



National Institute of Justice

Research in Brief

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Issues and Findings

Discussed in this Research in Brief: Findings from an NIJ-sponsored survey and selected site visits undertaken to identify innovative policies and practices to address the needs of mentally disordered offenders detained in the Nation's jails.

Key issues: In today's over-crowded jails, an alarmingly high number of inmates are afflicted with acute serious mental disorders requiring mental health treatment and services. Few jails are equipped to provide a comprehensive range of mental health services, yet they are legally and morally bound to meet at least a minimum standard of care.

Key findings: Most jails have no policies or procedures for managing and supervising mentally disordered detainees. Numerous challenges to providing treatment for them are indicated by the following findings:

- Approximately 84 percent of survey respondents reported that mental health services were received by one-tenth or fewer of their inmates.
- Smaller jails (those with capacities of up to 99) tend to provide screening and suicide prevention services but little else, while jails with capacities of more than 1,000 can offer comprehensive programs with multiple service components.

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Providing Services for Jail Inmates With Mental Disorders

by Henry J. Steadman, Ph.D., and Bonita M. Veysey, Ph.D.

With an unprecedented number of Americans currently in jail—either awaiting adjudication of their cases or serving short-term sentences—mentally disordered offenders could be expected to constitute a percentage of the inmate population corresponding to their proportionate place in society. In fact, the percentage of jail detainees—both male and female—with mental disorders is substantially higher than among the general population.¹

Increasingly, jails are perceived as alternatives to inadequate community-based mental health services,² but providing for appropriate treatment for inmates with mental disorders is a task for which most facilities are ill equipped. Whether prepared to do so or not, however, jails are constitutionally required to protect and at least minimally care for such detainees.

A National Institute of Justice (NIJ) survey sought to determine specific needs of inmates with mental health problems in U.S. jails, the types of programs being used to serve this population, existing policies to ensure adequate inmate supervision, and the allocation of resources associated with program and policy implementation. This

Research in Brief discusses the survey strategy and findings, as well as innovative programs and policies identified during site visits to 10 jails selected on the basis of survey results.

Research strategy

In the initial phase of a threefold research design, a survey was mailed to a random sample of 600 jails with capacities of between 20 and 50 (as rated in the 1991 American Jail Association's directory of jail administrators)³ to gather information on the types of mental health services available, facility-specific characteristics, and overall effectiveness of mental health programs. Data for larger jails (i.e., those with rated capacities of 50 or more) were obtained from a concurrent study using a similar methodology to assess jail diversion programs for the mentally disordered.⁴ Since sections of the mail surveys describing basic components of jail health services were virtually identical in the two studies, information was drawn from the "diversion" data set and combined with the new survey data on smaller jails. Of the 1,706 jails that received the survey, 1,053 (62 percent) responded.

Issues and Findings

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- Case management services that link detainees, on release, to community services are seldom provided in jails of any size.

Researchers identified a number of facilities that used limited available resources to implement innovative programs and policies in six core areas: screening, evaluation, and classification procedures; crisis intervention and short-term treatment practices; discharge planning mechanisms; court liaison mechanisms; diversion practices; and contracting procedures. Analysis of these innovative practices indicates that:

- Locating the jail as one agency in a continuum of county- and community-based services can lift barriers to the sharing of information, expertise, and resources that is required to address the needs of inmates with mental disorders.

- Jails interested in devising mental health services specific to their institutional needs should consider convening a work group that includes criminal justice, social services, mental health, substance abuse, political, and religious leaders to develop a communitywide response.

Target audience: Policymakers, correctional officials, local government agencies, and health and social service professionals.

During the project’s second phase, followup telephone interviews were conducted with 100 (a sample representing jails of all sizes) of the 149 combined mail survey respondents who had assessed their mental health services as “very effective” (see exhibit 1). Data were collected on services available within the community, including any linkages, and on special policies or practices that informed the relationship among the police, the courts, and local mental health centers. In addition, interviewers requested estimates of the number of persons requiring mental health services in the community, the number actually receiving such services, and the quality of services received. Of the 100 jails contacted, 87 completed telephone interviews.

Researchers selected 10 jails from the sample of phone respondents as having particularly noteworthy practices, poli-

cies, or procedures with regard to the management, supervision, and treatment of detainees with mental illnesses. The 10 jails—two small (rated capacity of less than 99), two medium-sized (rated capacity of 100 to 249), three large (rated capacity of 250 to 999), and three “mega” sized (rated capacity of 1,000 and over)—were contacted and agreed to participate in the third phase of the study—site visits (see exhibit 2).

Each site visit began with a comprehensive jail tour followed by interviews with each of the key people involved with the programs and policies being investigated. On average, 7 interviews were conducted at each site, and 49 program elements were examined.

Overview of the findings

Approximately 84 percent of survey respondents indicated that 10 percent or

Exhibit 1: Jails Rating Their Mental Health Services as “Very Effective”

	Rated Capacity	Frequency	Percentage Selected	Number 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

Exhibit 2: Study Sites Visited

Site	Rated Capacity
Shelby County (Memphis), Tennessee	2,845
Hillsborough County (Tampa), Florida	2,276
Pinellas County (Clearwater), Florida	1,979
Jefferson County (Louisville), Kentucky	823
Fairfax County (Fairfax), Virginia	614
Summit County (Akron), Ohio	402
Hampshire County (Northampton), Massachusetts	248
Henrico County (Richmond), Virginia	178
Page County (Clarinda), Iowa	29
Lee County (Leesburg), Georgia	23

fewer inmates were receiving mental health services. The types of mental health services available in American jails varied widely by facility size. As shown in exhibit 3, small jails tended to offer little more than screening and suicide prevention services, while mega jails provided full-fledged (often certified) inpatient psychiatric programs to accompany an array of screening, evaluation, special housing, and psychotropic medication service components. Few jails, regardless of size, offered case management services to link detainees leaving jail to community services.

Twenty-one of the 87 respondents in the phase 2 telephone interviews reported having instituted new programs and policies designed to maximize care to mentally disordered detainees

using the limited resources available. The research team found that innovation was not correlated with jail size.

Screening, evaluation, and classification

Of those jails responding to the mail survey, 88 percent provided at least some level of initial screening at booking. Of the jails participating in the telephone interviews, 76 percent reported screening all booked detainees. Researchers noted that the thoroughness of the process varied, however, from cursory to extensive.

Multitiered screening and evaluation. Eight of the 10 jails visited had implemented some form of a multitiered screening and evaluation process, as recommended by the

American Psychiatric Association’s (APA’s) Task Force on Psychiatric Services in Jails and Prisons⁵ (see exhibit 4).

Implementation of multitiered screening is expected, as a matter of course, in large jails and therefore would not be considered an innovative procedure. The researchers noted, however, a particularly effective three-tiered approach at the Summit County (Ohio) Jail that featured an initial evaluation of mental status by a booking officer, a cognitive function examination administered by a mental health worker, and an evaluation by a clinical psychologist.

Inmate classification. Although researchers found a few programs with innovative classification systems for mental disorders, only the Jefferson

Exhibit 3: Jail Mental Health Services by Size of Jail

Service	Size of Jail ¹						National Weighted Estimate (N=3,304)
	Very Small N=295	Small N=265	Medium N=268	Large N=156	Mega N=43	Total N=1,013	
Screening	74.9	91.1	93.9	96.8	97.7	88.3	83.0
Evaluation	47.1	63.6	80.8	91.7	97.7	69.0	60.4
Suicide Prevention	62.4	78.7	88.1	93.6	95.3	79.4	72.7
Crisis Intervention	32.2	43.0	57.9	76.9	83.7	50.6	43.4
Psychiatric Medications	27.1	39.5	62.5	85.9	100.0	51.5	41.9
Inpatient Care							
In Jail	29.2	11.2	10.3	26.9	53.5	20.4	23.9
Outside Jail	52.9	36.8	39.1	52.6	46.5	44.9	48.1
Therapy/Counseling	18.3	23.6	35.2	57.7	83.7	32.9	27.1
Special Housing Area	22.0	42.2	49.4	73.1	93.0	45.1	36.1
Discharge Planning	12.2	19.6	26.9	50.6	67.4	26.1	20.7
Average Number of Services	3.8	4.5	5.5	7.1	8.2	4.0	4.6

¹Rated Capacity (number of jails nationally):

Very Small	=	20–50	(N=1,874)	Large	=	250–999	(N=338)
Small	=	51–99	(N=545)	Mega	=	1,000+	(N=76)
Medium	=	100–249	(N=471)				

County (Kentucky) Jail stressed the importance of ensuring appropriate housing assignments for detainees with mental health treatment needs. Its “mental health manager” communicates with members of the jail’s classification team within 24 hours of arrest to determine the most appropriate residential setting for inmates with pending psychiatric classifications.

In the Fairfax County (Virginia) Jail, deputies in the classification depart-

Exhibit 4: American Psychiatric Association Task Force on Psychiatric Services in Jails and Prisons

Recommendations on Screening and Evaluation

- Initial screening performed at an inmate’s booking into the facility to ascertain suicide potential, mental health history, and current medications.
- Intake mental health screening performed by a member of the mental health staff within 24 hours of booking.
- Mental health evaluation completed by appropriately trained mental health professionals in response to referrals made from either of the preceding screening processes, from the custodial staff, or from detainees themselves; evaluation takes place, ideally, within 24 hours of referral.

Recommendations on Crisis Intervention

- Training to recognize crisis situations.
- Twenty-four hour availability of mental health professionals to provide evaluations.
- A special housing area for those requiring medical supervision.
- Round-the-clock availability of a psychiatrist to perform clinical evaluations and prescribe emergency medications.

ment are specially trained in jail mental health issues, including making appropriate referrals to the forensics and substance abuse staffs. A formal written policy involves mental health providers in classification decisions. Responsibility for inmate classification is delegated to an institutional classification committee, consisting of one representative each from the jail’s diagnostic and treatment, classification and programs, confinement, medical, and forensics departments. The committee assigns and, as needed, effects changes in inmate custody levels during confinement.

Crisis intervention and short-term treatment

Treatment programs made up the majority of innovative policies and practices discovered during this study. Some of the most noteworthy approaches are presented below.

Case management services. Because jail incarceration is of relatively short duration, case management can affect continuity of care and proper discharge planning. Case management was adopted 20 years ago at the Hampshire County (Massachusetts) Jail to coordinate services on an inmate-specific basis. All inmates, whether mentally disordered or not, are assigned case managers, who have a typical caseload of about 30 detainees. Inmate treatment needs are assessed at intake, and the case manager then provides individual counseling, meets with the family, and makes referrals to appropriate resources both inside and outside the facility. Assignment of each sentenced and pretrial inmate to a case manager facilitates the process from intake through discharge planning (and reentry, if applicable). A high level of contact between

client and case manager ensures that inmates have access to services and that they do not “slip through the cracks.”

Crisis intervention. Although the need for crisis intervention in the jail setting is clear, the best way to provide this service is not. See exhibit 4 for APA Task Force recommendations. Most jails visited during this study placed a high priority on providing crisis intervention services. Three facilities demonstrated innovative ways to deliver crisis intervention: two sites (Summit County, Ohio, and Shelby County, Tennessee) employ crisis intervention specialists, and one site (Jefferson County, Kentucky) has a crisis intervention team. All three facilities met or exceeded recommendations in the APA guidelines. The primary goals of those charged with handling crisis intervention in these facilities, whether a single specialist or a team, are 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 to inmates with mental disorders. 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 Jail, the crisis intervention specialist, a member of the jail’s staff, receives 40 hours of training per year from the facility’s mental health coordinator; in the Shelby County Jail, a technician specially trained in crisis intervention evaluates and refers clients to the infirmary psychiatrist, administers prescribed medications, maintains contact with involved agencies and community resources used for referrals, and assists the infirmary psychiatrist during patient assessment and treatment.

The crisis intervention team at the Jefferson County Jail consists of a mental health manager, a master’s level clinical psychologist, and a certified psychiatric mental health nurse. This jail also maintains an Inmate Suicide Watch Program, which uses two-man teams, consisting of inmates, to accompany correctional officers on their nightly rounds. The inmate observers receive training to recognize signs of depression and risky behavior.

Each of the jails reported that it is better able to manage and supervise mentally disordered offenders as a result of having specific positions responsible for handling crisis intervention and short-term treatment.

Discharge planning mechanisms

Consistent with results from a 10-year-old study of 42 jail mental health programs, discharge planning was found to be the weakest element of all programs for mentally disordered detainees.⁶ Researchers observed that most programs at the 10 facilities visited offered referrals on release, but they were not aggressive and included little or no followup. There were two exceptions. The Fairfax County (Virginia) Jail program links released detainees with mental health services and maintains incarcerated detainees’ family ties (see “Offender Aid and Restoration Program, Fairfax County, Virginia, Jail”). In the Hillsborough County Jail in Tampa, Florida, most discharge planning is handled by two social workers who set up appointments, make other arrangements (such as transportation or housing), and—most importantly—follow up to make certain that mental health appointments are kept.

Offender Aid and Restoration Program Fairfax County, Virginia, Jail

Discharge planning at the Fairfax County Jail links detainees, on release, with mental health and related services and also maintains the inmate’s family ties during incarceration—thus providing the individual with an additional postrelease support system and contributing to his or her success on the streets. The services of this particular program are provided by Offender Aid and Restoration (OAR), a 21-year-old private, nonprofit organization, located directly across the street from the jail; OAR is 90-percent funded by the county.

OAR’s professional staff consists of eight members, all of whom have at least a bachelor’s degree in criminal justice, psychology, or sociology; they work closely with the jail to provide services that ordinarily would not be available. The program’s essential elements include:

- 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 among the judge, the booking staff, the jail’s forensic unit, and the agency.

- Transportation and housing assistance to the mentally ill on release.
- Emergency services for those without plans at release.
- Volunteers trained to teach, mentor, and tutor educational classes in the facilities and serve as postrelease “guides.”
- Teachers—both professional and volunteer—to instruct in 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 family food, clothing, and other necessities during the former provider’s jail stay.

Discharge planning in the Fairfax County Jail is provided for every individual. One special and very important feature of the facility’s program for the mentally ill is that detainees deal with the same professional staff person from intake through discharge.

Although discharge planning and followup should be key aspects of jail mental health programs, most jails seem to believe that their responsibility ends when the detainee is released. Jails with programs addressing these issues start planning for discharge during the early stages of the detainee’s incarceration and have specific followup procedures in place to ensure maintenance of any linkage provided on release. In the long run, making the effort to provide comprehensive discharge planning would

benefit the detainee, the jail, and the community.

Court liaison mechanisms

Offenders typically pass through the jails and the courts during processing by the criminal justice system, and interactions between these institutions can be particularly significant to the mentally disordered detainee. In addition to holding and helping to stabilize mentally disordered offenders for the courts, jails provide valuable information to ensure that such individuals are

H Features of Court Liaison Programs

Hampshire County (Massachusetts)

The Forensic Clinic at Hampshire County Jail 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 nonprofit agency. Current staff consists of the clinical director, a part-time psychiatrist, two part-time clinical psychologists, three part-time licensed social worker clinicians, and a court clinic coordinator (who is a licensed social worker and is the liaison between the court and the Hampshire County Jail and House of Corrections).

Services include counseling inmates referred by the jail's caseworkers; conducting evaluations for competency and criminal responsibility; operating a weekly medication clinic; and participating in weekly meetings with jail caseworkers to review their referrals and set up service schedules.

This program is highly dependent on the qualifications, skills, availability, cooperation, and effectiveness of the jail's case managers. It works, in part, because the jail's case managers screen detainees before the Forensic Clinic program is involved, thereby facilitating the triage process to enable the clinic staff to focus attention on those inmates who need their services. In addition, because of the

limited time the Forensic Clinic staff spend in the jail, case managers inevitably inherit much of the responsibility for implementing the day-by-day elements of any treatment plan.

Pinellas County (Florida)

The court liaison program in Pinellas County initially focused on mentally ill misdemeanants. Staff did not want to send such individuals to a psychiatric hospital as "incompetent to stand trial" or "not guilty by reason of insanity," dispositions that could result in long-term, but unnecessary, hospitalization. This type of offender could be held in jail for 4 or 5 months while dispositions were processed.

Under a cooperative agreement worked out between the District Mental Health Board, the State's attorney, the public defender, and the judiciary, the court liaison goes into the jail to identify likely candidates for civil commitment as an alternative to the criminal justice track and follows through with the State's attorney and/or the public defender's office to secure a civil commitment hearing.

The civil commitment hearing is held at Pinellas Emergency Mental Health Services (a crisis stabilization unit for indigents), and arrangements are made for subsequent placement. On the placement date, the criminal charges are

dropped by the State's attorney in the morning, and the offender is transported to the treatment facility in the afternoon. To expedite matters, the court liaison walks the papers through the process, notifies all relevant parties, and arranges for post-release continuity of care.

Shelby County (Tennessee)

In Shelby County, a multiagency memorandum of understanding provides that each of the signing agencies (which include pretrial services and the public defender's office) appoint contact persons (boundary spanners) to act as liaisons with all other social service agencies and service providers.

The staff at pretrial services reports the legal status and court dates of those with severe mental illness to the appropriate agencies and assists in expediting court dates when appropriate. The public defender's office cooperates with pretrial services in communicating the legal status of cases involving the severely mentally ill, assists in expediting court dates, and enters court orders for evaluations as needed. The mental health liaison also meets periodically with the judges to remind them of the services available in the program.

Judicial recognition of the program's effectiveness is reflected in the speed with which the liaison is able to move up court dates for mentally disordered detainees.

processed appropriately by the judicial system. Similarly, the courts supply jails with information that facilitates management and retention or diversion to more suitable placements. In general, jail personnel at all sites know that the courts ultimately decide the fate of mentally disordered offenders and, thus, need to be considered in

planning and implementing mental health programs.

All of the sites visited had developed, at a minimum, relatively routine means for ad hoc dealings with the courts in response to special needs of the mentally disordered offender; several sites had developed specific pro-

grams to facilitate interactions (see "Features of Court Liaison Programs").

The Forensic Clinic, created in 1985 at the Hampshire County Jail in Northampton, Massachusetts, provides detainees with the services of a psychiatrist, psychologists, and social workers on site, in lieu of more costly

hospitalization. The major strengths of this program stem from its location within the jail: immediate treatment responses that decrease the number of psychiatric hospitalizations that otherwise would be required, good working relationships (facilitated by weekly meetings) among the court clinicians and the jail's case managers and correctional staff, and enhanced information sharing (e.g., patient mental health histories or current behavioral problems).

In the Pinellas County Jail in Clearwater, Florida, a court liaison goes into the jail to identify likely candidates for civil commitment, as an alternative to the criminal justice track, and follows the case through the courts to final disposition. This court liaison program appears to be an effective response to the problem of diverting mentally disordered offenders out of the criminal justice system and into a civil system specifically equipped to address their mental health needs. The court liaison maintains contact with and gains the cooperation of a number of players vital to ensuring that these transfers are smooth, that individuals are not lost in the shuffle, and that services are provided continuously and effectively.

A multiagency memorandum of understanding was drawn up in Shelby County, Tennessee, to the effect that all signatories agree to appoint contact persons to interact with other service agencies and providers. A program such as Shelby County's requires commitment from the community and involved agencies, particularly the community mental health providers, sheriff's department, and the jail's medical department. Bringing together the involved parties to talk and acknowledge their common needs is the

first critical step. Participants in this program have not yet developed a rapport with the public prosecutor, who views the jail as an acute mental health care facility. As a result the prosecutor's office is asked to become involved in individual cases only when it is absolutely necessary. Some problems have resulted from excluding prosecutors from the program's initial and ongoing planning meetings.

The court liaison program in Fairfax County, Virginia, 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 defendant should be in or out of jail. Although the program has been viable for only a short time, it has enhanced the management and supervision of mentally disordered offenders by diverting them from jail to more appropriate treatment settings. The program's success is credited, in part, to educating the courts and prosecutors to make critically important pretrial decisions. As is true of court liaison programs in general, this program's ability to effectively address the needs of the mentally disordered offender depends on developing the necessary communication and trust among the various players.

Key to the success of court liaison programs is open communication and cooperation among all parties. Inmates can sense if staff are working at cross purposes and may seek to exploit these differences. Further, mental health treatment particularly requires a consistent approach to be effective. The support, contribution, and input of all involved parties are necessary for the proper functioning of this type of program.

Diversion practices

One frequently proposed approach for responding to persons with mental illnesses in jails is to remove them from jail to appropriate community-based mental health programs. The team visiting the sites found excellent examples of both pre- and postbooking diversion programs.

Prebooking diversion—Hillsborough County. Officials in Hillsborough County, Florida, have established a Crisis Center as an alternative to jail, to which police can bring criminal offenders suspected of also having serious mental illnesses. The Crisis Center was developed by the current director 3 years ago to reduce recidivism and more efficiently use community resources. Here, assessment, crisis intervention, and treatment are provided to all persons needing those services. The center has the capacity to accept persons charged with offenses up to nonviolent felonies.

The program relies on a smooth relationship between the staffs of the center and the local police department. Prior to its implementation, the current center director visited all police agency roll call sessions to inform officers of the services available and the center staff's willingness and ability to work with law enforcement. The center's bilingual staff offers services in a secured area, and a system is in place to limit the presence of police officers to 20 minutes or less. The most seriously ill inmates can be sent to the center for better treatment than is available in the jail. Also, the Crisis Center has 24-hour nursing capabilities and, unlike the jail, can force medication when necessary because of its secure ward.

Prebooking diversion—Fairfax County. Another noteworthy

C Community Treatment Alternatives Program

Community Treatment Alternatives Program (CTAP) in the Jefferson County (Kentucky) Jail is a formal, written program implemented, run, and staffed by Seven Counties Mental Health Center in Louisville, Kentucky. Its purpose is to provide community-based mental health services as an alternative to incarceration for adjudicated offenders with chronic mental illness.

The criteria for admission into the program are chronic offender status (usually misdemeanants) along with severe mental illness. The target population, defined by guidelines developed by the State Department of Mental Health, includes, for example, individuals with bipolar disorders, but not those with primary substance abuse and personality disorders.

Clients are referred to the program by other mental health professionals, judges, an attorney, the court liaison, or a jail mental health worker. Caseworkers from Seven Counties visit the jail every morning to assess potential clients. Based on a review of this assessment, the case-

worker decides whether the detainee is appropriate for the program.

If the decision is affirmative, correctional services, community mental health services, and the courts work together to develop a coordinated plan for securing the detainee's release from jail and assist in meeting the detainee's mental health needs. CTAP detainees are released from jail directly into the community; approximately half live in their own homes; others reside in boarding homes or in housing provided through other programs—such as the Volunteers of America's Mentally Ill Men at Risk for Homelessness Program.

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.

Detainees in the community are supervised closely. In the first month after release, the detainee's contact is mainly

with the CTAP caseworker. After that, the case is turned over to Seven Counties staff. Detainees usually come into the center for appointments and, in addition, Seven Counties staff do home visits to check life management skills. Medications are monitored closely—some detainees must come to the center each day to receive their medications, while others are given injections.

The monthly meetings among jail mental health staff, CTAP caseworkers, and the court liaison provide an opportunity to strategize and decide who in the jail should be targeted for the program's services. CTAP detainees must sign a contract that commits them to the program for a 2-year period and sets out the jail term in case of revocation for such actions as failure to participate in the treatment plan. When a contract is violated, the detainee appears before the judge, who can change the sentence from treatment to the contract-specified jail term or to a new 2-year contract with additional prospective jail time added.

prebooking diversion program, the mobile crisis unit (MCU), was designed to divert mentally disordered inmates from jail through working with the family, the police, and the courts. Staffed and funded by Fairfax County, Virginia, the MCU consists of a home visit team for those unable or unwilling to go to a mental health center. It is staffed 7 days per week, from 3 p.m. to midnight. Each afternoon, when staff members arrive for duty, they check in with the seven or eight area mental health centers for referrals; reportedly, they receive at least two each day.

MCU services include suicide assess-

ment, prevention, and intervention; psychiatric crisis evaluation, intervention, and (when necessary) hospitalization; administration of medication in domestic disturbances; intervention in drug and alcohol crises that pose the risk of danger; stress reduction for service providers; and assistance for people coping with trauma or tragic events. Additionally, MCU team members serve as consultants to police SWAT teams in hostage-barricade incidents. If the incident is solely a mental health crisis, the team gathers background information on the perpetrator and makes all necessary arrangements for care (e.g., hospital beds). If the incident results in an ar-

rest, the MCU notifies the jail's forensic unit and provides it with essential background information. Other duties include:

- Going to police roll call sessions to train officers and magistrates in mental health issues.
- Educating families and the community about the criminal justice system.
- Providing backup for the jail's crisis intervention team.
- Acting, in lieu of police officers, as petitioners/recommenders for the mentally disordered at hearings.

Postbooking diversion. The comprehensive postbooking program in Jefferson County, Kentucky (see “Community Treatment Alternatives Program”) is designed to provide community-based mental health services as an alternative to incarceration for chronically ill adjudicated offenders.

Contracting procedures

Using university resources. 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 (Ohio) Jail, researchers discovered that assignments at the county jail are part of the local medical college’s community psychiatry rotation. The fact that rotations originate in the community, rather than in the forensic training program, is an implicit acknowledgment that mentally ill detainees are a community services responsibility.

The psychiatrist on a 3-month rotation is in the jail for 6 hours per week and primarily sees inmates already on medication or needing to be evaluated for medication. The jail’s “team approach” simplifies this task. Jail mental health staff screen inmates before the psychiatrist sees them; in jails that do not have such screening, the psychiatrist receives limited information regarding, for example, behavioral patterns, which makes it difficult to properly prescribe medications. Psychiatrists in the jail setting interact with jail administrators and correctional staff as well as treat patients.

The Henrico County Jail in Richmond, Virginia, contracts for psychiatric services with the local medical college through a fellowship in psychiatry. The fellow spends 3 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 2 weeks. Any problems between these visits are handled by the jail’s mental health staff. When asked if 4 hours per week of psychiatric coverage was sufficient, the staff answered in the affirmative since, as a rule, fewer than 30 inmates at any given time are on medication.

Coordination with community mental health services. The Alcohol, Drug Addiction, and Mental (ADM) Health Services Board is a county administrative board that controls all funding for Summit County (Ohio) mental health services.⁷

Each year Summit County and the ADM Board enter into a written agreement that sets out the functions, responsibilities, and rights of both parties for the following 12-month period. In general, the jail provides services directly, with additional responsibilities in the areas of clinical evaluation and quality assurance, and the board provides planning, funding, evaluation, and monitoring of alcohol, drug addiction, and mental health services. Funding is advanced to the jail on a grants management basis.

Privatization of mental health services. Three of the 10 jails visited were contracting for mental health services through a national private care provider, such as Correctional Medical Services (CMS) or Prison Health Services (PHS). For example, in the Pinellas County (Florida) Jail, the private contractor provides mental health services, required minimum staffing, professional liability insurance, and medications.

A benefit of the privatization model is that the national scope of the provider brings resources to the jail that would not otherwise be available to assist with management and supervision of mentally disordered offenders. Two of the jails with these contracts employ a contract monitor who ensures compliance with the contract terms, including maintenance of required accreditation standards and staffing patterns. In Hillsborough County, Florida, the position of contract monitor is itself a provision of the contract.

In addition to jails that contract for services with national health care providers, such as CMS or PHS, there are some, such as Hampshire County, Massachusetts, that contract with private for-profit or nonprofit community mental health agencies to provide specific services that would not ordinarily be available in the jail. This method can ensure the availability of needed services without using limited resources to create an internal program.

Taking action

Mental health litigation has established the legal right to treatment in custodial facilities—for pretrial detainees as well as sentenced inmates. Among its benefits, good mental health treatment can reduce security risks by minimizing the symptoms of mental illness, thereby decreasing potential disruptions to jail routines and injuries to staff and detainees.

The problems jails experience in connection with mentally ill detainees are associated with the absence of criminal justice policies, procedures, and standards specifically addressed to this group of offenders. Deficiencies in training, communication, and resources result from viewing the jail in

isolation, rather than as an integral part of a criminal justice system (that includes the police, the courts, defense attorneys, and prosecutors) with linkages to mental health and other human services based in the greater community.

Except for the largest jails in the major metropolitan areas, it is impractical to consider developing a comprehensive set of inhouse mental health services. A more prudent approach would have the jail making effective use of community mental health centers; psychiatric units of hospitals; private practitioners; university departments of psychology, medicine, and social work; and State mental hospitals. “Effective use” does not mean, necessarily, the actual transfer of inmates but, rather, drawing on staff expertise in these external programs and planning services in ways that optimize program resources.

The policies and programs implemented by jails in this study represent promising strategies that can be adapted to individual communities. Ultimately, each locality must decide what it needs and wants, how it can pay for it, and who needs to be brought together to make it happen. Five principles developed previously by the researchers⁸ should still be considered for possible guidance:

- The mentally disturbed jail inmate must be viewed as a community issue.
- The jail is, and should remain, primarily a correctional facility.
- Minimum professionally acceptable mental health services are required in every jail and lockup.
- Jail mental health services should focus on screening and identification

of need, crisis intervention and short-term treatment/stabilization, and case management/referral.

- There is no single “best” way to organize services.

Notes

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5. American Psychiatric Association, *Psychiatric Services in Jails and Prisons: Report of the Task Force on Psychiatric Services in Jails and Prisons*, Washington, DC: American Psychiatric Association, 1989.

6. Steadman, H.J., D.W. McCarty, and J.P. Morrissey, *The Mentally Ill in Jail: Planning for Essential Services*, New York: Guilford Press, 1989.

7. The funding source for these services is the Governor’s Office of Criminal Justice Services. Approximately 50 percent of ADM money comes from State coffers and 50 percent from a local mental health levy (a part of the county tax base). The ADM Board consists of eight members appointed by the county executive, five appointed by the Ohio Department of Mental Health, and the remainder by the Ohio Office of Drug Addiction and Alcohol Abuse.

8. Steadman, H.J. et al., “A National Survey of Jail Mental Health Diversion Programs.”

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