Management of Special Populations: Mentally Disabled Offenders (92-IJ-CX-K020)

FINAL REPORT

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EXECUTIVE SUMMARY

Background

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

Our research strategy, designed to address these issues, involved three phases: (1) a nationwide mail survey to a random sampling of all U.S. jails to determine the percentage of detainees receiving mental health services, the particular services available to these detainees, and the self-rated effectiveness of the jail's mental health services; (2) a follow-up telephone survey to a stratified sample of 100 of the mail survey respondents who had assessed their mental health services as "very effective"; and (3) 10 jail site visits during the final phase of the study.

Findings

Although there are numerous barriers to providing treatment for mentally disabled offenders in our nation's jails, we found that many jails have designed and implemented innovative programs and policies to maximize care to this group using the limited resources available. In all, we examined 49 program elements over the ten sites. For the purposes of this report, we have divided the observed innovative programs and policies into the following core areas: (1) screening, evaluation and classification procedures, (2) crisis intervention and short-term treatment practices, (3) discharge planning mechanisms, (4) court liaison mechanisms, (5) diversion practices, and (6) contracting procedures.

1. Screening, Evaluation and Classification Procedures

A critical first step in the identification of detainees with mental health treatment needs is the initial screening and assessment upon booking into the jail. The most thorough and cost-effective mental health screening process, models of which we found in eight of the ten jails that we visited, is a multi-tiered evaluation process. Although this type of screening should be a matter of routine in large jails, and therefore would not be considered an innovative procedure, we did find a particularly good example of multi-tiered screening at the Summit County Jail in Akron, OH.

Inmate classification--ensuring an appropriate housing assignment--is another important area of initial identification and assessment and is a continuation of the screening process. In the Jefferson County Jail in Louisville, Kentucky, a mental health professional is involved in the classification decisions to ensure appropriate housing for those detainees with mental health

treatment needs. In the Fairfax County Jail in Fairfax, VA, deputies in classification are trained in jail mental health issues and there is a classification committee which includes mental health representatives.

2. Crisis Intervention and Short-Term Treatment Practices

Treatment policies made up the bulk of the innovative policies and procedures that we observed during the course of this study. For example, due to relatively short terms of incarceration, case management is an important concept for jails in terms of continuity of care and proper discharge planning. At the Hampshire County Jail in Northampton, MA, every inmate in the jail, regardless of the presence of mental illness, is assigned a case manager who works with him or her from intake through discharge planning.

In addition to case management sevices, the need for crisis intervention in the jail setting is quite clear. The Summit County Jail in Akron, OH reports that having a "Crisis Intervention Specialist" as part of the jail's staff enables them to speed up the classification process for the mentally ill and to more effectively bring the mental illness to the attention of the mental health staff. In the Jefferson County Jail in Louisville, KY, the "Crisis Intervention Team" receives referrals from the corrections staff and helps the detainees cope through the development of problem solving skills. A technician, who is specially trained to intervene in crisis situations, serves as the "Crisis Intervention Specialist" for the Shelby County Jail in Memphis, TN. This specialist works closely with the jail's psychiatrist to provide a variety of mental health services.

Probably one of the more common "crises" that jails face in their day-to-day operations are inmate suicides and/or threats of suicide. In the Jefferson County Jail in Louisville, KY, there is an innovative policy designed to deal with this issue, called the "Inmate Suicide Watch Program." In this program, inmate volunteers assist correctional officers in monitoring all inmates for suicide potential.

3. Discharge Planning Mechanisms

Consistent with what we found a decade ago in a study of 42 jail mental health programs, the weakest part of all jail programs for mentally disordered detainees is discharge planning. Most of the programs we visited offer referrals upon release, but are not aggressive and include little or no follow-up. There were a couple of exceptions, however. The Fairfax County (VA) Jail is special in that it not only links detainees with mental health related services upon release, but it also concentrates on maintaining the detainee's family ties while incarcerated. In the Hillsborough County Jail in Tampa, FL, most of the discharge planning is handled by two social workers who set up appointments, make other arrangements for housing, etc. and--most importantly--follow up to make sure the appointments are kept.

4. Court Liaison Mechanisms

The interdependence of the jail and the court is particularly relevant for the mentally disabled offender. All of the sites visited had developed relatively routinized means for ad hoc interactions with the courts to respond to the special needs of mentally disabled offenders.

Furthermore, several had developed specific programs--each one different from the other-- to facilitate interactions between the jails and local courts concerning this inmate population.

One such program is the "Forensic Clinic" at the Hampshire County jail in Northampton, MA. The staff of this program includes a Court Clinic Coordinator, a licensed social worker, who works to establish and maintain necessary lines of communication and cooperation between correctional line staff, the case managers, and the forensic mental health staff.

In the Pinellas County Jail in Clearwater, FL, a "Court Liaison" goes into the jail to identify likely candidates for civil commitment as an alternative to the criminal justice track and follws the case through the courts to final disposition.

In Shelby County (Memphis), TN, a multi-agency memorandum of understanding was drawn up so that each of the signing agencies agreed to appoint contact persons to act as liaisons with all other service agencies and providers. Among the agencies involved in this cooperative agreement are pretrial srvices and the public defender's office.

The "Jail Review Program" in Fairfax, VA, is unique in that it is built into the screening process and is provided by magistrates in the jail who work with Pretrial Services staff on a 24-hour basis to make the initial decision on whether the defendants should be in or out of jail.

5. Diversion Practices

Currently, one of the most popular suggestions for responding to persons with mental illnesses in jails is to divert them from jail to appropriate community-based mental health programs. We found excellent examples of both pre- and post-booking programs. One example of a pre-booking diversion program involved the establishment, in Hillsborough County, FL, of a "Crisis Center" to which police could bring offenders instead of to the jail. A second example of a pre-booking diversion program is a mobile crisis unit in Fairfax County, VA. Among other duties, the team gathers background information on persons with mental illness and makes the necessary arrangements for care as an alternative to incarceration. An excelent example of a comprehensive post-booking program was found in Jefferson County (Louisville), KY. Its purpose is to provide community-based mental health services as an alternative to incarceration for chronically mentally ill adjudicated offenders.

6. Contracting Procedures

One of the most commonly mentioned problems facing U.S. jails with regard to mentally disordered detainees is the lack of adequate resources and staff. Several sites had innovative ways of gaining access to needed services with little or no resources. Two of the sites we visited--Summit County (Akron), OH and Henrico County (Richmond), VA-- contract for psychiatric services with the community psychiatry program at their local medical school. In Summit County (Akron), OH, the jail provides the direct mental health services, while a county administrative board provides planning, funding, evaluation and monitoring of the services. We found three of the 10 jails were contracting for mental health services through a national private care provider such as "Correctional Medical Services" or "Prison Health Services."

Conclusion

Each site had innovative ways of providing needed mental health services, but one factor, which has become very clear during the course of this and prior research, is that establishing appropriate services for jail detainees with mental illnesses requires that the jail be seen as but one agency in a continuum of county services. The jail is attempting to perform its custodial function of safe pre-trial detention while addressing the mental health problems of a community member whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs of the inmate are defined simply as the jail's problem. *The jail is a community institution, and the mentally disabled detainee is a community problem.*

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I. INTRODUCTION

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

In considering the goals set forth in NIJ's solicitation, the specific research questions our proposal was designed to address were:

(1) How do jail administrators manage mentally disabled offenders?

(2) What promising practices and/or strategies are jail officials currently using to manage this group?

(3) What new strategies and/or alternative approaches are being developed to better manage mentally disabled offenders in jails?

The purposes of this final report are: (1) to describe the research conducted; and (2) to describe those practices for managing mentally ill jail detainees that may be useful in jails throughout the U.S. We will begin with some background information, followed by our research strategy, and conclude with descriptions of some innovative programs and policies which jails have implemented to better manage and supervise mentally disordered offenders.

II. BACKGROUND

In most jurisdictions, a jail is a locally administered confinement facility with authorization to hold persons awaiting adjudication and/or those committed after adjudication to serve sentences of one year or less (USDJ, 1980). Two-thirds to three-quarters of all convicted criminals serve their sentences in jail, and it is the nearly universal place of detention for untried prisoners (Steadman, McCarty, and Morrissey, 1989). In 1991, there were approximately 3,353 jails in the U.S. (USDJ, 1990). Not only are large numbers of jails antiquated and barely able to meet minimal standards of care, but jail populations are exploding. Jail overcrowding is at epidemic proportions throughout the U.S. From 1980 to 1992, the number of persons in jail on any given day in the United States increased from 158,394 to 444,584 (USDJ, 1993). In the twelve month period preceding June 1990, there were approximately 10.1 million admissions and 9.9 million releases from jails across the country (USDJ, 1991).

A recent survey of a random sample of male jail admissions in Cook County (Chicago), IL found that 6.1% of those interviewed had a current psychotic illness and were in need of treatment services (Teplin, 1994). Among female Cook County detainees, the estimates of mental illness were even higher. Fully 14 percent of the female detainees had a current mental illness of schizophrenia or affective disorder (Teplin, unpublished). On a national level, this would indicate that approximately 700,000 admissions annually to U.S. jails were individuals with acute and severe mental illnesses.

This large number of jail inmates with mental health needs is often cited as an outcome of the deinstitutionalization policies of the 1970's (Abramson, 1972; Whitmer, 1980; Bonovitz and Bonovitz, 1981; NCJR, 1984; Belcher, 1988; Sherson et al., 1990). Cohen argues that "[i]responsible deinstitutionalization - release of mentally ill patients from psychiatric hospitals - is turning this country's county and local jails into the new mental hospitals and returning care of the mentally ill to the deplorable conditions that prevailed more than 300 years ago" (Goldsmith, 1988). There are no adequate data to assess whether, in fact, the large numbers of mentally ill in jails is the result of deinstitutionalization efforts or simply is a reflection of the increasing inmate population (Steadman et al., 1984). Regardless, the huge increases in the number of jail detainees, combined with even stable proportions of detainees with severe mental disorders, mean that there are more mentally ill persons in jail today than ever before.

From the perspective of persons responsible for providing mental health services to a seriously underserved population, the issue is not how did this large number of persons with mental illnesses come to be in our jails, but rather what can be done to better manage this population. Identifying successful ways of addressing this problem is what this project has been about.

Some of the major factors that have been identified as contributing to the jail problems connected with mentally ill detainees are associated with the lack of policies, practices and standards for inmates with mental health needs in the criminal justice system (Steadman, 1991). These include insufficient sharing of information, insufficient training, lack of communication

across systems, lack of fiscal incentives for community mental health services to admit mentally ill offenders, lack of coherent and consistent standards for jail mental health services, and no formal procedures to assure the development of discharge plans. The questions that drive this research are what types of procedures, policies, and programs are used with the mentally disabled while in jail, how are they organized and administered, which practices are considered effective, and what factors are associated with effective services.

Although there is a significant body of research, none of these projects examines the practical, day to day questions such as how and by whom policies for the management and supervision of mentally disabled offenders are developed; are such policies formal or informal, written or oral in nature; who is responsible for implementing and monitoring these policies and how are they carried out; who develops specific programs for mentally disabled prisoners, establishes their budgets, and carries them out; what variables (expected and unexpected) influence and effect the implementation of these programs, including the interactions between the various agencies responsible for this jail population; and so forth.

To best understand exactly how critical these questions are, it is helpful to place the jail and the mental health needs of its detainees in a systemic perspective, i.e., in the context of all the agencies involved in criminal justice processing. Instead of viewing the jail as a self-contained or closed system, a systemic, or interorganizational, approach to program development and evaluation looks both at the jail and its linkages with a variety of other organizations in its environment, such as law enforcement, the courts, the local bar, state mental health hospitals, psychiatric units in general hospitals, community mental health centers, and other health and human service agencies. It is especially true that in regard to mental health services, the jail cannot be considered in isolation.

Although the jail exists as a separate entity, its primary function is processing people and it is best characterized by its interaction with other relevant criminal justice agencies including the police, the courts, the legal community (defense attorneys and prosecutors), and, ultimately, community services. It is important to highlight this "systemic" aspect of the jail and to approach the issues in such a fashion.

The problems associated with the delivery of these services relate especially to individuals who, on the average, spend very short periods of time in jail.

The impact of jail overcrowding, in general, and the number of jail days spent by detainees with mental illnesses, in particular, on case processing by the courts are unclear (Goerdt, 1989). Unfortunately, regardless of the case management approach applied by courts, defendants with mental disorder are often excluded (taken "off track") from differentiated management schemes and different case tracking systems that expedite the flow of cases. Consequently, jail detainees with a mental disability may spend a disproportionate number of days in jail awaiting certain court events to take place, a delay not experienced by their counterparts without identified mental disorders.

The multitude of decisions made by the court during pre-trial hearings and at trial and sentencing can have significant bearing on whether and where a defendant with mental illness is incarcerated, how long he or she is incarcerated, and the nature and locus of mental health services he or she is likely to receive during and after incarceration (Keilitz, Hafemeister, and Wall, 1992).

A concept that assumes special relevance to the jail in its response to inmates with mental disorders and which has been carefully considered in this research is that of **boundary spanners** (Steadman, 1992). Boundary spanners are people in key positions in an organization whose role it is both to interact with other people in their own organization and to negotiate system interchanges with other organizations. For mentally disabled detainees, these interactions and negotiations may occur at the "front door" of the jail, and involve negotiation between jail staff and Personal Recognizance Staff, the family, community mental health service providers, or hospital staff. They may also be done by the case manager in-jail and may involve negotiation with the courts, attorneys, mental health providers or probation. Finally, the negotiation can occur at the "back door" of the jail and focus on finding a desirable community treatment program housing option, or social services.

Except for the largest jails in the major metropolitan areas, it is impractical to consider developing a comprehensive set of mental health services within a jail. This is warranted neither on the basis of need nor in terms of the dollars or physical space available. It is far more practical for the jail to make effective use of community mental health centers; psychiatric units of general hospitals; private practitioners; university departments of psychology, medicine, and social work; and state mental hospitals. "Effective use" does not necessarily mean actually transferring inmates, but does mean capitalizing on the expertise of the staffs of these programs and planning services in ways that can share program resources.

To establish appropriate services for such persons requires that the jail be seen as but one agency in a continuum of county services. The jail is attempting to perform its custodial function of safe pre-trial detention while addressing the mental health problems of a community member whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs of the inmate are defined simply as the jail's problem. *The jail is a community institution, and the mentally disabled detainee is a community problem.*

III. RESEARCH STRATEGY

Our research design was a three-tiered approach: (1) a mail survey; (2) a telephone survey; and (3) ten site visits.

A. Mail Survey

The first step was a nationwide mail survey to a random sampling of all U.S. jails to determine the percentage of detainees receiving mental health services, the particular services available to these detainees, and the self-rated effectiveness of the jail's mental health services. Its purpose was two-fold: (1) to enumerate and describe basic components of jail mental health services, and (2) to identify jail programs from which a sample can be drawn for telephone interviews.

For purposes of this study, jails with rated capacities between 20 and 50 were surveyed. Data for larger jails were obtained in PRA's concurrent study, "Diverting Mentally Ill Jail Detainees." That study assessed jail diversion programs for the mentally ill in all U.S. jails with a rated capacity of 51 or more beds and followed a similar methodology. Information was selected from that data set for use in this study.

The mail survey was distributed to 1706 jails (1106 through the Jail Diversion Study and 600 directly through this study) stratified by size and randomly selected from the American Jail Association's directory. We received responses from 1053 jails for a 62% response rate.

Responses to the mail survey were received from each of the 51 jurisdictions (50 states and Washington, D.C.) surveyed. The jails ranged in size from 13 to 9,997 detainees, and the annual bookings ranged from 8 to 99,997. Estimates as to the percentage of inmates receiving mental health services at the time of the survey ranged from 0 to 95%, with most responses falling in the 0 to 10% range. Roughly 84% of the jails responding indicated that 10% or less of their inmates were receiving mental health services. Fourteen percent of the respondents rated their jail's mental health services "very effective."

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

- Initial Screening for mental health treatment needs (88% of the respondent jails provide this);
- Follow-up Evaluations (provided by 68.8% of the jails); and,
- Suicide Prevention Services (found in 79.1% of the jails).

Crisis intervention and psychotropic medications were found to be commonly-used methods of treating and managing mentally disordered detainees -- especially in the larger jails. Overall, more than 50% of the jails reported providing these two services.

Less commonly-used interventions are psychotherapy and special housing units for the mentally ill. This we found to be especially true in the smaller jails.

Only 26.2% of the jails surveyed provided discharge planning, indicating a serious need in this area across all-sized jails.

B. Telephone Survey

The second phase of the study was a follow-up telephone survey to a stratified sample of 100 of the mail survey respondents. Because the primary objective of this study is to identify successful or innovative strategies, the sampling frame for the telephone interviews included only those jails that assessed their mental health services as "very effective." A total of 149 jails rated their services as such. A stratified sample was drawn in order to represent all-sized jails (see Table 1).

TABLE 1

Jails Rating Their Mental Health Services As "Very Effective"

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

In conducting this survey, we were interested in discovering why the jail's mental health services had been rated "very effective." As a means of discovering innovative programs and practices for treating, managing and supervising mentally disordered offenders, telephone respondents were asked whether or not they had a particularly effective policy or procedure in delivering each of their specific mental health services.

Of those stating that they did provide the pertinent services, the following percentages reported having a particularly effective way of doing so:

Initial screening (49/79)	62%
Follow-up Evaluation (47/82)	57%
Suicide Prevention (59/79)	75%
Crisis Intervention (49/78)	63%
Psychotropic Meds (37/82)	45%
Inpatient- In Jail (18/24)	75%
Inpatient- Out of Jail (29/69)	42%
Individual/Group Therapy (29/58)	50%
Special Housing Unit for M.I. (24/39)	62%
Discharge Planning (36/63)	57%

In addition, data were collected on community linkages, other services available in the community, and any special policies or practices the jails had with the local police, the courts, and/or the local mental health centers.

For example, we went through a list of agencies asking if there are key people in the jail who interact frequently with anyone in these agencies in regard to mentally disordered detainees. In addition, we asked for overall estimates of how many mentally ill with treatment needs in the community actually get services, and for overall assessments of the quality of these services.

All of the 100 jails selected for telephone interviews were contacted. Eighty-seven interviews were successfully completed.

C. Site Visits

Based on the mail and telephone data, we selected 10 jails for site visits. Jails were stratified by size and ten were selected as having particularly noteworthy practices, policies, or procedures in their management, supervision and treatment of mentally disordered detainees.

Some of the key features we considered to be important reflected core concepts which appeared many times during the course of our telephone interviews, such as "cooperation," "communication," "linkages," "information-sharing," "coordination," "liaison," and "boundary spanners."

All ten jails, two small (rated capacity of less than 99), two medium (rated capacity of 100-249), three large (rated capacity 250-999), and three mega (rated capacity 1000 and over), were contacted and agreed to participate in the study.

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

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

The following, listed with their rated capacities, are the 10 jails included in the site visits:

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

D. Focus Group Meeting

In June of 1993, NIJ sponsored a criminal justice/mental health focus group meeting. Participants included national experts in the field, representatives from state and federal agencies, consumers and advocates for the mentally ill. Henry J. Steadman Ph.D., this project's director, acted as facilitator.

This meeting involved a roundtable discussion of criminal justice/ mental health issues followed by breakout sessions in each of the following areas: police, custodial detention, adjudication processes, community supervision, and specific populations. The goals to be attained during these breakout sessions were (1) to identify the key mental health issues confronting the criminal justice system, (2) to identify policies/practices/approaches that appear to have successfully addressed these issues, and (3) to discuss possible implementation strategies.

IV. RESULTS

Although there are numerous barriers to providing treatment for mentally disabled offenders in our nation's jails, we found that many jails (21 of our 87 telephone respondents) have designed and implemented innovative programs and policies to maximize care to this group using the limited resources available.

For the purposes of this report, we will divide the programs and policies into the following sections: (1) screening, evaluation and classification procedures, (2) crisis intervention and short-term treatment practices, (3) discharge planning mechanisms, (4) court liaison mechanisms, (5) diversion practices, and (6) contracting procedures.

Innovative Policies and Procedures in Large Jails

A. Screening, Evaluation and Classification Procedures

1. Multi-Tiered Screening and Evaluation (Summit County (Akron), OH)

A critical first step in the identification of detainees with mental health treatment needs is the initial screening and assessment upon booking into the jail. We found that it was routine procedure in each jail that we visited (except for one very small jail) to include questions pertaining to mental health treatment history and suicidal ideology on the booking forms. Most of the jails in our sample (87%) reported that they provide initial screening and, of those involved in the telephone interviews, the majority (76%) reported screening 100% of the detainees booked into their jails. The thoroughness of the process varied, however, from cursory to extensive

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

Although this type of screening should be a matter of routine in large jails, and therefore would not be considered an innovative procedure, we did find a particularly good example of multi-tiered screening at the Summit County Jail. This facility employed a three-tiered approach consisting of (1) an initial mental status exam given to all detainees by a booking officer, (2) a

cognitive function exam administered by a mental health worker to all of those found to be in need of further evaluation, and (3) a clinical evaluation of all those indicating further need performed by a clinical psychologist. This screening and evaluation procedure epitomized the importance of this stage in the process and was especially reflective of that particular facility's philosophy of making mental health care a "number one priority."

2. Special Classification for Mental Disorder (Jefferson County (Louisville), KY; Fairfax County (Fairfax), VA)

Inmate classification -- ensuring an appropriate housing assignment -- is another important area of initial identification and assessment as it is a continuation of the screening process. Although we did find a few programs with innovative classification systems for mental disorder, only one stressed the importance of ensuring appropriate housing assignments for those detainees with mental health treatment needs. The "mental health manager" at the Jefferson County Jail routinely communicates with members of the jail's classification team within twenty-four hours of arrest to determine the most appropriate residential setting for inmates with pending psychiatric classifications.

In the Fairfax County Jail, deputies in the classification department are specially trained in jail mental health issues, and in who to refer to the forensics and the substance abuse staffs. In this facility, classification is a formal, written policy which involves mental health providers in classification decisions. Responsibility for inmate classification is delegated to an Institutional Classification Committee (ICC). The committee consists of one representative from each of the following departments in the jail: Diagnostic and Treatment, Classification and Programs, Confinement, Medical, and Forensics. The committee assigns custody levels to inmates and effects changes in their custody level during confinement whenever necessary. The involvement of forensics in the decision-making helps to assure that inmates' mental health status is taken into account and helps immensely with communication.

B. Crisis Intervention and Short Term Treatment Practices

Treatment policies made up the bulk of the innovative practices and procedures that we discovered during the course of this study. Here we will highlight some of the most noteworthy:

1. Case Management Services (Hampshire County (Northampton), MA)

Due to relatively short terms of incarceration, case management is an important concept for jails in terms of continuity of care and proper discharge planning. Staff members at the Hampshire County Jail reported using case management services quite successfully for the past twenty years. Every inmate in that jail, regardless of the presence of mental illness, is assigned a case manager, with each case manager having a caseload of about 30. Assigning a case manager to each detainee may not be a concept that is generalizable to all, or even most, jails, but its success in this jail does warrant discussion.

In this particular facility, case management services were developed as a means to better manage the needs of inmates by coordinating services according to their individual concerns. This individualized attention enables the jail staff to identify problems at an early stage and bring them to the attention of the appropriate individuals. The program operates by assigning each sentenced and pretrial inmate to a case manager who works with him or her from intake through discharge planning (and upon re-entry to the system if applicable). The treatment needs of each inmate are assessed at intake. The case manager then provides individual counseling, meets with the family, and makes referrals to appropriate resources both inside and outside the institution. A high level of contact between clients and case managers seems to make a real difference in ensuring access to services while reducing the probability of clients getting "lost" along the way.

2. Crisis Intervention Team (Jefferson County (Louisville), KY) / Crisis Intervention Specialist (Summit County (Akron), OH/ Shelby County (Memphis), TN))

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

In most of the jails that we visited, a high priority was placed on providing crisis intervention services. Examples of what is being done effectively in this area were found in three facilities that demonstrated innovative ways of providing crisis intervention. Two of these employed crisis intervention specialists and one had a crisis intervention team. All three facilities met or exceeded the APA guidelines.

The primary goals of those charged with handling crisis intervention in these facilities, whether a single specialist or a team, is to assess, stabilize as quickly as possible, house appropriately (e.g. into a mental health or special housing unit), and provide direct mental health services. Clients include those who are actively psychotic, those at risk of committing suicide, and those under the influence of drugs or alcohol.

In the Summit County (Akron), OH jail, the crisis intervention specialist is a member of the jail's staff and receives forty hours of training per year from the jail's mental health coordinator. The mental health coordinator reported that, through crisis intervention, they are better able to manage and supervise mentally disordered detainees by immediately attending to crisis situations. Having a crisis intervention specialist also enables them to speed up the classification process for the mentally ill and to more effectively bring the mental illness to the attention of the mental health staff.

In the Jefferson County, KY Jail, the crisis intervention "team" consists of a Mental Health Manager, a master's level clinical psychologist, and a certified psychiatric mental health nurse. When correctional officers obtain information at booking regarding potential psychiatric

problems, observe unusual behavior or if other situations arise (such as an inmate receiving bad news) they refer the client to the crisis intervention team. The team then works on problem solving skills to help the inmate cope.

The team reported that they rely on the "ownership" of the correctional staff and depend on them to notify the team of crisis situations. The members of the team consider the correctional staff to be very important, as stated by the psychologist who said, "They are our eyes and ears."

In the Shelby County, TN Jail, the crisis intervention specialist is a technician who is specially trained to intervene in crisis situations. The general duties of the specialist are to (1) evaluate and refer clients to the infirmary psychiatrist who provides medical and psychiatric care to inmates, (2) administer prescribed medication, (3) maintain contact with involved agencies and community resources used for referrals, and (4) assist the infirmary psychiatrist during assessment and treatment of patients.

Prior to the creation of this position, the jail did not have an employee who could do assessments, communicate results to the psychiatrist, and medicate patients. Currently, the program is reportedly running "very well", due in large part to a very good rapport between the jail's psychiatrist and the specialist. The Director of the medical department at the jail reported that the psychiatrist trusts the specialist explicitly and, as a result, they are able to hold telephone conferences in which the doctor feels comfortable prescribing and modifying medication orders.

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

3. Inmate Suicide Watch Program (Jefferson County (Louisville), KY)

The Inmate Suicide Watch Program is a formal written program implemented, run, and staffed by "Correctional Medical Systems" employees in the jail. The program was described as a participatory suicide prevention program with the stated goals of assuring the ongoing safety and well-being of the jail's inmates and promoting teamwork, compassion and a sense of responsibility among the program's participants. Inmate participants assist correctional officers in achieving the common goal of preventing inmate suicide or self-injury. In two-men teams, inmates accompany officers on their rounds each night from 10:30 p.m. to 7:00 a.m., monitoring all inmates, not only those known to be at risk.

The key players in the program are the correctional officers who supervise the inmate observers, the Correctional Medical Services' employee who selects and trains them, and the inmate observers themselves. These "watch inmates", who are volunteers, are selected through a process which is based in part on need in the areas with which they are most familiar (e.g. an inmate assigned to a 6th floor cell would be chosen to patrol the 6th floor). Inmates consider this a desirable position in the jail for which they are compensated with a minor stipend of $3.00

per week, a character reference for the court, and periodic special acts of appreciation and recognition by the jail administration.

In preparation for participation in the program, inmates receive "a couple of hours" of training on topics such as depression and suicide statistics (time frames, etc.). There is also an inmate handbook which describes the program, lists behaviors to watch out for, actions to be taken when risky behavior is observed, and a list of rules entitled "DOs and DON'Ts."

C. Discharge Planning Mechanisms

Consistent with what we found a decade ago in a study of 42 jail mental health programs, the weakest part of all jail programs for mentally disordered detainees is discharge planning. Most of the ten programs we visited offer referrals upon release, but are not aggressive and include little or no follow-up.

1. Contract Between Jail and "Offender Aid and Restoration (OAR)" (Fairfax County (Fairfax), VA)

We found only one especially effective and comprehensive discharge planning program. The discharge planning at the Fairfax County Jail is special in that it not only links detainees with mental health and related services upon release, but it also concentrates on maintaining the detainee's family ties while incarcerated. This provides the individual with an additional system of support upon release and most likely contributes to his or her success on the streets. The services of this particular program are provided by OAR, a twenty-one year old private, non-profit organization located directly across the street from the jail and 90% funded by the county.

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

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

- teachers - both professional and volunteer - to teach life skills, such as parenting and preparation for release,
- group therapy for inmates and their families,
- support groups for families and close friends of inmates,
- emergency funds for families for food, clothing, etc. while their providers are in jail.

Discharge planning in this particular facility is provided for every individual. One special, and very important, consideration which is made for those who are mentally ill is that they deal with the same staff person -- a professional, not a volunteer -- from intake through discharge.

2. Jail Program (Hillsborough County (Tampa), FL)

We found one other jail among the 10 we site visited that offered discharge planning. Most of the discharge planning there is handled by social workers from two community mental health centers. They set up appointments and arrange for housing and access to psychotropic medication. They also have the capacity to provide transportation and frequently will pick a client up when he or she is released and take them to their initial appointment, to get medication, or to housing. The social workers also follow up to make sure a second appointment is scheduled. At this point, a community-based case manager takes over.

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

D. Court Liaison Mechanisms

Jails have a close symbiotic relationship with the courts. Criminal offenders typically pass through both a jail and a court during their processing by the criminal justice system, with both having integral parts to play. Their interdependence is particularly relevant for the mentally disordered offender. All of the sites visited as part of this project had developed at a minimum relatively routinized means for ad hoc interactions with the courts to respond to the special needs of the mentally disordered offender. Furthermore, several had developed specific programs to facilitate interactions between the jails and local courts concerning this inmate population.

These interactions benefit both the courts and the jails. In addition to holding and helping to stabilize mentally disordered offenders for the courts, jails can also provide valuable information to ensure an appropriate processing of such individuals by the judicial system. Conversely, the courts, in addition to providing information to the jails that will make it easier for them to manage and hold these individuals, can also divert mentally disordered offenders to more appropriate placements.

The following is a description of the innovative types of programs focusing on liaisons with the courts that were employed at the sites visited. In general, jail personnel at all sites were very cognizant of the fact that the courts are the ultimate focal point for decisions regarding the fate of mentally disordered offenders, and, in order to respond appropriately to the mental health needs of these individuals, it is important to include the courts as a key component in their mental health programs.

1. Forensic Clinic (Hampshire County (Northampton), MA)

The Forensic Clinic in the Hampshire County Court was created in 1985 to provide on-site staff and services to jail detainees in lieu of more costly hospitalization.
It is administered and funded by the Department of Mental Health's Division of Forensic Mental Health which contracts for staff with Behavior Management (formerly called The Child and Guidance Clinic), a private, non-profit agency. Current staff consists of the clinical director, a part-time psychiatrist, two part-time clinical psychologists, and three part-time licensed Social Worker clinicians. The staff includes a Court Clinic Coordinator, a licensed Social Worker, who is the coordinator between the court and the Hampshire County Jail and House of Corrections.

The Court Clinic Coordinator spends four mornings per week (approximately one-half of her 32-hour work week) in the jail. Her responsibilities include: counseling inmates referred to her by the jail's caseworkers (e.g., suicidal inmates or those who require more "supportive contact" than the caseworker can provide); assisting the forensic psychologists with evaluations for competency and criminal responsibility; preparing preliminary medication assessments for the psychiatrist and then helping him during weekly medication clinic; and conducting weekly meetings with the caseworkers in the jail to review their referrals and set up her schedule for the following week.

The major strengths of this program appeared to be 1) that it is cost effective in that having her staff on-site (in the jail) and available to provide immediate treatment responses decreases the number of psychiatric hospitalizations of jail inmates that would otherwise be required; 2) that it has permitted a good working relationship between the court clinicians and the jail's case managers and correctional staff (facilitated by weekly meetings between them), which allows them to work cooperatively in responding to the needs of mentally disordered offenders; and 3) that it has opened the lines of communication between court and jail personnel and led to much improved information sharing (e.g., patient mental health histories, present behavioral problems, etc.). Being on-site appears to be a key for each of these.

This program is highly dependent on the qualifications, skills, availability, cooperation, and effectiveness of the jail's case managers (described above). It works in part, because the jail's case managers screen the detainees before her program is involved, thereby facilitating the triage process and enabling her staff to focus their attention on those inmates for whom services are appropriate. The Case Managers are the "eyes and ears" for the Forensic Clinic, identifying inmates who are in need of mental health services. In addition, because of the limited presence of the Forensic Clinic staff in the jail, the Case Managers will inevitably inherit much of the responsibility for implementing the day-by-day elements of any treatment plan.

The key element to the success of a program such as this will be establishing and maintaining necessary lines of communication and cooperation between correctional line staff, the Case Managers, and the forensic mental health staff. Inmates tend to be very cognizant of staff working at cross purposes, and may seek to exploit these differences. Furthermore, mental health treatment particularly requires a consistent approach to be effective. The support, contribution, and input of all three of these components are necessary for this type of program to function appropriately.

2. Court Liaison Program (Pinellas County (Clearwater), FL)

The Court Liaison Program is closely associated with the Pinellas County Jail. Although the director of the program was originally housed at the jail, when the current contractor for jail health services took over in 1992, they forced her to move to the Department of Social Services (believing that civil commitments were not their responsibility). The rest of the program's staff, however, remains in the jail. The forensic program consists of the director, a forensic social worker supervisor (Ph.D.), three forensic social workers (M.A.), and a secretary.

The Court Liaison program decided to initially focus on mentally ill misdemeanants. Staff did not want to send such individuals to a psychiatric hospital as incompetent to stand trial (IST) or not guilty by reason of insanity (NGRI), dispositions which could result in long-term, but unnecessary hospitalization. These individuals may not have had any prior offenses and may have simply exhibited bizarre rather than harmful behavior (i.e., they were not considered dangerous). Furthermore, such individuals could be held in jail for four or five months while these dispositions were processed and were generally not in a position to work out a plea bargain that would ensure that their mental health needs were adequately met. The crucial question was how to get them out of jail and ensure them continuity of care.

In response, a cooperative agreement was worked out between the District Mental Health Board, the State's Attorney, the Public Defender, and the judiciary. Under this agreement, the court liaison goes into the jail to identify likely candidates for civil commitment as an alternative to the criminal justice track. After identification and evaluation, the court liaison submits the inmate's name to the State's Attorney who reviews the file and agrees to drop the charges if the person is eligible for civil commitment. Alternatively, the court liaison contacts the Public Defender's Office (also alerting the State's Attorney), who files a motion for transportation to the civil commitment hearing. If the court grants the motion, a court order is written up. The

civil commitment hearing is held at Pinellas Emergency Mental Health Services (PEMS -- a crisis stabilization unit for indigents) (initially the hearing was actually held at the jail), arrangements made for subsequent placement (i.e., a bed date given), the inmate's release papers processed, and a van secured to transport the individual to the new placement. On the placement date, the person is nolle'd (i.e., the criminal charges dropped by the State's Attorney) in the morning and is transported to the treatment facility in the afternoon. The court liaison personally walks the papers through the process to expedite matters and notifies all relevant individuals.

The court liaison also arranges for continuity of care of these individuals after release. Anyone who is hospitalized is given a case manager by Human Resource Services (HRS). Both the case manager and the attorney representing the individual are notified when a person comes back into the jail. The court liaison tracks each client to be sure that no one falls through the cracks. She accomplishes this by sending a letter to the attorney requesting notification when the client is released either back into the community or to the Department of Correctional Services (DOCS).

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

3. Jail Mental Health Liaison Program (Shelby County (Memphis), TN)

A multi-agency memorandum of understanding was drawn up in which each of the signing agencies agreed to appoint contact persons (boundary spanners) to act as liaisons with all other social service agencies and service providers. Among the agencies involved in this cooperative agreement are pretrial services and the public defender's office. The staff at pretrial services work to communicate the legal status and court dates of the severely mentally ill to the appropriate agencies and assist in expediting court dates when appropriate. The public defender's office lend cooperation to pretrial services in communicating the legal status of cases involving the severely mentally ill, assist in expediting court dates, and enter court orders for evaluations as needed

The manager of the Shelby County Public Defender's Office,in her capacity as mental health liaison, reports that "information flows through (her)" and she is able to speed up cases or to recommend that they be handled differently. She talks with family members and directs them to the director of the jail's medical department so that they can share information with the family regarding specific inmates. The purpose of this is two-fold: it serves to lessen the

worries of the family, and it provides the jail's medical department with an additional source for obtaining relevant information, such as an inmate's treatment history. In general, public defenders pass information on to her as mental health liaison regarding "contacts," family members, friends, counselors, etc.

As mental health liaison, she also meets periodically with the judges to remind them of the services available in the program. She feels that they are relieved to be able to rely on her in her role as liaison. Among the specific tasks she undertakes are expediting court dates, with which she says she has "wonderful success." She is able to gather together all the relevant participants and the case usually gets put on the docket for the next day. She believes the high priority given to these cases is a result of the judges' recognition of how well the program works.

If a defense attorney has not been appointed, the director of the jail's medical department will go directly to the prosecutor to make suggestions (e.g., that charges be dropped for a severely mentally ill offender eligible for a mental health placement). Reportedly, her recommendations carry more weight with the prosecutor than those provided by the Public Defender's Office or even the mental health liaison within the Public Defender's Office. Indeed, when she has recommendations that the public defender is unwilling to pursue (e.g., when the defendant objects to the proposal), she will go to the prosecutor to discuss the case and the prosecutor usually adds her conditions to a proposed plea bargain (sometimes to the displeasure of the public defender). Furthermore, if neither the prosecutor or the public defender are willing to promote her proposal, she will take her recommendations directly to the court, to which she is asserted to have ready access. The director of the jail's medical department claims that her rapport with the courts is due in part to what she good-humoredly terms as "trade-offs." She and her staff do special favors for the judges such as taking their blood pressure, bringing them Tums, etc. It might be noted that other diversion programs often talk of similar "incentives."

A program such as this requires a large amount of commitment from the community and the involved agencies, particularly the community mental health providers, the sheriff's department, and the jail's medical department. Getting all the involved parties together to talk and to recognize their common needs is the first critical step. This program still finds it difficult to develop a rapport with an important component, namely, the public prosecutor. Participants in this program recommend educating the prosecutor's office to the fact that the jail is not an acute mental health care facility, and, further, only asking them to become involved in individual cases when it is absolutely necessary. Some problems result from excluding prosecutors from program's initial planning groups and in not involving them in meetings for the revision of the program.

4. "Jail Review"/ Use of Magistrate for Early Diversion of Mentally Disordered Offenders from Jail (Fairfax County (Fairfax), VA)

The Jail Review Program is a formal program implemented and run by Pretrial Services. It is built into the screening for criminal defendants as part of the decision on whether to order pre-trial detention for defendants who cannot bond out. This initial screening is provided by a magistrate before whom every detainee appears. Pretrial services has staff in the jail on a twenty-four hour basis who work with the magistrates in making the initial decision on whether the defendants should be in or out of jail.

Within three working days after arraignment, pretrial services staff interview the detainee, collecting information for the court, the defense, and the state. They then get right back to the magistrate with all of the pertinent information. They also meet with the judge each afternoon to review all cases. Although there is limited judicial action this early in the case, at this point if the detainee has no attorney, the court decides whether one will be appointed. If the detainee is mentally ill, the judge will give the case to either a court-appointed attorney or a private attorney instead of to the public defender's office in an effort to expedite matters.

The Jail Review Program was developed as a means to ensure a structured intervention to get the mentally ill offender out of the jail at the earliest possible stage. When mental health services within the jail identifies a detainee as mentally ill and in need of treatment, they can call Pre-Trial Services to handle this processing. The detainee should then be either hospitalized or sent into residential housing -- but not back to the jail. In addition, Pre-Trial Services is to facilitate discharge follow-up.

It is also the magistrate's responsibility to refer defendants for a forensic evaluation (i.e., to determine whether the defendant is IST or NGRI), and they may make it mandatory for a detainee to see forensic's staff before their release. To accomplish this they may release the detainee on his or her own recognizance with the condition that they see forensics first. This has a secondary gain in that if forensics determines that the detainee's mental status suggests a need for detainment, they will advise the magistrate and then hold the detainee for 60 minutes. This allows the magistrate time to issue a temporary civil detention order, provisionally release the offender on the criminal charges, and arrange for the police liaison to transport the offender to a mental health facility. This, however, is a relatively rare occurrence, particularly since there is now a concerted effort in this jurisdiction to divert mentally disordered offenders who have not committed a serious crime to mental health centers initially rather than processing them through the criminal justice system.

Although the program has been up and running for a very short time, it is reported to be operating well. It is believed to do a better job of managing and supervising the mentally disordered offender as it diverts many of them from the jail into more appropriate treatment settings. In part this is credited to teaching those empowered to make these critically important decisions, i.e., the courts, what these decisions are all about. As is true of court liaison programs in general, this program's ability to effectively address the needs of the mentally

disordered offender will depend in large part on its ability to develop the necessary communication and trust between the various players.

E. Diversion Practices

Currently, one of the most popular suggestions for responding to persons with mental illnesses in jails is to divert them from jail to appropriate community-based mental health programs. Diversion programs can be divided into two basic categories: pre-booking and post-booking. Pre-booking diversion provide the police with alternatives to arrest. Post-booking diversion involves the courts, prosecutors, public defenders, jail mental health staff, probation and community mental health services who all collaborate to move detainees with mental illness from jail to community treatment at the earliest possible time. We found excellent examples of both types of diversion in the sites we visited.

1. Pre-Booking Diversion Programs: The Crisis Center (Hillsborough County (Tampa), FL)/Mental Health Mobile Crisis Unit (Fairfax County (Fairfax), VA)

One example of a pre-booking diversion program involved the establishment, in Hillsborough County, FL, of a "Center" to which police could bring offenders instead of to the jail. The Center was developed by the current director three years ago to cut down on recidivism and make more efficient use of community resources. Here, assessment, crisis intervention and treatment are provided to all detainees with those needs. The Center has the capacity to accept all detainees with charges up to non-violent felonies.

The success of this program is dependent on the relationship between the staffs of the Center and the local police department. Prior to its implementation, the Director of the Center visited all of the police agencies' roll calls to inform them of the services available and of the Center's staff's willingness and ability to work with the police. In addition, the Center's bilingual staff offers services in a secured area of their facility employing a system which ensures that the police are never there longer than twenty minutes.

The mental health coordinator reports that the program is currently running very well and that it does help them to better manage and supervise the mentally disordered detainee. For example, the very sickest inmates can be sent out for better treatment than that in the jail due to lack of resources. Also, the Crisis Center has 24-hour nursing capabilities and can force medication when necessary where the jail cannot. Their secure ward makes this possible.

A second example of a pre-booking diversion program is a mobile crisis unit in Fairfax County, VA. This MCU, staffed and funded by the county, was described to us as a home visit team for those either unable or unwilling to go to a mental health center. The goal of the program was reported to be diversion from jail through working with the family, the police and the courts. It is staffed seven days per week from 3:00 p.m. to midnight. Each afternoon, when the staff arrive for duty at 3:00 p.m., they call to check in with the seven or eight area mental health centers for referrals. They reportedly receive at least two referrals per day.

The MCU team does suicide assessment, prevention, and intervention; psychiatric crisis evaluation, intervention, and hospitalization when necessary; medication in domestic disturbances; intervention where danger issues exist in drug and alcohol crises; stress reduction for service providers; and helps people cope with trauma or tragic events.

One of the MCU team's additional responsibilities is to serve as consultants to police SWAT teams in hostage-barricade incidents. If the incident develops into a mental health resolution, the team gathers background information on the individual and makes all the necessary arrangements for care (hospital beds, etc.). If circumstances end in a criminal justice resolution, the MCU notifies the forensic unit in the jail and provides them with all of the necessary background information. Other duties include:

- going to police roll calls to train police and magistrates in mental health issues and educating the community and families about the criminal justice system.
- providing back-up for the jail's Crisis Intervention Team.
- acting as petitioners/recommenders for the mentally disordered at hearings (instead of having the police do this).

2. Post-Booking Diversion: Community Treatment Alternatives Program (CTAP) (Jefferson County (Louisville), KY)

Community Treatment Alternatives Program (CTAP) is a formal, written program implemented, run, and staffed by Seven Counties Mental Health Center (Seven Counties) in Louisville, KY. Its purpose is to provide community-based mental health services as an alternative to incarceration for chronically mentally ill adjudicated offenders. The goal of the program is to arrange for an expedited release from jail so that more appropriate services can be provided. Once released, the program offers anger management groups, dual diagnosis groups, legal issues groups, and the services of social workers, case managers and psychiatrists. Its goal is to stabilize the client's mental illness and to reduce the likelihood of recidivism.

The criteria for admission into the program is chronic offender status (usually misdemeanants) along with a severe mental illness. The target population is defined by guidelines developed by the State Department of Mental Health, which includes individuals with schizophrenia, bipolar disorders, organic disorders, mood disorders, and major depression. They try to screen out substance abusers and personality disorders. Clients are referred to the program by other mental health professionals, judges, attorneys, the court liaison, or a jail mental health worker.

Caseworkers from Seven Counties visit the jail each morning on a routine basis to assess any potential clients. These assessments, a variation of a mental health status exam, include a survey of a client's personal data, treatment history, and current legal status. Based on a review of this information, the caseworker makes a decision as to whether the client is appropriate for

the program. If appropriate, correctional services, community mental health services, and the courts work together to develop a coordinating plan to secure the release from jail of the client and to assist the client in meeting his/her mental health needs. The CTAP caseworker will discuss the matter with the jail mental health manager, community mental health care providers, the prosecutor, and the defense attorney, and then present the resulting plan to the judge for a final decision.

CTAP clients are released from jail directly into the community. There they live in their own homes, in boarding homes, in beds in the community, or in housing provided through other programs -- such as the Volunteers of America's Mentally Ill Men at Risk for Homelessness Program. Approximately one-half live in their own homes. The CTAP caseworker places a high priority on helping set up appropriate housing before an inmate's release date. At times, judges cooperate in this effort by, for example, delaying release for a week or so until housing is found.

The CTAP caseworker also works to ensure that clients on psychotropic medication continue to receive the appropriate medication after their release from jail. They try to provide the client with enough medication for the time period between their release and their first doctor appointment. This can be accomplished in a number of different ways: by merely giving the client the medications remaining on the current prescription (if this will be enough), by setting up the first doctor appointment before the client's current prescription expires, or, failing that, by taking the client to Emergency Services for a new prescription.

Because treatment and services provided by Seven Counties is an alternative sentence worked out between the arresting officer, prosecutor, defense attorney, CTAP caseworker, and jail mental health manager in a plea bargain-type process, clients are supervised closely. In the first month after release, the client's contact is mainly with the CTAP caseworker. After that the case is turned over to Seven Counties staff. Clients usually come into the Center for appointments and, in addition, Seven Counties staff does home visits to check life management skills. Medications are monitored closely -- some clients must come to the Center each day to receive their medications, others are given injections.

An important component of the program are the monthly meetings between jail mental health staff, CTAP caseworkers, and court liaison to strategize and decide who in the jail should be targeted for the program's services.

CTAP clients must sign a contract which commits them to the program for a two-year period and which sets out the jail term in case of revocation. Failure on the client's part to participate in the treatment plan is handled as a violation of this contract and is reported to the court liaison who places the offender on the court's docket for the following day. Appearances before the judge can result in a change in the sentence from treatment to the specified jail term, or a new two-year contract with additional prospective jail time added.

F. Contracting Procedures

1. Linkage with Community Psychiatry Program at Local Medical School (Summit County (Akron), OH / Henrico County (Richmond), VA)

One of the more commonly mentioned problems facing U.S. jails with regard to mentally disordered detainees is the lack of adequate resources and staff. While interviewing a psychiatrist at the Summit County (Akron) Jail, we discovered an interesting program which addresses this problem: assignments at the county jail are part of the local medical college's Community Psychiatry rotation. It is important to note that the psychiatrists are not part of a forensic training program, but rather a community psychiatry program; this implicitly acknowledging the mentally ill detainee as a community services responsibility.

The psychiatrist on rotation is in the jail for a period of six hours per week. Most referrals that she receives are inmates on medication or those needing to be evaluated for medication. She reported that the "team approach" to mental health care in the Summit County Jail makes her job simpler. The staff screens the inmates before she sees them and, especially in the jail setting, the psychiatrist views this screening as terrifically important. In jails with only officers, there is no screening by mental health professionals and, therefore, no feedback to the psychiatrist regarding behavioral patterns, etc., which makes it more difficult to properly prescribe medications. The role of the psychiatrist in the jail setting is larger than merely treating the patient. Psychiatrists must also liaison with jail administrators and correctional staff.

In Henrico County, VA the jail contracts for psychiatric services with the local medical college through a fellowship in psychiatry. The fellow spends three days per week at the state hospital, one-half day in the jail, and the remainder of the week at the medical college. The psychiatrist handles medications exclusively, seeing each inmate who is on medication every two weeks. Any problems between these visits are handled by the mental health staff. When asked if four hours per week of psychiatric coverage was sufficient, the staff answered in the affirmative since there are usually fewer than 30 inmates at any given time on medication.

2. Coordination with Community Mental Health Services--Agreement Between the Jail and the Alcohol, Drug Addiction and Mental Health Services Board (Summit County (Akron), OH)

The Alcohol, Drug Addiction, and Mental Health Services Board (the ADM Board) is a county administrative board that controls all funding for Summit County mental health services. The funding source for these services is the Governor's Office of Criminal Justice Services. Approximately 50% of ADM money comes from state coffers and 50% from a local mental health levy (a part of the county tax base). The ADM Board consists of 8 members appointed by the county executive, 5 appointed by the Ohio Department of Mental Health, and the remainder by the Office of Drug Addiction and Alcohol Abuse.

Each year Summit County and the ADM Board enter into a written agreement which sets out the functions, responsibilities, and rights of both parties as they prepare to work with one another over the following twelve month period. According to the agreement, the jail provides the services directly, with additional responsibilities in the areas of clinical evaluation and quality assurance, and the board provides planning, funding, evaluation and monitoring of the alcohol, drug addiction and mental health services. Funding is advanced into the Jail on a grants management basis.

3. Privatization of Mental Health Services (Jefferson County (Louisville), KY; Pinellas County (Clearwater), FL; Hillsborough County (Tampa), FL)

We found three of the 10 jails site visited were contracting for mental health services through a national private care provider such as "Correctional Medical Services" or "Prison Health Services." For example, in the Pinellas County Jail, the private provider contract provides the following: (1) mental health services, (2) minimum staffing requirements, (3) professional liability insurance, and (4) medications.

A benefit for jails of the privatization model is that, due to the national scope of the provider, it brings resources to the jail that they would not otherwise have to help them better manage and supervise mentally disordered offenders. Two of the jails with these contracts also have a contract monitor who assures compliance with the terms of the contract, including making sure they maintain the accreditation standards and the staffing patterns required for the contract. In Hillsborough County, the position of contract monitor is included as part of the contract.

In addition to the jails that are contracting for services with national health care providers such as CMS or PHS, there are some, such as Hampshire County (Northampton), MA (see: Court Liaisons, "Forensic Clinic"), that contract with private for- or non-profit community mental health agencies for the provision specific services that would not ordinarily be available in the jail. This is an excellent method of ensuring that needed services are available to the jail without having to create an entire program within the jail on limited resources.

Innovative Policies and Procedures in Small Jails

During the course of the telephone interviews, we discovered that small jails frequently had interesting or innovative ways of supervising and managing detainees with mental illnesses in their jails. Often, the small jails had innovative policies or procedures that a large jail might take for granted. Below is an outline of the key practices which we considered as innovative for the management and supervision of mentally disordered offenders in small jails.

A. Screening, Evaluation and Classification Procedures

- Standardized mental health screening, such as forms and/or computer screening. Few small jails do this systematically, but some do effectively use forms that standardize screening for all bookings.

B. Crisis Intervention and Short-Term Treatment Practices

- Small jails, often lack fiscal resources, so they make informal use of "natural" resources in the community such as: family and/or clergy for crisis intervention; other inmates for social contact; 24-hour hotlines to local mental health providers; and, local volunteer organizations (such as AA or NA) who provide services in the jail.

C. Discharge Planning Mechanisms

- Discharge planning is often carried out informally through personal contacts between jail staff and mental health providers in the community.

D. Court Liaison Mechanisms

- Informal, personal contacts between the jail and the court help to expedite cases for detainees with mental illnesses; also, courts in smaller communities tend to be responsive to jail recommendations regarding detainees.

E. Diversion Practices

- Formal diversion programs are extremely rare in small jails; rather, diversion is done as needed on an informal, ad hoc basis when jail and mental health personnel become familiar with a detainee and his or her needs.

F. Boundary Spanning (Police-Jail-Mental Health) Mechanisms

- When police identify an individual with a mental health treatment need, they contact the local community mental health center for alternatives before bringing the individual to jail.

- Police provide back-up and coverage for jail staff.

- Police participate in community meetings designed to explain mental health law to law enforcement.

- Community has written policy which prevents corrections staff from accepting any individual into the jail who is suspected of having a mental illness and provides for the police to take the individual(s) for mental health evaluation.

- Two-day police training conducted by the mental health liaison and psychiatrist from the mental health center on jail mental health issues.

G. Contracting Issues

- Small jails can negotiate access to a larger jails' inpatient unit in a nearby community.

V. RESEARCH PROCEDURES

The research design involved a three-stage approach: 1) a mail survey of a stratified sample of jails, 2) follow-up telephone interviews of 100 selected programs, and 3) site visits to ten model programs. Basic information on policies and practices for managing mentally disabled inmates in jails requires a level of depth that a mail survey, alone, could not produce. Jail staffs have little time for such things. Consequently, the survey had to be brief. Yet it was necessary as a screening device, since without it, we would have wasted resources calling numerous jails who have non-existent or ineffective programs. The mail survey was needed to build an efficient sampling frame from which jails could be selected for in-depth study. The site visits were crucial to obtain sufficient information to write the NIJ report with the type of richness that will allow other jails to see how they could adapt for themselves actual model programs or the key principals on which they rest.

This three-stage approach is an iterative process distilling information regarding effectiveness in mental health services provision. The first stage identified effective programs via self-nomination. As part of the second stage, from the selected effective programs, key service components and management strategies were identified in telephone interviews. At this stage, we collected information both on existing program components, as well as on ideal types. The third stage, the site visits, included sites that most closely resembled the ideal types: that is, the programs that included the greatest number of components identified as critical or important on the basis of the results of the telephone interviews.

This study uses a stratified sampling design to elicit information about policies and practices for managing mentally disabled inmates in four sizes of jails, based on an assumption that jails of different sizes also have different demands, resources, capabilities and strategies for managing inmates with a mental disability in their care. This is an important distinction, because large jails are more likely to have, for example, formal mental health programs, written organizational agreements, elaborated policy manuals, and formal budgeting processes, while small jails are more likely to contract for services and to use highly variable informal methods to mange mentally disordered detainees.

A. Mail Survey

The purpose of the mail survey was two-fold: 1) to enumerate and describe basic components of jail mental health services, and 2) to identify jail programs from which a sample can be drawn for telephone interviews. PRA's concurrent study, "Diverting Mentally Ill Jail Detainees," followed a similar methodology, employing a mail survey which met the above needs in its assessment of jail diversion programs for the mentally ill. The mail survey component of the Jail Diversion Project had recently been completed, during which all jails with a rated capacity of 51 or more beds were surveyed. Information regarding the types of mental health services available, the overall effectiveness of the mental health services package, and descriptive characteristics of the jails were selected from the Jail Diversion data set for use in this study. In order, therefore, to obtain comparable information on smaller jails and a random

sample of all U.S. jails, it was necessary for us to survey those jails having rated capacities of 20 to 50 beds.

The mail survey used in this study was a one-page document which simply included a subset of items from the Jail Diversion Survey dealing with overall jail mental health program effectiveness which addresses the types of mental health services available, the overall effectiveness of the mental health services package, and descriptive characteristics of the jails (see **APPENDIX A**).

Our next task was to select the sample of small jails for the mail survey phase. Subjects were selected from the American Jail Association Directory of Jail Administrators Who's Who in Jail Management. A random sample of jails with rated capacities between 20 and 50 inmates (N=600) was drawn from all small jails in the U.S. Names, addresses, and phone numbers were obtained from the Jail Association Directory.

A cover letter was then developed (see **APPENDIX B**). This letter, which explained the project and its goals, wa directed toward jail administrators, and asked for their cooperation. The cover letter along with a stamped, self-addressed envelope was to accompany the mail survey when it was mailed.

After final revisions of the mail survey form and the accompanying cover letter, we conducted a pilot test of the form. Surveys were mailed to four small jails in nearby New York State counties - the Delaware, Lewis, Putnam and Tioga County Jails. Three of these four surveys were completed and returned to us. Follow-up phone calls to each of these three facilities revealed that the respondents had encountered no problems with the form and, subsequently, had no suggestions for its improvement.

Mailing of the 600 survey forms was then completed. This initial mailing resulted in the return of 126 surveys; a response rate of 21%. In order to ensure the highest return rate possible, we devised follow-up postcards (see **APPENDIX C**) which were mailed to subjects as reminders approximately one week after the initial mailing. This generated approximately 71 more responses and boosted our response rate to 33%.

A full second mailing was planned to all jails who had not responded three weeks after the surveys had been mailed. This second mailing consisted of a second cover letter (see **APPENDIX D**) and another copy of the mail survey. We received completed surveys from 368 jails for a final return rate of 61%.

The data entry phase of the mail survey portion of this study was completed as the forms were returned to us. This entailed writing an SPSS data entry program, devising a codebook, and entering and cleaning the data.

A preliminary review of the survey forms revealed 40 forms with missing data. In an effort to ensure quality control and to determine what steps, if any, should be taken in each

particular case, the Project's Director and Coordinator met to review these 40 forms. Subsequently, 30 of the forms appeared to have resolvable problems, so these 30 jails were telephoned to get more complete information.

Preliminary analysis of the mail survey data was conducted next. This analysis enabled us to draw the sample of jails for the next phase of our study, the telephone interview.

B. Telephone Survey

Because the primary objective of the study was to identify particularly successful or innovative strategies for the supervision and management of mentally disabled detainees, the sampling frame for the telephone interviews included only those jails that assessed their mental health services as "very effective." A stratified sample was drawn in order to represent all-sized jails.

Our next major task was to draft the telephone survey form. A lengthy revision process followed our completion of the initial draft. This revision process involved a number of PRA staff meetings, several phone calls, written correspondence and two meetings with a representative from our collaborators, NCSC.

Before beginning the telephone interviews, we conducted a pilot test. Ten jails were randomly selected from our sample; two from each of the five size categories: very small, small, medium, large and mega. Eight of the ten jails were successfully piloted. Several additional revisions were then made based on pilot data and input from the PRA staff interviewers. A final version was approved and printed (see **APPENDIX E**).

During this same time period, we also developed an SPSS data entry program along with a codebook for the close-ended telephone survey questions.

Data collection with the finalized version of the instrument was then begun. Because pilot-testing the survey form reduced our telephone interview sample to 94 jails, we first re-interviewed six of the jails involved in the pilot study, asking them the additional questions from our revised interview form. This enabled us to keep our sample at the desired level of 100 jails.

There were 87 successfully completed telephone interviews for a response rate of 87%. Of the non-respondent jails, all thirteen were reached. Eight declined to participate (for the most part, due to the length of the interview - approximately 30-45 minutes), and five requested that the survey be mailed to them and then either failed to return it or returned it with insufficient information.

At the conclusion of this phase of the study, the completed surveys were coded and the data from the forms were entered and cleaned.

Preliminary analysis of the telephone interview data allowed us to choose potential sites for the last phase of our study.

C. Site Visits

The first step, choosing the sample, was accomplished by five PRA staff members (including this project's director and coordinator, the project director of our NIMH Jail Diversion Study, and two research assistants involved in either or both of these two projects) who met to assess the features of the individual jail's programs. Eight sites were originally selected (two in each of four size groups: small, medium, large and mega) based on important programmatic policy and practice initiatives and geographic dispersion.

After the sample was chosen, we began making preliminary preparations for the site visits. This included obtaining the participation of the jails, scheduling the visits, and making travel arrangements.

The site visits were scheduled two per week and spread over a ten week period on a bi-weekly basis. In the week prior to each scheduled visit, we completed further pre-site preparation: setting up agendas (for example see **APPENDIX F**), scheduling interviews with specific key players, reviewing data from the mail and phone surveys, and planning specific questions to be asked about each innovative practice and policy. A general interview form was developed (see **APPENDIX G**) so that data could be collected in as systematic a manner as possible given the great variance between policies and practices being studied.

The first two site visits were conducted following our original methodology which involved a three-person research team consisting of two representatives from PRA and one from the National Center for State Courts. It had initially been anticipated that three-person teams were necessary because the site visits would involve some simultaneous data gathering from the jails and the courts. We found this not to be true. In fact, many of the personnel we were interested in interviewing were part of the jail's staff while others, due in large part to the level of participation of the jail, court, and mental health center staffs, arranged to come to the jail to meet with us.

We also decided after the first site visit that the three-person team approach could be intimidating to jail personnel, especially in smaller facilities. Therefore, we decided to reduce the teams to two people, one from PRA and one from NCSC. In making this decision, we also took into consideration the fact that, when choosing the jails to site visit, we had found both a large and a mega jail that stood out as having interesting policies and/or practices, but which could not be included in our sample due to our limitations of two jails from each of the four size groups. However, the travel expenses saved by cutting the research team to two persons enabled us to add these additional sites to the schedule which increased our sample to 10 sites (see **APPENDIX H**).

Each site visit began with a comprehensive jail tour, and then entailed interviews with each of the key people involved with the programs/policies which we were investigating. The intensity of the site visits varied. In the small jails, the tours took less than 30 minutes and only two key people were interviewed. In the larger jails, on the other hand, the jail tours took from one to two hours and interviews usually consumed the better part of two full days. We talked to a total of seventy key people - an average of seven per facility (range: two to 15; median: six and one-half).

Here, again, we found that the planned task was much more involved than we had anticipated. At each site, we set out to research an average of three innovative programs or policies. Once on site, however, we found, at a majority of sites (six of the ten sites: 60% of the cases), a number of additional programs that warranted study. We had anticipated investigating 33 separate programs/policies, but ended up actually investigating a total of 49 programs over the ten sites.

The interviews were conducted using an interview schedule which we developed prior to going on-site (see **APPENDIX G**). At the conclusion of the site visit phase, the data contained on these Interview Schedules served as the basis for our Field Reports. The data collected at each stage of the process is the basis for the final report to NIJ.

APPENDIX A

MAIL SURVEY

MANAGEMENT OF MENTALLY DISORDERED DETAINEES

MAIL SURVEY

As part of a National Institute of Justice funded study of mental health services for mentally ill persons in U.S. jails, we would like to obtain a little information about your jail and any mental health services it has. We would greatly appreciate your time and cooperation in completing this very brief form.

Name of Jail: _____

County(ies) Served: _____

State: _____

Name of person completing form: _____

Title: _____

Telephone #: (___) _____

SECTION 1: BACKGROUND INFORMATION

1. Jail Size:
   a. Jail Rated Capacity: _____
   b. Census Today: _____
   c. Number of Annual Bookings: _____

2. About what percentage of your census is receiving mental health services today? _____%

SECTION 2: MENTAL HEALTH TREATMENT SERVICES FOR YOUR JAIL'S DETAINEES

3. Please indicate which of the following services are provided in your facility *(Check all that apply)*:

- ☐ Intake Screening to identify mental health needs
- ☐ Assessment / Evaluation Services to determine mental health service needs
- ☐ Suicide Prevention
- ☐ Crisis Intervention Services
- ☐ Psychotropic Medication
- ☐ Inpatient Care - Within Jail
- ☐ Inpatient Care - Outside Jail
- ☐ Psychotherapy (individual or group)
- ☐ Special Housing Area for Mentally Ill Detainees
- ☐ Discharge Planning
- ☐ Other

Specify any other mental health services provided in your jail: _____

_____

4. Using the following scale, please rate the <u>overall</u> effectiveness of your jail's services for mentally ill detainees *(Circle one)*:

1	2	3	4	5
Not at all Effective	Barely Effective	Somewhat Effective	Moderately Effective	Very Effective

Please return survey form to: *Policy Research Associates, 262 Delaware Avenue, Delmar, NY 12054*

(11/15/92)

APPENDIX B

FIRST COVER LETTER

POLICY RESEARCH ASSOCIATES

November 30, 1992

1 –

Dear 2 – :

Policy Research Associates, Inc., with funding from the National Institute of Justice, is conducting a survey of U.S. jails concerning how they manage and supervise mentally ill detainees. The purpose of this survey is to determine what is effective in today's jails for the mentally ill detainee.

As an initial step, we are sending the enclosed one-page survey to 600 jails randomly selected from those listed in the American Jail Association's directory with a rated capacity of between 20 and 50 inmates.

Based on the information from this initial survey, we will conduct a follow-up telephone survey of 100 jails that have various types of mental health programs for mentally ill detainees. A name for the person completing the form is requested so we will have a person to contact if your jail is selected for the follow-up telephone survey. *None of the information will ever be reported in a way that would allow an individual jail or contact person to be identified.*

We ask that you take a few minutes to fill out this one-page form in the next few days and return it in the enclosed self-addressed envelope. It takes no more than five minutes to complete.

It is important for us to get as full a picture as possible of what is happening nationwide. Therefore, *we ask that you complete the form even if no mental health services are available in your facility*. We would like to know, for instance, how many jails do not have these services, especially among the smaller jails which are often not considered when these issues are discussed.

Thank you very much for your assistance with our survey.

Sincerely,

Henry J. Steadman, Ph.D.
President

/jj
Enclosure

262 Delaware Avenue
Delmar, New York 12054
(518) 439-7415
FAX (518) 439-7612

1825 I Street, N.W., Suite 400
Washington, DC 20006
(202) 429-2721
FAX (202) 429-9574

APPENDIX C

FOLLOW-UP POSTCARD

Dear Jail Administrator:

A few days ago we sent you a survey about your jail's efforts to manage mentally ill detainees. We know you are very busy, but we would ask you to complete our survey. Concerns regarding mentally ill offenders in jail are of growing importance today. Your response will be of great value in determining how best to to work with this population.

If you have any questions, please call collect at (518) 439-7415 and ask for me or Jodi Jackson.

If we do not hear from you in the next week, we will send another copy of the survey. Thank you for your assistance.

Henry J. Steadman, Ph.D.
Policy Research Associates
262 Delaware Avenue
Delmar, New York 12054

APPENDIX D

SECOND COVER LETTER

POLICY RESEARCH ASSOCIATES

December 14, 1992

Dear :

We know you are very busy and we are sorry to bother you again. So far we have obtained approximately 175 responses from the 600 jails we contacted about their management practices for mentally ill detainees. We have not yet received a response from you. Because we are especially interested in finding out which types of mental health services smaller jails provide to their detainees, we are once again soliciting your assistance.

We realize that, perhaps, you have set the survey aside to answer at another time, but we would ask that you take just 5 minutes and look at it-- it is very easy to complete.

As we mentioned before, this survey is just the first step in this project. Once we have a good estimate of which jails provide which services, we are going to select a sample for a telephone follow-up survey to gain more information about the various types of available mental health services.

We believe that the complex problems associated with the growing numbers of mentally ill persons in jails across the country need to be addressed as the situation worsens. We are very interested in learning how your jail is coping.

Thank you very much for your time and consideration.

Sincerely,

Henry J. Steadman, Ph.D.
President

/jj
Enclosure

262 Delaware Avenue
Delmar, New York 12054
(518) 439-7415
FAX (518) 439-7612

1825 I Street, N.W., Suite 400
Washington, DC 20006
(202) 429-2721
FAX (202) 429-9574

APPENDIX E

TELEPHONE INTERVIEW

PHSAMP.NIJ
03/25/93

NIJ-- TELEPHONE SURVEY SAMPLE
(N = 102)

The sampling frame for this portion of the study included all jails responding to either the NIMH mail survey or the NIJ mail survey which assessed their mental health services as "very effective."

We sampled 2/3 (66%) of all jails in the following categories: very small, small, medium, and large. Due to the limited number of mega jails in the study, we included all of these in our sample.

Five Jail Sizes

	Site Code	Rated Cap	Frequency	%Selected (Total)	NIMH Overlap- Phone	Site
NIJ: "Very Small"	0	20- 50	46	66% (31) *	N/A	N/A
NIMH: "Small"	1	51- 99	23	66% (15)	5	1
"Medium"	2	100-249	29	66% (17)	6	1
"Large"	3	250-999	37	66% (25) **	4	1
"Mega"	4	1000+	14	100% (14)	7	1
				N = 102	22	4

* Originally 32, but excluded Flathead MT due to its rating in Torrey report.

** Originally 26, but excluded Middlesex, NJ due to their refusal to participate in the NIMH phone survey.

NIJ Telephone Interview

Section I: Background Information

1. First, we would like to verify a couple of items from the mail survey.

   A. "Rated Capacity" reported on the survey: _____

   Is this still accurate? ☐ Yes ☐ No If no, _____

   B. "Census Today" reported on the survey: _____

   How many detainees are you housing today? _____

   C. "Number of Annual Bookings" reported on survey: _____
   Is this about right?
   ☐ Yes ☐ No If no, _____

2. Do you hold female detainees in your facility? ☐ Yes No ☐

   If yes, approximately what percentage of your detainees today are female? _____

3. Is the County Sheriff's Department responsible for the operation of the jail?

   ☐ Yes ☐ No If no, who is? _____

4. What geographic area does your jail serve?

   ☐ City: _____

   ☐ County: _____

   ☐ Other *(specify)*: _____

5. Is your jail currently operating under court order or consent decree in regard to mental health services for inmates?

   ☐ Yes If yes, elaborate: _____

   _____

   ☐ No If no, but it has in the recent past, what were the conditions of the order/decree?

   _____

   _____

6. When was your jail originally built? 19_____

6a. When was its most recent expansion or major renovation? 19_____

7. What is the design of your physical plant?

☐ Linear / Intermittent Surveillance (traditional style - must patrol to see into cells)

☐ Podular / Remote (Indirect) Supervision (Total visibility of all cells - limited interaction between staff and detainees)

☐ Podular / Direct Supervision (Total visibility of all cells - direct contact between staff and detainees)

8. Are detainees ever double-celled in your jail?

☐ Yes ☐ No

8a. About how many days in the past month were any inmates double-bunked? _____

8b. Do mentally ill detainees get any special considerations concerning double-celling? Explain:

_____

_____

9. Are jail employees provided with any training in recognition and response to mental disorders?

Who receives training? _____

Pre-service? _____

In-service? _____

Describe content of training: _____

Who conducts training sessions? _____

Where are they held? _____

For what duration? _____

IF THE SAME PERSON IS COMPLETING SECTION II,
SKIP QUESTIONS 10 & 11

10. What do you see as the three biggest problems facing U.S. jails today in regard to mentally disordered detainees?

A. _____

_____

B. _____

_____

C. _____

_____

11. What advice would you give to other jail administrators and mental health providers about how to find and manage the money needed to provide mental health services?

_____

_____

_____

_____

_____

Section II: Mental Health Services

12. On your mail survey, _____ rated the mental health services available to your detainees as "very effective." The scale was from 1 - "Not At All Effective" to 5 - "Very Effective." Do you agree with his/her rating?

☐ Yes ☐ No If no, how would you rate it?_____

1 - Not At All Effective
2 - Barely Effective
3 - Somewhat Effective
4 - Moderately Effective
5 - Very Effective

13. Could you tell me what there is about the mental health services available to your jail's detainees that makes you give a "_____" rating?

_____

_____

_____

_____

_____

IF RESPONDENT GAVE JAIL A "1", "2", OR "3" ON QUESTION 12, GO TO QUESTION 22

14. Could you tell me what you see as the special strengths of these mental health services?

_____

_____

_____

_____

_____

15. What do you think are the three most essential elements that make the mental health services for your jail detainees successful?

A. _____

_____

B. _____

_____

C. _____

_____

16. What are your reasons for saying these mental health services are successful?

_____

_____

_____

_____

Next, I would like to run through a list of mental health services that jails sometimes provide for their detainees. Very few jails in the U.S. can offer all, or even most, of them.

For each service, first, I would like to know whether your jail's detainees have access to the particular type of service and about what % of your detainees got that service in the past month (I am just looking for a "ballpark" estimate). As we go through each service, I will ask about whether you have ways of providing the services that have been particularly effective and that other jails might like to know about for their potential use.

17.

Service	Provided?	% Inmates in Last Month	Do you have any particular policies or practices for doing this that are especially important?
A. Screening for Mental Illness	☐ Yes ☐ No	_____%	
B. Evaluation for Mental Illness by a Mental Health Clinician	☐ Yes ☐ No	_____%	
C. Suicide Prevention	☐ Yes ☐ No	_____%	
D. Crisis Intervention	☐ Yes ☐ No	_____%	
E. Psychotropic Meds	☐ Yes ☐ No	_____%	

Service	Provided?	% Inmates in Last Month	Do you have any particular policies or practices for doing this that are especially important?
F. Inpatient Mental Health Care Within Jail (i.e.separate unit with 24 hour a day nursing coverage)	☐ Yes ☐ No	_____%	
G. Inpatient Mental Health Care Outside Jail	☐ Yes ☐ No	_____%	
H. Individual or Group Verbal Therapy	☐ Yes ☐ No	_____%	
I. Special Non-Medical Housing for Mentally Ill Inmates	☐ Yes ☐ No	_____%	
J. Discharge Planning to Link Detainees to Community-Based Mental Health Services	☐ Yes ☐ No	_____%	

18. Are the mental health services available to your detainees set up the same way today that they have been over the past year or two?

_____ Yes, pretty much the same

_____ Yes, but with some major changes

_____ No, not very much the same

18a. If changes, what were the key changes?

_____

_____

_____

_____

18b. Why were these changes made?

_____

_____

_____

_____

19. Where does the primary funding for your jail's mental health services come from?

Primary: _____

Secondary: _____

Other: _____

20. Has this changed significantly over the past few years?

☐ Yes ☐ No ☐ Don't Know

(If yes, why?) _____

_____

_____

_____

20. What advice would you give to other jail administrators and mental health providers about how to find and allocate the money needed to provide mental health services?

_____

_____

_____

_____

_____

_____

_____

21. Are there key people in your jail who interact frequently with personnel from each of the following agencies in regard to mentally disordered detainees?

a. local community mental health center ☐ Yes ☐ No If yes, position(s): _____

_____

b. local inpatient psychiatric unit ☐ Yes ☐ No If yes, position(s): _____

_____

c. state forensic unit ☐ Yes ☐ No If yes, position(s): _____

_____

d. social services ☐ Yes ☐ No If yes, position(s): _____

_____

e. local police ☐ Yes ☐ No If yes, position(s): _____

_____

f. courts - municipal ☐ Yes ☐ No If yes, position(s): _____

_____

g. courts - general jurisdiction ☐ Yes ☐ No If yes, position(s): _____

_____

h. courts - other ☐ Yes ☐ No If yes, position(s): _____

_____

22. a. Are there any ways that your jail's situation with mentally ill detainees could be improved by changing police practices in your area or by changing your jail's interactions with local law enforcement?

☐ Yes ☐ No

b. If yes, how? _____

_____

_____

_____

_____

23. a. How about the courts, are there ways your jail's situation with mentally ill detainees could be improved by changing courts practices or by changing your jail's interactions with courts?

☐ Yes ☐ No

b. If yes, how? _____

_____

_____

_____

_____

24. Next, I would like to get your impressions about the mental health services in the geographic area your jail serves.

First, I have a few questions about your overall estimates of how many of the mentally ill people in the community who need each type of service actually get it. The scale goes from 1 meaning "all persons who need it, get it" to 5 meaning "none get it." So, the rankings I'd like you to use are 1 = all, etc.:

1	2	3	4	5	8
All	Most	Some	Few	None	Don't Know

_____ 1. So, how many mentally ill persons in your area who need it get EMERGENCY MENTAL HEALTH SERVICES - *24-hour quick response, crisis assistance for clients and involved family/friends*

_____ 2. How many mentally ill persons in your area who need it get MENTAL HEALTH TREATMENT - *assessment and provision of inpatient, outpatient and/or day treatment services*

_____ 3. How many mentally ill persons in your area who need it get PSYCHOSOCIAL REHABILITATION - *social and group skills, daily-living and self-care, problem solving, and coping skills*

_____ 4. How many mentally ill persons in your area who need it get CASE MANAGEMENT - *single person/team responsible for helping clients obtain entitlements, services, housing*

_____ 5. How many mentally ill persons in your area who need it get PREVOCATIONAL/ VOCATIONAL - *employment opportunities, vocational rehabilitation services, supported/sheltered work*

_____ 6. How many mentally ill persons in your area who need it get SHELTER / HOUSING - *residential units within range of settings, from closely supervised to independent.*

25. Now I would like to get your overall assessments of the quality of support services that currently are available for mentally ill persons in the geographic area your jail services. That is, regardless of how many people who need the services get them, for those that do get them, how good are they.

1	2	3	4	5	8
Very Good	Fairly Good	Adequate	Fairly Poor	Very Poor	Don't Know

_____ 1. How would you rate the quality of care mentally ill persons get in EMERGENCY MENTAL HEALTH SERVICES - *24-hour quick response, crisis assistance for clients and involved family/friends.*

_____ 2. How would you rate the quality of care mentally ill persons get in PSYCHOSOCIAL REHABILITATION - *assessment and provision of inpatient, outpatient, and/or day treatment services*

_____ 3. How would you rate the quality of care mentally ill persons get in PSYCHOSOCIAL REHABILITATION - *social and group skills, daily-living and self-care, problem solving, and coping skills*

_____ 4. How would you rate the quality of care mentally ill persons get in CASE MANAGEMENT - *single person/team responsible for helping clients obtain entitlements, services, housing*

_____ 5. How would you rate the quality of care mentally ill persons get in PREVOCATIONAL/VOCATIONAL - *employment opportunities, vocational rehabilitation services, supported/sheltered work*

_____ 6. How would you rate the quality of care mentally ill persons get in SHELTER / HOUSING - *residential units within a range of settings, from closely supervised to independent*

26. What do you see as the three biggest problems facing U.S. jails today in regard to mentally disordered detainees?

A. _____

_____

B. _____

_____

C. _____

_____

27. Is there anything else regarding mentally disordered jail detainees that we haven't talked about that you would like to mention for us to take into consideration when we are writing our report for NIJ - any other problems or special concerns?

_____

_____

_____

_____

_____

_____

_____

Thank you for your time. Would you be interested in receiving a summary of our findings later this year when our project is completed.

☐ Yes ☐ No

If yes, please give me a mailing address: _____

_____

_____

_____

APPENDIX F

SITE VISIT AGENDA (example)

Policy Research Associates, Inc.
May 28, 1993

NIJ- MANAGEMENT OF MENTALLY DISORDERED OFFENDERS

SITE VISIT #3
JEFFERSON COUNTY
LOUISVILLE, KY

ID# 3-594
RATED CAPACITY: 823
SIZE: LARGE

CONTACT: GARY LONG, MENTAL HEALTH MANAGER

KEY TARGET AREAS

- CMS- a private vendor- provides mental health services
- CTAP- an alternative sentencing program for those identified with a major mental illness and minor charges (the court is their "staging area")
- Psychiatric Review Board (part of CTAP)- Formal Diversion Program
  - jail presents cases for possible diversion to this board
- Crisis Intervention- use a team approach

KEY PEOPLE INVOLVED

- Mental Health Manager (Gary Long)
- CTAP Representatives in the court (Liz Day/ Jim Burch)
- Program Rep who presents cases to the PRB (Jackie Seedy)
- A PRB Board Member (Phil Johnson, Psychologist or Bill Radamaker, attorney)
- A Crisis Intervention team member (Psychiatric R.N. or one of two MA therapists)
- A Correctional Representative (Lt. Colonel Mark Friedman)

JEFFERSON COUNTY, KENTUCKY (LOUISVILLE) SITE VISIT
JUNE 14 - 15, 1993
AGENDA

Monday, June 14, 1993

JJ--Delta
Leave Albany 6:15am (Cincinnati)
Arrive Louisville 9:27 am

TH--USAir
Arrive Louisville 10:46am

(Hotel Shuttle--Airport to Hotel)

Call Gary Long (502) 588-2185

Lunch on our own

Walk to Jail (approx. 8 blocks- less than one mile)
600 West Jefferson St. (40202)

1:00pm Meet with Gary Long, Mental Health Manager
- •Overview of Mental Health System
- •Preliminary introductions to jail mental health staff
- •Get copies of required documents/ procedural guidelines/ flowcharts, etc. for review before Tuesday's medical audit committee meeting
- •Partial jail tour

Tentative interviews (requires some flexibility due to nature of positions)
- •Interview of Crisis Intervention team member (Glenn, Shepp, or Dana)
- •Interviews of Jim Burch, Jackie Seedy, PRB Board Member (if avbailable and/or if time permits...)

(Overnight in Louisville)
Holiday Inn- Loiusville (Downtown)
120 W. Broadway (40202)
ph. (502) 582-2241
fax (502) 584-8591
Confirmation #65068560

Tuesday, June 15, 1993

9am Adjournment Court--tentative (depending on court docket for that day)

10am "Medical Audit Committee Meeting" (a weekly CMS-sponsored meeting)
chaired by Lt. Col. Mark Friedman
- •Interview Lt. Col. Mark Friedman
- •Remainder of jail tour

Tuesday, June 15, 1993 (cont'd)

Interviews to be scheduled

- Any that we were unable to complete on Monday afternoon

Northwest

Leave Louisville 6:55pm

Arrive Memphis 7:25pm

Pick up rental car-

APPENDIX G

SITE VISIT INTERVIEW

Policy Research Associates, Inc.
May 17, 1993

NIJ INTERVIEW SCHEDULE

Site: _____

Policy/ Practice: _____

Agency Name: _____ Today's Date: _____

Respondent(s): _____ Title(s): _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Interviewers_____ _____

OVERVIEW OF PROGRAM/ POLICY/ PRACTICE

A. Based on our telephone interview with you, we are particularly interested in getting details about how your _____ works. Our task is to find policies and practices in managing m.d.o. that could be useful for other jails. Could you tell us exactly how _____ works. [*Probe after initial description is given.] (See checklist to be sure all important points are covered)*

OVERVIEW OF PROGRAM/ POLICY/ PRACTICE

A. Based on our telephone interview with you, we are particularly interested in getting details about how your _____ works. Our task is to find policies and practices in managing m.d.o. that could be useful for other jails. Could you tell us exactly how _____ works. [*Probe after initial description is given.] (See checklist to be sure all important points are covered)*

B. Checklist:

- formal/ informal? *(circle choice)*
- who implements/ runs? _____
- who staffs? _____
- how are inmates identified for admission into program? _____

  _____
- what are the special management needs of this group? _____

  _____
- where are participating inmates held? _____
  - segregated/ integrated? *(circle choice)*
  - use of alternate facilities? _____
- how are they supervised? _____
- coordination with other agencies? _____

C. Is this a written or verbal program/ policy/ practice? _____

We are now interested in obtaining everything you have in writing about this program/ policy/ practice. (This includes forms, manuals, minutes of meetings, agendas, etc.)

B. Checklist:

- formal/ informal? *(circle choice)*
- who implements/ runs? _____
- who staffs? _____
- how are inmates identified for admission into program? _____

  _____
- what are the special management needs of this group? _____

  _____
- where are participating inmates held? _____
  - segregated/ integrated? *(circle choice)*
  - use of alternate facilities? _____
- how are they supervised? _____
- coordination with other agencies? _____

C. Is this a written or verbal program/ policy/ practice? _____

We are now interested in obtaining everything you have in writing about this program/ policy/ practice. (This includes forms, manuals, minutes of meetings, agendas, etc.)

HISTORY OF THIS PROGRAM/ POLICY/ PRACTICE

D. Who developed it? _____

_____

What specific problems were to be solved by this procedure/ policy? _____

_____

When was it developed? _____

Who are the key players? _____

_____

What are their roles? _____

_____

Were there any politics that had to be dealt with to establish this policy? _____

_____

What obstacles have you encountered? _____

_____

What steps have you taken to overcome these obstacles? _____

_____

HISTORY OF THIS PROGRAM/ POLICY/ PRACTICE

D. Who developed it? _____

_____

What specific problems were to be solved by this procedure/ policy? _____

_____

When was it developed? _____

Who are the key players? _____

_____

What are their roles? _____

_____

Were there any politics that had to be dealt with to establish this policy? _____

_____

What obstacles have you encountered? _____

_____

What steps have you taken to overcome these obstacles? _____

_____

BUDGET FOR THIS PROGRAM/ POLICY/ PRACTICE

E. Are there costs associated with this program/ policy/ practice?

No_____ Yes_____

F. Where does the funding come from?

Primary: _____

Secondary: _____

Other: _____

PERCEIVED EFFECTIVENESS OF PROGRAM/ POLICY/ PRACTICE

G. How <u>well</u> is this policy/ practice/ program running currently?

_____

_____

H. How does this help you better manage and/ or supervise the mentally disordered detainee?

_____

_____

_____

BUDGET FOR THIS PROGRAM/ POLICY/ PRACTICE

E. Are there costs associated with this program/ policy/ practice?

No_____ Yes_____

F. Where does the funding come from?

Primary: _____

Secondary: _____

Other: _____

PERCEIVED EFFECTIVENESS OF PROGRAM/ POLICY/ PRACTICE

G. How <u>well</u> is this policy/ practice/ program running currently?

_____

_____

H. How does this help you better manage and/ or supervise the mentally disordered detainee?

_____

_____

_____

I. Is there any documentation that it has led to improvements in detainees or in the jail?

NO_____ YES_____ *(If yes, please specify)*

_____

_____

_____

_____

J. Are there any plans for revisions in the future?

NO_____ YES_____ DON'T KNOW_____

If yes, why? _____

_____

What revisions are being planned? _____

_____

K. What recommendations do you have to offer to other jails in regard to _____?

_____

_____

_____

I. Is there any documentation that it has led to improvements in detainees or in the jail?

NO_____ YES_____ *(If yes, please specify)*

_____

_____

_____

_____

J. Are there any plans for revisions in the future?

NO_____ YES_____ DON'T KNOW_____

If yes, why? _____

_____

What revisions are being planned? _____

_____

K. What recommendations do you have to offer to other jails in regard to _____?

_____

_____

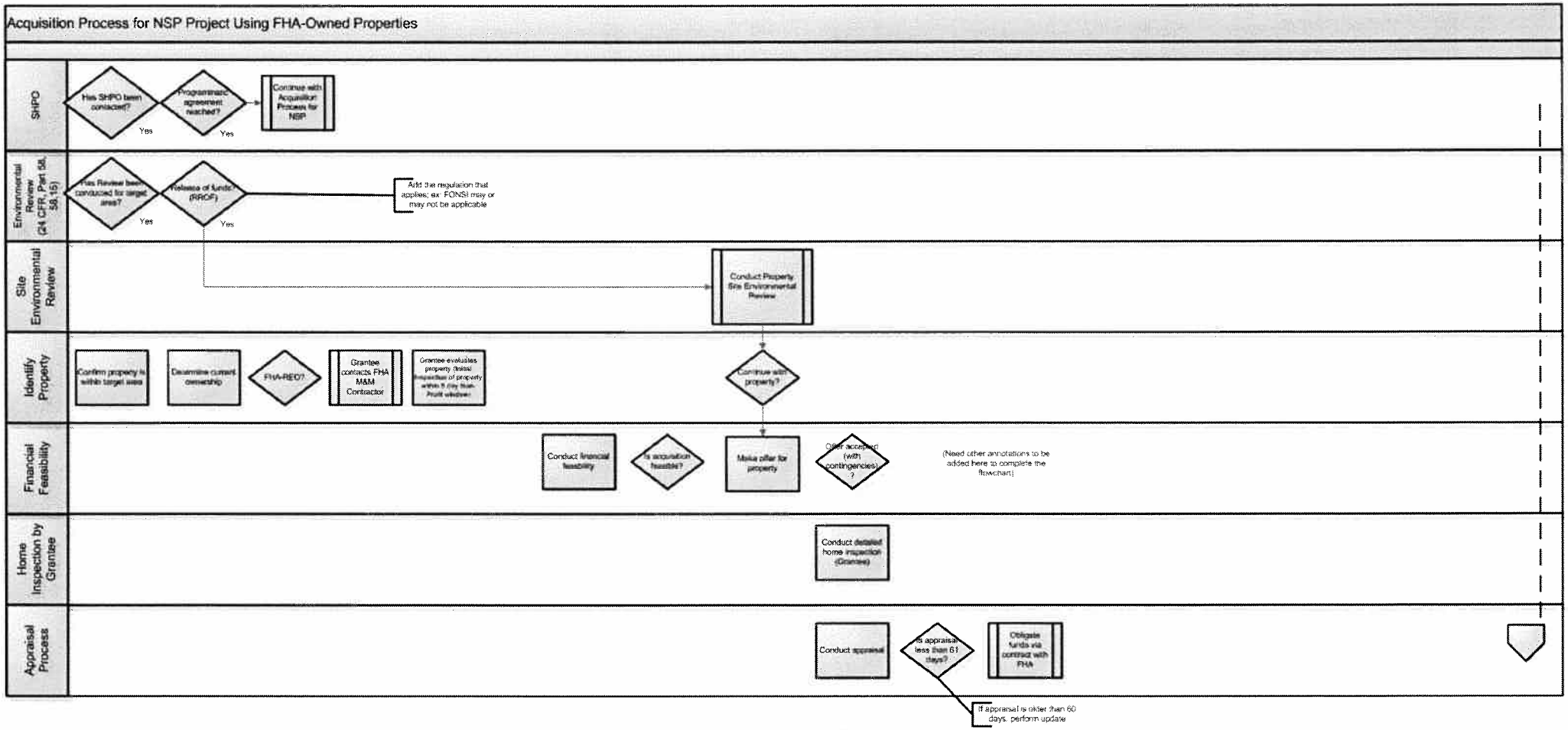
_____

APPENDIX H

SITE VISIT LIST

NIJ - MANAGEMENT OF MENTALLY DISABLED DETAINEES SITE VISIT LIST
(N=10)

Sites	Dates	Team
Hampshire County (Northampton), MA	5/18/93	Steadman, Jackson, Hafmeister
Summit County (Akron), OH	5/19 & 5/20/93	Steadman, Jackson, Hafmeister
Jefferson County (Louisville), KY	6/14 & 6/15/93	Jackson, Hafmeister
Shelby County (Memphis), TN	6/16/93	Jackson, Hafmeister
Pinellas County (Clearwater), FL	6/28 & 6/29/93	Jackson, Hafmeister
Hillsborough County (Tampa), FL	6/30 & 7/1/93	Jackson, Hafmeister
Fairfax County (Fairfax), VA	7/12 & 7/13/93	Jackson, Hafmeister
Henrico County (Richmond), VA	7/14 & 7/15/93	Jackson, Hafmeister
Lee County (Leesburg), GA	8/2/93	Jackson, Hafmeister
Page County (Clarinda), IA	8/3/93	Jackson, Hafmeister


Acquisition Process for NSP Project Using FHA-Owned Properties
SHPO
Has SHPO been contacted?
Yes
Programmatic agreement reached?
Yes
Continue with Acquisition Process for NSP
Environmental Review (24 CFR, Part 58, 58.15)
Has Review been conducted for target area?
Yes
Release of funds? (RROF)
Yes
Add the regulation that applies; ex: FONSI may or may not be applicable
Site Environmental Review
Conduct Property Site Environmental Review
Identify Property
Confirm property is within target area
Determine current ownership
FHA-REO?
Grantee contacts FHA M&M Contractor
Grantee evaluates property (Initial inspection of property within 5 day Right-Profit window)
Continue with property?
Financial Feasibility
Conduct financial feasibility
Is acquisition feasible?
Make offer for property
Offer accepted (with contingencies)?
(Need other annotations to be added here to complete the flowchart)
Home Inspection by Grantee
Conduct detailed home inspection (Grantee)
Appraisal Process
Conduct appraisal
Is appraisal less than 61 days?
Obligate funds via contract with FHA
If appraisal is older than 60 days, perform update