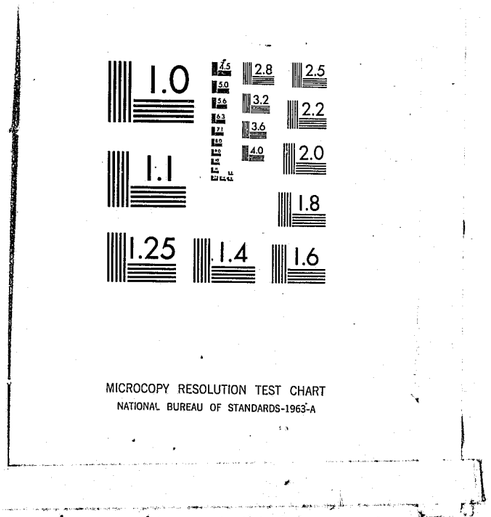

A

Mental Health Services in Local Jails

Agenda

Post-Workshop Dissemination, Research and Training

Planning Meeting

May 24, 1979

AGENDA

1. Review of Assignment or charge
2. Organization of material (see contents, following page)
3. Review of findings
4. Current activity
5. Current dissemination
6. Proposed research
7. Proposed training
8. Proposed demonstration
9. Future dissemination

CONTENTS

TAB O (cont'd)

2. National Institute of Corrections Jail Centers grant, "Mental Health Services Training," Carol H. Morgan, Principal Investigator

3. National Coalition for Jail Reform correspondence

B

C-896

M E M O R A N D U M

TO: Planning Committee Members DATE: April 18, 1979

FROM: Gary D. Reiner, Manager SNW's
William J. Araujo, Assistant Manager SNW's

RE: Mental Health in Jails/Follow-on Planning Committee Meeting

The Planning Committee meeting on "Mental Health Services in Local Jails" originally scheduled for April 26-27 has been re-scheduled for May 24, 1979. The meeting will be held at 5530 Wisconsin Avenue, N.W., Washington, D.C. 20015. It will begin at 9:00 a.m. and end at 5:00 p.m.

The purpose of the meeting is to discuss additional program and research initiatives applicable to the above subject matter and potential training workshop.

Chris Dunn has asked us to forward the enclosed research related commentaries and documents. It is important that you bring this materials with you to the meeting for discussion.

For those individuals who will be traveling by air, we have attached a travel form which should be completed and immediately returned to Arlene Trainor of the Executive Training Program Logistics Division. Your flight reservations will be made subsequent to its receipt. Please advice us of your ability to attend this Planning Committee meeting as soon as possible.

For your additional information we have attached a draft list of those individuals who have been invited to attend.

GDR/sp (8071)
Enclosure

cc: Christopher S. Dunn ✓
Paul Estaver
Sheldon S. Steinberg
Arlene Trainor
William Araujo
Betsy Hettinger

Updated 4/18/79

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Updated 5/22/1979

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C

Summary of Workshop Findings and Recommendations

Contributor	Findings	Current Dissemination
Gibbs	-- Typically, only incomplete records of inmates' jail histories exist. -- No systematic data collection exists. -- Methodological rigor of existing studies is low. -- Diverse definitions of pathology and behavior are employed in diagnosis. -- Findings diverge as to extent, but -- Substantial proportions of inmates do receive diagnostic labels. -- Self-destructive behavior is an alternative and useful indicator of stress in jails and its psychological sequelae -- Self-injury studies are limited by small samples available, restricted definitions of self-injury, and association typically only with demographic characteristics.	Recommend revised and edited version of paper in overall monograph/book.

Research	Training	Future Demonstration or Dissemination
-- Major research effort is needed on <u>what impact jail has on people</u>, in terms of stressors and problems, as well as vulnerabilities. -- Such research should employ sound methodological procedures, e.g. probability sampling, consistent definitions across jurisdictions, and measurement instruments of known reliability and validity. -- Elementary research about the kinds of information retrievable from jails should precede any large sample research. -- Research on the meaning of definitional inconsistencies (see Morgan summary).	-- Record keeping by jail personnel. -- Research training with special attention to jail problems.	Unknown

Contributor	Findings	Current Dissemination
Gove	-- Since mental illness is possibly feigned and since there are advantages (perhaps only perceived) to feigning, and since jail personnel have little if any psychiatric training, it is difficult to identify actual mental illness from feigned. -- Of some potential utility is the observation that some aspects of the jail experience -- critical life event, demeaning, anxiety promoting, uncertainty -- are exactly those which may predispose some persons to be receptive to psychotherapies and to make basic life changes.	Recommend revised and expanded version of paper in overall monograph/book.

Research	Training	Future Demonstration or Dissemination
-- Research on what is mental illness in jails has many dimensions, including: * (with respect to police in particular), what factors determine who among those who are mentally ill get routed into jail in comparison with those who do not; * what distinguishes individuals who become mentally ill in reaction to incarceration versus those who do not; * what features of incarceration precipitate mental illness; and * in view of the feigning potential, what is the relationship between an environment which has some factors motivating an individual to feign and some factors actually precipitating or causing mental illness and the accuracy of diagnosis. C.S. Dunn comment -- This research suggestion raises the whole issue of diagnostic accuracy, including the areas of false positive (i.e., not mentally ill but diagnosed as such -- perhaps feigning, perhaps poor diagnosis) and false negative (i.e., mentally ill but not diagnosed; e.g. the unscreened suicide or self-destructive behavior). The relationship of these diagnostic or prediction problems to legal doctrines of due process and liability is a more general issue that needs basic conceptual and empirical research.	C.S. Dunn comment -- What training for inmates to act as informal diagnosticians or service providers would be valuable or worthwhile? Research training in merging clinical and statistical prediction of mental illness and "dangerous" behavior.	Unknown Demonstration of use of inmates or information from inmates as aids in the diagnostic or treatment process.

Research	Training	Future Demonstration or Dissemination
-- If there are aspects of the jail experience motivating toward receptivity to psychotherapy, how does such a process work, when and how is intervention best provided, with what kinds of therapy or service? What potential does a forced confrontation with one's life trajectory and demonstration of plausible alternatives actually have for motivating to prosocial behavior?	See later comments regarding training of staff.	

Summary of Workshop Findings and Recommendations

Contributor	Findings	Current Dissemination
Megargee	-- The general problems confronting diagnosticians working in jails include: * limitations on staff, space, and resources; * the jail as an institution that fulfills many different social functions; * the extremely heterogeneous and voluminous population, some of whom are unable or unwilling to participate in conventional psychometric assessment; * the lack of mental health assessment professionals with criminal justice training or experience; * the lack of research on assessment as performed in jail settings, with respect to the reliability and validity of diagnoses. -- At arrest and initial appearance, the volume of cases brought, the brief time allotted, and practical as well as ethical constraints against testing all arrested individuals argue against direct assessment by mental health professionals. Instead, intake and custodial personnel should be trained to recognize and refer seriously disturbed or potentially suicidal persons. -- At pretrial detention, it is recommended that the MMPI be routinely administered. -- After conviction, additional psychological profiles of personality, ability, achievement, and vocational interest are recommended. -- Issues of confidentiality and coercion, especially with respect to obtaining incriminating evidence and the possible outcomes of assessment, often pit three parties (inmate, assessment staff, and management) against each other. Clear procedures and communications about the place and role of assessment, the limits of confidentiality, and the rights of inmates need to be devised.	Recommend revised and edited version of paper in overall monograph/book.

Research	Training	Future Demonstration or Dissemination
-- There is a great need for research that identifies the typical course of behavior over a pretrial detention period, with respect to such questions as how much anxiety is normal, how much should be cause for concern, what the patterns and processes of psychological deterioration and breakdown are.		Recommend expanded paper in professional journal that presents available information about performance of diagnostic tests in correctional settings, with special emphasis on jails. Some additional contact with the NIC survey sites would be useful here to determine more specifically those tests and measures that are currently employed in existing programs.
-- Research should be undertaken by correctional psychologists to test the validity of diagnostic procedures and inventories carried out in jail settings.	-- Additional training for mental health professionals in dealing with and functioning in the criminal justice system, and jails in particular.	
-- Research should be undertaken on factors that can assist police and intake workers in correctly recognizing and referring seriously disordered or potentially suicidal or dangerous behaviors.	<-------> -- Training police and intake workers in recognizing and providing service to psychiatric emergencies.	
-- Research is needed on the application of classification systems as aids to jail management among pretrial detainees.		
-- Research on organizational goals and role conflict needs to be more precisely focussed to the jail and mental health services context. Research needs to link the service delivery structural typology (see Morgan findings) to social psychological aspects of organizational climate.		Recommend short note about confidentiality and coercion issues and related legal doctrine in a criminal justice or corrections journal.

Contributor	Findings	Current Dissemination
Brodsky	-- Five models or types of mental health service interventions are identified. 1. Emergency services at local hospitals or community mental health centers. 2. Counseling and psychotherapy programs within jails offered by community mental health centers, typically offered on a part-time basis to inmates referred by jail staff. 3. Therapeutic communities within jails. 4. Referral and diagnostic centers -- separate wings conducting assessments to identify seriously disturbed individuals, to provide brief, crisis-oriented treatments, and to make referrals to community agencies. 5. Suicide prevention programs. -- Jail personnel are identified as involved with mental health services in two ways: (1) as recipients of services (i.e., as individuals exposed to a multitude of stressful conditions themselves that frequently provoke psychological disturbances or maladjustment), and as (2) potential service providers. -- Jail environments should be modified to remove noxious or threatening conditions like noise or multiple occupancy cells.	Recommend revised and edited version of paper in overall monograph or book.

Research	Training	Future Demonstration or Dissemination
-- Follow-up research on citizens who are jailed needs to be conducted in order to assess impact of jail experience.		-- The operation and functions of a mental health research unit within a jail needs a demonstration project and evaluation.
		-- Recommend expanded book that describes operation of the five different intervention models in terms of the content and impact of the interventions at the individual inmate, diagnostician, and therapist level.
-- Research on prevention of violence and suicides within jails needs to be done.		
-- Research on behavioral and health changes in jail officers, as well as screening of officer candidates needs to be done.	-- Staff selection and managing staff improvement training needs attention.	

Contributor	Findings	Current Dissemination
Singer	-- From the finding in Jones v. Wittenberg onward, there is no doubt in case law or in standards that the state must provide meaningful mental health services to pretrial detainees and prisoners. Much of the present effort is not toward establishing the legal duty, but toward determining new and innovative methods of delivering such services. -- The legal duty, reinforced by "standards," requires (1) adequate intake procedures for determining persons clearly in need of mental health services, (2) sufficient emergency processes for delivery of persons to mental health facilities rather than jails; (3) unfettered access by inmates to providers of health care, with no refusal of forwarding a request. (4) sufficient training for correctional employees so that they can recognize and temporarily treat emergency needs for mental health services; (5) written statements as to the limitations upon treatment, with respect to both restricting who may administer treatment (except emergency care) and requiring true and valid informed consent	Recommend edited version to appear in overall monograph book. Recommend longer version published as a separate monograph or separate law review article.

Research	Training	Future Demonstration or Dissemination
-- A policy analysis of compensation schemes for rendering required mental health services, and especially the Federal role therein, needs to be conducted. -- An analysis of the theoretic reasons for imposing upon the sheriff a duty for providing medical care without regard to which the prisoner had such medical care available to him before incarceration.		Recommend specific case law review on an annual or every-other-year basis. Recommend summary article for publication in a professional corrections or law and mental health journal.

Contributor	Findings	Current Dissemination
Singer (cont.)	-- Legal doctrine may also require a hearing before transfer to a mental health facility. A hearing may make the process more cumbersome, but serves to afford balancing the rights of those who in fact need treatment and protecting against added stigma those who in fact do not need treatment. -- Liability for failure to provide such services differs according to party responsible for failure: (1) where failure is that of a government agency, agency may be ordered to provide the services or close the institution; (2) where the failure is that of an individual sheriff or health care provider, the balance regarding liability is more difficult. Courts have generally spoken as though the individual at fault would bear the liability personally, but have established a series of defenses which tend to assure the defendant will not be found liable. (3) Following from inequities in this arrangement, it is recommended that governmental agencies which operate jails should be held liable in damages without regard to fault, while individual defendants should be liable only if theirs was the highest form of neglect or recklessness.	

Research	Training	Future Demonstration or Dissemination
-- An analysis of the current status of state laws on transfer from jails to mental hospitals, including an assessment of these laws in regard to elements of due process, needs to be conducted.		
-- An historical analysis of the sheriff's liability for deputies' actions should be conducted.		
-- The effects of a "no-fault" workers compensation type scheme in regard to damages for liability actions need to be researched.		

Contributor	Findings	Current Dissemination
Morgan	-- Of 845 total inquiries, representing potential contact contact with approximately 20 percent of U.S. jails, a total of 193 specific programs were identified, and 81 specific program descriptions were received. C. S. Dunn comment - Extrapolating from admittedly non-systematically sampled, non-representative data, if 81 specific, programs with confirmed content (i.e., sent descriptions) and 193 self-identified programs exist, representing about 20 percent of U.S. jails, then one might expect to find between 400-1,000 programs across the country (5 x 81 = 405; 5 x 193 = 965). This represents between about 10 to 25 percent of U.S. jails with specific programs for mental health services to jail inmates. NOTE BENE: These are my estimates, not Carol Morgan's; because her work was not undertaken for purposes of providing such statistical estimates, its sampling plan reflected other purposes and should not therefore be criticized ex post facto for its nature. -- From an analysis of the 81 program descriptions, it was found that: (1) no uniform definition of mental health or mental health services exists. It is noted that a common definition would help alleviate apparent confusion in discussing a program and its client population, as well as enhance the attribution of meaning to, and assessment of validity of, variations found in survey respones; (2) a program typology (actually a typology of program structural or relation to the jail itself) was, identified, consisting of "integral," "intersectional," "adjunct," and "combination" service delivery system system types; (see page 42 of full report.) (3) Although staff resources and budgets are commonly argued to limit expansion of jail services, the survey data suggest that -- for jails with ongoing	Recommend publication as a separate book. Recommend edited chapter for inclusion in overall monograph/ book.

Research	Training	Future Demonstration or Dissemination
-- More rigorous identification of range and scope of programs and services provided in jails needs to be pursued, including research on how available treatment strategies may or may not be efficacious when implemented in jail settings.	-- Research training in organizational survey techniques applied to criminal justice organizations, to assess topics such as institutional deflection of program goals, measurement of organizational climate, measurement and interpretation of program effectiveness.	
-- While common definitions are necessary for confidence in survey findings and methodological rigor, exploratory research needs to both identify variation in the type and nature of programs justified under the mental health rubric and to assess the meaning of that variation. (See the research suggestion by Steadman regarding analysis of community attitudes towards jails and types of mental health programming.)	-- New research strategies for obtaining, assessing, and interpreting "evaluative" or "program purposes or rationale" may need to be devised. Delphi-like iterative techniques may need to be applied. Organizational researchers may need to learn these new applications.	
-- The relationship of characteristics and environment within jail to service delivery system typology needs to be more precisely investigated.		
-- The definition and measurement of mental health service delivery program impact and effectiveness needs basic investigation.		

Contributor	Findings	Current Dissemination
Morgan (cont.)	programs -- these are not particularly acute problems. Staff shortages are the modal problem category for larger jails (500 +), while the "other" problem category is modal for jails of less than 50 and 50-499 population capacity. This modal response may indicate the unique character of problems specific to individual jails. (4) Contrary to conventional wisdom, the survey data seem to dispell the myth that security problems are increased by the introduction of treatment programs into the jail. Although the data reported are perceptions by administrators, under 50 percent responded that security had been affected at all with about 2/3 of those responding thusly indicating a positive effect, viz., in the reduction of tension between inmates, between inmates and staff, and education of officers as to recognizing and handling emotionally disturbed people. -- In addition to the statistical analyses and research recommendations made possible through the survey responses, the following issues were raised as a result of program site visits involving discussions with program representatives. They are generic impressions and require systematic investigation and validation. 1. Special mental health needs of female inmates and the current, relative lack of programs which include women require attention. 2. Staff separation of competency/sanity evaluation responsibility from treatment responsibility is recommended. 3. Selection and assignment methods for officers working with mental health programs need to be refined. 4. An 18-36 month period seems to be required for mental	

Research	Training	Future Demonstration or Dissemination
-- The impact of program on jail security and management needs to be assessed by more objective measures as well as with reference to jail staff and inmates.	Staff training programs for assessing and managing program impact problems may need to be developed.	

Contributor	Findings	Current Dissemination
Morgan (cont.)	health and security staff to develop rapport and for the program to be accepted.	
	5. Sheriff/jail manager's support is essential for a program to operate, but mental health program staff must expend the efforts to demonstrate credibility, change attitudes, and integrate into the jail's system.	
	6. A cell without padding more successfully prevents self-injury than a padded cell when used for isolating suicidal inmates.	
	7. When a "good" jail - mental health program has been developed and discovered, more individuals are sent to the program by law enforcement, courts, family referrals, etc.	
	8. The importance of effort and degree of influence exerted by a single person in initiating or implementing a program can not be stressed more strongly.	
	9. There is typically a reluctance of mental health centers staff to become involved in jail services.	

Contributor	Findings	Current Dissemination
Gottfredson	-- Research investment in corrections is inversely proportional to numbers of persons affected, with lowest amount spent on jails, which hold the largest numbers of persons. -- Four general and interrelated categories of information needs are identified (1) Improved conceptualization. (2) Improved measurement. (3) Improved classification for screening, prediction of various outcomes, and differential treatment. (4) Improved program evaluation. -- A broad framework for research that involves eight interrelated needs (see "Research" column).	Recommend for inclusion in overall mongraph/book.

Research	Training	Future Demonstration or Dissemination
(1) Program purposes need to be described in specific, measurable terms to promote increased agreement on common aims and increased understanding of different aims.	<u>State-wide</u> training initiatives (such as in Michigan program described by Carol Morgan) to bring together jail and mental health staff.	
(2) A national program providing minimal statistical data on jails, who is in them, why, with what mental health problems, and with what outcome (based on follow-up data).	Collaboration between LEAA/ BOC criminal justice system surveys and NIMH Division of Biometry and Epidemiology staff to identify most efficient and rigorous survey strategies. Federal agency in-house training.	
(3) Expansion of core of basic data from national surveys by local jail managers. Research needs to be done to ascertain what basic data are necessary and can be readily collected on a nationwide basis, and what range of additional locally maintained data is desirable and feasible.		Model jail management information system(s) for small and large jails, that includes program- and health-related data.
(4) Use of information systems for accomplishing necessary measurement and classification studies.		
(5) Use of information systems for accomplishing program monitoring, evaluations, and assessments.		
(6) Research on impact of employment in jails on staff.		
(7) Specialized, basic research on the measurement of stress and the impact of jail environments on the health and mental health of inmates and staff, on the role performance of these main people, as well as that of adjunct service providers, e.g. mental health professionals.		

Research	Training	Future Demonstration or Dissemination
(8) Establishment of research units within jails, to perform a variety of program assessment and improvement functions, as well as to assist in psychometric assessments of inmates and staff.	Requires creation of a new criminal justice role and training of incumbents in individual and program assessment techniques (which combines psychometric and applied sociological research perspectives).	

10B (cont.)

Contributor	Findings	Current Dissemination
Steadman	-- There are few program areas in either criminal justice or mental health systems that have less information available to planners and practitioners than mental health services to jails. -- Willingness to commit resources to developing adequate data bases is therefore crucial. -- Research suggestions presented were developed from a mental health research perspective since the conceptualization of conference papers and discussion was too narrow with respect to mental health, perhaps from an inadequate understanding of the operation of state and local mental health systems beyond those few segments that have come into direct contact with jails. -- Research on mental health services in jails is a precursor and mechanism of providing administrators and front line service providers with the information they need to perform more effectively. Thus, research is necessary simply to increase an agency's capabilities for informed action. -- Another reason for conducting research, particularly at the local level, is that information obtained is directly germane to funding requests. It provides necessary documentation. -- Research is recommended from a mental health perspective in four major areas. (See "Research" column).	

Research	Training	Future Demonstration or Dissemination
(1) What are and what have been the relationships between mental health systems and local correctional systems? This broad question needs to be addressed since existing law, empirical evidence, and conventional wisdom conflict. Mental health commitment laws have increasingly become stricter and have been thought to increase the proportion of jail population with mental health problems, but empirical evidence also indicates an increase over time in the proportion of mental hospital patients with arrest and multiple arrest records. In particular, research on these relationships across systems needs to focus on		
a. the impact of changing mental health legislation on jails;		
b. the impact of judicial rulings in mental health law and of national health standards;		
c. the nature and utilization of referral paths and processes into and out of each system. (A central focus here should be the police officer).		May require identification and tracing of an arrestee cohort.
(2) Research on correctional officer practices and needs, with special attention first to selection practices, and thereafter to training (as indicated by Brodsky), as well as the nature of jails as problematic work environments.		

Research	Training	Future Demonstration or Dissemination
(3) The wide range of views about the jail and its appropriate mental health service programs reflects a fundamental research need: viz., to determine what various groups see as the responsibilities of jails and the manner in which mental health services can be fit into the various models that communities may have for their jails. Criteria for a successful program must exist before program effectiveness can be measured. Research on community attitudes as a way of identifying programs that may be more capable of others for generating community support fits here. Also, research on the role of jail mental health services in the reduction of violence seems to have a community impact, in that up to one-fourth of all referrals for mental health services in some communities are for individuals described as violent.		
(4) Research needs to be conducted on the dynamics of program development, in other words, on the processes by which mental health service programs are developed, implemented, and how they affect the jail. Specific topics that should receive attention include: (a) the role of volunteers; (b) the location of services; (c) needs assessment; (d) the impact of mental health services on the formal and informal organization of the jail; and (e) the effects of receiving mental health services.		Requires identifying new or creating demonstration programs to serve as a research setting. (e) may require follow-up studies after release from jail and separation of effects of subsequent life events from those of time in jail in explaining outcome indicators.

D

NATIONAL CRIMINAL JUSTICE EXECUTIVE TRAINING PROGRAM

AGENDA
MENTAL HEALTH SERVICES IN LOCAL JAILS
September 27-29, 1978
Lord Baltimore Hotel
Baltimore, Maryland

Wednesday, September 27th

11:00 a.m. - 1:00 p.m. — REGISTRATION (Cavalier Foyer)

1:00-1:15 p.m — WELCOMING REMARKS (Cavalier Room)
Blair G. Ewing
Acting Director
National Institute of Law Enforcement and Criminal Justice, LEAA

Christopher Dunn
Special Assistant
National Institute of Mental Health

ORIENTATION
Allen F. Breed
Director
National Institute of Corrections

1:30-2:00 p.m. — NATURE OF MENTAL HEALTH PROBLEMS IN JAILS
"Psychological and Behavioral Pathology in Jails"
John J. Gibbs
Professor
School of Criminal Justice
Rutgers University
Newark, New Jersey

2:00-2:45 p.m. — Reactor Panel

Christopher Dunn (Chairperson)

Mohamed Al-Ibrahim
Chesapeake Physicians Association
Baltimore, Maryland

Thomas Peters
Director
Medical and Psychiatric Services
Department of Public Health
San Francisco, California

SPECIAL NATIONAL WORKSHOP

2:45-3:00 p.m.	BREAK
3:00-5:00 p.m.	Small Group Discussions
5:00-5:30 p.m.	Group Feedback and Synthesis
5:30-7:00 p.m.	RECEPTION (Cavalier Annex)
7:00 p.m.	DINNER (Cavalier Room) Welcoming Remarks The Honorable William D. Schaefer Mayor City of Baltimore

Thursday, September 28th

8:00-8:30 a.m.	MORNING REGISTRATION/COFFEE (Cavalier Foyer)
8:30-10:30 a.m.	INDIVIDUAL NEEDS ASSESSMENT AND INTERVENTION "The Process of Assessment" Walter R. Gove Professor of Sociology Vanderbilt University Nashville, Tennessee "Assessment Techniques" Edwin I. Megargee Professor of Psychology Florida State University Tallahassee, Florida "Intervention Models" Stanley Brodsky Professor of Psychology University of Alabama University, Alabama
10:30-10:45 a.m.	BREAK
10:45-12:00 p.m.	Reactor Panel Asher R. Pacht, (Chairperson) Clinical Professor of Psychiatry and Psychology University of Wisconsin-Madison Madison, Wisconsin Gordon Kamka Warden Baltimore City Jail Baltimore, Maryland

	Ronald Cann Assistant Director Mental Hygiene Administration Maryland Department of Health and Mental Hygiene Baltimore, Maryland Susan Stanton Director Department of Corrections Kansas City, Missouri John P. O'Brien County Sheriff Genesee County Flint, Michigan
12:00-1:15 p.m.	LUNCHEON SESSION (Salons A and B) "Major Recommendations and Implementation Plans of the President's Commission on Mental Health" Thomas F. A. Plaut Acting Deputy Director National Institute of Mental Health
1:15-3:00 p.m.	Small Group Discussions
3:00-3:30 p.m.	Group Feedback and Synthesis
3:30-3:45 p.m.	BREAK
3:45-5:30 p.m.	LEGAL PERSPECTIVES ON SERVICE PROVISION "Legal Issues" Richard Singer Professor of Law Rutgers University School of Law Newark, New Jersey "Implementation of Court Orders" Kay Harris Director, Washington Office National Council on Crime & Delinquency Washington, D.C.
5:30 p.m.	ADJOURN

5:30-6:30 p.m. — RECEPTION
Lord Baltimore Hotel

6:30-7:00 p.m — Tour of the "U.S.S. Constellation"
(Inner Harbor)

7:00-7:30 p.m. — Tour of Clipper Ship
"Pride of Baltimore"
(Inner Harbor)

Friday, September 29th

8:00-8:30 a.m. — REGISTRATION (Cavalier Foyer)

8:30-10:45 a.m. — SERVICE DELIVERY MODELS
Panel Discussion

Carole Morgan (Chairperson)
Corrections Management Consultant
Western Interstate Commission for
Higher Education
Boulder, Colorado

Norma Gluckstern
Administrator
Bureau of Rehabilitation and Programs
Prince Georges County
Upper Marlboro, Maryland

William J. Anthony
Assistant Sheriff
los Angeles Sheriff Department
Los Angeles, California

Mike Haley
Jail Administrator
Marengo County Jail
Linden, Alabama

Terry Pitcher
Training Officer
Department of Corrections
Lansing, Michigan

Errol Kwait
Director of Support Services
Cuyahoga County Jail
Cleveland, Ohio

Raymond Fjetland
Sheriff
Whittman County
Colfax, Washington

Nelson Stiles
Deputy Warden
Monmouth County Correctional
Institution
Water Works Road
Freehold, New Jersey

Brenda Hippard
Director
Department of Corrections
Napa, California

10:45-11:00 a.m. — BREAK

11:00-12:30 p.m. — Small Group Discussions

12:30-2:00 p.m. — LUNCHEON SESSION (Salons A and B)
"Jails - The Ultimate Ghetto"
Ronald Goldfarb
Partner - Goldfarb, Austern, and
Singer
Washington, D.C.

2:00-2:30 p.m — Group Feedback and Synthesis

2:30-3:30 p.m. — RESEARCH AND EVALUATION ISSUES
Panel Discussion

Phyllis Jo Baunach (Chairperson)
National Institute of Law Enforcement
and Criminal Justice, LEAA

Don Gottfredson
Dean
School of Criminal Justice
Rutgers University
Newark, New Jersey

Hank Steadman
Director
Bureau of Special Projects Research
Department of Mental Hygiene
Albany, New York

Paul Katsampes
Boulder County Justice Center
Boulder, Colorado

3:30~~-4:30 p.m.~~ 3:35

COFFEE BREAK

3:35-4:30 p.m.

"Synthesis"
Skip Mullaney
Executive Director
Offender Aid and Restoration, USA
Charlottsville, Virginia

4:30 p.m.

ADJOURN

Special National Workshop Group Reporters

Norma Gluckstern	Group I
Thomas Peters	Group II
Ronald Cann	Group III
John P. O'Brien	Group IV

Special National Workshop Group Facilitators

Craig Dobson	Group I
Gordon Kamka	Group II
Paul Estaver	Group III
Asher R. Pacht	Group IV

STICE
ECUTIVE
AINING
OGRAM

November 13, 1978

Mr. G. Martin Lively
ODTD Government Project Monitor
NILECJ/LEAA
4340 East West Hwy
South Tower III
4th Floor
Bethesda, MD 20014

Dear Martin:

Enclosed please find a copy of the Evaluation Report for the SNW on Mental Health Services in Jails held on September 27-29, 1978. In light of the fact that the workshop was co-sponsored by several organizations, and given the input from the Advisory Committee, we would suggest that you might wish to circulate the report among these actors.

Best regards,

Sheldon S. Steinberg
Project Director

SSS/eac (8071)
Enclosure

cc: Paul Estaver
Ty Hodanish
Ethel Foster

5530 WISCONSIN AVE., N.W. WASHINGTON, D.C. 20015 301/654-8338

Contract administered by University Research Corporation
For the National Institute of Law Enforcement and Criminal Justice
Law Enforcement Assistance Administration
United States Department of Justice

MENTAL HEALTH SERVICES IN LOCAL JAILS

Special National Workshop

Lord Baltimore Hotel
Baltimore, Maryland

September 27-29, 1978

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NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE
Executive Training Program in Advanced Criminal Justice Practices

FEEDBACK FORM

Special National Workshop
Mental Health Services In Local Jails
Baltimore, Maryland, September 27-29, 1978

Your responses to the following questions will help us assess the effect of this workshop and plan special national workshops to be delivered in the future.

Professional Category (circle one):

Sheriff — Academician/Researcher

Correctional Administrator — Mental Health Professional/Administrator

Other _____
(please specify)

1. WORKSHOP GOALS

The overall goals of this workshop are listed below. Please rate how well these goals were met by circling the number which reflects your opinion.

	Completely (100%)	Mostly (75%)	About half (50%)	Some (25%)	Not at all (0%)
• Define problems and needs	5	4	3	2	1
• Facilitate exchange of information between correctional and mental health officials	5	4	3	2	1
• Develop programmatic recommendations	5	4	3	2	1
• Provide impetus for change in mental health services at state and local levels	5	4	3	2	1

2. UTILITY OF WORKSHOP

Please circle the appropriate rating for the following sections:

	Excellent	Good	Satisfactory	Poor	Unsatisfactory
• How would you rate the usefulness of the entire workshop?	5	4	3	2	1
• How would you rate the usefulness of the discussion papers distributed prior to the workshop?	5	4	3	2	1

2. UTILITY OF WORKSHOP, cont'd.	Excellent	Good	Satisfactory	Poor	Unsati.
• How would you rate the amount of new information gained from the workshop?	5	4	3	2	1
• How would you rate the applicability of this information to your job setting?	5	4	3	2	1
• How would you compare this workshop with others you have attended?	5	4	3	2	1
3. UTILITY OF SPECIFIC SECTIONS					
• Nature of mental health problems in jails	5	4	3	2	1
• Individual needs assessment and intervention	5	4	3	2	1
• Legal perspectives on service provision	5	4	3	2	1
• Service delivery models	5	4	3	2	1
• Research and evaluation issues	5	4	3	2	1

4. WORKSHOP PARTICIPATION

Did you feel comfortable asking questions and/or contributing information during the workshop sessions? (Circle one)

YES NO DID NOT PARTICIPANT IN DISCUSSIONS

5. WORKSHOP METHODS

Please rate the following aspects of the workshop by circling the appropriate number.

	Excellent	Good	Satisfactory	Poor	Unsatisfactory
• USEFULNESS OF THE PLENARY SESSIONS	5	4	3	2	1
• CONTRIBUTION OF THE REACTIVE PANELS	5	4	3	2	1
• PRODUCTIVITY OF SMALL GROUP SESSIONS	5	4	3	2	1
• FORMAT OVERALL (mixture of plenary and small groups)	5	4	3	2	1
6. LOGISTICS AND TRAVEL ARRANGEMENTS	5	4	3	2	1

7. OUTCOMES FROM THE WORKSHOP

Do you expect to initiate any of the changes suggested at the workshop in the near future?

YES NO DON'T KNOW

If yes, what changes? _____

_____

8. If a post-workshop monograph is published, what specific information should be included?

9. What specific suggestions and recommendations do you have in regard to mental health in jails for future action for:

a) Local officials

b) Federal agencies

c) Researchers

10. Were there any topics that are of particular importance to your agency that you thought were not included in the workshop?

11. What was of most value to you in the workshop?

12. What was of least value to you in the workshop?

13. Comments and suggestions

Evaluation Report

SPECIAL NATIONAL WORKSHOP
on
MENTAL HEALTH SERVICES IN LOCAL JAILS

Baltimore, Maryland, September 27-29, 1978

A. BACKGROUND

The purpose of this report is to provide information for URC and LEAA managers on the reaction of participants to the Special National Workshop on Mental Health Services in Local Jails, Baltimore, Maryland, September 27-29, 1978

The Special National Workshop was jointly sponsored by the National Institute of Law Enforcement and Criminal Justice, the National Institute of Mental Health, and the National Institute of Corrections. The specific goals for the workshop included defining problems and needs, facilitating exchange of information between correctional and mental health officials, developing programmatic recommendations, and providing impetus for change in mental health services at state and local levels.

B. PARTICIPANTS' ASSESSMENT OF THE WORKSHOP

There were 49 participants at the workshop. This total does not include observers from the sponsoring agencies, other federal agencies, and consultants. At the end of the workshop, the participants were requested to complete a questionnaire providing URC with feedback on the workshop. Forty-four of the 49 participants (90 percent) completed and submitted this form. This report is based on the data collected by this questionnaire. The tabulated results on the quantitative data are presented in Appendix A. Responses to specific open-ended questions appear in Appendix B.

1. Workshop Goals

Participants were asked to rate how well they felt the goals of the workshop were met. On a 5-point scale (5 = completely met to 1 = not met at all) respondents rated the goals: define problems and needs, ficilitate exchange of information between correctional and mental health officials, and provide impetus for change, as mostly met, median rating of 4.0. The remaining goal: develop programmatic recommendations received a median rating of 3.0. The analysis of the data by professional category suggests that sheriffs felt the goals were met to a higher extent than any other group.

2. Workshop Utility

Overall the respondents found the workshop useful. They also indicated that receiving the discussion papers prior to the workshop was useful to them. The respondents felt that this workshop compared rather favorably with other training events they had attended, and that the amount and applicability of the information presented at this workshop was above average. The breakdown of the data by professional category does not indicate any consistent trends among the different categories. For complete display of the quantitative data, see Table 3.

3. Utility of Specific Sections

The participants were requested to rate five specific sections of the workshop according to their utility. The two sections that were most useful to the respondents were the legal perspectives on service provision and service delivery models. The breakdown of these data indicates that sheriffs felt that the sections on the nature of mental health problems in jails and service delivery models were most useful to them while the academicians/researchers rated the sections on legal perspectives on service provision, service delivery models, and research and evaluation issues as being of highest value to them. (see Table 4).

4. Workshop Methods

As can be noted from Table 5, the respondents were satisfied with the methods utilized during the workshop. As a group the sheriffs again tended to rate the methods higher than any other group. The correctional administrators perceived the reactive panels as a noteworthy aspect.

The logistics and travel arrangements were rated favorably (median rating = 4.0).

The data further suggest that most respondents felt comfortable asking questions and/or contributing information during the workshop sessions since only one person responded to this question with a negative answer and another person neglected to mark a response.

5. Outcomes from the Workshop

To determine whether the participants planned to utilize any of the information presented at the workshop, the following question was asked: "Do you expect to initiate any of the changes suggested at the workshop in the near future?" Almost half of the respondents (48 percent) stated that they would, 23 percent were not sure, 20 percent did not answer this question and 9 percent indicated that they would not.

The participants were also asked to suggest specific information that should be included in a post-workshop monograph. Among the suggestions were: Major issues and steps for modifying or developing mental health programs in jails (6), models presented and in use (5), research of mental health in jails (6), all papers presented with brief critiques (3), specific research needs (2). Additional suggestions were noted by individual respondents: Availability of technical assistance and resources, incidence of mental health problems and changes of incidence over recent years, evaluation of current model programs, legal implications, jail standards, individual needs assessment.

In addition, specific suggestions and recommendations for future actions by local officials, federal agencies and researchers were requested. There were few responses to this question and most of them did not address the question directly. Since this question required a two step analysis to determine the function of each group and then suggest actions--it appears that under the time constraints imposed, the question was too complex.

The responses to the question, "Were there any topics that are of particular importance to your agency that you thought were not included in the workshop?" mostly were individualized. Two respondents noted methods and techniques to bring about minimum level of mental health services and juvenile mental health issues. Some of the others noted by individuals were: Role/function of federal agency, effective community educational programs, clarification of mental health problems that are treatable and those which are not, more on service delivery models, methods of funding, epidemiological approach to mental illness and suicide in jails and in the community, transfers between mental and penal facilities.

Content Analysis of Respondents' Comments

The question, "What was of most value to you in the workshop?" elicited a range of responses from very general, e.g., "gained invaluable insights" to very specific "Carole Morgans' summary article." Most of the respondents expressed appreciation for the opportunity to meet other participants.

The converse question, "What was of least value to you?" evoked more specific comments, however, only one response recurred more than once: "the labelling theory" otherwise there did not appear to be any consensus among the respondents.

The respondents were free with their ideas under suggestions and comments (see Appendix B). Several suggestions related to the fact that this type of training should be provided on regional and local level. Overall the respondents indicated that the workshop was definitely worthwhile for them and should be continued, as expressed in the words of one participant, "Keep up the dialogue, make this a national issue, build legislative support and kee the momentum moving. All in all--a good experience--planning group to be complimented."

APPENDIX A

Special National Workshop
Mental Health Services in Local Jails

Table 1
Number and Percent of Respondents, by Professional Category

Professional category	N	Percent
Sheriff	6	14
Correctional Administrator	9	20
Mental Health Professional	15	34
Academician/Researcher	10	24
Other	4	9
Total	44	100

Table 2
Ratings on How Well the Workshop Goals Were Met, All Respondents and by Professional Categories

Goal	Total N	Total Median	Sheriff N	Sheriff Median	Cor. Admin N	Cor. Admin Median	M.H. Prof N	M.H. Prof Median	Acad./Res. N	Acad./Res. Median	Other N	Other Median
Define problems and needs	44	4.0	6	4.0	9	4.0	15	4.0	10	3.0	4	5.0
Facilitate exchange of information	44	4.0	6	4.0	9	4.0	15	4.0	10	4.0	4	4.0
Develop programmatic recommendations	43	3.0	6	4.0	9	3.0	14	3.0	10	3.0	4	3.0
Provide impetus for change	43	4.0	6	4.0	9	4.0	14	3.0	10	4.0	4	3.0

Table 3
Ratings on Workshop Utility, Total Respondents and by Professional Category

Utility aspects	Total N	Total Median	Sheriff N	Sheriff Median	Cor.Admin N	Cor.Admin Median	M.H. Prof N	M.H. Prof Median	Acad./Res. N	Acad./Res. Median	Other N	Other Median
Usefulness of entire workshop	43	4.0	6	5.0	9	4.0	14	4.0	10	4.0	4	4.0
Usefulness of discussion papers	43	4.0	6	4.0	9	4.0	14	5.0	10	4.0	4	3.0
Amount of new information	44	4.0	6	4.0	9	3.0	15	4.0	10	4.0	4	4.0

(continued)

Table 3 (continued)

Utility aspects	Total N	Total Median	Sheriff N	Sheriff Median	Cor. Adm. N	Cor. Adm. Median	M.H. Prof N	M.H. Prof Median	Acad./Res. N	Acad./Res. Median	Other N	Other Median
Applicability of information	44	4.0	6	4.0	9	4.0	15	4.0	10	4.0	4	4.0
Comparison of this workshop with others	43	4.0	6	4.0	8	4.0	15	4.0	10	4.0	4	4.0

Table 4
Ratings on Utility of Specific Sections, Total Respondents and by Professional Category

Section	Total N	Total Median	Sheriff N	Sheriff Median	Cor Adm. N	Cor Adm. Median	M.H. Prof N	M.H. Prof Median	Acad./Res. N	Acad./Res. Median	Other N	Other Median
Nature of mental health problems in jails	44	4.0	6	5.0	8	3.0	15	4.0	10	4.0	4	4.0
Individual needs assessment and intervention	44	4.0	6	4.0	9	3.0	15	4.0	10	4.0	4	3.0
Legal perspectives on service provision	43	4.0	6	4.0	9	4.0	14	4.0	10	5.0	4	4.0
Service delivery models	44	4.0	6	5.0	9	4.0	15	4.0	10	5.0	4	5.0
Research and evaluation issues	31	4.0	5	4.0	7	4.0	11	3.0	6	5.0	2	3.0

Table 5
Ratings on Workshop Methods and Logistics, Total Respondents and by Professional Category

Method	Total N	Total Median	Sheriff N	Sheriff Median	Cor Adm. N	Cor Adm. Median	M.H. Prof N	M.H. Prof Median	Acad./Res. N	Acad./Res. Median	Other N	Other Median
Plenary session	43	4.0	6	5.0	8	3.0	15	4.0	10	4.0	4	4.0
Reactive panels	44	4.0	6	4.0	9	5.0	15	4.0	10	4.0	4	4.0
Small group sessions	44	4.0	6	5.0	9	4.0	15	4.0	10	4.0	4	4.0
Format overall	44	4.0	6	4.0	9	4.0	15	4.0	10	4.0	4	3.0
Logistics and travel arrangements	41	4.0	6	4.0	9	5.0	13	4.0	10	4.0	3	3.0

APPENDIX B

Participants Comments

Special National Workshop
Mental Health Services in Local Jails
Baltimore, Maryland, September 27-29, 1978

What was of most value to you in the workshop?

- Not one particular item but generally overall the workshop was important to me.
- Opportunity to meet and discuss problems with professionals in the field.
- Ability to share concerns and concepts with other participants.
- Assisted me in defining Mental Health needs and approaches for supplying.
- Combination of hearing and reading different ways of dealing with mental health concerns.
- Carole Morgan summary article.
- Meeting my equal counter-part.
- Talking with other jail administrators. Touring Baltimore City Jail.
- Legal and future plans of federal government for expanding mental programs.
- The opportunity to see what other institutions are doing to implement or improve mental health services.
- Gained an invaluable insight into what programs have and can be implemented in jails with proper cooperation by all parties and/or agencies concerned.
- Presentations: legal, intervention and assessment, research, programs.
- Meeting others providing jails and Mental health Services.
- Interactions.
- Meeting and sensing where other participants were "coming from."
- Models session and publication.
- Aid to conceptualization of problems expressed from diverse perspectives; learning of specific programs.
- In terms of developing researchable issues, everything was important--talking with jail administrators and mental health professionals individually, in groups; plenary sessions outlined issues; papers set the stage.

Most value (cont)

- Hear what is going on around the country.
- Being sensitized to the issues which may have an effect on my future research.
- Hearing about and discussing the topic. Kay Harris' presentation.
- To know and share with others procedures and information.
- Service Delivery Models and that these have proven that cooperation is possible. Representatives from all agencies interested and working toward common goal.
- Presentation of Sample Programs presented by states 9/29/78 at 8:30 AM, (i.e., Service Delivery Models), and Carole Morgan's book and presentation.
- Exchange of information and particular experiences in dealing with jail population. Feedback from sheriffs and jail administrators concerning their perspectives on mental health personnel and approaches.
- Reports on various programs.
- Hearing points of view of various disciplines.
- Conversation with others re workable and unworkable issues.
- Models/small groups.
- Small group sessions.
- The opportunity to talk to and hear about how others have overcome obstacles to cooperation between MH and criminal justice.
- Opportunity to exchange ideas with others.
- Legal issues.
- Meeting/talking with participants.
- Hearing a broad range of insights on this difficult but important subject and meeting practitioners in that field.
- Information printed in papers.
- Service Delivery Models; Personal Interchange.

What was of least value to you in the workshop?

- Presentation of discussion papers.
- Papers and group.
- Labeling Theory.
- The academic notion of labeling--trying to define mental illness--a lot of time was spent on semantics.
- Theoretical.
- Listening to some of the presentations which were not an issue.
- Presentation of theoretical consideration; especially Gove-Megargee-Brodah.
- Lack of listening skills of many participants.
- Research presenters--probably because they have little client involvement with inmates' views of this problem.
- Small group discussions.
- Labeling theory presentation.
- Tuesday's academic presentation.
- Synthesis and feedback--reactor panels, wasn't much offered. Felt Carole Morgan's synopsis of her study expressed a bias not balanced by M.H. perspective (not to sound defensive!)--that being M.H. people "never" initiated jail programs.
- Lack of clear focus--i.e. are we concerned with mental health or mental illness.
- Reactors at beginning too long.
- Really a lot to learn and accomplish in such a short time: very intensive.
- Hard to say; all useful and informative.
- Needs assessment and intervention session.
- Not enough inputs from mental health administrators (i.e. planners of state and county levels.) Paper on labeling theory.
- Small group--we were so far off task so often that it had much less value than I had hoped. Furthermore, one member over-talked and under-listened, and this was very disruptive to me.

Least value (cont)

- All aspects were valuable; however, I felt the clinical outlook was emphasized and the operational aspect was somewhat ignored.
- Lack of specific goals for small groups.
- Listening to the academicians talk and watching them not listen back--preconceived definitions offered by M.H. "professionals."
- Panel speakers.
- Group summaries.
- Small groups--interesting, however not focused; generalized and talked about large jail issues, no problem-solving only problem identification.
- Legal aspects.
- Explanation of how conference came about.

Comments and Suggestions

- Next workshop start with Corrections administrators who can describe their programs and how they were started. This will provoke interchange. Have workshop at state level.
- Listen to and involve more of the local correction people, not only in participation but also in presentations. Use people who are actually "doing it" rather than people who are "theorizing it."
- Worst drawback was heat and smoke of room--make it impossible for me to remain in for more than 45 minutes or so without expressing considerable physical distress so I missed some papers. Next time, cut down on lights, increase ventilation and forbid smoking.
- Need: 1) time perspective; 2) epidemiological perspective in coalating the size and direction of the problems.
- Small group task should have been better structured.
- Groups in small group discussions were too large--also our facilitator was not skilled in keeping the group focused on the task at hand. This small group discussion could be more productive.
- That we get this form on the second day to give us time in which to respond. More time or large block of time each day for breather (to catch up on reading, etc.)

Comments and Suggestions (cont)

- Regional workshops including persons from this one as impetus for interest.

- Tighter control of beginning of workshop: 1) maintaining focus; 2) assigning specific tasks; 3) specialize the discussion groups; 4) more time for feedback from the groups and better effort at synthetization.

- Poor hotel accomodations--should be in a more centralized location. We need regional follow-up meetings.

- Small group sessions were excellent and very worthwhile. Need to implement workshops such as these on state levels with federal agencies present.

- 1) enjoyed the meetings and the people I met; 2) program planners and implementers are to be commended; 3) appreciated being invited.

- Keep up the dialogue, make this a national issue, build legislative support and keep the momentum moving. All in all--a good experience--planning group to be complimented.

- The collaboration in planning by NILECJ, NIC, and NIMH, Crime and Delinquency Center paid off well.

- Too much scheduled in too short a time.

- Would recommend guidelines for small groups so that discussion does not wander from the main topics.

- 1) Do more research in area of data collection on specific mental health problems and delivery systems; 2) make recommendations to concerned agencies on the need for standarized delivery system for mental health and medical services; 3) endorse programmatic planning by local governments.

- Never got clear definition of what mental health meant in conference discussions. Planning/logistics, etc. including pre-workshop papers (not content) was excellent. Liked workshop evaluation format. Fine handling of expenses--best I have ever experienced.

  Next step--Identify in 1,2,3 fashion what must be done prior to development of jail programs including mental health programs--then steps to program development. "How to" is still needed.

- Bring more diversity of mental health personnel into this kind of interaction approach. Behavioral psychologists seemed to be the most numerous and this is simply too narrow in terms of current acceptable established approach.

Comments and Suggestions (cont)

- Evaluation questionnaires should not be given out during session when presentations are being given--participants fill them out and do a dis-service to the speaker! Plan quiet time for that.

- The service programs ought to have been offered first and then the rest of the workshop could have been spent critiquing and/or expanding on the issues raised, problems identified, solutions tentatively explored.

  Research issues could have been identified better based on existing and already identified needs, some research issues were already self-evident and unanimously recognized and need not have been a further topic: definition of M.H., definition of population, etc.

- Very well planned--as to use of time, etc. Excellent program planning re: speakers.

  Suggestion: provide regional workshops of same nature.

- Future workshops done with pairs of community members--one jail, one M.H. to do action planning.

- Try to find funding for regional seminars of this nature.

- It is easier to complain than to suggest.

- Most needed is follow-up, building on the interest of the group and the development of a rough plan of action (and recommendations) further specifying what action can and should be taken on local, state, and federal levels and cooperatively between all of these.

  More information on service models would be very useful and guidelines on their funding and an initiative (federal) to make funding available.

- Within community of sheriff's tasks has always been this problem of coping with the mentally ill in jails and traditionally little or no treatment efforts with many of traditionalist sheriffs opposing such considerations since there has been the fear of jails being looked more upon as hospitals. In recent years, attitudes have changed and sheriffs, for the most part, receptive to help. Therefore, it is suggested that the mental health community take the lead in opening up a dialogue or when the sheriff asks, the door is open to more agressiveness in establishing a program to meet the minimum needs of inmates at the very least.

Discussion Paper

Psychological and Behavioral Pathology in Jails: A Review of the Literature

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Executive Summary

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

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

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

The studies reviewed are characterized by less than scientific sampling techniques, lack of control or comparison groups, and diverse definitions of psychological and behavioral

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pathology. The findings of two studies in which samples of men entering jails were examined for symptoms of pathology are quite divergent. In one study, approximately one-sixth of the newly arrived inmates reported a history of psychiatric hospitalization (Swank and Winer, 1976), and in another, more than two-fifths of the prisoners interviewed admitted psychiatric hospitalization (Schuckit, Herrman, and Schuckit, 1977). In the earlier investigation, over three-fifths of the new arrivals met the criteria of one of the researchers' diagnostic categories, while the later investigators reported that their diagnostic categories fit slightly less than half of their sample. In both cases, the proportion of the sample that received a diagnostic label is substantial and noteworthy. However, the considerable differences in the findings also warrant attention. Although these differences could reflect actual differences in the populations from which the samples were selected, they could also be attributed to differences in sampling designs or diagnostic schemes. However, in the absence of scientific sampling techniques, consistent definitions across studies, and reliable instruments, the answer remains in the realm of conjecture.

Estimates of the rate of behavioral pathology in jails based on referrals to institutional mental health personnel range from 35 per 1,000 prisoners (Swank and Winer, 1976) to 46 per 1,000 inmates (Petrich, 1976). In both of the studies cited above, the modal profile of the referred prisoner was quite similar. The average referred inmate was single, committed

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for a felony, and had a history of previous confinement.

The studies were also similar in the distribution of the referred inmates among some of the diagnostic categories. In both studies, functional psychosis was the most common diagnosis, and alcoholics were approximately 13 percent of each group. There were, however, substantial differences between the findings of the two investigations in the proportion of the samples contained in some of the other diagnostic categories.

Self-injury or self-destructive behavior is another measure of psychological disorder or breakdown. The investigations of self-injury reviewed are characterized by small sample size, restricted definitions of self-injury, emphasis on the method of self-injury, and analysis of demographic characteristics in an effort to identify self-injury prone inmates. Only three of the eight studies reviewed compare the self-injury group with a control sample drawn from the general jail population. Most of the research reviewed focuses on the characteristics of the man who injures himself, and it tends to overlook system-individual interactions.

The studies surveyed suggest that (1) self-injury is a more serious problem in jail than in prison or in the community, (2) most self-destructive acts are committed within 30 days of confinement and (3) there may be a link between self-injury and (a) violence, (b) ethnicity, and (c) mental illness. However, because in most of the studies reviewed the self-injury sample was not compared with a random sample of the general jail populations it is not possible to determine (1) whether or not

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the self-injury sample differs from the general jail population in terms of these factors, and (2) the strength of the association between self-injury and the variables of interest.

In some circles, a plea for additional research is considered trite, the banner of the actionless, or an excuse for lack of substance. In the area of psychological and behavioral pathology in jails, the call for additional research is not a plea or defense: it is a necessity. The "hell holes", as some call jails, will be with us tomorrow. If we want to ameliorate the stresses of jails for vulnerable groups, we need to know what those stresses are. If we wish to enhance the chances of psychological survival for susceptible men, we must know about the problems they face. The first step of action should be to gather some basic and reliable information on the nature and extent of psychological and behavioral pathology in jails. Our initial action should be research.

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

Introduction

Among the components of the American criminal justice system, one of the most heavily criticized and yet least studied is the jail. Edith Flynn states that "among any type of penal institution, the jail has the longest history. Paradoxically, it is the one institution about which we have the least knowledge." (1973:49) And Goldfarb, who refers to jails as the "ultimate ghetto of the criminal justice system," supports the same view with the following comment:

> Jails have been little studied, and widely misunderstood. There is sparse literature on the subject. The more recent pamplets are textbook treatises on jail management, security and operations; the few available books concentrate on administration: site planning, how to run competent jails, how to control a riot and prevent escapes, how to run a clean kitchen--the nuts-and-bolts problems facing jail personnel. (1975:1-2)

It is difficult to reconcile the scarcity of jail studies with the importance of jails. Literally millions are processed through jails each year, and for many of these people it is their first contact with the criminal justice system. (Flynn, 1973:68) There are over 5,000 jails in the United States, as opposed to about 400 prisons (Goldfarb, 1975:13), and it has been estimated that jails house between one and a half million and five and a half million persons per year. (Flynn, 1973:55, and Mattick, 1974:795)

Not only do jails process a greater number of people than do prisons, but the impact of the jail on the people they confine has been viewed as more damaging. Dostoyevesky observed in The House of the Dead that "...prisoners awaiting trial are

almost always, all over Russia, pale and wasted -- a sure sign that they are generally physically and spiritually worse off than convicted prisoners..." (1959:244) Goldfarb writes about what he considers a "shocking paradox":

> Our prisons are used to incarcerate men convicted of serious crimes and our jails (while housing some convicted men) primarily hold people who are awaiting trial, who have been convicted of nothing; yet our jails are far worse than our prisons. (1975:15)

These statements, which suggest the debilitating effects of the jail and the debilitated state of jail prisoners, raise a number of basic questions. One question refers to the nature or nuture issue. Do jails pose problems that result in psychological difficulties for otherwise normal individuals, or do jails house large numbers of individuals who are predisposed to experiencing psychiatric or psychological problems? A third possibility is that there is an interaction effect between predisposing factors and certain elements of the jail environment. Before this issue can be broached, however, an even more basic question should be answered. That is, what is the nature and extent of psychiatric difficulties or psychological problems in the jail setting? Answering this question is not a simple task.

Impediments to Accurate Estimation

A number of observers of American jails note that these institutions house a large number of persons suffering from serious psychological difficulties, and it has been reported that institutional personnel "...consider psychiatric illness to be the single major health problem among inmates in metropolitan jails." (Petrich, 1976:1439) However, there is limited

information on the actual extent (the proportion of the population afflicted) and nature (specific types) of these difficulties. There are three interrelated restrictions on the amount and quality of systematic information for estimating the nature and extent of mental illness in jail: records, responsibility, and reliability.

Hood and Sparks contend that the utility of agency collected data

> ...depends entirely on the quality of information which is available about offenders; and at the moment this is very low, wherever research is based on administrative records routinely kept by correctional agencies. Almost invariably, such personal and social data as are available in these records are haphazardly recorded, and are thus likely to be missing or inaccurate for a high proportion of cases ... (1970:185)

The experiences of researchers who have attempted to explore mental illness and other areas in jail attests to the accuracy of the above statement.[1] For example, Goldfarb reports that

> Because of the scanty available jail statistics, no one knows how many inmates suffer mental illness and need special health care as a result. Even as to the discrete

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[1]A survey of Nebraska county jails (1968-1969) showed that less than one-third of the counties complied with a minimum statutory requirement that an annual report on the jail be submitted to the district court clerk. (Arnot, 1969:26,29) In the same survey, only 29 percent of the jails reported that records were kept on prisoner illness. (Arnot, 1969:Table XIV) Adams and Burdman report in their survey of California county jails that "In studying and evaluating the county jails, the existing records of jails were found generally inadequate for evaluative or even descriptive purposes." (1957:93) One of the stronger indictments of jail record keeping practices has been made by Hans Mattick: "The American jail obtains very little information about the prisoners committed to its keeping, retains little of what is obtained in any usable form, and reports almost nothing of what is usable to higher authorities." (1974:793)

> group of self-identified disturbed inmates, no evidence is available to show the type and severity of their psychological problems or the lengths of time they spend incarcerated in local jails because of them. (1975:95)

In his study of incidents of self-injury in detention facilities, Gibbs discovered that the amount of missing data on men who had injured themselves while confined averaged approximately 40 percent and ranged from 8 percent for age to 57 percent for confinement history. (1978:72-73)[2]

One reason for the dearth of valid data on psychological problems and their associated characteristics in jail is the lack of responsibility and perceived need for collecting such information. The National Advisory Commission notes that:

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

Since information is typically gathered for present and future decision making and management purposes or for purposes of accountability, if one does not perceive one's self as a decision maker or accountable, the need for data collection does not exist.

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[2] The variables examined in the study by Gibbs (1978) included ethnicity, marital status, age, alcohol and drug addiction, arrest history (property, drug, and violence), committment offense, and confinement history. Gibbs compared the missing data percentages for a variety of jail and prison samples and found that the amount of missing data in the prison samples was negligible in comparison with the jail samples. (1978:76)

A related problem concerning responsibility for gathering information on mental illness in jails is the scarcity of jail personnel (researchers, social workers, psychologists, psychiatrists, etc.) who have an interest in the mental health area and who are willing to assume responsibility of data collection.[3]

> Since few jails have regular arrangements to obtain psychiatric medical services, and since intensive psychological testing and evaluation is rarely a feature of the jail intake process, there is no accurate count of the incidence of various mental disorders among inmates. (Goldfarb, 1975:103)

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

One problem area is the reliability or inter-rater consistency of estimates made by various institutional personnel. For example, Johnson (1976) interviewed a group of prison custodial personnel in New York State (n=81) and found not only wide variation in

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[3] A 1973 AMA survey found that only 13 percent of the jails included as part of national survey featured psychiatric services. (Petrich, 1976:1439) Arnot reported that only 7 percent of Nebraska's 90 county jails hired a physician who routinely made calls; 4 percent reported no physican to the jail; and 69 percent reported private physicians on call on a fee for service basis. (1969:36) In 1957; Adams and Burdman found that 88 percent of California jails had no psychiatric services, and 95 percent reported no psychological services or social workers available. (1957:64) LEAA's 1972 jail survey showed the following breakdown of professional employees in jails: medical doctor, 19 percent; nurse, 6 percent; psychiatrist, 3 percent; psychologist, 2 percent; social worker, 5 percent. (U.S. Department of Justice, 1975: Table 15, 37)

estimates of the proportion of inmates experiencing phychological problems (0-65 percent) but also considerable variability in definitions of what constituted a psychological problem. The reliability problem may not be solved by employing only the judgements of mental health professionals. There may be tremendous variation in the diagnostic schemes use by such personnel, and when the same diagnostic categories are used, the agreement among those making diagnoses may be low.

This section has provided a brief description of some of the problems involved in estimating the extent and nature of mental illness or psycholoigcal problems in jail populations. Subsequent sections will review the available research on these problems. These sections will furnish information on (1) the number of individuals who enter jails with existing psychological problems or histories of psychiatric difficulties, (2) the number of people who require psychiatric evaluation or treatment while confined, and (3) a review of the research on self-destructive behavior in jail.

In reviewing the studies presented, the reader should keep in mind that many of the problems mentioned in the present section (especially validity and reliability) make it difficult to generalize from the data summarized. When one considers that the definitions of psychological problems included in these studies may reflect behaviors that range from a man embroiled in a battle with alien powers who is attempting to escape their clutches by swallowing bed springs

to a prisoner who reports to an intake officer that he is mildly depressed at the prospect of confinement, the seriousness of the jail data problem begins to take its ominous shape.

Another problem that limits the generalizability of the findings of the studies reviewed is that most of the jails investigated were large urban jails. These jails may have been selected for a number of reasons: (1) the large populations of urban jails facilitate sample selection, and reduce the cost that would have been incurred selecting an equivalent sample from a number of smaller county jails (Gibbs, 1978:5), (2) urban jails sometimes furnish more complete records than those available at smaller jails (Gibbs, 1978:5), (3) large urban jails may be comparatively more likely to employ medical and mental health personnel who may be interested in conducting or supporting research, and (4) since large urban jails represent a large proportion of the nation's jail population (Flynn, 1973:59), they may also account for a lion's share of jail problems, and any information provided on them may be considered a substantial contribution (Gibbs, 1978:5).

Although smaller county jails may differ from large urban jails in terms of population density, proportion of sentenced and detained prisoners, population characteristics, size, and prisoner-staff ratio, it is possible that the problems of the county jail may be similar to those of the large urban jail. To answer this question, however, one must first

ascertain what types of problems are prevalent in larger jails. (Gibbs, 1978:5.6)

Problems at the Entry Stage

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

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

> On an ordinary day a typical detention facilty will have among its population first offenders, situational offenders, professional criminals, and violent men and women prone to act out their personality disorders. It will house parole violators en route back to prison, soldiers and sailors awaiting return to military jurisdiction, and recently convicted felons awaiting transfer to the state or federal penitentiary.

> It will also hold nonoffenders -- material witnesses; accused persons, complaints against whom will be dropped; and tragically, many individuals who are totally innocent. Some will be held but a few hours while others will wait months, as long as 18 months, for their day in court.
>
> In short, the typical jail is a catchall for society's unsolved problems including the sick, the weak, the inadequate, the occasional offender, the chronic thief, the vicious, and the innocent. But above all, it is a depository for the poor and the friendless. (Nagel, 1973:17)

> A growing majority of the population today is being held for trial or awaits some other dispostiion: an appeal or a transfer to another institution. The typical jail many contain persons serving out sentences or fines and may house parole violators en route back to the penitentiary, probation violators awaiting hearings, and persons awaiting transfer or extradition to other jurisdictions. Finally, it may hold sociomedical cases: the mentally ill, the alcoholic, and the drug addict, all of whose problems become simply exacerbated by the jail and who contribute disproportionately to the revolving door syndrome so typical of this institution. (Flynn, 1973:57)

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

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

It is obvious that the jail experts quoted above agree that mentally ill persons are entering our jails. The questions that now beg answering are (1) what proportion of the intake population do these people comprise, (2) what is the nature of their illness, and (3) what are their characteristics?

Two studies (Swank and Winer, 1976; and Schuckit, Herman, and Schuckit, 1977) present data which address questions 1 and 2 above. As part of a larger program at the Denver County Jail, Swank and Winer conducted clinical interviews with 100 newly admitted inmates[4] and classified them into psychiatric diagnostic categories.[5] The authors present data which show that 24 percent of the new arrivals reported a history of some type of psychiatric contact (evaluation, treatment, or hospitalization), 64 percent admitted no psychiatric history, and 12 percent were classified as undetermined. Of the 24

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4 Swank and Winer report that the " . . . 100 inmates were seen for psychiatric evaluation as they entered the jail in daily consignments. On these occasions all arriving inmates were seen . . . " (1976:1332) Since the consignments evaluated were not selected on a random basis, unknown biases could be reflected in the findings.

5 The diagnostic categories reported in the study were functional psychosis, organic psychosis, antisocial personality, neurosis, alcoholism, drug addiction, transient situational disturbance, mental deficiency, and convulsive disorder. The authors do no provide definitions for the diagnostic categories nor do they indicate if more than one examiner evaluated the inmate for purposes of reliability.

new admissions who reported psychiatric histories, 21 percent (n = 5) were included in each of the following categories: evaluation only, outpatient/day care, and long-term inpatient care. The remaining 37 percent (n = 9) had received short-term inpatient care. (See Swank and Winer, 1976:Table 1)

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

Schuckit, Herrman, Schuckit (1977) conducted structured personal interviews with 199 white, male, newly admitted prisoners to the San Diego jail who were arrested for non-drug related felonies and who did not have a previous felony conviction.[6] The interviews were classified by a psychiatrist into one of the six categories:[7]

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6 The restricted nature of the sample limits its utility for estimation purposes because any variation in rates by ethnicity, charge, or prior criminal history is eliminated.

7 "The 199 subjects were divided into diagnostic categories based on the psychiatric disorder which appeared first chronologically." (Schuckit, Herrman, and Schuckit, 1977: 119) There is no mention in the study of a reliability check on the diagnostic classification.

alcoholism, drug abuse, antisocial personality, affective disorder, organic brain syndrome, and no diagnosis.[8]

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

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[8]The authors defined their diagnostic categories as follows: "(1) Alcoholism These individuals had evidence of a major life problem in at least one of four life areas. Thus, they demonstrated an alcohol-related marital separation or divorce, or two or more nontraffic alcohol-related arrests, or physical evidence that alcohol had harmed health, or a job loss or layoff related to alcohol. (2) Drug abuse These individuals had a major life problem related to the abuse of drugs. Difficulties were the same as those outlined for alcoholism. (3) Antisocial personality (AP) These men demonstrated serious antisocial life problems (not directly related to alcohol or drugs) beginning before age 16 and occurring in all major life areas: problems in school (repeated suspension or expulsions), and difficulties with peers (frequent fights or using weapons, or hurting someone in a fight to a point requiring hospitalization), and problems with the family (frequent runaways or being considered by one or both parents to be incorrigible), and a history of serious police difficulties. (4) Affective disorder The exact criteria presented in the Woodruff text were utilized. To paraphrase, these persons showed a serious depressive mood lasting at least 2 weeks, along with changes in body functioning (fatigue, insomnia, constipation, etc.) and mind functioning (feelings of hopelessness, inability to concentrate, etc.) occurring at a time when alcohol and drug abuse were absent. (5) Organic brain syndrome (OBS) To meet this definition, the individual had to demonstrate confusion as well as at least one of the following: impaired orientation or memory or decreased intellectual functions." (Schuckit, Herrman, and Schuckit, 1977:118-119)

of those receiving a diagnosis or 5 percent of the entire sample in need of immediate treatment.

Schuckit, Herrman, and Schuckit's data indicate the 44 percent of the sample[9] had been hospitalized in a mental institution, 48 percent reported that they had experienced depression for more than two weeks, and 24 percent had attempted suicide. All three diagnostic groups included in the analysis (antisocial personality, drug abuse, and alcoholic) were more likely than the no diagnosis group to report that they had experienced depression, and those receiving diagnoses of antisocial personality or drug abuse were more likely to have attempted suicide than the no diagnosis group.[10] (See Schuckit, Herrman, and Schuckit, 1977: Table 2)

The authors also compared the groups by a number of background characteristics. The factors that differentiated the no diagnosis group from the three diagnostic category groups[11] were as follows:

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[9]Those diagnosed as suffering from organic brain syndrome or an affective disorder were not included in this analysis.

[10]Although the authors indicate statistically significant differences based on the chi square statistic, they do not provide any measures of strength of association between the diagnostic categories and psychiatric histories. In some cases, the strength of the relationship could be quite low, although the differences may be statistically significant due to a substantial number of cases.

[11]Differences between diagnostic groups are not reported in this paper due to length considerations.

(1) the no diagnosis group showed a lower average number of nonviolent arrests and average total arrests, (2) the diagnosis groups showed a higher average number of days per week drunk, and they were more likely to drive while intoxicated and to appear drunk in public, and (3) the diagnosis groups were more likely to have taken drugs intravenously. (See Schuckit, Herrman, and Schuckit, 1977:Table 3)

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

Another indication of the number of persons who enter jails with psychological difficulties is the number of persons who

are confined for mental observation,[12] those awaiting transfer to a mental hospital, and those who are not accused of a crime but who are imprisoned for engaging in bizzare behaviors which suggest mental illness. Some of the jail surveys conducted in various states collected relevant information in this area.

Arnot's survey of Nebraska county jails during 1968 and 1969 suggests that approximately 2 percent of the state's county jail population is confined for a mental health hearing. (1969:Table IV,II) An NCCD survey of 350 randomly selected cases at the Summit County Jail in Akron, Ohio showed that 7 percent of the sample was incarcerated for "suspicion of insanity". (NCCD, 1972:Table IV) Mattick and Sweet found in their 1967-1968 survey of Illinois jails that .2 percent of the jail population was being held for mental health authorities. And, Goldfarb reported that a 1964 Oklahoma survey indicated that

> ...in each of forty jurisdictions, as many as 24 percent of the individuals who appeared in court for sanity hearings previously had been detained in jail; four jurisdictions reported a pre-hearing jail rate of over 75 percent. (1975:97)[13]

Once again, we see that there is variation among the estimates. This could be due to actual differences among the jurisdictions or

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[12] Measures such as mental observation should be viewed with caution. In some jurisdictions, persons accused of certain offenses (e.g. homocide) are invariably placed on mental observation status independent of psychiatric diagnosis.

[13] Of course, it is not possible to estimate the number of persons confined who are in this situation since the number of people upon which the percentages are based is not provided.

it may be the result of differences in survey methodologies or counting rules.

This section contained a discussion of the number of people who enter jails with psychiatric problems and the nature of their difficulties. Of course, there may be a sizable group of people who enter jail problem free and respond to situational pressures in a pathological fashion, or there may be a considerable number of psychotics in remission whose symptoms become active after spending some time in jail.[14] The next section will include a survey of the findings on what proportion of the total jail population experiences psychological difficulties while confined. This section is not without problems; in most studies, it is not possible to separate those people who enter jails with problems (the topic of the present section) from those persons whose problems emerge during confinement.

At first glance, this chicken-egg dilemma may not appear to have great practical significance--something has to be done for both groups. However, if one wishes to measure the impact of the jail environment on nonpsychotic inmate (prisoners considered healthy when they enter the institution), or if one wishes to develop intervention or diversion programs for the two groups, information concerning the proportion of the population in each group and the nature of their problems becomes important.

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[14] It should be noted that some problems identified at the entry stage may be responses to the situational pressures of arrest or anticipatory anxiety concerning the prospects of detention.

The Nature and Extent of Psychological Problems in Jail Populations

The Swank and Winer study (1976) reviewed in the last section also contained an analysis of 445 prisoners who were referred to or requested to see the psychiatrist. If this figure is considered a measure of the number of people suffering from psychological problems in the jail population, the rate of psychiatric illness in the Denver County Jail during 1974 was 35 per 1000 inmates ((445/12,453)(1000)). If we consider only those referrals who received a diagnostic label (412) as ill, the rate becomes 33 per 1000 inmates.

As mentioned above, 412 inmates or about 93 percent of the prisoners evaluated were classified in a diagnostic category. The functional psychosis category contained the greatest number of persons receiving a diagnosis (25 percent) followed by the categories of other personality disorder (22 percent), antisocial personality (16 percent), and alcoholism (13 percent). None of the other categories (organic psychosis, neurosis, drug addiction, transient situational disturbance, or mental deficiency) contained more than 10 percent of the sample. The Swank and Winer data suggest that those inmates who are referred to jail mental health personnel have substantial problems. Approximately two-thirds of the inmates who were classified in a diagnostic category were considered either psychotics or personality disorders.

The modal profile of the referred inmate was white (57.3 percent), single (38.9 percent), committed for a felony (41.4 percent), previously convicted (56.9 percent), and between the ages of 20 and 29 (52.9 percent). Almost three-fifths of

the inmates referred reported psychiatric histories, and two-fifths had a history of psychiatric hospitalization.

When the referral group was compared with a nonrandom sample of newly arrived prisoners (n=100),[15] it was found that whites and men with psychiatric histories were over-represented in the referral group, and those committed for a felony and those without prior convictions were under-represented. (See Swank and Winer 1976:Table 1, 1132) Members of the referral group were also more likely to fit one of the diagnostic categories than were those included in the new admissions group (93 percent versus 64 percent), and they were comparatively more likely to be diagnosed as functional psychotics and less likely to be classified as alcoholics. (See Swank and Winer, 1976:Table 2, 1333)

Petrich (1976) conducted a study of King County Jail (Seattle) inmates who were referred to the institutional psychiatrist from September 1, 1973 to January 31, 1974. The staff psychiatrist examined 122 individuals of an estimated 200 individuals.[16] Based on the number of inmates examined and

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[15] Since the members of the newly arrived group did not have as much exposure to the jail environment or as much opportunity to be referred to the jail psychiatrist as inmates who had been confined for longer periods of time, the new admissions cannot be treated as a sample of the general jail population. Of course, here it is assumed that there is an association between time confined and chances for referral.

[16] Petrich reports that "A number of individuals were referred for treatment but were released from the jail prior to examination or were judged to need no psychiatric examination". (1976:1140)

the estimated number of people booked into the jail during the five month study period (2,625), Petrich computes a rate of psychiatric morbidity of 46 per 1000 prisoners.

The referral sample consisted of 102 males and 20 females. The male referrals differed from the general jail population in terms of age and ethnicity. Referrals were older and more likely to be members of a minority group than were members of the general population. The modal picture of the referred inmate in Petrich's sample looks similar to that described by Swank and Winer (1976). The majority of both male and female referrals were single,[17] confined on felony charges, had previously been arrested and confined, and reported a psychiatric history. Approximately one-third of the referrals reported that they had attempted suicide.[18]

There are also some similarities between the Swank and Winer study and the Petrich study in the distribution of the referred prisoners among the diagnostic categories.[19] The functional psychosis category contained one-fourth of the cases in the Swank

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[17] This category includes those who were never married, and those who are divorced or separated.

[18] Petrich does not compare his referral sample with the general jail population on any of the variables mentioned in the modal profile.

[19] In the Swank and Winer Study, the diagnostic categories (other than the convulsive disorder category which is not considered in this paper) are mutually exclusive. In the Petrich study, a referred inmate could receive more than one diagnosis. The comparisons between the two studies referred to in the text of this paper are comparisons between the percentage of persons in each Swank and Winer diagnostic category and the percentage of diagnoses in each Petrich diagnostic category.

and Winer study and about one-fifth of the cases in the Petrich study;[20] alcoholics were approximately 13 percent of the diagnoses in each study; there was only a 2 percentage point difference in mental defectives and neurotics in the two studies, and antisocial personality was the diagnosis in 16 percent of the cases in the Swank and Winer study and 23 percent of the cases in the Petrich study. Drug dependency, however, was diagnosed as the problem in 24 percent of the Petrich cases and in only 9 percent of the Swank and Winer cases.

Some of the state jail surveys include estimates of the number of persons in the jail population who are experiencing psychological problems. A 1968 NCCD survey of Wayne County Jail in Michigan found that over 8 percent (80 per 1000 inmates) of the jail population was receiving some type of medication to help control psychotic and psychoneurotic disorders. (NCCD, 1968:30). Olds' (1956) survey of the Baltimore City Jail showed that approximately 19 percent of the inmate population was afflicted with some type of mental disorder. Psychosis represented the greatest proportion of disturbances (28 percent) followed by chronic brain syndrome (13 percent), personality trait disturbance (12 percent), sociopathic personality (11 percent), and mental deficiency (4 percent).[21] And, Mattick and Sweet report:

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[20]For the Petrich study, the mania and schizophrenia cases were combined to compute the functional psychosis percentage.

[21]Olds' defines his diagnostic categories as: "Psychosis (unpredictable disturbance in emotion, thought, judgement, behavior, with or without brain damage).

> Although survey statistics must depend on the estimates and judgements of jailers not trained in psychiatry, they are indicative. More than 60 percent of the county jails held from 10 to 50 of such persons (mentally ill) varying from a few hours to more than 48 hours. (1970:12)

This section has presented information on (1) the number of jail inmates recognized as suffering from psychiatric disorders and (2) the nature of their illnesses. These are the cases who are referred to the jail mental health personnel by custodians and other jail employees. Persons who are troublesome or highly visable in other ways are probably overrepresented in this group. Those who suffer silently or whose symptoms take less dramatic forms in many cases will not become part of the referral population. If the number of these people were known and figured into the rate computation, the estimated rate of psychological problems among jail prisoners would be considerably higher.

The section the follows presents a review of the literature on another type of psychological problem -- self-injury.

(continued from preceding page)

Chronic brain syndrome without psychosis (relatively permanent brain damage due to alcohol, injury, or illness, with less than psychotic disturbances in emotion, thought, etc.).

Personality trait disturbance (emotionally unstable)

Personality pattern disturbance (includes a variety of conditions which can rarely be altered such as lack of physical and emotional stamina, inability to express feelings, inability to form significant relations with others).

Sociopathic personality (inability to conform or to profit from punishment or to maintain group loyalties; at war with the world).

Mental deficiency (defect of intelligence since birth) (1956:19).

The Significance of Self-injury

The reader may ask, "why include self-injury as a separate section when one of the diagnostic categories previously discussed would cover those who injure themselves?" The reasons are (1) self-destructive behavior is one of the most widely studied problems in jail, and it has been investigated with and without the use of standard diagnostic categories, and (2) content analyzed interviews with self-destructive prisoners have provided a richer picture of the problems experienced and the pressures faced by this group than that contained in any diagnostic category. Self-injury or self-destructive behavior is also an important measure of psychological disorder or breakdown for a number of other reasons:

(1) Self-destructive behavior is not uncommon in jail. Toch reports on the extent of self-injury in jails and prison: "...with even the most conservative figures we can show that the problem of self-mutilitation is endemic and that nothing commensurate occurs in other settings. If a problem even remotely similar were to arise in the outside world, it would provoke outrage and emergency intervention." (1975:127) Johnson notes that 41 percent of the inmate crisis situations described to him by prison staff members involved self-injury. (1976:30) The problem of self-injury also touches the lives of men who do not injure themselves. Inmates who report they are experiencing problems in confinement often provide information about suicidal thoughts to indicate the depth of their

distress. (Toch, 1975:283-284)

(2) Self-injury is not only statistically associated with a number of other indices of psychological stress (Johnson, 1976:30), but also goes beyond these measures by representing a wider range of motives, symptoms, problems, and concerns. (Toch, 1976:3) Other measures of psychological breakdown -- requests for protective segregation or commitment to a mental institution, for example -- may reflect a more limited set of concerns, such as fear or psychotic difficulties. (Johnson, 1976:30) Self-injury covers a broader spectrum of concerns.

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

Studies of Self-Injury

The available investigations of self-injury have been characterized by small sample size, restricted definitions of self-injury, emphasis on the method of self-injury, and analysis of demographic characteristics in an effort to develop a self-injury profile to identify self-injury prone inmates. Only three of the eight studies reviewed compare the self-injury group with a control sample drawn from the general jail population on the relevant variables. Most of the research reviewed is focused on the characteristics of the man who injures himself, and it tends to overlook system-individual

interactions or transactions.

It appears that self-injury is a more serious problem in jail than in prison or in the community. In those jails that contain both detention and sentenced prisoners, detention prisoners are the more likely to injure themselves. Esparza (1973) reported a suicide rate of 57.5 per 100,000 in a sample of the county jails in a Midwestern state. He compares this with the suicide rate of 10.5 per 100,000 in federal prisons (Rieger, 1971), and with the 16-17 per 100,000 suicide rate reported for the general male population. (Hendin, 1967) Heilig found that of the suicides committed in Los Angeles County jails in the years he sampled this population 96 percent occurred in the detention setting. (Heilig, 1973:49) In New York City jails, 93 percent of the men who committed suicide between October, 1970 and September, 1971 did so in a detention setting. (Martin, 1971:1)

The amount of time incarcerated prior to the self-destructive act was found to be an important variable in some of the investigations. Danto (1973a) reports that 6 of the 10 suicides he studied occurred within 30 days of incarceration. Esparza (1973) found that 67 percent of the suicides in his sample occurred within 90 days of confinement. Heilig (1973) reports that 19 of his 26 cases committed suicide within their first 24 hours of confinement. Fawcett and Marrs' (1973) data reveal that 52 percent of their combined attempt and suicide sample committed their self-destructive act within 30 days of confinement, including 19 percent of the sample who injured themselves within the first three days of institutionalization. Death within

the first 30 days of incarceration resulted in 69 percent of the suicide group. Beigel and Russell report in their study that "all the suicide attempts occurred in a period from the end of the first week to the end of the sixth week after placement in jail. None was found after six weeks, despite far longer stays in jail for many of the prisoners." (1973:110) Martin's (1971) data shows 62 percent of the suicides (n=13) occurring within the first 10 days of jail confinement.

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

The above findings suggest that many self-destructive inmates experience "entry shock". In other words, they find the transition from the streets to confinement so disequilibrating that they psychologically breakdown. When one considers some descriptions of the transitional problems related to jail entry, the "entry shock" explanation of jail self-injury seems plausible. In the passage below, Morton Hunt describes the intake agency for pre-trial detention, the arraignment court:

> ...the judge, brusque and quick, impassive and hardened to the endless stream of unrepentant thieves, whores, addicts, pushers, muggers, armed robbers, knife-wielders, and rapists, would listen, occasionally interrupt with a question or two, then snap out his orders, and ask the clerk for the next one. But he could do nothing else: nearly a hundred prisoners were still waiting, and all had to be arraigned and either released or turned over to Department of Corrections officers by mid afternoon. There could be no let-up for an instant, and so the accused came

> up one after another to stand before him, hearing a smattering of phrases fly back and forth, and being led away almost before they knew what he had said, most of them disappearing through the door back to the pens; a few others released because the judge had dismissed the charges against them or paroled them without bail, hesitated for a moment before quitting the courtroom, unable to believe that they too had not been swallowed by the system (Hunt, 1972:139)

The scene at the reception room of the jail is discordant, men shuffle and stumble from institutional vans to reception pens where they await processing, some immobilized by withdrawal pains, sweating, shuddering, and vomiting, others loudly protesting the legality of their incarceration, and the majority sitting staring into space in a state of disbelief or depression. In the background, reception officers bark their inquiries, and the machine that prints the inmate identification tags clicks its incessant click (Gibbs, 1978:14).

Initial reactions to jail may include disbelief followed by attempts to gain release (Wilderson, 1972). A man's initial internal query may concern issues of length of confinement and seriousness of charges. The newly arrived detainee may ponder the question of: "How did I get into this spot" and "How and when do I get out". It is at this point, after what may be a confusing shuffle through several segments of the criminal justice system, that a man may begin to feel victimized by the system, helpless and ashamed, may experience abandonment anxiety, and become plagued by uncertainty regarding his outside support and the length of his confinement (Gibbs, 1978:14-15).

In a rather lengthy excerpt from The Felon presented below,

Irwin portrays the jail experience:

> These experiences -- arrest, trial and conviction -- threaten the structure of his personal life in two separate ways. First, the disjointed experience of being suddenly extracted from a relatively orderly and familiar routine and cast into a completely unfamiliar and seemingly chaotic one where the ordering of events is completely out of his control has a shattering impact upon his personality structure. One's identity, one's personality system, one's coherent thinking about himself depend upon a relatively familiar, continuous, and predictable stream of events. In the Kafkaesque world of the booking room, the jail cell, the interrogation room, and the visiting room, the boundaries of the self collapse.
>
> While this collapse is occurring, the prisoner's network of social relations is being torn apart. The insulation between social worlds, an insulation necessary for the orderly maintenance of his social life, is punctured. Many persons learn about facets of his life that were previously unknown to them. Their business is in the streets. Furthermore, a multitude of minor exigencies that must be met to maintain social relationships go unattended. Bills are not paid, friends are not befriended, families are not fed, consoled, advised, disciplined: businesses go unattended: obligations and duties cannot be fulfilled -- in other words, roles cannot be performed. Unattended, the structure of the prisoner's social relations collapse.
>
> During this collapse a typical thought pattern often occurs. The arrested person usually reviews his immediate past and has second thoughts about the crime or crimes, or about the complex of behavior related to the crime. Facing the collapse of his personal world, the eventuality of conviction of a felony and a long prison term, he is very prone to express extreme regret. "Why did I do it?" "If only I hadn't done that." "Why did I get into this mess?" "If only I had another chance." All these typify his thinking. Regret and remorse probably reach the greatest intensity in the first few days when the impact of the disjointed experience is the greatest, but this type of reflection on his past continues throughout the presentencing phase (1970:39-40).

As previously mentioned, although most of the studies reviewed do not include comparisons between self-injury samples

and samples of the general jail population, they do provide some data on the characteristics of those who injured themselves. Danto (1973a) reports that 6 of the 10 suicides he studied at the Wayne County Jail were committed by prisoners charged with a violent felony. Esparza (1973) found that 84 percent of the cases he reviewed (n=66) had a violent personal crime appearing on their record. Wilmottee and Plat-Mendlwicz (1973) noted in their study of a Belgian jail that of the 137 crimes the 84 members of the self-injury group were suspected of committing, there were 48 violent personal crimes, 57 property crimes and 18 drug offenses. Fawcett and Marrs (1973) discovered that 67 percent or 14 of the 21 prisoners who committed suicide or who made "high intent suicide attempts" were charged with violent personal crimes including 9 homicide charges. And, the data collected in New York City detention facilities by Gibbs (1978) indicate that men who injure themselves are more likely to have a history of arrest for a violent offense and a violent charge pending than are members of a random sample of the general jail population.

In contrast to the findings reported above, Beigel and Russel (1973) report in their study of attempted suicides in Arizona jails that 50 percent of the control group was charged with a violent crime in comparison with 23 percent of the attempt group; the chi square computed for this difference was significant at the .05 level. Heilig (1973) found that of the 26 individuals who committed suicide none was charged with a violent personal crime. And, Martin's (1971) analysis of 13 suicides that occurred

in City of New York Department of Corrections institutions between October 1970 and September 1971 indicates that the vast majority of the cases were not charged with a violent crime.

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

Gibbs (1978) found that in comparison with the general jail population, the jail self-injury groups contained an under-representation of blacks (23 percentage points), and an over-representation of whites (13.7 percentage points), and latins (11 percentage points). Martin (1971) discovered that although whites comprised only 10 percent of the New York City jail population, they accounted for 38.5 percent of the suicides. Puerto Ricans also represented 38.5 percent of the jail suicides and they accounted for 25 percent of the jail population. Blacks were extremely underrepresented; although blacks represented 65 percent of the jail population, they accounted for only 23.1 percent of suicides. Esparza (1973) reported an ethnic breakdown for suicides and attempted suicides of about 80 percent white and 20 percent black. Heilig (1973) found that the overwhelming majority of the cases in his study were white. Only one black

and two Mexican-American suicides were reported. And, Fawcett and Marrs (1973) reported that 52.4 percent of the cases studied were white followed by 33 percent black and 14.3 percent latin.

The findings of two of the studies reviewed diverge from the trend described above. Danto (1973a) reported that 6 of the 10 cases he studied were black. And, Beigel and Russel (1973) found that although the difference was not statistically significant, there were 17 percent more non-whites (predominately Mexican-Americans) in the attempt group compared with the control group.

A review of the findings of the studies on self-destructive behavior in jails suggest that there may be a link between mental illness and self-injury, and prior suicide attempts and self-injury. Danto (1973a) reported that 7 of the 10 suicides he studied had a history of mental illness and 4 of the 10 cases had a history of prior attempts. Esparza comments, "these prisoners had also invariably received some type of psychiatric assessment and/or treatment since a high percentage of them had previously had a history of mental illness and previous attempts were known as 'mentals' to the jail authorities." (1973:35) He does not present a percentage figure to define what he considers a high percentage, and it is assumed "invariably" means all the cases received psychiatric evaluation or treatment.

Wilmotte and Plat-Mendleqicz (1973) indicate that 25 percent of the 84 cases studied were considered to be suffering from mental diseases: schizophrenics, epileptics with character disorders, and heavy drinkers. Fawcett and Marrs' (1973) mental illness category included recorded statements of suicidal threat or intent, symptoms of clinical depression recorded by county jail officers, and a history of psychiatric hospitalization. There were 22 indices of mental illness recorded for the sample. Unfortunately, the number of cases displaying these symptoms cannot be determined because of the fashion in which the data were recorded, i.e. the categories were not mutually exclusive. Finally, Martin (1971) discovered that 46 percent of the suicides reviewed were committed by prisoners who had a history of a suicide attempt.

A weighted average age of 25 was computed for those who completed or attempted suicide, and was based on the 4 studies which furnished average age information (Danto, 1973a; Esparza, 1973; Fawcett and Marrs, 1973; and Beigel and Russel, 1973). The modal age categories in Heilig's (1973) and Martin's (1971) studies were 20-29 and under 25, respectively. The two studies which compared self-mutilators with controls by age (Beigel and Russel, 1973; and Gibbs, 1978) present contrasting findings. Beigel and Russel (1973) found that those who committed acts of self-injury were younger than controls, whereas Gibbs (1978) discovered that self-mutilators were older than members of a randomly selected comparison sample.

The findings surveyed suggest that there may be a relationship between self-destructive

behavior in jail and violence, ethnicity, and mental illness. However, because in most cases the self-injury sample is not compared with a random sample of the jail population, it is not possible to determine (1) whether the self-injury sample differs from the general jail population in terms of these factors, and (2) the strength of the association between self-injury and the variables of interest.

In the one study that did make extensive comparisons between a jail self-injury population (415) and a random sample of the jail population (1188 unweighted and 1537 weighted to reflect adolescent and adult populations), those who injured themselves were more likely to be older, married, and/or drug addicts. They were also more likely to have (1) a history of previous arrest for a property, drug, or violent offense, (2) previous incarceration experience in jail or prison, and (3) a violent charge pending. (Gibbs, 1978:31) All these differences were statistically significant at the .05 level using the chi square statistic. However, the strength of association (phi) between self-injury and any one of the above variables never reached a magnitude of .20. The unimpressiveness of the strengths of these relationships indicates that knowledge of these personal history variables associated with self-injury in jail is not of great assistance in identifying or predicting self-injury prone inmates in jails.

What are the problems experienced by men who injure themselves while confined in jail? Danto notes guilt, hopelessness and social isolation (1973). Esparza mentions the shock of family separation. (1973:37) Fawcett and Marrs consider the self-destructive

acts of inmates a "decisive and desperate action of control over the outcome of their lives..." (1973:86) Specifically, they contend that:

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

The only study to systematically explore motives for self-injury in jail was conducted by the author. (Gibbs, 1978) Part of the data analyzed in this study were 333 tape recorded and transcribed clinical interviews with men who had injured themselves in jail (105) and prison (228).

The self-injury interview content was classified by means of a typology constructed by Toch. His content analytic scheme was developed by a process similar to analytic induction. The types or self-destructive themes were formulated progressively. With each batch of freshly transcribed interviews, the types were reformulated and refined until a typology of sufficient heuristic and parsimonious value was developed.

The final version of the typology contains 16 mutually exclusive self-destructive themes. Each theme represents one of three psychological dimensions (Impotence, Fear and Need for Support) and one of three qualitatively different types of crises. (Coping, Self-Perception and Impulse Management). Figure 1 presents the gross theme clusters that emerge when each

Figure 1

Typology of Personal Breakdowns[a]
(Gross Theme Clusters)

	Type of Difficulty		
Relevant Psychological Dimension	Coping (self and environment)	Self-perception (self and others)	Inpulse management (self and others)
Impotence	Helplessness and resentment	Hopelessness and self-doubt	Catharsis and self-hate
Fear	Isolation panic	Fear of prison pressures	Projected or subjective danger
Need for Support	Staff	Significant others	Mental health

[a] Source: Hans Toch, Men in Crisis. Aldine, Chicago: 1975, P. 24.

psychological dimension intersects with each type of difficulty. The specific themes included in each gross theme cluster and a description of each theme appear in Appendix A of this paper.

As with most typologies, Toch's is not merely the product of empirical derivation, theoretical perspective also substantially influenced the classification scheme. (Hood and Sparks, 1970: 185). The underlying assumption is that a psychological need or concern (Impotence, Fear, Need for Support) can emerge as a problem on three levels ranging from normal (Coping) to psychotic (Impulse Management). For example, Need for Support may arise as a Coping difficulty when a man has a medical problem which he feels requires the immediate attention of the institutional physician, a Self-Perception problem when a prisoner ponders abandonment by his family, or an Impulse Management difficulty when a man's urges are raging out of control, and he seeks professional intervention.

The classification process was designed to reliably spell out the concerns expressed by the respondents. Because the self-destructive event represented a configuration of motives, in many cases, capturing the complexity of the incident necessitated assigning some interviews more than one theme. The interviews were independently classified by the interviewer who conducted the interview and by an independent rater (Toch). Each interview received a primary or dominant theme, and in about half the cases, a secondary theme(s). Agreement ranged from 85 to 90 percent on primary theme and 75 to 80 percent on secondary themes. Where there was disagreement between

coders, a final classification would be arrived at by consensus. The process involved each rater presenting his reasons for a particular classification with reference to the interview text. The coders then made a joint classification in light of the information generated by their discussion of the interview.

Tables I and 2 display the coded content of the jail self-injury interviews. The data presented in Table 1 suggest that approximately one-fifth of the self-destrucitve motives found in the interview content were Coping (normal) difficulties, about one-fourth were Impulse Management (psychotic) problems, and over half were Self-Perception (neurotic) problems.

The data presented in Table 1 suggest that the majority of the self-destructive breakdowns result from problems of self-doubt, self-worth, or failure to measure up to self-imposed or more universal standards. One implication of this finding is that the jail environment challenges a man's competence and adequacy. Tests of worth require assessment. And, for some men, self-assessment means certain failure.

The finding that self-destructive men in jail report low self-esteem at the time of injury is not unexpected. Such problems are considered a common experience among suicidal persons:

> In their review of the literature on suicide from 1945 to 1956, Vitanza, Church, and Offendrantz (1957) find that one of the few points upon which researchers generally agree is that suicidal persons have self-derogatory feelings, feelings of worthlessness and self-hatred. Andics (1947), in a study of 100 persons who attempted suicide, found them to have feelings of unworthiness as well as a sense of meaninglessness. (Kobler and Stotland, 1964:14)

Table 1

The Jail Self-Injury Sample,
By Psychological Dimension &
Type of Crisis (n=215 themes)

Psychological Dimension	Type of Crisis			
	Coping	Self-Perception	Impulse Management	Total
Impotence	9.3%	18.2%	10.2%	37.7%
Fear	3.7	11.2	11.2	26.1
Need for Support	8.3	23.7	4.2	36.2
Total	21.3	53.1	25.6	100.0

Table 2

The Jail Self-injury Sample,
By Theme (n=215 themes)

Theme	Percentage of total themes
Sanctuary Search	.9%
Self-Victimization	8.4
Isolation Panic	3.7
Self-Classification	3.2
Aid Seeking	5.1
Self-Deactivation	8.4
Self-Sentencing	7.0
Self-Retaliation	2.8
Fate Avoidance	11.2
Self-Linking	16.3
Self-Certification	7.4
Self-Alienation	6.5
Self-Resease	3.7
Self-Escape	6.5
Self-Preservation	4.7
Self-Intervention	4.2
	100.0

When the psychological dimension (Impotence, Fear, or Need for Support) is taken into consideration, we see in Table 1 that the Impotence and Support dimensions each account for well over one-third of the self-destructive themes, and the Fear dimension represents about one-fourth of the themes. The data suggest that in jail feelings of helplessness, resentment, and/or loss of control and need for emotional sustenance and tangible assistance are more important self-injury motivators than fear for one's safety.

Conjoint consideration of both the type of crisis and psychological dimension of self-destructive breakdowns indicates that a Self-Perception crisis reflecting the Need for Support dimension is the most common type of breakdown (23.7 percent) followed by a Self-Perception crisis reflecting the Impotence dimension; none of the other categories appearing in Table 1 represent more than 15 percent of the self-destructive motives.

Table 2 shows that the most common self-destructive theme is Self-Linking (16.3 percent), and the second most common theme is Fate Avoidance (11.2 percent). None of the other categories appearing in Table 2 account for more than 10 percent of the self-destructive themes. These two most common self-destructive themes are defined and illustrated with interview excerpts in the next few pages.

> Self-Linking: A person's protest against intolerable separation from significant others, against perceived abandonment by them, or against his inability to function as a constructive member of a group. The person rejects the possibility of an independent life, feels that his well-being

> is inconceivable without the continuation of certain vital relationships, and that no satisfactory existence is possible without them (Toch, 1975:51).

Imprisoned men need the support of significant others in the community for a number of reasons--contact with outside reality, contrast to the coldness of the institutional environment, a sense of belongingness in the world beyond confinement. Family and friends also become important for self-definition, in that when one is loved, one is worthy. When support is withdrawn or not offered, one may feel alone or unwanted.

During the initial stage of incarceration, support from significant others may help absorb the shock of incarceration, and provide necessary tangible benefits--bail, counsel, clothing, money, and other necessities.

ARS 4:

> My case went to Supreme Court, and my wife didn't appear, my mother didn't appear. They didn't care for me, so what's the sense of me living?...So I came back to my cell, and I sat down and started thinking. Tears started running down my eyes. So I said, "Nobody cares for me on the outside, what's the sense of me living?"

* * * * * *

ELM 2:

> All I wanted was someone to help me out, and that was my mother. And she turned me down... what was the use of me keep on living without

nothing to fight for, without any family? Like there was nothing left for me, nothing else to do.

* * * * * *

> Fate Avoidance: A stance stemming from a person's inability to survive current or impending social situations which he fears because he sees himself as weak, ineffective, or unable to appropriately respond (Toch, 1975:51).

One of the deprivations associated with confinement is safety (Sykes, 1956). Lack of safety creates fear, which is tied to one's reputation of being a man. Toch explains the sequence in the following passage:

> The syllogism is built into the definition of maleness, from the perspective of the caveman to that of Hemingway. If a man is seen as afraid, other men are deemed to produce fear in him. If others can inspire fear, they are seen as stronger. To display fear is thus to admit weakness or submission, and to inspire fear is to proclaim power and dominance (1975:63).

Men who have difficulty managing their fears or fearful situations may find themselves permanently labelled as unmanly. Moreover, fear may permeate their perceptions, and virtually all situations may be seen as dangerous. Such fear reduces mobility and reduces self-esteem.

ATT 31:

I felt that there was no way out. I said, like, "Here I am trapped up here. I can't go to the yard. I can't do nothing." .....at this point I felt disgusted, I felt completely disgusted with myself. Because, like I said, all this running away that I caught myself doing, trying to avoid trouble. I said, "I'm still over here in the box.

Now there's no place to go." I said, "I can't walk about in fear because I never done it before." I never knew how it feels to be walking around constantly in fear. That someone is going to attack me. So I said, "My God, if I've got to go around walking the rest of my time like that, I'd rather be dead."

* * * * * *

ELM 64:

In reformatory, you have a person that's willing to knock himself out to prove to himself that he can stick you in the ass. Now if you let the man do this to you, you can't look at nobody in the face. So right there you're a self-failure if you let the guy knock you out. The man screwed me and got his thing off, and what are you supposed to do: You can't talk to your friends, they reject you.

* * * * * *

Gibbs (1978) also compared samples of jail and prison self-destructive inmates with each other and with random samples of their respective general population. His comparison of the jail and prison self-injury groups with their respective general populations demonstrated that the comparative statistical portraits of men who injure themselves in jail and those who break down in prison were almost antithetical. In comparison with the general jail population, men who suffered psychological

breakdowns in jail were more likely to be older, married, and/or drug addicts. They were also more likely to have previous confinement and arrest experience and violent pasts. In contrast, when compared with the prison general population, the prison self-injury group showed a higher proportion of prisoners who were adolescents, unmarried, not addicted to drugs, without prior criminal records, and without a previous history of incarceration.

The comparison of the self-injury samples by self-destructive themes showed that there were statistically significant differences between the jail and prison groups. Jail prisoners were more likely to break down in terms of Need for Support, whereas a comparatively greater proportion of the prison self-destructive inmates reported problems which reflected the Fear dimension.

Bettelhiem identifies two "primordial human anxieties"; these are concern about the loss of emotional sustenance from significant others or "separation anxiety", and fear of injury to one's physical person. (Bettelhiem, 1974:100) The findings just reported suggest that the jail and prison environments elicit responses from vulnerable men which differentially reflect these anxieties. Separation anxiety emerges more often as a jail self-injury theme than as a prison self-injury theme, and fear of injury to one's physical person is more often a dominate concern among men who injure themselves in prison than among their jail counterparts. Men who are sensitive to danger cues are vulnerable in prison, while men with strong dependency needs are susceptible to breakdown in jail.

Conclusion

In 1974 Hans Mattick wrote:

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

The studies reviewed in this paper demonstrate that we are still not in a position to see "...whether figures speak louder than rhetoric." The primitive nature of the methodologies employed provides us with modal portraits of mentally ill and suicidal inmates, however we do not know how they differ from other members of the jail population. We have estimates of the rates of self-injury and psychological breakdown in jail, however they are seldom based on probability samples; and we do not know if differences between estimates are due to sampling errors, differences in definitions, or geographical or yearly variation in actual rates.

There is a need for a survey of the populations of our nation's jails based on scientific sampling techniques, consistent definitions across jurisdictions, and reliable instruments. There is a need for specificity in our research questions, i.e. we need to know what impact jail has on what people. Above all, there is a need for accurate record keeping by jail personnel.

Such basic information will enhance our ability to develop and implement programs to (1) ameliorate the stresses of jail for vulnerable groups, and (2) identify and divert prisoners whose chances of psychological survival would be better in an other setting.

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Appendix A

I. Themes Related to Coping (Problems in the Adjustment of Man to prison)

(A, B: Overstimulation and Resentment)

A. Sanctuary Search: An effort by the inmate to escape from redundant preoccupations -- particularly with regard to problems in the outside world or in his own situation -- to which he finds no solution or closure. The object of his effort is to break the unproductive cycle and secure peace of mind.

B. Self-Victimization: A statement by the inmate of his inability to endure the self-defined status of victim of continued arbitrariness, inequity, or abuse by the criminal justice system or its personnel. The prisoner gives notice of his helplessness (demanding a truce) or advertises his accumulated resentment, where he feels retaliation is unsafe.

(C: Understimulation and Fear)

C. Isolation Panic: A demand for the inmate's release from isolated confinement which he finds fear-inspiring, intolerable, and obsessive. The prisoner dwells on the duration and/or circumstances of his situation, on his discomfort, and on his inability to engage in prison activities and social life.

(D, E: Quest for Assistance in Selective Coping)

D. Self-Classification: An inmate's effort to communicate to staff the seriousness of his need for a specific milieu between social or physical environments within which he can function and settings he finds it impossible to adjust to. He underlines the seriousness and importance of the distinction.

E. Aid Seeking: An inmate's demand for staff services which, as the inmate sees it, cannot be ignored by staff. Such a demand occurs when a physical problem becomes the focus of the inmate's discontent, and he becomes obsessed with the need for attention to his complaint and upset about staff failure to comply with or respond to direct requests.

(Toch, 1975:32-33)

II. Themes Related to Negative Self-Assessment (Problems Based on the Relationship Between Self and Others)

(A, B, C: Hopelessness and Self-Doubt)

A. Self-Deactivation: A lack of interest in day-to-day life, which is seen as an extrapolation or continuation of past

failures. This stage follows an inventory which makes the person increasingly apathetic and discouraged -- he sees no future role for himself, and loses interest and drive.

B. Self-Sentencing: An effort to cut losses and provide relief to others. This stage follows an inventory of past and current conduct vis-a-vis friends and relatives, which sparks shame, guilt, self-condemnation, and a dismal prognosis for the future. The person adjudges himself a complete liability to himself and others and sees no prospects for improvement.

C. Self-Retaliation: A person experiences self-hate or engages in self-punishment because he attributes his intolerable position to his own past acts, and feels justifiably angry and resentful at himself.

(D: Resourcelessness and Fear)

D. Fate Avoidance: A stance stemming from a person's inability to survive current or impending social situations which he fears because he sees himself as weak, ineffective, or unable to appropriately respond.

(E, F: Need for Significant Others)

E. Self-Linking: A person's protest against intolerable separation from significant others, against perceived abandonment by them, or against his inability to function as a constructive member of a group. The person rejects the possibility of an independent life, feels that his well-being is inconceivable without the continuation of certain vital relationships and that no satisfactory existence is possible without them.

F. Self-Certification: A person's effort to convince the other party in a degenerating or terminating relationship of his seriousness about the relationship and his inability to survive its dissolution. The effort takes the form of a dramatic demonstration of resentment, self-pity, or personal sincerity.

(Toch, 1975:51-52).

III. Themes Related to Impulse Management (Relationship of Self to Self)

(A, B: Capitulation to Internal Pressure-Catharsis and Self-Hate)

A. Self-Alienation: A reluctant or passive compliance with alien impulses and commands that direct the person to destroy himself.

B. Self-Release: A catharsis or strategic loss of control designed to discharge aggressive feelings and to end tension and discomfort related to such feelings. This occurs as a temporary loss of contact with reality after a cumulation of resentment, tension, and anger, and is followed by emotional drain and experienced relief.

(C, D: Projected or Subjective Danger)

C. Self-Escape: An effort to preserve sanity -- or to escape -- that is made when the person experiences strong, tension-provoking destructive impulses. The person may feel disturbed by imagined threats combined with experiences of his own destructive potential.

D. Self-Preservation: An attempt to escape cumulating harm, made when the person builds up the conviction that he is in substantial physical danger from pervasive, all-powerful enemies. The person may destroy himself because he fears imminent destruction by others.

(E: Need for Assistance with Internal Control)

E. Self-Intervention: A demand for professional help in the understanding and control of one's own impulses and moods. The person makes a last-ditch effort to secure such help through action because verbal requests for help are seen as nonproductive.

(Toch, 1975:93-94)

Figure # A-1

Typology Of Personal Breakdowns

Relevant Psychological Dimension	Type of Difficulty		
	Coping	Self-Perception	Impulse Management
Impotence	Helplessness and Resentment	Hopelessness and Self-Doubt	Catharsis and Self-Hate
	IA. Sanctuary Search	IIA. Self-Deactivation	IIIA. Self-Alienation
	IB. Self-Victimization	IIB. Self-Sentencing	IIIB, Self-Release
		IIC. Self-Retaliation	
Fear			
	Isolation	Prison Pressures	Projected of Subjective Danger
	IC. Isolation Panic	IID. Fate Avoidance	IIIC, Self-Escape
			IIID, Self-Preservation
Need for Support			
	Staff	Significant Others	Mental Health Personnel
	ID. Self-Classification	IIE. Self-Linking	IIIE. Self-Intervention
	IE. Aid Seeking	IIF. Self-Certification	

Discussion Paper

Labeling Mental Illness in Jails: A Theoretical Perspective

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Introduction

When I was first asked to write a paper dealing with the issues raised by labelling theory regarding labelling persons mentally ill in jails I thought it would be an easy task, as throughout my professional career I've been involved in writing about both labelling theory and mental illness. However, when I actually attempted the task I found it very difficult and it soon became clear that labelling theory, as the theoretical perspective has been developed, has very little bearing on the topic at hand. However, the interactionist's perspective out of which labelling theory has developed does point to a number of problematic issues involved in labelling persons mentally ill in jails. Because labelling theory is so popular and because persons concerned with the theoretical issues of labelling persons mentally ill in jails will almost inevitably turn to the labelling theory, I will first review the theory and point out why it, as a theory, is not appropriate to the task. I will then turn to a number of the problematic processes involved with regard to the mentally ill in jails. Hopefully this latter section will both serve to sensitize persons responsible for the imposition of such labels of mental illness in jails to the problematic aspects of the task and at the same time serve as the spring board for research which is very badly needed.

Since the early sixties labelling theory has been the most popular explanation of deviant behavior among sociologists. Labelling theory provides a general theoretical explanation of deviant behavior and not a specific explanation of a particular behavior. By this I mean labelling theory is used to explain a wide variety of deviant behaviors because it focuses on general social processes that are presumed to be basic to the development of most forms of stabilized deviant behavior. Labelling theory focuses on the actions of the audience when looking at imposition of a deviant label on a particular actor and secondly at the consequences for the actor when a deviant label is imposed.

One of the most fundamental distinctions made by the labelling theorists is between primary deviance, which may cause someone to be labelled as a deviant, and secondary deviance, which is the behavior produced by being placed in a deviant role. Regarding primary and secondary deviance, Lemert (1967:17) says:

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

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

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

Similarly Becker (1963:9) states:

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

Becker goes on to emphasize the distinction between rule-breaking and deviance, noting that many persons who commit rule-breaking acts do not receive a deviant label, while others who have committed no rule-breaking act may, by mistake, be labelled deviant.

What concern the societal reaction theorists have with an individual's personal and social attributes is focused on how these attributes affect the way others respond to an act of primary deviance. Thus, they are not concerned with whether a particular societal attribute is related to the likelihood that an individual will commit a deviant act but with whether that societal attribute facilitates or impedes that individual's ability to avoid the imposition of a deviant label.

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

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

Erikson (1962:311) goes on to state: "An important feature of these ceremonies in our culture is that they are almost irreversible."[1] Why might this be the case? According to the labelling theorists, the status of deviant is a master status which overrides all other statuses in determining how others will act toward one (Becker, 1963:33). Once a person is stigmatized by being labelled a deviant, a self-fulfilling prophecy is initiated, with others perceiving and responding to the person as a deviant (Becker, 1963:34; Erikson, 1962:311). Furthermore, once persons are publicly processed as deviants, they are typically forced into a deviant group (often by being placed in an institution). As Becker notes (1963:38), such groups have one thing in common—their deviance. They have a common fate, they face the same problems and, because of this, they develop a deviant subculture. This subculture combines a perspective on the world with a set of routine activities. According to Becker (1962:38), "Membership in such a group solidifies a deviant identity" and leads to rationalization of their position. According to the labelling theorists, once labelling has occurred, it is extremely difficult for the person to break out of the deviant status.

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

Two Basic Questions

In discussing societal reactions, it is useful to distinguish between labelling as a dependent and as an independent variable (e.g., Orcutt, 1973). We will first treat it as a dependent variable, which means we are concerned with explaining why certain people come to be labelled deviant and others do not.

The traditional view is that a person is labelled a criminal because of the commission of criminal acts; he or she is labelled mentally ill because he or she is mentally ill and behaves accordingly; or he or she is labelled physically disabled because he or she has a physical disability.

The societal reaction view is that a person is labelled as a deviant primarily as a consequence of societal characteristics--particularly, the power or resources of the individual, the social distance between the labeler and the labelee, the tolerance level in the community, and the visibility of the individual's deviant behavior (e.g., Scheff, 1966:100). The attribute which has received by far the most attention in the literature is the resources and power of the individual, and it is argued that persons with few resources and little power are the ones most likely to have a deviant label imposed upon them.

As is indicated by Becker (1963, 1967); Lofland (1969), Lemert (1951:394-97), Sagrin (1975), Rubington and Weinberg (1971), Gove (1975), Gibbs (1962), the labelling theorists side with the underdog, and they apparently equate the underdog with those on the margin of society who, because of their societal attributes, are ill-equipped to prevent the imposition of a deviant label. Thus, the labelling perspective provides an explanation for why those on the margin, for example the poor and the black, are particularly likely to be labelled deviant. In summary when labelling is treated as a dependent variable, labelling theory hypothesizes that the main cause of being labeled a deviant is the individual's marginal status.

Once a person has been labeled a deviant, the labelling theorists argue that reacting to persons as if they were deviants is the major cause of deviant identities and life styles. It is assumed that, without a societal reaction, most deviant behavior would be transitory. In contrast, if the individual is reacted to as a deviant, it is assumed that the deviant status will become more or less permanent. It is argued that deviant status will act as a master status, which will determine how others will act toward him or her across the range of social interaction. It is argued that he or she will be cut off from interaction with normals and channelled into contact with similar deviants. Furthermore, it is presumed that once this happens it becomes very difficult for the individual to return to a normal status.

As should be apparent from this discussion labelling theory as it has been developed focuses largely on processes involving the macroenvironment, typically society. It portents to explain why certain persons in society tend to be labelled deviant and why those labeled as deviant tend to establish a deviant career. Although labelling theory has been very popular among social scientists, particularly sociologists it has not withstood empirical analysis very well (

). In particular the data consistently indicate that persons are labeled deviant primarily because they have committed deviant acts and that typically a career of deviance is well established before an individual officially acquires a deviant label. The fact that labelling theory does not explain most deviant behavior, however, is not cause for ignoring it. Considerable evidence has accumulated that labelling theorists are focusing on real processes. Thus the problem with labelling theorists is not that the processes they describe do not exist, but that they have grossly overstated the importance of the processes.

Labelling theory as it has been formulated is very difficult to apply to the issue of the labelling of the mentally ill among the inmates housed in a jail. This is true for a number of reasons, however. I will touch on only two. First, as noted, labelling theory as formulated applies to processes that apply primarily at the macro level whereas the jail is perhaps best viewed as a comprehensive institutional setting where interaction operates on a more micro level. Second, inmates in jail have already gone through the process of being labeled criminals and thus, according to the labelling theorists, have already acquired a deviant master status which will make it difficult for them to later function in the world as normal adults. Thus the issue of labelling certain inmates in jail as mentally ill is not a process that fits well into the paradigm developed by labelling theory although the processes do have a number of things in common. As one might expect,

the interactionist perspective, out of which labelling theory developed, does provide important insights into the problematic nature of the process and consequences of labelling certain inmates in jail as mentally ill. I will now turn to a discussion of some of these processes.

A review of the literature indicates that very little is known about the occurrence of mental illness among inmates in jails. We know that the police are called not only when someone has clearly committed a crime but also when a person creates a serious disturbance and/or is perceived as a serious threat to others because of their actions or verbal behavior. When the police are called because a person has created trouble and/or is perceived as a threat to others they essentially have three possible courses of action. The police can attempt to calm the individual or individuals down by talking to them, isolating them, acting as mediators, etc. The police, on the basis of what they see and hear may decide an individual is mentally ill and play an official role in the initiation of commitment procedures to a mental hospital. Alternatively the police may arrest the individual who has created a disturbance on a variety of charges, a procedure which will generally lead to the individual being placed in jail. A review of the literature indicates that there is almost no data on the factors effecting a particular choice of action or with the frequency with which particular choices are made. The choice of action probably involves a complex set of factors including the behavior and demeanor of the individual, the behavior and demeanor of the complaintants, the nature of the acts perceived by the police as well as those alleged to the police, the ease of initiation to mental hospitalization as well as the perceived quality of the hospital, the condition and facilities available at the local jail, the established routine within the police department for dealing with such individuals, as well as the particular characteristics of the policemen involved. This a long list of factors which pre-

surely effect the particular choices made by the police and it seems reasonable that there will be a wide variety between different jurisdictions in the extent to which police route mentally ill individuals into jail. The variation in these factors may at least partially account for the wide variation in the proportion of persons in jail who are mentally ill (Petrich, 1976; Guze, Tuuson and Gotfried, 1962; Gloninger and Guze, 1970; Swank and Winer, 1976).

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

The institutional setting of jails and prisions are set up specifically to contain and control disruptive behavior. Disruptive behavior on the part of inmates is anticipated and is perceived as a normal if troublesome aspect of inmate behavior. To a large extent the degree to which inmates receive attention from the staff is directly related to the extent to which they are troublesome and this attention is typically directed at containing such behavior. This characteristic of interaction in jails between inmates and staff would appear to greatly effect the identification of mentally ill inmates. First, disruptive behavior which in the community would often lead to identifying a person as mentally ill in a jail will often lead to procedures which simply control or contain the behavior. In jails, in most cases it is only when the disruptive behavior takes on very persistent and bizarre forms that

it is apt to lead to the person being labeled mentally ill. Furthermore, persons whose mental illness is characterized by depression and withdrawal are not apt to be troublesome to the staff and thus they are not likely to be identified as mentally ill. The exception to this, of course, is when the inmate makes a serious suicide attempt. In summary the control procedures characteristic of jails makes it difficult to identify the mentally ill, and those identified as mentally ill are apt to be overtly disruptive and not to be those who are withdrawn, passive and depressed.

For inmates there are apt to be advantages, or at least perceived advantages, for being labeled mentally ill. In many jails being labeled mentally ill will lead to preferential treatment, ranging from being placed in a hospital to being released from duties and generally being able to do easy time. As a consequence, unlike the community where virtually everyone avoids the imposition of the label of mental illness in jails a substantial number of inmates will actively seek being labeled. In psychiatry one of the key indications that a person is mentally ill is that the person seeks or at least accepts the need for psychiatric treatment; however, as this indicator is very unreliable in jails the task of identifying the mentally ill in this setting is very difficult. In essence the staff confronts the task of attempting to distinguish between those who are really mentally ill from those who are feigning mental illness. We know mental illness is fairly easily feigned (Rosenhan, 1973) and psychiatrists can be readily deceived. As the staff in jails by and large have little psychiatric training they are apt to have even greater difficulty in distinguishing between the truly mentally ill and those who are feigning mental illness. The issue is compounded by the fact that some inmates appear to actually be on the borderline between being mentally ill and feigning mental illness and in these cases, even with complete information it might be impossible to determine whether or not they were mentally ill. In summary, in jails there are advantages for inmates for feigning

mental illness and the task of distinguishing those who are truly mentally ill from those who are not is extremely difficult, except in very clear cut cases.

Given that jails are structured so as to control disruptive behavior and the difficulty of identifying the mentally ill in jails it is reasonable to assume that the staff of jails will be relatively unconcerned with mental illness. This is particularly the case as most jails do not have the resources to provide effective psychiatric care. In at least one respect, however, jails provide a superior setting for psychiatric counseling, not only for those who are clearly mentally ill but also for those who are more typical inmates. Persons in jail tend to experience their incarceration as a very critical and demeaning life experience. They also tend to be very anxious and uncertain about their future. These characteristics in fact are exactly those which predispose someone to make basic life changes and to be receptive to psychotherapy (Gordon, 1977). Thus I would raise the possibility that for many inmates who are not mentally ill a brief and carefully structured framework which forces them to confront their life's trajectory and demonstrates plausible alternatives for returning to normal society has the potential for being fairly effective.

Implications

1. The underlying issue in the initial discussion of labelling theory is that the theory as it has been developed and applied has focused on (1) the initial application of a deviant label on an individual and (2) the consequences for the individual of having this label attached. However, the issue being focused on here is the consequence of labeling an individual mentally ill who has already been labeled a criminal and is an inmate in a jail. Thus we are concerned with the process by which criminals come to be labeled mentally ill and the consequences for the criminal that result from being labeled mentally ill. This is a much more

complex process than that usually dealt with by the labelling theorists and about which one can best make informed guesses. This process of attaching a new deviant label on someone already labeled deviant presumably has consequences on effect of the initial label. As this process is obviously an important ongoing one it obviously warrants serious investigation. As noted at present we know very little about these processes and it is probably the case that the individuals who have the most insight into these processes are the persons actually involved, both those doing the labelling and those being labeled. I suspect a systematic investigation focusing on the insights of these individuals would likely be the best place to start obtaining information on these processes.

2. Previous research has produced very disparate estimates of the proportion of persons in jails who are mentally ill. In fact I think it would be correct to say that we have little idea of the amount of mental illness found in jails and the factors which produce variation in this amount. Research is needed on the judicial system in general and the police in particular in terms of determining who among those that are mentally ill get routed into jail, with particular attention being paid to characteristics of the mentally ill who are sent to jail as compared to those who are dealt with in other ways. Furthermore, there are substantial grounds for assuming that incarceration in jail produces mental illness in some individuals but we know very little about what distinguishes individuals who become mentally ill in reacti to incarceration and those that do not. Furthermore, we do not know what the most problematic features of incarceration are in terms of precipitating mental illness.

3. The diagnosis of mental illness has always been problematic. However, in communities the task has at least been simplified by the fact that persons do not seek psychiatric care (and thus the label of mental illness) unless they have a serious emotional disturbance. Furthermore, in the community situations prospective

patients will often initially understate many of their difficulties. However, in jails a number of people will be motivated to be labeled and treated as mentally ill. This greatly magnifies the problem of correct diagnosis and is an area that has received very little research. Although there are a large number of issues that require research regarding diagnosis under this situation I would like to specificly note two. First, it is important to ascertain if under these conditions there is a much greater tendency than is usually the case to diagnose the person as <u>not</u> mentally ill. Second, it is important to look at the role the informal inmate network may play in arriving at a diagnosis. I mention this because it is the case that the inmates probably have a much more accurate 'reading' of the individual and probably have a fairly good idea of whether the inmate is pretending to be ill.

4. A great deal has been written about the consequences of how having been labeled mentally ill effects the persons when they return to the community. Although there appears to be a readjustment process that involves a number of problems, in general there appear to be very few long term negative effects to having been a mental patient (e.g., Gove, 1975). As far as I know there has been no research on the consequences for the criminal of having also been labeled mentally ill. For our purposes this would include both the reaction of other inmates when the individual was still incarcerated as well as the reaction of the community members when the criminal who has been labeled mentally ill is returned to the community.

5. Most inmates in jails are there for a brief time. For most of them it is a time of crisis and at such times persons tend to be particularly anxious and susceptible to change. This is clearly indicated in the research on psychotherapy as well as factors which produce abstention among alcoholics and drug addicts (e.g., McAuliffe, 1975). It seems to me that this crisis should be focused on, treating it as a clear indicator of the career path on which the inmate is on. If the negative

aspects of this career trajectory are sharply drawn out, and clear alternative paths provided it would seem to me that, just as in operant therapy, the negative experience of incarceration may facilitate a change in lifestyle.

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Discussion Paper

PSYCHOLOGICAL ASSESSMENT IN JAILS: IMPLEMENTATION OF THE STANDARDS RECOMMENDED BY THE NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS

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Executive Summary

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

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

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

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

Executive Summary

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

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

Introduction

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

THE ROLE OF DIAGNOSIS AND ASSESSMENT IN A JAIL SETTING

The Functions of Local Adult Institutions

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

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

First, local adult institutions are expected to serve as clearinghouses and referral sources for arrested individuals. Those suffering from physical illnesses

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[1] Draft of a paper to be presented to the Special National Workshop on Mental Health Services in Jails.

or wounds, major mental illnesses, alcoholism or addictions must be identified and referred to appropriate facilities (Standards 9.4.1 and 9.7.1). Intake workers are also expected to determine who is likely to be a menace to society or flee to avoid prosecution so that they can be maintained in secure facilities. Those who are not dangerous and can be trusted to return for court are to be released (Standard 9.4). All of these functions involve assessment.

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

A third function of the local adult institution is to serve as a correctional facility for convicted misdemeanants sentenced to periods of confinement. Like all correctional facilities, society simultaneously seems to require jails to punish, rehabilitate and incapacitate offenders, while deterring other would-be defenders, a melange of demands that are all too often mutually exclusive. While this process of punishment, rehabilitation, incapacitation and deterrance is proceeding, the jail is also responsible for the physical and mental health and well-being of the inmates, and for providing programs designed to foster positive change. At this stage, assessment is required to assist in both management and in programming.

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

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

Problems of Assessment in Jail Settings

The National Advisory Commission's Report on Corrections stated, "The most striking inadequacy of jails in their abominable physical condition" (1973, p. 275), and the deficiencies of the space, staff and resources found in most jails are too well known to bear repeating in this paper. Suffice to say that most jails and lockups range on a continuum from appalling to inadequate, and today, as in the past, much of the thrust of jail reform rightly focuses on correcting these physical conditions. A person who resides in the most deprived, depraved, vice-ridden, violent scabrous pit of iniquity should be able to go to jail secure in the knowledge that at least conditions will be no worse in the "slam" than they were in the slum. Yet, as Norval Morris points out,[2] some jails fail to meet even this dismal standard. In such settings, simply ensuring the physical and mental survival of the population must take precedence over any other reform.

But even in the best local facilities, those which meet the highest physical standards, problems peculiar to the role and functions of jails in our society will confront the psychologist. According to the Report on Corrections, "Because of their multiple uses, jails house a population more diverse than any other correctional institutions. The 1970 jail census found that of 160,863 persons held on the census date, 27,460 had not been arraigned, 8,688 were awaiting some postconviction legal action, 69,096 were serving sentences (10,496 for more than a year), and 7,800 were juveniles (1973, p. 274)."

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

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

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[2] Morris, N. Personal communication, October 28, 1976.

The volume of cases that must be processed through many jails also poses a considerable problem for the diagnostician; 7,984,547 people were taken into custody in 1975 (Gottfredson, Hindelang, & Parisi, 1977). For each individual arrested, a decision must be made whether or not they are suffering from a condition that requires referral to a hospital, mental health, detoxification, substance addiction or other community facility. If not, it must be determined if their release would pose a serious threat to the community and whether they are likely to require detention in order to ensure their presence in court. The sheer number of such cases and the limited time in which the decisions must be made precludes anything remotely approaching a full professional workup on each case, even though the decisions to be made are of the utmost importance to the individual offender, his family and employer, as well as to society in general. Even if psychological science was so advanced that a psychologist could make a complete and accurate assessment of each arrested individual simply by shaking his or her hand, there still would not be enough professional time available for each accused offender to receive that handshake. Professional time must be husbanded frugally, and its optimal allocation is a major problem for mental health professionals in jail settings.

Another general problem is the lack of mental health professionals equipped by experience or training to work in local correctional facilities (Ingram, 1974; Spielberger, Megargee & Ingram, 1972). A general rule of thumb in many criminal justice agencies is that it takes about a year for conventionally trained clinical psychologists or psychiatrists to be worth their salt in criminal justice settings since the nature of the clientele, the legal and administrative procedures required, and the type of problems and decisions encountered differ so greatly from those found in conventional mental health settings. A few clinical training programs such as those at Florida State University and the University of Alabama include criminal justice training and experience in their curricula, but until more programs do likewise, there will be a serious dearth of appropriately trained professionals for jails to call upon. For the time being, on-the-job training will continue to be the rule rather than the exception, so jail administrators should allow time for their mental health staff to obtain necessary supervision or consultation and to attend training sessions and workshops.

Mental health professionals accustomed to dealing with people who seek their services voluntarily often find it difficult to adapt to the legal and ethical strictures that govern jail inmates, especially during the pretrial phase. They

must adjust to the fact that the jail rather than the individual inmate is their client, and that confidentiality cannot be maintained if they are to do their diagnostic tasks. It is essential that psychologists, whether serving as consultants or employees, clearly define their roles with their employers at the outset and redefine them as administrations change. It is best if this is done in writing so there is no possibility of confusion when the inevitable conflicts and crises occur.

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

The limits regarding confidentiality, especially with respect to incriminating information and the possible outcomes of the assessment, must be communicated to those being evaluated so they can decide whether or not to cooperate with the assessment procedures. I inform a jailed individual who I am, who I am working for, why I am evaluating the individual, and the possible outcomes of that evaluation including who is privy to the information I obtain. When I am employed by the court or a law enforcement agency, I give individuals in the pretrial phase a Miranda-type warning with respect to their rights and the possible consequences of relinquishing them. If the accused does not wish to cooperate or wants to have counsel present during the evaluation, these wishes are respected. (Most clients assume that everyone in the jail is working for the police and prosecution so these admonitions are less constraining and inhibiting than psychologists unused to legal settings might suppose.)

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

Among convicted offenders being examined for programming, the issue of guilt has already been decided and there are fewer constraints on the diagnostic process.

Nevertheless, there will be limits on confidentiality in this setting as well which must be negotiated with the administration and communicated to the offender. In virtually all instances, the psychologist will be expected to pass on information that might result in harm to others such as a planned escape or assault. Jail administrations will vary on whether other data obtained in diagnostic or counseling sessions, such as references to undetected crimes, is expected to be transmitted. In any case it is essential that the administration, the mental health professional and the individual offender all have a clear understanding of the limits on confidentiality.

As part of the assessment process, the psychologist may be expected to help in program planning, not only for convicted offenders but for pretrial detainees as well. Detainees often need mental health services, but Standard 4.8.4.a clearly states that it is inappropriate to attempt to "rehabilitate" or change an unconvicted person detained awaiting trial.[3] Nevertheless, Standards 4.9.1.a,b, and c dictate that educational, vocational, recreational, treatment, and counseling programs should be available for pretrial detainees who wish to participate in them on a voluntary basis, with the records of such participation being kept confidential. The diagnostician called on to plan an individual's program may find it difficult to avoid rehabilitation while providing access to suitable helping programs.

A major problem facing diagnosticians is the fact that so little empirical research has been done on assessment in jail settings. The bulk of the assessment literature is focused on college students and psychiatric patients, populations that differ from jail populations in a number of respects, not the least of which is the motivational set that they bring to the examination. Of the mental health personnel available, it is typically only the psychologist who has received specific research training. If research is to progress beyond the vague speculations and statements of faith that I will offer in place of scientific knowledge in this paper, it is essential that psychologists in jail settings undertake research to test the validity of their diagnostic decisions and to devise techniques that will improve their validity while reducing their cost in time, professional personnel and, not the least, dollars. Yet the sheer demands for service are likely to exceed vastly the time available. In their initial bargaining with jail administrators, psychologists should insist that time and resources

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[3] The standards are notably silent about the possible impropriety involved in changing untried individuals by means of diversion programs.

be set aside for research aimed at validating and improving the diagnostic process in jail settings and that this time remain inviolate. Once embroiled in the chronic urgency that characterizes most jails, it is exceedingly difficult for the psychologist to obtain research time if it means a reduction in inmate services.

The problems thus far identified of inadequate resources, heterogeneous clientele, multiplicity of functions, volume of cases, ethical conflicts and a paucity of research pervade the diagnostic process at all stages. We shall now turn to an examination of the problems and procedures specific to each stage.

ASSESSMENT IN STAGE I: INITIAL SCREENING

Decisions to Be Made and Services Required in Stage I

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

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

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

> Each judicial jurisdiction should immediately take action, including the pursuit of enabling legislation where necessary, to establish centrally coordinated and directed adult intake services to:
>
> 1. Perform investigative service for pretrial intake screening. Such services should be conducted within 3 days and provide data for decisions regarding appropriateness of summons release, release on recognizance, community bail, conditional pretrial release, or other forms of pretrial release. Persons should not be placed in detention solely for the purpose of facilitating such services.

> 2. Emphasize diversion of alleged offenders from the criminal justice system and referral to alternative community-based programs (halfway houses, drug treatment programs, and other residential and nonresidential adult programs). The principal task is identifying the need and matching community services to it. . . .
> 5. . . . Most alleged offenders awaiting trial should be diverted to release programs, and the remaining population should be only those who represent a serious threat to the safety of others (Report on Corrections, 1973, p. 296).

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

Role of Diagnosis at Stage I

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

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

Problems of Diagnosis at Stage I

The decisions made at the time of initial screening probably have more far-reaching importance for the accused and society than those at any other stage, yet they must be made in the shortest time with the least amount of data. Because of the volume of cases at Stage I, individual interviewing and assessment by professional mental health personnel is out of the question in most jurisdictions,

yet the emotional and physical state[4] of the accused often precludes the administration of tests or other structured assessment devices.

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

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

Recommended Procedures and Techniques for Pretrial Screening

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

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

> When a law enforcement agency decides to take a person accused of crime into custody, it should immediately notify the appropriate judicial officer or agency designated by him. An investigation should commence immediately to gather information relevant to the pretrial release or detention decision. The nature of the investigation should be flexible and generally exploratory in nature and should provide information about the

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

accused including:

a. Current employment status and employment history.
b. Present residence and length of stay at such address.
c. Extant and nature of family relationships.
d. General reputation and character references.
e. Present charges against the accused and penalities possible upon conviction
f. Likelihood of guilt or weight of evidence against the accused.
g. Prior criminal record.
h. Prior record of compliance with or violation of pretrial release conditions.
i. Other facts relevant to the likelihood that he will appear for trial.

(Report on Corrections, 1973, p. 123).

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

Those individuals referred by the intake screening or custodial staff should then be evaluated by the mental health professionals. Processing of the referral will be expedited if the intake or custodial staff have been trained by the psychologist to administer the Minnesota Multiphasic Personality Inventory (MMPI). An audiotaped version will be required for those with low literacy levels, and Spanish or other locally common language versions should be available. The MMPI can be scored and profiled by clerical staff or computer. If the MMPI and an initial diagnostic interview, along with basic office tests of orientation, sensorium and the like, indicate that there is indeed cause for concern, then the case should be referred to an appropriate community mental health facility. Since such a facility will usually have its own intake procedures, there may be no need for a more extensive psychological workup at the jail.

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

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

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

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

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

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

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

The undercontrolled assaultive individual will be the easiest to recognize because of his long history of past violence. The overcontrolled assaultive person (Megargee, 1966) poses more problems. If there is an elevation over 80 on the MMPI O-H Scale (Megargee, Cook and Mendelsohn, 1967; Megargee, 1973), further evaluation might identify a potentially assaultive overcontrolled individual; however, it is likely that such people will slip through Stage I screening. The acutely psychotic assaultive person should be recognized by the procedures already delineated. However, a chronic psychosis, especially a paranoid state, might be missed. Routine testing with the MMPI might help, but at Stage I this is generally impractical and, as already noted, poses some ethical and legal problems.

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

The nature of the charges, community ties, employment record, criminal history and similar data collected upon intake will probably be more predictive of whether an individual will surrender himself for trial than any psychological tests (Report on Corrections, 1973, p. 109). Indeed, the writer is not aware of any data on using such tests to identify those likely to jump bail. Highly

successful actuarial tables have been devised, but they must be used with discretion. Obviously, releasing individuals such as Edward Metesky, New York City's "mad bomber," or David Berkowitz, the "Son of Sam," would be inappropriate despite the fact that both were first offenders and had stable employment histories.

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

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

Research Needed in Stage I

A number of research needs can be identified with respect to screening arrested individuals. Norms for the full MMPI with recently arrested individuals need to be developed. The burden of test administration on staff and on clients

would be eased considerably if one of the short forms of the MMPI was found to be as valid as the full MMPI when used with this population for the purposes outlined. Investigations need to be undertaken on using psychological tests to predict absconding on bail. The effects of the stress engendered by arrest on test scores also needs to be determined.

ASSESSMENT IN STAGE II: PRETRIAL DETENTION

Decisions to be Made and Services Required

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

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

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

1. Persons awaiting trial in detention should not be required to participate in any program of work, treatment, or rehabilitation. The following programs and services should be available on a voluntary basis for persons awaiting trial:
   a. Educational, vocational, and recreational programs.

   b. Treatment programs for problems associated with alcoholism, drug addiction, and mental or physical disease or defects.
   c. Counseling programs for problems arising from marital, employment, financial, or social responsibilities (Standard 4.9.1).

The Role of Diagnosis in Stage II

Although much of the placement of individuals within local facilities will be determined by the Standards cited above, psychological assessment can help in this process. In particular, it is desirable to identify those inmates who pose an aggressive threat to others and those who are most likely to be threatened - the predators and the prey as it were - so that these groups can be segregated from one another. Although the initial screening should have identified those individuals with major emotional problems, it can be expected that some will have been missed and that others will develop mental health problems over the course of confinement. Such individuals, especially those with suicide or selfmutilation potential, will need to be identified and evaluated.

Diagnosis of needs in various areas, such as education or counseling, will also be required to assist in program planning for each individual.

The Standards also call for periodic review of the need for pretrial detention (Standard 4.5.4); assessment may be required from time to time to determine whether the factors that led to the decision to detain the defendent, such as the likelihood he will act out in the community, still are operative or, indeed, whether in the fullness of time and given greater familiarity with the defendent and his behavior, that original recommendation still appears to be correct.

Diagnoses may also be made at the request of the Court for determination of a defendent's competency to stand trial and assist in his defense.

Problems Associated with Assessment in Stage II

Generally, there are fewer problems involved in assessment in Stage II than there were in Stage I. In Stage II there are more data available on which decisions can be based and there is less urgency for immediate decisions. The volume of cases should be considerably smaller. This allows time for more thorough data collection and rapport building. Nevertheless, some of the same problems remain. Chief among these is the fact that one is still dealing with unconvicted defendents who have a right to minimal intrusion in their lives consistent with the operation of the institution. Moreover, the fact that they are unconvicted necessitates the same injunctions regarding the informing the defendents of the limits regarding the confidentiality of the data obtained and the fact that incriminating material may be used in evidence

against them. As in Stage I, the writer recommends that data collected on individuals not subsequently adjudicated guilty be destroyed, unless kept for research with suitable safeguards.

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

Recommended Procedures and Techniques for Stage II

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

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

The MMPIs may be scored by clerical personnel or sent for computerized scoring services. Computerized interpretation should not be used except as an advisory input to a licensed clinical psychologist who has the final responsibility for MMPI interpretation (Eichman, 1972; Rodgers, 1972). The psychologist should be familiar with the jail population and with MMPI norms for such populations, including the data regarding the performance of various ethnic or racial groups. At the time of interpretation, the psychologist should also have the basic information regarding the case before him; as Rodgers (1972) points out, a "normal" MMPI profile with no

signs of anxiety or depression from an individual known to have committed rape and murder is a sign of pathology. (This is one reason why computerized interpretations which can not take such facts into account are not recommended.)

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

The MMPI can also be used to assist in the assignment of custody level and living area. The Standards mandate that all correctional agencies, whether community or institutional, should adopt comprehensive classification systems using clearly delineated categories and internally consistent groupings (Standard 6.1). Such a system has been devised for adult male offenders based on the MMPI (Megargee, 1977a; 1977b; Megargee & Bohn, 1977, Megargee & Dorhout, 1977, Meyer and Megargee, 1977) and Miller (1978) has recently extended the system to women. One advantage of the system is that it is based entirely on a uniform, easily obtained data base, namely the MMPI, and the bulk of the classification can be done by computer, thus facilitating its implementation in larger systems in which classification according to the Warren or Quay systems might be impractical.

The writer's MMPI-based classification system has recently been implemented as a guide to quarters assignments at the Federal Correctional Institution in Tallahassee, Florida, where, in conjunction with a consideration of such factors as known history of violence and physical size, it is used to sort inmates into those who are likely to be initiators of violence (about 15%), those who are likely to be recipients of violence (about 15%), and the average group at neither extreme (about 70%). Nine months after assigning the predators and the prey to different dormitories, Bohn (1978) reported a significant decrease in the level of violence; moreover, he reported that those assaults that had occurred had all taken place in the dormitory to which the more violence-prone inmates had been assigned. In the next phase of the experiment, it is planned to reassign officers from the more assault-free dormitories to provide closer surveillance on the violence-prone area in an attempt to reduce assaultive behavior still further.

Research is in progress on the applicability of the system in jail settings. Preliminary reports indicate that 95% of a jail population is classifiable according

to the system.[4]

Other classification systems which provide useful data with respect to management and treatment are the Interpersonal Maturity Level (I-Level) system devised by Marguerita Q. Warren and Ted Palmer (Warren, 1969) and the four-fold classification system devised by Herbert Quay (1974). One disadvantage of the I-level system is the fact that it requires extensive clinical interviewing by a person trained in I-level theory, although tests have been devised which purport to give accurate I-level classifications. A more serious drawback to its use in jails is that the research thus far has all been on juvenile delinquents; since interpersonal maturity should increase with age, it is not known how applicable the I-level system would be to the adult offenders found in jail settings.

This drawback does not apply to the Quay system which has been recently extended to adult populations (Quay, 1974). This system depends on a behavior checklist filled out by a custodial officer, a case history checklist filled out by a caseworker, and a test taken by the offender. If only the first two instruments were employed, no testing, with the associated problems of informed consent and invasion of privacy, would be required of the pretrial detainee. One drawback might be the lack of time for the officers who fill out the behavior checklist to become acquainted with the inmates. Bohn (1978) noted some difficulties with the reliability of behavior ratings made after only two weeks of observation. A good case history is also required. If the time and resources exist to allow good Quay ratings to be made, the system might be quite useful in jail settings.

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

Thus far we have discussed assessment during Stage II to identify possible problem cases which require further scrutiny and as an aid to management, specifically quarters assignment. In addition, the psychologist in a jail setting may also be asked to help determine competency to stand trial. To be incompetent to stand trial, a defendent has to have such a degree of emotional or cognitive impairment that he or she is unable to understand or participate in the proceedings or help his or her attorney in the preparation of a defense. Interviews focused specifically on the nature of the charges and proceedings, observations of everyday interactions with other inmates and staff, and individual intelligence and personality tests

[4] Cassidy, J. Personal communication, April 4, 1978.

currently provide the best data base for such determinations. Lipsitt, Lelos and McGarry (1971) have devised a "Competency Screening Test" which Rumreich (1973) has shown to have some validity in a mental hospital setting. If further research demonstrates its reliability and validity more conclusively, it could be useful in jail settings.

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

Research Needed in Stage II

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

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

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

ASSESSMENT IN STAGE III: POSTCONVICTION INCARCERATION

Decisions to Be Made and Services Required

After trial and conviction, some offenders will be sentenced to local adult institutions for periods of incarceration ranging from a few days to a year or more. Some of those entering the jail as convicted misdemeanants will be individuals who were detained prior to trial; others will be entering the jail for the first time. Both groups, however, will require an intake evaluation, and management and

programming decisions similar to those in Stage II will have to be made. Those who are mentally or physically ill or who have other special needs must be identified, each individual must be classified according to a comprehensive classification scheme, management decisions have to be made, and, as in Stage II, programming plans need to be formulated. Unlike Stage II, the post-trial offender can be assigned to programs and offender rehabilitation is now a legitimate objective.

Role of Diagnosis in Stage III

The role of diagnosis and assessment in Stage III is much the same as in Stage II, except that in dealing with convicted offenders who will be in residence for specified lengths of time, much more emphasis can be placed on program planning. Moreover, more diversified programs including work and study release can be considered since the population, unlike that in Stage II, will no longer consist solely of those who are escape risks and/or dangerous to society..

Problems Associated with Assessment in Stage III

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

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

Recommended Procedures and Techniques for Stage III

A substantial proportion of those sentenced to periods of incarceration in local adult facilities will be entering jail for the first time if the Standards'

injunctions with respect to pretrial detention were implemented.[5] Whether or not they were detained prior to trial, a new intake classification should be carried out upon entrance as a sentenced offender.

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

Convicted offenders have to be housed separately from pretrial detainees, and management classification decisions must be made. The writer would recommend the adoption of either his own MMPI-based system or the Quay adult system described in Stage II.

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

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

Intellectual ability should also be assessed. Few jails will have the mental health resources needed for individualized intelligence tests such as the Wechsler

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[5] If only the more serious and dangerous offenders were detained, it is likely that they were sentenced to state institutions and the milder offenders, who could be released on bail, sent to local institutions.

Adult Intelligence Scale (WAIS). The Revised Beta Examination, which does not depend on reading ability, has proven itself to be useful in adult correctional settings serving offenders from a variety of ethnic backgrounds. The California Short-Form Test of Mental Maturity (CTMMSF), which is available in grade levels from 1 through 16, requires 45 minutes to administer and is "among the best" group measures of verbal intelligence (Goldman, 1972). The Quick Word Test, which is also available in levels ranging from Grade 4 through college and professional adults can be used to give a reasonably accurate verbal I.Q. in 15 to 20 minutes of group testing time, but it is probably less valid than the CTMMSF (Nunnally, 1972). Bothe the CTMMSF and Quick Test probably underestimate the intelligence of minority group members, especially bilinguals, although they may accurately forecast their functioning level in typical English-speaking classes.

An educational achievement measure should also be adopted for high school and grade school dropouts for whom a GED program might be desirable. By far the best is the Stanford Achievement Test (SAT) (Merenda, 1965), but it requires several lengthy testing sessions and good reading ability which make it impractical in most jail settings. The individually administered Wide Range Achievement Test (WRAT) gives grade level estimates in arithmetic, spelling and reading, but its validity is questionable (Thorndike, 1972). Some jurisdictions might choose to screen new inmates with the WRAT and if the WRAT scores suggest deficiencies, follow-up with the SAT.

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

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

According to the Standards, the actual program plans should be formulated by a team including institutional staff members and representatives from community

agencies that might be involved, such as mental health, vocational rehabilitation and the like. A job placement expert is especially needed so that vocational training has some relation to job availability.

In addition to initial program planning, further assessment may be needed to monitor progress and adjustment over the course of confinement and to assist in release planning. It will be desirable to maintain records of adjustment and progress on a monthly basis to assist the treatment team in evaluating each individual's progress. The Megargee Interpersonal Adjustment Rating form, which is filled out by a custodial officer who has regular contact with the offender, and the Megargee Work Performance Rating form, which is compiled by the work crew supervisor, might be helpful in this process (Fowler & Megargee, 1976; Megargee, 1972b).

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

Research Needed in Stage III

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

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Discussion Paper

INTERVENTION MODELS FOR MENTAL HEALTH SERVICES IN JAILS

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Executive Summary

The need for improved mental health service delivery in jails is evidenced by the research on incidence of psychiatric disorders. While the actual rates are variable, up to two-thirds of all individuals confined in jail settings suffer from some disorder that may be categorized in the American Psychiatric Association Diagnostic and Statistical Manual II. There is a need for screening and referral or treatment of the most seriously disordered and many other moderately disordered individuals, partly in reaction to the confinement experience, who are in need of mental health assistance.

A number of models of mental health service delivery may be identified. They include:

1. Emergency services at local hospitals or mental health centers. Such services are offered within emergency rooms and usually are experienced with dissatisfaction by both hospital and jail personnel.

2. Counseling and psychotherapy programs within jails offered by community mental health centers. These are typically offered on a part-time basis to inmates who are referred by jail staff.

3. Therapeutic communities within jails. Separate living areas are set aside for intense programs for both pre-trial and post-trial inmates serving long periods of time.

Executive Summary

4. The referral and classification center. In this model a separate wing within the jail serves to conduct assessments, identify seriously disturbed individuals, offer brief crisis-oriented treatment, and refer suffering clientele to appropriate community agencies.

5. Suicide prevention programs in the jail. The development of programs explicitly directed at suicide prevention makes this an organizational goal, with staff members who may then be specifically accountable for achivement of the goal. Methods of suicide prevention include use of prisoners as well as staff, availability of crisis services, careful supervision and observation, and promoting specific staff accountability and responsibility.

Jail personnel are involved in mental health services in two ways. They should be both recipients of services directed at them, and be able to provide services to jailed citizens. They need to be recipients of services because of the moderate to severe stressors of working in the jail environment and role identity problems. The modest evidence available suggests that there are significant emotional hazards in such employment. The basic skills necessary to offer mental health services include demonstrating attitudes of fairness, friendliness, and consideration toward the jail inmates.

The prevention of mental disorders in jails is a difficult but an important priority. Among other appropriate steps are keeping individuals in single cells rather than in dormitories and jail settings, identifying, and eliminating stressful life events within the jail, removing noxious effects of noise and other environmental stimuli, and preventing jail incarceration of emotionally disordered individuals.

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Five specific research directions may be identified. They are: (1) follow-up research on citizens who are jailed, (2) investigations of parameters and behavior changes in jail officers, (3) mental health research-demonstration units within jails, (4) violence and suicide research, (5) research into prevention of mental disorders in jails.

Introduction

The written history of jails in America reads like a gothic horror story, with its foul forces and tragic consequences. It has been observed that "If verbal condemnation alone could do the work, the jail as an institution would have crumbled long ago. No penal institution, in fact no social institution of any kind, has been more scathingly denounced..." (Robinson, 1944, p. iii). Our task is not to reiterate all of the problems in jails. Yet mental health problems always occur in context, and the context in jails has been that of abominable physical conditions, sanitary and health inadequacies, untrained and insufficient staff, ineffective screening, unrelieved idleness, and the pervasive threat of violence (National Advisory Commission on Criminal Justice Standards and Goals, 1973). These problems are intimately identified with the jail as emotional stressor and with subsequent psychological strains of the confined persons. These noxious conditions and events, and ways to ameliorate them will not be discussed here, as we examine the narrower topic of mental health intervention models; however they are acknowledged as central difficulties that call for priority actions.

A definition of jails must be undertaken. We agree with Mattick (1974) that the term "jail" encompasses a variety of disparate facilities, ranging from

a three cell detention area in the sheriff's offices of a rural county to a thousand bed, complex prison typical of major urban centers. Both settings have in common the holding of arrested citizens for more than 48 hours and serving as intake point for the local criminal justice system.

With such diversity, the issues of mental health needs and services are more than a matter of scale. The smallest jails have been recommended for elimination because they cannot offer appropriate services of all sorts, and they would be replaced by regional community correctional centers. Similarly, the single large metropolitan jail has been criticized: "...with its inclusion of all functions in a single facility, (it) creates an unnatural physical and psychological environment" (National Advisory Commission on Criminal Justice Standards and Goals, 1973, p. 282). The recommended alternate is "...a network of dispersed facilities and services geographically located to perform their functions best" (p. 282). The development of more regional centers, and more flexibility in metropolitan jails are assumed in the present discussion of needs, standards, and models.

NEEDS

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

On the one hand, Kal (1977), using the American Psychiatric Diagnostic and Statistical Manual II, with a random sample of a county jail population, reports an overall morbidity rate of 50 percent DSM-II diagnoses among female inmates and 63 percent DSM-II diagnoses among the male inmates. He attributes these findings to "the uniquely heterogeneous nature of a county jail population compared to state or federal prisons and to indicate that florid psychotics represent the tip of the iceberg of mental health needs in a county jail. Even this segment is unlikely to be totally recognized by the jail authorities" (p. 463).

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

Two other investigations of incidence of psychiatric disorder in jails report findings somewhere between the Kal high estimates of 50 to 63 percent psychopathology and the three percent estimates from the Petrich study in King county. Swan and Winer (1976) evaluated 545 inmates in Denver County, Colorado. Of these prisoners 22 percent were diagnosed as psychotic and

23 percent had a history of either long term or multiple hospitalizations. One additional study of 199 male prisoners without prior felony convictions, and interviewed within one day after their arrests, concluded that 46 percent met psychiatric diagnostic criteria, but that only five percent needed acute treatment (Schuckit, Herrman, & Schuckit, 1977).

These diverse findings agree with our own summaries of studies of psychiatric evaluations of offenders (Brodsky, 1973). Studies of felons were found to have reported ranges of psychological disturbance ranging from 15 percent up to 85 percent of the offender sample. The range of psychotic illnesses in nine such studies was quite narrow, running between one and two percent of the populations investigated. We concluded at that time, "It is neiher reasonable nor appropriate to administer clinical services to justice clients in general....It is suggested that there may be a high potential inherent in the utilization of clinical services directed toward selected clientele within the justice system. There are, indeed, psychologically troubled offenders, in addition to those who develop impairments after their incrimination. Both are in need of psychological assistance. However,...the presumption of client homogeneity is incongruent with our knowledge" (pp. 66-67).

If indeed selected prisoners, and perhaps up to half of all citizens entering jails, are suffering from substantial mental disturbance, a need exists for major in-house programs for mental health service delivery. Such programs would be based on this perspective of the jail as a final filter to identify and aid the mentally disturbed. Thus, Mattick (1974) states, "In short, the jail

is a major intake center not only for the entire criminal justice system, but also a place of first or last resort for a host of disguised health, welfare, and social problem cases. The latter consist for the most part of a large number of highly vulnerable or treatable cases..." (p. 781). Since so many jail inmates stay such brief periods of time, if the jail is to function as a behavioral intake center of last resort, then the disguised social problems should be uncovered and intense, brief, crisis-oriented services delivered by professional staff.

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

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

EMERGENCY SERVICES AT THE HOSPITAL OR MENTAL HEALTH CENTER

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

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

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

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

JAIL COUNSELING AND PSYCHOTHERAPY

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

Thus the Greene County Guidance Center (Jail Counseling Project, 1978) of Xenia, Ohio developed its program in direct response to the awkwardness

of having two guards bring an inmate to the mental health center for evaluation or services. A psychiatric social worker spends four or five hours a week seeing referred inmates in a "safe, secure and private area" and providing consultation on specific cases and problems to the jail officials.

An alternate approach is to target specific jail subpopulations for psychotherapeutic services. These populations may include psychotic individuals, alcoholics, individuals with drug problems, youthful offenders, depressed or presuicidal individuals, and so on. Thus, in the Tuscaloosa, Alabama County Jail, McCarter, Colwick, and Goodwin (1978) report the development of a group therapy program. The staff members of a local mental health center offer weekly a 90 minute group therapy meeting for the drug and alcohol populations of the jail. Inmates with histories of violent crimes or escape charges are not permitted to take part in the group. The nature of the treatment is "primarily one of confrontation of irrational thinking, over-reliance upon maladaptive defense mechanisms, and maladaptive behavior for whatever reason" (p. 3). Although participation is totally voluntary, it is reported that 100 percent of the enrolled members attend. Furthermore, after discharge, approximately 45 percent of the individuals who have been involved in the group sessions continued to pursue at the mental health center the same treatment they began in jail.

THERAPEUTIC COMMUNITIES

Several jails have introduced therapeutic communities, in which staff and inmates join in an intensive, full-time, reciprocal-helping program.

In the therapeutic communities within jails, the residents live in a single area, engage daily or more often in a group meeting, and each individual assumes some responsibility for influencing the behaviors of fellow residents in positive and constructive ways.

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

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

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

THE ONE-STOP SOCIAL SERVICE CENTER

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

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

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

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

Goldfarb suggests that there would be specific treatment offered within this center. However, such treatment would be only short term and crisis

oriented, and would include detoxification and treatment activities for alcoholics and narcotic addicts. Goldfarb asserts "Any modern detention facility must be designed, staffed, and programmed to identify and assist arrested narcotic addicts" (p. 441). He further reports that most detoxification care for jailed alcoholics is insufficient. The detoxification process he proposes would include five to seven days of care in a alcoholic ward, for a complete detoxification process. Following that period, the confinees would be subjected to a psychological assessment and referral.

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

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

There is a more serious hazard. That is, that in spite of Goldfarb's assertion that only genuinely dangerous and high-risk individuals would be

kept in the one-stop social services wing, that the jail population would balloon. The existence of such an intake wing would likely cause many people to be sent to the jail for assessment and referral who would otherwise not be confined.

LIFE SKILLS ENHANCEMENT

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

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

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

SUICIDE PREVENTION PROGRAMS IN THE JAIL

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

Successful suicides are among the most dramatic, tragic, and galvanizing events within jails. They sharply focus the public's attention on the psychological trauma of imprisonment and the actual experience of living within jail.

Virtually every medium size or large jail has reported suicides of adults and teenaged youth with subsequent serious but short-lived reform efforts directed at jail conditions.

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

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

Several obvious steps may be taken. Pappas (1970) for example states "The jailer's best precautions against suicides are close supervision, ability to evaluate prisoners, knowledge of first aid, and established emergency procedures" (p. 94). Wilkerson (1973) urges recreational facilities,

hiring of professionals, and a sophisticated reception-diagnostic center as key elements in preventing and dealing with suicide. Danto (1973) encourages jailers to take suicide threats seriously, to not place potentially suicidal individuals in isolation, have immediate medical treatment available, encourage phone calls to relatives and attorneys, and promote good listening by the guards. We offer five recommendations for suicide prevention programs in jails.

Program Identity. The identification of a suicide prevention program in a jail setting by itself acknowledges explicitly that the problem is serious, that it occurs with sufficient frequency to merit the development of a program, and that there is a core of knowledge, skills, and responses which all staff should master. Thus, a first recommendation is the explicit commitment to and staff identification of a suicide prevention program. Information about the program should be made available to newly arrived prisoners.

Use of Inmate Resources. Jails confine large numbers of talented, often altruistic persons with much available time and little to do. Selecting and training the best among these individuals to assume responsible roles in suicide prevention, as well as other helping roles, is a key and important action. Their roles in suicide prevention would be both observation and immediate crisis intervention and counseling. Danto specifically urges the establishment of:

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

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

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

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

Expediting Help. Assuming that many prisoners in jail settings are sorely hurting, every effort should be made to expedite help in a variety of ways for confined persons. While we are describing it here in the context

Discussion Paper

PROVIDING MENTAL HEALTH SERVICES TO JAIL INMATES - LEGAL PERSPECTIVES

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Executive Summary

There is now a clearly recognized legal duty for both the county and the sheriff in charge of a county jail to provide meaningful access to all types of medical services, including mental health services. This duty, reinforced by an increasing number of "standards" established by nationally recognized agencies, both private and public, requires that there be (1) adequate intake procedures for determining persons clearly in need of mental health services, and sufficient, emergency processes for delivering such persons to mental health facilities rather than jails; (2) unfettered access by the prisoner to the provider of health care, including a requirement that no correctional employee refuse to forward such a request to the provider; (3) sufficient training for correctional employees so that they can recognize, and temporarily treat, emergency needs for mental health services; (4) written statements of the limitations of treatment, both by restricting who may administer treatment of any sort (except emergency care) and by requirements of true and valid informed consent.

This, however, is only half the story: while the law demands that the sheriff, or county, provide such services, it is also ready to look askance at those who provide such services too readily. Thus, for example, before a prisoner may be transferred to a mental health facility, there may be a need for conducting a hearing -- a cumbersome process which is likely to discourage such transfers. The legal system here

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is schizophrenic; it seeks to protect the rights of those who in fact need treatment, while also protecting, against added stigmatization, those who in fact do not need treatment. The result is an uneasy balance, which often seems to use the mental health provider, or the sheriff, as an unwilling fulcrum.

This ambivalence is underscored by the current legal doctrines of legal liability for failure to provide such services. Where the failure is that of a governmental agency, the agency may be ordered to provide the services or close the isntitution. Where the failure is that of an individual sheriff or health care provider, however, the balance is much more difficult to draw, particularly since diagnosis of and proper treatment for mental illness is sometimes exceptionally difficult. Thus, where prisoners injure other prisoners, or themselves, due to mental illness, courts have generally spoken as though the sheriff or mental health care provider would bear the liability personally, but have established a series of defenses which actually assure that unless there is the worst kind of negligence, or worse, the defendant will not in fact be liable. While this is probably equitable to the defendant, the fact is that the plaintiff, who was put in a position where he was unable to assist himself, has been injured. The paper therefore concludes with a suggestion that governmental agencies which operate local detention centers should be held liable in damages without regard to fault, while individual defendants should be liable only if

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theirs was the highest form of neglect or recklessness. This would restore the balance which the current legal doctrine of liability do not consider.

Researchable legal issues in this area include: (1) historical analyses of the beginning of sheriff's liability for deputies' actions; (2) the effect of a "no-fault," workers' compensation-type scheme on local government; (3) the current status of state laws on transfer from jails to mental hospitals, including a due process analysis; (4) an analysis of the theoretic reasons for imposing upon the sheriff a duty for providing medical care without regard to which the prisoner had such medical care available to him before incarceration.

Introduction

It scarcely seems possible that it was less than a decade ago that the legal revolution in corrections began. In 1967, when Fred Cohen prepared his report on the law of prisoners' rights for the President's Crime Commission,1/ virtually all his analysis was speculative. There was no major judicial decision on any aspect of corrections, and surely not concerning medical services for prisoners, much less for pre-trial detainees. Today, of course, that is different; virtually no one would challenge the notion that a prisoner has a legal right - ultimately protected by the Constitution - to adequate medical care. 2/ Not only courts, but independent interested organizations, such as the American Correctional Association, the American Medical Association, the American Bar Association, The National Sheriff's Association, and a host of others agree, and have attempted to articulate more definitely the contours of such a right. 3/

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

The first suit to seriously consider the broader ground of the sheriff's duty appears to have been Jones v. Wittenberg. 6/ There, in what has now become a typical "jail case", inmates of the Lucas County, Ohio jail

*As used in this paper, "state" means the responsible governmental authority.

sued in a class action suit on conditions generally in the jail. In sweeping order, which ranged from prescribing the kind of paint to be used on the walls to due process considerations, to mail, to nutrition, the court, in addition, ordered the sheriff to consider changes in the provision of mental health services. 7/

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

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

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

I. WHAT KINDS OF SERVICES

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

A. The Role of Standards

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

First, there are standards relating to corrections in general, such as those put forward by the National Advisory Commission on Criminal Justice Standards and Goals, 11/ the National Council of Crime and Delinquency, 12/ the United Nations, 13/ the Association of State Correctional Administrators, 14/ and the American Bar Association. 15/ These sets of standards, which are intended to cover all, or most, aspects of correctional life, spend very little time at all on medical facilities as such. Thus, for example, the National Advisory Commission devoted only two pages to health care in over six hundred pages in its volume, which covered all issues ranging from sentencing and legislative reforms to parole to community release, etc.

A second set of standards, recommendations, guidelines, etc.

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

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

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

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

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

The conclusion is somewhat dubious, particularly if one talks about legal standards and the application of the standards in litigation. Doctors, of course, are already familiar with the role which standards, promulgated by private bodies, have played in the expansion of negligence. Although courts once followed the so-called "locality rule" in assessing malpractice, 28/ that rule was abrogated in the famous case of Darling v. Charleston Community Memorial Hospital, 29/ where the court held that, among other things, nationally promulgated standards could be used to determine the standard of care necessary. This decision spawned progeny throughout the country, which have continued to rely upon nationally promulgated standards. 30/ While it is certainly true that, so long as there are various standards, some of which are more general than others, courts will be relatively free to select among the standards that are submitted to them as relevant, depending upon what the precise facts of the case demonstrate, and what the difficulties are that confront the court at the particular time, it is likely that, in the absence of any agreed-upon standard, the courts will look

primarily to the ABA draft because these standards are drafted by lawyers rather than by interested groups who might, or might not, have a hidden agenda in mind. Let me add, hastily, that I do not believe that to be the case. In most instances, the AMA/ACA standards are at least as demanding as the ABA standards. But there are some difficulties, nevertheless.

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

Nevertheless, all these standards do agree to a remarkably substantial extent. Thus, for example, virtually all the standards agree that there is a requirement of providing medical care, that the state must pay for this medical care, that mental care services are included in the provision of medical care which the state must provide, and that there is an obligation on the part of the state both to seek to treat mental illness and, if possible, to prevent its occurrence. In short, all agree that there is an obligation to either provide medical services, or to provide unrestricted access to medical services.

One final point on the standards: they are not Pollyanish. Recognizing that the size of jails varies considerably, there are no strict requirements that there be a specific number of doctors, nurses, licensed health professionals, etc., in the facility throughout a twenty-four hour period. Indeed, most of the standards do not require any such medical personnel to be on hand. Instead, the standards, and the case law,

generally accept, as for example the ABA standards do, the various methods by which medical services are now provided to prisoners: (1) in-house doctors, or other professionals; (2) on-call doctors; (3) arrangements with a near-by hospital either to visit the facility, or to have ill prisoners taken there.

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

B. Particular Requirements of Access

1. Entrance Examination

In 1972, the American Medical Association conducted a self-answer study of American jails. 31/ The results demonstrated a level of medical care so poor that it stunned even those familiar with jails generally. Of all the findings, however, perhaps none was so startling than the finding that intake medical examinations were given, as a matter of routine, only by 1.7% of all city jails, and 3.0% of all county jails. In another 50% of the jails, prisoners received examinations if something was "obviously" wrong, if they complained, or if they complained AND something was obviously wrong. But a full 47.3% of all responding city jails, and 48.5% of all responding county jails said that they gave NO medical examination to ANY prisoner.

Virtually all the standards recognize the need for preliminary medical examination at the initial intake process, including examination for obvious mental illnesses. 32/ But the standards are often unclear whether these preliminary examinations must be conducted by

a licensed physician much less by a licensed mental health practitioner. 33/

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

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

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

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

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

Isolation of the prisoner from other prisoners does not mean that he should be left alone; this is obviously the worst possible course of action to take with a potential suicide. If the prisoner is to be isolated, care must be taken to assure that someone is watching him at all times, while arrangements are made to transfer him to a mental health facility. 36a/

The courts have agreed virtually unanimously that preliminary medical examinations are required as a matter of law. 37/ And, as

we will discuss more fully later, the failure of a sheriff to protect against a person who, through the preliminary examination, indicates potential for suicide, has been viewed by several courts already as imposing liability on the sheriff if the suicide actually occurs. In short, the law, as it now stands, supports the approach taken by the standard setters.

2. Reasonable Access to Reasonable Treatment

Every correctional facility, jail, or prison must, therefore, provide "reasonable access" to both emergency and non-emergency medical assistance, including mental health services. Critical for this process is daily sick call — both the standards and the case law require this. 38/ But daily sick call is insufficient protection for the health of the prisoner unless he can assure that, in fact, he will see the physician. This means that no correctional officer will determine that the prisoner is "malingering", and fail to forward the request for sick call, and that every prisoner will indeed have access. 39/ It also means that, in a conflict between the doctor's orders and those of the sheriff, the doctor must be given preference. 40/

Other conflicts, of course, arise: 41/

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

The access must be to qualified medical personnel. Hardly anyone will be surprised by the statement that: 42/

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

Indeed, in many states, persons otherwise disallowed to practice medicine upon "normal" civilians are allowed to practice in state institutions - jails, prisons, mental hospitals, nursing homes. And it is clear that, as compared to the average $63,000 a year, prison doctors are drastically underpaid. 43/

The harshness of these facts is visited upon the prisoners. It is not surprising, therefore, to learn that one of the major complaints of the prisoners at Attica, as elsewhere in this country, concerned both the competence and the attitude of the prison doctor. 44/

Guards are not doctors. Virtually every national standard which has confronted the question of drug control in prison has provided that ONLY a licensed physician should dispense drugs of any kind. 45/ In some instances, the administration of the drug may be under the guidance of such a physician. The reasons are self-evident. There are probably more drugs, per capita, in prison than on the street and, almost certainly, more persons seeking to use them. Prison, as we have already seen, if we needed to be told again, is a dreadful place; it encourages, if it does not actually foster, mental anxiety, boredom, etc. And drugs can provide at least one superficial response. Notwithstanding these reasons for careful control, most state Attorneys General, who have issued opinions, have disagreed, indicating that non-medical personnel may administer drugs, assuming they have been prescribed. 46/ Presumably, the reason is economic — many small jails simply could not afford the kind of supervision required by the national standards.

Treatment means treatment, not pacification. It is generally acknowledged that in all correctional institutions, but especially jails, low-level, mind-affecting drugs are rather widely available to prisoners and, indeed, are often dispensed to prisoners - by doctors or other - to reduce the level of discontent and violence. 47/ Obviously, such abuse of drugs is not to be condoned.

This raises yet another question - does the prisoner, assuming competence, have the right to refuse treatment, including, but obviously not limited to, drugs? I believe the proper answer is yes, although there are some decisions which would appear to say that there is no such right. 48/ These cases, in my opinion, are clearly wrong. First, the sheriff and/or mental health professional is obligated, I believe, only to provide access to medical services. If the prisoner refuses such services when proffered, the duty has been met (assuming, of course, that the services are not so clearly inadequate, etc., that the proffer cannot be viewed as bona fide.) So from the viewpoint of legal liability, there is no need for the sheriff or others to press forward. Second, the prisoner's right to refuse treatment, based in part on his constitutional right to autonomy and privacy, 49/ should be respected, and his body held inviolate, as it has been (except in emergencies) under the common law. 50/

Whether agreeing to treatment, or refusing it, of course, the prisoner must be competent and, if competent and accepting treatment, must have given informed consent. 51/ There is no magic formula for informed consent; some states have definitions which differ substantially while most states have not even considered the problem

legislatively. For our purposes, a good, solid definition of informed consent is that found in the California Code: 52/

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

This very brief survey of potential conflicts between security needs of the prison and medical needs of the prisoner has, I hope, at least given the flavor of the issue: when there is a clash, the medical needs win. But accommodation is desirable, if possible. As Professor Neisser has written: 53/

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

3. Where Should Treatment Occur?

Thus far, we have assumed that the provision of mental services will occur in the jail. But ideally, treatment for mental illness should occur in a hospital, or other mental health facility, not a jail. 54/ Yet, there may be obstacles.

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

Second, state statutes may so define those subject to involuntary hospitalization that some persons deemed mentally ill may not qualify. For example, in some states (now a minority) it is a predicate for involuntary commitment that the person be BOTH mentally ill and dangerous to self or others. 55/ Other states may require both a showing of mental illness and some other criterion -- for example, New York requires that the patient be so disabled as to be unable to decide for himself. 56/

For those persons who cannot meet the second of these requirements, treatment in the jail may be the only alternative. 57/

Third, transfer to a mental hospital carries with it a potential additional stigma, a "grievous loss" which the prisoner

may suffer if so transferred. Just ten years ago, the United States Supreme Court held that before a prisoner could be transferred to a mental hospital, the same processes that would be used to commit a non-prisoner must be followed. 58/ Thus, prisoners who are thought to be mentally ill, and in need of commitment, must be given a hearing, etc., prior to (or in cases of an emergency, as soon as possible after) the transfer. 59/ These hearings are at the heart of the concept of liberty in a free society; nevertheless, they are, admittedly, a burden on the jail and the psychiatrist, and it is not unreasonable to assume that in some instances persons in the process will select to avoid such a hearing by attempting treatment in the jail facility.

One possible solution to at least some of this dilemma is to do what California has now done -- allow any jail prisoner to voluntarily commit himself 60/ (which does not require a hearing) if either a judge or the sheriff agrees AND the mental health director agrees. On the other hand, such a solution may be overbroad and induce prosecutors to seek jail commitment at least pre-trial, in situations in which the defendant otherwise would have simply been released. Intriguingly, California also provides that a jail inmate involuntarily transferred to a mental facility may -- without anyone's permission -- change to voluntary status. 61/ The experience of California is, at this point, so sketchy that it is difficult to know whether this concern is a realistic one; 62/ nevertheless, it does exist.

A fourth problem -- one which is difficult for the law to prove, much less wrestle with, yet which is undeniably present -- is the fact that many of the prisoners who might be subject to transfer are likely

to be the "troublemakers" in whatever institution they find themselves. Thus, the sheriff will be anxious to transfer them to the mental health facilities in the area, while the director of such a facility will be pressed, at least subconsciously, to find that the prisoner's mental illness has rapidly disappeared, and he may be returned to the jail. The arguably dangerous psychopathic prisoner thus becomes a ping-pong ball between the two departments. Moreover, the director may have substantial reason for rejecting such a transferee many local mental health centers are intended primarily for out-patient care, or for in-patient care of the most liberal kind. Consequently, there may be inadequate security to prevent the charged patient from escaping. 63/ This, of course, is not a proper response since there may well be -- indeed almost assuredly will be -- "free world" patients who need maximum security care, and yet who should not be shipped off several hundred miles upstate, to the "only" such facility. Yet, since the prisoner/patient must be near the site of his trial, such long distance transfers, as well as being undesirable from a humanitaria viewpoint, may well be invalid, as unduly restricting his access to counsel and the courts (at least prior to trial).

It is possible that statutory change in the process of transfers to mental hospitals, if the change expedited transfer, might reduce the number of suicides, but it is far from clear that that would be the result. In 1974, New York enacted legislation 64/ for just that purpose, but as Scott Christianson noted: 65/

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

> as those in penal institutions, even though the former usually provides closer supervision."

Assuming, however, the possibility of transfer, or even of commitment, of a mentally ill jail inmate, several questions yet remain, at least in terms of who bears legal responsibility for the prisoner while he is in the mental health facility. For example, is the prisoner still, legally, in the custody of the sheriff, so that if the prisoner escapes, it is the sheriff's responsibility? If so, then perhaps the sheriff ought to be able to "forbid" transfer on the basis of his own legal responsibility. Yet, such an act would clearly be an interference with medical judgments, something we have already indicated is both wrong in principle and increasingly recognized as invalid as a matter of law. The same question remains on the other side: should the mental hospital be able to refuse admission on the transfer on the grounds that it has inadequate security, etc.? 66/

The "solution", if I may call it that, is both simple and yet complex. It is that, in every county, there should be at least one state mental facility which has a reasonable number of high security wards, or beds, which allows the transfer to the facility. Legal responsibility for subsequent actions by the patient should be lodged on the director of the facility to which the prisoner is transferred, who takes on that risk as part of his job. 67/

II. A NOTE ON FINANCING

The county, or other governmental unit responsible for the jail, will, of course, be responsible for paying for medical services. There is, however, a possibility -- circumscribed by legal questions not yet resolved -- that these

agencies could seek federal help -- medicaid payments -- to cover, or at least defray, these expenses. The issue is a murky one.

The pertinent medicaid provision declares that a person is not eligible for medicaid if he is "an inmate of a public institution (except as a patient in a medical institution.)" 68/ Several questions of definition then arise: (1) who is an "inmate"; (2) what is a "public institution"; (3) what is a "medical institution". We will deal with these in inverse order.

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

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

and meets certain staffing needs. 69/ According to HEW interpretation, however, a jail infirmary is not ITSELF an "institution", but rather PART of a larger institution -- the jail -- which does not meet the definition of "institution." 70/ Therefore, a jail infirmary is NOT a "medical institution" so that a prisoner in such an infirmary, IF an "inmate of public institution" is not covered.

A prisoner transferred to a non-prison hospital, however, would surely seem to be "in a medical institution" as defined by the regulation. However, again according to current interpretation, such a prisoner is NOT an inmate in that institution, since custody remains with the sheriff. 71/ Therefore,

prisoners transferred to a place which would otherwise qualify as a "medical institution" cannot qualify for medicaid funds under this provision.

There is some good reason for this interpretation: the notion is that since the state is under an obligation to provide such medical services, the federal government should not be under an obligation to pay the state for providing those services. It is, in short, a measure of economy. Given other interpretations noted below, however, this rule is a difficult one to sustain.

First, the Medicaid statute itself provides that a person under 21 receiving in-patient care in a psychiatric hospital IS eligible for Medicaid payments, EVEN IF he is otherwise a jail inmate. 72/ Thus, in at least this one instance, the federal government does provide payment for the services, even though the state also has an obligation to provide these services. Why psychiatric services should be different from other services is not clear; nevertheless, a constitutional argument would be difficult to frame here, and would almost certainly be unavailing.

Second, current regulations of the Department of HEW provide that Medicaid will pay for services, psychiatric and other, for persons otherwise eligible, "for the month in which an individual became an inmate of a public institution."73/ Thus, a jail inmate, even if not in a psychiatric hospital, receiving inpatient care, will qualify for Medicaid payments during the first "month" of his incarceration. There is some question whether "month" means "calendar month" or the "first thirty days", although the Congressional history indicates that the term should be limited to "calendar month", since the purpose is for billing purposes. 74/ Thus, a prisoner who is incarcerated in jail on September 28 has only two days for eligibility, while one incarcerated on September 1 has 29 days eligibility.

These two exemptions — inpatient psychiatric care, and the "calendar month" — seriously undermine the notion that the Medicaid statute should

continue to be construed as it now is, on the theory that the federal government should not pay the state for performing the state's duties.

Nevertheless, even given these interpretations, there is still one other serious question as to whether a pre-trial detainee is an "inmate in a public institution." Clearly, the jail is a "public institution." Nevertheless, an individual is NOT an "inmate of public institution" if he is "in a public institution for a temporary emergent period pending other arrangements appropriate to his needs." 75/ One could argue that a pre-trial detainee, whose presence is in the jail only because he cannot raise bail, is in the jail "for a temporary emergent period." What his "needs" would be are unclear, but it again could be argued that his "need" is freedom, contingent upon bail. 76/

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

(1) to all jail inmates under 21 within the first "calendar month" of their incarceration;

(2) to all inmates under 21 transferred to a psychiatric institution for inpatient care.

They may not receive Medicaid reimbursement for medical services rendered to inmates: 77/

(1) over 21;

(2) under 21, for services rendered after the first calendar month.

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

III. LIABILITY AND DEFENSES

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

A. Contempt and Fines

I have already indicated that some courts have ordered massive changes in jails, including changes in the delivery of medical and mental health services. Because these changes are usually the kind that involve expenditures of large sums of money, a sheriff cannot be held liable for not having attained these changes on the budget he has had in the past. But delay, or obstinacy, in carrying out the court's order, once issued, can, and on several occasions has, resulted in stiff fines against correctional officers for contempt of court. 77/ Several months ago, the Director of the Department of Corrections of Rhode Island was fined $1,000 per day for every day he failed to implement a new classification scheme in the prison 78/ even though he had not been the director when the court order had initially been handed down. His responsibility, in other words, was institutional as much as personal.

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

B. Individual Liability

A mentally ill prisoner, or a person injured by a mentally ill prisoner, or his survivors, may sue a sheriff, or a mental health provider, either in state court or in federal court. If the suit is in state court,

the prisoner must prove that the defendant was negligent; 79/ if the suit is brought in federal court, the prisoner must show that the defendant was "deliberately indifferent" to his medical needs, or intentionally refused to meet them. 80/ Both these standards, and particularly the federal standard, are difficult for the prisoner to meet, but it should be noted that the sheriff may be liable for such indifference or intent on the part of his guards, assuming he has hired them, even if he was not aware of their acts. Thus, if a guard were to refuse to allow a prisoner sick call, and the prisoner suffered injury or died, the sheriff would be liable; the mental health care provider, not having been notified, has not been negligent, and would not be liable. 81/

Even if the prisoner demonstrates that there is some possiblity that the defendant could be liable under the relevant standard, both the sheriff and the mental health provider have a series of "defenses" to such actions, all of which basically hinge on the question of whether they were exercising a sound discretionary judgment, although ultimately proved wrong. If so, according to both state courts 82/ and the United States Supreme Court, 83/ the prisoner will not be allowed to collect. Moreover, if a mental patient injures himself or another, the sheriff can avoid liability by demonstrating that he did not know, or have cause to know, of the mental illness of the prisoner. The mental health care provider, of course, will have the same defense, but since he has the expertise to diagnose mental illness, his defense will not be so readily available.

Of course, the "rules" are easily stated, but their application is not always so simple. To explore the issue a bit more deeply, let us deal with an illustrative -- and the most relevant -- example: jail suicides.

C. Jail Suicides

In the last few years, an entire field of study - suicidology — appears to have become established, and there is no dearth of material generally on the issue of suicide. Nevertheless, there are few studies dealing directly with the question of jail suicides. A collection of materials on the subject can be found in JAILHOUSE BLUES. 84/ But even the studies in this collection differ on their findings, as might be expected in different jails. Thus in one study, the suicide rate reported was 57.4 per 100,000 in a sample of the county jails in a Midwestern state. 85/ Fawcett and Marrs, however, found a rate of approximately 16 per 100,000 in the Cook County Jail, 86/ and Heilig found a rate of approximately 8,or 2 per 100,000, depending on the year. 87/ Henden found a similar rate of 16-17 per 100,000. 88/

Almost all studies on jail suicides agree that the suicides occur relatively early on in the incarceration, although there is disagreement as to how early. Danto reports that 60% of the suicides occurred within 30 days of incarceration. 89/ Esparza found that 67% of the suicides in his sample occurred within 90 days of confinement, 90/ and Heilig found that 76% of suicides he studied occurred within their first 24 hours of confinement. 91/ Fawcett and Marrs found that 52% of their committed their self-destructive act within 30 days, with 19% injuring themselves within the first three days of institutionalization; 92/ Beigel and Russel report that all their suicides occurred within the first six weeks of placement in jails, 93/ and Martin found that 62% of the suicides occurred within the first 10 days of jail confinement. 94/

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

Attempting to draw some connection between suicides and mental illness, which is the focus of this study, is even more difficult. Farberow, for example, concludes that there is relatively little connection: 95/

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

Leonard also suggests the problems involved in drawing correlations: 96/

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

Greenberg concludes from this: 97/

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

On the other extreme, there are a number of authorities who argue that virtually all suicides occur from mental illness. 98/

In those instances where mental illness can be said to be involved in the suicide, then theoretically both the mental health expert and the sheriff might potentially be liable for having failed to prevent if it was clear that the victim was inclined toward such an action. In those instances, however, where there is no necessary link of mental illness and suicide, the sheriff alone might be liable under current standards. The difficulty, of course, with that approach is that the sheriff may be less able to diagnose suicidal tendencies, even those not necessarily caused by mental illness, than the doctor, and it seems harsh

to put that burden upon the shoulders of the sheriff. On the other hand, given what we do know about the importance of prison conditions and threats against life in giving impetus to suicides, the sheriff might be deemed more of an expert in some instances than even the mental health expert. The balance is a difficult one to draw and, in most instances, would be drawn not by "the law" but by the jury using its good common sense as guided by the instructions from the court.

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

D. The Law of Jail Suicides

The most obvious possible point of negligence in jail suicide is the weakest link - when the prisoner is first admitted to the jail. We have already seen that the sheriff, and the state, is under a duty to conduct at least a preliminary examination at that time. It is not surprising, therefore, that many of the cases finding liability essentially find negligence in not having conducted such an examination. In DeZort v. Hinsdale 99/ for example, the "prisoner" voluntarily sought jail commitment, indicating that he was concerned about his strong suicidal tendencies. Nevertheless, there was no physical or mental examination by the admitting guard. The court held that it was a jury question as to whether the jailer had been negligent. Similarly, in State ex. rel. Hayes v. Billings, 100/ deceased had been incarcerated by a sheriff who, according to the allegations, knew that he was without his mental capacity. When he fell from the upstairs hallway of the jail to the concrete floor below, the court held that the question of negligence was for the jury. Similar findings arise when the sheriff has good cause to know of the mental illness. 101/

Just as a sheriff may be liable for failing to properly ascertain at booking, or at some later point, the suicidal tendencies of his

prisoner, he may become liable when the prisoner, or someone else, informs him of the suicide potential of a charge.

The court's willingness to hold sheriffs in such situations is in some contrast to the general position of the law of torts to suicides and those who "cause" them. Traditional tort theories dictated no liability for persons who "cause" others to commit suicide, either on the theory that the "cause" had not been sufficiently proved, or that the victim's intervening act of self-destruction "broke" the causal chain. 102/ Only where the victim acts from an "uncontrollable impulse" spurred by the defendant's action has there even been the possiblity of liability, and then only recently. 103/

On the other hand, the vast majority of cases, particularly those which have dealt with treatment of those known, or suspected, to be suicidal have not resulted in liability on the part of either the doctor, or where there was also a jailer, the jailer. The crux of these cases, whether in state or federal court, has been the "discretionary" or "partial immunity" concept, based in part upon the difficulty of diagnosing mental illness, 104/ and in part upon the notion that the purpose of treatment requires risk taking in the general population. 105/

Yet, there are cases which go the other way. In Dinnerstein v. United States, 106/ for example, the trial court found negligence, and was upheld on appeal, where a patient, admitted because of suicidal tendencie was placed on a ward without restrictions and, within 24 hours, leaped to his death from a seventh floor unsecured window. The court quoted with approval the lower court view that "At the least, for the first few days... his movements should have been restricted so that he could be closely watched." And, so far as suicidal tendencies were concerned, the lower court said: "His own denial upon admission of suicidal ideation and even Dr. Gottlieb's belief that he was not imminently suicidal, cannot excuse the complete absence of precautions to insure the safety of a patient

with a suicidal gesture in his past..." As to the "open door" policy, the court declared: "While we must accept some calculated risks in order to insure the patient's legal rights and provide him with the most efficient therapy, we must also admit that errors in judgment do occur, and that when they do, medical authorities must assume their rightful share of the responsibility."

These cases — and their conflicting results — demonstrate the tension in which the law, reflecting the real world, finds itself. On the one hand, there is the duty of the sheriff to examine persons both upon initial examination and at later points. A failure to do this, or to follow the directions of a mental health professional when mental illness is detected, will result in liability. 107/ There is, consistent with this view, some tendency for the courts to suggest that where the evidence is dubious, the duty is to confine closely until a further diagnosis can be made. This would clearly be in accord with current penological standards. 108/

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

A SUMMARY

In brief, the law prior to the 1970's virtually never seriously considered the possiblity that a jailer, or a mental health professional, might be liable for the suicide of a person incarcerated in an institution.

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

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

EPILOG ON LIABILITY

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

But that does not deal with the issue of whether the government, as an entity, and regardless of the liability of its individual officers, should nevertheless pay for injuries sustained because it has incarcerated persons — albeit justifiably — in such institutions. A jail without substantial visiting hours, for example, is much more oppressive than a prison with meager visiting hours, since in prisons, at least, there are numerous "rehabilitational" activities not present in jails. If the lack of such activity "causes" mental illness, then perhaps the state should

be liable, without respect to fault. If the budget will not allow for the proper training in mental illness detection as well as first aid, the state should, as a cost of this decision, reap the consequences.

The government, after all, does this now in large part. It pays for all attorneys' fees for most state correctional employees and indemnifies them for most charges of liability found by the jury. If, instead of the negligence concept, a workers' compensation concept, akin to the notion that the prisoner is in a "work place" over which he has little or no control, were instituted, those payments could be avoided, and that money used to compensate — on a set scale — all prisoners who suffer from the lack of protection, medical care, proper safety devices, and the rest. This solution would clearly be much more equitable than the present system which requires so much fine line drawing in a situation in which the state holds — both literally and figuratively — all the knives.

CONCLUSION

The law is beginning to recognize the duty of the state — and the sheriff — to provide mental health services to prisoners who need them. In accord with national standards, and evolving case law, this means that there must be sufficient personnel, trained in both the detection and treatment of mental illness, present in the jails at all times. Otherwise, liability of the sheriff will surely result if the prisoner injures himself or others. Given the present law — in which the government generally refuses to accept responsibility for such injuries -- this is probably the best solution. But far preferable is a legal system which would (1) allow temporary transfers to mental health centers as soon as mental illness is diagnosed; (2) impose upon the government, as the ultimately responsible authority, liability for those injuries which do occur as a

result of the failure of fallible persons, attempting to do their jobs in a forthright and professional manner, without the necessity of having to demonstrate negligence. Persons do not seek the stress of jail, even those who voluntarily commit crimes, and the legal system should respond, in affirmative and remedial ways, to solve that dilemma.

FOOTNOTES

1. F. COHEN, THE LEGAL CHALLENGE TO CORRECTIONS (1967).

2. See, e.g., SOUTH CAROLINA DEPARTMENT OF CORRECTIONS, THE EMERGING RIGHTS OF THE CONFINED (1972): The United States Supreme Court has agreed, Estelle v. Gamble, 429 U.S. 97 (1976). The literature, and case law, is enormous. Of these, only a few really deserve mention. In the literature: Neisser, Is There a Doctor In the Joint, 63 VA. L. REV. 921 (1977) (hereafter Neisser); Plotkin, Enforcing Prisoner's Rights to Medical Treatment, 9 CRIM. L. BULL. 159 (1973); Comment, Eighth Amendment Right of Prisoners: Adequate Medical Care and Protection from the Violence of Fellow Inmates, 49 NOT. DAM. LAW. 454 (1973).

3. These and other standards are discussed infra, pp.

4. AMERICAN CORRECTIONAL ASSOCIATION, MANUAL OF CORRECTIONAL STANDARDS (3rd Ed. 1966) (hereafter ACA MANUAL).

5. BRESHER and DELLA PENNA, HEALTH CARE IN CORRECTIONAL INSTITUTIONS (1975).

6. 330 F. Supp. 707 (W.D. Ohio 1971).

7. Id. at 718.

8. See, e.g., Campbell v. McGruder, 416 F. Supp. 100 (D.D.C. 1975); Baines v. Government of the Virgin Islands, 415 F. Supp. 1218 (D.V.I. 1976); Leaman v. Hegelmoe, 437 F, Supp. 269 (D.N.H. 1977). Most important is Bowring v. Godwin, 551 F.2d 44, 47,49 (4th Cir. 1977):

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

9. ACA MANUAL, supra, n. 4.

10. NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS: CORRECTIONS (1973) (hereafter NAC).

11. PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND THE ADMINISTRATION OF JUSTICE, TASK FORCE REPORT: CORRECTIONS (1967) (hereafter 1967 REPORT).

12. NATIONAL COUNCIL ON CRIME AND DELINQUENCY, MODEL ACT FOR THE PROTECTION OF THE RIGHTS OF PRISONERS (1972) (hereafter NCCD).

13. FOURTH UNITED NATIONS CONGRESS ON PREVENTION OF CRIME AND TREATMENT OF OFFENDERS, STANDARDS MINIMUM RULES FOR THE TREATMENT OF PRISONERS (rev. ed. 1970) (hereafter U.N. RULES).

14. ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS, UNIFORM CORRECTIONAL POLICIES AND PROCEDURES (1972) (hereafter ASCA).

15. AMERICAN BAR ASSOCIATION, REPORT OF THE SPECIAL COMMITTEE ON THE LEGAL STATUS OF PRISONERS, reprinted in 14 AMER. CRIM. L. REV. 377 (1977) (hereafter ABA).

16. NATIONAL SHERIFFS ASSOCIATION, MANUAL ON JAIL ADMINISTRATION (1970) (hereafter NSA MANUAL).

17. NEBRASKA STATE BAR ASSOCIATION COMMITTEE ON CORRECTIONAL LAW AND PRACTICE, JAIL STANDARDS (1977) (hereafter NEB. JAIL STANDARDS).

18. NATIONAL SHERIFF'S ASSOCIATION, JAIL SECURITY; CLASSIFICATION AND DISCIPLINE STANDARDS (1974).

19. UNITED STATES BUREAU OF PRISONS, THE JAIL, ITS OPERATION AND MANAGEMENT (1970).

20. ILLINOIS COUNTY JAIL STANDARDS, CH. 14 (1972) in AMERICAN BAR ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION, MEDICAL AND HEALTH CARE IN JAILS, PRISONS, AND OTHER CORRECTIONAL FACILITIES (hereafter ABA/AMA COMPILATION) 49 (1973).

21. CALIFORNIA STATE BOARD OF CORRECTIONS REGULATIONS APPLYING TO JAILS AND OTHER LOCAL DETENTION FACILITIES, TITLE 15 (1973) in ABA/AMA COMPILATION, supra n. 20, at 53.

22. PENNSYLVANIA DEPT. OF CORR., MINIMUM STANDARDS AND OPERATING PROCEDURES FOR PENNSYLVANIA COUNTY PRISONS (1976).

23. SOUTH CAROLINA DEPT. OF CORRECTIONS, STANDARDS FOR COUNTY JAILS (1970) in ABA/AMA COMPILATION, supra, n. 20, at 58.

24. DEPT. OF HUMAN RESOURCES, JAIL STANDARDS AND GUIDELINES FOR OPERATION OF LOCAL CORRECTIONAL FACILITIES (1973).

25. AMERICAN MEDICAL ASSOCIATION, STANDARDS FOR THE ACCREDITATION OF MEDICAL CARE AND HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS (1978) (hereafter AMA). Since a draft form of these standards were adopted virtually verbatim by the AMERICAN CORRECTIONAL ASSOCIATION'S MANUAL OF STANDARDS FOR ADULT LOCAL DETENTION FACILITIES (1977), by which the ACA will assess jails for purposes of accreditation, they are probably the most important set of standards.

26. AMERICAN PUBLIC HEALTH ASSOCIATION, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS.

27. Anno., Standards for Health Care in Correctional Institutions in HEALTH CARE IN CORRECTIONAL INSTITUTIONS 35 (University Research Corporation, 1977).

28. See, e.g., Weintraub v. Rosen, 93 F.2d 544 (7th Cir. 1931); Mason v. Geddes, 258 Mass. 40, 154 N.E. 519 (1926).

29. 33 Ill. 2d 326, 211 N.E. 2d 253 (1965).

30. See, e.g., Purcell v. Zimbleman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Kakligian v. Henry Ford Hosp., 48 Mich. App. 325, 210 N.W. 2d 463 (1973); Fiorentino v. Wenger, 19 N.Y. 2d 407, 227 N.E. 2d 296, 280 N.Y.S. 2d 373 (1967). See generally, Dornette, The Legal Impact on Voluntary Standards in Civil Actions Against the Health Care Provider, 22 N.Y. L. REV. 925 (1977).

31. AMERICAN MEDICAL ASSOCIATION, MEDICAL CARE IN U.S. JAILS (1972) (hereafter AMA JAIL STUDY).

32. Thus, for example, the AMA, THE RECOGNITION OF JAIL INMATES WITH MENTAL ILLNESS, THEIR SPECIAL PROBLEMS AND NEEDS FOR CARE (1977) (hereafter AMA, RECOGNITION) declares at page 7:

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

The NSA MANUAL, supra n. 16, rule 20, paragraph 10, states that

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

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

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

It is clear, however, that this is not the current practice. A study in California in 1976 found that "More than 75% of the inmates diagnosed as mentally disordered received no mental health service. None of the studied counties performed systematic screening of inmates by people skilled in diagnosis." Arthur Bolton Associates, A STUDY OF THE NEED AND AVAILABILITY OF MENTAL HEALTH SERVICES FOR MENTALLY DISORDERED JAIL INMATES AND JUVENILES IN DETENTION FACILITIES (1976).

33. The American Medical Association Standards are clear: there is no such requirement. AMA, supra n. 25, Sec. 1011. Similarly, the American Bar Association standards, while requiring a preliminary examination, are strangely silent on the issue of who should conduct them. ABA, supra n. 15, Sec. 5.4. Other standards

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

34. UN RULES, supra n. 13, expressly provides for special rules dealing with insane or mentally abnormal prisons: 82(1). Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible. The UNITED STATES BUREAU OF PRISONS, THE JAIL - ITS OPERATION AND MANAGEMENT provides that persons who are in need of medical treatment should be refused admission. Similarly, AMA, supra n. 25, Standard 1024 says: "Admission to appropriate health care facilities in lieu of detention, should be sought for all suspected mentally ill or retarded inmates" which suggests that admission should be initially refused. Accord, Pa. Standards, supra n. 22.

35. AMA, RECOGNITION, supra n. 32 at p. 5.

36. NSA MANUAL, supra n. 16, Stan. XI 4.

36a. Thus, the AMA, RECOGNITION, supra n. 32, at 7, suggests that:

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

37. See Hamilton v. Landrieu, 351 F. Supp. 549 (E.D. La. 1972); Gates v. Collier, Smith v. Hongiston, Collins v. Schoonfield, 344 F. Supp. 257, 277 (D. Md. 1972), Hamilton v. Love, 328 F. Supp. 1182, 1186 (E. D. Ark. 1971).

38. ABA, supra n. 15 Sec. 5.2; U.S. BUREAU OF PRISONS, MEDICAL STANDARDS 37602, p. 17 (6/12/67); UN RULES, supra n. 13, at Sec. 25; NSA MANUAL, supra n. 16, Sec. 3; 15 Cal. Adm. Code Sec. 1161; AMA, supra n. 25, STANDARD 1016, intriguingly, varies the requirement of sick call according to the size of the population. Unfortunately, there is no discussion as to how that approach was reached. For case law in sick call, see Wayne County Jail Inmates v. Wayne County Board of Commissioners (Wayne County, Mich., Cir. Ct., May 17, 1971) at 161; Hamilton v. Love, 328 F. Supp. 1132. (E.D. Ark. 1971) (weekly, by stipulation).

Some standards will allow sick call by a non-physician, but the case law is more stringent. For cases holding that screening even by a nurse is deficient in terms of sick call, see Todaro v. Ward, 431 F. Supp. 1129 (S.D.N.Y. 1976), aff'd. _____ F.2d _____ (2d Cir. 1977); Dillard v. Pitchess, 399 F. Supp. 1225 (C.D. Cal. 1975).

39. According to all the standards of the correctional profession, this conflict is not really present. The American Correctional Association declared, a dozen years ago, that "To achieve quality medical care, any incompatibility between medical and prison rules must be resolved in the former's favor." ACA MANUAL, supra n. 4, at _____. Similarly, the National Advisory Commission on Criminal Justice Standards and Goals stated, in 1972: "Correctional personnel should not be authorized or allowed to inhibit an offender's access to medical personnel or to interfere with medical treatment." NAC, supra n. 10, Section 2.6. Accord, ABA, supra n. 15, Section 5.2(iii).

Indeed, the American Medical Association's Standards for the Accreditation of Medical Care and Health Services in Jails appears to have taken an unnecessarily reticent position on this issue. In its last draft before final adoption, the Association provided, in Section 5161, that "The physician has no restrictions imposed upon him by the facility administration regarding the practice of medicine." A comment to that section declared: "Security regulations applicable to facility personnel should also apply to the medical personnel." In the final Standards, however, the language of the comment was raised to the level of the Standard, and became the second clause. See AMA, supra n. 25, Section 1002. This change may be insignificant, in fact; but it augers ill for those who seek to establish that, where there is conflict, the medical judgment must always dominate.

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

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

40. In Sawyer v. Sigler, 370 F. Supp. 690 (D. Neb. 1970), for example, the warden had issued an order that all drug medication would be taken in liquid form, so as to avoid possible subterfuge and drug selling by prisoners. Sawyer, armed with an order from the prison doctor that he could not take the drug in those forms, and should be allowed to take the drug in pill form, sought relief in federal court under the Civil Rights Act, which he obtained. The Eighth Circuit affirmed the lower court order upholding the prisoner's position. 445 F.2d 818 (8th Cir. 1971). The order of the prison doctor was essential to Sawyer's victory, since other inmates in the same case complained about the same practice, but had no doctor's order that they receive the drug in pill form. Both courts denied relief to these prisoners. See also United States ex rel. Hyde v. McGinnis, 429 F.2d 864 (2d Cir. 1970), in which the court upheld a rule by the prison doctor that the prisoner take his medicine in liquid form. For other cases in which the prison doctor and the warden clashed, see Campbell v. Beto, 460 F.2d 765 (5th Cir. 1972); Mitchell v. Chester County Farms Prison, 426 F. Supp. 271 (E.D. Pa. 1976).

Several courts have required prison administrators to yield in assigning work to prisoners whom the doctor has rated as unable to do the work. Black v. Ciccone, 324 F. Supp. 129 (W.D. Mo. 1970); Woolsey v. Beto, 450 F.2d 321 (5th Cir. 1971); Martinez v. Mancusi, 443 F.2d 921 (2d Cir. 1970); Silborn v. Hutto, 509 F.2d 621 (8th Cir. 1975); Campbell v. Beto, 460 F.2d 765 (5th Cir. 1972).

41. Neisser, supra n.2, at 959-60.

42. Cost, Prison Health Care: Part of the Punishment?, 25 NEW PHYSICIAN 29-33 (April 1976). See AMA, supra n. 25, Section 1005 (requiring licensure).

43. Neisser, supra n. 2 at 926, note 29, declares that "prison medical staffs are clearly underpaid by prevailing medical standards" citing the ABA/AMA COMPILATION (3d ed. 1974) at 95, and the report of the medical panel concerning Menard Correctional Center at 5, 27, 29 filed in Lightfoot v. Walker, 73-238-E (E.D. Ill. November 18, 1976).

44. See NEW YORK SPECIAL COMMISSION ON ATTICA, REPORT: ATTICA, pp. 63-66.

45. ASCA, supra note 14, at 41: "The prescription, dispensing and administration of medication should be under strict medical supervision. The medical director should designate who, among appropriate health service staff, should be responsible for these functions"; ABA, supra note 15, Section 5.6; AMA, supra note 25, Section 1029 (physician orders; person trained by physician administers); NEB. JAIL STANDARDS, supra note 17, Sections 12-1 and 12-8 (staff may administer as ordered by physician).

46. Twenty-one Attorneys General responded to a letter requesting information on official opinions as to drug dispensing in correctional facilities. Of these, fourteen had not issued such an opinion. Of the remaining seven, five (Alaska, Kentucky, Minnesota, Georgia, and Wisconsin) allow someone other than a physician to administer the drugs. Pennsylvania agrees, if the drugs have been "distributed" by a pharmacist. One court has held that only licensed doctors or nurses may dispense drugs, under state law. Newman v. Alabama, 349 F.Supp. 278 (M.D.Ala.) aff'd 503 F.2d 1370 (1974), cert.den. 421 U.S. 948 (1975). Recently, Judge Johnson refused a petition to modify that order with regard to drugs prescribed by a doctor and maintained in the original package. Letter from Young Dempsey, Assistant Attorney General of Alabama to the author, May 1, 1978.

47. See the dissent of Mr. Justice Stevens in Estelle v. Gamble, arguing that the allegations there could be read as indicating "that an overworked, undermanned medical staff in a crowded prison is following the expedient course of prescribing nothing more than pain 'killers.'" At 110.

48. See, e.g., Peek v. Ciccone, 288 F.Supp.329 (W.D.Mo.1968).

49. Schwartz, Deprivation of Privacy as a "Functional Prerequisite": The Case of the Prison, 63 CRIM. L., CRIM. & POL. SCI. 229 (1972); Singer, Privacy, Autonomy and Dignity in the Prison: A Preliminary Inquiry Concerning Constitutional Aspects of the Degradation Process in Our Prisons, 21 BUFF. L. REV. 669 (1972).

50. See W. PROSSER, TORTS Section 9 (4th ed.1971).

51. The AMA, supra n. 25, standard 1008 deals exclusively with informed consent: "All examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, the informed consent of parent, guardian, or legal custodian applies where required by law."

52. CAL. WELF. & INST. CODE, Section 5326.2 (1976).

53. Neisser, op. cit. supra n. 2, at 971.

54. See letter from William Reid, Mentally Ill Offender specialist, Mental Health Program, Calif. Health & Welfare Agency, to author, 2/28/78: "Most mental health professionals with head jail units in county programs ... are opposed to the concept of providing any involuntary medication or other involuntary therapy inside the jail (except for) emergency intervention in order to remove an individual to a treatment facility."

55. See Developments - Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1202-04 (1974).

56. New York Mental Hygiene Law Section 31.01 (Supp. 1972).

57. A good example of the problem was found by the Bolton Study of the California system, supra note 32 at pp. 431-432. The study found that, of the inmates identified as mentally disordered, only about 60% were considered appropriate for transfer to a mental institution under the present legal standards and, indeed, that only 15% were considered appropriate for such transfer under the involuntary transfer provision. Thus, at least 40%, and perhaps as much as 85%, of the persons in jail who had mental disorders of a substantial nature - not personality disorders - were, at least in the view of the Bolton Study, not eligible to be transferred to a mental institution because of the definition of mental illness, which the Legislature had passed in order to protect the civil liberties of persons who otherwise were to be committed. This tension obviously must be resolved.

58. Baxstrom v. Herold, 383 U.S. 107 (1968). The court currently has before it a case asking whether due process requires such a hearing. Vitek v. Miller, 46 L.W. 3484 (1978). Even if the court follows the narrow decisions in Haymes v. Montayne, 427 U.S. 236 (1976) and Meachum v. Fano, 427 U.S. 215 (1976), both of which held that inter-prison transfers do not require due process, Baxstrom would remain to require a hearing if the state required one for civil commitment. Since most states do so require, the impact of Vitek is likely to be minimal.

59. Baxstrom involved a transfer of a prisoner whose term was ending; thus, the transfer was really more like a commitment. But it was soon applied to prisoners whose sentence had much time to run. United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir.), cert. den., 396 U.S. 847 (1969). It is possible, however, that the courts could view both Schuster and Baxstrom, and the cases which have followed them, as involving virtual commitment to the mental health system, rather than temporary transfer. If so, it is possible that less due process would be required, for example, for a short period for purposes of diagnosis. This would both follow the general concepts of the requirements for medical treatment generally (i.e., a hearing is not required before a prisoner is transferred to a hospital for an appendectomy) and perhaps be more realistic.

60. CAL. PENAL CODE, Section 4011.8 (1975).

61. CAL. PENAL CODE, Section 4011.6 (1975).

62. CAL. WELFARE & INST. CODE, Section 5403 (1978) requires a 5-year study of the efficacy of the program.

63. Thus, the Bolton Study, supra note 32 at 445, found: "There is an acute shortage of appropriate secure local treatment facilities for mentally disordered offenders throughout the state. County jail facilities seldom provide an environment conducive to mental health treatment, and local psychiatric treatment facilities generally lack the security capability necessary to protect the public from offenders who may be dangerous, or escape risks. Because of the lack of secure local treatment facilities, diversion of mentally disordered offenders from jails to local mental health facilities is limited to non-dangerous inmates who pose little risk."

Indeed, a 1972 survey found only 19 security hospitals, one of whose major functions was to provide comprehensive treatment for mentally disordered offenders, 23 mental health facilities, including facilities expressly for sex offenders, and 26 correctional institutions which had a comprehensive treatment program for mentally disordered offenders. ECKERMAN, A NATIONWIDE SURVEY OF MENTAL HEALTH AND CORRECTIONAL INSTITUTIONS FOR ADULT MENTALLY DISORDERED OFFENDERS, DHEW Pub. No. (HSM) 73-9018 (1972). Although the survey did not include mental hospitals which, as a matter of general treatment, also treated mentally ill offenders, and did not include facilities which did not treat "offenders", but detainees, the paucity of available institutions is nevertheless of great concern.

64. NEW YORK CORR. LAW, Section 402.

65. Christianson, In Prison: Contagion of Suicide, THE NATION 243 (Sept. 21, 1974).

66. CAL. PENAL CODE, Section 4011.8 effectively allows the mental health director to refuse to admit jail prisoners who seek to have themselves voluntarily committed, but does not articulate a reason for this power. The Model Penal Code allows the director of the Department of Mental Hygiene to withhold his agreement to a suggested transfer. Sec. 3.03.3(4).

Of course, it might be argued that the mental health facility always had de facto power to reject a patient it does not want by the sheer expedient of declaring that he is not mentally ill within the meaning of the relevant statutes which define their scope. There is, unhappily, good reason to believe that this occurs with some frequency. If the legal doctrines enunciated infra section _____ pp. _____ - _____ were applied, however, there might be less eagerness to apply at least this ploy, since arguably failure to properly diagnose serious mental illness could lead to liability when the patient harms himself or others.

67. Still another possible solution, where staff and members of the respective departments are not, as is all too often the case, at loggerheads over a number of issues, is to have the state department responsible for prison (and jail?) policy reach an agreement with the department responsible for mental health care generally. See, e.g., MEMORANDUM OF UNDERSTANDING BETWEEN NORTH CAROLINA DEPARTMENT OF CORRECTION AND NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES (Nov. 29, 1977). See KIEL, MENTAL HEALTH INTERVENTION FOR JAIL INMATES (paper delivered at the National Jail Conference

sponsored by the American Medical Association, August 21, 1977) at page 3. Such an agreement would, and should, cover issues of control reimbursement, authority, etc., and would at least provide a point from which further exploration of inter-agency cooperation could redound to the benefit of the clients.

68. 42 U.S.C. Section 1396d(a)(A).

69. 45 C.F.R. Section 248.60(5).

70. 45 C.F.R. Section 248.60(1).

71. See letter from Borge Varmer, Regional Attorney of the Department of Health, Education and Welfare, to Congressman Edward Koch, June 30, 1977, accord, POLICY INFORMATION RELEASE NO. 53 (H.E.W. Welfare Administration, Bureau of Family Services, April 26, 1967). See also Op. A.G. (Nev.) No. 64, Mar. 13, 1972, in CCH MEDICARE AND MEDICAID NEW DEVELOPMENTS, paragraph 26,454 (1972).

72. 42 U.S.C. Section 1396(a)(16).

73. 45 C.F.R. 248.60(a)(3)(i).

74. See S. REP. NO.404, Part I, 89th Cong., 1st Sess. 82 (1965).

75. 45 C.F.K. 248.60(a)(4)(ii).

76. With the renewal of the death penalty in many states, such no-bail detainees may occur. Nevertheless, the vast majority of detainees remain in jail only because of inability to post bond, and there would appear to be little reason to exclude them from Medicaid payments to which (assuming other eligibility) they would be entitled but for their poverty. Moreover, the "invidious discrimination" problem posed in the text should not be conclusive, since the no-bail statutes themselves do not cross that line.

77. Intriguingly, it is not only national Medicare and Medicaid that discriminate against prisoners who need mental treatment. According to the Bolton Study, supra note 32, at page 12, the California system (Medi-Cal) also denies benefits to persons diverted to community treatment programs under provisions of the California Penal Code. Thus, a potential major source of federal funding for community alternatives to jails is not utilized.

77a. Jackson v. Hendrick, No. 2437, Feb. Term (Phil. Ct. of Common Pleas, December 1, 1977) ($250,000 fine). Cf. Hamilton v. Love, 361 F.Supp. 1235 (E.D. Ark. 1973) (vacating order of contempt upon sheriff's compliance with order).

78. Palmigiano v. Garratty, _____ F.Supp. _____, 23 CR.L. 2106 (D.R.I. March 28, 1978).

79. See Upchurch v. State, 51 HAW 150, 454 P.2d 112 (1964); ISELE, CONSTITUTIONAL ISSUE OF THE PRISONER'S RIGHT TO HEALTH CARE 9 (AMA, 1976).

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

81. Thus, sheriffs have been held liable, or at least subject to liability, where they, or their guards, negligently failed to protect a prisoner in protective custody from an attack by other prisoners, Upchurch v. State, supra n. 79; where the plaintiff was exposed to other prisoners whom the sheriff knew, or should have known, were drunk, Glover v. Hazelwood, 387 S.W. 2d 600 (Ky.1964); Honeycutt v. Bass, 187 So.848 (La.App. 1939); Daniels v. Anderson, 195 Neb. 95, 237 N.W. 2d 397 (1975);

mentally disturbed, St. Julian v. State, 82 So.2d 85 (La.App.1955); or otherwise dangerous, Breaux v. State, 314 So.2d 449 (La. App. 1975); or exposed to a "kangaroo court. Ratliff v. Stanley, 224 Ky. 819, 7 S.W. 2d 230 (1928). Recently, courts have been willing to sustain possible causes of action for homosexual rape as well, Van Horn v. Lurchard, 392 F. Supp. 384 (E.D. Va. 1975).

82. Haino v. State, 61 N.J. 585, 297 A.2d 561 (1972); Travis v. Pinto, 87 N.J. Super. 263, 288 A. 2d 828 (1965).

83. Procunier v. Navarette, 98 S.Ct. 855 (1978); Wood v. Strickland, 420 U.S. 308 (1975).

84. JAILHOUSE BLUES (Danto, ed. 1973) (hereafter BLUES).

85. Esparza, Attempt and Committed Suicides in County Jails, in BLUES, supra n. 84, at p. 27.

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96. C. LEONARD, UNDERSTANDING AND PREVENTING SUICIDE 273 (1967).

97. Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N.Y.U. L.REV. 227, 236 (1974).

98. Bergler, Suicide: Psychoanalytic and Medicolegal Aspects, 8 LA.L. REV. 504 (1958); A. BRILL, FUNDAMENTAL CONCEPTIONS OF PSYCHOANALYSIS 262 (1921); D. HENDERSON and R. GILLESPIE, TEXTBOOK OF PSYCHIATRY 69 (10th ed. 1969). See also Havens, Recognition of Suicidal Risks Through the Psychological Examination, 276 N.ENG.J. MED. 210 (1967).

99. 35 Ill. App. 3d 703, 42 N.E. 2d 468 (1976).

100. 240 N.C. 78, 81 S.E. 2d 150 (1954).

101. Thus, in Porter v. County of Cook, 42 Ill. App. 3d 287, 355 N.E. 2d 561 (1976), the prisoner complained that he was "hearing voices." The doctor's certificate indicated the need for immediate hospitalization, but this did not occur. In order to drive away the voices, the prisoner set fire to his mattress, sustaining severe injuries, and nearly dying. A judgment award of damages was upheld. See also LaVigne v. Allen, 36 App. Div. 2d 981, 321 N.Y.S. 2d 179 (1971); Gioia v. State, 22 App. Div. 2d 181, 254 N.Y.S. 2d 384 (1964); cf., Thomas v. Williams, 105 Ga. App. 321, 124 S.E. 2d 409 (1962) (drunk prisoner not sufficiently protected).

102. Scheffer v. R.R. Co., 105 U.S. 249 (1882); Salsedo v. Palmer, 278 F.2d 92 (2d Cir. 1921).

103. Richardson v. Edgeworth, 214 So. 2d 579 (1969); Tate v. Canonica, 180 Cal. App. 2d 898, 5 Cal. Rptr. 28 (1960); Fuller v. Preis, 35 N.Y. 2d 425, 322 N.E. 2d 263 (1974). See generally Schwartz, Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry, 24 VAND. L. REV. 217 (1971).

104. Schwartz, supra, n. 103 at 236:

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

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

These latter two cases, then, agreed that there was a duty to the prisoner to protect him from his own folly, but found that the duty had been non-negligently carried out. In contrast, in the most important adverse case in this area — Lucas v. Long Beach, 60 Cal. App. 3d 341, 131 Cal. Rptr. 470 (1976) — the court challenged that very premise.

Lucas involved a 17-year old who had been booked for disorderly conduct when he was unable to pass basic tests for sobriety. Although he had been swaying, a breathalyzer test showed no significant amount of alcohol in his body, the officers

thereby concluding that he was on drugs. Three hours after being placed in the cell, the juvenile was found hanging by his neck in a noose constructed of a strip of cloth torn from a mattress cover. The court found no liability, denying even a duty to examine.

105. Baker v. United States, 226 F. Supp. 129 (D. Iowa 1964), aff'd, 343 F.2d 222 (8th Cir. 1965). Accord, Gregory v. Robinson, 338 So.2d 288 (Mo. 1960); White v. United States, 224 F. Supp. 127, 129 (E.D. Va. 1965), aff'd, 359 F.2d 989 (4th Cir. 1966).

106. 486 F.2d 34 (2d Cir. 1973). In Lucy Webb Hayes National School v. Perotti, 419 F.2d 704 (D.C. Cir. 1969), plaintiff's decedent had been admitted to the hospital for purposes of observation. The day after his arrival, he slipped out of the maximum security ward and jumped through a window. Plaintiff had two theories of negligence: (1) the hospital was negligent for not having stronger glass in the window; (2) the hospital was negligent for allowing the decedent to escape from the maximum security ward. On the first point, Bazelon, J., for the court, declared that "Since the emphasis in the new ward was to be upon therapy rather than confinement, they wished to create an open, pleasant atmosphere to the fullest extent possible." Therefore, using regular glass to achieve this end was not negligent. On the other point, the court held that there was a possibility of negligence, and the jury verdict was allowed to stand. See also Harper v. Cserr, 544 F.2d 1121 (1st Cir. 1976).

107. In Adams v. State, 71 Wash. 2d 14, 429 P.2d 109 (1967), for example, the doctors clearly recognized the patient's suicidal tendencies. Due to negligence on the part of the staff, however, the patient simply walked out of the hospital past two security posts left vacant by their occupants, in time to leap in front of an oncoming car. The court affirmed the judgment against the state. Obviously, the parallel for the jail cases is clear — while the psychiatrist may be safe from damages if the proper diagnosis and warnings are present, the sheriff and/or his staff may be liable if they carry out these warnings in a negligent manner.

108. U.S. BUREAU OF PRISONS, supra n. 19: "When a prisoner's disruptive or self-destructive behavior cannot be controlled by locking him up, it may be necessary to restrict his ability to move. If a mentally disturbed prisoner bangs his head against the wall or floor, it may be necessary to immobilize [him]. . . ."

Separate Publication

THE SPECIAL NATIONAL WORKSHOP ON MENTAL HEALTH SERVICES IN JAILS

SERVICE DELIVERY MODELS*

by Carole H. Morgan

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PAPER ON

"JUVENILE AND JAILS"

by
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(Not duplicated in time for inclusion - to be distributed later)

Jails and Mental Health: Suggestions Toward a Research Agenda [1]

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During the National Workshop on Mental Health Services in Jails, one theme recurred repeatedly regardless of specific topics discussed. This was the complaint of lack of knowledge: of absence of data, of insufficient information, and of plausible but untested hypotheses. As the last item on the conference agenda, a session was held for the purpose of identifying research needs to assist in the formulation of a general plan for study of mental health services in jails.

The agenda position for the discussion of research was reasonable, because the conference planners realized the earlier meetings would highlight such needs, as indeed they did. But in any criminal justice agency planning or administrative meeting it usually will be found also that research is last on the agenda; and the short shrift ordinarily given to research needs in this area continues to result in

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the later complaints of lacking information so often heard at this meeting. In order to address this need, research must be moved up on the agenda to a higher priority position. Managers desire action, but if they desire informed action and more rational decision-making then an increased emphasis must be given to information needs.

On both criminal justice and mental health agenda the topic of jails similarly has been given a low ranking. That is, jails, too, usually are last on the agenda; and this seems to be true of the agenda of criminal justice, mental health, and funding agencies alike. In corrections, which consists mainly of programs of jails, probation, prison, and parole, the investment of research effort has been just opposite that to be expected if the sheer numbers of persons involved were the criterion for the selection of focus. Thus, a good deal of study has been done of parole from prisons, affecting a relatively small number of persons; perhaps somewhat fewer studies have been made of prisons, which involve many more individuals; and very few studies of jail -- affecting a much larger number of persons -- are to be found. The investment is, apparently, inversely proportional to the numbers of persons affected! Within jails, perhaps more persons are held in custody awaiting adjudication than are confined to serve sentences; and few studies of these populations are available. Jails too should be moved up on the research agenda.

If research on mental health problems in jails is to be given a higher priority, there is needed also a general strategy for study in order that attention may be given to identifying priorities within that priority agendum. The purpose of this paper is to suggest a framework for such a general strategy of search. Four general categories of information needs will be discussed. These are interrelated; and together they can provide an integrated program for seeking gains in knowledge to assist in improved practice in this neglected area.

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

Improved Conceptualization

At the most general level of conceptualization, a question repeatedly asked in this conference was "What are jails for?" This seemingly simple question of the fundamental purposes of jails of course received complex answers from diverse perspectives. Besides the variety of views given from differing mental health orientations, a further complexity is given from the fact that jails are imbedded in the context of the criminal justice system -- and differing perspectives

of justice obtain as well. Thus, we have divergent, often conflicting views on the purposes of jails, from both mental health and justice perspectives; and any general effort toward improving programs must face the need for greater clarity of the theoretical bases for mental health programs in jails.

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

The views of mental health professionals tend to be derived from divergent viewpoints in psychiatry and psychology, from social theories of yet differing perspectives, or from innovations in clinical practice. Thus, clinical practice may be derived,implicitly at least, from the psychoanalytic perspective, or from behaviorism, or from phenomenological psychology -- orientations that are fundamentally in conflict. The labeling theories discussed in the conference (1) provide a yet markedly different frame of reference. An example of a yet distinct set of conceptions, also discussed in the conference, is given by the therapeutic community concept (2). These theoretical conceptions will implicitly or explicitly guide the implementation of programs to provide mental health services in jails; and if we are to learn how such programs succeed and fail it is imperative that the theoretical framework for the program be spelled out.

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

Consider, first, that portion of jail populations who are serving sentences imposed by the court. An analysis of current controversies concerning sentencing purposes will show that there are two general camps (each with subdivisions) (3). Each has a long history of philosophical underpinnings and debate. On the one hand, there are advocates of utilitarian purposes including treatment (rehabilitation), incapacitation, or general deterrence. These aims are pragmatic; they all are aimed at crime reduction. On the other hand, there are proponents of a retributive or desert perspective who perceive the imposition of penalties commensurate with the seriousness of the offense of conviction to be means to the fundamental purpose of just desert.

Second, consider the often larger portion of the jailed populace: those confined awaiting trial. These persons are not in jail for punishment, or even *as* punishment -- they have not been convicted of crime. Operationally, however, the circumstances of confinement are indistinguishable from those ostensibly being punished. Debate in this conference revolved

around issues of the traditional presumption of innocence, of the concept of preventive detention, and of the constitutionality of pretrial detention for any reason other than assurance of appearance for trial.

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

Improved Measurement

Once there is increased agreement and specification of what mental health services in jails are intended to do and how they are to do it, it may be expected to be clear that there is a very great need for improved measurement. Lord Kelvin has been quoted often to express this fundamental need:

> When you can measure what you are speaking about and can express it in numbers you know something about it, but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind (4).

Only a decade ago, the President's Commission on Law Enforcement and Criminal Justice completed its work (5). In its course they found that no one in America knew how many jails there were in this country. How many persons were confined? That was not known. How many had serious mental health problems before, during or after jail? No one knew. Many people still seem startled to learn that as recently as 1967 a Presidential Commission had to request a special survey even to estimate the number of jails. But we still lack even rudimentary information on the nature and extent of mental health problems in jails and on needs for or delivery of mental health services to people in jails.2

Not only do we lack solid information on the incidence and prevalence of mental health problems in jails, we lack systematic procedures for even keeping track of how many jails there are and how many persons are put in them. A basic need is for improved record keeping, on both national and local levels, to provide adequate statistical systems yielding descriptive data on the scope and nature of the problems. Such data systems need not be complex, or even unduly expensive. Yet, the information they could provide is a requisite to sound planning, it is essential for rational management, and it can provide a core of data fundamental to a variety of research purposes.

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2. How many jails are there now? One source indicates that in 1977 there were 3,921 (6). Another, dated 1975, asserted there were more than 5,000. (7). How many persons are jailed? Gibbs cites estimates (not counts) per year, of "between one and a half million and five and a half million persons" (8).

Unfortunately, another quotation on the topic of measurement may be required to give balance to the admonition of Lord Kelvin, already noted. The first Director of the National Institute of Law Enforcement and Criminal Justice thus cited St. Augustine:

> For so it is, oh Lord my God, I measure it;
> but what it is that I measure, I do not know (9).

The problems of reliability and validity of measurement discussed by Gibbs (10) and others in this conference attest to the needs for attention to these measurement concerns. The related issue of definitions of concepts to be measured is of course an integral part of the need for improved conceptualization already discussed.

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

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

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

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

There are other important measurement development problems. They include, as repeatedly emphasized by conference participants, more adequate attention to measurements of *staff* variables as well as those focused on inmates. The conference discussion called attention also to a variety of additional problems, including definition and measurement of diverse

concepts such as *stress, social climate, overcrowding, physical structure* of jails, and *program patterns*. Much discussion focused on the concept of stress and the perception that the social climates of jails may be modified to reduce stress and hence behavior disorders. How are such concepts to be measured or assessed?

The concept, stress, apparently was used with a variety of meanings in the conference discussions. For example, it was used to refer to "entry shock" as that term was employed by Gibbs (11) or to refer to noxious environmental conditions and events (as by Brodsky (12)), i.e., to environmental "press" (13). Others used the concept more generally, to refer to a situation and environment placing the person (i.e., the human organism) under great strain. This conception is similar to that of Selye, whose concept of "general adaptation syndrome" encompasses physiological as well as psychological adaptions to stress (14). There was, in any case, an apparent consensus in discussions that concepts of stress are important to further studies of the effects of jails. Examples of the questions raised included:

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

Improved Classification

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

Classification for Screening

Repeatedly, discussions in this conference pointed to

critical problems of screening at intake to jails. One problem is the early, accurate identification of potential suicide victims -- a requisite to development of intervention programs. Another screening problem identified was the need to quickly recognize inmates in need of protection, including those who are particularly at risk of victimization, including sexual abuse. Also, improved classification for custody (security) purposes, including identification of potentially assaultive or escape prone persons, was said to be needed.

Classification for Prediction

Problems of prediction were implicit in many of the conference discussions on a variety of topics; and the prediction problem is essentially one of classification (15). Issues concerning the setting of money bail, release on recognizance, or pre-trial diversion involve at least the problem of prediction of appearance for trial and, often, apparently, that of criminal behavior. The need for risk screening procedures such as those aimed at reduction of suicide, self-harm, escape, and victimization targets also points to prediction problems. In addition, the problem of classification for treatment may involve the problem of differential predictions of outcomes for various classes of inmates, given assignments to different treatments. Besides these needs for prediction methods to provide assistance in program assignment, prediction methods can be useful in program planning and in program evaluations (16).

Classification for Differential Treatment

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

Improved Program Evaluation

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

should include also systematic procedures that can give them and others unbiased estimates of the degree to which the programs are attaining their objectives (17). The problem of program evaluation generally has been neglected in respect to jails; and evaluations of mental health services in jails has been almost wholly lacking.

This lack was apparent in most of the specialized programs reviewed in this conference (18) and in related jail programs reviewed earlier in a somewhat similar way (19). In even the most promising programs, there is an absence of evaluation plans to permit later determinations of the effectiveness of the programs. As noted by Morgan (20) such evaluations are needed not only to assess the degree to which long range goals such as recidivism reduction are achieved but also to determine how goals such as decreased assaults, disruptive behavior, and jail disturbances may be attained. The general need for program evaluation is well recognized and it need not be belabored; nevertheless, the importance of evaluation studies to improved planning, effective management, and more rational and humane handling of persons in jail can hardly be overemphasized.

A General Strategy for Study

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

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

2. A national program providing minimal statistical data on jails, who is in them, why, with what mental health problems, and providing also data on follow-up outcomes is essential. A small core of basic data about the individuals jailed and what happens to them is required for both national planning and local management.

3. Jail managers need also an extension to this basic core of data in order to keep track of offenders and keep score on program results in ways idiosyncratic to local

needs and programs. This is required not only for a minimal accountability system but also to guide further program development.

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

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

6. In every aspect of these steps, attention should be given not only to record-keeping and analysis of offenders or alleged offenders, their treatment, and their subsequent careers; but it should be given also to the staff of the institutions. Here, the two aims mentioned by Brodsky should

be recalled -- purposes of assistance <u>to</u> staff and purposes of inmate assistance <u>through</u> staff (21).

7. Specialized, basic research such as the measurement of stress and the impact of jail environments on mental health are needed to augment this framework. A theme repeated throughout the conference was that we know little of the potential negative impacts of jail (on inmates or staff). Some inmates are seriously disturbed *before* they are jailed. Others are disturbed *while* they are jailed. Others are disturbed *as a <u>result</u>* of jail. These beliefs are widely held. They are poorly documented, but they are deserving of much further, detailed study.

8. Similarly, the research needs cited by Brodsky provide further examples of important areas for study that could build upon the framework proposed (22). He cites needs, for example, of

- follow-up research on confined citizens to determine the harmful, neutral, or positive impacts of jail confinement,
- research on jailers, to include task analyses, job performance, differences between bad and good officers in different types of settings, investigations of jail stresses and stress reduction techniques, and longitudinal studies of jail personnel over time,
- establishment of research demonstration mental health units in jails,
- specialized studies of violence and suicide, including information on "physical structures, milieu, size, staffing and program patterns

associated with high and low suicide and violence rates,"

- prevention research, including studies of effectiveness of programs of diversion of mentally ill from jails and other programs aimed at both primary and secondary prevention of mental disorders.

The research needs identified by Megargee at each "stage of assessment" he defined (23) can be incorporated in the general scheme proposed. They provide specific suggestions of needs in the measurement and classification areas.

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

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

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A RESEARCH AGENDA FOR MENTAL HEALTH SERVICES IN LOCAL JAILS

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CONTENTS

As one begins sketching a research agenda for the problems of mental health services for local jails the initial question that comes to mind is, why bother? It is fairly easy to compile a series of specific queries or general topics in an area as bereft of useful information as this. But having done this, so what? Appropriately, a number of the papers presented at this conference (Brodsky, 1978; Gibbs, 1978) and many of the opening remarks proposed research that was needed to rationally address the program issues inherent in their topics. However, the composition of a paper solely aimed at setting out a research agenda requires a distinct rationale. In this instance there appears to be one.

First, it is clear that there are few program areas in either the criminal justice or mental health systems that have less information available to planners and practitioners than mental health services to jails. Second, this conference itself indicates that the three federal agencies involved have recognized the information voids of these areas and are willing to commit resources to developing adequate data bases. This latter point is crucial. If this paper is worthwhile at all, it is in what it may contribute to the development of research resources and the reasoned dispersal of them. Without the commitment of resources and an associated eagerness from researchers, planners, and front line practitioners, this exercise is worthless.

So, with the anticipation that the two major conditions for a fruitful venture are present, the following outline of research priorities is offered. As will become apparent shortly, this agenda is developed from a mental health research perspective. This is the case for two reasons. First, this is the author's own research focus. Second, and more importantly, in reviewing the papers presented and from participating in the conference discussions it was clear that the conceptualization of jail mental health service problems and their solutions was

too narrow. This narrowness seemed to grow from an inadequate understanding of the operation of the state and local mental health systems beyond those few segments that have come into direct contact with the jails. It appeared that it would be profitable to look much more broadly at the issues involved in what to do with the mentally ill person in jail and what to do about the jails fostering florid symptomalogy and suicide.

However, before moving into the research content and methodologies that might be most productive in such endeavors, I first want to address the practitioner's question, why do research in the first place?

Why Do Research?

As one sheriff at this conference succinctly noted, "I don't want research. I want action.". I would counter by saying that this is exactly what doing research should be about - informed action. Research is nothing more than the systematic collection and analysis of information. When applied to programmatic questions, good research is simply a mechanism to provide the administrator and front line service provider with the information they need to more effectively carry out their jobs. When a proper collaboration between practitioner and researcher occurs, the products are exactly the "show me" type of research referred to by a conference participant. That is, when a problem is identified and framed into a researchable question, the appropriate information may be gathered and analyzed for both programmatic issues of the staff and whatever theoretical issues may be of interest to the researcher. One answer, then, to the question of "why do research" is simply to increase an agency's capabilities for informed action.

A second major reason to undertake research, even of the most descriptive

type, is to obtain program funds. It is very difficult to approach a state or county legislature or municipal government to request funds for mental health programs and not to be able to answer even the most basic questions that the politician will ask as to how many problems of what type there are. The crush of routine jail business has not generally fostered even basic record keeping systems. This absence can be problematic for a number of reasons, but clearly it is when funding requests are followed by questions for which answers are impossible. A standard reason for refusing requested funds is that they are not sufficiently justified. With current record keeping systems, documented justifications are often impossible. Without research, or program evaluation, legislators and fiscal officers are often provided easy outs in not developing mental health programs for jails.

While a number of other reasons might be offered for initiating research programs in local jails, these two appear to be the most significant. Jail personnel need to be better equipped to undertake informed action for mental health program development and administration. Mental health services cannot be effectively set up without new funds or the strategic reallocation of existing funds, both of which may require documentation of almost all phases of jail operations. Thus, the program of research outlined below could pave the way for action by aiding in funding and developing programs geared to actual needs.

Research Content

The first segment of this proposed research agenda focuses on the content of the research. The second section deals with some specific methods of research.

1. What are and what have been the relationships between mental health services and local jails? - This is the overriding question that grows out of the materials presented in this conference and from the limited research that is now available. The observation that, "although mental health Community Support Programs have been established to intervene in this alternative processing, the jails are still too frequently being used as a disposal for both the mentally ill and the mentally retarded" (Morgan, 1978:2) summarizes the views offered by many conference participants. There were a number of assumptions made consistently during the conference deliberations concerning the changing relationships between the mental health and criminal justice systems. These assumptions related to the rapid and fundamental changes that have occurred in the standards for involuntary civil commitment in many jurisdictions. These were seen as placing more persons in jail who formerly would have been in state mental hospitals where they were seen as still belonging. While the persons making these observations were some of the most competent persons in the U.S. to do so, there are serious questions as to the validity of their perceptions and how their observations coincide with those of mental health service providers. Sorting out the complexities of these issues and developing some data concerning these interrelationships both currently and historically is the first step in a research strategy. Why this is the case is data we have recently compiled.

As part of a project to ascertain the arrest rates of former mental patients in New York State, random samples of all patients released from New York State mental hospitals in 1968 and 1975 were followed. It was found that ex-patients were more often arrested than the general population. This difference resulted from the very high arrest rate of those released patients with two or

more arrests prior to their hospitalizations (Steadman et al., 1978; Cocozza et al., 1978. Mental patients with no arrests prior to hospitalization were arrested about as often as the general population. It was also determined that the rates of arrest for ex-patients had increased between 1968 and 1975. For our purposes here, however, the key finding was one which compared our results with a similar study done in the late 1940's in New York State (Brill and Malzberg, 1954.

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

The more difficult question was why had the proportion of male patients with arrests so greatly increased. Our hypothesis was that persons who formerly would have gone to jail were now being passed on to state mental hospitals in part due to the increasing overcrowding of prisons and jails while the deinstitutionalization of state mental hospitals was making more beds available. This explanatory

hypothesis appears to directly conflict with most of the observations expressed at this conference about the current relationships between jails and mental hospitals.

Put another way, when I hear the continued claim that jails have more mental health problems to contend with and that mental health service providers more and more avoid the treatment of persons charged with or convicted of crimes, I wonder how this can be true if more and more persons in mental hospitals have previously been arrested. It is not enough for the corrections person to say "Believe me, I know". While this is somewhat persuasive, given the day-to-day responsiblities of these people, it is not enough. What is clear is that there is little, if any, information on which to assess how the trends each system's personnel perceive can be occurring. Is someone wrong in their perceptions of their clientele? Are more mental patients criminals and more criminals mentally ill because of some consistent explanation? Who are the people who are "ping-ponging" back and forth between the two systems? How are the processes of transfer or refused transfer between the criminal justice and mental health systems operating? All of these are obviously unweildy questions requiring substantial clarification of specification to become managable research projects. Nevertheless, these larger issues about the interrelationships between the two systems on local, state and regional levels is badly needed. Without some data-based resolution, a basic understanding of recurring problems and shifting responsibilities between the two systems is unlikely.

With these general questions in mind, there are some specific content areas dealing with the general relationships of the two systems that can be productively specified.

a. <u>The Impact of Changing Mental Health Legislation on Jails</u> - One of the dominant topics in the deliberations of this conference was the impact on the local jail of more restructive involuntary civil commitment standards. Since the landmark 1969 revision of the California mental health code every statutory revision of mental health commitment codes has been more restrictive and more dependent on explicit demonstrations of a person's dangerousness to self or others. Arguably, this has resulted in more persons displaying nuisance behavior being booked and detained in jail. Typically, the corrections staff feels there are persons really in need of treatment and belong in a mental hospital rather than disturbing the jails routine and maybe further exacerbating the inmate's mental problems (Abramson, 1972). I say arguably since the other view has also been argued (Monahan, 1973). From this latter view many behaviors which were simply nuisance behaviors for many years had resulted in inappropriate mental hospitalizations for persons without treatable mental illness because mental hospitals were the easiest way to remove the nuisance without criminal procedures with more adequate due process protection and jail detention.

Here, as was the case in the above section, there are at least two very different views of evolving relationships between the mental health and criminal justice system. Each view has a substantially different interpretation of the impact of statutory changes on the jail and its programs. In fact, very little is known about the impact of statutory changes either in mental health commitment or criminal procedure codes. In some useful analyses (e.g. Kittrie, 1971) statutory histories are traced but hard data on changes within the two systems are sketchy. Research must be undertaken that will elucidate what does happen in local jails as a result of mental health and criminal statutory changes. These

studies need to be done in a wide variety of settings. The impact on huge metropolitan areas such as New York City or Los Angeles are probably not at all the same in less populous urban areas or in rural locales. Thus, even within the same state, there may be radically different impacts on jail mental health services from a statutory recodification. Currently we know little of what actually occurs.

b. The Impact of Judicial Rulings and National Health Standards - Another area that relates to the overall relationships between the criminal justice system and mental health services is the impact of various federal and state court rulings and the development of national standards for health services in jails. The conference paper by Harris (1978) examined the impact of judicial decisions and guidelines in four jurisdictions. She concluded that the main direct effects were decreased jail brutality and less inappropriate punishment. However, she felt that the experience in these four jurisdictions provided no support that the courts could be expected to be sources of affirmative social change. In a number of ways these findings are similar to those of Leaf (1976) on the impact of the Wyatt v. Stickney decision on state mental hospitals in Alabama. He concluded that while there were some improvements, they were much more limited than might have been anticipated by the comprehensiveness and specificity of the guidelines. Thus, the actual impacts on mental health services in jails that local and federal court decisions may have is unclear, but probably more limited that is often presumed. What becomes important, then, to determine are the circumstances in which greater or lesser changes occur and what the changes are.

Another type of promulgation whose effects on mental health service are unclear are quality of care standards such as those for mental health services now in draft stage by the American Medical Association. Such standards are often closely allied with judicial decisions; these decisions may relay upon standards

set by some such established professional group. The thoughtful development of such guidelines are thought to be beneficial since jails may then have standards which provide a rationale for program development and fiscal resources. However, little is known as to the real effects of such standards in any context and the use of standards in litigation by mental health advocates may ultimately result in as much aggrevation to the jails as benefit. Of course, a number of other scenarios are possible, such as the jail's personnel encouraging challenges by various legal aid groups to force the development of programs that they see as needed. Regardless, with the variety of possible positive and negative effects that judicial interventions and national program standards may have, it would be productive to begin developing data on what impacts on jail programs they really have.

c. Referral Process - A third research question focused on the relationships between the mental health and criminal justice systems relates to understanding the entrance and exit processes between the two systems. There is no systematic information available about the volume or types of referrals. Equally as important is the compilation of information on who is rejected for mental health services or jail detention and under what circumstances each occurs. Surely, inmates who attempt suicide merit mental health service responses. It is also clear that many, if not most, mental health facilities hesitate or outrightly refuse to accept persons who have outstanding criminal charges. What is needed is some documentation of actual referral and refusal patterns in various jurisdictions with specification of the characteristics of the inmates accepted and refused as well as specifications of the characteristics of the agencies involved and the dynamics of decision making at these key points.

A central focus of any research on referral processes must be the police officer. Despite assertions to the contrary by some conference participants, little is known about the police decisions in the street and shortly after arrest which result in a person being taken to mental health facility rather than jail. Bittner(1967), Rock (1968), and Snibbe (1973) have provided insightful frameworks and sketchy data about the relationship between the police and mental health services. However, these analyses have yet to provide systematic information on the patrol officer's day-to-day decision making about the use or non-use of mental health services or diversions for the arrestee or the potential arrestee. There is a critical need for systematic knowledge about the processes by which the patrol officer reaches decisions about what way to handle various types of violent, bizarre, or nuisance persons in varying jurisdictions under a range of conditions. Much too little attention is paid to the system inputs of jails and the working definitions of the key gatekeepers, while concentrating on the problems of persons already being processed in the system. This latter focus promises limited returns until a research is established that takes a comprehensive analysis of the key decisions made by the police officer on the street. Until a clearer picture is developed about the dynamics at the key interface points between the two systems, the formulation of coherent policies will wait.

2. Correction Officer Practices and Needs

Brodsky has noted that "for all practical purposes no useful scholarly information is available on jail personnel" (1978:31). Such a gap is a critical one given the importance jail personnel have for identifying mental health service needs or causing or exacerbating these needs. That the jail environment may produce stresses that are associated with conditions requiring mental health interventions is well accepted. It is surprising that so little attention has been devoted to the possible negative effects of this same environment as a work setting for jail personnel. If the jail's impact on the inmate brings out latent problems, then why should it not also be expected to do so on those for whom it is a work environment?

For whom, under what circumstances, and to what degree jails may be bad work environments are questions about which little is known. These issues become crucial when addressing policy concerns about the selection and training of correction officers. The majority opinion at this conference seemed to be that the selection process was more crucial than training since no amount of training would lead to a significant improvement in persons who were fundamentally ill equipped to be correction officers. However, as Brodsky noted in his discussion, the question of selection comes down to saying, "we want a good _____ for correction officers", but we do not know how to fill in the blank. Also, because so little research exists about jailer selection, selection criteria cannot be adequately formulated and indicators of successful job performance are insufficiently developed. Brodsky (1978) does offer a number of specific suggestions for research in this area that are well stated and demand action. These would be positive first steps in this critical topic area. As one conference participant suggested, maybe

"non-normals" make the best correction officers. If this were the case, tests that screen out marginal personalities of one type or another ultimately are a disservice to the mental health of both inmates and correction officers. Regardless, it does seem the research priorities should be focused on the selection process of correction officers with only secondary emphasis given to designing and implementing training programs.

3. Goals/Effects of Mental Health Treatment in Jails

Various depictions of the functions of jails were offered during this conference. Among these were "the jail as a public health outpost" and "jails providing what [services] the community does not". Mental health services to jails were seen as ranging from simply "meeting the needs of inmates" to "inmate management through mental health services". This wide range of views about the jail and its mental health services reflects a fundamental research need. This need is to determine what various groups see as the responsibilities of jails and the manner in which mental health services can be fit into the various models that communities may have for their jails. In other words, before anyone can assess the effectiveness of a jail program, mental health or otherwise, the criteria for a successful program must be specified. It may well be that from locale to locale the goals of jails vary and what is defined as "mental health services needs" also vary. On the other hand, the development of national standards alluded to above suggest that there may be some basic obligations that any inmate population can expect to be met in any jail.

One line of research that is suggested examines community attitudes towards jails. Such research might provide better indications of what mental health programs might receive community support and the methods by which programs might be

sold to the public. The issue of community resistances was raised during this conference in a number of ways. One way was the question, "how much service is owed to inmates"? Depending on one's definition of the goals of jails there were widely different responses suggested. A second phrasing of this question was the rhetorical question of one discussion group reporter who wondered "what the public would do if they knew we were meeting here?"

It is one thing to gather together a group of respected correctional and mental health professionals and to suggest what mental health programs are needed. It is another to implement these programs in the face of frequent public opposition and outright hostility emanating from community perception that this group of convicted persons is getting more services than the public at large. Thus, some survey information on the attitudes of the public, professionals, practitioners in the jails, and politicians would benefit these issues.

Another research issue that mixes public attitude assessment with empirical data on the phenomenon itself is the role of jail mental health services in the reduction of violence and subsequent crime. Newman and Price have observed that "jails hold those who society fears most (whether realistically or not), and jails are expected to return them as less fearsome" (1977:502). Similarly, there appears to be an expectation on the part of jail personnel that mental health services help decrease violence in jails. Petrich (1977) reported that almost one quarter of all referrals for mental health services in the Seattle area were for individuals described as violent. Likewise, Brodsky observed that "when confined persons become delusional, violent, incoherent, or otherwise seriously mentally disordered, they may be taken to a local hospital or mental health center" [emphasis added] (1978:6). The implicit link here between perceived need for mental health services and the reduction of violence in the jail and in the community is clear.

The public looks to the jail to reduce the probability of future crime, especially violent crime, and jailers look to mental health services to help reduce violence in jails. At this time neither expectation has much basis in fact. First, psychiatric interventions do not treat recidivism or violence per se. Treatment is geared to specific symptomatology which may not only not reduce recidivism, but also may actually increase it. For example, if the inmate is habitually involved in crimes of economic gain, through mental health treatment he may become a better functioning person making him a more competent criminal who is less often arrested and thus percipitates more crime. Just what the relationships may be between mental illness and mental health treatment in jails as far as reducing either violence in the jails, violence in the community or in reducing recidivism are unclear. Both the actual relationships between mental health interventions and violence and the public and professional expectations of mental health services in jails require intense research attention.

4. The Dynamics of Program Development

The final content area of this research agenda focuses on the processes by which mental health service programs are developed, implemented, and the manners in which they impact upon the jail. It means asking, what works for whom under what circumstances and how is it set up? The answers to these questions imply answers to the questions posed in the previous section. To assess what works or how well something works there must be some criterion against which success can be measured. Assuming that some consensus is possible about what are good programs, it is essential that some research efforts be geared to how such programs are set up, are made operational, and are maintained. These issues focus on questions of organizational development and administration. Megargee (1979) and Brodsky (1978), for example, discuss a number of programs that might be profitably implemented in

many jails. However, systematic information about just which programs would be useful for which types of communities and just how locales with widely varying needs and resources can go about establishing these and other programs is undeveloped. There may be a wealth of sound advice available as indicated by the conference panel on "Service Delivery Models", but this has yet to be systematically collected and distilled. Such "how to" data are essential to prevent the continual "reinvention of the wheel". Also, many worthwhile programs are established, run their course and are terminated, some by choice and some by exigencies. Research should be geared not only to the development processes, but also to the maintenance and termination processes as well.

Beyond this set of general programmatic issues there are a number of more specific research topics that could profitably be addressed.

a. Role of Volunteers

One specific question about program development and maintenance that arose a number of times during this conference was the role of volunteers in jail mental health programs. Many successful programs seem to have relied greatly on volunteers. However, there is no systematic information about which types of programs made more use, what types of persons provided what types of services, and the costs and benefits of each type of service provision. Such questions require research attention to maximize future program development.

b. The Location of Services

Related to program implementation and development are a bevy of questions about the optimum location of mental health programs intramurally or extramurally or in what combination. On one side are those such as Dr. Alan Stone, President of the American Psychiatric Association, who would recommend that "...prisoners

be given Medicaid and allowed to seek whatever medical help that they want
tside the institution." (1978:8). On the other side are the programs described
this conference where a full range of mental health services have been developed
thin the jail system, such as in the massive jails in New York City and Los
ngeles. Again the research questions are not either-or ones, but rather must
e framed as, what are the most efficacious and cost effective programs for whom
nder what conditions? As yet there is minimum information about what programs
exist, although Morgan's (1978) work is a giant first step. However, there are
no systematic analyses about optimum arrangements for various types of jails.

c. Needs Assessments

In part, the answers to the above research questions demand much more information of the type reviewed by Gibbs (1978), Brodsky (1978) and Gove (1978). This information focuses on the kinds and distributions of mental health problems of jail inmates. There is such rudamentary knowledge available assessing the needs of jail inmates that it is most difficult to develop models for programs and their implementation. Thus, a crucial first step in this research area is further work both on the distribution of specific psychiatric symptomatologies and on broader mental health problems such as the impact of the jail environment on inmate functioning. One outcome of comprehensive and detailed needs assessments may well be an increased realization of the limited number of jail problems that mental health services can actually be expected to ameliorate.

d. Impact of Mental Health Services on Jail Organization

Another area of program development characterized by inadequate information includes the uncertain effects of mental health programs on jail organization. That is, in what ways is the day to day routine of jails affected by the presence

of mental health service programs. Clearly when such programs are developed different personnel are present and the routines of the jail vary. More importantly, if comprehensive service programs are developed within the jail, inmates who might have been previously transferred to medical or psychiatric in-patient facilities remain in the jail's general or special population sections. On the other hand, the development of mental health services may result in the referral of inmates, either on outpatient or inpatient basis, to mental health services outside the jail, thus removing them from the jail population. There is no research that examines what impacts such changes in jail personnel and inmate populations may have on the operations of jails. As programs are developed, substantial benefits could accrue if these impacts are studied.

e. Effects on Receiving Mental Health Services

Another important aspect of the effects of mental health treatment is more at the individual level - what is the impact on the inmate of being labeled as mentally ill or receiving psychiatric treatment? This question has at least two facets. First, what is the effect on the inmate's day to day interactions with other inmates and correction officers and how might the changes in the interactions impact upon his/her mental health? Second, what is the impact on the term of incarceration of being so labeled? While these questions have been looked at in the circumstance of incompetency diversion (Steadman, Forthcoming), there is no information on whether receiving mental health treatment in jails increases or decreases detention time, or more accurately for which inmates in which types of jails does what kind of treatment have any effects? There are a number of hypotheses that might be generated about being labeled as mentally ill in jail, some of which flow directly from the labeling theory discussed by Gove (1978). In addition to these, however, there may be other much more crucial in the eyes of an inmate who is trying to make decisions about whether

seek out or to participate in some type of treatment program. These questions come down to asking what impact will this treatment have on the time he has to do. As yet there is nothing that could be told to such an inmate from research data.

This set of issues on the processes of program development completes the list of the major content areas of this research agenda. The next section deals briefly with two ideas about research methods to strategically address these and other content areas.

RESEARCH METHODOLOGIES

1. Cohort Studies

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

Currently it is most unclear what the careers of jail inmates are in terms of receiving voluntarily or involuntarily mental health treatment, particularly in state mental hospitals or outpatient programs, and how these experiences relate to their patterns of criminal activity and incarcerations histories. To begin demarcating the working relationships and changing responsibilities of mental health and jail agencies, it is essential that longitudinal studies of

large groups of many different types of inmates in different types of environments be undertaken. Much less is gained by selecting a group of inmates at one point in time and describing what percentage have formerly received treatment, how many have been in state mental hospitals and thus concluding that many inmates are appropriate candidates for mental hospitalization. One needs to know all those persons who have been at one time or another in the various detention and treatment programs and why some stay in, some filter out and some circulate back and forth, and why and how these phenomena occur. Cohort studies are a primary way of obtaining the answers.

2. Control Groups

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

What this suggests is that in any study to ascertain the characteristics of any high or low risk groups for any types of special screening or programs, it is essential to have control groups with which the inmates of potential programatic concern may be compared. Without such comparative data, much program money will be wasted.

A Major Research Limitation

Regardless of the research methods chosen or the issues being studied, a major consideration in any research agenda for jails are federal guidelines on the use of human subjects in research. Prisoners have been designated as a group abused by researchers over the years. Much of the abuse has centered on the use of prison inmates for drug studies. Jails, per se, have not been mentioned in the critical reviews of research practices in penal facilities. Nevertheless, the current spate of regulations restricting the types of research that may be done and detailing the guidelines that must be followed places limitations on research programs and cautions the program director wishing to institute research.

A key distinction to be kept in mind is the one between research and program evaluation. Generally program evaluation is seen as the collection of systematic data for administrative decision-making about the operation of any ongoing or pilot program. As long as such data collection is defined programatically to be geared towards developing an information base about program operations for direct decision-making, most proposed or current federal research regulations do not apply. However, when data collection is set up for its own merit without any direct feedback into regularized administrative decision-making, it may become defined as research. When this occurs, a whole series of regulations pertaining to informed consent and voluntary participation must be adhered to. Any person considering the development of any "research" program should clearly define the work to be done in the context of existing and proposed federal research and privacy regulations lest ethical and liability issues arise.

Conclusion

The research agenda outlined here is intended to provide persons responsible for planning, implementing and maintaining jails with the basic information from which appropriate mental health programs can be developed. The first step in developing the needed information base is to more clearly determine what are the actual relationships between the criminal justice and mental health systems. Only after these relationships are understood will it be possible to move towards framing and answering the other questions about mental health service to jails.

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

In laying out these priority areas for research in mental health services to jails, the focus has been on rather large problem areas, rather than enumerating many specific questions. It would seem more beneficial to proceed by establishing priority areas within which the interests of individual researchers and the needs of given agencies or regions could be merged to establish specific research projects which would offer mutual benefit. In this manner projects would be developed which would have the "show me", "we want action" components alluded to above. From the vantage point of large federal agencies, then, it would seem most advisable to list generic problem areas that suggest high

eld as guidelines for practitioners and researchers, leaving to them the ecification of particular research questions.

Certainly the information presented in this conference by jail dministrators and by mental health service providers in jails offered a most onvincing case for the need for innovative mental health service. However, efore one can realistically expect public or legislative support, much ore information is needed. Also, without more efforts, such as those of this conference, to build such a data base rational program development that avoids past errors and includes cost-effective development is impossible. The research agenda proposed here is geared to such goals. On the one hand, the crisis atmosphere communicated persuasively here may be nothing more than a cry for minor reorganization of existing programs and statutes. On the other hand, his crisis may require full scale modifications of jails and of community and state mental health services to deal with tens of thousands of individuals who need and are not receiving mental health services. Until the jailer, the researcher and the federal funding agencies join efforts, it will remain unclear which possibility is the more accurate. Research with action is needed.

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October 4, 1978

Blair G. Ewing
Acting Director
NILECJ

Phyllis Jo Baunach Phyllis Jo Baunach
Correctional Research Specialist

The Research Panel, "Research and Evaluation Issues," Mental Health Services for Jailed Offenders Conference, Friday, September 29, 1978

THROUGH: John Spevacek, Director, Correctional Research Specialist

On Friday, September 29, 1978, the research panel presented to the conference participants perspectives on research and evaluation issues in the area of mental health problems for jailed offenders. Panelists included Dean Don Gottfredson, School of Criminal Justice, Rutgers University, Newark, New Jersey; Dr. Hank Steadman, Director, Special Projects, Research Unit, New York State Department of Mental Hygiene; Mr. Paul Katsampes, (Discussant) Correctional Program Specialist for NIC in Boulder, Colorado; and Phyllis Jo Baunach, Chairperson. The panel session lasted for an hour.

BACKGROUND

From its inception, I have envisioned the purpose of the research panel to be twofold: 1) to provide to interested academicians, researchers, evaluators and practitioners in the immediate audience and in the reading audience for the proceedings an overview of researcherable issues in this previously overlooked area; and 2) to provide the NILECJ with issues papers to highlight, from two different perspecitves, research and evaluation issues that could be used in planning a research program in this area. Given this purpose, I selected panelists who represented the three areas of importance: research (Gottfredson), mental health (Steadman) and criminal justice (Kapsampes, who, by the way, has been a jail warden and only recently began working with NIC).

The panelists were instructed not to prepare papers prior to the conference as I wanted the completed papers to reflect the researchable issues as they have evolved from both panelists' background and experiences and discussions and sessions during the conference itself. For this reason, I required the panelists to attend all meetings with an eye to synthesizing the research and evaluation issues as they emerge from each session. The two panelists, Dean Gottfredson and Hank Steadman, are required to synthesize their knowledge of the literature, comments from the panel and thoughts

regarding in this area into a paper which includes a prioritized list of research and evaluation issues. Papers are due on October 29, 1978. These papers will be analagous to an issues paper I would otherwise write in this area and should be helpful in devising a research agenda in the area of mental health and jails.

Prior to the first plenary session, I met with the panelists to reiterate their mission and throughout the conference chatted with them regarding their observations. On the morning of the final day, the panel met as a group to discuss their perceptions and proposed approaches for the panel presentation. The conference suggested a number of themes which could be interwoven into a research program and we decided to cover these generally rather then to describe very specific research projects. The panel session was tape recorded. Copies of the tape are available through URC.

RESEARCH THEMES

In setting the tone for the discussion of research issues, I noted the importance of conducting three types of research. The first type of research entails conceptualization of the problem. It seemed clear to me from the conference that participants varied in their definitions (or lack thereof) of this "mental health" or "mental health problems." Unless there is a clear understanding of the nature of the problem conceptually, it will not be possible to define variables of interest, devise instruments for data collection or conduct meaningful studies in this area. In addition, I pointed out that without a clear definition of the problem area, it will not be possible to divide appropriate programs for clients. Thus, a clear, concise framework is required for conducting research and evaluation efforts. Secondly, research must focus on obtaining basic information regarding the extent of the mental health problems and the persons included in the target population. Again, it seemed clear to me from the previous sessions that neither mental health professionals nor criminal justice personnel had a clear idea of who requires services and what types of services they might need. One panel describing intervention models noted that there are very few services provided for jailed women. Some individuals I chatted with briefly disagreed with this and noted that all services provided for men are also available to incarcerated women as well. Thus, there seems to be some discrepancy. What, in fact, is the case? Additional basic data must be obtained which indicates the extent and types of poblems which jailed offenders of both sexes face. Additional basic data must be collected regarding what proportion of jailed populations is suicidal, depressed, or aggressive and what types of services might be best provided for them, if services are to be provided at all? What is and could be the role of jail personnel in providing mental health services? In addition, perhaps, some attention should be paid to understanding the mental health requirements for jail personnel themselves. Some preliminary research indicates that the blood pressure of staff increases steadily the longer they remain in their positions. Thus, the entire area of the roles, responsibilities and

strains on jail staff should be explored, with ultimate eye to perhaps, a long range goal of providing appropriate services to staff requiring them.

Finally, the third theme is applied research. There is a need to conduct careful assessments of programs already in operation and to set up experimental programs and monitor them closely to ascertain their efficiency and effectiveness over time. For example, many participants suggested that it may be impossible for small rural jails to expend limited resources on elaborate mental health programs for jailed offenders. Thus, it may be impossible to involve jail staff in screening and identifying mental health problems of offenders. Training programs of this nature could be established, implemented and evaluated in several selected jurisdictions.

Additional research issues discussed during the panel include the following:

1) There is a need to conduct research on the role of the police, judiciary and courts in identifying mental health problems at earlier levels, and thus, perhaps avoiding the sentencing of offenders with problems already manifested.

2) Research should be done in the area of determining under what conditions volunteers may provide an effective resource in working with jailed populations.

3) There seems to be a hydraulic effect with respect to populations in jails and hospitals (i.e., populations in mental health facilities may go up while jail populations simultaneously go down or visa versa). There is a need to determine the factors contributed to these changes and how they do so. In addition, research panelists noted a "ping pong" effect whereby clients end up first in one type of institution then at another time in another. Thus, sum to simply go back and forth from one type of facility to the other. What conditions foster these population shifts? Are they predictable and possibly controllable? What are the "careers" of these clients? Might they be characterized as "career criminals" of a sort?

4) With respect to legal research, there is a need to study the impacts of mental health legislation on jail populations, and the types, extent and nature of treatment programs and resources allocated to jails. One luncheon speaker, Tony Plaut of NIMH, suggested that there is legislation to be presented on the hill next spring regarding the Community Mental Health Centers Act. The Act would apparently provide for more of a community orientation for mental health services. In response to my question regarding an interface of criminal justice with the mental health area, he noted that it would

be possible for interested groups to influence this legislation to include such an interface. If appropriate, perhaps, respect to the research issues, whenever this legislation takes effect, its impact re garding jail populations, resources, etc., should be studied.

5) The goals of mental health treatment for jailed offenders should be catalogued and understood. It seemed clear from the conference that there were no clearly stated goals or definitions for mental health or for the purposes of treatment provided.

6) If labelled "mentally ill," what implications has this for the length and type of treatment provided, if any? How do administrators, staff and other inmates perceive an offender so labelled?

7) Under what conditions would which types of programs be effective and efficiently provided for which types of offenders? This type of question suggests an action-research orientation in which experimental programs may be set up and carefully tested, evaluated and refined in light of evaluation findings. This type of program fits in well with the agency's APDP approach.

8) In order to maximize resource allocation and usage, careful attention should be paid to the selection criteria procedures and to the training programs provided for jail staff.

9) Additional research is needed to classify clients in order to place them in the most appropriate facilities.

10) There is a need to develop improved measurement instruments and procedures to understand the phenomenon of the jail and problems confronting jailed offenders and staff. For instances, the reliability and validity of instrument used to determine "social climate" in jails is virtually non-existent. Yet, there is reason to believe that the environment of the jail may exascerbate mental health problems.

11) Finally, many participants expressed concern that researchers must be sensitive to the needs of the local jail planners and practitioners in their efforts. This suggested to me that the way in which research on jails is conducted must be structured carefully. Researchers should attempt to involve local practitioners in the process and to provide research results periodically which will assist jail personnel in their day to day operations.

CONCLUSION AND RECOMMENDATION

The panel itself was well received and stimulated several questions and comments from the audience regarding research issues. Given the seemingly primitive state-of-the-art in this area, it would be both appropriate and important for the NILECJ to initiate a research program in this neglected area. The research papers to be prepared by the two panelists from this conference should serve as starting points for developing such an agenda. It may be helpful to gather additional perspectives from the Institute's advisory committee. Finally, planning and execution of this conference has been possible throught the joint efforts of NIC, NIMH and the Institute. The planning process proceeded smoothly and successfully. This was, I believe, the first time the Institute undertook such a venture. Given the success of this joint participation, I recommend that we continue joint planning of research and perhaps regional and local workshops, training and demonstration programs in this area. Given the significance of both mental health and criminal justice perspectives in this area, it would be important to coordinate our efforts and to plan research and programs in this area jointly with these other agencies. Therefore, I recommend that any research or programmatic planning that occurs in LEAA should include the input of staff from each of these agencies.

Finally, I want to thank you for the opportunity to be involved in planning this conference and in facilitating the research panel. This experience has personally and professionally rewarding and fascinating. From this experience, I am firmly convinced that research and programmatic development are surely needed in the area of mental health and jails. I hope that the Institute will engage in research in this area and contribute to the provision of information to enhance our understanding of the dynamics underlying the identification of problems, the development of appropriate programs and the selection and training of staff to provide adequate mental health services for jailed offenders.

cc: Paul Estaver, ODTD

PJOBAUNACH:hd 10/3/78

P. JO BAUNACH CHRONS
ORP CHRONS
B. EWING CHRONS
CORRECTIONS CHRONS

TEXAS SOUTHERN UNIVERSITY
HOUSTON, TEXAS 77004

DEPARTMENT OF SOCIOLOGY

October 11, 1978

National Criminal Justice
Executive Training Program - Suite 1600
5530 Wisconsin Ave., N. W.
Washington, D. C. 20015

Dear Ty:

Seemingly, there are attitudes and perceptions held by those that manage jails of those that are managed that enhance or impede the delivery of mental health services to jailed inmates. Moreover, the culture that defines the environment of jails is influenced by ethnicity, race, and class position. Consequently, the majority that manage jails are also influenced and have attitudes and perceptions that associate ethnicity, race, and class position with criminality. This association has a permanency in attitude which implicitly and privately (even publicly) questions the value and usefulness of the delivery of such services to jailed inmates.

The questions to be answered that concern me resulting from this social dynamics are:

1) Is there a relationship between the racial, ethnic, and class position of those who manage jails and those who are managed, and the delivery of mental health services?

2) Is there a relationship between the attitudes and perceptions of criminality held by those who manage jails and the racial, ethnic and class position of those jailed, and the delivery of mental health services? Are these attitudes and perceptions related to the level of priority placed on the delivery of such services?

Another concern is that attention be given to the kind of environment into which individuals (the managers and the managed) are placed. The problem of mental health in jails can stem from individuals who are jailed with mental health problems, Those who develop such problems resulting from the jail environment, and, as a result of the combination of these two reasons, producing a peculiar set of problems. Individuals who are jailed with mental health problems could very well have those problems aggravated by the jail environment. The coming together of the nature and character of the environment of confinement with that brought by jailed inmates must be carefully researched. In this regard, a clear

distinction must be achieved with respect to the two environments and the problems they bring to each other and produce as a result of their coming together. The distinction will require a different response in terms of the delivery of mental health services.

The assumption that those that manage jails are not subject to mental health problems resulting from a variety of reasons, including the jail environment, should be questioned and researched.

Sincerely,

L. Alex Swan, Chairman

DRAFT

Federal/Local Expertise Networks for Criminal Justice Problems: Theory, Example, Evaluation*

Christopher S. Dunn
Center for Studies of Crime and Delinquency
National Institute of Mental Health
U. S. Department of Health, Education, and Welfare
5600 Fishers Lane
Rockville, Maryland 20857

*For presentation at the Academy of Criminal Justice Sciences, March 16, 1979.

The usual pattern of information flow in organizational development or innovation is typically thought to be postively correlated with authority or status hierarchies in organizations, and negatively correlated with information flow in organizational monitoring and control activities. Program development or organizational change decisions are typically made on the basis of knowledge development activities conducted by researchers in academe or in special research units within organizations. The results of these "research" activities are used to suggest or devise policy or programmatic changes, which may evenutally be implemented by decision-makers or managers. Finally, if such changes are to be implemented, line personnel or staff are frequently the last ones to be consulted about the nature and viability of the proposed innovations. In more enlightened, less bureaucratic agencies, some "operational" research may have been conducted to suggest the impact or unanticipated consequences of the desired changes, or perhaps some "normative-reeducative" planned change activities may even have been utilized to assist staff in "internalizing" the rationale and spirit for new programmatic directions, goals, and means in addition to simply implementing required innovations.

When viewing such activities from without, academic or specialized research units are frequently accorded the highest status in such change processes because of their omniscience, and program staff the lowest because of their relative ignorance and frequent resistance. Decision-makers fall somewhere in between, in part higher than staff because of their leadership roles, but also lower than researchers because their omnipotence is frequently the direct challenge of program staff's resistance, and not necessarily the substance of

the recommended changes.

Information flow in the above innovation or changes hierarchy is thus from researchers to decision-makers to program staff. In contrast, information for "management" may typically flow in precisely the opposite direction, from program staff to managers (to researchers if the control problems are sufficiently complex or taxing on managerial abilities). Alternatively, more enlightened organizations may involve "operational researchers" on a fairly routine basis, but somewhere along the line a decision-maker or manager invests some time and energy in making "resource allocation" decisions about which control problems require the efforts of the operational researchers.

It should not be presumed or concluded that researchers or decision-makers possess all the knowledge or wisdom that may frequently be attributed to them as a consequence of the status hierarchy and information flow patterns described above. Although researchers may be organizationally located so as to best "see the whole picture" and decision-makers located so as best be able to act on that vision, it may well be the case that program personnel have the most detailed, most up-to-date knowledge about what works and what doesn't, about what makes a difference and what doesn't. The mere possibility of such knowledge suggests that the typical organizational innovation strategy, viz., basic research - program development - implementation, is not the only or necessarily most efficacious strategy. Ignoring or overlooking the type of knowledge described above not only may set in motion patterns of interpersonal friction and resistance to change, but may also mean that basic research solutions are not accurate or appropriately timed.

The problem discussed above would seem to exacerbated by the typical research and training support programs in criminal justice underwritten by Federal monies. In other words, basic research and improvement of personnel

have been the major themes girding and guiding many Federally-supported criminal justice research and development activities, perhaps largely due to acceptance of the untested assumption that researchers "create" knowledge and more knowledgeable staff "apply" these creations in the service of organizational change decisions.

The present paper seeks to describe an alternative to the model outlined above; the alternative presented is based more on the logical shortcomings of the basic research and training model and on the logical advantages inherent in it than on empirical research. And the method chosen for its unveiling is not particularly scientific, viz., a case study approach. But in reviewing the theory, example, and evaluation of a particularly unique effort at beginning to improve mental health services in local jails, it is hoped to demonstrate how an alternative view of the sources and application of knowledge may offer another, equally valid, organizational innovation strategy, one which may also have distinct advantages in maximizing Federal/local cooperation and resources.

The recent President's Commission on Mental Health (PCMH, 1978) documented the fact that over the past 25 years the supply of mental health professionals and paraprofessionals has more than doubled. These persons have found employment in many sectors outside traditional mental health agencies, for example, in court clinics or in correctional institutions. The Commission also documented that by 1976 the direct cost of providing mental health services was estimated to be about $17 billion, which was about 12 percent of all health service costs. Despite these trends in services, and despite significant and productive mental health and criminal justice research, many persons who should have benefitted from the aforementioned changes still receive in adequate care.

The President's Commission is clear about who the unserved and under-

served are. They note that:

> This is especially true of people with chronic mental illness, of children, adolescents, and older Americans. Racial and ethnic minorities, the urban poor, and migrant and seasonal farmworkers continue to be underserved. In rural America there are few facilities and few people trained to provide mental health care. (PCMH Report, 1978:4)

The President's Commission list focuses attention on the underserved as representing an important source of information about the fundamental problems that remain to be solved in the delivery of mental health services, as well as to indicate the direction for targeting of public programs and funds. Clearly, the President's Commission did not say that the above-mentioned groups are the only groups for whom service improvements are needed, nor did they say that no improvements and developments in both knowledge and understanding about mental health and about mental health service delivery have been made. Instead, their rationale for focusing on the unserved and underserved was that by concentrating on the difficulties that these groups experienced in obtaining care, some fundamental problems in planning, organizing, delivering, and financing services throughout the mental health system could be more clearly seen.

Although there may be professional differences of opinion about mental health and mental illness in jails, and about what can be done effectively by whom, there is on the other hand consensus that correctional populations and especially inmates of local jails would fit the President's Commission description of an "underserved" population. A recent study drawing upon the first comprehensive national survey of inmates of local jails provides an example. In that study, Goldkamp (1978) notes:

> Inmates of American jails were disproportionately young (between 18 and 24), male (about 95 percent), and black in contrast with the total non-institutionalized U. S. population in 1972....Nearly half of all inmates were unemployed at the time of their admission to jail....Income earned during the year prior to incarceration was exceedingly low for all inmates; more than half earned less than $3,000 and about nine-tenths earned less than $7,500....About half of all

> inmates were single (never married), while about one-quarter were divorced, separated, or widowed....Two-fifths (42 percent) of all inmates reported that, since their confinement, dependents they had supported prior to incarceration had to rely on public assistance. (Goldkamp, 1978:25-26).

> Overall, about 25 percent of all inmates of American jails were in custody in central cities, 52 percent were in custody in the balance of SMSA areas, and about 23 percent were held in rural areas....(Using another measure, viz., jail capacity) [a]pproximately 35 percent of all inmates were held in jails containing up to 99 persons; 33 percent were in facilities holding from 100 - 499 persons; about 20 percent were held in very large jails with populations between 500 and 999 persons; and nearly 12 percent were held in jails with populations of 1,000 or more. (Goldkamp, 1978:23-24)

Goldkamp's data permits a comparison of underserved populations vis-a-vis mental health services and populations over-represented in jails: the populations are in fact one and the same. This rough comparison should not be interpreted to mean that all persons in jails need mental health services or that all persons not receving adequate mental health services are criminal. Instead, the proper point of the comparison is that because the populations are in fact the same, the President's Commission has implicitly defined jails as within the penumbra of "underserved." In another way, the President's Commission is more explicit about this fact, since it states (albeit without any supporting documentation) that "a high percentage of jail and prison inmates are mentally disabled" and subsequently recommends that "Mentally disabled persons in detention or correctional institutions should have access to appropriate mental health services on a voluntary basis and such access should not be connected with release considerations." (PCMH Report, 1978:45)

Despite all the attention that jails and that mental health have independently received, the President's Commission as well as numerous other critics and commentators on U. S. jails are virually silent in regard to (1) the nature of mental health problems in jails, (2) what services should be provided, and (3) the institutional locus of the service providers. In view of the

proliferation of knowledge about basic criminal justice processes and problems and about mental health and mental illness and in view of the apparent shortage of application of this knowledge vis-a-vis mental health and mental health services in jails, three Federal agencies became active in ameliorating that shortage well in advance of the activities of the President's Commission on Mental Health. These agencies were the National Institute of Corrections (NIC), the National Institute of Law Enforcement and Criminal Justice (NILECJ), and the National Institute of Mental Health (NIMH). An initial meeting of representatives from the three agencies led to the establishment of a small, interagency planning group of four Federal agency representatives and four persons from academic institutions and local agencies having special competencies and areas of knowledge (viz., law, correctional psychology, jail and correctional administration, and community support systems).

Six planning meetings were held from October 1977 to June 1978 to conceptualize and develop the content, format, roster of participants, and dissemination plans for what came to be known as the Special National Workshop on Mental Health Services In Local Jails. This Workshop was held on September 27 - 29, 1978 in Baltimore, Maryland and involved the participation in faculty and attendee roles of about 100 persons from local jails, community mental health organizations, state departments of correction and of mental hygiene, and universities.

It is worthwhile to review the consensus that developed as a result of the intensive substantive work performed by the Workshop planning group. Altogether, the work of the planning group indicated that:

(1) There are a variety of mental health related problems in jails: some may require emergency psychiatric intervention in life-threatening circumstances; some may require continued or close monitoring by

trained or sensitized jail personnel; some cannot be dealt with only by jail personnel, and perhaps may not be successfully dealt with or "treated" by anyone.

(2) There exists a broad range of scientific and experiential information both about: (a) these problem behaviors and conditions; and (b) individual assessment and intervention techniques, service delivery programs, and legal issues that arise in regard to these behaviors and interventions.

(3) That information is, however, rarely systematically focused on jails or their inmates and is rarely available in a systematic fashion so that it can be used to shape and guide the development of service programs by local corrections and mental health administrators and staff who deal with such problems on a regular basis.

Based on the foregoing considerations, the Workshop planning effort consequently emphasized the integration of knowledge from different disciplines and different professions through: (1) the preparation of reviews of existing knowledge (i.e., formal papers); and (2) the creation of a Workshop agenda format that allowed for thorough dialogue among the participants concerning the topics and information covered by the papers. Simultaneously, the Workshop planning group was concerned with the utility and dissemination of the available and critiqued papers. In that regard, the Workshop was viewed as a crucial first step for three different but important dissemination and utilization activities: (1) the publication and distribution of a Workshop Proceedings, thereby making available on a nationwide basis the collective discussions, findings, and recommendations of the participants of the Special National Workshop; (2) the formal and informal follow-on activities of the Workshop participants, either in their own program development roles or their potential to act as

consultants to others who would develop programs; and (3) the development of a topical agenda for the criminal justice and mental health research communities that would, if undertaken, fill existing information gaps.

In all, five major curricula areas were developed, including sessions on (1) the nature of mental health problems in jails; (2) the techniques and processes of assessing and intervening with a variety of individual psychopathologies; (3) legal issues surrounding the provision of mental health services in jails; (4) the nature and operation of a range of existing service delivery programs; and (5) the identification of necessary and recommended research and action in regard to the four foregoing areas. Each of the curricula areas formed the basis for a Workshop session, and at each session the format followed was typically the presentation of a "state-of-the-art" paper, followed by formal, written responses and critiques often involving the perspectives of different professions or disciplines, followed by the convening of small, mixed-occupation groups to thoroughly discuss the issues raised by the authors and commentators and to formulate a set of recommended actions and/or research.

The participation format was the primary reason for limiting the number of particpants. In essence one of the underlying aims of the Workshop was to expand the information base of the existing natural local professional and administrative leadership in the area of mental health services to jails. This strategy derives directly from an opposite view of the nature of information flow and status hierarchy involved in organizational change and innovation discussed at the outset. In contrast to the broad Federal strategy of centralizing basic research capabilities within universities and research agencies, and providing training funds to encourage basic collegiate education for all or most criminal justice personnel, the strategy pursued here with respect to mental health services for jails assumes that there is or has been a diffusion of

knowledge and skills to the local level, and that the essential problem in service development (beyond the ever-present fiscal resources problem) is the lack of a systematic applied framework for the existing and available knowledge and expertise. Consequently, viewing the Special National Workshop as an opportunity to (1) create a highly knowledgeable, multi-profession, multi-discipline-based group of local experts and (2) create a written body of knowledge that such experts could utilize in formal or informal consultative activities and which can be disseminated on a nation-wide basis, seems to be responsive to the essential problem.

If such an approach is valid, then we should expect to see (1) internal consistency between evaluations of utility of content of the Workshop, format used in developing and presenting the information, and anticipation of follow-on use (i.e., engaging in consultative and program development activities at the local level) and (2) some relation between all of these Time 1 (immediate post-Workshop) assessments and a Time 2 assessment of actual participation in desired follow-on activities (assuming of course that motivational and logistical supports remain constant or are reinforced as necessary). Such data have not yet been analyzed with respect to item (1) above, and the required follow-up data for item (2) may not be possible to obtain. Nevertheless, a first look at some of the marginal distributions of two evaluation rating form items make the outlook somewhat promising. These data (not reported in this draft) suggest that there was a widespread sense among participants that (1) the service delivery models aspect of the curricula (i.e., the most locally-based, locally-derived set of information, as well as the one that involved the largest presentation role for locally-based participants) was consistently viewed as the most useful information; and that (2) it was indeed refreshing for local participants to see and experience the interim

results of successful cooperative activity among Federal agencies designed to involve local participants in information-development and dissemination programs.

In conclusion, such a strategy not only may work because of a more accurate assessment of the nature of the innovation problem as being one mainly of knowledge application rather than knowledge-creation; to the extent that it relies on a conscious strategy of maximizing local participation in identifying locally-derived and applied approaches and solutions and effecting communication of these across jurisdictions and professions, the strategy maximizes the use of available information resources and minimizes the cost of starting from scratch with another basic research project that may do nothing more than reinvent the wheel.

References and evaluation data supplied upon request to:

Dr. Christopher S. Dunn
Center for Studies of Crime and Delinquency
National Institute of Mental Health
U. S. Department of Health, Education, and Welfare
5600 Fishers Lane
Rockville, Maryland 20857

national institute of corrections

JAIL CENTER P.O. Box 9130, Boulder, CO 80301 (303) 443-7050
FTS: 323-6786

March 20, 1979

Paul Estaver
LEAA
NILE/CJ
633 Indiana Avenue, N.W.
Washington, DC

Dear Paul:

Enclosed is a copy of our proposed Mental Health Services Training grant for local jails.

If I may be of further assistance, please contact me.

Sincerely,

Paul Katsampes
Correctional Program Specialist

Enclosure

Department of Justice • Bureau of Prisons

FEDERAL ASSISTANCE

1. TYPE OF ACTION (Mark appropriate box): ☐ PREAPPLICATION ☒ APPLICATION ☐ NOTIFICATION OF INTENT (Optl.) ☐ REPORT OF FEDERAL ACTION
2. APPLICANT'S APPLICATION: b. DATE 1979 02 02
3. APPLICATION IDENTIFIER: b. DATE ASSIGNED NA 19
Lease Blank

SECTION I—APPLICANT/RECIPIENT DATA

4. LEGAL APPLICANT/RECIPIENT
a. Applicant Name: Training Associates: Services to the
b. Organization Unit: Criminal Justice System
c. Street/P.O. Box: P.O. Box 4237
d. City: Boulder d. County: Boulder
e. State: Colorado e. ZIP Code: 80306
f. Contact Person (Name & telephone No.): Carole Morgan 303/442-4263

5. FEDERAL EMPLOYER IDENTIFICATION NO.

6. PROGRAM (From Federal Catalog): a. NUMBER b. TITLE

7. TITLE AND DESCRIPTION OF APPLICANT'S PROJECT: Initiating and Improving Mental Health Services in Jails. Project will provide information and understanding for jail mental health teams to solve their specific community's service needs by creating a neutral climate for sharing and action planning.

8. TYPE OF APPLICANT/RECIPIENT (A-State, B-Interstate, C-Regional/District, D-County, E-City, F-School District, G-Special Purpose District, H-Community Action Agency, I-Higher Educational Institution, J-Indian Tribe, K-Other (Specify): non-profit criminal justi research & consulting fi) Enter appropriate letter: K

9. TYPE OF ASSISTANCE (A-Basic Grant, B-Supplemental Grant, C-Loan, D-Insurance, E-Other) Enter appropriate letter(s): A

10. AREA OF PROJECT IMPACT (Names of cities, counties, States, etc.): national

11. ESTIMATED NUMBER OF PERSONS BENEFITING: 150

12. TYPE OF APPLICATION (A-New, B-Renewal, C-Revision, D-Continuation, E-Augmentation) Enter appropriate letter: A

13. PROPOSED FUNDING

a. FEDERAL	$ 74,748 .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ 74,748 .00

14. CONGRESSIONAL DISTRICTS OF: a. APPLICANT 2nd b. PROJECT national

15. TYPE OF CHANGE (For 15a or 12a) (A-Increase Dollars, B-Decrease Dollars, C-Increase Duration, D-Decrease Duration, E-Cancellation, F-Other (Specify):) Enter appropriate letter(s):

16. PROJECT START DATE: 1979 03 01

17. PROJECT DURATION: 12 Months

18. ESTIMATED DATE TO BE SUBMITTED TO FEDERAL AGENCY: 1979 02 02

19. EXISTING FEDERAL IDENTIFICATION NUMBER: NA

20. FEDERAL AGENCY TO RECEIVE REQUEST (Name, City, State, ZIP code): National Institute of Corrections, 320 First St., N.W., Washington, D.C. 20534

21. REMARKS ADDED: ☐ Yes ☒ No

SECTION II—CERTIFICATION

22. THE APPLICANT CERTIFIES THAT ▶ a. To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

b. If required by OMB Circular A-95 this application was submitted, pursuant to instructions therein, to appropriate clearinghouses and all responses are attached:

	No response	Response attached
(1) NA	☐	☐
(2)	☐	☐
(3)	☐	☐

23. CERTIFYING REPRESENTATIVE: a. TYPED NAME AND TITLE: Frank Dell'Apa, President b. SIGNATURE c. DATE SIGNED: 19 79 02 02

SECTION III—FEDERAL AGENCY ACTION

24. AGENCY NAME: Department of Justice
25. APPLICATION RECEIVED: 19
26. ORGANIZATIONAL UNIT: National Institute of Corrections
27. ADMINISTRATIVE OFFICE: Bureau of Prisons
28. FEDERAL APPLICATION IDENTIFICATION
29. ADDRESS: 320 First St., N.W., Washington, D. C. 20534
30. FEDERAL GRANT IDENTIFICATION
31. ACTION TAKEN: ☐ a. AWARDED ☐ b. REJECTED ☐ c. RETURNED FOR AMENDMENT ☐ d. DEFERRED ☐ e. WITHDRAWN
32. FUNDING

a. FEDERAL	$ .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ .00

33. ACTION DATE ▶ 19
34. STARTING DATE 19
35. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)
36. ENDING DATE 19
37. REMARKS ADDED: ☐ Yes ☐ No
38. FEDERAL AGENCY A-95 ACTION: a. In taking above action, any comments received from clearinghouses were considered. If agency response is due under provisions of Part I, OMB Circular A-95, it has been or is being made.
b. FEDERAL AGENCY A-95 OFFICIAL (Name and telephone no.)

STANDARD FORM 424 PAGE 1 (10-75)
Prescribed by GSA, Federal Management Circular 74-7

SUMMARY

This project will provide four three-day regionally distributed training sessions for 50 teams composed of key representatives of the jail, mental health system and county commissions from each participating jurisdiction.

The project will assume two roles--1) serving as a neutral convener to develop a climate of understanding and sharing, and 2) providing information and understanding which will result in specific solutions for provision of adequate mental health in jail services in the communities represented.

Sessions will incorporate the provision of knowledge, information, and data required to design mental health service delivery in jails and planning teams to implement the designs. An adult education approach will be used to insure increased knowledge and awareness, coupled with skill development.

Project resources will be committed to monitor and provide follow-up referrals or technical assistance to insure implementation of design strategies planned at the training sessions.

The project will also develop a catalog of resources and materials that are available in the literature, on site, and in various programs. This will include materials, operations, and specialist consultants. Catalogs of resources will be available on request.

OBJECTIVES AND NEED FOR ASSISTANCE

Recent court decisions,[1] along with newly established detention standards and an enlightened and concerned body of jail administrators, have given top priority to the need for mental health services in jails. Because of the recent "patient's rights" movement within mental health, which includes the right to refuse treatment and stricter standards for involuntary admissions to psychiatric hospitals, more and more mentally ill individuals remain in the community. Their disturbing behavior is highly visible and is not tolerated by a fearful public which increasingly demands justice system intervention. The result is that the jail now houses many more individuals who are clearly psychotic or, at least, manifest episodic bizarre behavior.

It is estimated that anywhere from 1½ million to 5½ million persons annually pass through the nearly 4,000 jails in the United States. Mental health authorities report that in the general population 15% of the citizenry are mentally ill, disturbed or disordered, and that 10% are in need of immediate professional help. The implication for the jail is that its population is likely apt to reflect an exaggeration of these already startling figures.

Recognition of this growing problem and the need for identifying and integrating existing knowledge was demonstrated by the Special National Workshop on Mental Health Services in Local Jails, in September 1978,

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[1] BOWRING v. GODWIN, 551 F 2d 44 (4th Cir 1977); FINNEY v. HUTTO, 410 F Supp 251 (E.D. Ark 1976); O'BRYAN v. COUNTY OF SAGINAW, 437 F Supp 582 (E.D. Mich 1977); hold that mental health needs are an extension of medical treatment and as such must be considered to be part of the inmate's "fundamental right to care" constitutionally mandated.

a cooperative effort of the National Institute of Mental Health (NIMH), the Law Enforcement Assistance Administration (LEAA), and the National Institute of Corrections (NIC). The workshop survey report[2] describing the problem and paucity of known mental health - jail programs is attached.

While statistical data does not provide a high level of preciseness, nevertheless, responses compiled for this national survey emphatically support the estimates that there are minimally three-fourths million mentally ill, disturbed or disordered persons in jail. These estimates suggest that at least 5% are psychotic and in some jurisdictions, up to 75% of the incarcerated population need mental health services.

Although there has been a recent concern displayed on the local and federal level by mental health and criminal justice representatives over the lack of care available to many of these persons, each discipline has traditionally ignored or shunted the blame for the deficiencies to the other.

The inevitable result has been judicial intervention and the interpretation that jail conditions in themselves could create a need for mental health - jail services, and the failure to provide such services was a violation of the inmate's constitutional rights.[3]

Since the courts refusal to accept jailer excuses of limited staff, money, or resources and the trend toward public rejection of increased

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[2] Carole Morgan, Service Delivery Models (Colorado, 1978).

[3] For example, GATES v. COLLIER, 501 F 2d 1291 (5th Cir 1974) held that jail conditions were so barbarous that they contributed to cruel and unusual mental health treatment; O'BRYAN v. SAGINAW, 437 F Supp. 582 (Mich 1978) cited the totality of conditions and jail operations threatened the sanity of inmates and violated due process; and WILKINS v. GODWIN, F Supp 22 Crim L Rptr 2173 (W.D. Va 1977) held that the totality of conditions and failure to provide services violated 8th and other amendments.

spending are expected to continue, it seems only reasonable that the jails must collaborate with the existing mental health systems to fulfill the courts' service provision mandates.

Furthermore, there is a sound logic in seeking help from the mental health system which has had experience and a demonstrated competence in caring for the mentally ill. A successful mutuality of roles among jailers and mental health providers results when the jailer is able to do what he/she does best, namely to insure for institutional/inmate safety and security and the mental health professional concentrates on offering the necessary individualized care.

Historically, this division of responsibility has not been achieved because of the schism between jailers and mental health representatives bordering on antagonism. A lack of communication and unwillingness to cooperate between the two professions is widespread. Inaccurate perceptions of responsibilities, mistaken notions of respective roles and incident distortions have created a formidable barrier between these systems.

Since jails are mandated to make services available to the mentally ill, disturbed or disordered, and the community mental health agencies offer the services required, it is only a matter of bringing the key leader and decision maker of these two systems together to confront the problem and devise a specific strategy to solve it.

This situation can be overcome with dialogue among the parties which seek to develop a mutual interest and commitment to solving a shared problem.

This project will serve as a neutral convener to develop a climate of sharing and understanding that will:

1. increase the level of awareness and knowledge regarding the extent and nature of the problem by those directly responsible and involved in each jurisdiction;
2. achieve a shared acceptance of responsibility and commitment to achieve a solution by each participant;
3. devise an action strategy for each jurisdiction to insure provision of required mental health - jail services in accord with constitutional and humane requirements.

RESULTS OR BENEFITS EXPECTED

This project will provide four regional training sessions of 3-days duration for key leaders and decision makers representing the jail, the mental health system and significant others who will take on the responsibility of designing strategies and implementing these strategies for delivery of mental health services to inmates in jail. A minimum of 50 jurisdictions with three to four representatives, totaling 150 people will be involved in this national effort.

Training will consist of the provision of knowledge, information and skill to design and develop tailored strategies for delivery of service by "teams" which consist of representatives of jails, mental health, and significant others. Training will focus on:

Defining the Problem

-- Awareness and understanding of the problem in terms of need, requirements, and effect.

Planning to Solve the Problem

-- Skill in planning and team work to design intersystem cooperative efforts.

Designing the Strategies

-- Mutual design of a plan which incorporates responsibility and specified tasks/roles of each.

Post-training activities will focus on assisting each jurisdiction to implement its plan by provision of technical assistance, information, and other means.

APPROACH

This project will consist of four phases:

Phase I - Design of Training Module

- Announce and post the training opportunity.
- Select training sites.
- Select "team" participants.
- Synthesize available information into a 3-day module.
- Refine a syllabus.
- Finalize materials, instruments, and approach.

Phase II - Deliver Training (4 regional sessions, 3 days each)

- First session - Linking mental health and jail systems to initiate/improve mental health - jail services.
- Second session - Linking mental health and jail systems to initiate/improve mental health - jail services.
- Third session - Linking mental health and jail systems to initiate/improve mental health - jail services.

- Fourth session - Linking mental health and jail systems to initiate/improve mental health - jail services.

Phase III - Activities Review and Assistance

Coordinate follow-up technical assistance to jurisdictions involved in the session and monitor activities instigated by the project.

Phase IV - Assemble Deliverables

Printed document which will provide information to assist practitioners with the design development and implementation of mental health service programs in jails.

-- Final Project Report

Design of Training Module

- Announce/Post: Use of film produced as part of the Special National Workshop sent to regional resource jail centers to stimulate interest within geographic area.
- Participant "team" selection will be based upon the following:
  - -- the expressed interest in mental health - jail programming demonstrated by a mental health care provider, jail manager and significant community representative (elected commissioner or involved supportive agency administrator) from each jurisdiction.
  - -- the individual expressing interest must hold a representative position with the managerial decision-making ability to establish and implement systemwide policies/procedures.
  - -- commitment to attend a training session from at least two of the three community representatives will be required to constitute a "team" invited to participate.

Each jurisdiction will be responsible for providing the travel costs for its team representatives.

In some cases a stipend from the project will be made available to one or more of the team members if an interest has been proven and a need can be evidenced by the requesting community.

- Training sites selected whenever possible at exemplary mental health - jail program sites.
- Focal point of sessions will be the development of an action agenda by each team. See attached "Action Planning." Every trainee will leave the session with knowledge of mental health constitutional mandates and detention standards for jails and with better communication/management skills to implement a strategy for increasing mental health service for the inmate.

A pre-training questionnaire will seek information from each participant in the following core questions:

1. What mental health - jail services are available?
2. What are the administrators' concerns about moving toward providing services?
3. What specifically is needed in terms of knowledge, information and skills to comply with mandated services?

Deliver Training

Training will consist of communication/management and substantive operational material components.

Introduction lecturette

Readings - audio-visual aids

Exercises/instruments

Bibliography/ resources

- Communications/management to facilitate dialogue and encourage intersystem approach to problem resolution.
- Skills to design action agenda.
- Substantive material on legal and social responsibilities to provide mental health - jail services and operational model service delivery programs as alternative systems.

DAY 1	Registration	• Communications
	Preliminaries	• Role perception checking
	Introductions	• Team development
	Expectations	• Planning interagency cooperative efforts
		• Resource development
DAY 2		• Legal/social mandates
		• Standards
		• Service delivery models
DAY 3		• Action agendas

Activities Review and Assistance

Monitor: 60-90 day review of program progress (implementation of agendas) and problems.

Follow-up technical assistance will be provided in terms of making materials and regional resource referrals and project staff technical assistance to selected participating sites.

An on-going evaluation will be developed in-house to assist in designing and adjusting the training module for maximum impact. The project will be evaluated on the basis of demonstrable increases in program development by jurisdiction involved in the training. NIC Jail Center evaluation capability will be used for the development of instruments and data gathering.

Assemble Deliverables

A catalog consisting of an inventory of relevant legal decisions, standards, programs, materials and resources will be compiled on a state-by-state basis. The format will be designed for the highest level of usefulness.

The alternative methods for developing service delivery programs, including the problems and considered degree of success, which result from the project will be cataloged.

Information will be collected directly from the NIC Jail Center Resource Information Center (including the workshop national survey data), through a telephone grapevine, and by methods to be developed. Additional factors which will facilitate this data collection are:

- Training Associates location in Boulder, which allows linkage to other NIC projects holding training in Boulder
- Jail Center staff
- Project Director's previous national efforts and association with jail and mental health practitioners

The objective of the catalog is to provide wide access for beginning programs to link with available and developing programs, materials, and resources.

PROJECTED TIMETABLE

	MONTHS 1	2	3	4	5	6	7	8	9	10	11	12
STEP 1												
DESIGN OF TRAINING MODULE												
Design, distribute brochure and film	---											
Recruit and select participants		----------										
Develop preliminary module	---											
Refine syllabus		---										
Finalize modules, instruments and approach			----									
STEP 2												
DELIVER TRAINING												
1st Regional Session				---								
2nd Regional Session					---							
3rd Regional Session						---						
4th Regional Session							---					
STEP 3												
COORDINATE FOLLOW-UP ASSISTANCE AND MONITOR PROGRESS												
Provide project technical assistance							----------					
Secure NIC JC technical assistance							- - - - - - - -					
Monitor activities											----------	
STEP 4												
DELIVERABLES												
Printed document linking mental health and jail systems to initiate/improve mental health - jail services											---	
Final Report											---	

EVALUATION

Cognitive, attitudinal and process data will be obtained on a pre- and post- basis at each session. A special instrument will be designed geared to this project.

Behavioral changes will be measured by "action agendas" which ask the participants for specific action commitments after they return home, detailing "who, what, when, and where."

RESOURCES

Work accomplished in the 1978-79 WICHE/NIC Jail Training Project in the area of medical/mental health will be the basis for the design and development of training.

Staff for the project will include the Project Director, Carole Morgan,* a Training/Curriculum Specialist, and a secretary. Position descriptions are seen in the budget narrative. The Project Director has invested a substantial effort over the past 12 months in the collection/collation of available materials and the identification of services and resources in this area. An example of the degree and nature of the effort is seen in the attached document. (See attached Service Delivery Models.)

Other resource persons will include WICHE/NIC Jail Training project staff, consultants and faculty who have a demonstrated record of achievement in jailer training or who have shown competence in the management of a mental health - jail program. Additional resource practitioners will be included for the training sessions within their respective regions.

The program will be domiciled in the WICHE Building offices, from which organization accounting, printing, library and related services will be available. Because WICHE cannot accept this activity under its charter, the project will be accepted by Training Associates, a consortium of consultants who provide services to the criminal justice system. Training Associates is a non-profit Colorado organization.

* See attached vita.

REGION I WORKSHOP

COMMUNITY MENTAL HEALTH AND THE JUSTICE SYSTEM:
SOME KEY ISSUES AND DEVELOPMENTS

September 25-26, 1978

September 24

6:00 P.M.	Registration Meeting of Workshop Planning Group and Resource Persons
7:00 P.M.	Social Hour and Cash Bar

September 25

8:00 A.M.	Breakfast
8:30 - 9:00 A.M.	Registration
9:00 A.M.	Welcoming Remarks - T. Leon Nicks, Ph.D. Director, Division of Alcoholism, Drug Abuse, and Mental Health Programs DHEW Region I Boston, Massachusetts
	- Gary E. Miller, M.D. Director, New Hampshire Department of Mental Health Concord, New Hampshire
	Conference Plan - Saleem A. Shah, Ph.D. Chief, Center for Studies of Crime and Delinquency National Institute of Mental Health Rockville, Maryland
9:15 A.M.	Plenary Session:
	Chairperson - Eric A. Plaut, M.D. Commissioner, Connecticut Department of Mental Health Hartford, Connecticut
	"Recent Developments in Mental Health Law" Prof. Alexander Brooks, Rutgers University Law School
10:00 A.M.	Questions and Discussion

September 25 (Continued)

10:15 A.M. Panel Discussion:

(1) Alan W. Cook, J.D.
District Judge, Superior Court
Northfield, Vermont

(2) Gary E. Miller, M.D.
Director, New Hampshire Department of Mental Health
Concord, New Hampshire

(3) Michael A. Peszke, M.D.
University of Connecticut Health Center
Farmington, Connecticut

(4) Stephen Schwartz, J.D.
Attorney, Northampton State Hospital
Northampton, Massachusetts

11:15 A.M. Coffee Break

11:30 A.M. Small Group Discussion*

12:30 P.M. Lunch

2:00 P.M. Plenary Session:

Chairperson - Thomas D. Rath, J.D.
Attorney General, State of New Hampshire
Concord, New Hampshire

"Recent Developments in Juvenile Law and Policy"
Prof. Donald Dickson, Rutgers University, School of Social Work

2:45 P.M. Questions and Discussion

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* The Small Groups will bring up issues, problems and developments in their states and localities pertaining to mental health law and will address related implications for CMHCs and justice system interactions. The membership of these groups will remain constant throughout the workshop in order to facilitate continuity of discussion, with the exception of the resource persons who may rotate among the groups.

September 25 (Continued)

3:00 P.M. Panel Discussion:

(1) Jack Lightfoot
Child and Family Services
Manchester, New Hampshire

(2) Thomas Perras
Director, Juvenile Services Project
Montpelier, Vermont

(3) George Zitnay, M.D.
Commissioner, Maine Department of Mental Health and Corrections
Augusta, Maine

(4) Edward V. Healy, J.D.
Associate Justice, Family Court of Rhode Island
West Warwick, Rhode Island

4:00 P.M. Coffee Break

4:15 P.M. Small Group Discussion

5:30 P.M. Adjourn

(Planning session for the second day -- involving NIMH and RO staff, resource persons, small group leaders and rapporteurs)

6:00 P.M. Dutch Treat Cocktail Hour

7:00 P.M. Dinner

September 26

8:00 A.M. Breakfast

9:00 A.M. Plenary Session:

Chairperson - John Ambrose, J.D.
President-Elect, National Council of Community Mental Health Centers
Washington, D.C.

"Developing CMHC and Justice System Interactions"
Dr. Robert L. Sadoff, Clinical Associate Professor of Psychiatry, University of Pennsylvania

September 26 (Continued)

9:45 A.M. Questions and Discussion

10:00 A.M. Panel Discussion:

(1) Joseph Bevilacqua, Ph.D.
Director, Rhode Island Department of Mental Health, Retardation and Hospitals
Cranston, Rhode Island

(2) Louis E. Kopolow, M.D.
Division of Mental Health Services Programs
National Institute of Mental Health
Rockville, Maryland

(3) Paul Lipsitt, Ph.D., J.D.
Erich Lindemann Mental Health Center
Boston, Massachusetts

(4) Roger Straus, Ll.B., Ph.D.
Director, Washington County Mental Health Services
Montpelier, Vermont

(5) Joseph Souza
Probation Officer, Third District Court
New Bedford, Massachusetts

11:00 A.M. Coffee Break

11:15 A.M. Small Group Discussion

12:45 P.M. Lunch

(Small Group rapporteurs meet with Resource Persons and NIMH and RO staff)

2:00 P.M. Plenary Session:

Chairperson - Richard Surles, Ph.D.
Commissioner, Vermont Department of Mental Health
Montpelier, Vermont

Reports from Small Groups

September 26 (Continued)

2:45 P.M. "The Workshop in Retrospect: Some Major Themes, Concerns, and Next Steps"
Dr. Saleem A. Shah, Chief, Center for Studies of Crime and Delinquency, NIMH

3:15 P.M. Panel: Brief Comments from Resource Persons (Brooks, Dickson and Sadoff)

3:30 P.M. General Discussion

4:00 P.M. Closing Remarks - Dr. Leon Nicks

ADJOURN

Small Groups

Group I

Group Leader/Moderator	- Lawrence Osborn, M.D. DHEW, Region I
Resource Person	- Professor Alexander Brooks
Local Resource Person	- Michael A. Peszke, M.D.
Rapporteur	- Dr. Diana Weidenbacker Central New Hampshire CMHC Concord, New Hampshire

Group II

Group Leader/Moderator	- Roger Straus, Ll.B., Ph.D. Director, Washington County Mental Health Services Montpelier, Vermont
Resource Person	- Donald T. Dickson, Ph.D., J.D. Associate Professor, Graduate School of Social Work Rutgers University New Brunswick, New Jersey
Local Resource Person	- Paul Lipsitt, Ph.D., J.D. Erich Lindemann Mental Health Center Boston, Massachusetts
Rapporteur	- Jackie Jenkins Roxbury Court Clinic Roxbury, Massachusetts

Group III

Group Leader/Moderator	- Dr. Nicholas Verven Greater Manchester Mental Health Center Manchester, New Hampshire
Resource Person	- Robert L. Sadoff, M.D. Clinical Associate Professor of Psychiatry University of Pennsylvania Philadelphia, Pennsylvania

Small Groups
(Continued)

Group III (Continued)

Local Resource Person	- Bjorn Lange, J.D. New Hampshire Legal Assistance Concord, New Hampshire
Rapporteur	- Paul Applebaum, M.D. Massachusetts Mental Health Center Boston, Massachusetts

Group IV

Group Leader/Moderator	- Ron Andrews Deputy Director, Department of Mental Health Concord, New Hampshire
Resource Person	- Saleem A. Shah, Ph.D. Chief, Center for Studies of Crime and Delinquency NIMH, Rockville, Maryland
Local Resource Person	- Gene Balcanoff, M.D. Suffolk County Superior Court Clinic Boston, Massachusetts
Rapporteur	- Dr. William Stableford Franklin Grand Isle Mental Health Services St. Albans, Vermont

Small Group Assignments

Group I

Dr. Joseph Bevilacqua
Ms. Diane Blake
Prof. Alexander Brooks
Dr. Philip Gibeau
Judge Edward Healy
Ms. Dorothy King
Dr. Stuart Meyers
Dr. Lawrence Osborn
Dr. Michael Peszke
Dr. Eric Plaut
Ms. Jean Ratner
Mr. Karl Schnecker
Mr. Herman Stegeman
Dr. Diana Weidenbacker
Ms. Jo Ann Wright

Group II

Dr. Willard Bredenberg
Mr. John Borus
Prof. Donald Dickson
Ms. Delores Goode
Ms. Jackie Jenkins
Dr. Brian Joseph
Mr. Jack Lightfoot
Dr. Paul Lipsitt
Dr. Gary Miller
Dr. Leon Nicks
Dr. Carlos Santiago
Mr. Stephen Schwartz
Dr. Robert Simmons
Dr. Roger Straus
Mr. Paul Tausek
Mr. Ecford Voit

Group III

Dr. Paul Appelbaum
Mr. Joseph Dorflinger
Dr. Francis Hersey
Dr. Louis Kopolow
Mr. Bjorn Lange
Mr. James O'Connor
Mr. Thomas Perras
Ms. Kathleen Quinlan
Mr. Thomas Rath
Dr. Robert Sadoff
Mr. Charles Shur
Mr. Morris Smith
Dr. Nicholas Verven
Mr. John Weaver
Ms. Chase Wittenberger
Dr. George Zitnay

Group IV

Mr. John Ambrose
Mr. Ron Andrews
Dr. Gene Balcanoff
Judge Alan Cook
Mr. Lanse Crane
Ms. Edward Healy
Dr. Michael Ingall
Dr. Henry Payson
Dr. Anthony Raynes
Ms. Mitzi Reynolds
Dr. Saleem Shah
Mr. Joseph Souza
Dr. William Stableford
Dr. Richard Surles
Mr. Bill Wright

National Coalition for Jail Reform
NEWS RELEASE

1735 New York Avenue N.W., Washington, D.C. 20006 • Telephone 202/785-9577

For Immediate Release

Contact: Judith Johnson

JAIL REFORM COALITION ORGANIZED BY MORE THAN 40 NATIONAL GROUPS

WASHINGTON, D.C.--People who don't belong in jail, and jail conditions that aren't suitable for people, were the concerns that impelled representatives from more than 40 national organizations to establish the National Coalition for Jail Reform.

Meeting recently at Harpers Ferry, West Virginia, representatives from such groups as the American Bar Association, the American Correctional Association, the National Association of Counties, the National Council on Crime and Delinquency, the National League of Cities, the National Governors Association, and the National Sheriffs Association formed the first broad based alliance in the criminal justice field. Within the next three months, the representatives will ask their organizations to formally approve membership in the coalition.

According to the 1970 U.S. census, 52 percent of the people in jail have never been convicted of any crime; most are awaiting trial. The F.B.I. Uniform Crime Reports show that alcohol offenses are the most common reasons people are arrested. One out of seven arrests is for public drunkenness. Most people in jail have not committed any violent crime.

Due to these statistics, the National Coalition for Jail Reform contended at the Harpers Ferry meeting, that inappropriate confinement and universally decried conditions in our nation's jails detract from, rather than enhance, public safety.

The coalition agreed that there are serious problems in our local and county jails. Many groups have been working on this problem, but lacking close coordination with other groups, their efforts have been largely ineffective.

The National Coalition was formed to mount a systematic and unified attack to eliminate inappropriate confinement and inappropriate conditions. Each of these national organizations will be working together with their state and local affiliates

and the local community to resolve these problems.

At the meeting, coalition members approved a statement outlining the philosophy and objectives of the coalition. According to the mission statement, "By alleviating the lamentable conditions in jails, providing just and effective sanctions against criminal behavior, and removing from jails those people who are inappropriately confined, the coalition hopes to reduce the growing financial burden of jail confinement on taxpayers and provide a greater degree of public safety."

In preparation for a conference next April, designed specifically to deal with the elimination of inappropriate confinement, committees will be directed to examine which target groups and the offenses for which they are confined are inappropriate.

After these target groups are identified, alternatives to confinement and decriminalization of certain offenses will be discussed and then strategies for implementation of appropriate alternatives will be developed. The representatives of these national organizations will jointly develop policies, action models, strategies and constituencies to bring about change.

The coalition believes that the problems of the jails are, after all, the problems of the community. Success, they explain, will be much greater with this wide range of groups working together to improve our jails.

Efforts to form a National Coalition for Jail Reform began at a meeting last February at the Johnson Foundation's Wingspread Conference Center in Racine, Wisconsin. The group met again in May in Minneapolis, where the framework for the coalition was developed. Facilitation for the coalition is being provided by the American Arbitration Association.

The organizations working within the coalition are: American Arbitration Association, American Bar Association, American Civil Liberties Union, American Correctional Association, American Institute of Architects, American Medical Association, American Public Health Association, Association of State Correctional Administrators, Benedict Center for Criminal Justice, Commission on Accreditation for Corrections, Committee for Public

Justice, Correctional Economics Center, Council of State Governments, Edna McConnell Clark Foundation, Fortune Society, International City Management Association, Interreligious Task Force on Criminal Justice, John Howard Association, Law Enforcement Assistance Administration of the U.S. Department of Justice, National Association of Blacks in Criminal Justice, National Association of Counties, National Association of Criminal Justice Planning Directors, National Center for State Courts, National Clearinghouse for Criminal Justice Planning and Architecture, National Conference of State Criminal Justice Planning Administrators, National Conference of State Legislators, National Council on Crime and Delinquency, National District Attorneys Association, National Governors Association, National Institute of Corrections of the U.S. Department of Justice, National Jail Association, National Jail Managers Association, National League of Cities, National Legal Aid and Defender Association, National Moratorium on Prison Construction, National Sheriffs' Association, National Street Law Institute, National Urban League, North Shore Unitarian Veatch Program, Offender Aid and Restoration of the United States, Pretrial Services Resource Center, Southern Coalition on Jails and Prisons, Unitarian Universalist Service Committee, United States Conference of Mayors.

NATIONAL COALITION FOR JAIL REFORM

Fact Sheet on Jails in the United States

From the 1970 U.S. Census Report

Only 43% of those in jails are serving a sentance. The majority of people in jail have been convicted of no crime; most are awaitingtrial and can't afford bail.

1 out of 4 jails has no visiting facilities.

47 jails have no operating flush toilet.

2 out of 3 juveniles held in adult jails have not been convicted of a crime.

86% of the jails in counties or cities over 25,000 have no facilities for exercise or recreation.

9 out of 10 jails have no educational facilities.

From the National Institute of Corrections, Jail Study-1972

25% of the jails are over 50 years old.

Only 25% of jail inmates have graduated from high school.

One half of them earned less than $2000 the previous year.

25% of the jail inmates cannot read or write.

There were 141,600 people in jail on the day of the survey.

42% of the inmates are Black.

25% of the jail population is between the ages of 21 and 24.

From the U.S. Department of Justice, Law Enforcement Assistance Administration Source Book of Criminal Justice Statistics, 1977.

There are 3,921 local jails.

More people are arrested for drunkenness than for any other offense in the nation (1 out of 7 arrests).

More than 1 out of 3 arrests in the U.S. is for drunkenness, drunk driving, disorderly conduct or vagrancy.

From The American Jail in Transition, Proceedings of the Second National Assembly on the Jail Crisis, 1978

America's 4000 local jails receive approximately 5 million persons every year. (This means that jails handle 25 times the number of people handled by all state and federal prisons.)

6789

National Coalition for Jail Reform

1730 Rhode Island Avenue, N.W., Washington, D.C. 20036 • Telephone 202/296-8630

April 2, 1979

Chris Dunn
Center for Studies of Crime
and Delinquency
National Institutes of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

Dear Chris:

Enclosed please find some information concerning the National Coalition for Jail Reform. The coalition is the first broad-based coalition in the criminal justice field. It has two focuses--inappropriate confinement and inappropriate conditions. At the moment, it is targeting groups that are inappropriately confined in jail and developing strategies and alternatives to remove these groups from jails.

For your information and use, enclosed is a press release and a copy of our mission statement. Also enclosed is a fact sheet on jails in the United States.

Later this month is a conference where we plan to delve much deeper into our target groups (public inebriate, mentally ill/mentally retarded, juveniles) and develop strategies to focus on the jail situation. If you would like any other information, or if I can help you with further questions, please feel free to contact me.

Sincerely,

Judith

Judith Johnson
Executive Director

3 Enclosures

P.S. Many thanks for all the things you sent - they just arrived.

MISSION STATEMENT
FOR THE
NATIONAL COALITION ON JAIL REFORM

For more than a decade it has been acknowledged that there are serious deficiencies in the American criminal justice system. In no area do these pervasive problems appear more severe than in local and county jails, through which most individuals enter the criminal justice system. The National Coalition for Jail Reform contends that inappropriate confinement and universally decried conditions in our nation's jails detract from rather than enhance public safety.

The reform efforts of a great number of individuals and organizations, including governmental agencies and public interest groups, have been ineffective. Contributing to this failure has been a lack of consensus on reform goals and of public support for them. It is urgent that we begin a coordinated effort to surmount these problems.

No workable criteria for determining which persons should be confined in our jails presently exist. Until such criteria have been determined, we believe we can more productively identify those persons and behaviors for which confinement is not justified. Stopping unwarranted confinement will also make achievement of safe and humane conditions within jails more probable.

By alleviating the lamentable conditions in jails, providing just and effective sanctions against criminal behavior, and removing from jails those people who are inappropriately confined, the Coalition hopes to reduce the growing financial burden of jail confinement on taxpayers and provide a greater degree of public safety.

The members of the Coalition subscribe to the following:

- The Coalition supports the elimination of inappropriate confinement. This should be accomplished by imposing constraints on the criminal justice system, such as prohibiting the incarceration of certain groups of people. Additionally, persons who have engaged in certain behaviors customarily treated as offenses should not be dealt with through the criminal justice system.

- The Coalition believes that even when authority exists to confine an individual, the authority should be exercised sparingly and the decision to do so should be made thoughtfully and carefully. This objective will be more easily obtained as sound alternatives to confinement are developed, refined and implemented.

- The Coalition believes that the development and enforcement of sound standards are necessary prerequisites to the improvement of jail conditions. These standards must deal with the physical aspects of the jail, identification of an appropriate jail population, and the jail's social environment, services, personnel, management and administration.

- The Coalition believes an absence of public concern for and involvement with jails has contributed substantially to the evolution of the situation we seek to remedy. Public awareness of the present jail situation must be heightened and citizen support for jail reform efforts increased.

- The Coalition recognizes that the problems of the jails are the problems of the community. Successful remedial efforts will require the involvement of a wide variety of community groups and governmental agencies. Effective cooperation between the public and private sectors and among all levels of government is long overdue.

To achieve the Coalition's principles, members jointly will develop policies, action models, strategies and constituencies to bring about change in two basic areas: inappropriate confinement of many persons and inappropriate conditions in many jails. Our action models and strategies will require identifying jurisdictions and decision makers receptive to change, groups for additional Coalition participation, specific alternatives to existing procedures, incentives to change, and methods of public education.

The Coalition asks that all those who are dedicated to these principles join hands in a national effort for jail reform. It is only through reform that the jail will contribute positively to the solution of our criminal justice problems.

END