the main cell block which was not ideally suited for this purpose. These physical features of the jail probably contributed to a certain inefficiency in operation, but also allowed closer contact and communication between inmates and staff--which is not always present in

more modern, electrically-operated facilities.

The jail housed approximately 215 inmates on an average daily basis during the course of the study. This included both male and female inmates and youths seventeen and older. The jail sees many of the problems and types of individuals usually associated with a large urban environment. The inmates are generally young and many come in with alcohol and drug-related problems and a relatively high incidence of communicable diseases.

b. Description of the "pre" health care system and medical environment

Primary inmate health care services were delivered in the jail by a team of health care professionals. The overall coordination of this team was the responsibility of the jail's medical director who was trained in clinical pharmacy and as a drug abuse specialist. Assisting the medical director on a full-time basis were two male nurses--an RN on the day shift and an LPN on the evening shift. A female nurse also came to the jail five days a week for an hour each day to take care of the health needs of the female inmates. The medical director and the two full-time staff nurses provided twenty-four hour on-call medical coverage to the jail on a rotational basis, in addition to their regular hours.

Primary physician coverage was provided by a team of three doctors from the emergency room of a local hospital. Under an arrangement with the jail, one of these doctors came to the facility on weekdays to provide essential physician services and conduct sick call. The

arrangement under which the team of physicians worked in the jail was relatively new and one that had been developed at the urging of the medical director who had been dissatisfied with previous physician coverage.

At the time of the initial visit, the medical facilities in the jail consisted of a small, one room dispensary outside the main cell block area. The medical director also had a small office in the main rotunda area where medical records were kept. The jail physician and medical staff all agreed that the medical facilities at the jail were inadequate, both in terms of space and equipment. They were all eagerly awaiting the start of the jail renovation program, which was to include a total revamping and enlargement of the in-house medical facilities. In addition to an improved dispensary area, a space was to be remodeled that would serve as a jail infirmary.

All the people interviewed stated that they felt the jail's efforts to get accredited hinged on the renovation of the medical facilities inside the jail. Without the renovation they did not believe the jail could meet all of the AMA standards. In part, this belief was due to an initial misunderstanding of the standards, but also it was due to their desire to demonstrate that the renovations were necessary if better health care was to result.

Efforts to improve the jail's health care delivery system were occurring long before the facility's involvement in the AMA program. The medical director was originally brought into the jail five years before this study began to help deal with drug dependent inmates.

The need for better health care services was then recognized and more medical staff were added. The RN position was created on a permanent basis while the LPN was hired to staff a temporary job position. All of the jail's medical personnel, including the physician, felt that another full-time nurse was needed at the jail in order to keep up with the volume of work and adequately perform follow-up communicable disease testing. This view, however, was not unequivocally shared by the jail's top administration.

The medical staff and physicians seemed attuned to ways of improving the jail's health care delivery system. Even before the jail's involvement in the AMA program, the medical director had developed a series of forms and initiated substantive changes at the jail. One form he developed was a parental authorization to treat seventeen-year-old inmates who were being held at the jail. This form was needed because a person between seventeen and eighteen years old was not considered an adult in the medical field, but was old enough under state law to be incarcerated in an adult facility.

In addition to the parental authorization form, a drug formulary was developed and a system devised to keep daily medical statistics. The medical director's background in pharmacy also proved beneficial in helping the jail switch to a unit dosage system of distributing medications. This was done to prevent the excessive availability of medications in the jail.

The jail physician indicated that the individual inmate medical record had also been changed to reflect a more problem-oriented

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approach to patient health care. He further stated that a better system of physician referral for speciality care had been implemented in the six months he had been working in the jail.

At the time of the initial on-site visit, the jail was utilizing one of the area's three private hospitals for most of its standard outpatient hospital and clinic needs. The medical director stated, however, that he hoped to begin using the area's public hospital to provide these same services and thereby save a substantial portion of the jail's medical budget. Whenever extensive hospital care was required, the jail could make arrangements to have the inmate transported across the state to another public hospital.

The city health department provided the jail with the supplies it needed to do inmate tuberculosis testing. The medical director indicated that he was concerned not only with testing inmates when they were first admitted to the jail, but also prior to their release. He noted that national studies had shown that inmates frequently contract the disease while incarcerated. The jail also routinely performed venereal disease testing on sentenced inmates. The state department of health assisted the jail with this testing, especially by helping with follow-up identification and tracking.

Inmates with drug and alcohol problems and those needing psychiatric treatment were major concerns of the jail's medical staff. Because prisoners were usually brought to the jail after being arraigned before a judge (and usually after spending a short period of time in a police lockup), the sheriff was required by law to

accept custody or risk being held in contempt of court. The medical staff indicated that it was not uncommon for prisoners to be brought in suffering alcohol or drug withdrawal complicated by medical or psychiatric problems. When this occurred, the inmate had to be taken to an appropriate medical facility--either the nearby state mental hospital or the general medical hospital used by the jail--where his/her condition could be more appropriately evaluated and stabilized.

The sheriff and medical director had both sought additional medical resources from the regional mental health agency and the local medical society. However, their efforts proved unproductive. The regional mental health agency declined to become involved at the jail, citing as a reason that its philosophy of deinstitutionalization was in conflict with the criminal justice system.

The local medical society was well aware of the jail's needs and problems. In the past it had responded to inmate complaints about the adequacy of the jail's health care and had also been approached on several occasions by the sheriff and medical director for assistance in locating medical resources for the jail. It appeared that the jail's requests received no response, however. Nevertheless, the local medical society had been kept informed of the jail's involvement in the AMA program.

Besides the problems of gaining access to community resources mentioned above, the jail also faced transportation and security difficulties whenever inmates required medical services outside the jail. This was particularly problematic when dental care was needed.

The jail hoped that this problem would be alleviated in the future when more staff was hired through the Comprehensive Education and Training Act (C.E.T.A.) and the medical unit was remodeled. Plans called for the installation of a dental chair at that time, and the medical director hoped that arrangements could then be worked out to bring a dentist and a dental hygienist into the jail on a regular basis.

c. Description of the "pre" political environment

The political environment surrounding Jail Five seemed very favorable to its participation in and successful completion of the AMA program. Not only was the jail hoping to get its health care delivery system accredited, but it was also working toward accreditation of the entire jail operation. Strict state standards were being mandated and the jail was working toward early compliance with those too. In addition, one other large jail facility in the state was under court order to improve its health care system and the medical director at Jail Five had been named in several suits which touched on his facility's health care services.

The jail was fortunate in being able to secure federal grants and matching local funds to renovate its facilities. The plans to renovate the jail were a source of controversy at the county commission level, however. The county commissioner who was interviewed indicated that he preferred building a new jail to renovating the old one. The sheriff and the rest of the commissioners, on the other hand, preferred retaining the existing jail. They felt that a new jail would not be

built with the same quality as existed in the old one and would probably have to be constructed on the outskirts of the city. The present jail was in close proximity to the downtown area and accessible by public transportation. Not only was the existing location more convenient for inmates' families, but also for the operation of the jail as a whole.

The sheriff credited the medical director with getting the jail initially interested in the AMA accreditation program. He said his medical director had been talking health care accreditation since the AMA announced its program in 1975 and was elated when the program became available to the jail through the state medical society in 1978. The medical director credited the sheriff with the enthusiasm and support needed to get the jail into and through the program. This feeling was also shared by the deputy master.

The entire jail staff was aware of the facility's involvement in the accreditation effort and, according to the sheriff, all were very much in favor of it. The sheriff indicated that by improving medical services at the jail, a need for inmate services was being filled which the jail staff realized created a better environment, and hence made its job that much easier. The jail's RN also stated that on several occasions, correctional officers had come up to him and showed positive interest by inquiring about the accreditation program.

The medical director and sheriff were both interested in improving health care services at the jail for humanistic reasons and as a measure of protection against liability suits. Both hoped the accredi-

tation program would help insure the impartial and sane treatment of inmate medical needs. They also felt that having an impartial third party do the accreditation would help demonstrate that the jail was performing in an adequate fashion.

Except for the fact that everyone interviewed felt accreditation would have to wait on the renovation of the jail's medical area, there was only one other less-than-positive feeling about the accreditation effort. The entire medical staff felt that the correction officers would be reluctant to do any of the receiving screening as called for in the standards, and unless paid time-and-a-half, would not participate in CPR or first aid training. It was explained that the correction officers were afraid of having anything to do with jail health care for reasons of personal liability and their union would require adequate compensation for additional training. However, the sheriff and deputy master did not feel these were major problems and thought that they could be handled without much difficulty. It was indicated that the RN at the jail was a certified CPR instructor and that if need be, additional funds would be requested for staff training. The sheriff felt that when the C.E.T.A. employees started working at the jail, enough manpower would be available to do the training without recourse to overtime pay.

The sheriff and the medical director indicated that the local press generally reacted favorably to the jail and supported inmate programs. The sheriff said that he was elected on a humanistic platform, and the press was positive, but cautious toward him. The medical

director said that he had arranged tours of the jail for medical groups and on occasion, given public addresses.

d. Description of the "pre" economic environment

Everyone interviewed indicated that the county commissioners were fairly receptive to the needs of the jail and that the jail was fairly adept at obtaining federal grants. As previously mentioned, matching local funds had been authorized so that the jail could receive federal money for needed physical renovations. In addition, the jail had received a small grant to assist it in attaining total jail accreditation and was looking foward to hiring more staff under the CETA program.

Before funds could be appropriated for the health care needs of the jail, the medical director had to submit a budget with appropriate justifications to the deputy master and the sheriff for their approval and inclusion in the total jail budget. The sheriff, in turn, submitted his budget to the county commission which then forwarded it on for state review and ultimate approval. At each step along the way, deletions and cuts in appropriations were possible.

The medical director indicated that this budgetary process was a cumbersome and aggrevating method of obtaining needed resources. Requests for health related items took time, had to be planned for, and were often seemingly lost amid the large requirements of the jail. Even obtaining necessary equipment and supplies involved bureaucratic-type nuisances.

The medical staff saw a need to upgrade the LPN position at the jail from a temporary job classification to a permanent one, and also

to have another nurse added to the staff. They felt these actions were necessary in order to keep up with the essential medical services at the jail and to assist in providing twenty-four hour on-call coverage when medical personnel were not present at the facility. They stated that providing twenty-four hour coverage was personally burdensome and disruptive of their lives, in spite of the fact that they were adequately compensated when called into the jail on an emergency. The jail administration felt that without additional justification, however, new medical staff positions would not be approved.

The medical director indicated that he would also like the jail to pay for professional liability insurance for the medical staff. At the time of the initial site visit, the medical director was the only person with such coverage and he paid for that himself. The county commissioner was aware of the medical liability suits against the jail and the medical director and seemed sympathetic to the problem. The sheriff also indicated that liability insurance was a justifiable expense that ought to be looked into.

In an overall sense, the political system at the county and state levels seemed supportive of the economic needs of the jail. The top jail administrators were also aware of the medical requirements of the inmates and enthusiastic about improving health care services. While the jail's medical unit did not get everything it requested, it had come a long way since the time the medical director first began working in the facility.

2. Progress Made in Attaining Standards

Jail Five's initial self survey indicated that it was already meeting approximately 71% of the AMA standards when it first entered the program. The jail was complying with most segments of the thirteen service standards, although essential parts of several were not being met as consistently or as thoroughly as required. For example, the jail was doing a form of receiving screening at booking, but the inquiries into the prisoner's state of health were not as extensive or complete as they needed to be. Further, not all inmates were receiving a health appraisal within fourteen days of incarceration and communicable disease testing was only routinely performed on sentenced inmates. Perhaps the most obvious shortcoming was the lack of adequate routine dental care.

Besides not fully meeting several of the essential service standards, the jail needed to make many improvements in the procedural area. First, the jail did not have a written agreement with the group of physicians responsible for providing routine inmate health care. Second, written job descriptions, most written standard operating procedures, and written standing and direct orders did not exist. Third, and perhaps most problematic, the jail's correction officers were not all adequately trained in first aid and CPR, nor had the booking officers been instructed in receiving screening or symptom recognition. Jail Five also failed to meet the two environmental standards applicable to food handlers.

At the time of the investigator's follow-up visit, Jail Five was

in the process of implementing all the AMA standards. A short time following this visit, the jail reported on a second self-survey that it felt it was in full compliance with the standards and an on-site accreditation survey was conducted. Although the official results of this on-site inspection are not yet known, preliminary indications pointed to the likelihood of the jail receiving accreditation.

The following is a thorough review of the changes which occurred in the jail over the course of the study period:

> First, a formal relationship was developed with the local public hospital which provided for more extensive out-patient referral which the jail needed. These referrals include dental and eye examinations and treatment. The use of this hospital not only improved inmate services, but also reduced direct jail medical costs.
>
> Second, an expanded receiving screening was initiated the week the investigator made his follow-up visit. Implementing this receiving screening involved booking officer training and the use of an expanded format similar to the example supplied by the AMA.
>
> Third, the jail established a program to insure correction officer training in first aid and CPR. One of the jail's nurses indicated, however, that he felt the first aid training being taught at the state level and utilized by the jail was still inadequate.
>
> Fourth, with the help of the jail's physicians, the medical director developed the necessary written job descriptions and standard operating procedures.
>
> Fifth, the medical director was shifted into an expanded administrative role and away from the direct delivery of inmate medical care for which he was not licensed or formally trained. He was also taken off twenty-four hour on-call status.
>
> Sixth, fourteen day physical assessments and communicable disease screening on all inmates were brought up-to-date and kept current as called for in the standards. This was made possible by moving the LPN from the evening to the day shift.

Seventh, the inventory and control of pharmaceuticals, needles, and surgical instruments was tightened.

Eighth, better transportation arrangements were developed which allowed expanded delivery of health care services outside the jail.

Ninth, correction officers were given the training and task of distributing some daily medications, thus freeing up medical staff for other duties.

Tenth, a C.E.T.A. worker was assigned to the medical staff to provide clerical support. This temporary staff position facilitated compliance with the written requirements of the standards as well as other administrative responsibilities of the medical director.

And finally, the jail physician stated that inmates in punitive isolation were receiving improved medical coverage and care.

Table III indicates that Jail Five felt it was in 100% compliance with the standards when it completed the second self-survey. Perhaps this will prove to be an overly optimistic self-appraisal considering that some of the standards had only been in place a short while. Nevertheless, the changes which occurred at this jail and the effort necessary to accomplish them were substantial.

3. Factors Contributing to the Extent of Progress Made

Undoubtedly the most important factors contributing to the success of Jail Five were the drive and enthusiasm of the sheriff to get accredited and the real desire of the medical director and jail physicians to provide the best possible medical care. Added to this was the fact that the jail was located in a state where the concept of accreditation was being enthusiastically endorsed. Not only were most of the jails in the state working toward total jail accreditation, but a kind of rivalry and peer pressure existed among the sheriffs

in the state. New state jail standards also seemed to exert some pressure.

The jail was fortunate to come into the program with an already well-developed health care system. In addition, the county commission appeared willing to provide a sufficient level of resources to the jail. The influence of the state medical society project director cannot be overlooked. The project director helped stimulate interest in accreditation throughout the state and provided necessary technical assistance to the jail. In addition, a state-wide conference on correctional health care was held that prodded Jail Five into accelerated action.

The progress that Jail Five made did not come easily nor without some internal jail turmoil. It was apparent to the investigator that the medical director and jail's physicians were concerned that if the jail received accreditation, one of their strongest arguments for additional staff and resources would be diluted. The planned jail renovations had not taken place at the time of the follow-up visit and were not scheduled to begin until the Fall. Also, the jail's medical unit did not receive the additional nurse it wanted. Because of fiscal considerations and the fact that the size of the jail's dispensary could not accommodate additional medical staff, alternatives to more medical personnel were being considered.

A problem of communication also seemed to create some tension. While the sheriff had set the goal of achieving accreditation for sometime in the Spring, the medical staff felt that a much longer time period

was required. A lack of sufficient coordination and planning on the part of the medical director, coupled with a lack of awareness of the real progress being made on the part of the top jail administrators, led to internal turmoil which probably could have been avoided. The entire medical staff felt that the accreditation of the jail's health care delivery system was not getting the priority it deserved. However, the jail administration did appear to give it strong support when needed. For example, the LPN was moved off the evening shift over some apparently strong objections. Further, the correction officers and booking officers started doing medication distribution, and receiving screening, in spite of the fact that they were initially opposed to performing these jobs for fear of personal liability. The deputy master overcame their objections by putting legal questions to rest. Also the availability of transportation for health care purposes was improved.

Jail Five is a good example of the advantages and disadvantages that some facilities experience in trying to improve their health care delivery system.

G. Jail Six (#9-2)

The initial on-site visit to Jail Six took place on September 27, 28, and the morning of the 29th, 1978. At that time, the following individuals were interviewed: the sheriff who is legally responsible for the jail, the deputy master who is in charge of jail operations, the captain in charge of the jail's medical services, the jail physician, the jail nurse, the jail's human services coordinator, and the chairman of the county commission. In addition, brief conversations were held with the captains in charge of transportation, classification, booking and finance.

1. Pre-program Picture

a. General characteristics

Jail Six is a large facility which is located in the second most populous county in the state. It serves an urban and suburban population of approximately 650,000 people. The jail complex was built in 1973 in a sparsely developed area that is in relatively close proximity to the county's main urban center. It has a design-rated capacity of 267 inmates, but during the course of this study, it had an average daily population of almost 277. At one time in December, the daily inmate count reached 308.

The jail is a modern facility with an electronically operated system. Inmates are housed in individual cells and many in-house resources are present that benefit both the inmates and jail administration. Jobs are made available to the sentenced inmates in such areas as the facility's school, print shop, and motor pool. It should

be pointed out that the jail makes a clear distinction between sentenced and non-sentenced individuals. These two groups are strictly segregated from one another in separate sections of the jail.

Women are also housed at the jail. Because of previous litigation, every attempt is made to insure that they receive the same benefits as the male residents.

b. Description of the "pre" health care system and medical environment

At the time of the initial on-site visit, primary inmate health care was delivered in the jail by a physician, a full-time registered nurse, and a medically-trained correction officer, who served as the jail's medical officer. The physician came to the jail five times a week for a few hours, but also saw inmates in his office at a local hospital. The registered nurse was new to the jail, having begun working there the same month this study began. Prior to her arrival, the medical officer was the only full-time health care person at the jail. The medical officer held the rank of captain and was responsible for the coordination and delivery of inmate health care services. According to the physician and nurse, the medical officer was trained, competent and highly capable of handling the emergency and routine health care needs of the jail population.

In addition to this primary health care team, a forensic psychiatric team and a dentist came to the jail on a regular basis. The psychiatric team consisted of a phychiatrist, a registered nurse and five social workers. The psychiatrist and social workers came to the

jail only once a week, but the nurse came five times a week. The social workers were also available on-call. Most dental services were provided in the jail by a group of dentists, one of whom came in once a week.

The jail also had an established program of alcohol and drug detoxification and rehabilitation. Depending upon the severity of the condition, prisoners needing detoxification from alcohol or drugs were either handled in the jail or at the "detox center" at the city hospital. Alcoholics Anonymous held meetings in the jail twice a week--one night for female inmates and one night for individuals on work release. There were also three alcohol and drug counseling programs available in the local community.

The medical facilities in the jail consisted of a large dispensary and an eight bed infirmary. However, the infirmary had never been used since the opening of the jail in 1973, because there were no full-time medical personnel available to staff it. Prior to the initial on-site visit, the jail had applied for a federal grant to hire three additional full-time nurses. With this hoped for staff, plans were being made to begin utilizing the infirmary and providing the jail with twenty-four hour a day medical coverage. Both the jail administration and the medical officer believed that by having around-the-clock medical coverage and an operating infirmary, the use of local hospital facilities could be sharply reduced.

The jail utilized the local city hospital for most of its emergency needs, outpatient clinic care, and in-hospital bed care. A

large teaching medical center was also used sometimes in emergency situations. At one time, the jail had tried making an arrangement with a local medical school for the delivery of health care in the facility, but this did not work out. The sheriff, the deputy master, and the medical officer all stated they were very pleased with the current arrangements the jail had with the physician and the city hospital.

Since the jail physician was on the city hospital staff, many administrative delays and hospital expenses could be avoided when an inmate was brought in for treatment. For instance, it was not necessary to process inmates through the emergency room for routine care. Instead, they could be taken directly to see the doctor. This was a savings both in terms of staff time and hospital charges.

The jail had its own program of in-service training in first aid and CPR, besides utilizing the first aid course available through the state-run correction officers school. A short time prior to the initial on-site visit, the jail had conducted a CPR course. At the suggestion of one correction officer, this course was made available to everyone at the jail, including the inmates. About eighty inmates availed themselves of this opportunity and took part in the training.

Wherever possible, Jail Six utilized the medical resources available through the county and the state. The county hospital provided the necessary supplies and testing for tuberculosis. Two state mental hospitals provided emergency and long term psychiatric hospital care and the state department of health conducted routine environmental

health inspections of the jail.

However, the administrative staff members indicated some areas where they felt improvement in the health care system still had to be made. The sheriff stated that the dental care had to be expanded. The deputy master said the jail had a real problem with the handling of prescribed and contraband medications and drugs, and the correction officers especially were looking for help in combating this situation. He further stated that he wanted about twelve correction officers to attend an EMT course, so each shift would be covered in case of a medical emergency. He felt it would be particularly advantageous if some of the transportation officers had this training, so they would be better equiped to handle emergencies while on the road. The human services coordinator saw a real need to formalize the jail's health care delivery system. More records needed to be kept and procedures spelled out in writing to insure that inmates received equal medical care and the services for which they were entitled. She felt that the AMA program would be most beneficial to the jail in this area.

The sheriff's background in alcohol counseling made him very attuned to ways of getting necessary medical resources for the jail. He was also aware of the importance of gaining outside assistance and support in improving the jail and not trying to go it alone. He wanted the community to accept its responsibility to provide the necessary services. For that reason, he wanted members of the county medical society deeply involved ("up to their ass") in inmate health care and saw the AMA program as a step along those lines.

c. Description of the "pre" political environment

The sheriff was legally responsible for the functioning of Jail Six. He had been appointed to the office to fill out the unexpired term of his predecessor and was running unopposed in the next election. As he stated, his previous occupations seemed to be perfect preparation for the job of sheriff, because they gave him the counseling, rehabilitation and leadership experience which the job demanded.

Although the sheriff was the person legally responsible for the jail, the deputy master was responsible for the day-to-day operation of the facility. He had sixteen years experience in running the jail, and his expertise and direction seemed to exquisitely complement the overall operating philosophy of the sheriff. The entire top jail administration appeared to function with a high degree of harmony and unison.

The sheriff stated that he had a good working relationship with the county commission, which was one governmental body that had to approve the jail's budget. The sheriff said that he pursued an "up-front" type of communication with the commission and kept them informed of his feelings on jail issues, even if these were not always popular with them. He believed that because of this open and honest communication, the commissioners were more accepting of the jail's needs. However, both the sheriff and the county commissioner who was interviewed, stated that the jail had to demonstrate a real need before new resources would be allocated for the jail's use. For that reason, the sheriff was afraid that an AMA accreditation of the jail might

be a false signal to the commission that the jail no longer needed additional health care resources. Failure to get accredited, on the other hand, would work as leverage in arguments for more resources.

The sheriff and deputy master both stated that they enjoyed a good working relationship with the news media and the public in general. They both indicated that the jail often got coverage in the press and they themselves made appearances on television every three or four months. After one particularly serious incident at the jail, the press was allowed to interview the inmates. The jail, however, was always handicapped somewhat in responding to its critics because the state law did not allow the release of information from inmates' records which could be used in support of the jail's side of a controversy. The jail also had a policy of not answering letters to the editor in the local press.

At the time of the initial visit, the political environment both in and outside the jail seemed very receptive to the accreditation concept. The entire jail staff, but particularly the sheriff and deputy master, were genuinely concerned with the humanistic needs of the inmates. Several suicides in previous years appeared to have had an especially lasting effect on the jail, as did a riot which occurred in the old facility.

The entire jail staff demonstrated a very open and friendly communication system from the sheriff on down. Everyone connected with providing health care services at the jail, including the line supervisory personnel, was thoroughly informed about the AMA program. The sheriff and the human services coordinator had attended an orientation

meeting conducted by the jail project director from the state medical society. The information they gained from this meeting had been passed along to other staff.

Like many other jails in the state, Jail Six was involved in an effort to get its entire operation accredited, not just the health care aspects. New state jail standards also seemed to be a positive motivating factor at this facility. Everyone interviewed felt that complying with any national or state standards would automatically require more documentation, and therefore would involve more work. If there was any reluctance regarding implementing the AMA standards, it was due to this anticipation of more paperwork. For the most part, however, those jail personnel who were interviewed seemed willing to accept the added work as a necessary aspect of modern jail operation. They saw it as beneficial to the inmate, to the jail facility, and to themselves as well.

Jail Six had experienced a variety of inmate law suits including some where issues of health care were in dispute. In the past, a noted underground radical figure had sued the jail repeatedly during the time of her incarceration. At the time of the initial visit, five suits were pending. The jail's administration did not exhibit much concern about inmate law suits, but it was interested in better ways to safeguard against future legal actions.

The sheriff got Jail Six involved in the AMA program because he felt that it would help improve the medical environment at the facility and in that way, create a more positive inmate atmosphere. This then

would indirectly make the operation of the jail that much easier. The sheriff credited the influence of two other sheriffs in the state with getting him initially interested in health care accreditation. This type of peer influence among sheriffs was apparently a strong motivating factor throughout the state.

d. Description of the "pre" economic environment

The jail's operating budget had to be approved not only by the county commission, but at the state level as well. As previously indicated, requests for additional resources required substantial justification of need before approval could be hoped for. Jail Six, however, seemed fairly adept at building a positive case for itself and documenting its needs. It was only one of three new jails built in the state since 1900, according to the sheriff.

Although the jail already had many excellent resources and the staff was very professional and paid accordingly, some of the individuals interviewed--including the jail physician--indicated that there was real resistance at the county and state level to increases in jail funding. When overtime pay was not available, the medical officer said that he still received the full cooperation of the staff for first aid and CPR training. Many correction officers came to the classes on their own time.

One of the sheriff's primary goals was to open the jail's infirmary. In order to do this, he applied for a federal grant and local matching funds for three additional full-time health care staff. Providing better inmate health care was the primary motivation for opening the infirmary, but it was hoped that health care costs could be

reduced too, by reducing the jail's dependence on the city hospital.

The physician was relatively new to the jail when the study began. Because of his association with the city hospital, many extraneous hospital charges could be avoided. The finance officer stated that this was a substantial savings to the jail, since hospital costs were a large part of the facility's medical budget.

2. Progress Made in Attaining Standards

When this study began, Jail Six was fortunate in having many community health care resources already available for its use. Table III indicates that it began the program with the highest level of compliance with the standards of any of the ten jails--79%. It met most of the thirteen service standards, over two-thirds of the twenty-one procedural standards and all eight of the environmental standards.

However, the jail still had some significant changes that had to be accomplished before it would be ready for accreditation. For example, the receiving screening procedure at the jail had to be made more thorough and the booking officers trained. Fourteen day physical assessments had to be performed on all inmates in the institution, not just the sentenced ones. Although communicable disease testing was being done, it was not being routinely performed on everyone.

In addition, most standard operating procedures and job descriptions had to be written down, a formulary had to be developed, written emergency procedures revised, an inmate consent form created, and dental charting and screening begun on all newly arrived inmates.

As Table III shows, Jail Six was able to accomplish all of these

things, and by the end of March was ready for an on-site inspection. In addition to correcting the deficiencies just mentioned, the jail signed a formal contract with the physician and city hospital covering the services they delivered. An improved method of distributing and recording medications was also developed, and, as the medical officer stated, the whole inmate medical file was improved. The facility acquired more medical equipment too, including a resuscitator and six first-aid kits. Further, a vehicle was put on twenty-four hour stand-by status in case of medical emergencies.

The jail also developed and expanded its in-house correction officer training program. Besides training the booking officers in receiving screening and the line staff in first-aid and CPR, a psychiatrist conducted a class on the recognition and handling of inmates with mental problems. In all areas, it was apparent that the jail tried to meet the spirit of the AMA standards as thoroughly as it met the letter.

3. Factors Contributing to the Extent of Progress Made

The enthusiasm and concern of the sheriff and the deputy master for the well-being of their jail and the inmates in their custody was undoubtedly the primary factor contributing to the jail's success. The medical officer stated that he was a bit skeptical at first about the standards and reluctant to start implementing them because of the additional work he envisioned they would create. However, the entire jail became involved in the accreditation effort and the medical officer worked diligently, putting in overtime hours in order to get the jail ready for its first on-site accreditation inspection.

The medical officer's opinion about the standards and their intent changed markedly during the course of the study. At the time of the follow-up visit, he was thoroughly committed to implementing the standards and stated that they were one catalyst that had worked to create real positive changes in the jail's health care delivery system.

The medical officer felt that without the addition of the full-time registered nurse to the staff in September, 1978, it would have been very difficult to meet the standards. Even with the addition of this full-time medical person, it took the coordination of the entire jail staff to get the work accomplished. The deputy master was thoroughly involved in seeing that the written procedures and job descriptions were developed, reviewed, and then implemented. He wanted more than something in writing; he wanted something that would be used as well.

The written aspects of the standards proved to be the most difficult for Jail Six to meet. They required extra effort on the part of the medical officer and put a real burden on the limited clerical staff at the facility. However, both the deputy master and medical officer stated that the examples from the AMA and one other jail in the state greatly facilitated their efforts.

The influence of the state project director for the medical society and the enthusiasm for accreditation throughout the state should not be overlooked as important contributory factors in the jail's success. The state project director helped foster the peer influence among the sheriffs by organizing a state-wide press conference to announce which

jails were entering the health care program and then, followed up this conference by holding a one day state-wide workshop on correctional health care that spotlighted the individual jail's efforts.

The fact that Jail Six did not encounter any resistance from the medical community or from its funding sources should not be overlooked when analyzing its success. The jail's physician was in favor of implementing the standards and insuring that their intent was fully met. Through his efforts the jail was also able to arrange better coordination with the city hospital for the delivery of health care services. Further, the county commission showed positive support for the health care needs of the jail's inmates by allocating the necessary resources for additional medical staff.

The human services coordinator indicated that the effects of the accreditation program within the jail have all been positive. Not only have health care services been improved, but they have received a new priority within the facility. The accreditation effort helped to highlight the health care needs of the inmates--both to the jail staff and to the local community. The effort to get accredited also was good, she stated, because it required the entire jail staff to pull together to get the job done.

While Jail Six did not have as far to go to get accredited as many jails in the AMA program, it made some real improvements in its health care delivery system that should benefit both the inmates and the jail. Without the influence of the sheriff, the deputy master, the state project director, and the atmosphere for accreditation within the state, these changes probably would not have taken place.

H. Jail Seven (#13-1)

The initial on-site visit to jail seven occurred the last day of August and the first day of September 1978. During that visit the following individuals were intensively interviewed: the warden, the deputy warden, the jail physician, the jail nurse, and a circuit court judge who is secretary of the county prison board. In addition, the investigator spoke informally to several correction officers during their lunch break.

1. Pre-program Picture

a. General characteristics

The jail, which is known as the county prison, serves an area with a population of around 103,000. This area is predominantly agricultural in character, although the jail is located on the outskirts of a moderately sized city where a large proportion of the county's residents live. The population of the county was described as both religious and conservative. The conservative nature of the community tends to place tight fiscal restraints on county expenditures while the religious influence approves efforts aimed at helping the more unfortunate people in the area.

The jail facility itself was built in 1972 with a design rated capacity of 129 inmates. However, because the average daily population is much less than that, most inmates are housed in individual cells. As is typical of many newer facilities, this county jail has a glassed-in central control room which governs the movement and security of persons within the main cellblock area. This design

allows for the efficient operation of the jail with relatively few personnel but also has the tendency to isolate the jail staff from the inmate population.

b. Description of the "pre" health care system and medical environment

At the time of the initial on-site visit, primary inmate medical services were delivered in the jail by a physician, who was under contract with the jail, and by licensed practical nurses from the county nursing home which is adjacent to the jail grounds. The physician provided sick call and performed physical examinations on all newly arrived inmates three times a week. He was assisted in his duties by one of the nurses from the nursing home who came to the jail daily to make up inmate medications.

Through an arrangement worked out with the county commission, the nurses began coming into the jail several months prior to the investigator's initial visit. This arrangement allowed the county nursing home to add one more nurse to its staff but required that part time nursing services be provided to the jail on a daily basis. The nurse given primary responsibility for coming to the jail stated, when interviewed, that she enjoyed the work because it added some variety to her other duties.

Everyone questioned concurred that the presence of the nurses, all of whom are female, has had a positive effect on inmate attitudes toward the health care they receive. Prior to the arrival of the nurses, the jail physician indicated he was shown a lot of disrespect

by the inmates. During conversations with inmates, the doctor, who is Korean, was often derided and his competency questioned. The usual comment was that the doctor was afraid to prescribe anything stronger than tylanol or could not make a correct diagnosis. On the other hand, the deputy warden felt the doctor was quite competent and would be very difficult to replace in a community where no other physicians appeared interested in providing medical services at the jail. The deputy warden's only concern was that the doctor seemed susceptible to being conned by the inmates' medical complaints.

The deputy warden coordinated and ran the health care system in the jail which is just one of his many responsibilities. He stated, when interviewed, that the job of formalizing the jail's health care delivery system into written procedures as called for in the standards, would primarily be his to accomplish. The warden felt that his deputy would be a little hesitant to take on this added work but that he would do it regardless because of his sincere desire to improve the overall functioning of the jail. At the time of the initial visit, the warden and deputy warden had not considered the role the jail physician or nurse should play in the facility's efforts to implement the standards. In fact, neither had been informed of the jail's involvement in the AMA program prior to this first visit.

The medical care area of the jail consisted of a dispensary and one cell which could be used for medical isolation and bed care. The dispensary was roomy but sparsely equipped for its size, although it did have an examining table and a locked cabinet for medications.

The doctor did state he would like more equipment, but also indicated that he realized the financial problems involved. Whenever additional resources were needed, the doctor said he was not at all reluctant to utilize what was available in the community.

There were two general medical hospitals in the community and the jail is within a reasonable distance of more specialized hospital care that had been utilized in the past. Mental health resources in the area were used by the jail for on-going mental health services and in order to get an inmate into the state mental hospital. The local mental health clinic also provided outpatient care which was funded through a mental health board. At the time of the initial on-site visit, a local alcohol center provided detoxification services that were often utilized by the jail and police in lieu of incarceration. Unfortunately, this center was closed down while the study was in progress and the jail's responsibility for alcohol detoxification will probably increase accordingly.

To provide dental services, the jail utilized a local dentist but had plans to begin using the dental facilities available at the adjacent nursing home. In this way it was anticipated that some problems of security and the jail's dependency on the sheriff's department for transportation could be overcome.

As Table III indicates, jail seven was already providing most of the health care services called for in the AMA standards when it entered the program. The areas where it was most deficient in this regard was in providing dental services, routinely testing all inmates

for communicable diseases, and adequately screening all prisoners for medical problems at intake. In addition to these lack of services, the other major deficiency faced by the jail was in the area of correctional officer training in first aid, C.P.R., and the proper dispensing of medications as called for in the standards.

c. Description of the "pre" political environment

The provisions of the state law call for a person designated as warden to run a jail the size of Facility Seven. In turn, the warden is responsible to a county jail board, which in the case of Jail Seven, was a seven member supervisory body composed of three county commissioners, one of the county's two circuit court judges, the warden, and two other individuals. Although the prison board was given fiscal responsibility for the jail and had to approve the warden's budget and any extraordinary expenditures, the real fiscal authority ultimately rested with the three county commissioners who made the monetary appropriations.

The county prison board appeared to give the warden a free hand in the jail's operation with the only restraints placed upon him being fiscal ones. These restraints, however, apparently played a significant part in any planning decisions the warden undertook. For example, the warden delayed informing the county commissioners of the jail's involvement in the AMA program until such a time as the program could be shown to be beneficial to the county. In this way he hoped to forestall any initial negative reactions on the part of the commissioners based solely on a possibility of increased costs.

For that reason the investigator was unable to interview a county commissioner when he first visited the jail.

The warden stated that historically the press was antagonistic toward the jail, but in recent years had been more favorably disposed. He felt that if the AMA health care program did not add appreciably to jail costs, then the local press and community would take a positive approach toward it. The deputy warden stated that the religious character of the community made real opposition to jail programs more difficult when they were presented as doing something for someone in need. However, he felt that most people in the community were unaware of what went on inside the jail and would only voice opposition to the program if they felt inmates were getting better care than the public in general.

The warden and deputy warden both indicated that improving inmate health care services was the primary reason for the jail's involvement in the AMA program. In addition, the warden felt that by being involved and eventually becoming accredited, it would help remove the stigma that inmates receive poor health care while in jail. The deputy warden thought the accreditation program would help insure that the medical care within the jail was equivalent to outside standards and would show that the jail was providing the kind of services usually found only in much larger institutions.

The primary motivating factor for the jail's involvement in the AMA program was the warden's sensitivity to the health care needs of the inmates. The warden was pictured as a progressive minded person who constantly worked to improve inmate services at the jail. The

warden indicated that he had been aware of the AMA program and had hoped to become involved in it long before it was made available within his state. The warden's concern for providing adequate inmate services seemed to carry over to the deputy warden and the other staff at the jail.

The jail appeared to be run on a friendly but very formalized system. Staff were expected to follow the directives and procedures established by their superiors. This seemed to allow for a very efficiently run facility with authority and responsibility concentrated at the top. Considering the size of the jail, the number of line staff was relatively small, consisting of only sixteen full-time correctional officers and four part-time substitutes. A small support and service staff also worked in the jail.

d. Description of the "pre" economic environment

Low pay and lack of overtime funds for training purposes characterized the economic environment surrounding the jail. The low pay created a staff turnover problem and an accompanying shortage of professionally trained jail personnel. At the time of the investigator's first visit, the jail had just suffered several correctional officer resignations and informally several others indicated they would resign if their pay were not increased by ten percent or more. Because of the usual shortage of personnel, it was difficult for the jail to spare anyone to attend the state-run correctional officer academy for basic first aid instruction. The lack of overtime funds also meant that if any after-hour training for such things as C.P.R.

were to be undertaken, it would have to be handled on a voluntary basis. Such an approach, the deputy warden felt, would only attract forty to fifty percent of the staff. Fortunately several of the correctional officers were also volunteer firemen and already had first aid and C.P.R. training.

Before nonemergency surgery or similar procedures were performed on an inmate, the funding had to be approved by the prison board. The jail physician indicated, however, that funding approval is usually just a matter of routine. He further stated that the board had never failed to approve what he recommended or tried to interfere with his practice of medicine at the jail. Often, when costly medical care was needed, an inmate was released from prison so that a funding source other than the jail's could be used for his care.

As already indicated, the fiscally conservative nature of the community played an important role in any planned change the jail undertook. The warden had to be especially careful in the way he presented the AMA program to the county commissioners in order to prevent any initial negative reaction. When interviewed, the circuit court judge who served as secretary of the prison board, indicated the fiscal conservatism of the county commissioners by stating that they were very reluctant to incur public debt and therefore, public works were usually fully paid for before they were undertaken. Likewise, funding was usually made available more readily for building permanent physical facilities than for providing continuing community services.

The county prison appears to be an example of what the judge was saying. The county commissioners were willing to provide funds for a new facility, but, as everyone interviewed seemed to indicate, would be somewhat reluctant to pay for many more services within the facility or to increase the wages of the line correctional staff sufficiently to insure their retention. The warden even indicated that the jail population was lower than several years previously because of the commissioners' desire to hold down jail expenditures.

However, contrary to the general fiscal conservatism that everyone painted of the county commission, they had seen fit to pay for a generally high level of health care services at the jail. Getting these services was probably a product of a long gradual struggle, but nevertheless, they were in place. It appeared that if it could be demonstrated that jail services were beneficial, the county commissioners had the funds and the begrudging willingness to pay for them.

2. Progress Made in Attaining Standards

As Table III indicates and as previously stated, Jail Seven was complying with most of the thirteen service standards at the time it entered the AMA program. In addition, it already fully met all but one of the eight environmental standards. Where it was most severely deficient was in the area of the twenty-one procedural standards, especially those requiring correctional staff training, written job descriptions for the medical personnel, and written standard operating procedures. However, even with these deficiencies, Jail Seven was meeting approximately 71% of the AMA standards when the first self-

survey was completed.

Although the jail's health care delivery system was already firmly established at the time the jail entered the program, during the six months of this study, it only made minor progress toward meeting more of the AMA standards and the changes that occurred were not significant. However, in the two months immediately after the investigator's follow-up site visit, (i.e. March and April) more changes did occur at the jail which are reflected in the progress indicated by Table III. Operating procedures and job descriptions were being written by the deputy warden, an adequate receiving screening program was implemented, and the medical staff started performing the routine communicable disease testing called for in the AMA standards. In addition, the warden made it a policy that at least one correctional officer attend the state training academy where first aid is taught every time it is offered. By the middle of May, the jail's self-survey report indicated that it was meeting about 80% of the standard's requirements.

Although Jail Seven was implementing the changes necessary to meet more of the standards, it was still not ready for an on-site accreditation survey. In May, the deputy warden indicated by phone that the cost of providing the dental services and routine communicable disease testing could prove to be a prohibitive factor in the jail's efforts. However, the warden had indicated at the time of the follow-up visit that the jail's involvement in the AMA program meant that medical expenditures were not as readily questioned as previously. He saw a real benefit to having an outside stamp of approval on the

services he was trying to deliver in the jail.

3. Factors Contributing to the Extent of Progress Made

It appears that the warden is the primary motivating factor for the jail's involvement in the AMA program and the chief reason why some progress has been made toward getting the facility's health care delivery system accredited. The deputy warden is also an important element, since the task of getting the job accomplished lies primarily on his shoulders. Both men sincerely seem to take pride in their jail where changes had already been implemented prior to the involvement of the AMA program. It seems clear that both men would now like some outside recognition for their jail and the type of job they have accomplished.

The investigator feels fairly confident that the jail will become accredited in the near future, although the task could have been accomplished much sooner. Both the warden and deputy warden indicated that receiving accreditation was one of their top priorities in the coming months. With the possible exception of some fiscal constraints, the jail did not face any apparent roadblocks in its efforts to get accredited. Most of the services were being provided and resources were available to effect further changes. However, because some resources were not utilized, delays were encountered which could have been avoided.

The warden and deputy warden did not attempt to involve the jail doctor or nurses in the accreditation effort. The deputy warden took the entire of task of formalizing the jail's health care system on

himself on top of his many other responsibilities. At the time of the follow-up visit, the physician and nurses knew little more about the accreditation effort than they did six months earlier. In fact, the nursing supervisor at the nursing home only found out about the program through a letter from the investigator requesting information about jail costs. A phone call from her and a subsequent personal interview indicated that she was very interested in the accreditation effort and would assist the jail in whatever way she could. She was especially interested in helping formalize the role of her nurses in the jail.

Besides not utilizing the medical staff, the jail did not avail itself of the resources available through the project director at the state medical society level. Although offered, the jail did not request much assistance from the state project director, who only made one visit to the jail and that came late in the year. Thus it would appear that the warden's and deputy warden's desire to "go it alone," coupled with their many other responsibilities, delayed the jail's efforts in achieving accreditation.

I. Jail Eight (#13-2)

The initial on-site visit was made to Jail Eight on September 5, 1978. At that time the jail administrator, the chairman of the county commission, and the jail physician were interviewed. The investigator also spoke briefly with several of the jail staff and the sheriff who is legally responsible for the jail.

1. Pre-program Picture

a. General characteristics

Jail Eight is located in the heart of a major tourist area. This means that the area has a high transient work force as well as numerous vacationers. The daily population of the county varies between 45,000 and 200,000 people depending on the season. While the tourist trade is a major mainstay of the local economy, reportedly it also brings with it problems more usually associated with an urban environment. The daily population of the jail sometimes reflects this fact.

The jail facility itself is over 100 years old, having been built in the 1870s. The physical characteristics of the jail have created problems, both in terms of providing health care services and ensuring security. The facility has the capacity to house twenty-nine prisoners but averaged less than eighteen a day during the course of the study. Most sentenced inmates were boarded in a neighboring county jail where the number of boarders often ran as high as forty-five or fifty. No juveniles or women were kept at the jail because of the lack of space and staffing problems.

b. Description of "pre" health care system and medical environment

At the time of the initial visit, the jail did not have any in-house health care facilities or equipment. The jail utilized the services of a physician who lived directly across the street and came in three or four times a week to hold sick call and give physical examinations to the newly admitted inmates. These physical examinations were required by state law within forty-eight hours of a prisoner's incarceration. When newly arrived prisoners were booked at the jail, they were isolated from the general population until the doctor examined them. Whenever medical equipment was needed to treat an inmate, it was either brought over from the doctor's office or the inmate was escorted across the street. Although the doctor stated he would like to see more medical equipment at the jail, he felt it was not essential because his office was so convenient.

The jail physician looked upon his service to the jail as his civic responsibility which he had performed for many years. Although he was past eighty years old, he was still extremely alert and maintained a very active private practice. Many of the prominent citizens of the community were his patients, including the county's two circuit court judges. There was no doubt that everyone respected the doctor and held him in the highest regard. One inmate even commented about the concern the doctor had shown him, although several others thought he was too old to know what he was doing. The jail administrator and correction officers appeared to have confidence in his ability and did not hesitate to call on him when a medical problem occurred.

The doctor stated that he had a very good relationship with the

county authorities and they had always supported him in the practice of medicine at the jail. The doctor readily utilized the hospital emergency room, outside consultants, and dentists in delivering health care to the inmates. He felt that the correction officers were competent and could easily perform the type of receiving screening called for in the standards.

The jail staff all agreed that it would be difficult to replace the jail physician when he retired. Not only would the cost be substantially increased, but the level of services would probably be far less. The physician felt that other doctors in the community who had covered the jail for him in the past would be willing to take the responsibility for the jail. The jail administrator stated, however, that none of these physicians wanted to come to the jail and that inmates had to be transported to their offices. This was very burdensome and time-consuming because all jail transportation had to be supplied through the sheriff's department.

The city in which Jail Eight is located is served by one general hospital which is three miles from the jail. The jail generally utilized the emergency room of this hospital to clear prisoners with possible medical problems before they were booked or when emergency situations occurred.

There were several mental health and drug counseling resources available to the jail which it had utilized in the past. A tri-county mental health center provided outpatient care and follow-up, and did evaluations for possible psychiatric commitments. There were

three possible places where an inmate could be committed, but two of these were seldom used by the jail and none was closer than thirty-five miles.

The jail also had access to a multi-county drug and alcohol clinic which provided some rehabilitation counseling to the inmates. Whenever inmates showed signs of alcohol or drug withdrawal, they were referred to the hospital for detoxification, however. In the past, the jail had also participated in a methadone maintenance program.

All laboratory services that the jail required were provided through the local hospital. Dental services were provided by one dentist whose office was a half mile from the jail. The local board of health also came to the jail periodically to inspect the kitchen facilities.

c. Description of the "pre" political environment

The county's sheriff is legally responsible for the jail but has turned over complete control of its operation to the jail administrator. The county commission appropriates all funds for the jail and has ultimate responsibility for its functioning.

The jail administrator had an assistant under him who handled much of the day-to-day work. Under the assistant administrator was one lieutenant, two shift sergeants and twelve correction officers, some of whom held the rank of corporal. The lieutenant had been with the jail a long time and his responsibilities were more administrative than supervisory.

The jail administrator stated that the facility was in a transition

period and only gradually getting used to a structured and formalized system of operation. The overall management of the jail appeared to be very strict, especially with regard to questions of security.

The jail administrator was brought in to run the jail in October 1977 after a dangerous prisoner escaped by taking the doctor hostage during sick call. The jail administrator is a retired military officer whose background was in hospital administration. He stated that he encountered some resistance when he first arrived because he had no correctional experience. However, this resistance was overcome by making personnel shifts, working with the staff in making changes, increasing salaries, and upgrading line positions. The jail administrator expected his staff to work as a team in the joint operation of running "our" jail.

The administrator relied on his staff for the daily operation of the jail and he seemed to seek out their opinions and advice on ways of improving the security and handling of prisoners. Before the investigator's initial site visit, he shared what he knew about the AMA program with members of the jail staff who appeared very enthusiastic, he said. The administrator stated that AMA accreditation was only the first step in what he hoped would result in total jail accreditation.

Although the sheriff had turned the operation of the jail over to the jail administrator, he still retained legal responsibility for what happened and therefore kept informed of jail matters by frequently eating lunch at the facility. The jail administrator

stated that the sheriff would like to divest himself of the legal responsibility for the jail. This would be possible if the county formed a prison board, but as yet it had chosen not to do so. The state law required that a circuit court judge be a member of the prison board, but the president of the county judges refused to appoint a member judge, citing that he felt it would result in a conflict of interest. His reasoning was that not only would the judge be sentencing inmates to a jail he shared responsibility for operating, but he might also be hearing cases where the operation or condition of the jail was in dispute.

The chairman of the county commission was very supportive of the jail administrator and the changes he had initiated at the facility. He was also very much in favor of building a new facility in four or five years because he felt that housing inmates in another county's jail was very inefficient and costly. Because of the tentative plans to build a new facility, the county commission was not in favor of renovating the old jail to any great extent. The commissioner indicated structural changes would have to be kept to a minimum and the jail administrator's plans for a medical examining room might not be approved.

d. Description of the "pre" economic environment

When the jail administrator first took over the operation of the facility, he had the pay of his staff increased and initiated a stepwise promotion and salary system. In order to increase salaries and make other changes he thought necessary, the administrator greatly

exceeded his budget. Because the county commission was very supportive of the changes that were occurring in the jail, they did not object to funding them. However, the county commissioner indicated when interviewed, that in the future, the jail would have to budget more carefully ahead of time for the things it needed and then stay within its budget. The expenditures which occurred outside the budget in the past would not be tolerated as readily in the future. The county commissioner said that the administrator was able to get the funds the jail needed because he was a professional administrator and knew how to justify expenditures.

The county commissioner further stated that the jail physician enjoyed such a good reputation in the community and with the county commission that anything he requested or needed was almost automatically approved. The jail physician indicated that he always received the full cooperation of the jail staff and that he never had any problem getting the jail to pay for any treatment he prescribed for an inmate. It should be noted, however, that the doctor only charged $6.00 a visit when he came to the jail and, according to the county commissioner, neglected to bill for many of his services.

2. Progress Made in Attaining Standards

Many significant changes occurred at Jail Eight, but not many of these were reflected in meeting more standards. As Table III indicates, the jail began the AMA program meeting about 53% of the standards, but by the end of the study period, it had only improved to 58%. However, this should not be taken as the only indicator of

the progress made.

When Jail Eight entered the program it reported meeting all eight of the environmental standards, about half of the service standards, but only a few of the procedural standards. The jail physician held sick call, but inmates' complaints were not collected daily. Each incoming inmate was seen by the jail physician within the first forty-eight hours of his stay, but many of the physical assessment requirements outlined in the standards were not being performed. Perhaps most importantly, inmates were not being screened when they were first booked at the jail and there was no formal written procedure outlining what to do in an emergency. While resources were available in the community to help inmates with drug or mental problems, these resources did not deal very effectively with the real situations that occurred in the jail. In addition, the jail was almost totally lacking any formalized written procedures for dealing with medical situations that occurred.

The changes which took place in the jail were in the areas of formalizing the health care system and in obtaining better cooperation from the health care resources already available outside the facility. The local mental health clinic began taking a more active part in jail health care. Inmates needing psychiatric hospitalization were receiving it before a crisis occurred and the next budget called for a counselor to come to the jail on a regular basis. The jail administrator was also pushing to get better cooperation from the local alcohol and drug program. He did some research on his own and visited

a successful program in another community which he was trying to have adopted by the agency that was supposed to be serving his jail. In addition, all the correction officers received CPR training and part of the jail was remodeled to include a room with an examining table and some other medical equipment. This remodeling gave the physician a place to work in a secured area.

Perhaps the most important change, according to the jail administrator, was an awareness on the part of the staff that the jail had a responsibility for dealing with the medical needs of the inmates. The operation of the jail was becoming formalized, and this included the health care delivery system. The administrator was putting all procedures in written form and creating a jail operations manual. At the time of the follow-up visit, some health care procedures had been developed and a receiving screening process was about to be implemented. The jail physician stated that he had noticed a change in the atmosphere within the jail, especially in the attitudes of the inmates. Although the jail still had a long way to go to get accredited, real substantive changes were occurring that were not reflected in the standards.

3. Factors Contributing to the Extent of Progress Made

There are a number of reasons why this jail was able to make the progress it did and several factors that kept it from achieving AMA accreditation during the period of the study. The jail administrator must be considered the primary motivating factor within the jail and the reason it made progress thus far. He brought to the jail a back-

ground in hospital administration and an appreciation of the importance of a formalized procedural system. He was able to recognize the inadequacies of the jail and then set about remedying the situation. He got the jail involved in the AMA program because he saw in it a way to accomplish what he had already intended to do. Not only does the jail administrator want AMA accreditation, but he wants all aspects of the jail's operation accredited.

In addition to the personal qualifications and interest of the jail administrator, progress at the jail was facilitated by an open and friendly communication between the administrator, the county commissioners, and the physician, whose offices are all within several hundred yards of one another. The county commissioners hired the jail administrator with the idea that he would make changes, and they have been supportive of what he has done. The jail administrator received the resources he needed from the county commission because he was able to justify the need. He was able to substantially exceed his budget the first year and has since had it increased for the current year.

Part of the commissioners' motivation for supporting the jail may be their high regard for the doctor. He was placed in danger when the inmate escaped from the jail and has also been sued by another inmate for malpractice. Although the doctor came to no harm and the malpractice suit was unfounded and is being dismissed, the commissioners were interested in seeing that the same problems did not reoccur.

Several incidents at the jail during the period of the study also

demonstrated the need for a health care delivery system that had written procedures which worked. In the absence of written procedures, the jail had been fortunate that two prisoners were refused admittance to the jail in spite of the objections of the arresting officers. Only because the booking officer was alert to a potential medical crisis was disaster averted in each case. Instead, both individuals were sent to the emergency room of the hospital for medical clearance. In one case, the prisoner proved to have a severe skull fracture and was not drunk as the arresting officer suspected. If he had been admitted to the jail instead of the hospital, he probably would have died. In the second case, the prisoner was an alcoholic going through delirium tremens and was kept at the hospital for three days before being admitted to the jail. It was recognized that written procedures would have greatly simplified the decisions the booking officers were called upon to make.

The jail administrator has gained the support of his staff. He has gotten them pay increases and promotions. Incidents at the jail have demonstrated the need for the type of formalized system he advocates. He also gave a commendation to the booking officer who refused admittance to the prisoner with the skull fracture. These things have added up to higher staff morale and a jail that is run more professionally.

However, the jail could probably have made more progress than it did in meeting the AMA standards. The primary reason why it did not, according to the jail administrator, was that other priorities came before improving the health care program. Some physical aspects of the jail needed to be changed, and the security system of the jail needed

to be formalized. In addition, the investigator also noted that the jail administrator took the entire task of formalizing the health care system upon himself. He did not really seek the assistance of the jail physician, who in turn, felt he was being remiss in not developing the written procedures called for in the standards. The jail administrator had a resource available, namely the jail physician, that should have been included in the overall accreditation effort. The jail still has a long way to go to get accredited, and it will take the physician's involvement to get the job accomplished.

J. Jail Nine (#13-3)

The initial on-site visit was made to Jail Nine on September 6, 1978. At that time the sheriff, the chairman of the county commission, and the jail physician were interviewed.

1. Pre-program Picture

a. General characteristics

Jail Nine is located in a modest-sized city in what is otherwise a predominantly rural, agricultural area. The jail serves one of the smallest counties in the state both in terms of square mile area and population, which only numbers about 16,500 people. Accordingly, the jail itself is a small facility designed to house about twenty prisoners in individual cells. However, because of the small average daily inmate population (i.e., less than six), several of the cells were converted to other uses for the benefit of the inmates. The sheriff's office and official residence are attached directly onto the front of the jail. Built in 1892, the facility was originally designed so that the sheriff and his wife could take care of the maintenance and security of the prisoners without much assistance.

The community appeared basically conservative in character with economy being one of the primary considerations of the elected officials. The area is fortunate in having a large teaching and research medical center nearby, which is a major industry and also a source of local pride. The presence of this hospital affords the jail many resources which otherwise would probably not be available in such a small community.

b. Description of the "pre" health care system

At the time of the initial on-site visit, the jail had no in-house medical facilities. Inmate medical services were usually delivered through the local hospital emergency room or at the office of a local physician whom the jail hired on a fee-for-service basis. This physician sometimes came to the jail but said he preferred to see inmates at his office because the facilities were better. He stated that he would like to see the sheriff equip an examining room at the jail, but did not feel it was essential for the delivery of health services to inmates.

The local physician was hired to work for the jail in an effort to cut costs. The county commissioners recruited the physician to provide primary inmate medical care, whereas previously, it had all been done through the emergency room of the hospital. By hiring the physician, the jail's routine medical costs were reduced by nearly fifty percent per inmate visit.

The sheriff coordinated the delivery of all medical services for the jail. With the exception of a physical exam within forty-eight hours of a prisoner's incarceration as required by state law, inmate medical services were handled on an "as-needed" basis. However, the sheriff did exhibit a genuine concern that inmates receive needed medical care.

Because of the jail's proximity to the medical center, inmates were boarded there from other jurisdictions while they received medical treatment. The clean condition of the jail and the personal attention

inmates received there, often meant that a treating physician would keep an inmate at the jail instead of in the hospital during the course of his care. This was the case with one inmate at the time of the first site visit.

It should be pointed out that the jail has not had many serious medical problems in the past, but the potential is there--especially with inmates being boarded at the facility for treatment at the medical center. The sheriff stated that since January 1975, there had been only two serious medical incidents, and these were both from alcohol withdrawal. The greatest source of medical concern to the jail appeared to result from inmates with psychiatric problems. As a precautionary safeguard, the sheriff had a policy requiring medical clearance from the hospital before he would accept any prisoner who appeared to have a medical problem. The county commissioner stated that most of the jail's medical problems were minor injuries suffered in the exercise yard that the state had required them to put in.

In addition to the medical center, there is a state-run mental hospital in the county where the jail has had inmates committed after an evaluation. The county is also served by a mental health and mental retardation clinic which has provided the jail with outpatient services. The sheriff had, on one occasion, also utilized a hotline referral service in a neighboring county.

The medical center provided the jail with detoxification facilities, if these were needed. In addition, the county had a detoxification and rehabilitation service which offered residential treatment.

On occasion, inmates had been committed there by the court, in which case the jail was no longer responsible for their care. The jail physician also indicated that the medical center referred alcoholics to the state mental hospital for treatment.

Both the sheriff and jail physician stated that the medical center probably employed over one hundred doctors and dentists. However, both indicated that in the county there were maybe only two or three real community doctors and perhaps twice that number of dentists. The jail physician was himself employed by the mental hospital to provide general medical care to the residents and only had a small private practice on the side.

c. Description of the "pre" political environment

The sheriff was appointed to fill out the unexpired term of his predecessor who had held the elected job for many years. His appointment was a logical choice since he had run for sheriff in the last election and only lost by a few votes to a long-time incumbent. The job of sheriff carries with it the title of warden which means the sheriff is legally responsible for the operation of the jail.

The sheriff appeared to have the full cooperation of all his men. Since taking office, he was able to get the county to raise the correction officer salary from $2.65 to $3.75 an hour. The sheriff did not appear to expect much initiative on the part of his staff, but felt that giving them additional work and responsibility would be welcomed because it would help relieve the tedium of the job. Once a month, the sheriff would hold a staff meeting, at which time

he discussed the operation of the jail and entertained suggestions for changes.

Everyone interviewed seemed to agree that the overriding consideration of all the people in the county was to cut costs and to save money wherever possible. The sheriff said that he got involved in the AMA program because he thought he would receive some money out of it with which to set up a medical examining room inside the jail. The county commissioner said that he would have no problem supporting the program and allocating resources for it, if the program did not require a lot of money for things which the jail really did not need or would seldom use. He complained that the state government had already forced the county to hire correctional officers in order to insure that a person would be present in the cell area at all times. Also the state had required the jail to put in an expensive recreation yard. The county had to comply with the state requirements or close the jail, which was not an acceptable alternative. The commissioner was of the opinion that since the state made the requirements for the jail, then it should also bear the costs of compliance.

The sheriff indicated that even though economy was a primary consideration of the county government, he was able to get just about anything he needed for the jail simply by threatening to make it a public issue at the county council meeting or in the local press. He further stated that he was actively trying to improve the jail and the public's image of his department and he felt he had already established a good relationship with the local press. As a public

relations effort, he planned an open house to show the improvements he had already undertaken, which consisted of a thorough cleaning and painting of the inside of the jail. Paint was also scraped off of the cell block windows, which made the area a lot brighter. It was obvious that the sheriff was proud of the changes he had initiated and that the AMA program was another part of his effort at overall jail improvement.

d. Description of "pre" economic environment

The sheriff was also interested in economy and was striving to cut unnecessary costs, while at the same time trying to improve the overall operation and condition of the jail. The hiring of the local physician was a case in point.

The sheriff stated that any medical costs the jail incurred were paid without question by the county commission because the members fully understood that the jail must provide certain basic services to the inmates. He indicated that the initial reaction of the chairman of the county commission to the AMA program was: first, will it help the jail; and second, will it cost or save the county money. As previously indicated, economy was foremost on the minds of the county commissioners. The sheriff recognized this fact, however, and was considering various ways of obtaining needed medical equipment from sources that would not require a large monetary outlay.

2. Progress Made in Attaining Standards

Table III indicates that Jail Nine started the AMA program next to the bottom in terms of overall standards compliance and at the

bottom in terms of service and procedural standards being met. During the period of the study, not much progress was made with regard to meeting more of the standards as evidenced by the fact that the jail only went from 43% to 45% compliance. Where the jail was most deficient was in the procedural area. Services were being provided to the inmates, but not in the manner specified by the standards. The correction officers had all received some first aid training at the state correctional officer school, but sick call, dental care, detoxification and mental health services were still being provided on an "as-needed" basis under an informal type of health care delivery system. This type of system was only possible because the few number of inmates and small jail staff (the sheriff, deputy sheriff, and four correction officers) allowed close personal communication. In addition, the fact that no serious medical problems had occurred meant there was no external pressure to really change the system.

However, some changes did take place in the jail which were not reflected in terms of more standards being met, but were nonetheless improvements in the health care delivery system. The sheriff was in the process of converting a cell with bathroom facilities into a medical examining room. At the time of the follow-up visit, he had already obtained a desk and examining table and was in the process of getting a file cabinet in order to separate the inmate medical records from the confinement records. In addition, he indicated that a formal receiving screening of all new inmates was to be instituted following the example from the AMA guidelines. He also appointed one

correctional officer with a college degree to draft needed written procedures for the jail and was looking into the possibility of having a physician assistant come to the jail from the medical center to hold regular sick call. Perhaps most important, however, was the fact that the sheriff and his staff understood what the AMA program entailed and had some enthusiasm to get accredited. The sheriff was also now receiving support and guidance from a physician at the medical center in his efforts to upgrade and formalize the jail's health care delivery system.

3. Factors Contributing to the Extent of Progress Made

The sheriff originally entered the AMA program with an erroneous expectation, namely that the jail would receive funds to upgrade its health care system. During the course of the study, the jail nearly dropped out, which was due in part to pressure from the chairman of the county commission, who was afraid that the program would end up costing the county money. Through the intervention and influence of the medical society project director, and more importantly, a physician from the local medical center (who also was connected with the AMA program at the state level), the sheriff and the county commissioners were convinced that it was in the jail's best interest to stay involved.

The progress that has been made was due largely to the enthusiasm of the sheriff to upgrade and improve his jail in any way possible. The interest shown by the physician from the local medical community, coupled with the sheriff's better understanding of what the standards

entailed, were also important contributing factors. The work of formalizing the health care system and getting accredited still rests almost entirely with the sheriff, however. This could prove to be a bottleneck which might prevent the jail from finally getting accredited. There are no outside pressures, either from the medical community, law suits, or the public, which might force the sheriff to act. On the other hand, if additional costs are incurred, it may create some opposition within the county commission. To get accredited the sheriff will have to be a self-motivator.

This jail still has a long way to go. Whether it gets accredited or not will depend primarily on the sheriff himself and secondarily, on the support and technical assistance he is able to obtain from the local medical community and the state medical society. Contact with other sheriffs in the accreditation program may also be beneficial and prove to be the catalyst for ultimate success. The jail physician has not been involved or shown any interest in improving the jail's health care system. Because of this, the sheriff indicated he was considering changing doctors. He could probably find the additional support he needs in the local medical community without too much trouble though, so changing jail physicians should not prove to be a negative factor. The most positive move the jail could make would probably be the addition of the physician assistant the sheriff indicated he would like to have come into the jail. This would go a long way toward improving and stabilizing this jail's health care delivery system.

K. Jail Ten (#13-3)

On September 7, 1978 the initial on-site visit was made to Jail Ten. At that time, the investigator interviewed the warden, the deputy warden, the jail physician, a matron at the jail who assisted the doctor administratively, and the chairman of the county commission, who was also president of the county prison board.

1. Pre-program Picture

a. General characteristics

Jail Ten is located in a fairly large city in a county with a population of about 116,000 people. It is an old jail which was originally built in 1867 and since then has been renovated and enlarged several times. The jail is generally not overcrowded and houses both male and female inmates. The daily population averages slightly under fifty but fluctuates by as many as fifteen or twenty according to the county commissioner.

In addition to the inmates housed at the jail itself, a work release program boarded other inmates at the local YMCA. Once an inmate entered the work release program, the jail was no longer legally responsible for the individual's health care, although technically, the person was still in the jail's custody. While the jail is considered a small facility for purposes of this study, administratively and structurally, it has more things in common with most medium-sized jails.

At the time of the initial site visit, there were seventeen full-time and ten part-time correction officers employed by the jail, in

addition to the warden, deputy warden, and their supporting staff. Each shift had a commander and assistant commander who were responsible for booking prisoners into the jail. All of the jail staff dressed in civilian clothing while the inmates wore blue collar type uniforms. This was done, it was explained, so that the inmates could be readily identified from the civilians.

Because of the county's size, the state law required that a warden run the jail and that the overall operation of the facility be governed by a county prison board. The board is responsible for approving the warden's budget and then submitting this budget to the county commission for funding. However, it should be noted that the three county commissioners were prison board members and the chairman of the commission was also president of the board.

b. Description of "pre" health care system and medical environment

There were no medical facilities inside the jail. Sick call was held twice a week at the facility by a physician who was under contract. Sick call took place in two rooms that were not medical examining rooms and were normally utilized for other purposes. Also, one bed was set aside for inmate bed care, but this area could not be considered as anything resembling an infirmary. One matron acted as an administrative assistant to the doctor and handled much of the routine medical liaison work between the jail and the community.

From all indications, only with the arrival of the present warden had inmate health care become a real priority of the jail administration.

For example, prior to his appointment in early 1977, the jail felt obligated to accept all prisoners regardless of their medical condition. The warden changed this and implemented a procedure where medical clearance was made mandatory before the jail would accept anyone with an obvious medical problem.

The warden stated that he would like to be able to deliver more health services inside the jail and cut down on the inconvenience and cost of outside transportation. He said he would also like to see a registered nurse on the jail staff to relieve the work load of the physician. The physician, however, felt that a paramedic would be more suitable to the jail setting.

As one of his top priorities, the warden had attempted to arrange a contract with one of the two local hospitals to provide total health care services to the jail. Unfortunately, this effort proved unsuccessful as the hospital was not receptive to the idea.

The warden stated that all the correction officers received first aid training within the first six months of employment and were offered refresher courses periodically. Three correction officers were emergency medical technicians (EMT) and three more were scheduled to take the EMT course. The warden and the three EMTs are all CPR trained as well. The jail physician indicated that a follow-up EMT-2 course was also available in the area.

The physician clearly indicated that he was not overly excited about practicing medicine at the jail. He compared it to making house calls and felt that the jail might have a problem attracting a

replacement doctor should he resign. The warden, on the other hand, felt that finding a replacement physician would probably not be that difficult, since there were over one hundred doctors in the community. However, he stated that he felt the present jail physician delivered excellent service to the inmates and he hoped he would renew his contract with the jail when it expired.

The city where the jail is located is served by two general hospitals. The jail physician is part of a team at one of these hospitals which provides emergency room coverage. The deputy warden stated that quite often inmates were transported to the emergency room for more extensive examination and treatment when the jail physician was on duty there.

In addition to the two area hospitals, there was also a mental health and mental retardation office, which worked with the jail in getting inmates committed for inpatient treatment. One of the area hospitals also had an outpatient mental health unit, which offered a counseling program that the jail utilized. Once a week, an intake worker visited the jail and set up programs for inmates who needed such services. However, the county commissioner and the warden felt that the mental health problems of the jail's inmates were only being addressed after a crisis occurred. Therefore, they both believed that the mental health resources provided to the jail were really inadequate.

There were two drug rehabilitation programs in the area, but neither offered detoxification services which the jail could utilize.

Instead, the only recourse open when an inmate needed detoxification was to send the individual to one of the local hospitals. In the past, the jail had utilized both of the drug rehabilitation programs, but at the time of the initial site visit, the jail was using only one such service.

The local office of the state department of health provided some communicable disease testing. The jail also had access to two local dentists, both of whom were within four miles of the jail.

When Jail Ten entered the AMA program, then, it was already providing many of the services required by the standards including: some form of receiving screening, sick call, some communicable disease testing, and a health appraisal on all inmates within a few days of their being booked. In addition, the warden was working at formalizing all the procedures at the jail, not just the medical ones. Different individuals commented that an improved receiving screening would be very beneficial not only to the inmates, but to the booking officers as well. They felt that by formalizing the screening procedures, a lot of the personal discretion as well as personal uncertainty would be removed from the booking process. The booking officer would be able to act more confidently and with less fear of personal liability.

c. Description of the "pre" political environment

Everyone interviewed agreed that the present warden was one of the most important motivating factors in implementing positive changes at the jail. He was described as "progressive-minded" and sincerely interested in significantly improving the services offered to the

inmates. Prior to being appointed warden, he ran the jail's work release program. The county commission hired him as warden with the intention that he would straighten out the administration of the jail and make improvements in its overall operation. The previous warden was described as an "old line" correction officer with a limited educational background and few administrative skills, who had run the jail in an informal and generally haphazard fashion.

At the time of the initial visit, the responsibility for running the jail appeared to be shared by the key administrators with the jail staff. The warden stated that compliance with administrative directives and the implementation of needed changes were attained not so much through recourse to authority as through a process of staff education. Staff meetings were held in order to discuss and sell new ideas. Funds were allocated for outside training and promotions were based, in part, on an individual's interest in improving his or her job skills.

The deputy warden had advanced through the correction officer ranks at the jail, which gave him the day-to-day technical expertise which served to balance out any lack of line experience the warden might have had. The position of deputy warden was one which the present warden asked the county commission to reinstate after it had been eliminated as unnecessary by his predecessor. The position of deputy warden that was recreated carried with it a good deal of responsibility, according to the warden, along with a certain necessity for continually proving its worth.

From the interview with the chairman of the county commission, it appeared that the warden had gained the support of the commission in his efforts to improve all aspects of the jail. The warden had discussed the AMA program with the chairman and kept him fully informed of developments. The chairman seemed totally supportive of the accreditation concept and stated he would be willing to allocate more resources to the jail, but that the program would have to demonstrate that the benefits were worth any added expense. He felt strongly that the community was not responsible for correcting all of an inmate's medical problems simply because s/he was incarcerated.

When first visited by the investigator, the jail was facing a federal class action suit where the adequacy of its health care system was one of the major issues in dispute. The warden saw this suit as a real source of pressure on the county commission to approve better jail services. Additionally, he felt that if the jail failed to get accredited, this would not place pressure on him, but upon the prison board and county commission to allocate more resources to the jail. The warden saw his job as one where it was his responsibility to keep the prison board members fully appraised of the problems and opportunities confronting the jail. It was then their responsibility to decide upon the direction the jail must take, after appropriate recommendations from him.

The chairman of the county commission appeared to fully support and actively communicate with the warden. He stated that with the recommendation of the warden, he had no hesitancy about the jail

entering the AMA program. However, he still voiced concern about the cost of the program and the extent of the benefits that could be derived. The commissioner appeared to be an independent-minded individual who expressed the belief that a community was better off relying on its own resources to accomplish goals and solve its problems. For that reason, he appreciated the fact that the AMA program was directed toward jail self-help.

The jail had an active program of community education and was also aware of many potential resources which might prove beneficial. The warden believed in educating the public about the jail and stated that he carried out a personal program of public speaking. In addition, interested groups were invited into the jail and the local press received quarterly jail population statistics and reports of any serious problems. The warden had already considered the Governor's Commission on Crime and Delinquency, several local benevolent foundations, direct federal grants, and the National Institute of Corrections as possible funding sources for future improvements in the jail.

d. Description of the "pre" economic environment

The warden used some economic incentives inside the jail to help promote his policies and gain the support of the staff. As previously indicated, the position of deputy warden was reinstated and a former shift commander promoted to fill the vacancy. Other promotions inside the jail were based, in part, on the individual's willingness to improve his or her job skills. When correction staff took part in job related training, like EMT school, the jail also paid them overtime.

The overall condition of the jail would seem to indicate that the county commission had not been interested in spending money on this facility in the past. From interviews with the warden and county commissioner, it appeared that the county commission and prison board were only beginning to realize that present day jail requirements were far greater than those of the past. The warden stated that with proper direction and supporting arguments, he had been successful in getting his requests through the county commission. The county commissioner also seemed supportive of the warden's efforts and interested in improving inmate services. The progressive nature of the jail's administration probably reflected, in part, the position of the county commission. After all, they had a lot to do with appointing the warden, and it was interesting to note that funding seemed directed more toward inmate services than toward facilities and equipment.

2. Progress Made in Attaining Standards

Jail Ten was able to make some progress in complying with the AMA standards between the time it first entered the program and the time of the follow-up visit. Its first self-survey indicated the facility began at the highest level of compliance of any of the five small jails--72%. With the exception of the areas of receiving screening and detoxification, the jail was meeting many aspects of the thirteen service standards. It also reported complying with all eight of the environmental standards. It was in the area of procedural standards that the jail was most deficient. For example, the jail met most of the requirements for staff training, but did not have written procedures

for the delivery of most health care services, a quarterly or annual report as outlined in the standards, or a complete medical record-keeping system.

As Table III indicates, the jail made some progress during the period of the study, but not sufficient progress to warrant an on-site accreditation survey. The jail improved its receiving screening and the correction officers received better first aid training, but the jail was still deficient in the areas of detoxification and written procedures. The deputy warden also said that the communication between the physician and correction staff needed to be improved by way of more written direct and standing orders.

In spite of the fact that the jail only stood at 81% compliance at the time of the follow-up site visit, and still had to meet some parts of tough essential standards, the warden and deputy warden were confident that a health care delivery system that met the standards could be in place by late Spring and that the facility would be ready for an on-site inspection sometime in the summer months. Their optimism was based on the fact that the county commission had changed its thinking about the jail and was now more firmly behind the program to improve its overall operation, especially the health care aspects. The commission had allocated funds for the jail to contract for the expertise it needed to bring its health care system up to standards. This meant that a private outside group, with knowledge in jail health care, was being hired to help formalize the health care system and recruit needed medical personnel. The jail was supposed to move from

a system where the doctor came in twice a week and was assisted by the correction staff, to one where the physician came in once a week to supplement the services of a medical team of nurses which visited the jail on a daily basis.

In addition, both the warden and deputy warden indicated that mental health services were improving at the jail. The system of dealing with mental problems was slowly changing from one which reacted only after a crisis to one which tried to forestall or prevent crises from occurring.

3. Factors Contributing to the Extent of Progress Made

Perhaps the most important change which occurred with regard to Jail Ten was the change in thinking of the county commissioners toward the necessity of an adequate health care delivery system. When the jail entered the AMA program, the commission was perhaps reluctantly supportive and cautious in its appraisal of what really needed to be changed. By the time of the follow-up site visit, the warden and deputy warden both indicated the county commissioners were anxious to get the jail accredited, had allocated additional funds for the jail, and were even talking about the possibility of building a new facility.

There were several reasons for this change in their thinking, but the most important was the pending federal class action suit. The warden and deputy warden left no doubt that the county government was very concerned about the outcome of the suit and the repercussions which might ensue. This suit, they felt, was also a primary factor

in helping to change the thinking of the correction staff since it tended to make them conscious of their own responsibilities and the degree to which they were personally liable for the actions they took while on duty.

In addition to the law suit, the personal enthusiasm of the warden and the careful initiative he implemented were important factors in the progress and change the jail realized. This enthusiasm carried over to the deputy warden but did not appear evident in the jail physician or in the local medical community. For instance, the warden was unable to get a hospital contract, the mental health services were not what they could be, and the jail had to contract with a private company in order to get the medical expertise and staff that the facility needed.

The state medical society representative made one technical assistance visit to the jail at which time the meaning and intent of the standards were discussed. However, the real value of this assistance was in demonstrating to people outside the jail, through the self-survey, that the jail had some real deficiencies when judged against national standards. The health care statistics that the jail maintained and the data collected on the extent of transportation used to deliver health care services outside the jail, also contributed to the total impact.

The change in the jail is perhaps best characterized by the feelings of the deputy warden. At first, he was a little skeptical about the standards. He felt they were probably too stringent and

required too much work, both to implement and to adhere to. However, that feeling changed during the course of the study to one where he saw a great benefit to having an adequate health care delivery system. He no longer felt that the standards were asking too much. A formalized system relieved the correction officers from a lot of the uncertainty under which they previously worked while at the same time, it protected the inmate. Relations and communications between the inmates and the jail staff improved and the jail and its staff were more protected from liability.

This jail was not accredited during the course of the project year and did not make as much progress as some of the other jails which entered the program at the same time. While it looks favorable for eventual accreditation, resources are still needed from the local medical community if it is to succeed. Enthusiasm was always there on the part of the warden. Now it is also there on the part of the county commission, but it is still needed on the part of the local medical community.

PART THREE: IMPACT ASSESSMENT

IV. Measures of Impact of the AMA Program

A. Introduction

In the previous section, the progress of each of the ten jails in improving its health care delivery system was detailed individually. In this chapter, a variety of measures of the impact of the AMA program on the jails' health care systems, their personnel and inmates, will be presented and comparisons between jails made.

As noted in the chapter on methodology, the jails were asked to keep a variety of statistics regarding both the extent of health care services provided as well as items affecting the delivery of these services, such as population fluctuations, transportation needs and cost. These data were to be kept for the full six-month study period. Whenever possible, pre-study statistics were gathered as well in order to provide a more reliable baseline from which to measure change. With the exception of Jail Two where no data were collected, all of the jails kept the statistics requested, albeit with varying degrees of accuracy and completeness.

In addition to these statistical measures, data were gathered regarding other effects of the AMA program. Questionnaires were administered on a pre-post basis to inmates at all ten facilities to determine their opinions regarding the health care offered. Pre-post questionnaires were also given to booking officers to assess whether their attitudes regarding inmates' needs and the health services offered at their jails changed over the course of the study. Finally, indications of staff attitudes regarding the utility of

implementing receiving screening were obtained at the time of the investigator's follow-up site visits.

The findings from these various measures are presented in the subsections which follow. Before turning to them, however, it is worth reiterating that the results from these measures should be interpreted with caution. While the reliability of some of the data collected was questionable, the most serious limitation was undoubtedly the short time period of the study itself.[34/] Six months is not sufficient to determine the lasting effects of change, especially since many of the improvements which took place at the ten jails occurred mainly during the latter months of the study. Thus, wherever changes on a pre-post basis are noted, they should be taken only as possible indications of future trends, rather than as firmly established facts.

B. Effect on Extent of Health Services Delivered

In Part Two, the primary measure used to gauge the extent of improvements made at individual jails was a pre-post self-survey. In other words, jail officials were asked to indicate which of the AMA standards their jail complied with at the beginning of the study period and again at the end. As a back-up measure, staff at each jail was asked to keep statistics regarding the types and extent of medical, mental health and dental services offered.[35/] As will be seen from the discussion below, these statistical measures corresponded well

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34/ For more detailed information, see the chapter on methodology and limitations of data collected.

35/ See Charts 1-9 in Appendix H for details.

with the measures of change indicated by the self-surveys.

Charts 1-4 in Appendix H show the number and types of health care services delivered during the study period for the four small jails for which data were available.[36/] When compared with the column on pre-post compliance with service standards from Table III (see p. 33) it can be seen that the same increases (or lack thereof) in service standards complied with are reflected in the health care statistics.

Chart 1 for Jail One shows that virtually no non-emergency medical services were offered until the last two months, which corresponds with the time when the nurse started coming to the jail. The availability of mental health and dental care did not appear to change, though.

Chart 2 for Jail Eight indicates slight increases in the availability of routine medical services during the last two months, not accounted for by population increases during that same time period (see Table IV on next page). In addition, some routine dental services begin to show up in the last month, but other changes are not evident. These occurrences are consistent with the pre-post data on Table III which reflect a small increase in the number of service standards complied with.

As for Jail Nine, Chart 3 shows no appreciable change in the type or extent of services offered from September to the end of February, in spite of slight increases in daily population figures for the last two months (see Table IV). Again, this is consistent with Table III data which indicate only a small increase in the number of service

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36/ As previously noted, no statistical data were kept in the fifth small facility, Jail Two.

Table IV

Average Daily Population Figures by Jail by Month

Jail	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Average for Six Month Period	Approximate Number of Inmate Days Served During the Study Period (181 Days)	During a Projected Year (365 Days)
One	14.1	13.3	10.4	11.3	12.7	10.4	12.1	2,190	4,416
Two	- - - - - - - - - - - - - - - - D A T A N O T A V A I L A B L E -								
Three	103.8	97.8	115.1	99.7	96.8	95.0	101.4	18,353	37,011
Four	96.8	84.7	90.5	72.8	69.2	80.9	82.4	14,914	30,076
Five	215.8	215.8	215.8	213.7	201.1	196.1	209.9	37,992	76,614
Six	264.4	284.1	282.0	290.8	280.6	279.1	280.3	50,680	102,310
Seven	70.8	74.3	78.7	80.5	70.4	72.1	74.5	13,485	27,192
Eight	18.5	19.0	16.2	Data NA	17.8	20.3	18.3	3,312	6,680
Nine	3.1	4.8	5.0	4.2	5.4	6.7	4.8	869	1,752
Ten	42.9	42.8	43.9	43.6	50.3	57.0	46.6	8,435	17,009

standards met by this facility.

The other small facility, Jail Ten, was already complying with most of the thirteen service standards when it entered the program. This is clearly indicated in Chart 4, Appendix H, which shows continuous provision of both emergency and routine health care services.

Statistics from the three medium-sized facilities also support the data from Table III. The figures from Chart 5 (Appendix H), for Jail Three show an interesting pattern of provision of services. It can be seen that little but emergency care was available for the first two months, sick call and a few other routine services were available the next two months, but some of these were no longer offered the last two months. This is somewhat puzzling until it is recalled that Jail Three hired a nurse on a demonstration basis for November and December to prove to the county board that it would be more cost-effective to offer some services in-house. Her employment was temporarily suspended in January (hence the reduction in services), until the county board approved a permanent nursing position which she resumed in March. Presumably, if Jail Three continued to keep health care statistics, the totals for March and later months would again reflect an increase in services.

Chart 6 (Appendix H) for Jail Four shows continuous provision of several types of routine medical services throughout the study period. This is reflective of the on-going health care system which was in place prior to participation in the AMA program. This facility already had a contract with a physician group and the services of a nurse

five days a week. Some routine mental health services were also available pre-program and continued to be provided. Hence, the most important increases evident from Chart 6 occurred in the dental service area. In the latter months, dental screening and restorative procedures began to be more available.

As for Jail Seven, Chart 7 (Appendix H) shows no dramatic increases in either the type or extent of health care services offered. It should be noted, though, that this jail was already providing most of the services required by the AMA standards (see Table III and Appendix G). Few routine dental services were available pre-program, however, and this situation had not changed appreciably by the end of February.

In reviewing Charts 8 and 9 (Appendix H) for Jails Five and Six respectively, the strong positive relationship between size of facility and extent of health care services offered pre-program becomes clear. Both of these large jails offered non-emergency medical and mental health services prior to participation in the AMA program, and Jail Six offered a variety of types of routine dental care as well. In spite of the extensive services offered initially in these two jails, increases in certain categories of health care still occurred.

At Jail Five, Chart 8 shows that the availability of sick call increased during the last two months, even though the average daily population (ADP) for those same months was lower than for previous ones. This was undoubtedly due to the fact that the night shift nurse started working days and the health care team was thus able to see more inmates. Similarly, the number of physical exams and lab

tests being performed increased substantially in January and February, although the population decreased. This suggests that this facility began complying with the standard requiring full health appraisals for all inmates within fourteen days.[37/] Chart 8 also points to the initiation of routine dental screening in January. However, this service was suspended in February while the health care staff sought clarification of what dental screening should entail. At the time of the investigator's follow-up visit in March, this screening had been resumed.

Like the previous facility, Jail Six was already providing most types of services required by the AMA standards. Still, the extent of services was increased in some categories, although the ADP decreased slightly (see Table IV). For example, proportionately more physical exams were being done in the latter months (see Chart 9) and the number of lab tests being given in January and February increased almost eighteen times over the previous four month average. In addition, dental screening was initiated during the last two months.[38/]

As a final check on changes in the jails' extent of compliance with the AMA standards, each facility was asked to keep length of stay (LOS) figures for the six-month study period. Aside from assisting the jails in determining the extent of health care staff and

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37/ Unfortunately, the lack of length of stay statistics for this jail do not allow substantiation of this.

38/ Chart 9 also shows a decrease in the extent of non-emergency mental health care offered during January and February. However, this is believed to be due to the failure of the jail to include one category of service previously reported on, rather than a true decrease in the availability of this service.

resources needed, LOS figures provide a useful cross-check on compliance, since many of the AMA service standards governing non-emergency care are time-linked.[39/] For example, physical examinations and lab tests must be performed on all inmates within fourteen days. This is an essential standard and all jails interested in being accredited must comply. A similar situation obtains with respect to dental care--e.g., to be in compliance, screening must be done within the first fourteen days and routine examinations and follow-up treatment must be provided after ninety days.[40/]

Table V (see next page) summarizes the length of stay figures during the study period for the eight jails where data were available.[41/] If we compare the LOS statistics from Appendix I with each jail's corresponding health care statistics from Appendix H, seeming deficiencies in the latter become more understandable, especially for those jails claiming increased compliance with service standards over time.[42/] For example, the lack of routine dental services at Jail One (see Chart 1, Appendix H) is not quite so disturbing when Table V shows that in six months, only one inmate stayed longer than ninety

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[39/] Obviously, emergency services are not time-linked and must be provided immediately.

[40/] It should be noted that the dental standard is not mandatory, though.

[41/] Breakdowns by month for individual jails are available in Charts 1-8 in Appendix I.

[42/] Table III (page 33), shows that by the end of the study period, all but Jails Eight and Nine were complying with almost all aspects of the thirteen service standards.

Table V

Length of Stay Figures for September 1978 through February 1979 by Jail

Facility	< 24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		> 90 Days		Totals	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
One	148	53	73	26	30	11	17	6	10	4	1	0*	279	100
Two	- - - - - - - - DATA NOT AVAILABLE - - - - - - - - - - - - - - - - - -													
Three	553	40	434	32	175	13	156	11	53	4	0	0	1371	100
Four	436	36	482	40	83	7	72	6	89	7	43	4	1205	100
Five	- - - - - - - - DATA NOT AVAILABLE - - - - - - - - - - - - - - - - - -													
Six (a)	291	14	850	41	333	16	186	9	161	8	253	12	2074	100
Seven	60	20	81	27	31	10	46	15	43	14	44	14	305	100
Eight (a)	94	26	154	42	60	16	19	5	19	5	19	5	365	99*
Nine	12	38	11	34	1	3	2	6	3	9	3	9	32	99*
Ten	65	24	75	27	30	11	30	11	28	10	48	17	276	100
Totals	1659	28	2160	37	743	13	528	9	406	7	411	7	5907	101*

(a) = Accuracy of these data is not definitely known. * = Errors due to rounding.

days. The same was true for Jail Three (see Chart 5, Appendix H) with respect to dental services, but again, Table V indicates that during the study period, no inmates were incarcerated for longer than ninety days.

Similar checks can be made for the categories of physical examinations and lab tests by comparing the LOS figures from Appendix I for the months these standards were said to be complied with, with the health care figures for the same months from the charts in Appendix H. Suffice it to say that for the most part, the correspondence between the standards the various jails said they complied with and what the LOS and health care statistics showed was very good.

C. Effect on Transportation Requirements

It was also of interest to determine what effect implementing the AMA standards would have on the jails' transportation requirements. Hence, each facility was asked to keep a record of the number of times inmates were transported out of the jail to receive health care services in the community. Again, all of the facilities except Jail Two kept these requested statistics. The jails' health care transportation requirements for the six-month study period are summarized on Table VI (see next page) and monthly breakdowns by jail are available in Charts 1-9 in Appendix J.

From Table VI, it can be seen that in virtually all the jails, the most usual reason for transporting an inmate to a community health care provider was for non-emergency medical care. Jails Five and Eight were the exceptions. In the former facility, non-emergency

Table VI

Transportation for Health Care Reasons by Jail by Type by Service
September 1978 - February 1979

Jail	Size	Non-emergency Trips: Dental	Non-emergency Trips: Psychiatric	Non-emergency Trips: Medical	Emergency Trips Within 24 Hours of Admission: Dental	Emergency Trips Within 24 Hours of Admission: Psychiatric	Emergency Trips Within 24 Hours of Admission: Medical	Emergency Trips Occurring Later: Dental	Emergency Trips Occurring Later: Psychiatric	Emergency Trips Occurring Later: Medical	Total Trips by Service: Dental N	Total Trips by Service: Dental %	Total Trips by Service: Psychiatric N	Total Trips by Service: Psychiatric %	Total Trips by Service: Medical N	Total Trips by Service: Medical %	Total Trips by Type: Non-emergency N	Total Trips by Type: Non-emergency %	Total Trips by Type: Emergency N	Total Trips by Type: Emergency %	All N	All %
One	Small	0	4	12	0	0	0	0	2	5	0	0	6	26	17	74	16	70	7	30	23	100
Two	Small	DATA NOT AVAILABLE																				
Three	Medium	21	17	105	0	0	2	0	0	17	21	13	17	10	124	77	143	88	19	18	162	100
Four	Medium	16	3	23	0	1	3	0	0	15	16	26	4	7	41	67	42	69	19	31	61	100
Five	Large	89	19	51	1	2	3	1	6	30	91	45	27	13	84	42	159	79	43	21	202	100
Six	Large	3	22	194	2	1	20	5	7	126	10	3	30	8	340	89	219	58	161	42	380	100
Seven	Medium	19	121	66	0	0	6	0	1	18	19	8	122	53	90	39	206	89	25	11	231	100
Eight	Small	5	17	3	0	0	1	0	0	1	5	18.5	17	63	5	18.5	25	93	2	7	27	100
Nine	Small	3	3	11	0	0	0	0	0	2	3	16	3	16	13	68	17	89	2	11	19	100
Ten	Small	14	6	26	0	0	2	0	0	3	14	27	6	12	31	61	46	90	5	10	51	100

dental care was the most frequent reason for transporting an inmate to a community provider, whereas in the latter facility, it was non-emergency psychiatric care. These statistics should not be taken as indications of the different types of health care needs of inmates in different facilities, however. Rather, they are more a reflection of the extent of medical, dental and psychiatric care available at each facility. In other words, medical treatment is more often available than dental or mental health care.[43/]

More importantly, however, the statistics on Table VI are a reflection of the type of health care delivery system in place at each facility. A glance at the last column shows that there is no consistent pattern regarding the number of trips taken for health care reasons and the size of the facility. For example, Jail Seven, which is a medium-sized facility, had considerably more trips than the other two medium-sized jails (numbers Three and Four), and more than even one of the large facilities (Jail Five). Again, this is not a measure of the availability of health care services per se, since jails with fewer trips could be providing the same services in-house.

Transportation requirements for health care reasons, then, are inevitably linked to the jail's health care delivery system model. Whether they will increase or decrease as a result of implementing the AMA standards depends largely on the type and extent of health care services available pre-program, and whether any new services are to be provided in-house or in the community.

[43/] To some extent, this may be a function of the AMA standards, since they mandate that certain types of medical services be available, but allow more choice in the extent of dental and mental health services which should be offered.

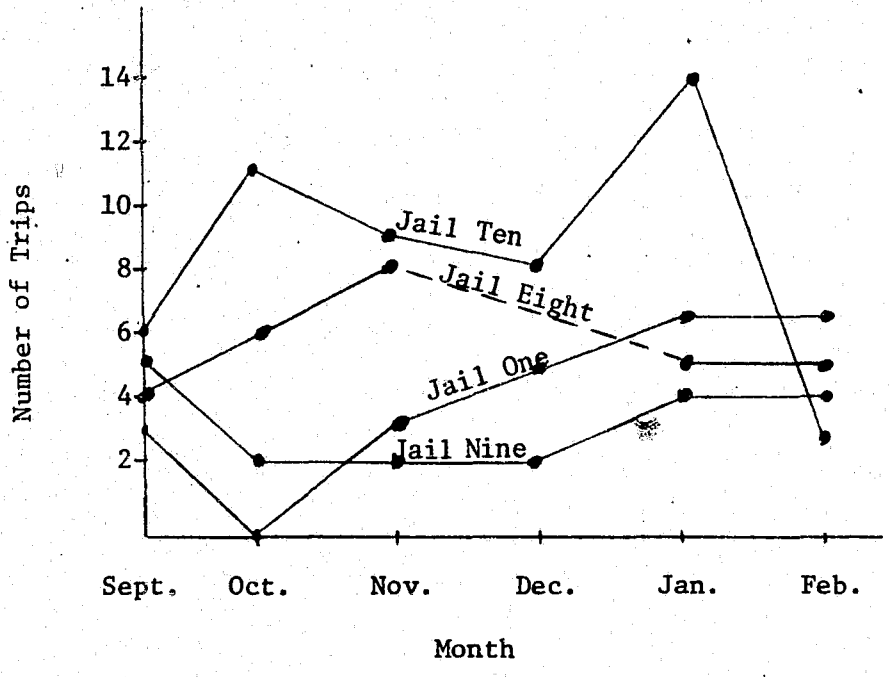
This point becomes clearer if we analyze the transportation requirements of each jail on a monthly basis and compare these statistics with changes which occurred in the health care delivery systems over the course of the study period. Changes in transportation requirements for health care reasons for small, medium and large-sized jails are depicted on Graphs 1, 2, & 3 respectively (see pp. 166, 168, 171). It is readily apparent from all three graphs that there is no consistent pattern of change in transportation requirements by size of facility. Again, it is necessary to know what changes, if any, took place in the health care delivery system model at each jail in order to understand the increases or decreases in transportation requirements for health care reasons.

Graph 1 (see next page) clearly shows that the four small jails had different transportation patterns over the course of the study period. For Jail One, it can be seen that the number of trips for health care reasons in September was lower than that of the other three small jails. There were no trips taken in October, but in November, the number of trips began to increase and continued to rise steadily during the remaining months. This transportation pattern is consistent with the changes which occurred in Jail One's health care system. In the latter months, health care services were increased and hence, more transportation was needed.

The transportation patterns for Jails Eight and Nine can be accounted for in a similar fashion. The number of trips at the former facility increased slightly during the middle months and then

Graph 1 - Small Jails

Transportation for Health Care Reasons



(Note: Broken line indicates no data were available that month.)

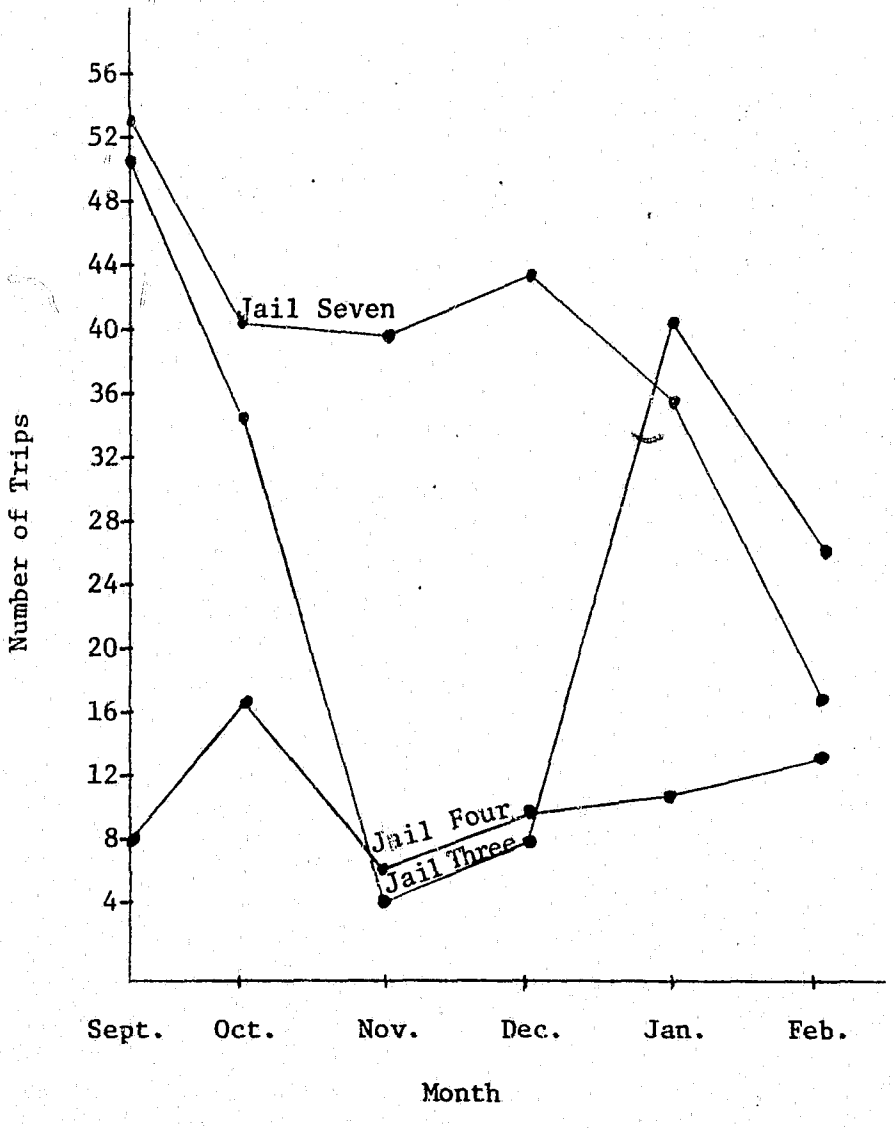
dropped back to about its previous level, whereas the opposite occurred at the latter facility. The slight increases at Jail Eight corresponded to the initiation of psychiatric services (see Chart 2, Appendix J), while the slight decreases at Jail Nine may simply have been due to a difference in inmate needs for those months. In any case, changes in the transportation figures for these two jails during the study period were not very dramatic. This is consistent with the lack of significant improvements in the health care services offered at these two jails.

As for Jail Ten, the fairly erratic pattern of transportation requirements is less easy to explain, especially since the number and types of health care services did not change very much over the course of the six-month study period. A glance back at Table IV shows that population fluctuations do not provide an explanation either, since the transportation needs were lowest when the population figures were highest (i.e., in February). Since there were no changes in health care staff and few increases or decreases in the type or extent of services offered, it may well be that at this jail, changes in transportation requirements were linked to differences in inmates' needs for certain services.

Graph 2 (see next page) depicts the transportation requirements for the three medium-sized jails. The trip pattern for Jail Three is most unusual, since it starts high in September, drops dramatically during November and December, increases significantly in January, and begins to drop again in February. The sharp decreases for November

Graph 2 - Medium Jails

Transportation for Health Care Reasons



and December are especially noteworthy, since Table IV indicates that the average daily population was somewhat higher during these two months than in previous or later months. Again, the pattern makes sense when it is recalled that a nurse was hired on a demonstration basis during November and December. Since she began providing services in-house, fewer trips to the hospital emergency room were needed. Her services were suspended in January (hence the increase in transportation requirements), but later resumed. Clearly, health care transportation needs at Jail Three were linked to changes occurring in its delivery system.

Graph 2 also shows that the transportation pattern for Jail Four remained fairly constant, even though Table III indicates increases in the extent of services offered. Again, the most likely explanation is related to the delivery system, which was already in place pre-program. Jail Four had a good-sized medical facility and was offering a number of services in-house on a regular basis. Thus, even though previous services may have been expanded and new services added, the setting for delivering these services did not change. Hence, transportation requirements were unaffected by implementing the AMA standards and continued to be dependent upon the changes in inmates' needs for care not available at the facility itself.

As for Jail Seven, there appears to be no ready explanation for the decrease in transportation requirements during the last two months. Table IV shows small decreases in the ADP for January and February, but not enough to account for the substantial drop in the number of

trips made (especially in the latter month). A glance at Chart 7, Appendix J, indicates that the sharp decrease in the number of trips in February occurred primarily in the category of non-emergency psychiatric trips. Perhaps this service was suspended for some reason during that month.

Transportation requirements for the two large facilities are depicted in Graph 3 (see next page). Once again, monthly changes in the number of trips taken for health care reasons are linked to the types of delivery systems in place. For example, Jail Five was offering virtually all of the services mentioned in the AMA standards when it entered the program (see Table III). Hence, working toward accreditation did not affect the transportation requirements at this jail. Whatever changes did occur were undoubtedly related to changes in inmates' needs for services not offered in-house.

Jail Six was also offering a substantial number of services pre-program. The significant decrease in transportation requirements from September to October is easily accounted for, when it is recalled that a nurse was added in September. Hence, in subsequent months, less use of the hospital emergency room was required, since more services could now be provided in-house.

In summary then, the effect of implementing the AMA standards on a jail's transportation requirements seems to be dependent on two factors: the type of delivery system in place pre-program and whether new services are to be provided in-house or in the community. If a jail is already delivering a substantial number of services mentioned in the AMA standards--regardless of where these services are being

CONTINUED

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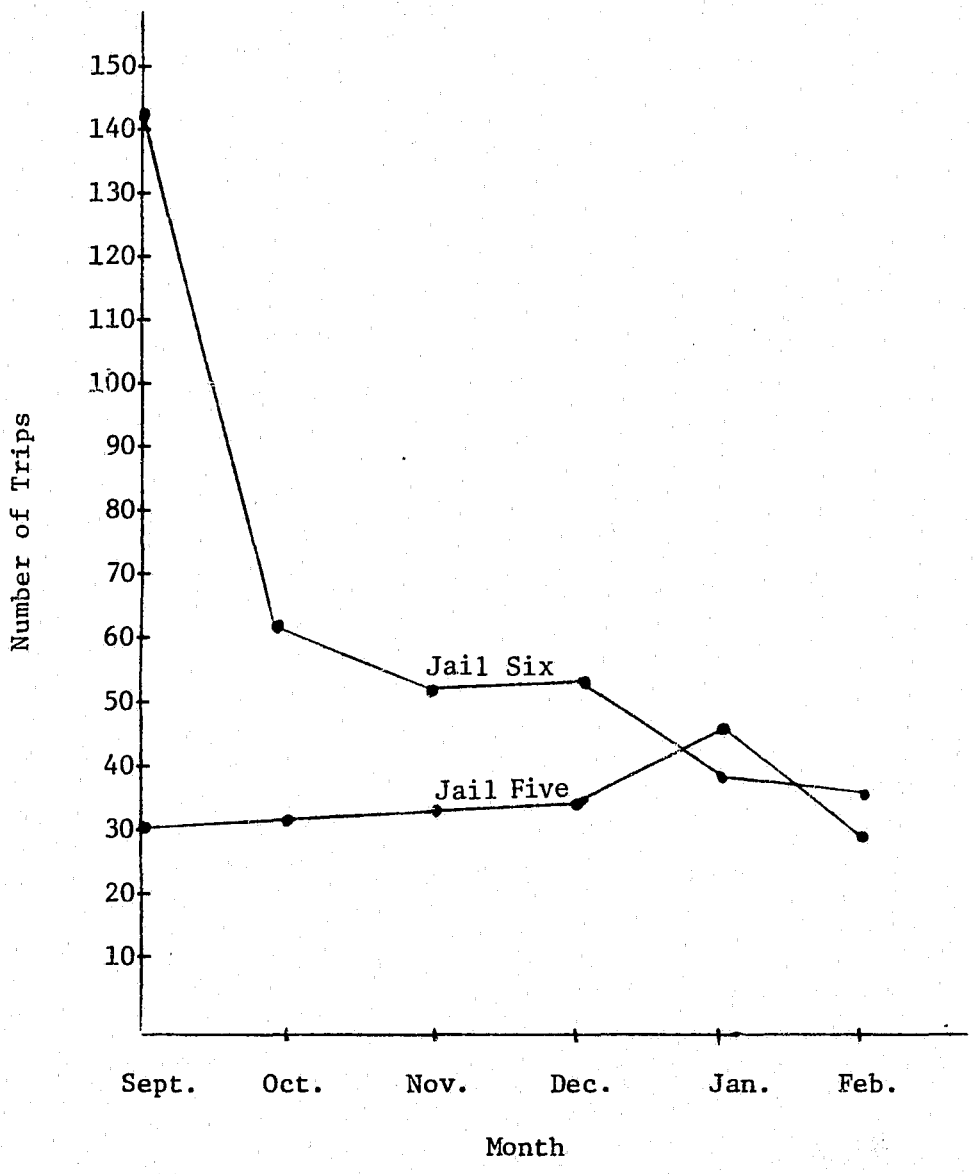
Graph 3 - Large Jails

Transportation for Health Care Reasons



provided--then implementing the AMA standards is likely to have little effect on the jail's transportation needs (see patterns for Jails Four and Five). On the other hand, if few services are available initially, where the new services are to be provided will determine the effect their addition will have on transportation requirements. For example, when Jail One added services, it began utilizing community health care providers more and hence, its transportation needs increased somewhat. The reverse was true for Jails Three and Six, since their new services were provided in-house.[44/]

D. Effect on Rate of Serious Incidents

Another measure of the impact of implementing the AMA standards was to determine what effect this might have on the rate of serious medical incidents in jails. Hence, data were gathered regarding a variety of serious medical incidents which occurred in the ten jails pre-program and the facilities were asked to keep similar statistics during the course of the study. A summary of the former is presented in Table VII and of the latter in Table VIII (see next two pages).

From Table VII, it can be seen that there appears to be a positive relationship between the size of the facility and the total number of serious medical incidents which occurred pre-program, but there is no consistent pattern with regard to type of incident. However, this may not be a totally reliable interpretation for two reasons: first, the last two columns of Table VII indicate that the length of time for which

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44/ Since few changes were made in the health care systems at Jails Eight and Nine, transportation patterns remained fairly stable. The fluctuations for Jails Ten and Seven were not as easily accounted for.

Table VII

Number of Serious Incidents Occurring Pre-Program

Jail	Size*	Type of Incident						Average # of Incidents Per Month	# of Total Incidents Occurring Within 1st 24 Hours	# of Months of Pre-Program Data	Time Period
		Attempted Suicides	Alcohol or Drug Withdrawal	Injuries	Seizures	Other	Total				
One	S	0	0	0	0	0	0	0	0	5 months	1/78-8/78
Two	S	0	0	0	0	0	0	0	0	32 months	1/76-8/78
Three	M	2	0	32	0	6	40	1.38	?	29 months	4/76-8/78
Four	M	11	0	2	0	0	13	.65	2	20 months	1/77-8/78
Five	L	40	240	206	0	0	486	11.05	251	44 months	1/75-8/78
Six	L	----	------	NO	DATA	AVAILABLE	----	----	----	----	----
Seven	M	4	3	6	0	4	17	.53	5	32 months	1/76-8/78
Eight	S	7	6	0	1	0	14	.32	1	44 months	1/75-8/78
Nine	S	0	2	0	0	0	2	.05	2	44 months	1/75-8/78
Ten	S	3	0	1	3	3	10	.50	5	20 months	1/77-8/78

* S = Small; M = Medium; L = Large

Table VIII

Number of Serious Incidents Occurring During Study Period
(September 1978 Through February 1979)

Jail	Size*	Type of Incident						Average # of Incidents Per Month	# of Total Incidents Occurring Within 1st 24 Hours	Average # of Pre-program Incidents Per Month	June Accreditation Likely?
		Attempted Suicides	Alcohol or Drug Withdrawal	Injuries	Seizures	Other	Total				
One	S	1	0	0	0	0	1	.17	?	0	Yes
Two	S	- - - - - - - - - - - - N O D A T A A V A I L A B L E - - - - - - - - - - - -								0	Rec'd in March
Three	M	0	0	0	0	0	0	0	-	1.38	Yes
Four	M	2	0	1	0	0	3	.5	0	.65	Yes
Five	L	11	0	49	0	0	60	10.00	9	11.05	Yes
Six	L	- - - - - - - - - - - - N O D A T A A V A I L A B L E - - - - - - - - - - - - - - - - - -									Yes
Seven	M	0	2	3	3	2	10	1.67	2	.53	No
Eight	S	0	2	1	2	0	5	.83	3	.32	No
Nine	S	0	0	0	0	0	0	0	-	.05	No
Ten	S	1	0	0	0	0	1	.17	1	.50	No

* S = Small; M = Medium; L = Large

pre-program data were available varied greatly, and second, the definition of what constituted a "serious medical incident" may have differed from jail to jail. Still, while comparisons between jails may be questionable, those made within jails on a pre-post basis ought to be somewhat more reliable.

Table VIII shows the number of different types of serious medical incidents which occurred during the study months. While the time period was much too short to establish definite patterns--especially considering that many of the improvements in the jail's health care systems did not take place until the latter months--these data do seem to suggest that there was a reduction in the total number of serious incidents in those facilities where accreditation is likely. The same was not true for the four jails which did not make sufficient improvements in their health care systems to ensure accreditation this year.[45]

E. Effect on Inmate Attitudes

The pre-post questionnaires which were distributed to inmates at the ten jails were designed to measure whether inmates' attitudes about their jail's health care system changed as a result of the jail's participation in the AMA program. The process of developing the questionnaires, their content and how they were distributed have already been discussed.[46]

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[45] Tables VII and VIII do not give any figures for the number of deaths at the ten jails. This was not due to an oversight on the part of investigators, but rather to the fact that there was only one death at any of the jails, and it occurred pre-program.

[46] See the Methodology section, pages 22-25, of this report. See also Appendix E for an example of the questionnaire.

In this section, the findings with respect to changes in inmate attitudes will be analyzed.

Table IX on the next page gives the pre and post questionnaire response rates for the ten jails. It should be noted that only in Jails One, Two and Nine did the number of respondents taking the pre and post questionnaires equal the total number of inmates incarcerated at these jails on the day the questionnaires were administered. At the other seven jails, the number of respondents represented only a sample and not the universe of inmates incarcerated in these facilities. This fact, coupled with the fact that the sample sizes are small, means that interpretation of the findings with respect to inmate attitudes should proceed with caution. Any differences between pre and post results should be taken as only suggestions of change rather than as established facts.

The column headings on Table IX identify three different sets of respondents. Group One consisted of all inmates who took the pre questionnaire. Their responses represented the baseline measure of inmate attitudes about the health care system in their jails. The next column is labeled "Pre/Post Pairs." Respondents in this category represent a sub-set of Group One. These inmates took the pre-questionnaire when everyone else did (and hence, were included in Group One), but they all took the post questionnaire at different times (the day before each was released) and mailed them in to the investigators. The last column is labeled "Group Two." These individuals represent inmates who were incarcerated at the ten jails at the time of the investigators' on-site follow-up visits. They took only the post questionnaire.

Table IX

Pre and Post Inmate Questionnaire
Response Rates by Jail

Jail Number	Size	Group One	Pre/Post Pairs	Group Two
		Total number of inmates completing a pre-questionnaire	Number of inmates taking a pre-questionnaire who also completed a post-questionnaire	Total number of inmates completing only a post-questionnaire
One*	Small	9	0	7
Two*	Small	6	4	9
Three	Medium	10	0	10
Four	Medium	10	6	10
Five	Large	10	0	10
Six	Large	10	7	10
Seven	Medium	10	6	11
Eight	Small	9	0	8
Nine*	Small	4	0	7
Ten	Small	10	8	10
TOTALS	--	88	31	92

*At these three jails, the number of Group One and Group Two respondents completing pre and post questionnaires respectively represented the total number of inmates who were incarcerated in these jails on the day the questionnaires were administered. This was not true for the other seven facilities (see the Methodology section for a discussion of the sampling procedures used at the jails).

Ideally, pre/post attitude change studies should be conducted on the same set of respondents. This is extremely difficult, however, when the population of interest is jail inmates, since they are not all incarcerated on the same day and do not all stay for the same length of time. Hence, the usual approach to surveying inmate attitudes is to sample different sets of inmates at different points in time. The main assumption here is that the basic characteristics of inmates at any given jail remain constant. Thus, any changes in attitudes which occur over time are presumably attributable to whatever program intervention is being studied.

This was essentially the methodology employed in the current study of inmate attitudes regarding health care issues. The basic comparisons in attitude change, then, were between aggregate responses of Group One and Group Two, which were composed of <u>different</u> inmates who were assumed to have similar characteristics. In addition, though, pre-post comparisons were possible for a few of the <u>same</u> inmates, i.e., the sub-set of Group One who took the post questionnaire when they were released.

Thus, in the analysis which follows, differences between the aggregate responses of Group One and Group Two will be examined first. Then, similar comparisons will be drawn for the sub-set of the Pre/Post Pairs. Finally, both Group One versus Group Two aggregate responses and the Pre/Post Pairs aggregate responses will be examined, taking into account the likelihood of the jails' receiving accreditation.[47]

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[47] Only aggregate responses are presented here. Breakdowns by jail for each variable on a pre-post basis can be found in Charts 1-18, Appendix K.

1. Group One versus Group Two Comparisons

In reviewing mean differences in attitudes toward health care issues between Group One and Group Two respondents, it should be noted that none of the differences were statistically significant.[48/] However, on most of the questions, the findings indicated that the attitude change over time was in the right direction -- i.e., indicating a positive effect of the AMA program. These variables were as follows:

a. Fewer of the Group Two inmates were ever concerned that they might become ill because they were in contact with other inmates who were sick and not receiving treatment;

b. More of the Group Two respondents felt they were receiving appropriate care more often on sick call;

c. Slightly more of the Group Two inmates rated the physician's attitude toward them as somewhat more positive and more rated the attitudes of other medical staff toward inmates as more positive;

d. More of the Group Two respondents felt the jail physician treated them with respect than did Group One inmates;

e. Fewer of the Group Two inmates believed that sick call was misused by others who were not really ill;

f. More Group Two respondents felt that non-physician medical staff usually spent enough time with them at sick call;

g. Fewer indicated that they had ever been denied access to medical care and the same results obtained with respect to dental and mental health care as well;

h. More of the Group Two inmates rated the mental health care availability as at least fair; and further

i. More Group Two respondents believed that the jails they were incarcerated in were trying to improve the health care services offered to inmates.

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[48] It should be recognized that statistical significance is very difficult to obtain when using small samples. The use of "two tail probability" on the t-tests further reduced the likelihood of obtaining significant results.

There were a few questions, though, where Group Two inmates responded in what seemed to be a less positive fashion about the health care system than did Group One individuals. For example, more Group Two inmates indicated they had seen the doctor less often and fewer felt the doctor usually spent enough time with them at sick call. These attitude changes may have reflected changes in the type of personnel providing care, however. When a jail moves from an "emergency only" to a routine system of care, the likelihood of inmates seeing non-physician health care staff more often than physicians tends to increase. Some support for this position can be found in f. above, where Group Two inmates indicated they were more satisfied with services provided by non-physician staff.

Post responses to some other questions were less easily explained, however. For example, slightly more Group Two individuals felt that if an inmate had a heart attack, the emergency action necessary to save his or her life would be only "fair." Similarly, slightly fewer Group Two respondents were "fairly confident" that jail staff would perform proper life-saving procedures in an emergency situation. Further, somewhat more of the Group Two inmates indicated they sometimes did not go to sick call because they did not believe their illnesses would be treated. A few more also said that their own health "had gotten a little worse" since being incarcerated and a couple more stated that getting a pill to calm their nerves was "pretty hard" rather than "very hard."

While the differences in responses between Group One and Group Two to the items noted in the paragraph above were very small, they were in

the wrong direction. It is possible that the small increase in the number of post versus pre respondents was enough to cause these differences. In addition, for many of these variables, the charts in Appendix K which give breakdowns by jail indicate that many of the increases in negative responses occurred in Jails Seven, Eight, Nine and Ten -- which were the four jails which made the fewest improvements. Increases in negative attitudes at these facilities contributed to the slight increases in aggregate negative responses for the ten jails as a whole.

In addition to running frequencies and t-tests, scales were developed for three separate factors: a) inmate attitudes regarding the accessibility[49] of health care services; b) inmate attitudes regarding the availability and adequacy of health care; and c) inmate opinions regarding the attitudes of health care staff toward inmates. The only items from the inmate questionnaire which were included in these scales were those which clustered together on factor analysis. It should be noted, though, that none of the items were weighted. All three were simple additive scales.

Mean responses for Group One and Group Two inmates on each scale were compared in two different ways: both without and with substitution of the mean for missing cases. On the runs without substitution, the differences in the means between Group One and Group Two were in the wrong direction on all three scales, although none of these differences

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[49] This term refers to whether or not inmates have easy access to health care services which are provided by the jail. Sometimes, services are available, but inmate access is restricted by correctional and/or medical staff.

were statistically significant. On the runs with substitution, differences between the Group means were still in the wrong direction, but still not statistically significant for both the accessibility scale and the availability/adequacy scale. On the attitude scale, the direction of change in the Group means was positive, but again, not significant.

2. Pre/Post Pairs Comparisons

For five of the jails,[50] it was possible to make pre/post comparisons of attitude changes for the same inmates. Although the number of respondents was smaller than that of Group respondents, the results ought to be somewhat more reliable because pre/post attitude changes were being measured on the same individuals. To ensure that the pre attitudes of the Pair respondents did not differ from the pre attitudes of the other respondents in Group One, t-tests were run on their mean responses on the three scales. No statistically significant differences in their response patterns were found on any of the scales. Further, since the Pair respondents completed their post questionnaires at different times, t-tests were run on the differences among Pair respondents in their response patterns to the three scales by their length of stay. Again, no statistically significant differences were found.

In taking a look at the results of attitude changes which occurred for the Pre/Post Pairs, a number of the findings were similar to those obtained for the Groups in terms of the direction of change. In addition, some of the differences in Pair inmates' pre/post attitudes

[50] See Table IX.

were statistically significant at the .05 level or better. The items on which Pair findings were in the same direction as Group findings are outlined below. Those which represented statistically significant differences are marked with an asterisk.

Pair attitudes changed over time like Group attitudes as follows:

a. On the post questionnaire, fewer were concerned that they might become ill because they were in contact with other inmates who were sick but not being treated;

b. Significantly more felt they were getting the care they should on sick call most of the time;*

c. More rated the physician's attitude toward inmates in a more positive fashion and significantly more indicated that other medical staff attitudes toward inmates had improved;*

d. The number indicating that the jail doctor treated them with respect increased;

e. On a post basis, more of the Pair respondents felt that non-physician medical staff usually spent enough time with them at sick call, and unlike the Group results, more Pair inmates also felt the doctor spent enough time with them;

f. Like the Group results, fewer of the Pairs indicated on follow-up that they were often denied access to medical, dental or mental health care;

g. More of the Pairs rated the mental health availability as good; and

h. More of the Pairs believed that their jails were trying to improve health care services.

In addition, there were other positive changes in Pair attitudes not found in the Group responses, such as:

i. A significant increase in the number of times the Pairs reported seeing a doctor (which was undoubtedly a function of their length of stay);*

j. A signficant increase in the number of Pairs on follow-up who indicated that they believed if an inmate had a heart attack in their jail, the emergency action necessary to save his or her life would be at least "fair;"*

k. An increase in the number of Pairs who said they would be "fairly confident" that proper life-saving procedures would be performed in an emergency.

l. A decrease in the number of Pair respondents who said that they usually or occasionally decided not to go on sick call because they did not think they would be treated; and

m. An increase in the number of Pairs who said it was at least "pretty hard" to get a pill to calm their nerves down or help them sleep.

Interestingly, though, more of the Pair respondents on follow-up felt that inmates often went to sick call when they did not really need to. This suggests that an increase in the availability of health care services may lead to an increase in inmate malingering. Finally, like the Group respondents, more of the Pairs felt that their own health status "had gotten a little worse" since being incarcerated. Thus, it appears that inmate attitudes regarding their own health status are independent of improvements which occur in a jail's health care system. In other words, inmates may recognize that positive changes have been made in their jail's health care delivery system, yet still believe that their own health status has declined as a result of being incarcerated.

Another important finding occurred on the Pair runs analyzing pre/post changes in mean responses on the three additive scales. With substitution of the mean for missing cases, positive results were obtained on the composite scale measures of accessibility of health care services, medical staff attitudes and availability and adequacy of health care services. Further, pre/post changes were significant beyond the .05 level on the latter scale.

3. Group and Pair Comparisons by Accreditation

In the two previous sections, changes in inmate attitudes were presented in an aggregate fashion for the ten jails taken together. The extent of the improvements in the health care systems at different jails was not taken into account. Hence, it was of interest to see whether the results on the composite scale measures would change if analyses were done which included a measure of accreditation probability.

The ten jails were divided into two types: those where sufficient improvements had occurred to make accreditation in June likely (Jails One-Six) and those where some improvements had occurred but not enough to warrant accreditation in June (Jails Seven-Ten). Pre/post comparisons of both Group and Pair mean responses on the three composite scales were made by accreditation status. The results were as follows:

a. For the six "accredited" jails, pre/post comparisons of Group responses indicated that inmate opinions improved on all three composite measures and on the one measuring medical staff attitudes toward inmates, the differences were highly signficant.

b. For the four "non-accredited" jails, none of the differences between Group One and Group Two respondents' attitudes were significant, but Group Two inmate opinions were less favorable toward their jail's health care system on all three scales.

c. On the Pair comparisons by accreditation status, again, post responses indicated more favorable opinions on all three scales for inmates in the three "accredited" jails for which data were available, although these differences were not statistically significant. Interestingly, the same results were obtained in the two "non-accredited" facilities where Pair data were provided, and on the availability and adequacy scale, the difference in mean response was significant beyond the .05 level. Thus, some improvements seemingly occurred in these two facilities which were discernible to inmates, even though accreditation by June of 1979 was not deemed likely.

F. Effect on Booking Officer Attitudes

The pre/post questionnaires which were completed by booking officers at the time of the investigators' initial and follow-up visits were designed to measure changes in their opinions regarding: 1. their jail's health care system and 2. the extent of inmates' medical needs.[51] Table X gives the booking officer response rates by jail.

From Table X, it can be seen that there were eighteen individuals who took only the pre-questionnaire (Column A), eighteen different individuals who took only the post questionnaire (Column B), and forty-five booking officers who took both the pre and the post questionnaires (Column C). In some cases, follow-up questionnaires could not be administered because of staff turnover and in others, booking officers simply did not complete the questionnaires a second time. In all cases, however, response rates at each jail represented the majority of officers performing booking at both points in time. In other words, the response patterns of these booking officers ought to be fairly representative of the attitudes of those not sampled.

In analyzing the questionnaire results, pre/post comparisons were made between two different sets of respondents. First, the aggregate responses of all those taking the pre-questionnaire (Column D) were compared with the aggregate responses of all those taking the post questionnaire (Column E). These are referred to as "Group" comparisons. Second, the aggregate responses of those who took both questionnaires

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[51] See pages 25-26 in the chapter on methodology for a description of the process used in developing and administering the questionnaire, and Appendix F for an example of the questionnaire itself.

Table X

Pre and Post Booking Officer Questionnaire
Response Rates by Jail

Jail	Size*	A # Taking Only Pre Questionnaire	B # Taking Only Post Questionnaire	C # of Pairs Taking Both the Pre and the Post Questionnaire	D Total # Taking Pre-Questionnaires (Column A+C)	E Total # Taking Post-Questionnaires (Column B+C)	F Total # Taking Any Questionnaires (Column A+B+C)
One	S	2	2	7	9	9	11
Two	S	0	2	1	1	3	3
Three	M	3	1	5	8	6	9
Four**	M	0	1	1	1	2	2
Five**	L	2	1	4	6	5	7
Six**	L	0	0	5	5	5	5
Seven	M	4	7	9	13	16	20
Eight	S	3	4	4	7	8	11
Nine	S	1	0	5	6	5	6
Ten**	S	3	0	4	7	4	7
TOTALS	-	18	18	45	63	63	81

* S=Small; M=Medium; L=Large

** In these four jails, booking was done by specially designated booking officers. In the other facilities, a variety of jailers on each shift performed booking.

(Column C) were compared against each other. These are referred to as "Pair" comparisons. Since the primary measure of interest was attitude change occurring among the same booking officers over time, only the aggregate Pre/Post Pair comparisons are discussed below. Group comparisons are presented in Charts 1-30 in Appendix L, along with breakdowns by individual jails.

1. Pre/Post Pair Comparisons

The primary threat to the validity of the Pre/Post Pair responses was one of testing.[52] In other words, booking officers who took the pre questionnaire were familiar with the post questionnaire items and may have discussed the "right" answers among themselves. Thus, individuals taking only the pre questionnaire (Column A) and those completing only the post questionnaire (Column B) were used as controls regarding the possible effect of testing on Pair responses.

t-tests were run on the mean responses of individuals taking only the pre questionnaire against the pre responses of the Pairs. Their response patterns did not differ significantly on any variable except one. Significantly more of the Pair respondents rated the health care in their jail as "good," whereas the mean response for the pre-only individuals was more often "fair." t-tests were also run comparing the mean responses of the post-only set with the post responses of the Pairs. Here, no statistically significant differences were found. In other words, testing appears to not have been a serious internal validity

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[52] See Donald T. Campbell and Julian C. Stanley, Experimental and Quasi-Experimental Designs for Research, Chicago: Rand McNally (1966), pp. 5-9.

threat, since the response patterns of the control groups were similar to those for the Pairs.

The Pair findings regarding changes in booking officers' pre/post opinions about their jails' health care systems were all positive, although none of the differences were statistically significant.[53] Still, the data suggested that by the end of the study period, the following changes had occurred:

a. More booking officers rated the health care available in their jails as "good" or "excellent" than had previously;

b. Fewer were sometimes concerned that they might become ill because they were in contact with inmates who were sick and not being treated;

c. More rated their jail's procedures for handling potential suicides as "good" than had initially, and the same was true regarding their jail's procedures for detecting and treating inmates with communicable diseases; and on follow-up

d. More Pair respondents indicated they were at least "fairly confident" that inmates who were of danger to themselves or others were being identified at booking and then handled appropriately.

The latter result probably represented a true change in booking officer opinions, since a control question showed there was no change whatsoever in Pair respondents' estimates of the frequency with which "dangerous" inmates were booked into their jails during equivalent pre and post six month periods. Estimates of the number of such prisoners also showed virtually no change over time.

Changes in booking officers' opinions regarding inmates' medical needs were also of interest. Somewhat surprisingly, Pair estimates of the

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[53] It should be noted that two-tail probability tests were used, which makes significance harder to achieve.

percent of inmates needing some form of medical treatment at booking declined, although the difference was not statistically significant. This could well be an independent measure of disease incidence, though, and as such, is of little concern. The same was not true regarding booking officers' opinions of inmate malingering, however. Here, significantly more of the Pair respondents believed on follow-up that "some" or "most" of the inmates' medical complaints at booking were not nearly as serious as the inmates claimed.[54/]

It is possible that as booking officers became more aware of health care issues, they also became more cynical about inmates' health care needs. It is also possible, though, that their heightened awareness and additional training in handling inmate medical problems enable them to make more accurate assessments of inmates' medical needs. Some support for this latter interpretation is found in Pair responses to two other questions.

First, on the post questionnaires, more of the booking officers indicated they were less often uncertain regarding the medical action which should be taken when a prisoner was brought in with a health problem. Second, on a post basis, estimates of the frequency with which inmates were needlessly sent to the hospital or the doctor's office simply as a precautionary measure had declined. While neither of these results was statistically significant, they are at least suggestive of an increased ability on the part of booking officers to accurately identify inmates' health care needs.

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[54]The two-tail t probability equaled .018.

2. Pre/Post Comparisons by Jail Accreditation Status

In the previous section, aggregate pre/post Pair responses were analyzed without regard to the likelihood of different jails achieving accreditation in the near future. Hence, it was of interest to determine whether the findings would be the same when the extent of the jails' improvements in their health care systems was taken into account. As with the analyses of the Inmate Questionnaires, the jails were divided into two sets: Jails One-Six, where sufficient progress had occurred to make June accreditation likely and Jails Seven-Ten, where some improvements had been made but not enough to warrant accreditation in June.

In comparing the pre/post responses of booking officers completing both questionnaires in the "accredited" jails (numbers One-Six) with those for the Pair respondents as a whole, the results were essentially the same. The direction of change in opinions was the same on all variables except one. Booking officers in "accredited" jails believed there had been an increase in the frequency of inmates who were dangerous to themselves or others, whereas the aggregate Pair responses showed no change over time. Again, this may be due to an increased ability on the part of some booking officers to identify inmates with medical problems.

There was one other important difference in "accredited" Pair and aggregate Pair responses. While the direction of change was the same for both sets of respondents, the reduction in the number of booking officers at "accredited" facilities who reported being uncertain less often regarding what medical action to take when a prisoner was brought

in with a health problem achieved statistical significance. This finding becomes even more important when it is compared with the pre/post Pair responses of booking officers in "non-accredited" facilities (numbers Seven-Ten) which showed no change in their level of uncertainty over time.

Other differences in pre/post Pair responses of booking officers in "non-accredited" facilities when compared with those in "accredited" jails were as follows:

a. There was a slight increase in the number who rated the health care in their jails as "fair" rather than "good;"

b. There was no change in the number reporting the frequency of unnecessary trips to the hospital or doctor's office;

c. There was an increase in the number who reported being occasionally concerned that they might become ill because they were in contact with inmates who were sick and not being treated;

d. There was no change in the booking officers' ratings of the adequacy of their jail's procedures for detecting and treating inmates with communicable diseases; and

e. On the control variable, booking officers in "non-accredited" facilities reported a slight decrease in the frequency of inmates who were dangerous to themselves or others being booked.

Thus, on at least a few questions, the post opinions of booking officers at "accredited" jails had become more positive than was true for their counterparts in "non-accredited" facilities.

Attempts to develop composite scale measures of changes in booking officers' opinions regarding a. their jail's health care systems and b. inmates' medical needs were not entirely successful, since a number of the questions did not hold together on factor analysis. Suffice it to say that on the two scales which were developed, pre/post comparisons

by accreditation status did not reveal any significant findings different from those reported above.

G. Effect on Cost Requirements

The cost of inmate health care is a major concern of jail administrators and local government officials. Increasingly, local community action groups and state and federal courts are viewing adequate inmate health care as a right which cannot be denied. When changes in a jail's health care delivery system are proposed, inquiries about cost usually arise. For that reason it was of interest to study the effect, if any, that implementing the AMA standards had on a facility's cost requirements.

Ideally, it should be possible to answer questions about the cost of implementing various changes in a jail's health care delivery system before they take place. Unfortunately, the lack of reliable data and the complexity of the entire cost question make it difficult even to obtain reasonably complete estimates of past health care expenditures. Simultanteously, the extent to which a jail conforms to the AMA standards varies from facility to facility. Compliance with the standards may imply additional health care costs, but not all standards require dollar outlays to assure conformity and not all jails with high average daily health care expenditures necessarily score high on a compliance scale.

The cost of inmate health care is dependent both upon the level of services being offered and the efficiency with which they are delivered. However, in addition to questions of cost, consideration should also

be given to the quality of the health care being offered as well as issues of security--which still remains the primary function of any jail.

The ten jails in this study exhibited a wide range in terms of both the total cost of their health care delivery systems and the average daily cost of health care per inmate day served.[55/] Such variations were the result of: 1) jail size; 2) the extent of health care services being offered; 3) the relative needs of the inmate population; 4) the means by which various health care services were delivered; and 5) the political, economic, and medical environments in the local community.[56/]

The discussion which follows first takes a general look at the five factors mentioned above and then tries to relate them to the changes in the health care costs of the jails in this study. It should be noted that much of this discussion was based upon the personal observations of the investigators and jail personnel. Because of this, a qualitative rather than a quantitative assessment of jail health care costs was made. A complete quantitative analysis incorporating direct and indirect expenditures from all related sources as well as explicit and implicit costs was not possible, given the

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55/ See Appendix M for a breakdown of some of the health care costs incurred by nine of the ten jails involved in this study.

56/ See Billy L. Wayson and Gail S. Funke, et al., Local Jails, Lexington, Mass.: Lexington Books, D.C. Heath and Company, (1977) for a further discussion of overall jail costs and the problems associated with their study.

limited time period and the secondary nature of the cost aspect of this study. Individual summaries by jail of the quantitative data collected in conjunction with this study are presented in Appendix M.

1. General Determinants of Jail Health Care Costs

Because of the economies and diseconomies generally assumed to be associated with scale, jail size may affect the average health care cost per inmate-day-served. However, isolating cost factors which can be directly associated with scale is extremely difficult, if not impossible, given the wide variation in other variables which also affect health care expenditures. For the nine jails in the study where cost data were available, an impact on average health care cost per inmate-day-served, due to jail size, was not discernible. Therefore, no generalizations could be made about the effect of scale on the cost or savings which may be associated with the implementation of the AMA standards.

Unlike jail size, the extent of health care services offered prior to the implementation of the AMA standards did have some readily discernible effects on health care costs, as well as some less discernible masked effects which should also be mentioned. If a jail wishes to be accredited, the standards require the delivery of certain health care services such as: a physical assessment of each inmate within fourteen days of incarceration, routine communicable disease testing on all inmates, chronic and convalescent care, etc. Jails already providing the required routine health care services prior to their entry into the accreditation program should not experience changes in

costs associated with these services. However, facilities which must increase the level of their health care services will experience some change in their routine health care expenses. The extent and direction of these changes will be dependent upon the number and type of services being added as well as the efficiency with which they are delivered.

Generally, it was noted that adding more services added to routine costs, unless there was an accompanying improvement in the efficiency of a jail's health care delivery system. However, the masked effects derived from providing good inmate health care services can be very cost effective. These effects on cost, though, are more implicit than direct. Primarily, good health care implies good preventive medicine. By early identification and treatment of health care problems, extraordinary expenditures can often be avoided. For instance, potential emergencies can be anticipated and handled routinely; inmates needing specialized care (as in the case of the mentally ill) can be transferred to facilities more equipped to deal with their individual problems; communicable diseases can be identified and inmates isolated before an entire jail population or the community is exposed; etc. It is difficult to put a dollar figure on these types of implied benefits, but they are elements in health care costs which should not be overlooked.

Health care costs are also affected by the relative health care needs of inmate populations and the length of time inmates are incarcerated. Different types of inmate populations can be associated

with varying degrees of health care problems and their accompanying costs. Jails which see a relatively higher proportion of older inmates or those with inmates having unusually serious or chronic medical problems, will also experience higher hospital, clinic, laboratory and other related medical expenses. Likewise, jails where average length of stay is relatively longer will experience higher health care costs. The longer an inmate stays at a jail, the more thoroughly his or her health care needs must be met. The AMA standards recognize this fact and directly link the delivery of certain health care services to length of time an inmate is incarcerated. For example, a physical assessment and dental screening must be completed within the first fourteen days of an inmate's incarceration, and dental treatment is to be initiated within three months if the health of the inmate would otherwise be adversely affected. Therefore, the proportion of inmates staying longer than fourteen days and ninety days will have a direct bearing on required health care services and their associated costs.

The means by which health care services are delivered is probably the one area where a jail has the greatest degree of flexibility and where efficiency can have the greatest impact on health care costs. How health care is delivered has a direct bearing on security, transportation, and personnel staffing expenditures. It may also affect who pays for a service--i.e. whether the money comes out of the jail's health care budget or from some other community source.

Where savings occurred which could be associated with the imple-

mentation of the AMA standards for the jails studied, it was usually due to a more efficient utilization of health care and correctional resources. For example, in many situations, a nurse was brought in to perform many of the duties which would otherwise have to be done by the jail physician. Since the nurse is a less costly resource than the jail physician, this is a more efficient use of available medical resources and thus, more services could be delivered for the same cost or the same amount of a service for less cost.

Perhaps the most dramatic and noticeable effects on jail health care costs occurred when the delivery of health care services was shifted from the community to inside the jail. Such a shift usually reduced the costs and problems of security, transportation and certain overhead expenses commonly associated with the use of facilities like a hospital emergency room. The degree and extent of the potential savings were dependent upon the relative costs of the resources involved and the extent to which changes had to be made within the jail itself in order to handle the requirements of an in-house health care delivery system. Obviously, it does not pay for a jail to invest in in-house health care facilities, if these are going to be grossly under-utilized. The degree to which in-house versus in-community facilities and resources should be utilized must be carefully balanced in order to achieve the most efficient means of health care delivery.

The final determinant of health care costs was the political, medical and economic environments found in the local community. These environments determine the price that must be paid for the delivery

of health care services, as well as what services are available to the jails. In addition, these environments also help determine if legal expenses due to inmate suits will play a significant part in determining health care costs.

2. General Findings of Health Care Costs by Jail

All six jails in this study that went through on-site accreditation surveys had to increase the level of inmate health care services in various degrees. The effect of these increases in health care services varied greatly between facilities. At Jail One and probably at Jail Two, the increase in inmate health care services resulted in a direct increase in health care costs. Not only were more services being paid for, but as Table VI, page 163 indicates, at Jail One at least, routine transportation for health care reasons also increased. In addition, these two jails arranged for part-time nursing services which added to overall health care expenditures. Obviously, however, it was felt that the large increases in health care services were worth the increases in health care costs.

At Jails Four, Five, and Six, the level of services had to be increased, but not nearly as dramatically as in Jails One and Two (see Table III, page 33). In Jail Four, the increase in health care services was largely picked up by the jail nurse. Costs undoubtedly increased for such things as communicable disease testing, but these increases were not appreciable.

At Jail Five, a shift in medical and correctional staff responsibilities and the utilization of the area public hospital, allowed

for a substantial increase in health care services, while direct health care costs to the jail remained almost unchanged. The use of correction staff in the distribution of medications meant that a jail nurse was freed-up for other responsibilities and that both medical and correctional personnel were being more efficiently utilized.

At Jail Six, the addition of a nurse to the jail staff meant that personnel costs immediately increased. However, by having a full-time jail nurse, more services could be delivered inside the jail at less cost than they were previously being delivered in the community. The opening of the infirmary at Jail Six may also reduce the jail's in-patient hospital expenses in the future. Whether this proves to be cost effective will depend on the expense of staffing and operating the infirmary.

The most dramatic cost changes occurred at Jail Three. This jail began delivering routine health care services in-house instead of relying on the emergency room of a local hospital. During a short demonstration period in November and December 1978, the jail showed that the cost of a part-time nurse could more than offset the cost of emergency room care and in addition, provide improved health care services. Not only were emergency room costs greatly reduced during this period, but transportation requirements also went down significantly (see Table VI, p. 163). This shift in the means of health care delivery also greatly facilitated the job of the correctional staff at the jail and reduced their responsibilities for health care triaging.

Besides the illustrations mentioned above, certain other major

influences on health care costs were noted at the ten jails in the study. The first of these concerns legal expenses related to a jail's health care delivery system. Six of the ten jails indicated that legal suits had been brought against them in the past where inmate health care was an issue in dispute. Three of these jails were under such suits at the time of the study and in one other jail, the physician was being sued by a former inmate for malpractice. The judge interviewed in conjunction with the study at Jail Seven indicated that the potential savings in legal costs could be a significant argument for an improved health care system. This seemingly was borne out at Jail Ten where a class action suit was pending and apparently, was a strong motivating factor in gaining additional financial resources for the jail.

A second influence that should be mentioned is extraordinary health care expenditures that periodically occur. Usually such costs arise because of serious illness or injury resulting in in-patient hospital care. During the period of the study, extraordinary health care expenses apparently occurred at two facilities, Jails One and Four.[57/] At Jail One, an inmate had to be treated for a broken ankle, which created medical bills totally out-of-proportion to what the jail normally experienced. At Jail Four, the number of in-hospital bed-care days was far greater than at any of the other facilities in the study and created substantial medical costs for several of the

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57/ See Appendix M, Cost Summary Sheets One and Six for further cost information on these extraordinary expenses at these two jails.

months for which data were available. However, it should be noted that the policy that was followed with regard to inmates needing hospital care varied greatly between jails. Several jails followed a policy of seeking the release of inmates facing costly medical problems, and in this way these jails displaced the cost of these problems to other social agencies. In one jail at least, an opposite approach was followed for those inmates where it was felt that proper medical care would not be forthcoming if he or she were released. Therefore, when looking at and comparing health care costs, it may be appropriate to disregard the extraordinary expenditures or to calculate in a displacement cost.

A third influence that should be mentioned is those costs and services which are borne by outside agencies and facilities and supplied to the jail "free-of-charge." The extent of these services varied greatly between facilities in this study. Generally, jails in more urban environments had a greater potential for access to these services, but this did not always translate into usable inmate resources. When calculating health care costs, the value of these services should be included, but, as noted in Appendix M, getting even a rough cost estimate is very difficult.

Thus, when looking at the AMA standards and the cost of their implementation, it should be noted that no definitive conclusions can be drawn. Most of the standards are procedural in nature and require only a minimum expense to achieve compliance--that minimum being the staff time it takes to write the procedures and to orient

the jail staff regarding their use. Other standards requiring on-going health care services may or may not result in additional costs to a jail. Whether implementation of the AMA standards will result in additional expenditures can only be determined on a jail-by-jail basis when all aspects of health care costs (direct and indirect, explicit and implicit) have been taken into account.

V. Effect of Receiving Screening

Largely because of cost considerations, the AMA standards only require full health appraisals (including physical examinations and communicable disease testing) to be performed on all inmates staying longer than fourteen days. Receiving screening is mandated for all inmates at the time of admission, however.

Receiving screening is most often performed by a booking officer who has received training in how to recognize signs and symptoms of various illnesses and in how to respond appropriately when certain medical problems are detected. It usually consists of the booking officer making a visual inspection of the inmate's health condition on admission and of asking the inmate questions designed to identify potential or actual medical problems of a serious nature. Results of the receiving screening are recorded on a form which has been approved by the jail's responsible physician. A copy of the form is then sent to the medical department and serves to initiate the inmate's medical record.

While not as thorough nor as reliable as a full health appraisal, AMA staff believe that receiving screening is an important and innovative aspect of their program. Consequently, the investigators were interested in determining what effect initiating receiving screening would have on improving the health status of inmates.

The short duration of the study period as well as cost considerations precluded a detailed examination of the effect of receiving screening. Further, attempts to gather data on some objective measures

proved futile. For example, while it was obviously desirable that there had been only one death at any of the ten jails pre-program and none occurred during the six month study period, this also meant that "reduction in the number of deaths" could not be used as an impact measure. Similarly, there were no disease epidemics at any of the jails either before or during the study period, and hence, "reduction in the incidence of disease epidemics" could not be used as a measure of the effect of receiving screening either.

Problems developed regarding other measures also. For instance, jail staff were asked to keep a record of all serious medical incidents occurring in their facilities during the study period, and to note which ones happened during the first twenty-four hours of an inmate's incarceration. If there were reductions over the baseline figures in the number of serious incidents occurring during the inmate's first day, presumably, these reductions could be attributed--at least in part--to the jail's initiating receiving screening. However, Tables VII and VIII show that these results were inconclusive. Good data on the number of incidents occurring within the first twenty-four hours were not available for Jails One, Two, Three and Six on one or the other of the tables. Pre/post differences for Jail Four especially, and Jail Five seem to suggest that the incidence of serious medical problems happening within the first twenty-four hours decreased over the course of the study period, whereas the incidence for Jails Seven - Ten either stayed the same or increased somewhat. It should be noted, though, that baseline data were collected for as long as

forty-four months whereas program data were collected for only six months. Hence, it is not possible to draw valid conclusions regarding the effect of receiving screening or reducing the incidence of serious medical problems occurring on admission.

While the above measures proved unworkable, other data were gathered regarding the effect of implementing a receiving screening program which proved to be more revealing. These data were of two types: a subjective measure of medical and correctional staff opinions about the benefits of performing receiving screening, and a more objective one designed to assess changes in booking officers' reactions to medical emergencies. The findings with respect to each of these measures are discussed separately below.

A. Staff Opinions Regarding Receiving Screening

At the time of the investigator's follow-up visits, medical and correctional staff at each jail were asked a number of questions related to receiving screening. Specifically, they were questioned about changes which had taken place in their jail's admission procedures and what effect these changes had had.

Prior to their participation in the AMA program, none of the ten jails were performing receiving screening as it is defined by the AMA. At best, inmates were usually asked only general questions at booking such as "Do you have any medical problems?" or "Are you taking any medications?" By the time of the investigator's final site visits, though, receiving screening had been initiated at all of the jails except Jails Eight and Nine, and the latter facility planned to begin

implementation later in March. All of the jails except Jail Eight had developed receiving screening forms in line with the sample form appearing in the AMA's Practical Guide. In addition, booking officers had received training in the administration of the new forms and in follow-up referral procedures when problems were identified, in all but Jails Eight and Nine.

Medical and correctional representatives at each jail were asked what their opinions were regarding the standard requiring receiving screening, and they were unanimous in their support. When asked whether the initiation of receiving screening had had any effect on preventing medical problems at their jails, the results were again overwhelmingly positive. A number of the staff interviewed mentioned medical problems that had been picked up during receiving screening which might have been overlooked previously. For example, one jail mentioned identifying an epileptic and a diabetic, whereas others had detected potential suicides. Interestingly, some of the more dramatic examples came from Jail Eight where no formal changes in admission procedures had occurred. Staff there recalled one instance of what turned out to be a skull fracture and another of alcohol withdrawal where inmates were referred immediately for medical care. Even though formal receiving screening had not been initiated at Jail Eight, staff there attributed the quick action of the booking officers to a heightened awareness of inmates' medical needs.

Virtually all of the staff members interviewed indicated that the major effect of receiving screening on the jail staff had been one of

increasing their awareness regarding potential and actual medical problems of inmates.[58] While some respondents stated that booking officers did not like the additional paperwork involved, there was general agreement that no active resistance to performing receiving screening had developed. Seemingly, the benefits of performing receiving screening to reduce the potential legal liability of the jails and the booking officers, and the increased protection for the inmates outweighed the inconvenience of filling out longer forms.

As to the effect that initiating receiving screening had had on the inmates, again there was general agreement. Aside from the obvious benefit of identifying inmates' medical problems which may have previously gone undetected and thus, untreated, a number of respondents stated that it had made inmates more aware of the fact that the jails were interested in providing them with adequate health care.[59] Further, some stated that inmate complaints about health care availability had declined, which they believed was at least partially due to implementing receiving screening, along with other improvements in their delivery systems.

B. Booking Officers' Reactions to Medical Emergencies

It was also of interest to determine whether initiating receiving screening and training booking officers in the new admission procedures

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58/ Some support for this belief was found in the pre/post comparisons of items on the Booking Office Questionnaire. See Chapter IV, Section F of this report.

59/ Some evidence of this may be implied from positive inmate attitude changes which occurred on items contained in the Inmate Questionnaire. See Chapter IV, Section E of this report.

would result in any changes in their reactions to medical emergencies. Thus, a section was included on the pre/post questionnaires administered to booking officers at the ten jails, which described six hypothetical situations they might encounter in admitting inmates to their facilities.[60/] For each situation, respondents were asked to determine (1) whether they felt the situation presented a medical problem, (2) what they would do at booking, given the particular situation, and (3) why they would react in that fashion.

Pre/post changes in booking officer Pair responses for each situation are discussed individually below. Comparisons are made regarding changes in response patterns over time between booking officers in "accredited" versus those in "non-accredited" facilities. Pre/post Group responses and breakdowns by individual jails may be found in Charts 13-30, Appendix L.

1. Possible Internal Injury Case

Most of the booking officers in both types of facilities correctly identified the fact that a potential medical problem existed, and there was virtually no change in these numbers over time. With respect to the proper procedure to follow though, some differences occurred, although they were not statistically significant. There was an increase in the number of correct answers for both types of booking officers over time, but proportionately more of those in "accredited" facilities responded appropriately on a post basis than did those in "non-accredited" facilities. The former were more likely to consult immediately with a medical authority about the proper action to be taken, whereas the latter were more likely to wait and have a doctor check out the inmate at a later time.

60/ See Section B, questions 1-6, on the sample questionnaire provided as Appendix F.

2. Diabetic Case

Virtually all of the booking officers in both types of facilities agreed that a medical problem existed and there was no change in this measure over time. More of the booking officers in "accredited" jails responded appropriately on a post basis, though, than did their counterparts in "non-accredited" facilities. In other words, there was an increase over time in the number of the former who said the inmate should be transported immediately to a hospital or a clinic, whereas there was a slight decrease in the number of the latter responding similarly on a post basis. Neither of these changes was significant, though.

3. Alcohol Withdrawal Case

Again, virtually everybody in both types of facilities agreed both pre and post that a medical situation existed. There was an increase over time in the number of booking officers who indicated that they would follow a more correct procedure in both types of facilities. The pre/post change for booking officers at "accredited" jails on this item was statistically significant, though, and this was not true of the other type.

It should be noted that the usual procedure listed for this case on follow-up for booking officers at "accredited" facilities was to consult with a medical authority by phone whereas many of the booking officers at "non-accredited" jails were more likely to wait and have a doctor check out the inmate later. It seems that staff at both types of jails may still need additional training regarding the serious nature of alcohol withdrawal. These types of cases should be transported to a hospital or detoxification center immediately, since serious complications or even death can result, if proper treatment is not received.

4. Head Injury Case

All the booking officers at "accredited" jails and all but one of those at "non-accredited" facilities correctly identified both pre and post that this case represented a potential medical problem. There was an increase in the number of correct procedure responses at both types of jails, but these changes were not statistically significant for either. Still, more of the booking officers in "accredited" jails were more likely to transport the inmate immediately to the hospital or clinic than were booking officers in "non-accredited" facilities.

5. Potential Suicide Case

The mean response both pre and post at both types of facilities was that this case "possibly" presented a medical problem. There was a slight increase over time in the number of booking officers at "accredited" jails who felt it did not represent a medical problem, and a slight increase in the number who felt it did at "non-accredited" jails, but neither change was significant. Initially, the mean response for both types of booking officers regarding the procedure they would follow was that they would not seek medical advice, but they would closely observe the inmate for further developments. On a post basis, the opinions of booking officers at "non-accredited" facilities had not changed, whereas the other type of booking officer was more likely to have the inmate checked out by a doctor or another medical person at some later point in time.

6. Probable Hepatitis Case

Again, virtually everybody pre and post believed that this case presented a medical problem. With regard to the correct procedure to follow, there was an increase over time in the number of booking officers of both types who said they would either isolate the inmate immediately or transport the inmate immediately to a hospital or clinic. Neither of these increases was significant, though.

Thus, it seems as though by the end of the study, booking officers at both types of facilities were somewhat more apt to follow appropriate procedures regarding handling inmates presenting medical problems on admission than they were initially, although only one of the changes was statistically significant.[61/] For most of the cases, somewhat more of the booking officers in "accredited" jails responded appropriately on a post basis than did their counterparts in "non-accredited" facilities, but these differences were not marked.

61/ This was the increase over time in the number of correct procedure responses for booking officers in "accredited" facilities for handling the alcohol withdrawal case.

This finding is not surprising when it is recalled that all of the jails except one "non-accredited" facility (Jail Eight) had initiated some changes in their admitting procedures by the end of the study. New receiving screening forms had been implemented in all but Jail Eight, and at least some training in the new procedures had occurred at all but Jails Eight and Nine.

PART FOUR: SUMMARY AND CONCLUSIONS

APPENDICES

VI. SUMMARY AND CONCLUSIONS

The primary purpose of the intensive study of these ten jails was twofold. First, the investigators were interested in determining whether the factors contributing to the extent of progress made by the ten jails in improving their health care delivery systems could be isolated. Second, the investigators wanted to study what effect implementing the AMA standards would have on different aspects of the jails' operations and on the attitudes of both inmates and correctional staff. The methodology employed and the specific findings in regard to each measure have been sufficiently detailed in the body of this report. What follows is a summary of some of the more important results obtained and the investigators' conclusions regarding the overall effect of the AMA program on improving the health care systems at these ten jails.

A. Case Study Analysis

In order to determine the reasons why some jails are able to improve their health care system sufficiently to attain accreditation while others are not, ten of the jails participating in the third year AMA program were selected for intensive study. At the beginning of the program, all ten jails fell into the middle range of initial compliance with the AMA standards -- i.e., all were meeting at least 40% but less than 80% of the standards. For all but the largest jails, significant deficiencies were found in the type and extent of health care services provided (see Table III) and most of the jails met few of the procedural standards.

By the end of the six month study period, dramatic improvements had occurred at two jails (numbers One and Three) and substantial changes had been implemented at four more (numbers Four, Five, Six and especially, Jail Two). All six of these facilities had made sufficient improvements to make accreditation in June likely. As for the other four jails (numbers Seven - Ten), none had increased its level of compliance with the AMA standards by more than 10% on a pre/post basis.

In analyzing the factors which may have affected the extent of progress made in improving health care at these ten sites, the investigators were concerned primarily with the medical, political and economic environments in which the jails were situated. Pre/post analysis of data gathered regarding these factors led the investigators to the following general conclusions:

1. The single most important factor influencing the extent of improvements which occurred in these jails' health care systems was the amount of support and cooperation received from the medical community, whether inside or outside the facilities. The best positive illustration of this effect happened at Jail Three. Prior to its participation in the AMA program, this facility had been unable to interest the medical community in providing regular health care services to the jail. Hence, the only alternative open to Jail Three was to use the local emergency room as needed, which was an inefficient and costly way to deliver care. This facility's participation in a program sponsored by the AMA helped to turn around the medical community's policy of non-involvement, especially after the jail was able to demonstrate that a more cost-effective method of delivering care was possible. Other positive examples may be found in Jails Two and Four.

   Negative examples of this effect were found in Jails Seven, Eight, and Ten. In the first two facilities, the administrative staff had not solicited the support and cooperation of their own medical staff -- even though data collected by the investigators revealed that their interest may have been there. In Jail Ten, the warden solicited the services of an outside

consulting firm to help him improve the health care and thus, bypassed the local medical community. None of these latter three facilities made substantial improvements in their health care systems during the study period.

2. Interest and enthusiasm on the part of a jail's top administrative staff was a necessary, but not sufficient condition for positive changes to occur. The individuals primarily responsible for the jails' becoming involved in the AMA program initially were almost invariably the top administrative staff, and their continuing support was demonstrated throughout the study period in all ten jails. However, their interest in and of itself was not enough to produce substantial change as illustrated by Jails Seven - Ten.

   By the same token, when strong support for the program was coupled with good cooperation from the medical community, significant improvements could be made. This effect is best illustrated by Jails One and Four. In the former jail, the prime motivator for change was the sheriff, who was supported in his efforts by one of the local physicians. In the latter facility, the jail physician was the one pushing for accreditation and he received good cooperation from the jail's administration. The administrative staff and the medical community working together were able to make substantial improvements in both instances. This effect was also demonstrated in Jails Two, Five and Six, and ultimately in Jail Three.

3. Economic considerations appeared to have little effect on either the success or failure of the jails in implementing substantial changes. The economic environments in which these ten jails were located were different, but there appeared to be no consistent association between a willingness of the county to provide additional funds and the extent of improvements made. Some of the jails located in fiscally conservative areas were nonetheless able to effectively implement most of the standards. In some instances (e.g. Jail Three) this may have been due to the fact that the jail was able to demonstrate that implementing the AMA standards could result in a cost savings to the county. In other fiscally conservative areas, though (e.g. Jails One and Six), substantial improvements were made even though additional expenditures were required. Conversely, at Jail Eight and to some extent Jail Ten, a receptive economic environment did not result in extensive improvements in these health care systems.

   The only place where fiscal restraint seemed to be directly associated with the lack of progress made was at Jail Nine. Here, the sheriff entered the AMA program for the express -- albeit mistaken -- purpose of obtaining funds for his jail. When it was learned that no monies would be forthcoming, county administrators had to reconsider whether the jail should be involved. Ultimately, one of the local physicians, who had

an interest in accreditation, convinced the county officials than the jail's continued participation would be worthwhile.

Seemingly then, for these ten facilities, economic considerations were not the primary determinant of the extent of progress made.

4. Similarly, the internal and external political environments of the jails seemed to be secondary factors regarding the extent of improvements. Jails where correction officers were expected to react somewhat negatively with respect to procedural changes affecting them (e.g., numbers Three and Five) did as well as jails where correctional staff were expected to be fully supportive (e.g., numbers Two, Four and Six).

   External political considerations had no consistent influence. While a state-wide effort to involve all jails in working toward full accreditation of their facilities (and not just the health care aspects) was undoubtedly a positive influence on Jails Five and Six, Jails One - Four in other states were able to make substantial progress without this favorable political climate.

   The fact that no active resistance -- whether internal or external -- developed in Jails One - Six undoubtedly contributed to the speed with which changes were made. The lack of political resistance in Jails Seven - Ten, however, was not accompanied by substantial progress. Seemingly, then, political considerations were not the key factors influencing change.

5. Other considerations such as the availability of health care resources in the community and the adequacy of in-house medical facilities also appeared to be secondary factors. Jail Two -- with only two physicians serving the town and no local hospital -- was still able to attain accreditation in March. Jails Three and Five -- with poor overall conditions due largely to the extreme age of these facilities -- were both able to implement sufficient standards to make accreditation in June likely.

   At first glance, the fact that jails can become accredited in spite of the seeming difficulties noted above may appear to be a defect of the AMA's Standards. In truth, it is one of their more positive aspects. The standards require only that certain services be provided to inmates. They do not specify where or how these services should be obtained. Since the standards are "service based" rather than "facility based," correctional and medical staff at each jail can decide for themselves what the most efficient and effective method of delivering health care would be, given the constraints of the health care resources available in the community and the adequacy of their own in-house facilities.

6. Finally, while secondary in nature, the influence that the medical societies' State Project Director (SPD) can have on producing positive changes should not be overlooked. In the three states where there was consistent involvement with the jails on the part of the SPDs, important progress was made. The four jails where few pre/post changes occurred were all located in a state where the SPD provided less direct assistance.

   This should not be construed to mean that the failure of jails to improve their health care systems can be attributed to a lack of sufficient technical assistance provided by the SPD. As stated previously, the key determinants of the extent of progress made were undoubtedly the support and cooperation of the medical community coupled with a strong desire on the part of the jail's administration to work toward accreditation. Nevertheless, support and guidance from the SPD in the form of continued technical assistance obviously facilitates the process of smooth and rapid change. In at least one jail, the assistance of the SPD was believed by jail staff to be the primary reason why accreditation was achieved so quickly.

B. Measures of Impact

The second major purpose of the Ten Jail Study (TJS) was to determine the effect of the AMA program on different aspects of the jails' operations and on the attitudes of staff and inmates regarding their jail's health care system. Hence, a variety of impact measures were developed to assess pre/post changes which occurred in these jails as a result of their participation in the AMA program.

The major limitation of this aspect of the TJS was undoubtedly the short time period of the study itself. As stated elsewhere, six months is not sufficient to determine the lasting effects of change -- especially since most of the improvements in the jails' health care systems did not occur until the last couple of months. Further, this fact probably contributed to the failure of most of the observed pre/post differences to achieve statistical significance.

Summaries of the findings regarding each impact measure are outlined below. The reader is reminded, however, that while many of the results were in the right direction -- i.e., they showed a positive effect of participation in the AMA program -- the lack of statistical significance means that they should be interpreted with caution. Thus, wherever pre/post differences are found, they should be construed only as possible indications of future trends and not as definitive measures of the impact of the AMA program.

1. Effect on extent of health services delivered

   The primary measure used to gauge the extent of improvements made at the ten jails was a pre/post self-survey regarding the standards the jails complied with. As a back-up measure, jail staff were asked to keep monthly statistics regarding the types and extent of health care services offered. For the most part, these statistical measures corresponded well with the data contained in the self-surveys.

   In general, implementation of the AMA standards was accompanied by an increase in the type and extent of health services offered, not accounted for by fluctuations in the jail's daily population figures. Jails One and Three - Six[62] which showed the largest gains in compliance with the AMA standards as measured by their pre/post self-surveys (see Table III), also showed the greatest increase in services on the independent statistical measures (see Charts 1, 5, 6, 8 and 9 in Appendix H).

2. Effect on transportation requirements

   The major finding with respect to the impact of the AMA program on the jails' transportation requirements for health care reasons was that there was no consistent pattern of change. Whether these requirements increased or decreased was dependent upon (a) the type and extent of health care services offered pre-program and (b) whether any new services added were provided in-house or in the community.

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[62] Statistical data were not kept at Jail Two.

If a jail was already providing a substantial number of services pre-program, implementation of the AMA standards appeared to have little effect on transportation requirements (see trip patterns for Jails Four and Five on Graphs 2 and 3, pages 168 and 171, respectively). On the other hand, if few services were available initially, where the new services were provided determined the effect this had on transportation requirements. Increased utilization of community health care resources was usually accompanied by an increase in transportation requirements (see the trip pattern for Jail One on Graph 1, page 166). The reverse was usually true when the new services were provided in-house (see patterns for Jails Three and Six on Graphs 2 and 3, pages 168 and 171, respectively).

3. Effect on rate of serious incidents

Comparison of pre/post data collected regarding the rate of serious medical incidents seemed to indicate a reduction in these rates over time in the facilities where accreditation was likely (see Tables VII and VIII). The investigators have little confidence in these results, however, since the length of time for which pre-program data were available varied greatly from jail to jail, as did the accuracy of the statistics. In some instances, pre-program figures were based on the "best estimates" of the jail staff rather than on actual records. In addition, the definitions of what constituted a serious medical incident may well have differed from place to place, which would have affected the recording of these statistics. Hence, the investigators do not believe that any valid conclusions can be drawn regarding the effect of the AMA program on the rate of serious medical incidents in jails.

4. Effect on inmate attitudes

A number of changes occurred in inmate attitudes over time and most of them were in the right direction. The most reliable indications of the effect of implementing the AMA program on inmate attitudes were found in the response patterns of those inmates (labeled "Pairs" in this report) who took both the pre and post questionnaires.

Statistically significant differences beyond the .05 level between pre and post responses of the Pairs were found on the following items:

a. On a post basis, significantly more of the inmates felt they were getting the care they should on sick call most of the time;

b. More rated both the physician and non-physician staff attitudes toward inmates in a more positive fashion than they had previously;

c. More of the Pairs reported seeing the doctor more frequently (which was undoubtedly due in part to the increase in their length of stay); and

d. More rated the expected response to a medical emergency by jail staff more positively than they had initially.

In addition, the composite scale measure of the availability and adequacy of health care showed significant changes on a pre/post basis. In other words, on follow-up, more inmates believed that the availability and adequacy of health care services in their jails had improved. Comparisons by jail accreditation status revealed some pre/post differences for both Group and Pair respondents, but few were significant (see page 185).

Positive -- albeit not significant -- attitude changes were found on a number of other items contained in the inmate questionnaires as well. It should be recognized, though, that the inmate samples at each jail were small, and in most cases, the representativeness of their attitudes was questionable due to non-random selection procedures which were utilized.

5. Effect on booking officer attitudes

The Pair findings[63] regarding changes in booking officers' pre/post opinions about their jails' health care systems were all positive, but none of these differences were statistically significant. Changes in their opinions regarding inmates' medical needs revealed one significant finding: more of the Pair respondents believed on follow-up that "some" or "most" of the inmates' medical complaints at booking were not nearly as serious as the inmates claimed. While this could be interpreted as an increase in the cynicism of booking officers regarding inmates' medical needs, there was at least some evidence to suggest that it was due to their increased ability to make more accurate assessments of inmates' medical needs (see the discussion on pages 189-190).

When analyzed by jail accreditation status, the only significant difference between pre/post responses of booking officers in

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[63] See pages 186-188 for definitions of the terms "Pair" and "Group."

"accredited" versus "non-accredited"[64] facilities was as follows: more of those in "accredited" jails reported being uncertain less often regarding the proper medical action to take when a prisoner was brought in with a health problem. There were other items where the post responses of booking officers at "accredited" jails had become more positive than was true for their counterparts in "non-accredited" facilities, but these differences were not statistically significant.

6. Effect on cost requirements

Lack of reliable cost data as well as the limited time period and the secondary nature of this aspect of the TJS, precluded a quantitative analysis of the cost of improving health care at each jail. Qualitative analysis of the effect of implementing changes in health care on costs led the investigators to conclude that there was no consistent pattern. Implementing the AMA standards resulted in increases in a jail's expenditures in some cases and in a cost-savings in others. In general, the cost analysis revealed that the key determinants regarding whether implementing the AMA standards would increase or decrease a jail's expenditures were:[65]

a. The type and extent of additional services offered;

b. The method of delivering various health care services;

c. The relative needs of the inmate population; and

d. The political, economic and medical environments in which the jail was located.

General conclusions could not be drawn regarding economies or diseconomies associated with scale (i.e., jail size).[66]

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[64] See page 191 of this report for definitions of these terms.

[65] It should be noted that this discussion regarding costs refers primarily to the thirteen service standards. The cost of implementing a number of the procedural standards is a one-shot expense related to the staff time and resources involved in writing up procedures.

[66] See the section on cost factors, pages 193-199, for a discussion of the effect of each of these determinants on cost. See also pages 199-202 for a description of the effect of implementing standards on costs at individual jails.

Other factors affecting costs which must be accounted for include:

a. potential savings derived by preventing more serious medical problems from developing by providing routine care;

b. potential savings from the avoidance of law suits which might otherwise have occurred;

c. extraordinary expenditures resulting from catastrophic illnesses (which a jail cannot easily predict nor control); and

d. services provided to a jail by outside agencies "free of charge."

Thus, it should be apparent that whether implementation of the AMA standards will result in an increased or decreased cost/benefit ratio can only be determined on a jail-by-jail basis, after all aspects of health care costs (including direct and indirect as well as explicit and implicit) have been taken into account.

C. Effect of Receiving Screening

A mini-study was conducted to determine the effect of implementing a receiving screening program on the health status of inmates. While several planned measures proved unworkable (see discussion on pages 204-206), two types of measures were developed.

The first was a subjective measure of medical and correctional staff opinions' regarding the benefits of performing receiving screening. These data were gathered at the time of the investigators' follow-up visits and revealed the following:[67]

1. Medical and correctional staff at all ten facilities were unanimous in their support of the standard requiring receiving screening.

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[67] It should be noted that none of the ten jails initially had a receiving screening program as defined by the AMA. By the end of the study, receiving screening had been implemented at all but Jails Eight and Nine, and the latter facility was planning to initiate it later in March.

2. In those jails where it had been implemented, the overwhelming majority believed that receiving screening had prevented more serious incidents from occurring, and several related anecdotes mentioned in the body of this report illustrate this effect.

3. There was general agreement that the primary effect on the jail staff of initiating receiving screening was one of increasing their awareness regarding potential and actual medical problems of inmates.

4. The major effect on the inmates of starting receiving screening -- aside from the obvious benefit of identifying medical problems which may have gone undetected and thus, untreated previously -- was usually reported to have been an increased awareness on their part of the fact that their jails were trying to improve health care services.

The second measure of the effect of initiating receiving screening was somewhat more objective. A section was included on the pre/post questionnaires administered to booking officers at the ten jails which described six hypothetical situations they might encounter in admitting inmates to their facilities. Their pre/post reactions to these medical emergencies were compared to see whether they were making more appropriate decisions regarding handling these emergencies after receiving screening had been implemented and they had been trained in the new admitting procedures.

Comparisons regarding changes in response patterns over time between booking officers in "accredited" versus those in "non-accredited" facilities revealed only one statisticalyy significant difference.[68] In all six cases, though, post responses were more appropriate than pre responses

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[68] This occurred in their responses to the handling of the "alcohol withdrawal" case, where significantly more booking officers in accredited facilities tended to respond more appropriately.

for both types of booking officers.[69] This is not surprising when it is recalled that at least some changes occurred in receiving screening procedures in all of the jails except one.

In summary, then, the Ten Jail Case Study revealed that the key factor influencing the extent of progress made at these facilities was the extent of support and cooperation received from the medical community (both inside the jail and out). Interest and enthusiasm on the part of the jails' top administrative staff was a necessary, but not sufficient, condition to produce positive change. Political and economic considerations were found to be only secondary influences. The most important external factor seemed to be related to the amount and type of technical assistance provided by medical society State Project Directors.

As for impact measures, some positive effects of the AMA program were found regarding increases in the extent and type of health care services provided and on improving the attitudes of both inmates and booking officers regarding the effectiveness of the health care systems at their jails. Initiating receiving screening was also found to be of benefit. No consistent pattern could be discerned regarding the impact of implementing the AMA standards on transportation and cost requirements. The effect of participating in the AMA program on the rate of serious medical incidents at the jails could not be measured reliably.

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[69] Comparison of Pair responses with those of two control groups indicated that testing was not a significant validity threat (see discussion on pages 188-189).

P O S T S C R I P T

The investigators' assumptions regarding the likelihood of accreditation for Jails One through Six were confirmed. On June 6, the AMA's National Advisory Committee made the following decisions:

Jail One: Two year accreditation was awarded.

Jail Two: Two year accreditation was received in March, contingent upon a revisit within sixty days confirming continued compliance with newly-implemented service standards. Confirmation was subsequently received and accreditation awarded.

Jail Three: Two year accreditation was awarded

Jail Four: One year accreditation was awarded, contingent upon a revisit to confirm continued compliance with newly-implemented service standards.

Jail Five: Two year accreditation was awarded, contingent upon a revisit to confirm continued compliance with newly-implemented service standards.

Jail Six: Two year accreditation was awarded, contingent upon a revisit to confirm continued compliance with newly-implemented service standards.

(Jails Seven through Ten did not participate in Round VI of the accreditation process).

APPENDIX A

ABBREVIATION KEY

ABBREVIATION KEY

ADP - Average Daily Population

AMA - American Medical Association

CETA - Comprehensive Education and Training Act

CPR - Cardio-Pulmonary Resuscitation

EMT - Emergency Medical Technician

I/PP - Inmate Patient Profile

LEAA - Law Enforcement Assistance Administration

LPN - Licensed Practical Nurse

LOS - Length of Stay

RN - Registered Nurse

SPD - State Project Director

TJS - Ten Jail Study

Symbols and Abbreviations Used in Charts

< = greater than

> = less than

N = number

% = percent

$\bar{X}$ = mean

= number

S = small

M = medium

L = large

APPENDIX B

EXAMPLE OF APPLICATION FORM

American Medical Association Program to Improve Medical Care and Health Services in Jails

Application for Accreditation of Medical Care and Health Services in Jails

Instructions for completing the American Medical Association's Application for Accreditation of Medical Care and Health Care Services in Jails.

Some of the Items on this questionnaire may not apply to your particular facility. In such cases, please mark NA in the answer space.

Question 16 is for purposes of our information only. The answers we receive will be used in an evaluative context and will **not** affect the status of your application in any manner.

American Medical Association Application for Accreditation of Medical Care and Health Services in Jails

1-1. Name of facility_____

1-2. Address of facility_____
City State Zip

1-3. Facility phone number (_____)_____

1-4. Approximate population of area served by facility_____

2-1. Title of official legally responsible for facility_____

2-2. Name of official_____

2-3. Address of official_____
City State Zip

2-4. Phone number of official (_____)_____

3-1. Year facility was built_____

3-2. Any major renovations? Yes_____ No_____

3-3. Year of renovations_____

3-4. Briefly describe_____

Number of admissions to facility in previous year

4-1. Adult males _____

4-2. Adult females _____

4-3. Juvenile males _____

4-4. Juvenile females _____

4-5. TOTAL ADMISSIONS _____

5-1. Design rated capacity_____

5-2. Average daily population for previous year_____

5-3. Average daily intake_____

In the previous year, what **percent** of your inmates would you estimate stayed:

6-1. Less than 24 hours _____% 6-3. One to two weeks _____%

6-2. One day to a week _____% 6-4. Longer than two weeks _____%

7-1. Are there any persons currently providing medical care to inmates of jail?

Yes_____ No_____

If you answered yes, please complete the rest of Section 7.

7-2. Number of physician hours/month:_____

7-3. Number of nurse hours/month:_____

7-4. Number of physician's assistant hours/month:_____

7-5. Hours/month provided by others (please specify type) :_____

7-6. Name of physician responsible for medical care._____

7-7. Address of physician:_____
City State Zip

7-8. Phone number of physician: (_____)_____

8-1. Is regular sick call conducted by a trained medical person? Yes_____ No_____

8-2. How often is sick call held?_____

8-3. What level of staff performs sick call?_____

9-1. Does your facility have a medical examining room? Yes_____ No_____

9-2. Does your facility have any medical bed space? Yes_____ No_____

10-1. Does your jail do any routine screening for potential medical problems within the first few days of an inmate's admission to your facility? Yes_____ No_____

If you answered yes, please complete the rest of section 10.

10-2. Who performs this screening?_____

10-3. When is this screening done?_____

11-1. Does your jail offer on-going medical services or just emergency medical treatment?

On-going_____ Emergency only_____

11-2. Name of hospital providing emergency or in-patient services_____

11-3. Hospital address_____
City State Zip

11-4. Hospital phone number (_____)_____

11-5. Name of facility providing ambulatory clinical services_____

11-6. Facility address_____
City State Zip

11-7. Facility phone number (_____)_____

12-1. Does your jail offer on-going mental health services or just emergency mental health treatment? On-going_____ Emergency only_____

12-2. Name of hospital providing psychiatric in-patient services_____

12-3. Hospital address_____
City State Zip

12-4. Hospital phone number (_____)_____

12-5. Name of facility providing outpatient mental health services_____

12-6. Facility address_____
City State Zip

12-7. Facility phone number (_____)_____

13-1. Does your jail offer on-going dental services or just emergency dental treatment?

On-going_____ Emergency only_____

13-2. Name of dentist or dental clinic providing dental services_____

13-3. Dentist or clinic address_____
City State Zip

13-4. Denist or clinic phone number (_____)_____

14-1. Does your jail offer medically supervised alcohol detoxification? Yes_____ No_____

If you answered yes, please complete the rest of section 14.

14-2. Name of medical facility providing detoxification services_____

14-3. Facility address_____
City State Zip

14-4. Facility phone number (_____)_____

15-1. Does your jail offer medically supervised drug detoxification? Yes_____ No_____

If you answered yes, please complete the rest of section 15.

15-2. Name, medical facility providing detoxification services_____

15-3. Facility address _____ City _____ State _____ Zip

15-4. Facility phone number (_____) _____

16-1. Have there been any law suits against your jail within the past five years where the adequacy of the health care services offered was an issue? _____

If you answered yes, please complete the rest of section 16.

16-2. Is your jail currently under such a suit? _____

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17. What types of benefits do you think your jail would derive for being in the health care program?

_____

_____

_____

18. Do you think you would have much difficulty in getting your medical staff to assist you with changes in jail's health care system if this proved necessary in order to meet the AMA's standards?

_____

_____

_____

19. If improving the health care in your jail required an increase in the jail's medical budget, would you be willing to go to the funding body and request the additional funding?

_____

_____

_____

20. If you are unable to provide information on the cost of current medical care, are you willing to help obtain this information and develop records to reflect future changes?

_____

_____

I hereby apply to the AMERICAN MEDICAL ASSOCIATION for accreditation of medical care and health services of the facility for which I am legally responsible.

_____

Signature

_____

Title Date

APPENDIX C

EXAMPLES OF PRE/POST INTERVIEW SCHEDULES

1. Example of interview schedule for jail physician and key medical staff at time of initial site visit

2. Example of interview schedule for sheriff and jail administrators at time of follow-up site visit

EXAMPLE OF INTERVIEW SCHEDULE FOR
JAIL PHYSICIAN AND KEY MEDICAL STAFF
AT TIME OF INITIAL SITE VISIT

1. How did you first learn about the jail health care program?

2. What do you think were the motivating factors that led the jail to get involved in the project?

3. What do you hope that this project accomplishes?

4. Have you discussed the program with other people connected with the jail? If yes, what was the initial reaction of the sheriff? What was the initial reaction of the rest of the medical staff?

5. When you discussed the program with these people, did you consider the advantages and disadvantages of being involved? If yes, what were the advantages you considered? What were the disadvantages you considered?

6. How receptive do you think the jail's funding source is to the needs of the jail? Have you discussed the health care program with the people who allocate these funds? If yes, what was their initial reaction?

7. What kind of cooperation can you expect from the sheriff and the jail staff? If resistance, how do you plan to overcome this resistance?

8. Have people in the jail, either medical or security staff, come up with any ideas for improving the medical care, such as resolving any conflicts between medical care and jail security needs? If yes, could you describe these ideas?

9. How difficult is it going to be for your jail to come into compliance with the following AMA standards?
   - o 14-day requirement for physical exams?
   - o communicable disease screening?
   - o 90-day requirement for dental exams?
   - o doing the receiving screening?
   - o what is your feeling about a contractual arrangement where you assume medical responsibility for the jail?
   - 0 getting the SOPs and job descriptions developed and written?

10. What kind of medical resources does your community have?

	How many	How far away
Hospitals		
Mental Health Resources		
Detox facilities or programs		
Community doctors		
Health department		
Dental services		
Schools (medical, dental, nursing, physician assistant)		

JAIL PHYSICIAN AND KEY MEDICAL STAFF INTERVIEW
(continued)

11. Have you developed a plan or timetable for implementing the standards and achieving accreditation? If yes, what is this plan? Do you anticipate having to go outside of the jail staff to get additional resources to help you make the needed changes? Do you think you might be able to utilize the resources of the state or county medical society? Have you considered any jailor training programs? How about the community medical resources you previously described to me?

12. If your present plan for obtaining the necessary resources fails, do you have an alternate plan in mind?

13. Do you foresee any resistance to improving your jail's health care system either from the local community, the local government, or from within the jail? If resistance anticipated, will this resistance cause any serious problems? Have you given any consideration to possible ways of overcoming this resistance?

14. Who in the jail do you find is the most supportive of improving the health care system? Who outside the jail is most supportive?

15. Have you established any sort of incentive for the people who are going to have to do the work of getting the jail accredited? Do you personally have any incentives for wanting to get the jail accredited?

EXAMPLE OF INTERVIEW SCHEDULE FOR
SHERIFF AND JAIL ADMINISTRATORS
AT TIME OF FOLLOW-UP SITE VISIT

1. What is your opinion of the AMA jail health care program and the standards now that you hae been involved with both for some time?

2. What do you feel are the two or three most valuable aspects of the program?

3. Has the program lived up to your early expectations?

4. What is the reaction and feelings of other key jail staff toward the health care program? Have their opinions changed any since your jail entered the program?

5. What kinds of changes occurred in your jail's health care delivery system as a result of your involvement in the program?

6. Was there any reluctance on the part of your staff to making any of these changes? How did you go about overcoming the reluctance?

7. Have there been any specific disadvantages to being involved in the health care program?

8. How receptive are people outside the jail to the health care program?

9. Have you had to go outside the jail for resources to implement any of the AMA standards? (If yes) who have you had to go to and why? How receptive have they been?

10. How close are you to getting accredited? What has been accomplished so far? What still needs to be done?

11. Are you satisfied with your jail's efforts toward reaching accreditation?

12. Which aspects of the standards are you finding or did you find the most difficult to implement?

13. What is your opinion of the standard requiring receiving screening of all inmates upon admission to the jail? Has this receiving screening had any effect on preventing medical problems at the jail? What changes in receiving screening have occurred at your jail? (a) forms, (b) staff training, (c) when did these changes occur? Has it had any effect on your security or medical staff? Has it had any effect on prisoners being booked? (If so, what?)

14. Have you begun utilizing any other community medical resources since the last time I visited your jail? (If yes, what are they?)

SHERIFF AND JAIL ADMINISTRATORS INTERVIEW
(continued)

15. How much assistance did the state medical society's representative give you? What kinds of additional assistance could you have used? How much contact have you had with him or her?

16. Would you enter the program again now knowing everything that is involved in getting accredited?

17. What have been the primary factors that have aided the jail in attempting to achieve accreditation?

18. What were or are the primary obstacles that have (had) to be overcome before you could achieve accreditation? (from within the jail? from outside the jail?)

APPENDIX D

EXAMPLES OF MANAGEMENT INFORMATION STATISTICS FORMS AND INSTRUCTIONS WHICH ACCOMPANIED THEM

1. Introduction to the Jail Health Care Documentation Study
2. Instructions for Completing Form A "Jail Population Data"
3. Instructions for Completing Form B "Transportation for Health Care Reasons"
4. Instructions for Completing Form C "Number of Health Services Delivered"
5. An Example of Form D - Changes in the Jail's Health Care System

B. Jaye Anno
Evaluation — Research — Consulting
11200 LOCKWOOD DRIVE • SILVER SPRING, MARYLAND 20901 • 301—593-8199

INTRODUCTION TO THE JAIL HEALTH CARE DOCUMENTATION STUDY

Your jail is currently involved in the American Medical Association's (AMA) Program to Improve Medical Care and Health Services in Jails. The AMA's program is currently in its third year of operation with nearly 150 jails presently participating in fourteen states. Hopefully, your jail's involvement in the AMA program will result in an accreditation award that certifys that the health care offered to the inmates of your jail meets certain professional standards.

Your jail is also one of several jails taking part in an intensive documentation of the impact that the accreditation program has on health care within a jail. Past experience has shown that before most jails meet the standards for accreditation, they must add additional health care services or modify those that already exist. In the coming months you should notice changes taking place within your jail and with your assistance, we will document the impact that these changes have upon the medical care and health services that inmates receive.

Your role in measuring this impact is vital because without accurate information from you, the final results will be misleading and perhaps meaningless. The importance of your role and the necessity for accurate statistical data can not be over emphasized.

The information that you will be collecting will be used to evaluate the "real" impact of the AMA's national program. Your jail was asked to participate in this intensive documentation study because in many respects it's health care system is very typical of other jails throughout the country. The information gained at your jail will be used to help jails similar to your own improve their health care systems.

The information that you will be sending us on a monthly basis may be information that your jail already keeps. If not,

it is the type of information that is necessary for sound management and future health care planning. In addition, it is information required by one of the AMA's standards on accreditation -- Standard 1003 (see the AMA's Practical Guide pp. 35 & 36 and the AMA's Standards for the Accreditation of Medical Care and Health Services in Jails).

The information you will be collecting falls into four categories:

- information on the entire jail population (FORM A)
- transportation needed to deliver medical services (FORM B)
- information on the number of health services delivered (FORM C)
- changes which occur in the jail's health care system (FORM D)

We invite your comments at any time throughout the coming months and ask that you contact us by mail or by phone if any questions or problems arise (feel free to reverse the charges).

Sincerely,

B. Jaye Anno, Allen H. Lang

ADDRESS: B. Jaye Anno Associates
11200 Lockwood Drive
#1513
Silver Spring, Maryland 20901

PHONE NUMBER: (301) 593-8199

INSTRUCTIONS FOR COMPLETING FORM A
"JAIL POPULATION DATA"

Please maintain FORM A on a daily basis. We realize that for many jails, keeping this form represents a duplication of statistics, but it is absolutely necessary that we have this information for the American Medical Association study. Recording the information should only take a few minutes each day and this will insure that we receive uniform information from all the participating jails.

D A I L Y P O P U L A T I O N -- This statistic is arrived at by simply adding the daily intake and subtracting the daily releases from the daily population of the previous day.

For example -- let us suppose that today we need to calculate the daily population for July 9. Take the daily population for July 8 and to this figure add the daily intake for July 9. Then take this "new" number and subtract the daily releases for July 9. The result should be the daily population figure for July 9.

If the daily population on July 8 was 167 and the daily intake for July 9 was 32 and the daily releases for July 9 were 46, the daily population for July 9 would be 153.

167 + 32 = 199 - 46 = 153 = DAILY POPULATION

D A I L Y I N T A K E -- This is simply the total number of inmates booked into the jail during the day.

D A I L Y R E L E A S E S -- This is simply the total number of inmates released from the jail during the day.

L E N G T H O F S T A Y D A T A -- This information is easy to keep track of if done on a daily basis. Each time an inmate is released, determine the number of days he or she was incarcerated and place a tally mark in the appropriate box (eg) less

than 24 hours, 1 to 7 days, etc. Remember, the number of tally marks (𝍸 𝍸 ||) should equal the total number of releases during the month.

We are asking that you supply us with your jail population data on FORM A so that we will have uniform statistics from each jail in the survey. This information will be used to help calculate health care costs and needs of the jail on a per unit basis.

JAIL NAME: Smith County Jail

EXAMPLE

LENGTH OF STAY DATA

Number of Inmates Released During the Month Staying:

Less Than 24 Hours	𝍸 |||
1 to 7 Days	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 |
8 to 14 Days	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 ||||
15 to 30 Days	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 |||
31 to 90 Days	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸
More Than 90 Days	𝍸 𝍸 𝍸 𝍸 |

TOTAL NUMBER OF TALLIES 360

EXAMPLE

FORM - A JAIL POPULATION DATA

(Before completing, see instructions for Form A)

DAILY RELEASES	DAILY INTAKE	DAILY POPULATION	
12	14	109	1
10	6	111	2
8	8	107	3
12	21	107	4
16	18	115	5
14	12	117	6
9	7	115	7
8	5	113	8
6	9	110	9
8	11	113	10
8	7	116	11
14	23	115	12
20	21	124	13
6	3	125	14
14	9	122	15
12	11	117	16
11	8	116	17
10	16	113	18
17	22	119	19
24	36	124	20
26	8	136	21
14	6	118	22
6	9	110	23
4	6	113	24
8	7	115	25
14	8	114	26
6	23	108	27
20	4	125	28
8	7	109	29
3	6	108	30
0	5	111	31
360	362	3435	Monthly Totals

JAIL STUDY - FORM A
([illegible])

INSTRUCTIONS FOR COMPLETING FORM B
"TRANSPORTATION FOR HEALTH CARE REASONS"

On this form you will notice a number of items directed specifically at the first few hours of an inmate's incarceration. We are asking for this information because it is generally believed that the first twentyfour hours after an inmate is booked is the most likely time for a crisis situation to occur. We would like to find out if this is also true for your jail.

T R A N S P O R T A T I O N -- It is important that the information about transportation for health care reasons be kept as accurately as possible. Transportation of inmates to places outside the jail is usually rather expensive and one area that may be greatly effected by changes in a jail's health care system. For this reason we are asking that you keep a daily log type record - FORM B.

Emergency trips may be to many different places, but most likely, will be to a hospital emergency room, a medical or psychiatric clinic, a drug or alcohol detoxification center, a doctor's office, or a dentist's office.

By E M E R G E N C Y W E M E A N an unplanned trip caused by a crisis situation or a potential crisis situation.

In the first three columns on FORM B labeled "Emergency trips within inmate's first 24 hours," please give a daily count of the number of inmates requiring emergency trips outside the jail within the first twentyfour hours of their incarceration.

In the middle three columns on FORM B labeled "All other emergency trips," please give a daily count of the number of inmates requiring emergency trips outside the jail after the first twentyfour hours of their incarceration.

INSTRUCTIONS FOR FORM B (Continued)

In the last three columns on FORM B labeled "All nonemergency trips," please give a daily count of the number of inmates requiring nonemergency trips outside the jail for health care reasons at any time during their incarceration.

By N O N E M E R G E N C Y W E M E A N planned trips which are not the result of a crisis situation such as an appointment to have an inmate's eyes examined or to have a psychiatric evaluation performed or as a referral to a medical specialty clinic.

FORM B - TRANSPORTATION FOR HEALTH CARE REASONS

(Before completing, see instructions for Form B)

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Totals
EXAMPLE	EMERGENCY TRIPS WITHIN INMATE'S FIRST 24 HOURS																																
	Trips for Medical Reasons	0	0	0	0	0	0	1	3	0	0	0	1	0	1	1	0	0	0	0	0	0	1	0	0	0	1	0	1	0	0	0	10
	Trips for Psychiatric Reasons	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	5
	Trips for Dental Reasons	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EXAMPLE	ALL OTHER EMERGENCY TRIPS																																
	Trips for Medical Reasons	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	4
	Trips for Psychiatric Reasons	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2
	Trips for Dental Reasons	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	5
EXAMPLE	ALL NONEMERGENCY TRIPS																																
	Trips for Medical Reasons	4	0	0	0	8	0	0	0	5	0	4	2	0	0	6	0	2	0	0	4	0	5	0	4	0	3	2	2	0	5	4	60
	Trips for Psychiatric Reasons	0	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	1	0	0	0	1	0	8
	Trips for Dental Reasons	1	0	0	4	0	0	0	0	0	0	2	0	0	0	0	0	0	0	3	0	0	2	0	0	0	0	0	0	0	2	2	16

JAIL NAME: SMITH COUNTY JAIL

INSTRUCTIONS FOR COMPLETING FORM C
"NUMBER OF HEALTH SERVICES DELIVERED"

FORM C asks for the number of various kinds of health care services delivered to inmates of the jail. The form is meant to be maintained on a weekly basis. The information requested on FORM C is the heart of the health care study and must be completed as accurately as possible. The categories listed on FORM C are straightforward and self-explanatory. If, however, a question should arise, please do not hesitate to contact our office.

The three categories, medical report, psychiatric report, and dental report, should be kept separate for reporting purposes. If a person is receiving some form of psychiatric treatment, do not include that treatment under both the medical report and the psychiatric report.

The last category on FORM C asks for "Other Services Delivered." If your jail provides other health care services that are not covered by the specific categories provided, please use this space to indicate what these services are and the number of times they were delivered.

Also, please note that when we ask for the number of times inmates received various kinds of services, we want the frequency of services delivered. Therefore, if an inmate goes on sick call ten times during the month, he should be counted ten times.

The following are a number of specific items we would like to call to your attention in the medical report.

Item f, "Number of times inmates received medical consults/ treatment in or outside the jail" refers to special services

delivered outside of regular sick call. This might include such things as a visit to an ear, nose and throat specialist, a gynecologist, physical therapist, surgeon, etc.

Item g, "Total number of medications dispensed" refers to all medications whether prescribed for medical, psychiatric or dental reasons.

Items h and i, "Number of lab tests performed" and "Number of x-rays taken" refer to the actual number done. If more than one lab test is done from a given specimen, then more than one test should be counted. Likewise, if an inmate gets more than one x-ray when he goes for x-rays, then all the x-rays should be counted.

E X A M P L E E X A M P L E

FORM C

NUMBER OF HEALTH SERVICES DELIVERED

(Before completing, see instructions for FORM C)

for the month of

	FOR THE WEEKS OF				
MEDICAL REPORT:					
a. Number of sick call visits by inmates.....	204	361	281	249	193
b. Number of admission physical exams given within 14 days of incarceration.....	22	31	30	26	19
c. Number of times inmates received emergency medical care in or outside the jail.....	4	6	3	0	0
d. Number of inmates receiving bed care in the jail.....	1	1	2	1	2
Total number of bed care days delivered inside the jail.....	5	7	9	7	6
e. Number of inmates receiving bed care outside the jail.....	0	0	0	0	0
Total number of bed care days delivered outside the jail.....	0	0	0	0	0
f. Number of times inmates received medical consults/treatment in or outside the jail.....	2	3	4	3	2
g. Total number of medications dispensed.....	264	291	306	314	252
Number of psychotropic medications dispensed.....	48	56	56	62	54
Number of placebo medications dispensed.....	39	47	43	51	28
h. Number of lab tests performed.....	146	179	167	183	132
i. Number of X-rays taken.....	2	0	0	4	1
PSYCHIATRIC REPORT:					
a. Number of times inmates seen on a non-emergency basis for psychiatric consults/treatment...	3	7	7	6	4
b. Number of times inmates seen on an emergency basis for psychiatric consults/treatment.....	0	2	2	0	0

JAIL NAME: SMITH COUNTY JAIL

E X A M P L E

E X A M P L E

FORM C (Continued) for the month of

FOR THE WEEKS OF

0	1	0	0	2

PSYCHIATRIC REPROT (continued):

c. Number of inmates transferred out of the jail to psychiatric facilities.....

DENTAL REPORT:

a.	Total number of inmates seen by the dental care provider(s)..	46	53	62	49	36
b.	Number of inmates receiving emergency dental treatment.....	2	3	0	0	2
c.	Number of inmates receiving dental screening within the first 14 days of incarceration..	22	31	30	26	19
d.	Number of restorative procedures performed (count each procedure such as a filling or root canal)	53	67	69	54	41
e.	Number of extractions performed (count number of teeth pulled)..	4	6	1	7	3
f.	Number of dental preventive treatments performed (oral prophylaxis).....	0	3	2	6	1
g.	Number of dental prosthetics provided (false teeth, etc.)....	0	0	1	0	0

OTHER SERVICES DELIVERED:
(please specify type and amount)

_____

_____

_____

JAIL NAME: SMITH COUNTY JAIL

E X A M P L E

FORM D - CHANGES IN THE JAIL'S HEALTH CARE SYSTEM
(Before completing, see example for FORM D)

What changes have occurred in the jail's health care system during this reporting month? (Give an AMA standard which corresponds to each change if you feel it applies.)

(1) A FORMULARY WAS DEVELOPED (FULFILLS STANDARD 1028)

(2) RECEIVING SCREENING WAS BEGUN ON ALL NEWLY ARRIVED INMATES (FULFILLS STANDARD 1011)

(3) THE RECEIVING SCREENING FORM BECOMES A PART OF THE MEDICAL RECORD AT THE TIME OF THE FIRST MEDICAL ENCOUNTER (PARTIALLY FULFILLS STANDARD 1030)

(4) A REGISTERED NURSE WAS ADDED FOR 20 HOURS PER WEEK (NO APPLICABLE STANDARD)

(5) A CONTRACT TO HAVE A LOCAL PHARMACY SUPPLY THE DRUG NEEDS OF THE JAIL ON A DAILY BASIS WAS SIGNED. THIS MEANS DRUGS ARE NO LONGER STORED AT THE JAIL (NO APPLICABLE STANDARD)

APPENDIX E

EXAMPLE OF INMATE QUESTIONNAIRE

P L E A S E R E A D

Please answer all the questions on this survey. It should only take a few minutes of your time.

The answers you give will be an important part of a larger survey being done at jails in four states as part of the American Medical Association's Jail Health Care Program. In each of these jails we are asking inmates the same questions about the health care services which are available to them.

All the answers you give will be kept confidential and will not be given to any person connected with the jail.

Remember, it is your opinion that is important and the one we want, so pick the best answer that applies to you. We have left a blank after each question for any comments you may care to make.

INMATE QUESTIONNAIRE

Please give today's date _____ _____ _____
month day year

What day were you admitted to this jail?

_____ _____ _____
month day year

1. Are you ever concerned that you may become ill because you are in contact with an inmate who is sick and not being properly treated for his or her sickness?

   - o no - never
   - o yes - sometimes
   - o yes - a lot of the time
   - o yes - all the time

   ANY COMMENTS_____

2. Do you get the care you think you should be getting when you go on sick call?

   - o yes - every time
   - o yes - most of the time
   - o yes - some of the time
   - o no - never

   ANY COMMENTS_____

3. How many times have you seen a doctor or medical person since you were addmitted to this jail?

   - o none
   - o one
   - o two or three
   - o four or five
   - o six to ten
   - o more than ten

   ANY COMMENTS_____

4. If an inmate had a heart attack, how good do you think the emergency action necessary to save his or her life would be?

   - o very good
   - o good
   - o fair
   - o poor

   ANY COMMENTS_____

5. Which words BEST describe the attitude of the jail doctor towards the health of the inmates?

- o he cares a lot and seems really concerned
- o he cares a little and seems concerned some of the time
- o he is indifferent and does not seem really concerned
- o he is hostile and does not seem concerned at all

ANY COMMENTS_____

6. Which words BEST describe the attitude of other medical staff towards the health of the inmates?

- o they care a lot and seem really concerned
- o they care a little and seem concerned some of the time
- o they are indifferent and do not seem really concerned
- o they are hostile and do not seem concerned at all

ANY COMMENTS_____

7. Have you ever been in any other jail besides this one?

- o no - never (if no, go to question 8)
- o yes - one other jail (answer the rest of question 7)
- o yes - several other jails (answer the rest of question 7)

In general, how would you compare the medical care you get in this jail with the medical care you got in the other jails?

- o a lot worse in this jail
- o a little worse in this jail
- o about the same in this jail
- o a little better in this jail
- o a lot better in this jail
- o I cannot really compare the medical care

ANY COMMENTS_____

8. Do you think this jail is trying to improve the health care services it offers to the inmates?

- o yes
- o no
- o don't know

ANY COMMENTS_____

CONTINUED

3 OF 6

9. Have you ever been denied access to medical care when you felt you really needed it?

- o no - never (if no, go to question 10)
- o yes - one time (answer the rest of question 9)
- o yes - several times (answer the rest of question 9)
- o yes - all the time (answer the rest of question 9)

If you answered "yes," who usually denied you this access? (CHECK ONLY ONE ANSWER)

- o doctor
- o nurse
- o other medical person
- o correction officer - guard
- o some other person (please give his job title only)

_____

ANY COMMENTS_____

10. Does this jail have a procedure for handling inmates who need to be detoxified from alcohol or drugs?

- o yes (if yes, answer the rest of question 10)
- o no (if no, go to question 11)
- o don't know (go to question 11)

In your opinion, how good is this jail's detoxification procedure?

- o very good
- o good
- o fair
- o poor

ANY COMMENTS_____

11. How much respect does the jail doctor show you?

- o a lot of respect
- o some respect
- o a little respect
- o no respect

ANY COMMENTS_____

12. How often do you feel inmates go on sick call who don't really need to see a medical person?

- o never
- o sometimes
- o often
- o very often

ANY COMMENTS_____

13. When the doctor sees you on sick call, do you think he spends enough time with you?

- o yes - every time
- o yes - most of the time
- o yes - sometimes
- o no - never

ANY COMMENTS_____

14. When other medical staff see you on sick call, do you think they spend enough time with you?

- o yes - every time
- o yes - most of the time
- o yes - sometimes
- o no - never

ANY COMMENTS_____

15. Has your health changed since you have been in this jail?

- o yes - it has gotten a lot better
- o yes - it has gotten a little better
- o yes - but it has gotten a little worse
- o yes - but it has gotten a lot worse
- o no - it has stayed the same

ANY COMMENTS_____

16. How good is the care given to inmates in this jail who have mental problems?

- o very good
- o good
- o fair
- o poor
- o don't know

ANY COMMENTS_____

17. How often do you have a medical problem but decide not to go on sick call because you feel it will not be treated?

- o all of the time
- o most of the time
- o sometimes
- o never

ANY COMMENTS_____

18. If an emergency medical situation occurred in the jail that required immediate action in order to prevent death, how confident are you that the proper life-saving procedure would be performed?

- o very confident
- o fairly confident
- o somewhat confident
- o not at all confident

ANY COMMENTS_____

19. Have you ever been denied access to dental care when you felt you really needed it?

- o no - never (if no, go to question 20)
- o yes - one time (answer the rest of question 19)
- o yes - several times (answer the rest of question 19)
- o yes - all the time (answer the rest of question 19)

If you answered "yes," who usually denied you this access? (CHECK ONLY ONE ANSWER)

- o doctor
- o dentist
- o nurse
- o other medical person
- o correction officer - guard
- o some other person (please give his job title only)

_____

ANY COMMENTS_____

20. Have you ever been denied access to mental health care when you felt you really needed it?

- o no - never (if no, go to question 21)
- o yes - one time (answer the rest of question 20)
- o yes - several times (answer the rest of question 20)
- o yes - all the time (answer the rest of question 20)

If you answered "yes," who usually denied you this access? (CHECK ONLY ONE ANSWER)

- o doctor
- o psychiatrist
- o nurse
- o other medical person
- o correction officer - guard
- o some other person (please give his job title only)

_____

ANY COMMENTS_____

21. How easy is it to get a pill to calm your nerves down or help you sleep?

- o very easy
- o pretty easy
- o pretty hard
- o very hard

ANY COMMENTS_____

22. Has this jail's health care system changed any since you were admitted?

- o yes (if yes, answer the rest of question 22)
- o no (go to question 23)
- o don't know (go to question 23)

What effect have these changes had on this jail's health care system?

- o made it a lot better
- o made it a little better
- o made it neither better or worse
- o made it a little worse
- o made it a lot worse

ANY COMMENTS_____

23. Would you be willing to fill out a similar survey the day before you get released?

- o yes
- o no

Thank you for helping us with this survey. The information you have given us will be kept confidential.

****
* NOTE: The questionnaire administered at *
* the time of the follow-up site visit did *
* not contain question #23. *
* The questionnaire left with the *
* jail for inmates to complete prior to *
* their release did not contain question #23 *
* and also had the following instructions: *
****

F I N A L I N S T R U C T I O N S

In order to keep the information in this survey confidential, please fold and put the completed survey in the envelope provided and seal the envelope. Thank you for the time and help you have given us.

APPENDIX F

EXAMPLE OF BOOKING OFFICER QUESTIONNAIRE

P L E A S E R E A D

Please answer all the questions on this survey. It should only take a few minutes of your time.

The answers you give will be an important part of a larger survey being done at jails in four states as part of the American Medical Association's Jail Health Care Program. We are currently making this survey of booking officers in these jails in order to determine their opinions concerning the health care services which are available to inmates within their jail.

All the answers you give will be kept confidential.

Remember, it is your opinion which is important in this survey and the one we want. Thank you for the time and help you are giving us.

JAIL NAME: _____

YOUR NAME: _____

TODAY'S DATE: _____
month day year

BOOKING OFFICER QUESTIONNAIRE

A-1. How would you rate the health care in this jail?

- o excellent
- o good
- o fair
- o poor

ANY COMMENTS _____

A-2. How long have you worked as a booking officer at this jail?

- o less than three months
- o three months to a year
- o one to two years
- o two to five years
- o more than five years

ANY COMMENTS _____

A-3. What percent of all prisoners brought in for booking would you estimate need some form of medical treatment?

- o less than 10%
- o 10% - 25%
- o 26% - 50%
- o 51% - 75%
- o more than 75%

ANY COMMENTS _____

A-4. From the following list, check ALL of the actions that it would be possible for you to take if a prisoner was brought in with a health problem.

- o refuse to accept custody of the prisoner from the arresting officer
- o send him to a hospital emergency room
- o take him to a doctor's office
- o take him to a dentist's office
- o put him in a special cell for observation
- o call a doctor (dentist) for advice
- o have a medical person examine the prisoner in the jail within a short time (less than an hour)
- o send the prisoner to the jail infirmary
- o refer the prisoner to an outside agency (drug rehab center, alcohol detox center, etc.)
- o other (please specify) _____

ANY COMMENTS _____

A-5. From the following list, check all of the types of medical training you have had:

- o first aid
- o symptom recognition
- o cardio-pulmonary resusitation (CPR)
- o other (please specify) _____

ANY COMMENTS _____

A-6. How often are you uncertain of what medical action should be taken when a prisoner is brought in with a health problem?

- o very often
- o frequently
- o occasionally
- o never

ANY COMMENTS _____

A-7. How many prisoners brought in for booking with medical complaints complain about medical problems that are not nearly as serious as they make out?

- o all of them
- o most of them
- o some of them
- o none of them

ANY COMMENTS _____

A-8. How often at booking do you feel inmates are needlessly sent to the hospital or the doctor's simply as a precautionary measure?

- o very often
- o often
- o seldom
- o never

ANY COMMENTS _____

A-9. Are you ever concerned that you may become ill because you are in contact with an inmate who is sick and not being properly treated for his sickness?

- o no - never
- o yes - occasionally
- o yes - quite often
- o yes - it is a constant concern

ANY COMMENTS _____

A-10. In your opinion, how good is your jail's procedure for detecting and handling potential suicides?

- o very good
- o good
- o fair
- o poor

ANY COMMENTS _____

A-11. How good do you think your jail's procedure is for detecting and treating inmates with communicable diseases?

- o very good
- o good
- o fair
- o poor

ANY COMMENTS _____

A-12. In your opinion, how often do prisoners who are a danger to themselves, other inmates or jail personnel get booked and placed into the general inmate population at your jail?

- o frequently
- o sometimes
- o seldom
- o never

ANY COMMENTS _____

A-13. Using your present booking procedure, how sure are you that prisoners who are a danger to themselves, other inmates or jail personnel will be identified at booking and handled in such a manner that no harm occurs?

- o very sure
- o fairly sure
- o unsure
- o very unsure

ANY COMMENTS _____

A-14. Of all the prisoners that you booked within the last six months, how many would you estimate proved to be a danger to themselves, other inmates, or jail personnel within the first 48 hours of booking?

(Give a number: none, one, two, ...ten, etc.)

_____

ANY COMMENTS _____

A-15. Have any changes occurred in your booking procedures since last September that require jail personnel to pay closer attention to a prisoner's health when he is first brought into the jail?

- o yes (If yes, answer the rest of this question)
- o no (If no, go to the next section)

What effect do you feel these changes will have on helping to prevent health care problems and emergencies in the jail?

- o a great effect
- o some effect
- o a little effect
- o no effect

ANY COMMENTS_____

****
* NOTE: The questionnaire administered *
* at the time of the initial site visit *
* did not contain question A-15. *
****

INSTRUCTIONS

This section presents six hypothetical situations. From the brief descriptions of each, try to determine if you think a medical problem exists, what procedure you would follow at the time of booking, and briefly tell why you would follow this procedure.

B-1. A prisoner is brought in complaining of police brutality. He is very hostile toward the arresting officer and claims that another officer poked him in the abdomen with a billy club and his stomach now hurts. The prisoner pulls his shirt up, but you can see no bruises or other evident sign of injury.

Does this situation present a medical problem?

- o yes
- o no

What would you do at booking given this situation and why?

_____

_____

_____

B-2. A prisoner is brought in speaking incoherently and acting as if he is intoxicated. The arresting officer states he found the person wandering around skid row in this same condition. The person is unable to provide any information, but you notice the prisoner's breath is sweet, not alcoholic smelling.

Does this situation present a medical problem?

- o yes
- o no

What would you do at booking given this situation and why?

_____

_____

_____

B-3. A local derelict, who everyone calls "Mad Dog" because he drinks MD 20/20, is brought in for booking. You have seen him drunk many times before. Surprisingly, he's obviously sober and claims he hasn't had anything to drink in four days. It seems this time "Mad Dog" was caught trying to steal money out of a cash register because, as he says, "A voice told me it was o.k. to borrow the money and use it to buy a bottle." He has the shakes and claims to be alternately burning up and then shaking with cold.

Does this situation present a medical problem?

- o yes
- o no

What would you do at booking given this situation and why?

_____

_____

_____

B-4. A very drunk person is brought in singing and talking incoherently. You notice a bump on his forehead, obviously from receiving a blow to the head, but when you question him, he is unaware how he got the bump and claims it doesn't hurt or bother him. Before you can begin to book him, he falls asleep and attempts to wake him only result in incoherent responses.

Does this situation present a medical problem?

- o yes
- o no

What would you do at booking given this situation and why?

_____

_____

_____

B-5. An out-of-town businessman is brought in after being arrested at "Madame's" which was just raided. He already has his lawyer working on his release and should be out by the next morning. He is very quiet, submissive, constantly stares at the floor, and responds in a mumbled voice.

Does this situation present a medical problem?

- o yes
- o no

B-5. (Continued)

What would you do at booking given this situation and why?

_____

_____

_____

B-6. A prisoner is brought in with needle tracks in his arm, obviously from doing hard drugs. The whites in his eyes are yellowish and it appears on observation the person has jaundice.

Does this situation present a medical problem?

- o yes
- o no

What would you do at booking given this situation and why?

_____

_____

_____

Thank you for the time and help you have given us.

APPENDIX G

PRE-POST COMPLIANCE WITH
AMA STANDARDS BY JAIL

Chart 1 - Initial Self-Survey Results
- Percent Compliance

Chart 2 - Follow-up Self-Survey Results
- Percent Compliance

CHART 1

RESPONSES OF THE TEN JAILS IN THE STUDY TO THE INITIAL SELF-SURVEY INDICATING THE PERCENT OF COMPLIANCE WITH EACH OF THE AMA'S FORTY-TWO STANDARDS

PERCENT COMPLIANCE WITH EACH STANDARD										JAIL # / STANDARD #
Ten	Nine	Eight	Seven	Six	Five	Four	Three	Two	One	
100	67	67	100	67	67	100	0	67	67	1001[P]
100	50	100	100	100	100	100	50	100	100	1002[P]
0	0	0	0	0	50	50	50	0	0	1003[P]
12	0	0	29	24	12	35	0	0	0	1004[P]
50	50	50	50	100	100	100	0	50	50	1005[P]
N/A	N/A	N/A	0	0	0	100	0	0	0	1006[P]
0	N/A	N/A	100	0	0	100	0	100	0	1007[P]
100	0	100	100	100	100	50	100	100	100	1008[P]
50	N/A	0	100	100	75	100	0	100	25	1009[P]
63	50	50	0	100	75	0	0	50	50	1010[P]
61	0	50	0	100	95	28	0	89	78	1011[S]
92	67	9	84	92	92	92	0	0	0	1012[S]
50	75	25	100	50	100	100	0	100	75	1013[P]
0	0	100	0	100	100	100	100	0	0	1014[P]
100	0	0	100	100	100	100	100	100	100	1015[S]
100	0	100	100	100	100	100	0	0	0	1016[S]
100	50	100	100	100	100	0	0	0	50	1017[S]
100	0	0	100	100	100	67	100	0	0	1018[S]
80	0	100	100	100	0	50	80	50	0	1019[P]
0	0	0	0	100	0	100	0	67	67	1020[P]
100	67	67	100	100	67	67	67	100	67	1021[S]
100	100	100	100	0	100	100	100	100	100	1022[S]
67	33	33	33	33	0	33	33	0	0	1023[S]
100	0	0	0	100	0	0	0	100	0	1024[P]
50	0	50	50	50	50	50	50	50	50	1025[S]
0	0	0	100	50	100	100	0	50	0	1026[S]
0	0	100	100	100	100	33	0	100	100	1027[S]
58	0	0	42	67	42	45	42	38	20	1028[P]
100	67	0	100	33	100	100	33	67	33	1029[P]
57	29	14	57	71	100	100	29	0	0	1030[P]
100	0	0	0	100	100	100	0	100	0	1031[P]
100	0	0	100	100	100	100	100	0	0	1032[P]
67	67	0	67	67	67	67	33	67	67	1033[P]
100	100	100	100	100	100	0	0	0	0	1034[E]
100	100	100	100	100	100	100	100	100	100	1035[E]
100	100	100	100	100	100	100	100	100	100	1036[E]
100	100	100	100	100	100	100	100	100	100	1037[E]
100	100	100	60	100	100	60	100	100	100	1038[E]
100	100	100	100	100	100	100	100	100	100	1039[E]
100	100	100	100	100	0	100	0	100	0	1040[E]
100	100	100	100	100	0	100	100	100	100	1041[E]
100	100	100	100	100	100	100	100	100	100	1042[S]
72%	43%	53%	71%	79%	71%	74%	42%	61%	45%	

KEY:
P=Procedural S=Service E=Environmental

CHART 2

RESPONSES OF THE TEN JAILS IN THE STUDY TO THE FOLLOW-UP SELF-SURVEY INDICATING THE PERCENT OF COMPLIANCE WITH EACH OF THE AMA'S FORTY-TWO STANDARDS

PERCENT COMPLIANCE WITH EACH STANDARD										JAIL # / STANDARD #
Ten	Nine	Eight	Seven	Six	Five	Four	Three	Two	One	
100	67	67	100	100	100	100	100	100	100	1001[P]
100	50	100	100	100	100	100	100	100	100	1002[P]
0	0	0	50	100	100	50	100	100	100	1003[P]
12	0	6	47	100	100	100	100	100	100	1004[P]
50	50	50	50	100	100	100	100	100	100	1005[P]
N/A	N/A	N/A	100	100	100	100	100	100	100	1006[P]
0	N/A	N/A	100	100	100	100	100	100	100	1007[P]
100	0	100	100	100	100	50	100	100	100	1008[P]
50	N/A	0	100	100	100	100	100	100	100	1009[P]
63	50	50	0	100	100	100	100	100	100	1010[P]
84	0	67	100	100	100	100	100	100	100	1011[S]
92	67	59	100	100	100	100	100	100	100	1012[S]
75	75	75	100	100	100	100	100	100	100	1013[P]
100	0	100	0	100	100	100	100	100	100	1014[P]
100	0	33	100	100	100	100	100	100	100	1015[S]
00	0	100	100	100	100	100	100	100	100	1016[S]
100	50	100	100	100	100	50	100	100	100	1017[S]
100	67	0	100	100	100	100	100	100	100	1018[S]
80	0	60	100	100	100	100	100	100	100	1019[P]
33	0	33	33	100	100	100	100	67	100	1020[P]
100	67	67	100	100	100	100	100	100	100	1021[S]
100	100	100	100	100	100	100	100	100	100	1022[S]
100	33	33	33	33	100	100	100	67	67	1023[S]
100	0	0	0	100	100	100	0	100	100	1024[P]
100	0	50	50	100	100	100	50	100	100	1025[S]
100	0	0	100	100	100	100	100	100	100	1026[S]
0	0	100	100	100	100	100	100	100	100	1027[S]
67	17	20	42	100	100	70	92	100	100	1028[P]
100	67	33	100	100	100	100	100	67	100	1029[P]
57	29	14	86	86	100	100	100	100	100	1030[P]
100	0	0	50	100	100	100	100	100	100	1031[P]
100	0	0	100	100	100	100	100	100	100	1032[P]
67	67	0	67	67	100	67	100	67	67	1033[P]
100	100	100	100	100	100	0	0	0	100	1034[E]
100	100	100	100	100	100	100	100	100	100	1035[E]
100	100	100	100	100	100	100	100	100	100	1036[E]
100	100	100	100	100	100	100	100	100	100	1037[E]
100	100	100	60	100	100	60	100	100	100	1038[E]
100	100	100	100	100	100	100	100	100	100	1039[E]
100	100	100	100	100	100	100	0	100	100	1040[E]
100	100	100	100	100	100	100	100	100	100	1041[E]
100	100	100	100	100	100	100	100	100	100	1042[S]
81%	45%	58%	80%	96%	100%	92%	91%	94%	98%	

KEY:
P=Procedural S=Service E=Environmental

APPENDIX H

STATISTICS REGARDING THE NUMBER AND TYPES
OF HEALTH CARE SERVICES DELIVERED BY JAIL BY MONTH

Chart 1 - Jail One

Chart 2 - Jail Eight

Chart 3 - Jail Nine

Chart 4 - Jail Ten

Chart 5 - Jail Three

Chart 6 - Jail Four

Chart 7 - Jail Seven

Chart 8 - Jail Five

Chart 9 - Jail Six

CHART 1

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL ONE

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0
Oct.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nov.	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Dec.	0	0	1	0	2	0	0	0	0	1	0	0	0	0	0	0	0
Jan.	2	2	2	0	5	4	1	0	0	0	0	0	0	0	0	0	0
Feb.	9	2	0	0	11	2	0	0	0	1	0	0	0	0	0	0	0
TOTALS	11	4	5	0	19	7	1	1	0	2	0	0	0	0	0	0	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 2

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL EIGHT

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	30	24	0	0	6	0	7	4	1	1	0	0	0	0	0	0	1
Oct.	25	24	2	0	0	0	6	5	1	2	0	0	0	0	0	0	0
Nov.	27	28	1	0	0	5	0	7	0	0	1	0	0	1	0	0	0
Dec.	DATA NOT AVAILABLE																
Jan.	43	35	1	0	0	0	1	4	0	1	0	0	0	0	0	0	0
Feb.	39	23	0	0	0	1	0	1	0	0	0	0	3	0	0	0	0
TOTALS	164	134	4	0	6	6	14	21	2	4	1	0	3	1	0	0	1

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 3

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL NINE

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Oct.	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nov.	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0
Dec.	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0
Jan.	0	0	0	0	3	0	0	1	0	0	0	0	0	0	0	0	0
Feb.	0	0	0	0	3	0	0	1	0	0	0	0	0	0	0	0	0
TOTALS	0	1	2	0	10	0	0	3	0	0	0	0	3	0	0	0	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 4

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL TEN

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	79	30	2	2	2	1	0	21	0	2	1	1	0	1	0	2	0
Oct.	77	25	1	0	2	3	1	26	1	1	0	0	1	2	0	0	0
Nov.	63	25	1	0	6	2	3	8	1	1	0	1	0	1	0	0	0
Dec.	65	37	2	2	2	2	1	0	1	0	0	0	0	2	0	0	0
Jan.	74	38	0	0	0	6	3	8	0	0	0	1	2	2	0	0	0
Feb.	58	31	0	0	3	2	1	11	0	1	0	0	0	0	0	0	0
TOTALS	416	186	6	4	15	16	9	74	3	5	1	3	3	8	0	2	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 5

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL THREE

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	0	0	44	0	0	0	0	6	0	0	0	0	0	0	0	0	0
Oct.	0	0	27	2	0	0	0	4	0	0	0	0	0	0	0	0	3
Nov.	26	0	1	0	27	0	0	1	0	0	0	0	1	0	0	1	3
Dec.	24	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	1
Jan.	0	0	3	0	24	0	0	2	0	0	0	0	0	0	0	0	12
Feb.	0	0	7	0	12	0	0	2	0	0	0	0	0	0	1	0	4
TOTALS	50	0	82	2	64	0	0	17	0	0	0	0	1	0	1	1	23

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 6

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL FOUR

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	294	74	2	14	3	48	0	0	0	0	0	0	0	2	2	2	0
Oct.	339	76	2	13	7	105	7	28	0	2	0	0	0	6	0	0	10
Nov.	310	51	4	16	6	101	1	2	0	0	0	0	4	1	0	0	0
Dec.	236	47	1	12	10	108	6	10	0	1	0	10	3	8	0	0	0
Jan.	261	49	4	11	3	103	3	11	1	1	0	49	3	8	2	0	0
Feb.	207	60	6	6	11	145	1	7	0	0	0	60	0	1	0	0	0
TOTALS	1647	357	19	72	40	610	18	68	1	4	0	119	12	26	4	0	10

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 7

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL SEVEN

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	143	41	4	1	25	19	7	39	2	0	0	0	0	0	0	0	0
Oct.	131	57	1	0	8	6	3	47	1	1	2	3	0	1	1	0	0
Nov.	154	35	2	0	14	6	4	44	0	0	1	5	0	0	0	0	0
Dec.	171	25	10	0	11	19	16	38	0	0	3	1	0	3	1	0	0
Jan.	113	21	2	2	12	36	4	38	1	0	4	0	0	7	0	0	0
Feb.	132	33	2	0	13	16	0	20	0	0	2	1	0	2	0	0	0
TOTALS	844	212	21	3	83	102	34	226	4	1	12	10	0	13	2	0	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 8

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL FIVE

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	468	35	5	0	39	15	6	6	2	2	0	0	0	20	0	0	0
Oct.	445	18	6	0	20	33	17	8	0	5	0	0	0	19	0	0	0
Nov.	451	20	8	0	24	24	12	13	2	5	0	0	0	26	0	0	0
Dec.	381	21	7	0	13	29	6	7	0	3	0	0	0	15	0	0	0
Jan.	509	32	8	0	16	72	14	3	2	3	0	32	0	29	3	0	0
Feb.	429	33	15	0	3	92	4	3	0	6	0	0	0	18	0	0	0
TOTALS	2683	159	49	0	115	265	59	40	6	24	0	32	0	127	3	0	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

CHART 9

NUMBER OF HEALTH CARE SERVICES* DELIVERED BY MONTH
JAIL SIX

	MEDICAL SERVICES							MENTAL HEALTH SVCS.			DENTAL SERVICES						
	Sick Call	Physical Exams	Emergency Care	Bed Care	Other Consults/ Treatment	Lab Tests	X-Rays	Non-Emergency Treatment	Emergency Consults/ Treatment	Transfers to Psychiatric Facilities	Emergency Dental Treatment	Dental Screening	Restorative Procedures	Extractions	Preventive Treatments	Prosthetics	General Non-Emergency Care
Sep.	668	20	60	4	16	66	13	130	7	2	25	0	17	28	35	12	0
Oct.	621	57	11	8	39	50	13	127	10	3	4	0	32	16	23	6	0
Nov.	560	45	12	5	53	47	20	206	13	1	2	0	20	17	30	2	0
Dec.	554	40	8	3	53	16	6	146	9	2	0	0	35	18	49	0	0
Jan.	754	52	19	2	19	756	9	30	5	1	6	57	33	17	0	2	0
Feb.	587	79	18	1	17	818	10	26	1	1	4	18	48	16	0	1	0
TOTALS	3744	293	128	23	197	1753	71	665	45	10	41	75	185	112	137	23	0

*These totals represent the number of services provided and not necessarily the number of inmates seen, since the same inmate may have received more than one service in any given category. Note also that these totals include all services provided, whether inside or outside the jail.

APPENDIX I

LENGTH OF STAY FIGURES
BY JAIL BY MONTH

Chart 1 - Jail One

Chart 2 - Jail Three

Chart 3 - Jail Four

Chart 4 - Jail Six

Chart 5 - Jail Seven

Chart 6 - Jail Eight

Chart 7 - Jail Nine

Chart 8 - Jail Ten

CHART 1

LENGTH OF STAY FIGURES BY MONTH
JAIL ONE

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	30	56	17	31	4	7	2	4	1	2	0	0	54	100
October	36	51	16	23	5	7	7	10	5	7	1	1	70	99*
November	29	66	11	25	2	5	1	2	1	2	0	0	44	100
December	28	62	7	16	7	16	3	7	0	0	0	0	45	101*
January	13	43	7	23	6	20	3	10	1	3	0	0	30	99*
February	12	33	15	42	6	17	1	3	2	6	0	0	36	101*
TOTALS	148	53	73	26	30	11	17	6	10	4	1	0*	279	100

*Errors due to rounding

CHART 2

LENGTH OF STAY FIGURES BY MONTH
JAIL THREE

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	112	37	87	29	44	14	43	14	19	6	0	0	305	100
October	101	38	111	42	23	9	28	11	0	0	0	0	263	100
November	117	48	77	32	27	11	20	8	3	1	0	0	244	100
December	73	38	55	28	22	11	29	15	14	7	0	0	193	99*
January	98	56	39	22	27	16	7	4	3	2	0	0	174	100
February	52	27	65	34	32	17	29	15	14	7	0	0	192	100
TOTALS	553	40	434	32	175	13	156	11	53	4	0	0	1371	100

*Errors due to rounding

CHART 3

LENGTH OF STAY FIGURES BY MONTH
JAIL FOUR

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	89	38	79	34	19	8	19	8	20	9	7	3	233	100
October	83	36	96	41	14	6	14	6	21	9	5	2	233	100
November	82	36	92	41	15	7	16	7	12	5	9	4	226	100
December	85	42	76	37	12	6	8	4	19	9	3	1	203	99*
January	50	33	69	46	6	4	6	4	8	5	11	7	150	99*
February	47	29	70	44	17	11	9	6	9	6	8	5	160	101*
TOTALS	436	36	482	40	83	7	72	6	89	7	43	4	1205	100

*Errors due to rounding

CHART 4

LENGTH OF STAY FIGURES BY MONTH
JAIL SIX [a]

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	41	11	171	47	59	16	29	8	3	<1	63	17	366	100
October	61	20	80	27	51	17	51	17	30	10	25	8	298	99*
November	40	11	146	40	63	17	33	9	43	12	40	11	365	100
December	49	13	194	52	55	15	35	9	27	7	15	4	375	100
January	55	14	158	41	55	14	23	6	28	7	69	18	388	100
February	45	16	101	36	50	18	15	5	30	11	41	15	282	101*
TOTALS	291	14	850	41	333	16	186	9	161	8	253	12	2074	100

a = Accuracy of these data is not definitely known.
*Errors due to rounding

CHART 5

LENGTH OF STAY FIGURES BY MONTH
JAIL SEVEN

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	17	27	20	32	7	11	7	11	8	13	4	6	63	100
October	11	17	21	32	8	12	5	8	9	14	11	17	65	100
November	12	24	16	31	6	12	7	14	5	10	5	10	51	101*
December	10	18	13	23	4	7	8	14	13	23	8	14	56	99*
January	6	16	5	14	3	8	6	16	5	14	12	32	37	100
February	4	12	6	18	3	9	13	39	3	9	4	12	33	99*
TOTALS	60	20	81	27	31	10	46	15	43	14	44	14	305	100

*Errors due to rounding

CHART 6

LENGTH OF STAY FIGURES BY MONTH
JAIL EIGHT [a]

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	22	27	39	48	4	5	7	9	3	4	6	7	81	100
October	22	30	35	48	5	7	3	4	7	10	1	1	73	100
November	22	30	28	38	6	8	6	8	5	7	7	9	74	100
December	----------		----------		----------	DATA NOT AVAILABLE		----------		----------		----------		
January	23	32	21	29	24	33	1	1	2	3	1	1	72	99*
February	5	8	31	48	21	32	2	3	2	3	4	6	65	100
TOTALS	94	26	154	42	60	16	19	5	19	5	19	5	365	99*

a=Accuracy of these data is not definitely known
*Errors due to rounding

CHART 7

LENGTH OF STAY FIGURES BY MONTH
JAIL NINE

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	3	50	0	0	0	0	0	0	2	33	1	17	6	100
October	1	33	2	67	0	0	0	0	0	0	0	0	3	100
November	1	20	2	40	0	0	1	20	1	20	0	0	5	100
December	3	50	2	33	0	0	0	0	0	0	1	17	6	100
January	2	33	3	50	0	0	0	0	0	0	1	17	6	100
February	2	33	2	33	1	17	1	17	0	0	0	0	6	100
TOTALS	12	38	11	34	1	3	2	6	3	9	3	9	32	99*

*Errors due to rounding

CHART 8

LENGTH OF STAY FIGURES BY MONTH
JAIL TEN

Month	24 Hours		1-7 Days		8-14 Days		15-30 Days		31-90 Days		90 Days		Total Releases	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
September	10	23	10	23	3	7	5	11	2	5	14	32	44	101*
October	10	22	11	24	3	7	7	15	8	17	7	15	46	100
November	9	20	10	22	9	20	8	17	1	2	9	20	46	100
December	7	18	16	41	4	10	3	8	3	8	6	15	39	100
January	13	30	12	27	6	14	3	7	5	11	5	11	44	100
February	16	28	16	28	5	9	4	7	9	16	7	12	57	100
TOTALS	65	24	75	27	30	11	30	11	28	10	48	17	276	100

*Errors due to rounding

APPENDIX J

TRANSPORTATION FOR HEALTH CARE REASONS
BY JAIL BY MONTH

Chart 1 - Jail One

Chart 2 - Jail Eight

Chart 3 - Jail Nine

Chart 4 - Jail Ten

Chart 5 - Jail Three

Chart 6 - Jail Four

Chart 7 - Jail Seven

Chart 8 - Jail Five

Chart 9 - Jail Six

CHART 1

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL ONE

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	0	0	2	0	0	0	0	0	1	0	0	3	3
October	0	0	0	0	0	0	0	0	0	0	0	0	0
November	0	2	0	0	0	0	0	0	1	0	2	1	3
December	0	2	1	0	0	0	0	1	1	0	3	2	5
January	0	0	4	0	0	0	0	0	2	0	0	6	6
February	0	0	5	0	0	0	0	1	0	0	1	5	6
TOTALS	0	4	12	0	0	0	0	2	5	0	6	17	23

CHART 2

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL EIGHT

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	1	1	2	0	0	0	(0	0	0	1	1	2	4
October	0	5	0	0	0	0	0	0	1	0	5	1	6
November	1	6	0	0	0	0	0	0	0	1	6	0	7
December	----------					DATA NOT AVAILABLE							----------
January	0	4	0	0	0	1	0	0	0	0	4	1	5
February	3	1	1	0	0	0	0	0	0	3	1	1	5
TOTALS	5	17	3	0	0	1	0	0	1	5	17	5	27

CHART 3

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL NINE

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	0	0	5	0	0	0	0	0	0	0	0	5	5
October	0	0	0	0	0	0	0	0	2	0	0	2	2
November	2	0	0	0	0	0	0	0	0	2	0	0	2
December	1	1	0	0	0	0	0	0	0	1	1	0	2
January	0	1	3	0	0	0	0	0	0	0	1	3	4
February	0	1	3	0	0	0	0	0	0	0	1	3	4
TOTALS	3	3	11	0	0	0	0	0	2	3	3	13	19

CHART 4

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL TEN

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	3	2	0	0	0	0	0	0	1	3	2	1	6
October	3	2	5	0	0	0	0	0	1	3	2	6	11
November	1	1	6	0	0	0	0	0	1	1	1	7	9
December	2	1	3	0	0	2	0	0	0	2	1	5	8
January	5	0	9	0	0	0	0	0	0	5	0	9	14
February	0	0	3	0	0	0	0	0	0	0	0	3	3
TOTALS	14	6	26	0	0	2	0	0	3	14	6	31	51

CHART 5

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL THREE

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	0	6	39	0	0	1	0	0	4	0	6	44	50
October	3	4	24	0	0	1	0	0	2	3	4	27	34
November	1	1	2	0	0	0	0	0	0	1	1	2	4
December	1	2	4	0	0	0	0	0	1	1	2	5	8
January	12	2	24	0	0	0	0	0	3	12	2	27	41
February	4	2	12	0	0	0	0	0	7	4	2	19	25
TOTALS	21	17	105	0	0	2	0	0	17	21	17	24	162

CHART 6

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL FOUR

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	2	0	4	0	0	0	0	0	1	2	0	5	7
October	5	1	7	0	1	1	0	0	2	5	2	10	17
November	1	0	3	0	0	0	0	0	2	1	0	5	6
December	3	1	4	0	0	0	0	0	1	3	1	5	9
January	4	1	3	0	0	0	0	0	2	4	1	5	10
February	1	0	2	0	0	2	0	0	7	1	0	11	12
TOTALS	16	3	23	0	1	3	0	0	15	16	4	41	61

CHART 7

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL SEVEN

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	0	26	23	0	0	1	0	0	3	0	26	27	53
October	2	30	8	0	0	0	0	0	1	2	30	9	41
November	4	22	11	0	0	1	0	0	2	4	22	14	40
December	4	22	7	0	0	1	0	0	10	4	22	18	44
January	6	19	7	0	0	2	0	1	0	6	20	9	35
February	3	2	10	0	0	1	0	0	2	3	2	13	18
TOTALS	19	121	66	0	0	6	0	1	18	19	122	90	231

CHART 8

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL FIVE

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	17	1	5	0	1	0	0	1	5	17	3	10	30
October	17	5	4	0	0	0	0	1	6	17	6	10	33
November	21	4	1	0	0	0	0	0	7	21	4	8	33
December	11	3	13	0	0	0	1	1	5	12	4	18	34
January	15	0	23	0	0	0	0	3	3	15	3	26	44
February	8	6	5	1	1	3	0	0	4	9	7	12	28
TOTALS	89	19	51	1	2	3	1	6	30	91	27	84	202

CHART 9

TRANSPORTATION FOR HEALTH CARE REASONS
JAIL SIX

Month	Non-Emergency			Emergency Within First 24 Hours			Later Emergencies			Total Trips			All
	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	Dental	Psychi-atric	Medical	
September	0	22	34	2	0	16	4	3	60	6	25	110	141
October	1	0	43	0	1	2	1	2	11	2	3	56	61
November	0	0	37	0	0	1	0	1	12	0	1	50	51
December	0	0	45	0	0	1	0	0	8	0	0	54	54
January	1	0	18	0	0	0	0	0	18	1	0	36	37
February	1	0	17	0	0	0	0	1	17	1	1	34	36
TOTALS	3	22	194	2	1	20	5	7	126	10	30	340	380

APPENDIX K

RESULTS OF SELECTED QUESTIONS
FROM THE INMATE QUESTIONNAIRE

Explanation of the Charts

EXPLANATION OF THE CHARTS

The charts which appear in this appendix represent the mean score responses to selected questions from the inmate questionnaire (see Appendix E for an example of the questionnaire). Charts were not compiled for those questions which had a significant number of missing answers or where a majority of the respondents answered "don't know."

Each chart has two measures of possible change. The first measure is the change in mean score between the group of inmates taking the pre-questionnaire at the time of the initial site visit and the group of inmates taking the post-questionnaire at the time of the follow-up visit. These two groups are composed of separate individuals. The second measure is the change in mean score of inmates taking the pre-questionnaire at the time of the initial site visit and the same inmates taking the post-questionnaire at the time of their release.

Those questions which dealt with opinions or attitudes were scored in such a way that a lower mean score represents a more favorable response. For example, "no, never" is a more favorable answer than "yes, sometimes" to the question "Are you ever concerned that you may become ill because you are in contact with an inmate who is sick and not being properly treated for his or her sickness?" Therefore, an answer of "no, never" would be scored "1" while an answer of "yes, sometimes" would be scored "2". Hence, the lower the mean score, the more favorable the overall response for an individual jail or for the total group of ten jails.

Changes in the mean score between the pre and post surveys represent a possible indication of an improvement or decline in inmate attitudes or opinions. The word possible should be emphasized because of the

extremely small sample sizes at each jail. Further, it should be noted that other factors could very easily have influenced the results at each jail besides a change in inmate attitudes or opinions. Some of these factors or biases may be: the manner in which the questionnaires were administered; the particular conditions in the jails on the days the questionnaires were administered; and for those inmates who responded to two questionnaires, a carry-over effect may exist from the first testing. Because of sample size and these possible biases, caution should be exercised when interpreting these charts.

CHART 1

Inmate Question # 1: Are you ever concerned that you may become ill becuase you are in contact with an inmate who is sick and not being properly treated for his or her sickness?
1=no,never; 2=yes,sometimes; 3=yes,a lot of the time; 4=yes,all the time

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	9	2.286	7	0	0	0	0
Two	1.167	6	1.667	9	1.250	4	1.250	4
Three	2.600	10	2.000	10	0	0	0	0
Four	2.111	9	1.667	9	2.333	6	2.333	6
Five	2.500	10	2.333	9	0	0	0	0
Six	2.556	9	2.200	10	2.714	7	2.000	7
Seven	2.100	10	2.818	11	2.167	6	1.833	6
Eight	1.556	9	1.500	8	0	0	0	0
Nine	1.000	4	1.286	7	0	0	0	0
Ten	1.400	10	1.889	9	1.375	8	1.250	8
TOTAL	2.023	86	2.000	89	1.999	31	1.742	31

Possible range of responses: 1-4

CHART 2

Inmate Question #2: Do you get the care you think you should be getting when you go on sick call?
1=yes,every time; 2=yes,most of the time; 3=yes,some of the time; 4=no,never

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.000	9	2.000	5	0	0	0	0
Two	1.333	3	2.167	6	1.333	3	1.750	4
Three	3.000	10	2.000	10	0	0	0	0
Four	2.500	10	2.333	9	2.667	6	2.500	6
Five	1.800	10	2.400	10	0	0	0	0
Six	2.400	10	2.100	10	2.857	7	1.714	7
Seven	3.400	10	3.455	11	3.667	6	3.000	6
Eight	2.625	8	2.143	7	0	0	0	0
Nine	1.000	4	1.800	5	0	0	0	0
Ten	2.333	9	2.778	9	2.143	7	1.625	8
TOTAL	2.506	83	2.390	82	2.655	29	2.096	31

Possible range of responses: 1-4

CHART 3

Inmate Question #3: How many times have you seen a doctor or medical person since you were admitted to this jail?
1=none; 2=one; 3-two or three; 4=four or five; 5=six to ten; 6=more than ten

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.556	9	2.571	7	0	0	0	0
Two	1.000	6	2.444	9	1.000	4	1.250	4
Three	2.100	10	2.600	10	0	0	0	0
Four	3.100	10	2.444	9	2.500	6	3.167	6
Five	4.778	9	4.100	10	0	0	0	0
Six	3.700	10	3.667	9	4.286	7	4.143	7
Seven	3.900	10	3.364	11	3.500	6	4.167	6
Eight	3.111	9	2.375	8	0	0	0	0
Nine	3.750	4	2.857	7	0	0	0	0
Ten	4.100	10	3.333	9	4.375	8	4.875	8
TOTAL	3.161	87	3.011	89	3.387	31	3.774	31

Possible range of responses: 1-6

CHART 4

Inmate Question #4: If an inmate had a heart attack, how good do you think the emergency action necessary to save his or her life would be?
1=very good; 2=good; 3=fair; 4=poor

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.556	9	3.833	6	0	0	0	0
Two	2.333	6	2.714	7	2.500	4	2.750	4
Three	3.300	10	3.000	10	0	0	0	0
Four	3.375	8	3.222	9	3.667	6	3.800	5
Five	3.100	10	3.000	9	.0	0	0	0
Six	2.667	9	2.700	10	2.714	7	2.000	7
Seven	3.500	10	3.727	11	3.500	6	3.000	6
Eight	2.556	9	3.125	8	0	0	0	0
Nine	1.750	4	1.857	7	0	0	0	0
Ten	3.000	10	3.556	9	3.000	8	2.375	8
TOTAL	3.012	85	2.826	86	3.097	31	2.700	30

Possible range of responses: 1-4

CHART 5

Inmate Question #5: Which words BEST describe the attitude of the jail doctor towards the health of the inmates? 1=he cares a lot and seems really concerned; 2=he cares a little and seems concerned some of the time; 3=he is indifferent and does not seem really concerned; 4=he is hostile and does not seem concerned at all

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	3	2.200	5	0	0	0	0
Two	1.500	2	1.333	6	1.500	2	1.500	2
Three	3.000	1	0	0	0	0	0	0
Four	2.333	9	1.778	9	2.333	6	2.400	5
Five	1.900	10	2.000	10	0	0	0	0
Six	1.400	10	1.700	10	1.429	7	1.571	7
Seven	2.800	10	2.909	11	3.000	6	2.333	6
Eight	1.750	8	2.000	7	0	0	0	0
Nine	1.333	3	1.000	5	0	0	0	0
Ten	1.900	10	2.111	9	1.750	8	1.500	8
TOTAL	2.000	66	1.972	72	2.035	29	1.857	28

Possible range of responses: 1-4

CHART 6

Inmate Question #6: Which words BEST describe the attitude of other medical staff towards the health of the inmates? 1=they care a lot and seem really concerned; 2=they care a little and seem concerned some of the time; 3=they are indifferent and do not seem really concerned; 4=they are hostile and do not seem concerned at all

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.667	3	1.750	4	0	0	0	0
Two	0.000	0	1.000	5	0	0	1.500	2
Three	2.750	4	1.333	6	0	0	0	0
Four	2.250	8	2.111	9	2.333	6	2.167	6
Five	2.000	10	1.800	10	0	0	0	0
Six	1.500	10	1.600	10	1.571	7	1.143	7
Seven	2.667	9	2.600	10	3.000	5	2.167	6
Eight	1.000	2	2.000	5	0	0	0	0
Nine	1.250	4	1.167	6	0	0	0	0
Ten	1.900	10	2.500	8	1.750	8	1.625	8
TOTAL	2.033	60	1.863	73	2.077	26	1.724	29

Possible range of responses: 1-4

CHART 7

Inmate Question #11: How much respect does the jail doctor show you?
1=a lot of respect; 2=some respect; 3=a little respect; 4=no respect

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.500	2	1.800	5	0	0	0	0
Two	3.000	1	1.500	6	3.000	1	2.333	3
Three	3.667	3	1.000	2	0	0	0	0
Four	1.750	8	1.875	8	2.000	6	2.167	6
Five	1.778	9	2.143	7	0	0	0	0
Six	1.900	10	1.500	10	2.000	7	2.000	7
Seven	3.100	10	3.273	11	3.333	6	3.167	6
Eight	1.714	7	2.143	7	0	0	0	0
Nine	1.333	3	1.400	5	0	0	0	0
Ten	1.889	9	2.556	9	1.571	7	1.375	8
TOTAL	2.129	62	2.086	70	2.222	27	2.133	30

Possible range of responses: 1-4

CONTINUED

4 OF 6

CHART 8

Inmate Question #12: How often do you feel inmates go on sick call who don't really need to see a medical person?
1=never; 2=sometimes; 3=often; 4=very often

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.200	5	2.000	6	0	0	0	0
Two	2.000	5	1.222	9	2.000	3	2.000	2
Three	1.889	9	2.250	8	0	0	0	0
Four	2.125	8	2.375	8	2.167	6	3.167	6
Five	2.111	9	2.125	8	0	0	0	0
Six	2.500	10	2.667	9	2.571	7	2.857	7
Seven	2.300	10	2.091	11	2.333	6	2.667	6
Eight	2.444	9	2.143	7	0	0	0	0
Nine	1.500	4	1.667	6	0	0	0	0
Ten	3.000	9	2.000	9	2.857	7	2.625	8
TOTAL	2.269	78	2.062	81	2.448	29	2.760	29

Possible range of responses: 1-4

CHART 7

Inmate Question #11: How much respect does the jail doctor show you?
1=a lot of respect; 2=some respect; 3=a little respect; 4=no respect

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.500	2	1.800	5	0	0	0	0
Two	3.000	1	1.500	6	3.000	1	2.333	3
Three	3.667	3	1.000	2	0	0	0	0
Four	1.750	8	1.875	8	2.000	6	2.167	6
Five	1.778	9	2.143	7	0	0	0	0
Six	1.900	10	1.500	10	2.000	7	2.000	7
Seven	3.100	10	3.273	11	3.333	6	3.167	6
Eight	1.714	7	2.143	7	0	0	0	0
Nine	1.333	3	1.400	5	0	0	0	0
Ten	1.889	9	2.556	9	1.571	7	1.375	8
TOTAL	2.129	62	2.086	70	2.222	27	2.133	30

Possible range of responses: 1-4

CHART 9

Inmate Question # 13: When the doctor sees you on sick call, do you think he spends enough time with you?
1=yes,every time; 2=yes,most of the time; 3=yes,sometimes; 4=no,never

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.500	2	1.500	4	0	0	0	0
Two	2.000	2	1.000	2	2.000	1	2.000	2
Three	3.000	6	1.000	1	0	0	0	0
Four	2.111	9	2.333	9	2.000	6	2.500	6
Five	1.667	9	2.875	8	0	0	0	0
Six	1.700	10	2.200	10	1.857	7	2.143	7
Seven	3.400	10	3.364	11	3.667	6	3.667	6
Eight	1.875	8	1.667	6	0	0	0	0
Nine	1.250	4	1.286	7	0	0	0	0
Ten	2.444	9	2.778	9	2.286	7	1.375	8
TOTAL	2.261	69	2.328	67	2.408	27	2.310	29

Possible range of responses: 1-4

CHART 10

Inmate Question #14: When other medical staff see you on sick call, do you think they spend enough time with you? 1=yes,every time; 2=yes,most of the time; 3=yes,sometimes; 4=no,never.

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	4.000	1	3.000	4	0	0	0	0
Two	3.000	1	1.000	3	0	0	2.000	1
Three	3.200	5	1.714	7	0	0	0	0
Four	2.500	6	2.714	7	3.000	3	2.750	4
Five	2.100	10	2.444	9	0	0	0	0
Six	1.800	10	2.000	10	2.000	7	2.000	7
Seven	3.444	9	3.400	10	3.800	5	3.400	5
Eight	3.000	3	2.000	5	0	0	0	0
Nine	1.500	4	1.286	7	0	0	0	0
Ten	2.750	8	3.143	7	2.667	6	1.333	6
TOTAL	2.544	57	2.362	69	2.762	21	2.261	23

Possible range of responses: 1-4

CHART 11

Inmate Question #15: Has your health changed since you have been in this jail?
1=yes,it has gotten a lot better; 2=yes,it has gotten a little better; 4=yes,but it has gotten a little worse; 5=yes,but it has gotten a lot worse; 3=no,it has stayed the same

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	4.000	8	3.143	7	0	0	0	0
Two	2.833	6	3.556	9	2.750	4	3.500	4
Three	4.400	10	3.333	9	0	0	0	0
Four	3.333	9	3.778	9	3.333	6	3.833	6
Five	2.556	9	3.111	9	0.	0	0	0
Six	2.800	10	2.800	10	3.000	7	3.143	7
Seven	4.000	10	3.273	11	4.167	6	3.500	6
Eight	3.000	9	3.857	7	0	0	0	0
Nine	2.250	4	2.429	7	0	0	0	0
Ten	2.000	10	4.000	9	2.000	8	2.000	8
TOTAL	3.176	85	3.333	87	3.000	31	3.097	31

Possible range of responses: 1-5

CHART 12

Inmate Question #16: How good is the care given to inmates in this jail who have mental problems?
1=very good; 2=good;3=fair; 4=poor; 5=don't know

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.667	6	3.833	6	0	0	0	0
Two	3.000	3	3.000	2	3.500	2	3.000	2
Three	4.000	7	3.333	3	0	0	0	0
Four	3.600	5	3.000	4	3.500	4	3.200	5
Five	3.000	8	3.000	8	0	0	0	0
Six	3.000	6	2.778	9	3.000	3	2.500	4
Seven	3.750	8	3.750	8	4.000	4	3.250	4
Eight	3.000	6	3.000	6	0	0	0	0
Nine	2.000	2	1.600	5	0	0	0	0
Ten	2.625	8	3.250	8	2.500	6	2.143	7
TOTAL	3.254	59	3.085	59	3.210	19	2.727	22

Possible range of responses: 1-5

CHART 13

Inmate Question #17: How often do you have a medical problem but decide not to go on sick call because you feel it will not be treated?
1=never; 2=sometimes; 3=most of the time; 4=all of the time

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.857	7	2.000	6	0	0	0	0
Two	1.500	6	1.556	9	1.500	4	1.500	4
Three	2.250	8	1.444	9	0	0	0	0
Four	2.125	8	2.000	9	2.200	5	1.833	6
Five	1.667	9	2.100	10	0	0	0	0
Six	1.800	10	2.000	10	2.143	7	1.571	7
Seven	2.600	10	2.400	10	2.667	6	1.833	6
Eight	1.222	9	1.625	8	0	0	0	0
Nine	1.000	4	1.167	6	0	0	0	0
Ten	1.600	10	2.222	9	1.375	8	2.125	8
TOTAL	1.815	81	1.884	86	1.967	30	1.806	31

Possible range of responses: 1-4

CHART 14

Inmate Question # 18: If an emergency medical situation occurred in the jail that required immediate action in order to prevent death, how confident are you that the proper life-saving procedure would be performed?
1=very confident; 2=fairly confident; 3=somewhat confident; 4=not at all confident

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.625	8	3.714	7	0	0	0	0
Two	2.500	6	2.625	8	2.250	4	2.500	4
Three	3.250	8	3.000	8	0	0	0	0
Four	3.111	9	2.889	9	3.167	6	3.500	6
Five	2.556	9	2.600	10	0	0	0	0
Six	2.700	10	2.600	10	2.857	7	2.143	7
Seven	2.900	10	3.000	10	3.167	6	3.000	6
Eight	2.556	9	3.000	7	0	0	0	0
Nine	1.250	4	1.667	6	0	0	0	0
Ten	2.900	10	3.333	9	3.000	8	2.250	8
TOTAL	2.819	83	2.857	84	2.936	31	2.645	31

Possible range of responses: 1-4

CHART 15

Inmate Question # 19: Have you ever been denied access to dental care when you felt you really needed it?
1=no, never; 2=yes, one time; 3=yes, several times; 4=yes, all the time

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.250	8	1.500	6	0	0	0	0
Two	1.167	6	1.000	9	1.250	4	1.250	4
Three	1.286	7	1.200	10	0	0	0	0
Four	1.750	8	1.750	8	2.000	5	1.333	6
Five	1.556	9	1.375	8	0	0	0	0
Six	1.500	10	1.500	10	1.571	7	1.429	7
Seven	1.700	10	1.818	11	2.000	6	2.000	6
Eight	1.143	7	1.286	7	0	0	0	0
Nine	1.250	4	1.000	7	0	0	0	0
Ten	1.333	9	1.167	6	1.429	7	1.143	7
TOTAL	1.423	78	1.378	82	1.655	29	1.433	30

Possible range of responses: 1-4

CHART 16

Inmate Question #21: How easy is it to get a pill to calm your nerves down or help you sleep:
1=very hard; 2=pretty hard; 3=pretty easy; 4=very easy

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.250	8	1.800	5	0	0	0	0
Two	2.000	3	2.000	7	2.000	2	2.667	3
Three	1.000	9	1.125	8	0	0	0	0
Four	2.375	8	1.375	8	2.800	5	1.833	6
Five	1.444	9	2.000	8	0	0	0	0
Six	2.333	9	1.600	10	2.143	7	1.167	6
Seven	1.300	10	1.600	10	1.333	6	1.500	6
Eight	1.800	5	1.500	6	0	0	0	0
Nine	3.000	4	2.500	6	0	0	0	0
Ten	1.375	8	1.889	9	1.429	7	2.375	8
TOTAL	1.685	73	1.714	77	1.889	27	1.862	29

Possible range of responses: 1-4

CHART 17

Inmate Question #22: Has this jail's health care system changed any since you were admitted?
1=yes; 2=no; 3=don't know

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.857	7	1.500	6	0	0	0	0
Two	2.000	1	1.167	6	2.000	1	2.000	3
Three	2.000	8	1.429	7	0	0	0	0
Four	1.333	3	2.000	3	1.000	2	2.000	4
Five	1.625	8	2.000	6	0	0	0	0
Six	1.250	8	1.333	6	1.000	6	1.000	5
Seven	2.000	7	2.000	9	2.000	4	1.500	6
Eight	2.000	7	1.750	8	0	0	0	0
Nine	2.000	3	2.000	4	0	0	0	0
Ten	1.333	6	2.000	6	1.200	5	1.429	7
TOTAL	1.724	58	1.705	61	1.333	18	1.520	25

Possible range of responses: 1-3

CHART 18

Inmate Question # 22(b): What effect have these changes had on this jail's health care system?
1=made it a lot better; 2=made it a little better; 3=made it neither better nor worse;
4=made it a little worse; 5=made it a lot worse

	Inmates completing pre-questionnaire at time of initial site visit		Inmates completing post-questionnaire at time of follow-up visit		Inmates completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of release			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.250	4	2.000	2	0	0	0	0
Two	0.000	0	2.200	5	0	0	0	0
Three	2.667	3	2.000	4	0	0	0	0
Four	2.250	4	2.667	3	2.333	3	2.750	4
Five	1.667	3	2.200	5	0	0	0	0
Six	1.286	7	1.250	4	1.333	6	1.667	6
Seven	4.000	2	4.000	7	3.000	1	2.667	6
Eight	0.000	0	2.500	4	0	0	0	0
Nine	1.000	1	2.667	3	0	0	0	0
Ten	2.200	5	1.000	1	2.200	5	1.250	4
TOTAL	2.069	29	2.632	38	1.933	15	2.100	20

Possible range of responses: 1-4

APPENDIX L

RESULTS OF SELECTED QUESTIONS FROM THE BOOKING OFFICER QUESTIONNAIRE

Explanation of the Charts

EXPLANATION OF THE CHARTS

The charts which appear in this appendix represent the mean score responses from the booking officer questionnaire (see Appendix F for an example of the questionnaire). Charts were not compiled for questions four and five where mean score responses would not be meaningful.

Each chart has two measures of possible change. The first measure is the change in mean score between the group of all booking officers completing the pre-questionnaire at the time of the initial site visit and the group of all booking officers completing the post-questionnaire at the time of the follow-up site visit. The second measure is the change in mean score between only those booking officers completing both the pre-questionnaire at the time of the initial site visit and the post-questionnaire at the time of the follow-up site visit. These booking officers are a sub-group of all booking officers completing the pre and post-questionnaire.

Those questions which dealt with opinions or attitudes (Charts 1, 4, 5, 6, 7, 8, 9, 10, 11) were coded in such a way that a lower mean score represents a more favorable response. For example, "excellent" is a more favorable answer than "good" to the question "How would you rate the health care in this jail?" Therefore, an answer of "excellent" would be scored "1" while an answer of "good" would be scored "2." Hence, the lower the mean score, the more favorable the overall response for an individual jail or the total group of ten jails. Changes in the mean score between the pre and post surveys represent a possible indication of an improvement or decline in booking officer opinions or attitudes.

Those questions which dealt with the hypothetical medical situations (Charts 13 through 30) have no one response that is necessarily correct. However, some responses may be considered more correct than others. Given a certain situation, a booking officer may be considered to be over-reacting or under-reacting, but the most correct response would be neither an over nor under reaction. Therefore, changes in the mean score between the pre and post surveys toward the more preferred response represent a possible indication of an improvement in booking officer response.

The word possible should be emphasized when looking at the changes which indicate improvement or decline in booking officer responses. First of all it should be noted that the sample size is small. Furthermore, for those booking officers who responded to two questionnaires, a carry-over effect may exist from the first testing. Other biases may also be present which were discussed in the body of this report. Therefore, caution should be exercised when interpreting these charts.

CHART 1

Booking Officer Question #1: How would you rate the health care in this jail?
1=excellent; 2=good; 3=fair; 4=poor

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.000	9	1.889	9	1.857	7	1.857	7
Two	2.000	1	1.667	3	2.000	1	1.000	1
Three	2.750	8	2.500	6	3.000	5	2.600	5
Four	2.000	1	2.000	2	2.000	1	2.000	1
Five	1.833	6	2.000	5	1.750	4	1.750	4
Six	1.800	5	1.200	5	1.800	5	1.200	5
Seven	1.846	13	1.687	16	1.667	9	1.556	9
Eight	2.714	7	2.143	7	2.667	3	2.333	3
Nine	1.333	6	1.800	5	1.400	5	1.800	5
Ten	2.000	7	2.250	4	1.750	4	2.250	4
TOTAL	2.048	63	1.887	62	1.932	44	1.841	44

Possible range of responses: 1-4

CHART 2

Booking Officer Question #2: How long have you worked as a booking officer at this jail?
1=less than three months; 2=three months to a year; 3=one to two years;
4=two to five years; 5=more than five years

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.889	9	3.333	9	3.857	7	3.429	7
Two	4.000	1	4.333	3	4.000	1	4.000	1
Three	3.500	8	3.500	6	3.400	5	3.600	5
Four	1.000	1	2.500	2	1.000	1	2.000	1
Five	4.500	6	3.800	5	4.500	4	4.250	4
Six	5.000	5	4.600	5	5.000	5	4.600	5
Seven	3.308	13	3.250	16	3.667	9	3.778	9
Eight	3.429	7	2.857	7	3.333	3	3.667	3
Nine	2.500	6	2.600	5	2.400	5	2.600	5
Ten	4.000	7	4.500	4	4.500	4	4.500	4
TOTAL	3.651	63	3.452	62	3.750	44	3.727	44

Possible range of responses: 1-5

CHART 3

Booking Officer Question #3: What percent of all prisoners brought in for booking would you estimate need some form of medical treatment?
1=less than 10%; 2=10%-25%; 3=26%-50%; 4=51%-75%; 5=more than 75%

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.556	9	1.778	9	2.429	7	1.714	7
Two	1.000	1	2.333	3	1.000	1	2.000	1
Three	1.375	8	1.833	6	1.400	5	2.000	5
Four	1.000	1	1.500	2	1.000	1	1.000	1
Five	2.500	6	2.400	5	2.500	4	2.500	4
Six	1.400	5	1.400	5	1.400	5	1.400	5
Seven	1.846	13	1.500	16	2.000	9	1.333	9
Eight	1.857	7	2.714	7	2.000	3	1.667	3
Nine	1.500	6	1.800	5	1.400	5	1.800	5
Ten	1.429	7	1.500	4	1.250	4	1.500	4
TOTAL	1.810	63	1.839	62	1.796	44	1.682	44

Possible range of responses: 1-5

CHART 4

Booking Officer Question #6: How often are you uncertain of what medical action should be taken when a prisoner is brought in with a health problem?
1=never; 2=occasionally; 3=frequently; 4=very often

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.444	9	1.778	9	2.571	7	1.857	7
Two	2.000	1	2.333	3	2.000	1	2.000	1
Three	2.625	8	1.833	6	2.600	5	1.800	5
Four	2.000	1	3.000	2	2.000	1	3.000	1
Five	2.333	6	1.600	5	2.000	4	1.750	4
Six	2.000	5	2.400	5	2.000	5	2.400	5
Seven	2.077	13	1.875	16	1.889	9	2.000	9
Eight	2.000	7	1.875	8	2.000	3	1.750	4
Nine	2.000	6	1.800	5	2.000	5	1.800	5
Ten	1.714	7	2.000	4	1.750	4	2.000	4
TOTAL	2.159	63	1.937	63	2.111	44	1.956	45

Possible range of responses: 1-4

CHART 5

Booking Officer Question #7: How many prisoners brought in for booking with medical complaints complain about medical problems that are not nearly as serious as they make out?
1=none of them; 2=some of them; 3=most of them; 4=all of them

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	3.000	9	3.000	9	3.000	7	3.143	7
Two	2.000	1	2.000	3	2.000	1	2.000	1
Three	2.625	8	2.667	6	2.800	5	2.800	5
Four	2.000	1	2.000	2	2.000	1	2.000	1
Five	2.667	6	2.400	5	2.500	4	2.500	4
Six	2.200	5	2.600	5	2.200	5	2.600	5
Seven	2.462	13	2.375	16	2.333	9	2.444	9
Eight	2.714	7	2.875	8	2.667	3	3.000	4
Nine	2.333	6	2.400	5	2.200	5	2.400	5
Ten	2.286	7	2.750	4	2.000	4	2.750	4
TOTAL	2.540	63	2.571	63	2.467	44	2.667	45

Possible range of responses: 1-4

CHART 6

Booking Officer Question #8: How often at booking do you feel inmates are needlessly sent to the hospital or the doctor simply as a precautionary measure?
1=never; 2=seldom; 3=often; 4=very often

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	9	1.889	9	2.429	7	1.857	7
Two	3.000	1	2.000	3	3.000	1	2.000	1
Three	3.250	8	3.167	6	3.400	5	3.400	5
Four	2.000	1	2.000	2	2.000	1	2.000	1
Five	2.167	6	2.400	5	2.000	4	2.750	4
Six	3.750	4	2.800	5	3.750	4	2.800	5
Seven	1.923	13	2.375	16	1.889	9	2.333	9
Eight	2.429	7	2.000	8	2.333	3	1.750	4
Nine	2.333	6	2.200	5	2.400	5	2.200	5
Ten	2.286	7	2.000	4	2.250	4	2.000	4
TOTAL	2.452	62	2.302	63	2.477	43	2.363	45

Possible range of responses: 1-4

CHART 7

Booking Officer Question #9: Are you ever concerned that you may become ill because you are in contact with an inmate who is sick and not being properly treated for his sickness?
1=no,never; 2=yes,occasionally; 3=yes,quite often; 4=yes,it is a constant concern

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.889	9	1.444	9	1.714	7	1.429	7
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	2.000	8	2.833	6	2.400	5	2.600	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.800	5	2.000	5	2.000	4	2.000	4
Six	1.800	5	1.400	5	1.800	5	1.400	5
Seven	1.462	13	1.500	14	1.333	9	1.250	8
Eight	2.286	7	1.625	8	2.000	3	1.750	4
Nine	1.333	6	1.600	5	1.400	5	1.600	5
Ten	1.429	7	1.250	4	1.000	4	1.250	4
TOTAL	1.710	62	1.623	61	1.614	44	1.591	44

Possible range of responses: 1-4

CHART 8

Booking Officer Question #10: In your opinion, how good is your jail's procedure for detecting and handling potential suicides?
1=very good; 2=good; 3=fair; 4=poor

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.222	9	2.667	9	2.000	7	2.571	7
Two	2.000	1	1.667	3	2.000	1	1.000	1
Three	3.625	8	2.833	6	3.600	5	2.800	5
Four	1.000	1	2.000	2	1.000	1	1.000	1
Five	2.333	6	2.600	5	2.250	4	2.250	4
Six	2.000	5	1.800	5	2.000	5	1.800	5
Seven	2.000	13	1.687	16	2.111	9	1.889	9
Eight	2.714	7	2.375	8	2.667	3	2.250	4
Nine	1.667	6	1.600	5	1.800	5	1.600	5
Ten	2.429	7	2.000	4	2.500	4	2.000	4
TOTAL	2.349	63	2.127	63	2.267	44	2.089	45

Possible range of responses: 1-4

CHART 9

Booking Officer Question #11: How good do you think your jail's procedure is for detecting and treating inmates with communicable diseases?
1=very good; 2=good; 3=fair; 4=poor

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	9	3.000	9	2.286	7	3.143	7
Two	2.000	1	1.333	3	2.000	1	1.000	1
Three	3.500	8	2.833	6	3.400	5	2.800	5
Four	1.000	1	1.500	2	1.000	1	1.000	1
Five	2.600	5	2.000	5	2.667	3	1.500	4
Six	1.600	5	1.600	5	1.600	5	1.600	5
Seven	2.000	13	1.800	15	2.000	9	1.556	9
Eight	2.429	7	2.125	8	2.333	3	2.500	4
Nine	1.667	6	2.400	5	1.800	5	2.400	5
Ten	2.429	7	2.500	4	2.500	4	2.500	4
TOTAL	2.306	62	2.177	62	2.227	43	2.182	45

Possible range of responses: 1-4

CHART 10

Booking Officer Question # 12: In your opinion, how often do prisoners who are a danger to themselves, other inmates or jail personnel get booked and placed into the general inmate population at your jail?
1=never; 2=seldom; 3=sometimes; 4=frequently

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.444	9	2.778	9	2.286	7	2.857	7
Two	1.000	1	2.333	3	1.000	1	3.000	1
Three	3.125	8	2.833	6	3.400	5	2.800	5
Four	2.000	1	2.500	2	2.000	1	2.000	1
Five	2.500	6	2.600	5	2.750	4	2.500	4
Six	2.200	5	2.200	5	2.200	5	2.200	5
Seven	1.923	13	2.250	16	1.889	9	2.222	9
Eight	2.857	7	2.125	8	2.667	3	1.750	4
Nine	1.500	6	1.400	5	1.600	5	1.400	5
Ten	2.286	7	2.250	4	2.250	4	2.250	4
TOTAL	2.317	63	2.333	63	2.289	44	2.289	45

Possible range of responses: 1-4

CHART 11

Booking Officer Question #13: Using your present booking procedure, how sure are you that prisoners who are a danger to themselves, other inmates or jail personnel will be identified at booking and handled in such a manner that no harm occurs?
1=very sure; 2=fairly sure; 3=unsure; 4=very unsure

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.222	9	2.556	9	2.143	7	2.571	7
Two	2.000	1	1.667	3	2.000	1	1.000	1
Three	3.000	8	2.333	6	2.800	5	2.200	5
Four	1.000	1	1.500	2	1.000	1	1.000	1
Five	2.333	6	2.200	5	2.500	4	2.000	4
Six	1.800	5	1.800	5	1.800	5	1.800	5
Seven	1.769	13	2.067	15	1.778	9	2.000	9
Eight	2.286	7	1.625	8	2.333	3	1.750	4
Nine	1.833	6	1.600	5	2.000	5	1.600	5
Ten	2.333	6	2.250	4	2.000	4	2.250	4
TOTAL	2.161	62	2.032	62	2.089	44	2.000	45

Possible range of responses: 1-4

CHART 12

Booking Officer Question #14: Of all the prisoners that you booked within the last six months, how many would you estimate proved to be a danger to themselves, other inmates, or jail personnel within the first 48 hours of booking?
(Give a number)

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.444	9	1.444	9	1.571	7	1.857	7
Two	150.000	1	0.000	2	150.000	1	0	0
Three	7.750	8	14.500	6	11.800	5	15.400	5
Four	5.000	1	4.500	2	5.000	1	5.000	1
Five	24.667	6	3.500	4	7.000	4	3.500	4
Six	9.400	5	8.000	5	9.400	5	8.000	5
Seven	1.615	13	1.313	16	1.444	9	1.333	9
Eight	3.571	7	7.125	8	4.000	3	1.250	4
Nine	1.500	6	2.200	5	1.400	5	2.200	5
Ten	2.857	7	2.750	4	2.000	4	2.750	4
TOTAL	7.937	63	4.311	61	4.341	44	4.273	44

Possible range of responses: 0-150

CHART 13

Booking Officer Question #B-1: Hypothetical situation regarding claim of police brutality with poke in the abdomen with a billy club. Does this situation present a medical problem? 1=yes; 2=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.222	9	1.222	9	1.143	7	1.143	7
Two	1.000	1	1.333	3	1.000	1	1.000	1
Three	1.125	8	1.333	6	1.200	5	1.400	5
Four	2.000	1	1.500	2	2.000	1	2.000	1
Five	1.167	6	1.400	5	1.250	4	1.250	4
Six	1.000	4	1.250	4	1.000	4	1.250	4
Seven	1.692	13	1.533	15	1.667	9	1.556	9
Eight	1.429	7	1.375	8	1.333	3	1.250	4
Nine	1.000	6	1.200	5	1.000	5	1.200	5
Ten	1.571	7	1.667	3	1.500	4	1.667	3
TOTAL	1.321	62	1.381	60	1.309	43	1.372	43

Possible range of responses: 1-2

CHART 14

Booking Officer Question #B-1: Hypothetical situation regarding claim of police brutality with poke in the abdomen with a billy club. What would you do at booking given this situation? 1=have inmate immediately transported to hospital, clinic, etc.; 2=consult with medical authority by phone about proper action to take; 3=have doctor check out inmate (presumably at later time); 4=wait but closely observe; 5=do essentially nothing

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	9	2.000	8	2.143	7	1.667	6
Two	2.000	1	2.000	2	2.000	1	2.000	1
Three	1.750	8	2.500	6	1.600	5	2.800	5
Four	5.000	1	3.000	2	5.000	1	4.000	1
Five	2.500	6	2.800	5	3.000	4	3.000	4
Six	1.600	5	2.200	5	1.600	5	2.200	5
Seven	3.667	12	3.571	14	3.444	9	3.444	9
Eight	3.429	7	2.375	8	3.667	3	1.500	4
Nine	2.000	6	2.500	4	2.200	5	2.500	4
Ten	2.857	7	3.333	3	2.000	4	3.333	3
TOTAL	2.714	62	2.628	60	2.305	44	2.644	42

Possible range of responses: 1-5

CHART 15

Booking Officer Question # B-1: Hypothetical situation regarding claim of police brutality with poke in the abdomen with a billy club. Why would you follow this procedure? 1=correctly identifies possible trauma; 2=does not identify possible trauma but shows concern for inmate's welfare; 3=does not identify possible trauma but shows concern for jail's responsibility; 4=does not identify possible trauma

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.714	7	2.200	5	1.833	6	2.250	4
Two	1.000	1	2.000	2	1.000	1	3.000	1
Three	1.333	6	2.000	2	1.400	5	2.000	2
Four	1.000	1	1.000	1	1.000	1	0	0
Five	2.333	3	2.000	2	1.000	1	2.000	2
Six	1.000	1	1.000	3	1.000	1	1.000	3
Seven	2.750	12	2.750	4	2.667	9	2.750	4
Eight	3.000	5	2.000	5	2.667	3	1.000	2
Nine	2.500	4	1.000	2	2.333	3	1.000	2
Ten	3.000	1	3.000	1	0	0	3.000	1
TOTAL	1.963	41	1.895	27	1.490	30	1.800	21

Possible range of responses: 1-4

CHART 16

Booking Officer Question # B-2: Hypothetical situation regarding apparently intoxicated prisoner with sweet-smelling breath.
Does this situation present a medical problem?
1=yes; 2=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.000	9	1.222	9	1.000	7	1.143	7
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	1.000	7	1.000	6	1.000	4	1.000	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.000	5	1.000	5	1.000	3	1.000	4
Six	1.000	5	1.000	5	1.000	5	1.000	5
Seven	1.000	13	1.071	14	1.000	9	1.000	9
Eight	1.143	7	1.000	8	1.333	3	1.000	4
Nine	1.000	6	1.200	5	1.000	5	1.200	5
Ten	1.000	7	1.000	3	1.000	4	1.000	3
TOTAL	1.014	61	1.049	60	1.033	42	1.034	44

Possible range of responses: 1-2

CHART 17

Booking Officer Question #B-2: Hypothetical situation regarding apparently intoxicated prisoner with sweet-smelling breath.
What would you do at booking given this situation?
1=have inmate immediately transported to hospital, clinic, etc.; 2=consult with medical authority by phone about proper action; 3=have doctor check out inmate; 4=wait but closely observe for further developments

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.778	9	2.222	9	1.714	7	2.000	7
Two	2.000	1	1.667	3	2.000	1	2.000	1
Three	1.500	6	1.000	5	1.000	3	1.000	4
Four	2.000	1	2.000	2	2.000	1	2.000	1
Five	2.600	5	1.600	5	3.000	3	1.750	4
Six	1.800	5	1.600	5	1.800	5	1.600	5
Seven	2.692	13	2.308	13	2.444	9	2.125	8
Eight	1.667	6	1.375	8	1.667	3	1.250	4
Nine	1.833	6	2.600	5	2.000	5	2.600	5
Ten	1.667	6	1.500	2	2.333	3	1.500	2
TOTAL	1.894	58	1.787	57	1.996	40	1.657	41

Possible range of responses: 1-5

CHART 18

Booking Officer Question #B-2: Hypothetical situation regarding apparently intoxicated prisoner with sweet-smelling breath. Why should this procedure be followed"
1=correctly identifies possible onset of diabetic attack; 2=does not identify possible onset of diabetic attack but does show concern for inmate's welfare; 3=does not identify possible onset but does show concern for jail's responsibility; 4=does not identify possible onset of diabetic attack

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.000	7	2.500	2	2.400	5	2.500	2
Two	1.000	1	1.000	2	1.000	1	1.000	1
Three	2.000	4	1.600	5	2.000	3	1.750	4
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	2.200	5	1.800	5	2.333	3	2.000	4
Six	1.000	4	1.000	5	1.000	4	1.000	5
Seven	1.900	10	1.667	12	1.857	7	1.143	7
Eight	2.400	5	1.857	7	2.333	3	1.750	4
Nine	1.800	5	1.333	3	1.750	4	1.333	3
Ten	1.500	4	1.667	3	2.000	2	1.667	3
TOTAL	1.680	46	1.542	46	1.767	33	1.514	34

Possible range of responses: 1-4

CHART 19

Booking Officer Question # B-3: Hypothetical situation regarding local derelict with the shakes. Does this situation present a medical problem?
1=yes; 2=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.000	9	1.000	9	1.000	7	1.000	7
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	1.250	8	1.333	6	1.200	5	1.400	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.000	6	1.000	5	1.000	4	1.000	4
Six	1.000	5	1.000	5	1.000	5	1.000	5
Seven	1.000	13	1.071	14	1.000	9	1.000	9
Eight	1.000	7	1.000	7	1.000	3	1.000	4
Nine	1.167	6	1.200	5	1.200	5	1.200	5
Ten	1.143	7	1.333	3	1.250	4	1.333	3
TOTAL	1.056	63	1.094	59	1.065	44	1.093	44

Possible range of responses: 1-2

CHART 20

Booking Officer Question # B-3: Hypothetical situation regarding local derelict with the shakes. What would you do at booking given this situation? 1=have inmate immediately transported to hospital, clinic, etc.; 2=consult with medical authority (by phone) about proper action to take; 3=have doctor check out inmate; 4=wait but closely observe for further developments; 5=do essentially nothing

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.889	9	1.556	9	2.143	7	1.571	7
Two	2.000	1	1.667	3	2.000	1	1.000	1
Three	3.375	8	3.000	5	3.600	5	3.500	4
Four	2.000	1	1.500	2	2.000	1	2.000	1
Five	2.667	6	1.800	5	2.750	4	1.750	4
Six	2.000	4	1.800	5	2.000	4	1.800	5
Seven	3.231	13	2.857	14	3.556	9	2.778	9
Eight	2.167	6	2.000	8	2.333	3	1.750	4
Nine	1.833	6	1.750	4	2.000	5	1.750	4
Ten	2.714	7	3.000	2	3.000	4	3.000	2
TOTAL	2.388	61	2.093	57	2.538	[illegible]	2.090	41

Possible range of responses: 1-5

CHART 21

Booking Officer Question #B-3: Hypothetical situation regarding local derelict with the shakes. Why would you follow this procedure?
1=correctly identifies possible onset of the DTs and/or serious mental problem;
2=does not correctly identify possible onset of DTs but shows concern for inmate's welfare;3=does not identify possible onset but shows concern for jail's responsibility;
4=does not identify possible onset of DTs

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.333	6	1.000	3	1.000	4	1.000	3
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	2.167	6	2.250	4	2.400	5	2.667	3
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.667	6	1.000	5	1.250	4	1.000	4
Six	1.000	3	1.000	3	1.000	3	1.000	3
Seven	2.333	9	1.400	10	2.167	6	1.167	6
Eight	1.833	6	1.143	7	1.000	3	1.000	4
Nine	1.400	5	1.000	4	1.500	4	1.000	4
Ten	1.333	3	2.000	2	2.000	1	2.000	2
TOTAL	1.507	46	1.279	43	1.432	32	1.283	31

Possible range of responses: 1-4

CHART 22

Booking Officer Question #B-4: Hypothetical situation regarding drunk with bump on head who falls asleep. Does this situation present a medical problem?
1=yes; 2=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.000	9	1.000	9	1.000	7	1.000	7
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	1.000	8	1.000	6	1.000	5	1.000	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.000	6	1.000	5	1.000	4	1.000	4
Six	1.000	5	1.000	5	1.000	5	1.000	5
Seven	1.154	13	1.133	15	1.111	9	1.111	9
Eight	1.000	7	1.000	8	1.000	3	1.000	4
Nine	1.000	6	1.000	5	1.000	5	1.000	5
Ten	1.000	6	1.000	3	1.000	3	1.000	3
TOTAL	1.015	62	1.013	61	1.011	43	1.011	44

Possible range of responses: 1-2

CHART 23

Booking Officer Question #B-4: Hypothetical situation regarding drunk with bump on head who falls asleep. What would you do at booking given this situation and why? 1=have inmate immediately transported to hospital, clinic, etc.; 2=consult with medical authority (by phone) about proper action to take; 3=have doctor check out inmate (later); 4=wait but closely observe for further developments; 5=do essentially nothing

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.556	9	1.444	9	1.714	7	1.571	7
Two	2.000	1	2.000	3	2.000	1	2.000	1
Three	1.375	8	1.000	6	1.400	5	1.000	5
Four	2.000	1	2.000	2	2.000	1	2.000	1
Five	1.667	6	1.400	5	1.750	4	1.250	4
Six	1.250	4	1.400	5	1.250	4	1.400	5
Seven	2.417	12	1.786	14	2.222	9	1.625	8
Eight	1.714	7	1.143	7	1.667	3	1.250	4
Nine	1.500	6	1.750	4	1.600	5	1.750	4
Ten	1.000	7	1.333	3	1.000	4	1.333	3
TOTAL	1.648	61	1.526	58	1.660	43	1.518	42

Possible range of responses: 1-5

CHART 24

Booking Officer Question # B-4: Hypothetical situation regarding drunk with bump on head who falls asleep. Why would you follow this procedure?
1=correctly identifies possibly serious head trauma; 2=does not correctly identify possibly serious head trauma but shows concern for inmate's welfare; 3=does not correctly identify possibly serious head trauma but shows concern for jail's responsibility; 4=does not identify possibly serious head trauma

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.000	4	1.000	4	1.000	2	1.000	2
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	1.667	6	1.400	5	1.800	5	1.500	4
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	2.000	2	1.000	4	1.000	1	1.000	3
Six	1.000	3	2.000	3	1.000	3	2.000	3
Seven	1.545	11	1.556	9	1.375	8	1.833	6
Eight	1.750	4	1.000	8	1.000	3	1.000	4
Nine	1.600	5	1.000	3	1.750	4	1.000	3
Ten	1.000	3	3.000	1	1.000	1	3.000	1
TOTAL	1.356	40	1.396	42	1.192	29	1.433	28

Possible range of responses: 1-4

CHART 25

Booking Officer Question #B-5: Hypothetical situation regarding out-of-town businessman arrested in raid. Does this situation present a medical problem?
1=yes; 2=possibly; 3=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.333	9	2.556	9	2.429	7	2.714	7
Two	2.000	1	1.667	3	2.000	1	1.000	1
Three	2.625	8	2.667	6	2.600	5	2.600	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.833	6	2.600	5	1.750	4	2.500	4
Six	2.000	5	1.500	4	2.000	5	1.500	4
Seven	2.231	13	2.188	16	2.333	9	2.111	9
Eight	2.429	7	1.750	8	2.333	3	1.500	4
Nine	2.000	6	2.600	5	1.800	5	2.600	5
Ten	3.000	7	3.000	3	3.000	4	3.000	3
TOTAL	2.145	63	2.153	61	2.124	44	2.052	43

Possible range of responses: 1-3

CHART 26

Booking Officer Question # B-5: Hypothetical situation regarding out-of-town businessman arrested in raid. What would you do at booking given this situation?
1=have inmate immediately transported to hospital, clinic, etc.; 2=consult with medical authority (by phone) about proper action to take; 3=have doctor check out inmate (later); 4=wait but closely observe for further developments; 5=do essentially nothing

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	4.333	9	4.333	6	4.429	7	4.400	5
Two	5.000	1	4.000	2	5.000	1	4.000	1
Three	4.286	7	4.333	6	4.500	4	4.200	5
Four	4.000	1	4.000	2	4.000	1	4.000	1
Five	3.250	4	3.250	4	3.000	2	2.667	3
Six	3.800	5	3.000	5	3.800	5	3.000	5
Seven	4.000	12	3.833	12	4.125	8	4.125	8
Eight	4.200	5	4.000	7	4.333	3	4.000	3
Nine	3.833	6	3.400	5	3.600	5	3.400	5
Ten	4.571	7	4.000	2	4.750	4	4.000	2
TOTAL	4.127	57	3.815	53	4.154	40	3.779	38

Possible range of responses: 1-5

CHART 27

Booking Officer Question # B-5: Hypothetical situation regarding out-of-town businessman arrested in raid. Why should this procedure be followed?
1=correctly identifies possible suicide; 2=does not identify possible suicide but does show concern for inmate's welfare; 3=does not identify possible suicide but does show concern for jail's responsibility; 4=does not identify possible suicide

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	2.667	9	2.667	6	3.000	7	3.000	5
Two	0	0	1.000	2	0	0	1.000	1
Three	1.500	4	1.667	6	1.333	3	1.600	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.250	4	2.000	4	1.500	2	1.333	3
Six	1.600	5	1.000	5	1.600	5	1.000	5
Seven	1.545	11	1.125	8	1.500	8	1.200	5
Eight	1.250	4	1.429	7	1.333	3	1.250	4
Nine	3.000	3	1.000	2	2.500	2	1.000	2
Ten	1.667	6	1.000	2	1.750	4	1.000	2
TOTAL	1.720	46	1.389	44	1.724	35	1.338	33

Possible range of responses: 1-4

CHART 28

Booking Officer Question #B-6: Hypothetical situation regarding prisoner with needle tracks and apparent jaundice. Does this situation present a medical problem?
1=yes; 2=no

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.111	9	1.000	9	1.143	7	1.000	7
Two	1.000	1	1.000	3	1.000	1	1.000	1
Three	1.375	8	1.167	6	1.600	5	1.200	5
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.000	6	1.000	5	1.000	4	1.000	4
Six	1.000	5	1.000	4	1.000	5	1.000	4
Seven	1.000	13	1.000	14	1.000	9	1.000	9
Eight	1.000	7	1.000	8	1.000	3	1.000	4
Nine	1.167	6	1.000	5	1.200	5	1.000	5
Ten	1.000	7	1.000	3	1.000	4	1.000	3
TOTAL	1.065	63	1.017	59	1.094	44	1.020	43

Possible range of responses: 1-2

CHART 29

Booking Officer Question # B-6: Hypothetical situation regarding prisoner with needle tracks and apparent jaundice. What would you do at booking given this situation?
1=isolate inmate immediately; 2-have inmate immediately transported to hospital, clinic, etc.; 3=consult with medical authority (by phone) about proper action to take; 4=have doctor check out inmate; 5=wait but closely observe for further developments; 6=do essentially nothing

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.889	9	2.333	9	1.857	7	2.286	7
Two	3.000	1	3.667	3	3.000	1	3.000	1
Three	3.250	8	2.500	4	3.600	5	2.500	4
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	2.500	6	2.400	5	3.000	4	2.000	4
Six	2.000	5	2.400	5	2.000	5	2.400	5
Seven	2.000	13	2.000	14	2.000	9	1.889	9
Eight	2.857	7	2.375	8	2.333	3	2.500	4
Nine	2.667	6	2.200	5	2.800	5	2.200	5
Ten	2.000	7	2.333	3	2.500	4	2.333	3
TOTAL	2.316	63	2.321	58	2.409	44	2.211	43

Possible range of responses: 1-6

CHART 30

Booking Officer Question # B-6: Hypothetical situation regarding prisoner with needle tracks and apparent jaundice. Why should this procedure be followed?
1=correctly identifies possible contagious disease; 2=does not correctly identify possibility of contagious disease but shows concern for inmate's welfare; 3=does not correctly identify possible contagious disease but shows concern for jail's responsibility; 4=does not identify possible contagious disease

	All booking officers completing pre-questionnaire at time of initial site visit		All booking officers completing post-questionnaire at time of follow-up visit		Only booking officers completing both pre-questionnaire at time of initial site visit and post-questionnaire at time of follow-up visit			
					PRE-SURVEY		POST-SURVEY	
Jails	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
One	1.800	5	2.500	2	1.800	5	1.000	1
Two	0	0	2.000	1	0	0	0	0
Three	3.000	6	2.000	5	3.250	4	2.250	4
Four	1.000	1	1.000	2	1.000	1	1.000	1
Five	1.000	2	1.333	3	1.000	1	1.333	3
Six	1.000	2	1.333	3	1.000	2	1.333	3
Seven	1.900	10	1.500	4	1.857	7	1.000	2
Eight	1.750	4	1.400	5	1.333	3	1.333	3
Nine	3.000	5	4.000	1	2.750	4	4.000	1
Ten	2.750	4	2.500	2	3.500	2	2.500	2
TOTAL	1.911	39	1.957	28	1.943	29	1.750	20

Possible range of responses: 1-4

APPENDIX M

MEDICAL COST DATA

Comments about the Cost Data Collected

Cost Summary Sheet 1 - Jail One

Cost Summary Sheet 2 - Jail Eight

Cost Summary Sheet 3 - Jail Nine

Cost Summary Sheet 4 - Jail Ten

Cost Summary Sheet 5 - Jail Three

Cost Summary Sheet 6 - Jail Four

Cost Summary Sheet 7 - Jail Seven

Cost Summary Sheet 8 - Jail Five

Cost Summary Sheet 9 - Jail Six

COMMENTS ABOUT THE COST DATA COLLECTED

The cost information in the following summary sheets represents data that were collected from nine of the ten jails in the study. The information is incomplete and, in many cases, based upon crude estimations. Nevertheless, it is presented in order to give some idea of the differing health care expenditures faced by the jails as well as a crude estimation of the effects on costs which can result from different health care delivery system models.

Attempts were made to collect the most complete cost data possible, given the limited time period and the secondary nature of this aspect of the study. Generally, the most accurate cost data reflected actual jail expenditures for health care personnel and services. However, even these data must be looked at cautiously. Fiscal years began at different times (e.g., July, December, January) and expenditures were often reported in the month in which they were paid, not the month in which they were incurred. Attempts to get outside agencies and facilities to estimate the value of the health care services which they provided to the jail went largely unheeded. Only a small fraction of the inquiries sent out were answered.

The six categories into which the cost data were divided represent both direct and indirect expenses and explicit and implicit costs. Where it was thought appropriate, costs were reduced to so many cents-per-inmate-day-served, based on the figures presented in Table IV found in the body of the report. This was done in order to create a common

denominator for comparisons between jails. However, extreme caution should be exercised before too much is read into these figures.

First, the cost data were not equally reliable or complete between all of the jails. Second, the six categories into which the data were divided did not always contain the same items for analysis at each facility. Third, cost-per-inmate-day-served was greatly affected by changes in the size of the inmate population. For example, if health care personnel costs remained constant, but the average daily inmate population declined, cost-per-inmate-day-served would increase. And fourth, the quality of health care services cannot be reduced to dollar figures. Thus, higher health care costs did not necessarily represent better health care services.

COST SUMMARY SHEET 1
JAIL ONE (SMALL)

1. Medical Care Providers

- Primary physician services were paid on a fee-for-service basis. No estimate of this cost was available.
- The county nurse's services were paid on an hourly basis. She began coming to the jail regularly once a week in January 1979 (cost to jail = $36 in January, $81 in February).

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis. No reliable estimates of costs per inmate were available due to the short study period and the relative infrequency of service utilization. One serious medical problem (a prisoner with a broken ankle) created a substantial increase in the jail's medical costs during the study period.

3. Facilities

- An examination room was provided for the jail nurse in January 1979. First aid kits were also stocked and medical records placed in a separate, locked cabinet. No estimates were available for the cost of these changes in the jail's facilities.

4. Medical Training

- In January, personnel were trained in first aid and the recognition of symptoms of mental illness and retardation. At the beginning of the study period, one correction officer and three road deputies already had CPR training. No cost estimates were available for this training.

5. Transportation

- Road deputies usually handled routine transportation for medical services. Their base pay was $6.17 per hour plus approximately $2.10 per hour in overhead for a total cost of $8.27 per hour. Each trip took approximately 1.25 man-hours or cost an estimated $10.34. There were 23 trips for medical reasons during the six month study period for an estimated transportation cost of $237.82 or approximately 10¢ per inmate-day-served. This did not include vehicle maintenance costs for which there were no estimates available.

- The hospital ambulance service provided the jail with emergency transportation if needed, which was billed at $30 per trip. No cost data were available for this service for the period of the study.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- Correction officers and road deputies provided 24-hour security coverage when an inmate was hospitalized. A correction officer's base pay was $5.17 per hour plus approximately $1.80 per hour in overhead for a total cost of $6.97 per hour. No inmates were hospitalized during the period of the study.
- Correction officers distributed medications and assisted the nurse at sick call. No estimate of the time this entailed was available.

7. Drugs

- For the period of February 1978 through August 1978, the jail spent $141.98 on drugs and medications. No estimates for the cost of similar items were available for the study period.

8. Legal

- There have been no medical suits brought against this jail.

COST SUMMARY SHEET 2
JAIL EIGHT (SMALL)

1. Medical Care Providers

- Primary and specialty physician services were paid on a "fee-for-service" basis. The jail physician came into the jail three times per week for a total of approximately five hours. When he was unavailable, a relief physician covered the jail. The total cost of physician services in 1978 was $2,546.90 or approximately 38¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.
  Hospital costs in 1978 equaled $1,764.23.
  Clinic costs were included in hospital costs.
  Mental health care costs were unknown.
  Drug counseling costs were unknown.
  Dental care in 1978 equaled $159.00.
  Medical laboratory costs were included in hospital costs.
  Total known costs of medical services provided in 1978 equaled $1,923.23 or approximately 29¢ per inmate-day-served.

3. Facilities

- A room was being equipped for the use of the jail physician as part of a jail remodeling program. This room was also meant to serve other purposes besides the delivery of health care services. The cost of remodeling and equipping the room for the use of the physician was unknown.

4. Medical Training

- All correction officers at the jail received first aid and CPR training through a state training course. Sixteen hours of the 120 hours course were devoted to this training or 13.33%. The jail paid $54 per individual for mileage to attend this training plus the correction officer's regular salary. The cost of the training to the state was unknown. In addition to this course, all personnel at the jail received an eight-hour training and certification class in CPR in October 1978.

COST SUMMARY SHEET 2
(continued)

5. Transportation

- Deputy sheriffs usually handled routine transportation for medical services. Their base pay was $6.25 per hour plus approximately 10% additional in overhead for a total cost of about $6.87 per hour. Usually, two deputies handled the transportation of inmates. Trips for mental health care or to the hospital were estimated to average 5 man-hours. Trips for other medical reasons were estimated to average two man-hours. For the five months for which data were available for Jail Eight, there were twenty trips for mental health care or to the hospital, and five trips for other medical reasons. These trips totaled approximately 110 man-hours for an estimated transportation cost of $755.70 or approximately 23¢ per inmate-day-served. This did not include vehicle maintenance costs for which there were no estimates available.
- Emergency transportation for medical reasons was sometimes handled by an ambulance service for which the jail was charged $25.00 per trip. In 1978 there were four such trips for a total cost of $100.00.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- The sheriff's department provided security coverage when an inmate was hospitalized and security was required. No inmates were hospitalized in 1978.
- Correction officers distributed medications and assisted the physician at sick call. It was estimated that these duties amounted to 12 man-hours per week. Correction officer base pay was $4.43 per hour plus approximately 10% additional in overhead for a total cost of about $4.87 per hour or $58.44 per week. This amounts to approximately 46¢ per inmate-day-served for the six month period of the study.

7. Drugs

- In 1978, the jail spent $433.63 on drugs and medications. No estimates for the cost of similar items were available for the study period.

8. Legal

- There were no estimates available for the cost of medical suits brought against the jail or the jail physician.

COST SUMMARY SHEET 3
JAIL NINE (SMALL)

1. Medical Care Providers

- Primary and specialty physician services were paid for on a "fee-for-service" basis. These costs amounted to $150.00 in 1978 or approximately 9¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis. Estimates of the costs of these services were unavailable.

3. Facilities

- A room was being equipped for the use of the jail physician. This room was available for other uses besides the delivery of health care services. The cost of equipping this room was unknown.

4. Medical Training

- All correction officers at the jail received first aid and CPR training through a state training course. Sixteen hours of the 120 hour course were devoted to this training or 13.33%. The jail estimated that it cost the facility $522.60 to send one correction officer through the course or $69.51 for the first aid and CPR portion of the training. The jail sent three men through this course in 1978 for a cost of approximately 12¢ per inmate-day-served. This cost included the correction officer's salary, the cost of his replacement at the jail, and mileage.

5. Transportation

- Correction officers usually handled routine transportation for medical services. Their base pay was $3.98 per hour plus an estimated overhead cost of approximately 10% additional for a total cost of about $4.38 per hour. Usually, two correctional officers handled the transportation of inmates, which averaged about one hour per trip or two man-hours total. During the period of the study, there were 19 trips for medical reasons for an estimated transportation cost of $166.44 or approximately 19¢ per inmate-day-served. This did not include vehicle maintenance costs for which there were no estimates available.
- An ambulance service was used one time by the jail for which it was not billed.

COST SUMMARY SHEET 3
(continued)

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- The sheriff's department provided security coverage when an inmate was hospitalized and security was required. No inmates were hospitalized in 1978.
- Correction officers distributed medications, which was estimated to amount of 3.5 man-hours per week. This amounted to approximately 46¢ per inmate-day-served for the six month period of the study.

7. Drugs

- In 1978, the jail spent $821.14 on drugs and medications. No estimates for the cost of similar items were available for the study period.

8. Legal

- There have been no medical suits brought against this jail.

CONTINUED

5 OF 6

COST SUMMARY SHEET 4
JAIL TEN (SMALL)

1. Medical Care Providers

- Primary physician services were paid on an hourly basis. The physician came to the jail for about 3½ hours per week. It was estimated that this amounted to a cost of $105 per week or $5,460.00 per year for approximately 32¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were provided on an "as needed" basis. No cost estimates were available for these services.

3. Facilities

- The jail had no facilities specifically for the delivery of health care services.

4. Medical Training

- Correction officers at the jail received first aid and CPR training through a state training course. Sixteen hours of the 120 hour course were devoted to this training or 13.33%. The jail paid for correction officers' transportation to attend this training plus the correction officers' regular salary. The cost of the training to the state was unknown.
- One correction officer also attended an EMT course lasting 81 hours. The jail paid his regular salary while he attended plus $25 for books and supplies.

5. Transportation

- The sheriff's department handled routine transportation for medical services. Deputy sheriff base pay averaged about $4.66 per hour plus approximately 19% additional in overhead for a total cost of about $5.55 per hour. Usually, two deputies handled the transportation of inmates. A routine trip for medical reasons was estimated to average five man-hours. For the six months of the study period, Jail Ten experienced forty-six routine trips for medical reasons for a total of 230 man-hours. The estimated transportation cost equaled $1,276.00 or approximately 15¢ per inmate-day-served. This did not include vehicle maintenance costs for which there were no estimates available.
- Emergency transportation for medical reasons was sometimes handled by an ambulance service for which the jail was charged $10 per trip.

COST SUMMARY SHEET 4
(continued)

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- The sheriff's department provided security coverage when an inmate was hospitalized and security was required. This entailed three sheriff's deputies per day. During the course of the study, the jail reported nine days of inmate bed-care outside the facility requiring an estimated 216 man-hours of security at about $6.87 per hour for a total estimated cost of $1,483.92.
- The third shift supervisor spent about seven hours per week performing health care-related activities (e.g., distribution of medications, etc.). Estimating the base pay at $5.51 per hour plus approximately 19% additional in overhead, the cost per hour for the shift supervisor's services was approximately $6.56 per hour. For a year, this would equal 365 man-hours or 14¢ per inmate-day-served.
- The medical secretary at the jail spent about seven hours per week performing administrative activities related to the delivery of health care services. Estimating the base pay at $4.66 per hour plus approximately 19% additional in overhead, the cost per hour for the medical secretary's services was about $5.54 per hour. For a year, this would equal 365 man-hours or 12¢ per inmate-day-served.
- No estimates were given for the amount of time correctional officers spent assisting the physician during sick call (i.e., providing security, etc.).
- Three correction officers were EMT trained. They only handled emergency medical situations and no estimates were given for the amount of time this entailed.

7. Drugs

- No estimates were given for the cost of drugs and medications.

8. Legal

- No estimates were given for the cost of medical suits brought against the jail. However, this facility was under suit during the period of the study.

COST SUMMARY SHEET 5
JAIL THREE (MEDIUM)

1. Medical Care Providers

- Primary and specialty physician services were provided on an "as needed" basis during the period of the study from many different sources. Individual physician payments totaled $891.88 in 1978 or approximately 2¢ per inmate-day-served.
- An LPN was hired for a short period of time in November 1978 on a demonstration basis. The cost of the LPN's services was not available.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.
  Hospital costs incurred in 1978 equaled $9,158.62 or about 25¢ per inmate-day-served.
  Clinic costs incurred in 1978 were included in other totals.
  Reported costs for mental health care totaled $1,062.00 in 1978 or about 3¢ per inmate-day-served.
  Drug counseling costs incurred in 1978 equaled $246.00 or less than 1¢ per inmate-day-served.
  Medical laboratory costs were included in other totals, except for radiologists' charges, which totaled $243.50 in 1978 or less than 1¢ per inmate-day-served.
  Total cost for medical services and physician providers equaled $1,602.00 in 1978, or approximately 31¢ per inmate-day-served.

3. Facilities

- The jail had no facilities for the delivery of health care services.

4. Medical Training

- New correction officers received orientation training which involved some first aid. No estimate was available for the cost of this training.

5. Transportation

- Routine transportation outside the jail for medical services was handled by sheriff's deputies. Usually, one deputy transported an inmate, but sometimes two, if the individual was thought to be dangerous. Their base pay was estimated at $7.45 per hour plus a guessed overhead rate of 20%, for a total cost of about $8.94

per hour. One trip averaged about two man-hours. There were 143 routine trips during the six month study period for an estimated transportation cost of $2,556.84 or approximately 14¢ per inmate-day-served. This did not include vehicle maintenance costs, for which there were no estimates available.
- Emergency transportation was usually handled by the fire department rescue service. No estimate of the cost of this service was available.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- The sheriff's department provided security coverage when an inmate was hospitalized and security was required. This entailed three sheriff's deputies per day. During the course of the study, the jail reported four days of inmate bed-care outside the facility, requiring an estimated 96 man-hours of security at about $8.94 per hour for a total estimated cost of $858.24.
- Correction officers distributed medications and arranged for the handling of inmate medical services. It was estimated that this entailed six hours of a correction officer's time each day or about 2,190 man-hours per year. Again, figuring a cost of $8.94 per man-hour, this equaled approximately $19,578.60 or about 53¢ per inmate-day-served.

7. Drugs

- In 1978, the jail spent $850.05 on drugs and medications.

8. Legal

- There were no estimates available for the cost of medical suits brought against this jail.

COST SUMMARY SHEET 6
JAIL FOUR (MEDIUM)

1. Medical Care Providers

- Primary and specialty physician services were paid on a "fee-for-service" basis. In addition, the jail had a contract with a physician group to supervise the jail's health care delivery system. This contract was for $15,000 a year, but included the services of a nurse, who came into the jail between twenty-five and thirty hours a week. For the seven-month period from September 1978 through March 1979, Jail Four spent $18,196.10 on primary and specialty physician services and payments under the contract with the physician group. It is estimated that of the $18,196.10 cost incurred during this period, $10,000.00 pertained to payments under the terms of the physician group contract or two-thirds of the total contract cost. Pro-rating the contract on a twelve-month basis, this comes to $2,250.00 a month or $8,750.00 for a seven-month period. The adjusted total cost for medical care providers equals $16,946.10 or approximately 97¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.

  During the seven-month period from September 1978 through March 1979, a total of $44,621.62 was spent on in-patient and out-patient hospital care, clinic services, mental health care, and medical laboratory services. (A breakdown of this cost figure into the separate categories was not available). The costs incurred in the months of September and October 1978 were an inordinant percent of the total cost for the seven-month period (i.e., 60%). During these two months, inmates received thirty-seven days of in-patient hospital bed-care. For the remaining five months covered by these cost data, there were only six days of in-patient hospital bed-care. During this same seven month period, $1,233.00 was spent on dental care. Thus, total known costs of medical services provided in this seven-month period equaled $45,854.62. (Because of the apparently misleading effects of the unusual number of in-patient hospital bed-care days during this period, no cost per inmate-day-served was calculated).

3. Facilities

- Two examination rooms and two infirmaries (six beds total) plus a supply room and bathroom comprise about 1% of the total jail facility. The cost of maintaining and equipping the jail's health care facilities was unknown.

COST SUMMARY SHEET 6
(continued)

4. Medical Training

- Correction officers received first aid and CPR training through a correctional officer academy. The cost of this training was unknown. In addition, there was occasional in-service training in various aspects of inmate health care. The cost of this training was also unknown.

5. Transportation

- Two correctional officers usually accompanied up to three inmates on routine trips for health care reasons. Their base pay was $6.64 per hour plus an unknown overhead cost estimated at 15% for a total cost of $7.74 per hour. Each trip took approximately two man-hours, and, thus, cost an estimated $15.48. Forty-two inmates received routine health care services outside the jail during the period of the study. Estimating an average of two inmates per routine trip, there were 21 trips for medical reasons for an estimated transportation cost of $325.08 or approximately 2¢ per inmate-day-served. This excluded vehicle maintenance costs (for which there were no estimates available) and emergency transportation handled by the jail staff -- possibly seventeen trips for an additional cost of $263.16 or about 2¢ per inmate-day-served.
- Emergency transportation was occasionally provided by an ambulance service. When used, it usually cost the jail $100.00 per trip. During the seven months from September 1978 through March 1979, the jail spent $375 on ambulance transportation.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- Correction officers provided 24-hour security coverage when an inmate was hospitalized. The cost of one correctional officer man-hour was estimated at $7.74. During the course of the study, inmates were hospitalized a total of forty-three days requiring about 1,032 man-hours of security, costing approximately $7,987.68. Again, however, it should be mentioned that this was probably an exceptional number of hospital bed-care days for this jail for this period of time.
- Correction officers distributed medications and assisted the nurse at sick call. No estimate of the time this entailed was available.

COST SUMMARY SHEET 6
(continued)

7. Drugs

- For the seven-month period from September 1978 through March 1979, the jail spent $2,690.26 on drugs and medications.

8. Legal

- There have been no medical suits brought against this jail since the new facility opened in 1975 and the nurse began delivering health care services.

COST SUMMARY SHEET 7
JAIL SEVEN (MEDIUM)

1. Medical Care Providers

- Primary physician services were provided on a contract basis. The jail physician received $9,000.00 yearly, which included all overhead. This equals about 33¢ per inmate-day-served.
- Specialty physician services were paid on a "fee-for-service" basis. No cost estimates were available for these services.
- Nursing services were provided to the jail by the county nursing home. It was estimated that this amounted to 21 man-hours of service per week, at a base pay rate of $4.55 per hour plus additional overhead costs of $0.79 per hour for a total cost of $5.34 per hour. This equals approximately $5,832.37 per year or 21¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.
- No estimates of hospital costs were available. The local hospital utilized by the jail estimated that in-hospital bed-care averaged $152.43 per day in September 1978.
- Dental care costs were about $10 per visit according to the jail. No more accurate dental cost estimates were available, however.
- No estimates of the cost of providing other medical services were available.

3. Facilities

- Approximately 1% to 2% of the jail facility is devoted to the delivery of health care services. The jail's 1978 budget allocated $66,300 for facility maintenance and operation. One and one-half percent of this total equals $994.50 for the year.

4. Medical Training

- Correction officers at the jail received first aid and CPR training through a state training course. Sixteen hours of the 120 hour course were devoted to this training or 13.33%. The jail paid approximately $37.00 in mileage for each individual who attended the course plus their regular salaries. The cost of the training to the state was unknown. Three correction officers attended the training in 1978. A correction officer's hourly cost was estimated at $4.14 plus 15% additional in overhead for a total cost of $4.76 per hour, Thus, the cost of the first aid and CPR training equals approximately $81.09 per correction officer.

COST SUMMARY SHEET 7
JAIL SEVEN (MEDIUM)

1. Medical Care Providers

- Primary physician services were provided on a contract basis. The jail physician received $9,000.00 yearly, which included all overhead. This equals about 33¢ per inmate-day-served.
- Specialty physician services were paid on a "fee-for-service" basis. No cost estimates were available for these services.
- Nursing services were provided to the jail by the county nursing home. It was estimated that this amounted to 21 man-hours of service per week, at a base pay rate of $4.55 per hour plus additional overhead costs of $0.79 per hour for a total cost of $5.34 per hour. This equals approximately $5,832.37 per year or 21¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.
- No estimates of hospital costs were available. The local hospital utilized by the jail estimated that in-hospital bed-care averaged $152.43 per day in September 1978.
- Dental care costs were about $10 per visit according to the jail. No more accurate dental cost estimates were available, however.
- No estimates of the cost of providing other medical services were available.

3. Facilities

- Approximately 1% to 2% of the jail facility is devoted to the delivery of health care services. The jail's 1978 budget allocated $66,300 for facility maintenance and operation. One and one-half percent of this total equals $994.50 for the year.

4. Medical Training

- Correction officers at the jail received first aid and CPR training through a state training course. Sixteen hours of the 120 hour course were devoted to this training or 13.33%. The jail paid approximately $37.00 in mileage for each individual who attended the course plus their regular salaries. The cost of the training to the state was unknown. Three correction officers attended the training in 1978. A correction officer's hourly cost was estimated at $4.14 plus 15% additional in overhead for a total cost of $4.76 per hour, Thus, the cost of the first aid and CPR training equals approximately $81.09 per correction officer.

COST SUMMARY SHEET 8
JAIL FIVE (LARGE)

1. Medical Care Providers

- Primary physician services were paid according to a written agreement between the jail and a group of physicians. They provided about five hours of physician services at the jail per week at the rate of $40.00 per hour. During 1978, these services cost $10,580.00 or about 14¢ per inmate-day-served.
- Specialty care services from other physicians cost $3,425.00 for this same twelve-month period or about 4¢ per inmate-day-served.
- Three full-time medical staff at the jail cost a total of $43,700 in wages per year plus an overhead estimated at 25.5% for a total cost of $54,843.50 per year or 72¢ per inmate-day-served. This total did not include any overtime pay which the medical staff received for "on-call" duty.
- In 1978, the visiting nurse at the jail cost $1,383.00 which included overhead. This represents about 2¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, mental health care, drug counseling, dental care, and medical laboratory services were all provided on an "as needed" basis.
  In 1978, hospital bed-care costs equaled $3,425.00.
  Hospital emergency room care cost $4,860.00.
  Out-patient clinic care cost $3,660.00.
  Mental health care, including some services free to the jail, cost $1,050.00.
  The cost of drug counseling services was unknown.
  Dental care services cost $4,275.00.
  Medical laboratory services cost $2,752.00.
  Thus, total known medical services costs equaled $20,022.00 or about 26¢ per inmate-day-served.

3. Facilities

- The jail has a small dispensary and office for the delivery of health care services at the jail. No estimate was available for the cost of routine maintenance of these facilities.
- Medical supplies and equipment cost the jail $990.00 in 1978. This cost did not include surplus supplies the jail received free of charge.

COST SUMMARY SHEET 8
(continued)

4. Medical Training

- In 1978, thirty-six correction officers received CPR training under a grant. An esimate of the cost of this training was not available. However, one correction officer's pay per hour was about $6.83 plus an overhead estimated at 25.5% for a total cost of $8.57 per hour. Thus, the cost of sending one correction officer through the course would be equivalent to $68.56.
- Correction officers also attended a correction officer school, which included instruction in first aid. No estimate of the cost of this training was available, however.
- The jail's registered nurse took additional training to qualify as a CPR instructor. No estimate of the cost of this training was available.

5. Transportation

- Two correction officers usually accompany up to three inmates on routine trips for health care reasons. Routine transportation was estimated by the jail to cost $8,720.00 in 1978. The exact basis for this estimate is unknown, but it is equivalent to about 11¢ per inmate-day-served.
- Emergency transportation was handled by the first department ambulance service. No estimate of the cost of this service was available.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- Correction officers provided 24-hour security coverage when an inmate was hospitalized. The cost of one correctional officer man-hour was estimated at time and a half or $12.86 per hour. During the period of the study, the jail did not report any hospital bed-care days.
- Correction officers distributed medications and assisted with security in conjunction with sick call. It was estimated that these duties entailed about three man-hours per day, or 1,095 man-hours per year. Calculated on the rate of $8.57 per hour, this is equivalent to $9,384.15 per year or 12¢ per inmate-day-served.

7. Drugs

- The cost of drugs in 1978 was reported to be $2,702.00 or close to 4¢ per inmate-day-served.

COST SUMMARY SHEET 8
(continued)

8. Legal

- No estimates were available for the cost of medical suits brought against the jail or jail personnel. The cost of liability insurance, which some medical staff carried as protection against legal actions, was also unknown.

COST SUMMARY SHEET 9
JAIL SIX (LARGE)

1. Medical Care Providers

- Primary physician services were provided on a contract basis. The jail physician received $15,000 yearly, which included all overhead expenses. This equals about 15¢ per inmate-day-served.
- The jail nurse and medical officer were employed by the jail and received a combined salary of $29,031.36, not including overhead costs. Estimates of overhead costs were not available. The cost of the jail medical staff, not including overhead expenses, thus equals about 28¢ per inmate-day-served.
- Specialty physician services were provided on an "as needed" basis. In 1978, these services cost $9,908.50 or 10¢ per inmate-day-served.

2. Medical Services Provided

- Area hospital, clinic, and medical laboratory services were provided on an "as needed" basis.
- Mental health care, drug counseling, and dental care were provided at the jail on a regular basis.
  In 1978, in-patient hospital care cost $39,286.05 or about 38¢ per inmate-day-served.
  Out-patient clinic care cost $4,362.00 or about 4¢ per inmate-day-served.
  Medical laboratory services (both those paid out of the jail's budget and those provided at no charge to the jail) cost $12,741.00 or about 12¢ per inmate-day-served.
  Mental health care services provided by the forensic mental health team cost an estimated $439.91 per week. This included 61 man-hours of services per week from a psychiatric nurse, mental health specialist, and consulting psychiatrist. In addition, the cost of staff transportation to and from the jail cost about $23.52 per week for a total cost of $463.43 per week or $24,164.63 per year. This is equivalent to nearly 24¢ per inmate-day-served.
  The cost of drug and alcohol counseling was not available.
  Dental care cost $3,797.00 or nearly 4¢ per inmate-day-served.
  Miscellaneous medical expenses equaled $1,066.00 or 1¢ per inmate-day-served.

3. Facilities

- Approximately 2½% of the jail facility is devoted to the delivery of health care services. No estimate of the cost of maintaining these facilities was available.

COST SUMMARY SHEET 9
(continued)

4. Medical Training

- All correction officers at the jail received in-service first aid and CPR training. No estimate of the cost of this training was available.
- Correction officers also attended a correction officer school, which included instruction in first aid. No estimate of the cost of this training was available either.

5. Transportation

- Two correction officers usually accompany up to three inmates on routine trips for health care reasons. It was estimated that in the three-month period from December 1, 1977 to February 28, 1978, there were 214 trips for medical reasons involving 912 man-hours at the rate of $7.45 per hour, not including overhead costs. These trips totaled 4,305 miles of travel. The cost of routine transportation for health care reasons per inmate-day-served thus exceeded 7¢.
- Emergency transportation was handled by jail staff and a jail vehicle or by an ambulance. No estimate of the cost of emergency transportation was available.

6. Correction Officer Duties in Conjunction with the Delivery of Inmate Health Care Services

- Correction officers provided 24-hour security coverage when an inmate was hospitalized. During the course of the study, no inmates were hospitalized.
- Correction officers distributed medications and assisted with security in conjunction with sick call. It was estimated that these duties entailed about three man-hours per day or 1,095 man-hours per year. Calculated at the rate of $7.45 per man-hour not including overhead, this is equivalent to $8,157.75 per year or more than 8¢ per inmate-day-served.

7. Drugs

- The cost of drugs and medications in 1978 was reported to be $9,020.08 or close to 9¢ per inmate-day-served.

8. Legal

- No estimates were available for the cost of medical suits brought against the jail or jail personnel. The jail has a budget line which covers all legal defense, but it was not broken down by type of suit.

END