

North Carolina Jails and Inmates with Mental Illnesses and Developmental Disabilities

A Report and Analysis



Funded by the North Carolina
Governor's Advocacy Council for Persons with Disabilities

***I called the hospital and I say, "My son's in jail and he needs to be in the hospital," and she says, "We don't take criminals."
--Family member***

Preface

The two studies contained here examine the operation of county jails and the consequences of jail policies and procedures for the thousands of individuals with mental illnesses (MI) or developmental disabilities (MR/DD) incarcerated on any given day across North Carolina. The studies were recommended by the federally mandated Protection and Advocacy for Persons with Mental Illness Advisory Committee (PAIMI), and were subsequently commissioned by the Governors Advocacy Council for Persons with Disabilities (GACPD).

The study by Jennie Vaughn and Anna Scheyett both at UNC Chapel Hill School of Social Work is based on structured interviews of jail administrators and officers and written survey responses from consumers and family members. With a remarkable 80 of 93 active jails participating, this study provides a comprehensive overview of procedures for intake screening, availability of

“Well, I think they should investigate them and...try to get them some help, you know, first. ‘Cause putting people in jail ain’t always the answer.”

--Consumer

medical and mental health services, hospitalization and suicidality, access to and dispensing of medications, and

coordination with community mental health providers.

The study demonstrates the wide diversity in policy, and resultant range of quality, in treatment of jail inmates with MI or MR/DD in North Carolina. It also highlights the challenge of coordination of care between community providers and jails, as well as the challenge of limited resources within the jails for service provision.

The companion study by Melissa Floyd Taylor at UNC Greensboro School of Social Work provides a sampling of the experiences of people with MI and MR/DD and their collaterals: family members, jail personnel and local management entity (LME) workers. From these semi-structured interviews one gets a vivid picture of participant needs, concerns, and personal opinions. GACPD highly recommends using these studies in tandem when considering policy options around these issues.

It is clear from the studies that inmates, their families, and jail administrators are pleading for help. The Vaughn and Scheyett study provides thoughtful analysis of survey results and suggests many possible improvements to jail policy. The study recommendations that emerged from both studies are not an academic wish list. They are supported by best practice from the literature, however they are also firmly grounded in

“I know what we got going on here ain’t working. I can’t tell you how to make it better though.”

--Jail personnel

common sense.

It is hoped that these jail studies will be a helpful source of information for jail administrators, county commissioners, state officials, and legislators to consider when forming jail and community support policies. Additionally, it is hoped that Local Management Entities (LMEs) can address the need for coordination and continuity of care for clients who are incarcerated.

While a detailed fiscal analysis is outside the scope of this report, implementing the strategies contained in these recommendations seems unlikely to create hardships for county budgets, and could even save total tax dollars. In addition, the societal benefits for our communities, and particularly for thousands of incarcerated individuals, would be enormous.

In addition to implementation of recommendations from these studies, the most important “next steps” in this area may be examination of various jail diversion programs, which address the issues of people with MI and MR/DD who are caught up in the criminal justice system but prior to, and just after booking. These and other similar programs have the promise of preventing the inappropriate and costly incarceration of many people with MI and MR/DD who should never have been sent to jails or prisons in the first place.

The GACPD is truly grateful to researchers Jennie Vaughn, Anna Scheyett, and Melissa Floyd Taylor for their insight and hard work in producing these important jail studies. Without their dedication and commitment to persons with disabilities

“I think we need someone here to evaluate these inmates when they come in. These officers are not trained to do that. They see them as just another crazy person that they have to deal with.”
--Jail nurse

in North Carolina, this study would not have become the exceptional research and policy tool you see before you.

Additionally, the GACPD would like to extend very special thanks to the more than 150 jail staff, LME staff, and consumers and family members whose participation made these studies possible and meaningful.

Allison Breedlove

Acting Executive Director, GACPD

Hon. Mark D. Urban

Chairman, GACPD

Identification and Treatment of Individuals with Mental Illness and Mental Retardation/Developmental Disability in North Carolina Jails

Executive Summary

Goals

To determine the current procedures in North Carolina county and regional jails regarding individuals with MI or MR/DD. Specifically:

- How are individuals with MI or MR/DD identified during the jail intake process?
- What are the procedures for service provision to jail inmates identified as having MI or MR/DD?
- What are the procedures for communication with community-based service providers regarding jail inmates identified as having MI or MR/DD?

Methods

1. Interviewed jail administrators from across the state to identify their practices regarding identification and care of inmates with MI or MR/DD.
 - a. Interview protocol and guide for jail administrators developed in collaboration with an advisory group chosen by GACPD.
 - b. Letters describing the study and introducing the research team were sent to sheriffs and jail administrators.
 - c. Jail administrators were contacted by telephone and asked to participate in a 30-question telephone interview.
 - d. Eighty of the 93 (87%) active jails participated in telephone interview.
 - e. Responses were entered into computer verbatim during the interview.
 - f. Interviewees were asked to fax screening tools to researchers; 31 were received and reviewed.
 - g. Transcripts were reviewed and coded and descriptive statistical analyses were completed.
2. Gathered information from individuals with MI or MR/DD and their family members regarding experiences they have had with a jail incarceration in North Carolina.
 - a. Survey protocol and instrument were developed in collaboration with an advisory group chosen by GACPD.

- b. Researchers contacted leaders of five advocacy groups that serve consumers of mental health and MR/DD services and their family members: The Arc of North Carolina (formerly The Association of Retarded Citizens); NAMI-NC (the North Carolina chapter of the National Alliance for Mental Illness); NC Mental Health Consumers Organization; The Autism Society of NC; The Brain Injury Association of NC. Contacted their local affiliates and asked them to distribute surveys to their membership with a self-addressed stamped envelope.
- c. Fifty surveys were returned.
- d. Surveys were reviewed and coded and descriptive statistical analyses were completed.

Highlights of Results

- *Jails in North Carolina are stressed*, on average reportedly running at 107% of capacity. Jailers expressed concern about staffing demands when housing individuals with MI and about the fiscal demands inmates with MI placed on their jails, particularly concerning medications.
- *Jails are not screening for MI or MR/DD effectively* through the use of an evidence-based screening tool, though nearly all jails (77, or 96%) report that they screen for MI. Almost none of the jails interviewed reported that they formally screen for MR/DD (only 5, or 6%). In addition, screening often relies solely on officer observation (with no questions about MI or MR/DD asked directly to the inmate) and is done primarily by jail officials who do not receive adequate and ongoing training in identifying and working with individuals with MI or MR/DD.
- *Privacy is an issue*. Less than half of jails interviewed (33, or 41%) consistently conduct intake screenings in a private setting. Only 6 (8%) jails reported dispensing medication in a private setting.
- *Suicide protocols vary*. Reasonable steps, such as frequent/constant observation and removal of harmful objects, were consistently present, but greater variation was seen in protocol around clothing and restraints. Some jails reported providing suicide smocks while others left inmates in their underwear. Four jails reported having a restraining chair for uncontrollable inmates.
- *Consumers often wait for medications*. In half of the jails interviewed there was a wait of over three days for inmates to receive needed medication; in nearly 12% of jails the wait could be over two weeks.
- *Inmates may not always get their usual medication*. Over one-third of jails reported having a formulary and another 20% said they did not have a formulary but made medication substitutions at times. This was also reported by individuals responding to our written survey.

- *Handling emergencies is difficult for jails.* Transfer of inmates to Central Prison Safekeeping or a state psychiatric hospital is the usual strategy, but this can be a lengthy process, takes up large amounts of jail staff time, and is not necessarily clinical best practice.
- *Getting consumers mental health care while in jail is difficult.* On-site mental health personnel are not common. Jails rely on their LME for care of inmates with MI; over 30% of jails reported having to take inmates out of the jail (in handcuffs and shackles) to receive care.
- *Communication between jail and community care is erratic.* 60% of jails report contacting provider at admission, but only 19% report always contacting provider at release and only 9% of jails report always being contacted by community provider when consumer in jail. 61% of written surveys said they were not allowed to contact their provider while in jail.
- *Jails are concerned about adequacy of mental health system.* Though 14 (18%) stated that they felt the LME worked well with the jail, 24 (30%) expressed concern about the ability of the LME and mental health system to provide adequate services to inmates and those at risk of arrest and 13 (16%) expressed concern about the difficulty they had in accessing mental health services post-mental health reform.

Recommendations

- Adopt use of evidence-based screening tools to identify individuals with MI or MR/DD, and those at risk of suicide, and ensure that jail staff have ongoing training.
- Have a private place and process for the intake screening and provision of medication.
- Hire/contract with a trained mental health professional; if this is not possible, 24/7 access to consultation from a mental health professional in the community is needed.
- Streamline procedures to access medications to ensure no interruption in medication.
- Jails need additional resources to cover the cost of psychotropic medications.
- LME mobile crisis teams should provide care to inmates in crisis in the jail.
- Negotiate with local hospitals to provide emergency services and hospitalization to inmates.
- Streamline processes for inmate hospitalization at both the state psychiatric facilities and Central Prison Safekeeping.
- Jails and LMEs need quick and frequent communication, including information to the jail about the inmates' community-based prior treatment

and medications, as well as any other relevant information that would help jail staff with the individual while incarcerated and information about date of inmate release to the LME.

- Inmates should be released with an appointment made at a community provider.
- A comprehensive evaluation of mental health reform's impact on incarceration rates and access to services while in jails for individuals with MI or MR/DD is needed.
- Jail diversion programs are needed across the state to prevent unnecessary incarceration of individuals with MI or MR/DD
- A "Jail Inmates with MI or MR/DD" ad hoc Task Force is needed at the State level to make and disseminate recommendations of ways in which county, regional, and state-level efforts can ensure that jail inmates with MI or MR/DD are better served.

**Identification and Treatment
of Individuals with Mental Illness
and Mental Retardation/Developmental Disability
in North Carolina Jails**

by

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Purpose

Individuals with mental illnesses (MI) and mental retardation or developmental disabilities (MR/DD) are overrepresented in the criminal justice system. A study in California revealed that between 4% and 10% of prison inmates had a developmental disability and the rates were thought to be even higher in jails (Petersilia, 1997). Similarly, a recent study by the U.S. Bureau of Justice Statistics documented that nationally an estimated 56% of state prison inmates and 64% of local jail inmates have mental health problems. In addition, the study revealed that many of these inmates are unable to access treatment in the criminal justice system; in the study only 33.8% of prison inmates and 17.5% of jail inmates received treatment after incarceration (James and Glaze, 2006).

The issue of high rates of incarceration among individuals with MI has been highlighted as a priority issue in the President's New Freedom Commission on Mental Health report, emphasizing the need for adequate coordinated treatment rather than incarceration for people with mental illnesses (New Freedom Commission on Mental Health, 2003). Despite this emphasis, the criminal justice system continues to be overloaded with individuals with MI and MR/DD, and has in many cases become the *de facto* care system for these individuals. (For a more in-depth review of the literature on criminal justice and persons with MI or MR/DD see Appendix A.)

In North Carolina, the issue of the incarceration of individuals with MI or MR/DD is particularly urgent, given the dramatic transformation of the mental health, developmental disabilities, and substance abuse service system as the result of State Law 2001-437. A recent report from an outside consulting group identified significant problems with continuity of care for services in the North Carolina system, resulting in service and coordination gaps (Thompson and Broskowski, 2006). Anecdotal reports indicate that the numbers of individuals with MI or MR/DD unable to access adequate and consistent treatment is increasing, resulting in higher numbers of these individuals in local jails.

A point-in-time census conducted by the U.S. Bureau of Justice (James and Glaze, 2006) found that on June 30, 2005, there were 17,171 inmates in North Carolina jails. If, as national statistics cited above indicate, 64% of these inmates have mental health problems and 5% a developmental disability, then on any given day, nearly 11,000 individuals with mental health problems and more than 850 individuals with a developmental disability are in jail, and less than 1 in 5 of them will receive treatment while they are there.

Given this situation, the Governor's Advocacy Council for Persons with Disabilities (GACPD) determined that an examination of North Carolina jails and their identification and treatment of individuals with MI or MR/DD was essential. Therefore, the overall goal of this project was to examine the procedures currently used for identification of inmates with MI or MR/DD in North Carolina

county jails, to determine policies and procedures for service provision to these identified inmates, and to make recommendations for amelioration of problem areas and expansion and dissemination of identified effective practices.

Our overarching research question was thus: What are the current procedures in North Carolina county jails regarding individuals with MI or MR/DD? Specifically we wished to determine:

- How are individuals with MI or MR/DD identified during the jail intake process?
- What are the procedures for service provision to jail inmates identified as having MI or MR/DD?
- What are the procedures for communication with community-based service providers regarding jail inmates identified as having MI or MR/DD?

Our strategy was twofold: first, to interview jail administrators from across the state to identify their practices regarding identification and care of inmates with MI or MR/DD; and second, to gather information from individuals with MI or MR/DD and their family members regarding experiences they have had with a jail incarceration in North Carolina.

Methods

An interview protocol and interview guide for jail administrators and a paper survey for individuals with MI or MR/DD and their families were developed in collaboration with an advisory group comprised of leadership from GACPD as well as consumers and other advocates with interest and experience in the topic (see Appendix B for a list of Advisory Group members). All protocols, guides, and surveys were approved by this group. In addition, study documents and protocols for both the survey and interviews were approved by the Behavioral Institutional Review Board (IRB) of the University of North Carolina at Chapel Hill.

Jail Administrator Interviews

Detailed letters describing the study and introducing the research team were sent to sheriffs in each county and to jail administrators in each of the state's 96 jails (94 county jails and two regional jails). These letters explained the purpose of the study and informed the recipients that researchers would be calling them in the near future to request a telephone interview with the jail administrator or his/her designee. Most of North Carolina's 100 counties have a jail or detention center operated under the auspices of the county sheriff. A few small, rural counties have pooled their resources and share a jail; the Albemarle Regional Jail houses inmates from Camden, Currituck, Pasquotank, and Perquimans Counties in the northeastern part of the state, and the Bertie-Martin Regional Jail houses inmates from those two counties. Jails in three counties—Mitchell, Hyde, and Tyrrell—are not operating at this time. Thus, though there are 96 total jails,

there are only 93 county jails in operation. Some counties have multiple facilities, but the facilities in each county are run by the same organization; for the purposes of this study, these multiple units were counted as a single jail.

Following the introductory letters, jail administrators were contacted by telephone and asked to participate in a 30-question telephone interview. Some administrators designated another jail official or jail medical official to complete the interview. Interviews ranged in length from 15 to 60 minutes, with most taking approximately 30 minutes. Eighty jails participated in the study, for a response rate of 86%. To avoid concerns of inter-rater reliability, a single researcher (jsv) conducted all interviews. For 72 of the 80 interviews, the interviewer typed verbatim subjects' responses while the interview was taking place. Responses to 7 other interviews were recorded by hand. One subject was unable to schedule a telephone interview but faxed a written response. To ensure confidentiality, interview subjects were assigned an ID number, and no names and locations were included in interview transcripts.

A second researcher (ams) reviewed the transcripts, coded and entered data, and performed statistical analysis. Descriptive statistical analyses were completed for all salient variables. A few variables in the original interview instrument were not analyzed because of high rates of missing data as a result of the interviewee choosing not to respond or being unable to access the information needed.

During the interviews, interviewees were asked if they would be willing to fax the researchers a copy of their screening instruments for MI and/or MR/DD. Thirty-one screening instruments were returned to the researchers. These were coded and descriptive statistical analyses completed.

Survey of Individuals with MI or MR/DD and Family Members

Researchers contacted leaders of five advocacy groups that serve consumers of mental health and DD/MR services and their family members:

- The Arc of North Carolina (formerly The Association of Retarded Citizens)
- NAMI-NC (the North Carolina chapter of the National Alliance for Mental Illness)
- NC Mental Health Consumers Organization
- The Autism Society of NC
- The Brain Injury Association of NC

After providing information about the study, researchers requested permission to contact local group affiliates statewide to ask them to announce the study at one of their upcoming meetings and distribute surveys to individuals with MI or MR/DD and family members. Researchers contacted these local affiliates by telephone; a letter or email was sent to those who could not be reached by phone after repeated attempts. Researchers also contacted a number of

unaffiliated MI consumer advocates and asked them to distribute surveys to appropriate parties.

The survey consisted of 23 questions set at approximately an 8th grade reading level. Surveys were enclosed in self-contained survey packets which included all information and resources necessary to answer and return the survey. Each packet contained a consent form describing the purpose and methods of the study, a copy of the survey, and a stamped, addressed return envelope. Care was taken to ensure anonymity of survey respondents. Respondents were asked not to sign the consent form, and the survey contained no questions regarding the identity or location of the jail where the respondents had been detained.

In total, surveys were sent to 175 groups and affiliates. In addition, a follow up email or letter was sent to each affiliate leader four weeks after the initial contact, asking that they remind members to return surveys. Researchers could not determine the actual number of surveys given to potential respondents, since the local affiliate leader did the actual distribution. However, response rates were low. Only 50 surveys were returned, and of these, only 46 were completed by individuals with experience with North Carolina jails and were thus usable. Given that incarceration rates among individuals with MI or MR/DD are high—a study by the National Alliance of the Mentally Ill (1992, as cited in Weisman, Lamberti, & Price, 2004) found that 40% of individuals with severe mental illness (SMI) surveyed reported having been arrested—this low response rate was surprising. Reasons for this are not known, but may include the stigma of incarceration or the difficulty of reporting painful events such as incarceration for oneself or a loved one.

Results

Jail Administrator Interviews

Interviewee and Jail Characteristics

Figure 1 provides a description of interview subjects for the 80 telephone interviews conducted for this report. Most interviews (58, or 70%) were conducted with a jail official¹, usually the jail administrator, known also as the jail director or chief jailer. An assistant jail administrator was interviewed at a few jails (6 or 7%). Some jails referred researchers to jail medical officials, such as the jail's medical administrator (10, or 12%) or other members of the jail's medical staff (8, or 10%). At one large jail, a director of jail programs completed

¹ For purposes of this report, *jail official* refers to an officer or administrator who has received law enforcement training and certification; *jail medical official* refers to a nurse, doctor, or other medical specialist who has received extensive medical training and certification.

the interview. At three jails, a jail official and a jail medical official asked to do a joint interview; thus, 83 persons were interviewed at the 80 jails.

Figure 1

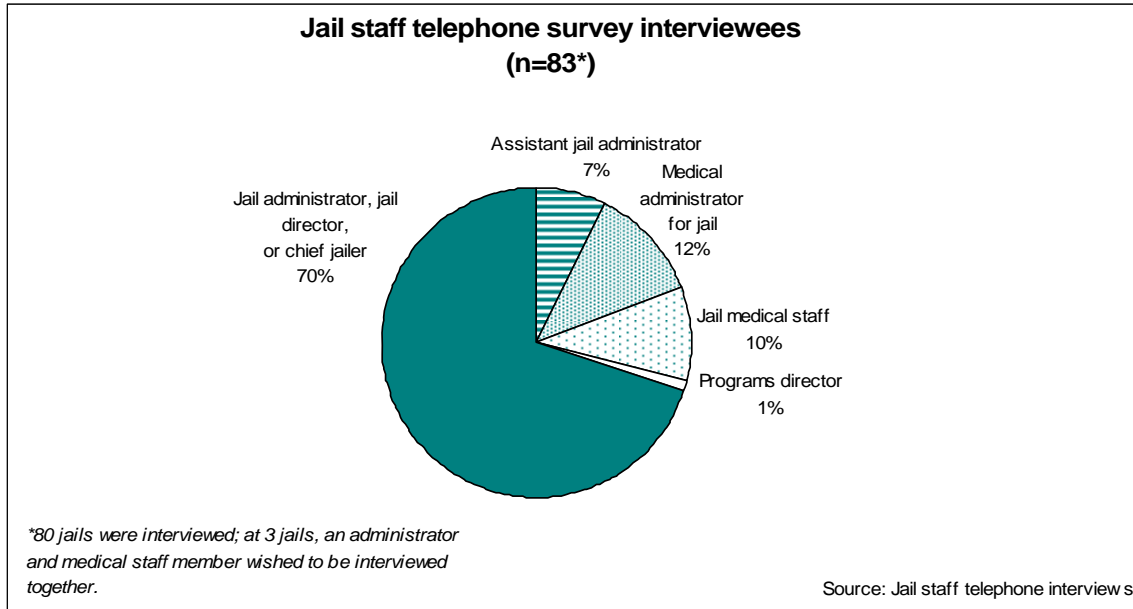
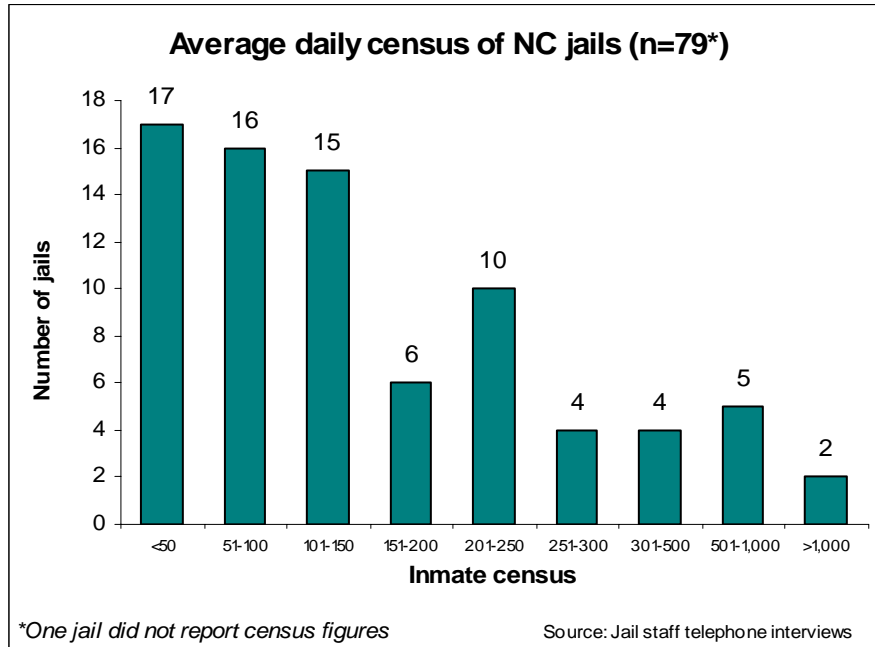


Figure 2 provides a graphic representation of size, determined by average daily population, of jails interviewed. While the majority of inmates in North Carolina are held at a handful of very large jails, such as those in Mecklenburg and Wake Counties, most of the jails in North Carolina are quite small. The smallest jail holds an average of 8 inmates per day, and 17 of 79 jails that provided census data (22%) hold less than 50 inmates at any given time. It should be noted that many jails are operating over capacity. Though the range was wide (48%-216%), on average jails in North Carolina reported running at 107% of capacity.

Figure 2



Identifying Individuals with MI or MR/DD

As stated above, national statistics state that up to 64% of persons in jail have a mental illness. Estimates for the number of persons in jail who have MR/DD run from 4 to 10%. Interestingly, estimates by jail officials in this study vary widely, with estimated proportion of individuals with MI ranging from 4.5%-50% and individuals with MR/DD ranging from 1%-25%.

Despite these statistics, almost none of the jails interviewed (only 5, or 6%) reported that they formally screen for MR/DD, as shown in **Figure 3**. A significant percentage of jails (54%) said their sole method of detection of persons with MR/DD was by officer observation, either during intake and booking or during the inmate’s incarceration. “We ask a lot of questions during intake and booking,” said one interviewee. “By the end of that, we’re able to pick up on if someone [has that condition].”

In contrast, nearly all jails (77, or 96%) report that they screen for MI. The level of screening varies widely, however. Of the 77 jails that reported screening inmates for MI, only 4 reported that they ask in-depth questions, beyond basic questions on suicidality or “are you being treated for/have you been seen for a medical or mental illness,” to inmates. (See *Results: Screening Tools* for additional details.)

Figure 4 describes who screens incoming inmates. While medical staff conducts screenings of incoming inmates at 8 of the 77 jails that answered this

interview question (10%), most jails (69, or 90%) rely on a jail official to conduct this screening, though in 6 of these 69 cases the results of the screening are subsequently reviewed by medical staff. Jail officials are required by the state to obtain Detention Officer Certification (DOC); they must complete a 150-hour curriculum at a law enforcement academy. This includes 6 hours of instruction about MI and 5 hours about suicide prevention. Additional material about detection of MI and suicidal intent among new inmates is covered in the portion of the course about processing inmates (7 hours).

In addition to this training, jail officials are required to receive a minimum number of continuing education hours each year; some of this coursework may be about mental health issues. According to interviewees, jail officials at 28 of the 77 jails (36%) that screen for MI have received such continuing education or another form of training in addition to DOC curriculum.

Figure 3

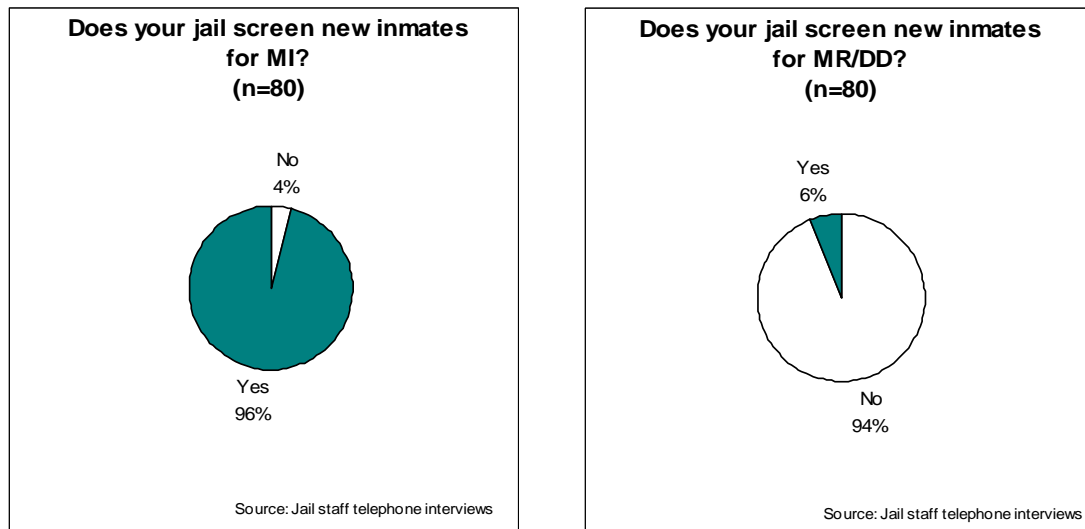
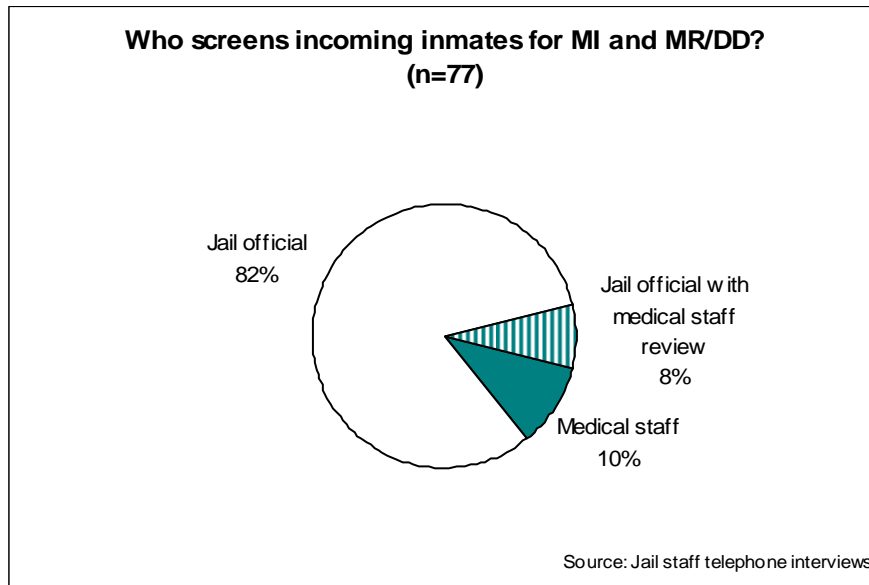


Figure 4



Almost without exception, intake screenings are conducted in the jail’s booking area; only 1 of the 80 jails interviewed reported conducting the screening at another location. These booking areas are not always private. As shown in **Figure 5**, less than half of jails interviewed (33, or 41%) consistently conduct intake screenings in a private setting where no one can overhear; a third of jails (26, or 33%) rarely or never conduct screenings in a private setting; and 17 jails (21%) do so only some of the time.

Availability of Medical and Mental Health Services

Availability of medical and mental health services varies widely in North Carolina jails. As shown in **Figure 6**, most jails (72, or 90%) interviewed have some type of medical personnel onsite on a regular or as-needed basis, usually through contract with a provider or provider agency. Four jails (5%) reported that they transport inmates with medical needs to a private doctor in the community with whom they have a contract. Four jails (5%) stated they transport inmates to a local hospital or to Safekeeping at Central Prison to receive medical care.

The most common type of onsite medical provider is the nurse—usually an RN, though sometimes an LPN. Most jails also have a doctor on call in case of emergency or for consultation. Jails usually have a nurse three to seven days a week, and a doctor once or twice a week.

Despite the high number of persons with mental illness in today’s jails, very few jails have psychiatric or mental health personnel who work onsite. Fortunately, many public mental health agencies are able to send a service provider (usually a social worker or counselor) to the jails in their catchment area.

Nearly half the jails interviewed (38, or 48%) reported that their mental health Local Management Entity (LME) will send a counselor or other service to the jail to assess an inmate at least some of the time. However, a significant portion of jails (27, or 34%) report that they must transport inmates to a LME or other designated provider for assessment or treatment, including 3 jails (4%) that transport all inmates requiring mental health treatment to a local hospital or to Safekeeping at Central Prison in Raleigh. These jails that must transport inmates are almost without exception small and medium-sized jails in rural counties that likely can least afford the staff time or expense; jails must pay \$65 per person per day for Safekeeping, plus additional medical and medication costs, which can be quite high.

Figure 5

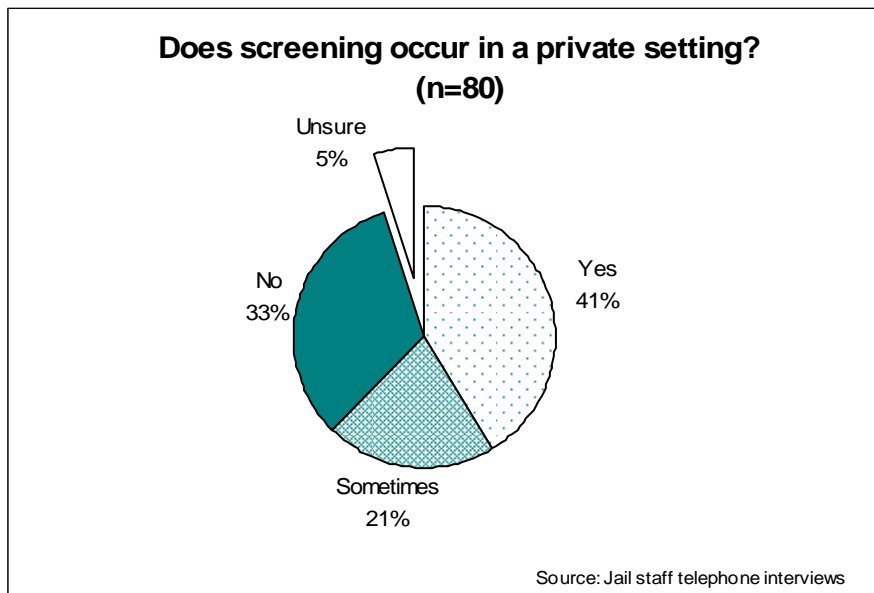
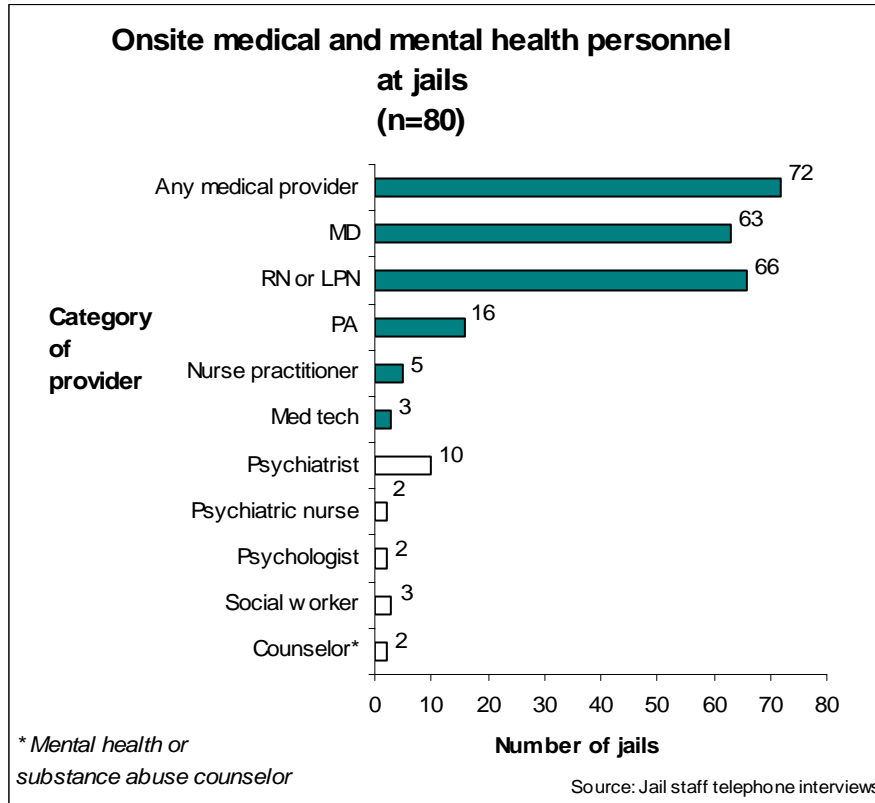


Figure 6

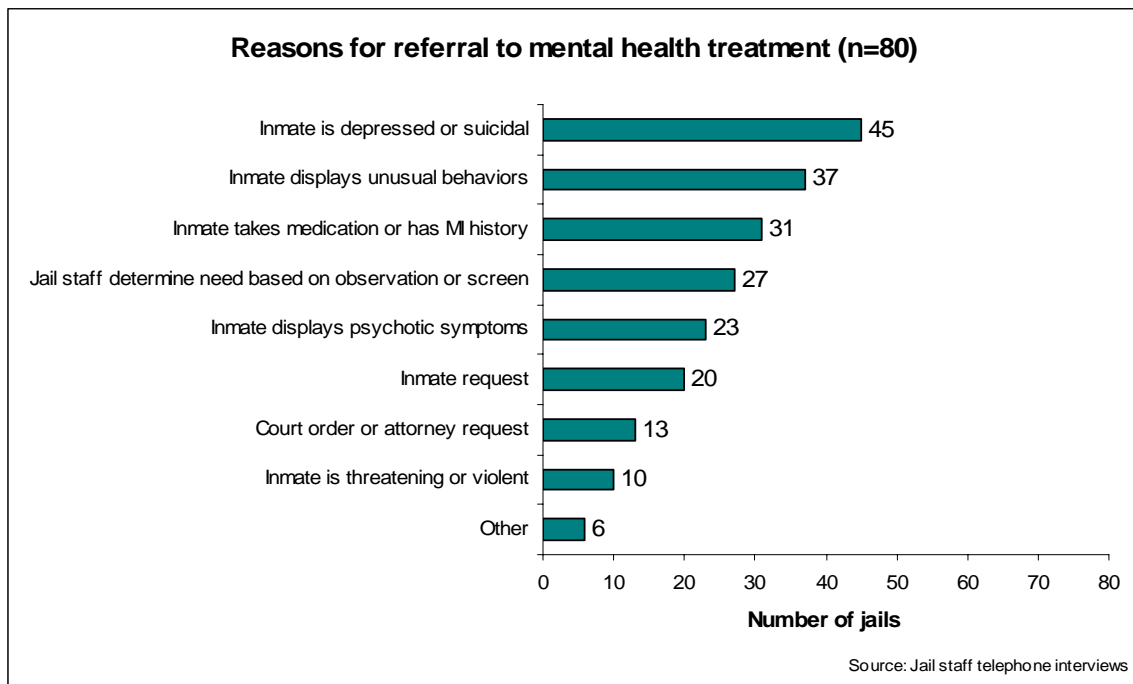


A small number of jails (12, or 18%) provide psychiatric services in-house. These are usually very large jails in densely populated counties. Most jails, however, must work closely with local mental health providers.

A few jails reported they regularly communicate with their public mental health agency; they talk on the phone every day or send an inmate roster (this is public information) to the LME so that workers there can communicate information to ACT Teams, social workers, or to the jail. Others reported varying levels of cooperation. One county jail reported that the local LME had refused to accept any jail inmates and that the county was forced to transport all inmates in need of mental health services to Safekeeping, several hours away.

Inmates are referred to receive mental health services for a variety of reasons, as shown in **Figure 7**. The most commonly cited reason was being depressed or suicidal; displaying unusual behaviors was another common reason cited. One third (27, or 34%) of jail staff interviewed also rely on intake screening tools and observation to determine if an inmate needs mental health treatment.

Figure 7



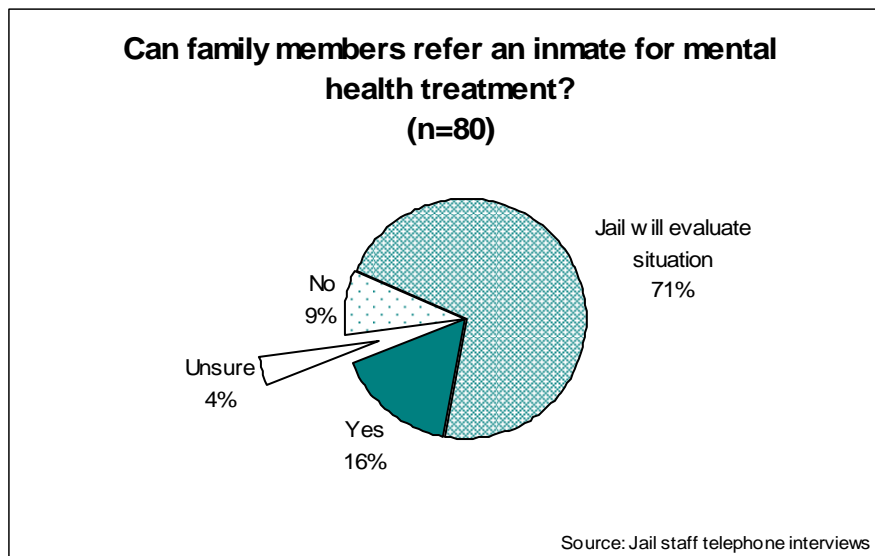
Interviewees report that inmates are not always forthcoming about MI during intake screenings, which typically rely at least partially on self-report; some inmates are under the influence of alcohol or drugs or experiencing withdrawal symptoms at the time they are screened and thus unable to provide adequate information. Thus, family members of persons with MI can be a vital resource for jail officials, according to jail interviews. These family members often call the jail after learning that a family member has been detained and provide information about medication and other needs. Many family members also request that the jail provide mental health services for their loved one.

Officials at most jails interviewed reported that they welcome input from family members of persons with mental illness. As shown in **Figure 8**, 13 jails (16%) said they arrange for mental health services for any inmate whose family requests them; most jails (57, or 71%) said that they accept phone calls from family, gather as much information as possible, and then do a follow-up evaluation of the inmate to determine if services are truly necessary. This follow-up prevents the use of limited resources on persons who don't truly need them, interviewees said. Only 7 jails (9%) stated that they do not accept referrals from family members.

A number of jail officials stated that they didn't communicate more effectively with mental health centers or family members because of HIPAA (the Health Insurance Portability and Accountability Act) regulations. HIPAA, instituted in 2003, has strict requirements regarding the disclosure of any personal health

information (PHI). Jails are subject to HIPAA rules regarding disclosure of PHI. However, names of persons in jail and charges filed against them are public information. Thus, while a doctor or jail official may not legally discuss an inmate's personal health information without the inmate's consent, they may communicate the fact that an inmate is being held in jail and the nature of their charges.

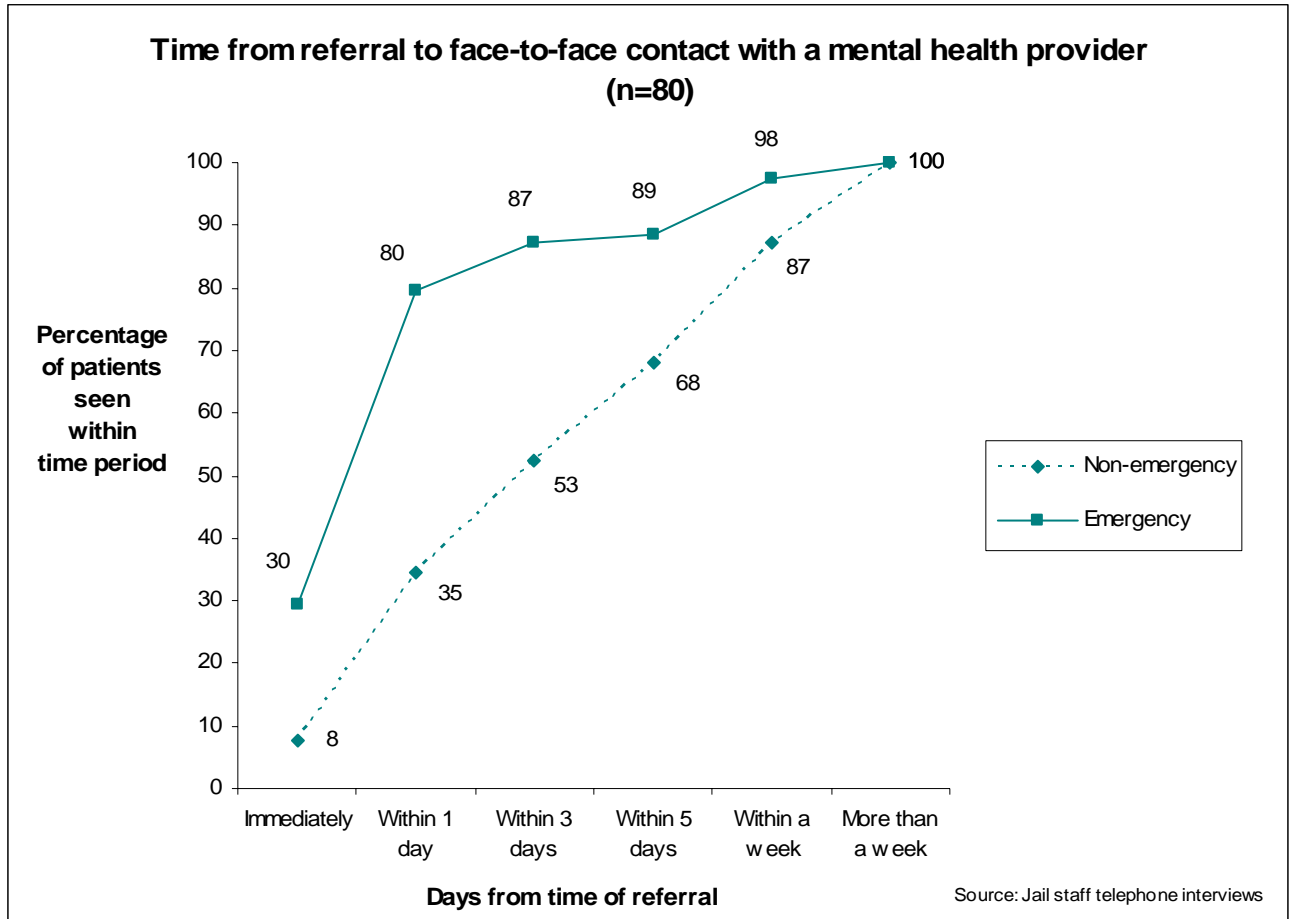
Figure 8



Once an inmate is referred for mental health services—either by family members, jail officials, jail medical staff, or self-referral—the reported lag time is often surprisingly short. Interviewees have reported that in many rural communities, the wait for an appointment at a public mental health clinic may be months – but for jail inmates, services are often received within hours or days. **Figure 9** shows that in cases of emergency, interviewees report that 4 in 5 inmates (80%) are seen by a mental health provider within 24 hours, and 87% are seen within 72 hours. As can be expected, the waiting period for non-emergency services is significantly longer; still, more than half (53%) of inmates who need to see a mental health care provider can do so within 72 hours. (It is important to note, however, that most of these providers are able only to perform a mental health assessment; they cannot prescribe medication.)

Mental health care in county jails is generally paid for by the county, although specific funding structures vary. All interviewees identified county funding in one form or another—either through the jail budget directly, through jail funds paid to a provider through a contract, or through county funds to another agency like a public health department or LME. At most jails, mental health care costs are combined with other healthcare costs in a single budget line item.

Figure 9

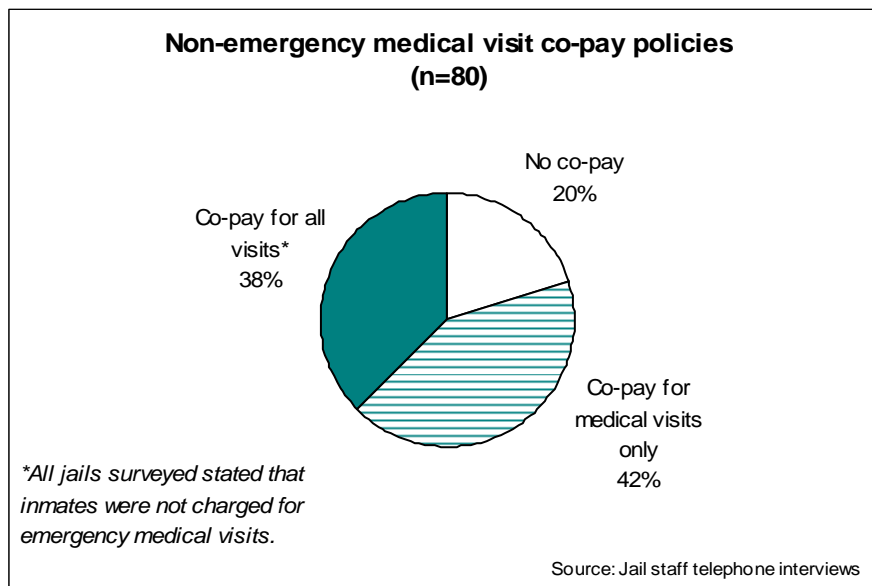


Jail medical costs are significant, according to officials interviewed, and most jails pass some of these health care costs on to inmates in the form of a co-payment for non-emergency medical visits. As shown in **Figure 10**, 64 of the 80 jails interviewed (80%) charge a co-pay for at least some types of non-emergency medical visits. (The typical co-pay amount reported was \$10, which is the maximum allowed by state statute; only four jails reported a lower co-pay of \$5.) Mental health care is usually provided at no charge, however. Almost half the jails interviewed (34, or 42%) differentiated between medical and mental health visits; inmates at these facilities are not required to pay to see a mental health provider. In addition, many jails reported that they charge one co-pay per medical condition; thus, a person who is checked monthly to monitor schizophrenia would be charged only once, no matter how many medical visits they receive for that condition.

Health care is always available for inmates, interviewees reported, regardless of their ability to pay. Inmates who do not have the ability to pay still receive treatment; however, their accounts are debited. Inmates are not required to pay

off their accounts before leaving jail, but if they return to jail at a later date, they remain accountable for their past debt. Jail medical administrators and other jail medical staff interviewed stated that co-pays were charged not to recoup costs—“a lot of our inmates have negative account balances,” said one interviewee—but instead to prevent unnecessary visits. Jails that did not charge a co-payment for medical visits were mostly small, with a daily census of less than 50.

Figure 10



Hospitalizations and Suicidality

A common theme voiced by jail officials is that jails are not equipped to serve persons who have serious mental illness. Of particular concern to interviewees is their inability to provide care for inmates with serious or life-threatening mental health issues, who therefore must be hospitalized. Each jail has its own protocol for the psychiatric hospitalization of inmates.

As is shown in **Figure 11**, many jails interviewed (64, or 80%) take inmates to a state psychiatric hospital – either Dorothea Dix Hospital, which has a forensic unit, or the hospital that serves their catchment area (Broughton in western North Carolina, for example). Others (19, or 24%) rely on local general hospitals. Most jails use both types of hospitals; their choice is determined by availability of bed space and the nature of charges against the inmate.

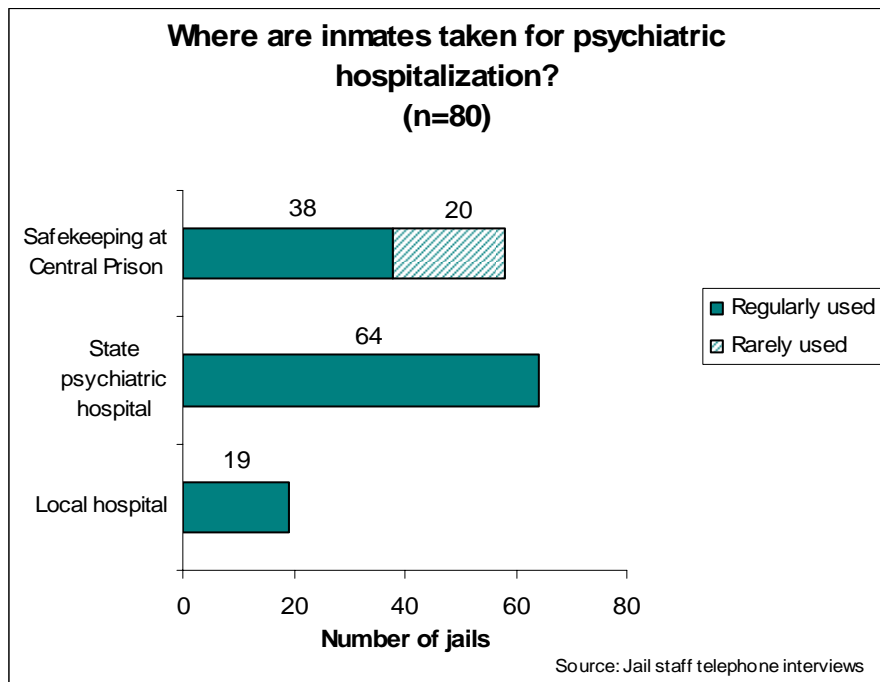
Many interviewees reported difficulty in having inmates admitted to the state psychiatric hospital, noting that they needed to have the inmate put on detainer first so that the hospital would not release the inmate at the conclusion of treatment but return him or her to jail; other jails reported that they often try to

have an inmate's charges dropped or bond reduced to secure hospital admittance.

Gaining access to Safekeeping, the facility at North Carolina's Central Prison that houses and treats state and county inmates who need comprehensive health care, can also be cumbersome and complex, interviewees reported, involving a local doctor, a doctor at Central Prison, and an order from the judge. Each county is guaranteed only two patient beds at any time, and these beds are often taken by persons with complex medical conditions such as AIDS or emphysema. Safekeeping is also prohibitively expensive for some counties, especially small, rural ones; as stated above, the jail is charged \$65 per day per inmate, not including the cost of medical procedures and medications.

A number of interviewees noted that it can take several days to a week before an inmate may be admitted to Dix for a forensic evaluation and stated that they were expected to provide an officer to stay with the inmate the entire time of the evaluation. (In the past, interviewees reported, an officer could drop an inmate off at the hospital and pick him or her up at the conclusion of the evaluation several days or weeks later.)

Figure 11



Suicide risk is high in jails, and jails throughout the U.S. have pushed recently to institute practices designed to lower the incidence of suicide (Winter, 2003). In North Carolina, suicide prevention is covered extensively in the state's Detention Officer Certification Course, and state law requires jails to create detailed

protocols. All but 4 of the jails interviewed (76, or 95%) stated that they had written procedures about handling inmates who have attempted or appear at risk for suicide.

Most interviewees reported that they place at-risk inmates in observation cells, usually alone, though three interviewees specifically stated that they place at-risk inmates with others if possible to help protect their mental health by not feeling so alone. These observation cells could be holding cells at the front of the jail, or could be special “suicide cells.”

Frequent observation of the at-risk inmate—at least four times an hour and sometimes continuously—is part of protocol at all jails interviewed. Typically, jails take away all clothing, bedding and personal items, including books and even eyeglasses. Inmates are left with a mattress and, in most cases, one or more alternative items to provide warmth and coverage. Nearly two-thirds of jails interviewed (52, or 65%) provide a paper suit or, more frequently, a “suicide smock”, e.g., a sturdy, thick blanket with Velcro closures and holes for the head and arms (when worn it looks like a rain poncho minus the hood). A number of jails (40, or 50%) provide a blanket made of similar material. Some provide both a blanket and a smock or gown. These items cannot be twisted or torn and thus cannot be used as hanging or choking implements.

While most jail officials interviewed seem to provide a high level of care for inmates deemed to be a suicide risk, a few use policies that may seem harsh. Some jails (12, or 15%) reported allowing inmates to keep their underwear but provided nothing else; one jail reported leaving highly suicidal inmates completely naked. Four jails (5%) stated that inmates who have already attempted suicide or are deemed to be in particular danger are placed in cells with no toilet; bodily waste is drained through a grate in the floor. Additionally, four jails (5%) stated that they use a restraint chair for violent or otherwise uncontrollable inmates, though one of these interviewees said the chair had not been used in three years.

Medications

Many persons with a mental illness take psychiatric medication; often this medication must be taken at least once a day, and sometimes even more frequently. Most of the jails interviewed (69, or 86%) allow inmates to bring their medication with them to jail. Additionally, 21 jails (26%) specifically stated that they encourage inmates’ family members to bring their prescription to the jail if possible, and at least one county encourages arresting officers to retrieve any prescription medication before transporting an inmate to jail. Shortly after an inmate’s arrival, jail officials or jail medical staff inspect the medication and, after receiving the inmate’s authorization to release his or her medical information, verify the prescription with the inmate’s psychiatrist, mental health clinic, or

pharmacy. The medication is then turned over to jail medical staff to package into daily doses.

For the bulk of inmates who do not bring medication to jail, obtaining a prescription is much more difficult. The jail must first secure the inmate's written permission to contact their medical or mental health provider; only then can they contact that provider to obtain a new prescription. Inmates who have not recently seen a provider must be examined before a prescription can be written. After a prescription is written, it must be filled by the jail medical staff or by a contracted pharmacy before it can be dispensed.

Two jails interviewed stated that they dispense only medication provided by a jail-affiliated pharmacy to prevent the smuggling into jails of unauthorized substances.

Figure 12 shows the time it takes for inmates to receive medication in jail (from the time of referral until medication is received), according to jails interviewed. Despite the legwork required to verify incoming inmate's prescriptions, most jails reported that inmates received medication fairly quickly after arrival – often within 24 hours. Nearly half of the jails stated that inmates with current prescriptions receive medication the same day (26, or 33%) or the next day (10 or 12%). Fifteen jails (19%) reported taking a week or longer. Nine jails (11%) were unable to provide data.

Inmate medication costs are covered by the county, according to those interviewed; costs are paid directly through the jail's medical budget, or are covered under the jail's contracted medical provider. (Most such contracts cap their coverage; overages are paid for by the jail.) About 1 in 4 jails interviewed (19, or 24%) charge a co-pay for prescription medication, ranging from \$1-\$5 for a 30-day supply. Medications are not always provided as prescribed; 31 jails (39%) reported that they have a formulary that they try to stick to, 16 jails (20%) said they do not have an official formulary but do make substitutions for expensive medications at least some of the time.

While inmates' medications are prepared and packaged into individual dosages by a nurse or pharmacy at all jails surveyed, policies differ regarding who hands out these medications and in what setting, as shown in **Figure 13**. At 28 of the jails interviewed (35%)—mostly jails with a daily census of 150 or more—daily medication is dispensed by a registered nurse or nurse practitioner, often accompanied by a detention officer. Ten jails (12%) reported that medical staff members dispense medication during the hours they are on duty—usually weekday mornings and at lunchtime—and detention officers dispense medication at other times. Medications are dispensed only by detention officers at 42 jails (53%).

A few jails stated that inmates receive psychotropic and other prescription medication in a private room or office, but most jails reported that such medication is dispensed in the inmates' living quarters—in most jails, on the cell block. Inmates line up and come one at a time to the pharmacy cart to receive their medication; in many jails, a staff person then inspects each inmate's mouth to be sure all pills have been swallowed. This procedure allows for some amount of confidentiality; while cellmates know that an inmate takes medication, they do not know the type or identity of the medication the inmate receives. True privacy, however, is rare for inmates taking medication, as shown in **Figure 14**.

Figure 12

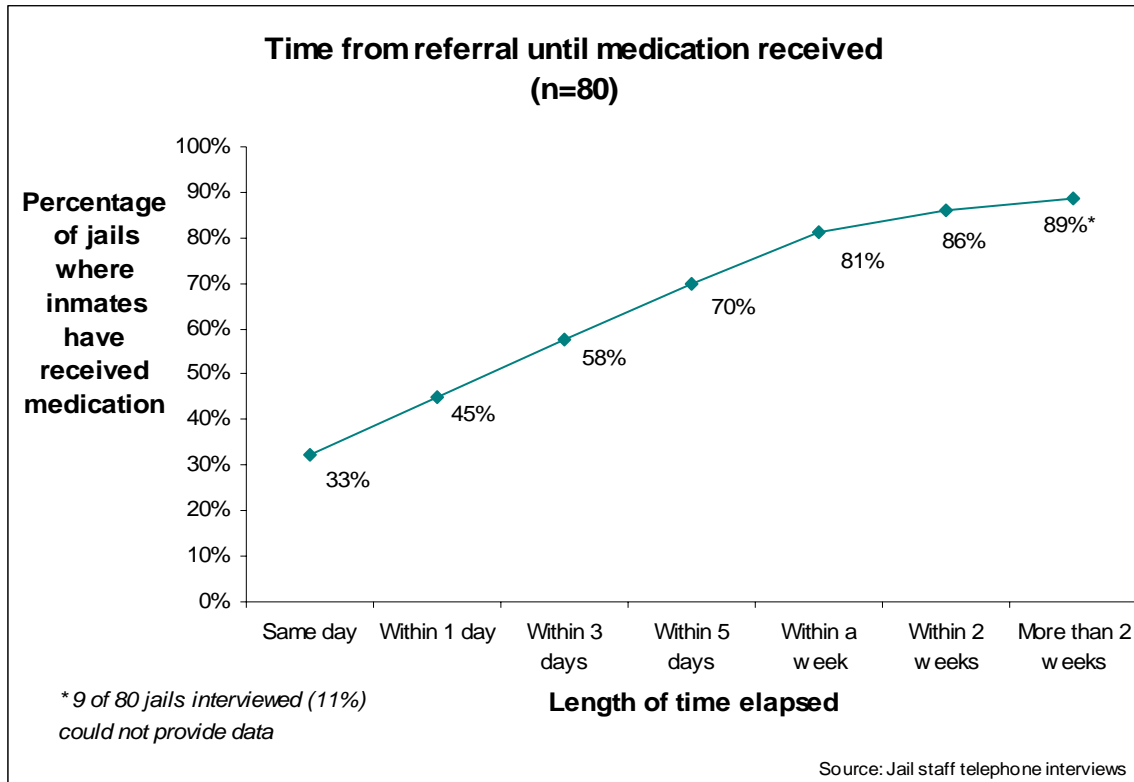


Figure 13

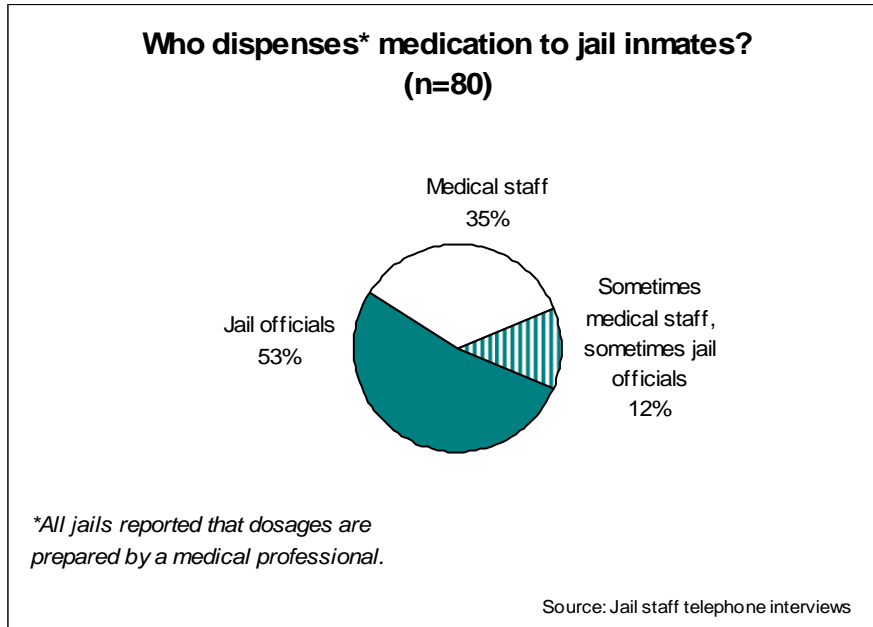
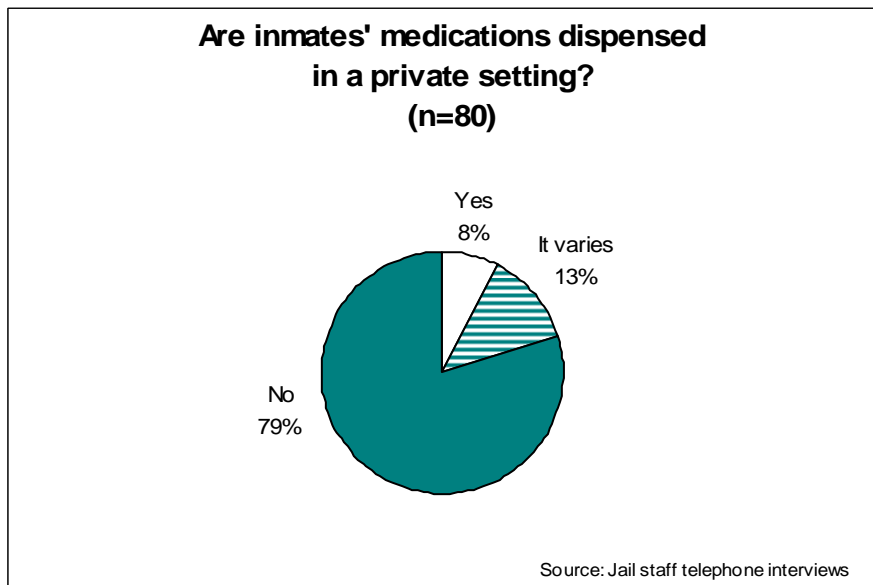


Figure 14



Relationship with community mental health providers

Only a few jails in the state (12 of 80 interviewed, or 18%) provide mental health care in-house; most jails have to work closely with local providers to obtain mental health services for their inmates. Jails reported differing levels of cooperation with local mental health providers (usually LMEs).

As shown in **Figure 15**, more than half of the jails interviewed (49, or 61%) reported that they always contact the mental health care provider of incoming inmates with known mental illness, if only to secure an inmate's prescription medication; only a handful (7, or 9%) said they never make such contact or do so only occasionally. However, fewer than 1 in 5 jails (15, or 19%) said they always contact an inmate's care provider upon release, although many of those who said they did so only occasionally said they do notify providers for inmates who seem at particularly high risk. Jails gave a variety of reasons for this lack of follow-up, including the fact that jail medical staff, who may be the only ones aware that an inmate has a mental illness, often are not informed that an inmate has been released until after the fact. They also cited the high level of inmate turnover—approaching 15% per day in many jails—and stated that they simply did not have the staff time to make these follow-up calls.

Despite a chronically heavy work load, one jail official in a small, rural county stated that she and the jail staff have at times gone out of their way to ensure that inmates with severe mental health conditions are released to a guardian or care facility, even if they have to arrange for a new placement. “If we don't take care of them right the first time around, they're just going to end up right back here,” the interviewee said.

LMEs and other community mental health providers might be expected to share the burden of communication with jails about some of the community's most vulnerable citizens, but many jails reported such communication was not consistent, as shown in **Figure 16**. Only 7 of the jails interviewed (9%) reported that LMEs and other community providers always contact them; 22 jails (28%) said they sometimes receive contact from these providers. Well over half the jails said they received communication from their LME either never (23, or 28%) or only occasionally (26, or 32%). Two jails (3%) were unsure of their level of communication with their community-based provider.

Figure 15

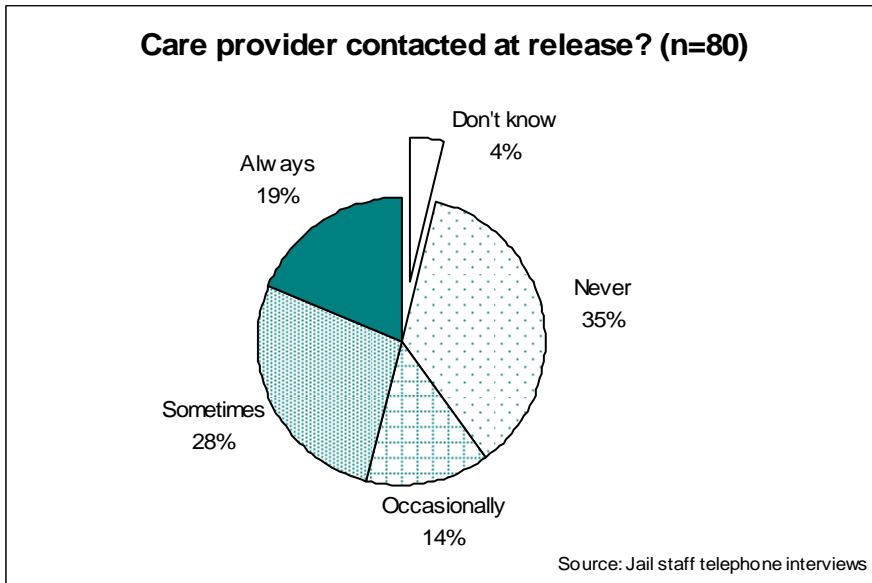
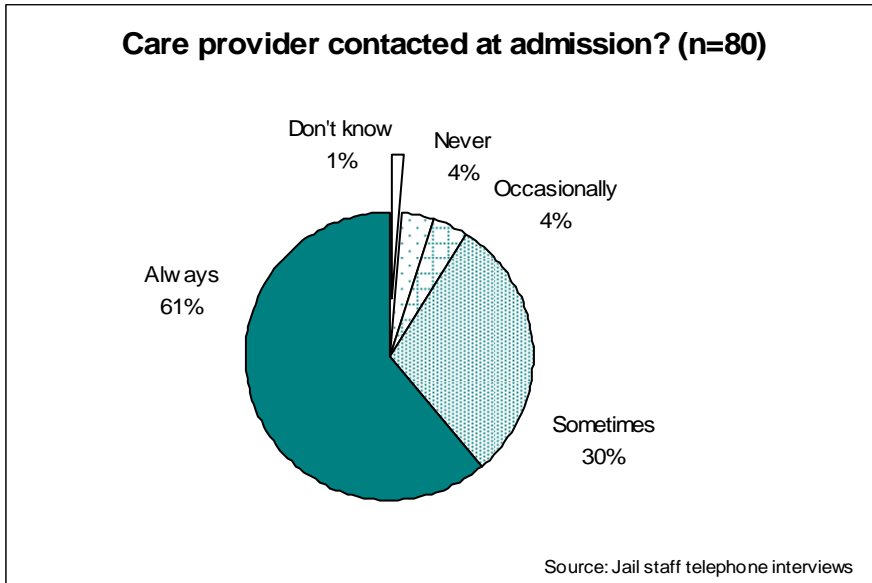
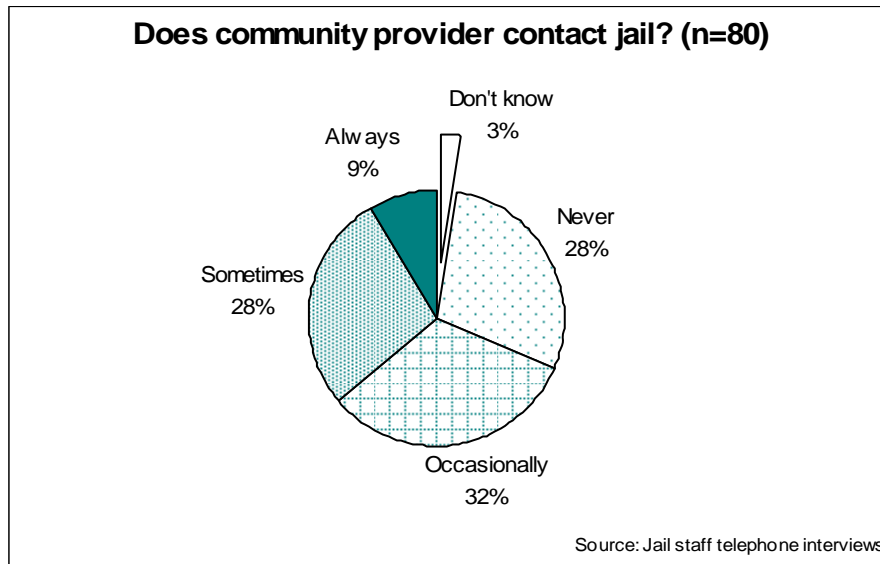
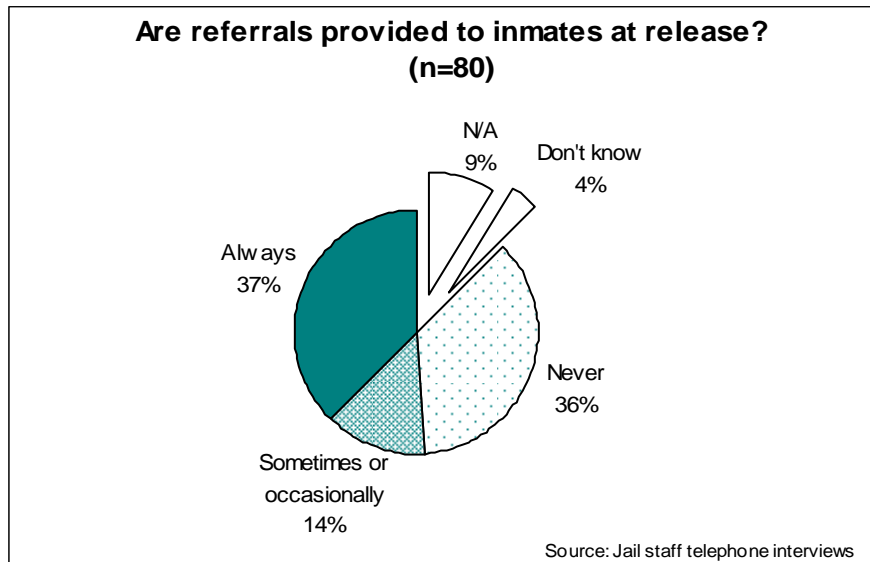


Figure 16



Jail can be a stressful place, and the circumstances and consequences of being arrested and jailed can cause significant psychological strain. Said one jail medical official: “If you have any kind of mental illness, going to jail will bring it to the surface.” This, plus the fact that many persons who are arrested and jailed are chronically underserved and underprivileged, means that many people may have their symptoms of mental illness come to someone’s attention for the first time while they are in jail. Many people are in jail for a short period of time and are unable to receive mental health services during this brief period. Thus, follow-up mental health services can be extremely important. However, just over a third (30, or 38%) of jails interviewed said they always refer an inmate to a mental health provider upon release if they don’t already have one, as shown in **Figure 17**; 29 jails, or 36%, said they never do so; and 11 jails (14%) said they sometimes or occasionally do so. (It should be noted, however, that several interviewees said all inmates who are known to need services receive them while in jail and thus would not need to be referred upon release. Many of the above-referenced inmates would have received services while in jail from the same publicly funded mental health provider to whom they would have been referred upon release. This is not true in all cases, however.)

Figure 17



In addition to answering specific interview questions, a number of interviewees volunteered information regarding their perspective on the relationship between the jail and the LME or LME-referred provider. In 14 (18%) cases interviewees specifically stated that they felt the LME worked well with the jail, making comments such as “I have a good relationship with the LME” and “The medical director and I coordinate a lot together.” However, 24 (30%) interviewees expressed concern about the ability of the LME and mental health system to provide adequate services to inmates and those at risk of arrest. Specifically, 13 (16%) interviewees expressed concern about the difficulty they had in accessing mental health services post-mental health reform. One interviewee stated, “[Inmates] used to go to the area program, but the area program has discontinued. Now we are trying to hire a psychiatric nurse to do these screenings. We’re in a transition period . . . there is currently no established psychiatrist in the county.”

A number of interviewees (11, or 14%) also expressed concern about the lack of community services and resultant increase in individuals with mental illnesses in the jails. One stated: “I really hope with Dix closing down that the state takes a serious look at mental illness and what we’re doing with these people. It seems like instead of hospitals we’re building more and more prisons and they’re being filled with people with mental illness.” A second interviewee expressed frustration and concern by saying: “Facilities like my jail have become home to mentally retarded, to mentally ill, to street people, to everyone else. This is not the place for [them]. I’m sorry, it’s not. But until [the decisions-makers in the mental health system] do something . . . how are we supposed to cope?”

Jail Screening Instruments

Researchers examined the 31 jail intake screening instruments provided by jails interviewed to determine the nature and extent of screening questions in four areas:

- current or past psychological and/or psychiatric treatment
- alcohol and drug use
- depression and suicide risk
- MR/DD

Current or past psychological and/or psychiatric treatment. Almost without exception (30 of 31, or 97%), screening instruments reviewed for this study asked inmates whether they were currently using medication for a medical condition, and most (24, or 77%) asked if the inmate had been hospitalized recently or within the past month. Many went on to ask if the inmate had ever or was currently seeing a psychiatrist (19, or 61%) or had ever received mental health treatment (20, or 65%).

Alcohol and drug use. Most screening instruments received (25, or 81%) included several questions about past and/or current alcohol and drug use, including what kind, how much, and time of last use; most (26, or 84%) included screener observation or inmate self-report about withdrawal symptoms. About a quarter of the screening instruments (8, or 26%) asked whether the inmate had a history of treatment for substance abuse issues.

Depression and suicide risk. Jails often relied solely on officer observation to detect depression and suicide risk in incoming inmates; questions about these conditions were not addressed to the inmate. Of the 12 screening instruments received containing questions about depression, 11 asked the screener to observe whether the inmate appeared depressed, while only 1 instrument directed this question to the inmate.

The literature (Brown, n.d.) suggests that a comprehensive screening for suicide risk would include visual observation by a trained individual, an evaluation of specific areas which are considered predictive of suicide risk, such as hopelessness or excessive shame or having experienced a recent loss, and the following two questions directed to the individual being screened:

- Have you ever considered or attempted to harm or kill yourself?
- Are you thinking of harming or killing yourself now?

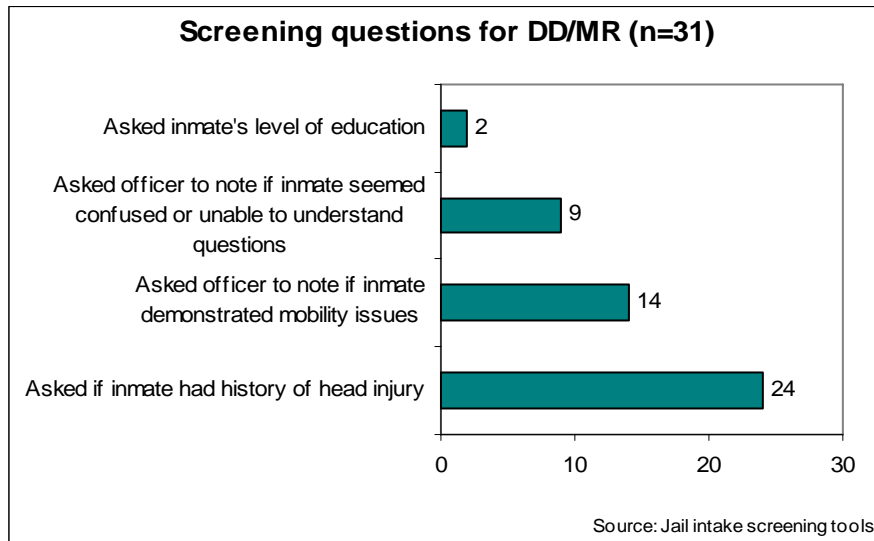
While most of the screening instruments received (25, or 81%) asked screeners to infer from observation if the inmate's demeanor or behavior "suggest[s] risk of suicide" (albeit without listing specific symptoms or warning signs), only about half (17, or 55%) included screener observation plus the above-mentioned two questions directed to the inmate. Five instruments (16%) contained neither of these two self-report questions. Others asked one question but not the other: 3 (10%) asked inmates only whether they were considering suicide now, but not

about past thoughts or attempts; and 6 (10%) asked inmates to report only if they had considered or attempted suicide in the past, but not if they were considering it now. Only a few instruments contained questions about specific areas which are considered predictive of suicide risk, such as feeling or appearing hopeless (5, or 16%), experiencing or appearing excessively ashamed (6, or 19%), experiencing a recent loss (5, or 16%), or having a family history or mental illness or suicide (8, or 26%).

MR/DD: None of the 31 screening instruments received contained questions about MR/DD *per se*, although several did contain questions that could help identify persons with these disorders. As shown in **Figure 18**, about one third of screening instruments (9, or 29%) asked whether the inmate seemed “mentally confused,” a vague term that could be used to describe a person with MR/DD but could also be used to describe a person under the influence of alcohol or drugs, or someone who was experiencing hallucinations or experiencing a psychotic episode. Two of the screening instruments (6%) asked the level of education completed by the applicant, which can be a reasonable proxy for MR/DD. One screening instrument (3%) asked if the interviewee had been in special education classes in school, a simple question that could detect a significant percentage of persons with MR/DD.

Traumatic brain injury, or TBI, besides causing significant medical complications, can also result in symptoms that look like mental illness or MR/DD. Most of the screening instruments received (24, or 77%) ask if inmates have had a recent head injury; others specify within the last 72 hours. Some persons with severe or profound mental retardation also have physical disabilities, including cerebral palsy or other motor difficulties. Such disabilities can create situations of extreme vulnerability among inmates who are placed in the jail’s general population. In an effort to prevent such situations, many jails screen for physical or mobility impairments. Fourteen of the 31 screening instruments received (45%) had such a question, usually based on screener observation.

Figure 18



Consumer and family surveys

Despite concentrated outreach efforts, we had a very low return rate on the written surveys of consumers and family members. We distributed survey packets to 175 consumer organizations and mental health advocates; however, the number of surveys that ended up in the hands of persons within the target study population is unknown. We received 50 responses, 46 of which were from persons or family members of persons with MI and/or MR/DD who had spent at least one night in a jail in North Carolina. While this response is too small to be statistically significant, it does provide a glimpse of 46 people's stories, and these stories are worth knowing.

Survey respondents were primarily mental health consumers (27, or 59%), followed by family members of someone with a mental illness (21, or 46%), primary MR/DD consumers (6, or 13%), and family members of individuals with MR/DD (5, or 11%). It should be noted that some respondents reported fitting into multiple categories. Most respondents (32, or 70%) had experienced only one incarceration, and incarceration dates ranged from 2006 to as far back as 1968.

When asked about screening for mental illness or MR/DD in jail, 7 (15%) respondents stated they were screened for mental illness and 3 (7%) reported being screened for MR/DD. In addition, only 8 (17%) respondents reported being asked at jail intake if they took medication.

Twenty (43%) respondents reported that they requested medication while in jail. The time from request until they received medication varied widely. As can be seen in **Figure 19**, 6 of these individuals (30%) reported receiving their medication within 48 hours; 3 of these (15%) said their received their medication less than a day after requesting it. Six (30%) respondents said it took less than two weeks (but more than 2 days) to receive their medication. Disturbingly, 5

(25%) respondents reported never receiving their medication. In addition, of those who received medications, 6 (30%) reported being given a medication different than their usual one (one could suppose this to be a generic or cost-based substitution.)

As shown in **Figure 20**, respondents reported difficulty in accessing care when needed. When asked if they had been allowed to contact their community provider, only 12 (26%) stated they had been allowed to do so. Another 13 (28%) said they had been allowed to see a jail provider.

Similarly, respondents reported difficulty with continuity of care at release. As indicated in **Figure 21**, only 5 (11%) respondents said their community mental health or MR/DD provider had been contacted upon their release, and only 14 (30%) stated their family had been contacted.

Many respondents described difficulties during their incarceration. Six (13%) respondents reported that jail staff were verbally abusive or cruel to them. Four of these reported physical assault (one reported being raped by a fellow inmate, and three reported physical assault by guards). In one of these a mother wrote that her son was sprayed with pepper spray for no apparent reason. We received many poignant responses, including a five-page letter from the parent of a mental health consumer containing an account of her son's experiences and impassioned plea for change – not only in the jail system, but in the entire state mental health system. “What other disease puts people in jail? . . . There is no place for the mentally ill.”

Figure 19

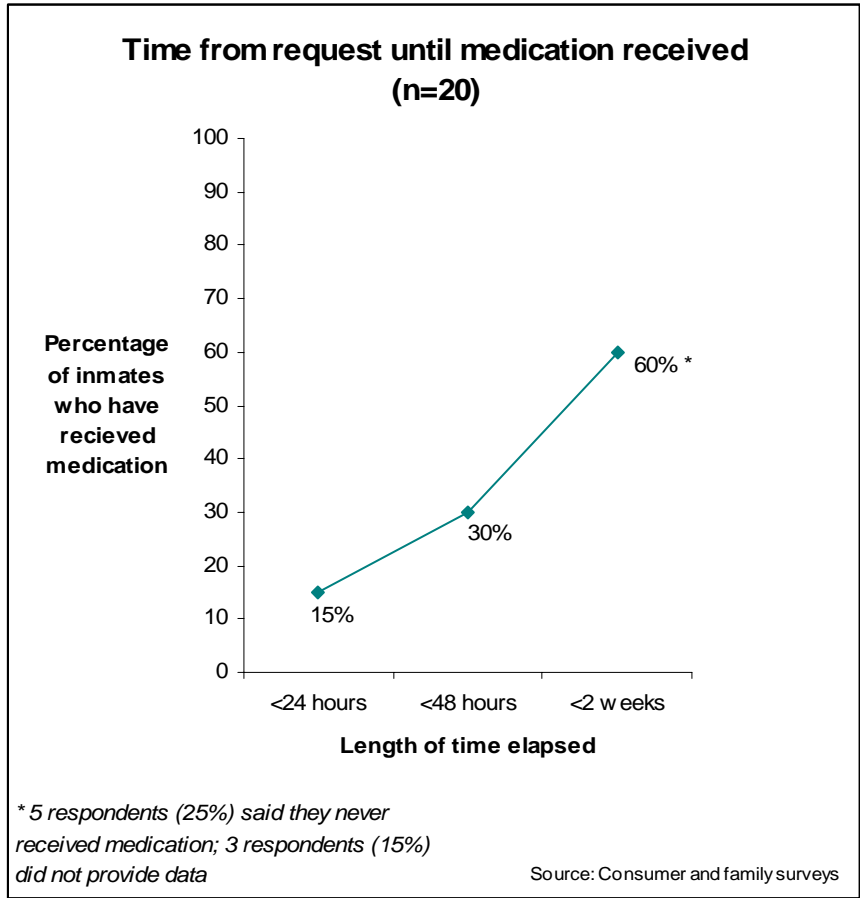


Figure 20

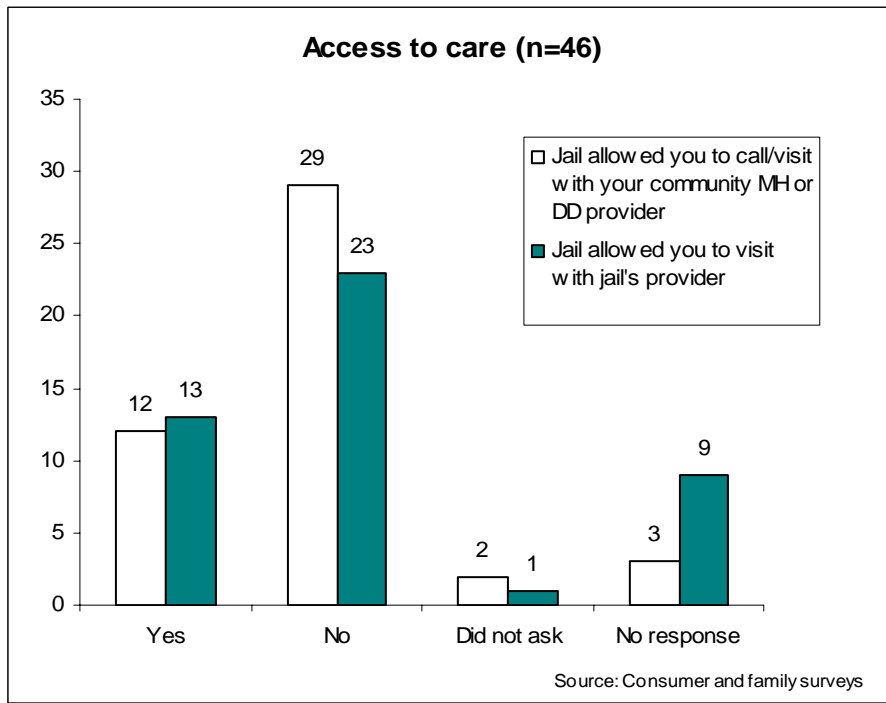
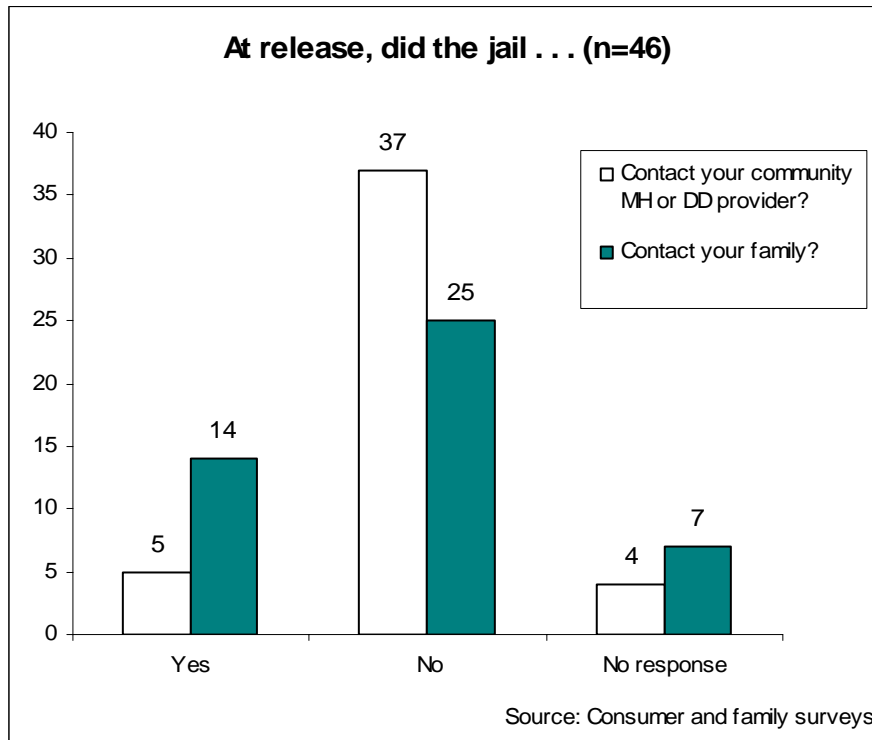


Figure 21



Discussion

Based on our findings, a picture begins to emerge of a troubled intersection of two systems—the jail system and the mental health, developmental disability, and substance abuse services system. Both systems are under stress, attempting to provide services without sufficient resources to meet the needs of all who come to them. Those with multiple challenges who require specialized services, such as individuals who have been arrested and have MI or MR/DD, may well have the lowest chance of getting their needs met.

In our interviews with jailers we heard about county jail systems that are often over capacity, on average running at about 107% of capacity. Jailers expressed concern about adequate staffing as well, and were particularly worried about the staffing demands when individuals with MI had to be accompanied by an officer during the commitment process or during forensic evaluations. Finally, jailers expressed concern about the fiscal demands housing inmates with MI placed on their jails, particularly concerning medications. Since jails are required to pay for inmate medications while incarcerated, a few inmates with expensive psychotropic medications could deplete a jail's pharmacy budget. One jailer reported that a single inmate, whose psychiatric medication costs totaled \$350/month, consumed nearly two-thirds of the jail's entire medication budget.

From interviews, our review of screening tools, and survey responses it was clear that individuals with MI or MR/DD are not being consistently identified when they enter the jails. Jails are not screening for MI effectively through the use of an evidence-based screening tool and, on the whole, are not screening for MR/DD at all. In addition, screening often relies solely on officer observation (with no questions about MI or MR/DD asked directly to the inmate) and is done primarily by jail officials who do not receive adequate and ongoing training in identifying and working with individuals with MI or MR/DD. A few exemplary programs do report regular in-service training for officers on suicidality, MI, and other disabilities. A final concern is the lack of privacy reported by many jails during the screening process. If screening occurs where others can overhear it is less likely that an inmate will self-identify as having any stigmatizing conditions, whether MI, MR/DD, or a medical condition such as HIV. Given that adequate care is impossible without identification of inmates' MI or MR/DD needs, this lack of consistent, quality screening is concerning.

If an inmate does not self-identify, another source of information may be the family. Most jails reported taking calls from family with information regarding the inmate's MI. Only a few considered this information sufficient for a referral for treatment; the majority used it as a "red flag" requiring further investigation by jail medical staff. Of real concern was the fact that nearly one-tenth of the jails interviewed stated they would not take a referral for treatment from a family member, thus refusing a potentially valuable source of information on the inmate.

Identification of individuals with MI is particularly important given the risk of suicide. It was therefore disconcerting to observe that screening questions used to identify inmates that may be suicidal vary widely from jail to jail, and are often not as thorough as recommended by best practices. Again, given that much screening depends on officer observation, the lack of ongoing in-service training on suicidality is of concern.

Protocols for ensuring the safety of inmates identified as at risk for suicide varied from jail to jail. Though reasonable steps, such as frequent or constant observation and the removal of harmful objects, were consistently present, greater variation was seen in protocol around clothing and restraints. Some jails reported providing suicide smocks while others left inmates in their underwear. Four jails reported having a restraining chair for uncontrollable inmates. Given the recent changes in policy around seclusion and restraint protocols and training requirements in hospitals and residential settings, the fact that four jails can restrain inmates with MI without having gone through a similar training is of concern. Overall, these practices in a subset of the jails raise questions about respect for the basic human dignity of individuals with MI.

Another reason for the importance of accurate identification of individuals with MI is to ensure they continue receiving needed psychotropic medications. Frequently jails reported that inmates who brought their medications with them would receive them after the medication had been verified by a medical

professional. If inmates did not have their medication with them, then an elaborate process of contacting the community provider, or if there was none, making an appointment with a provider, occurred. In nearly half of the jails interviewed, this resulted in a wait of over three days for inmates to receive needed medication; in nearly 12% of jails the wait could be over two weeks. When medication was obtained, it was almost universally dispensed in a non-private setting, again increasing the risk of stigma and increasing consumer reluctance to request medication.

We found that inmates may not always get their usual medication when they do receive a psychotropic. Over one-third of jails reported having a formulary and another 20% said they did not have a formulary but made medication substitutions at times. Difficulty accessing medication and medication substitution was also reported by individuals responding to our written survey. This substitution was always driven by cost; as mentioned above, jails are responsible for the cost of inmate medication while in jail, and many jails have limited pharmacy budgets. Since medication is often an essential part of attaining and maintaining stability for people with MI, a lag time or medication switch can be truly problematic and result in decompensation and emergency situations.

Many jailers clearly stated that they felt particularly ill-equipped to handle emergency situations with inmates with MI. When inmates are in crisis and require hospitalization, jail officials have to deal with a number of issues beyond the crisis itself. First is finding a hospital to take the inmate. Interviewees indicated that few local hospitals took inmates with MI, and that the state psychiatric facilities or Safekeeping at Central Prison were their primary option. However, barriers exist to accessing these facilities as well. Sending inmates to a state psychiatric hospital requires drawing up a detainer (to ensure that the inmate is returned to jail upon release from the hospital) or having inmate charges dropped or bond reduced. Sending inmates to Safekeeping requires the coordinated efforts of two doctors and a judge, and is costly for the jail. Both options require transport and supervision by an officer and can take up significant manpower and time. Though no jailer specifically stated how long it took from the time of crisis onset until hospitalization, it was obviously a lengthy process.

Perhaps the most challenging aspect of having inmates with MI is getting them care while in jail that is continuous and congruent with community-based treatment. Interviews with jailers revealed that the vast majority of jails have some form of on-site medical staff, and all inmates have access to medical care. However, on-site mental health personnel are much less common. As a result, jails must rely on their LME or LME-designated provider for care of inmates with MI. This care varied in location, timeliness, and level of communication and cooperation. Though the majority of jails reported that their LME would send someone to the jail at least some of the time for a minimum of initial assessment (though less often for medication evaluation), over a third of jails reported having to take inmates out of the jail to receive care for MI. This involved transporting inmates with an officer, which jailers often saw as a depletion of their staffing

resources. One jailer even reported that transportation for medical and mental health appointments was so demanding that the jail had “an entire unit whose primary responsibility is transport.” In addition, transport to a mental health provider requires taking the inmate into the community in handcuffs and shackles, which one might imagine to be a stressful and humiliating experience for the person with MI.

Jailer reports on the level of collaboration between jail and LME or LME-designated provider varied widely, from some jails that reported daily communication between themselves and the LME to one jail that reported the LME would not provide care to their inmates, but rather referred them to a private provider who charged over \$100 per hour for care, a prohibitively expensive rate for a jail with a limited budget. The vast majority of jails reported that they always or sometimes contacted the inmate’s provider upon arrest (though it must be remembered that this is only for those inmates *identified* as MI or MR/DD, which as stated above is often based on a flawed screening system.) This was contradicted somewhat by consumer survey responses reporting that 61% were not allowed to contact their community provider while in jail. In addition, the information shared during communication between provider and jail seemed to vary from simply reporting the consumer was in jail to detailed questions about care needs.

Communication originating with the provider to the jail was not as frequently reported, with less than half of jails reporting that the community provider always or sometimes contacted the jail. Clear and regular communication between jail and community provider is essential for continuity of care to ensure that inmates continue to receive needed medications and services. The inconsistent level of this communication across the state is an area of concern as well.

Release from jail is a time of high risk—releasees may be homeless or returning to undesirable situations. This is particularly true of releasees with MI or MR/DD. Though a few exemplary jails clearly worked hard to make sure inmates with MI or MR/DD were released to a care provider or family member, in most cases jails did not contact providers upon inmate release, nor did they provide inmates who did not have a provider with a referral. (To be fair, it should be stated that many of the interviewees who reported that they did not provide a referral upon release to inmates who did not have a provider, stated that they did not need to provide such a referral because the inmate had received services while in jail and thus had established a relationship with a care provider. However, procedures and channels of contact are often different for persons in jail than for those in the community. Referrals should be made in all cases in which an inmate did not have a service provider before coming to jail.) Since post-release services are important to prevent recidivism this lack of continuity of care at release increases the risk of repeat offenses and mental health crisis for inmates with MI or MR/DD.

Though informative, we acknowledge a number of limitations to this study. First, all data with the exception of screening tool reviews are based in self-report, and thus subject to both recall and social desirability bias. In addition, selection bias may have been present. The jail administrators who refused to participate in the study may have been significantly different in their responses and views than those willing to be interviewed. Similarly, those consumers and family members willing to complete a written survey may have been motivated by desire to tell a particular story, and not representative of the larger experience of individuals with MI or MR/DD who have been jailed. Finally, our outreach efforts for the written survey went through established advocacy group channels, thus the most vulnerable individuals, those not connected to any support, would not be reached. Obviously a great deal of additional research is needed to more fully understand the situation of individuals with MI or MR/DD in jails.

Despite its limitations, our study provided a snapshot of the current situation in North Carolina jails. The picture that emerged from our research was one of jails that on the whole struggle to do the right thing given limited resources and limited knowledge. We found evidence of real ignorance of people with MI or MR/DD among jail staff, with occasional references to “those kinds of people” or “people with mental medications” and stories from consumers of unnecessary harm or cruelty such as being pepper sprayed for no reason. However, we also heard statements of true concern and kindness from jail staff. One interviewee stated: “[Inmates] are human beings and they deserve to be treated as such. . . . These people are someone’s sons and daughters, and someone out there loves them.” Most clearly we heard the struggle and frustration of inmates with unmet treatment needs in jail and of jails in trying to access care for inmates with MI. In a number of cases we were told that this struggle had gotten worse since mental health reform began in 2001. However, based on what we found, we believe there is cause for guarded optimism and that a number of changes can be made to improve the situation of individuals with MI or MR/DD in the jails of North Carolina.

Recommendations

In order to ensure that individuals with MI or MR/DD receive appropriate supports and services once they are in a jail setting, it is essential that they be identified as having a MI or MR/DD as soon as possible. Effective screening instruments are thus tremendously important. The literature indicates that screening tools such as the Correctional Mental Health Screen (Ford and Trestman, 2005) and the Brief Jail Mental Health Screen (Steadman et al, 2005) are both quick and effective instruments for most jail populations. (For a more complete discussion of screening instruments, see the literature review in Appendix A.)

- *Jails could adopt use of evidence-based screening tools to identify individuals with MI or MR/DD, and ensure that jail staff are trained in their use. Jails would benefit from relying on triangulation—screening tools,*

observations of arresting officer and observing/booking officer, and self-report—to identify inmates with MI or MR/DD.

- *Jail staff would benefit from ongoing training in MI and MR/DD. Given financial and staffing limitations, it may be useful to have on-line or CD-based training that could be completed by staff at their own pace. In addition, training from LME staff could be provided at low cost and would have the added benefit of strengthening relationships between jail and LME staff.*

Jail inmates are at risk of suicide, and should be screened for suicide risk and monitored to ensure their safety. This can be done in ways that preserve both life and dignity. Again, effective screening is essential, as is effective protocol regarding isolation, restraint,

- *Jails could adopt use of evidence-based screening processes for inmates at risk of suicide, and provide jail staff with training in both screening and responding to suicide risk.*
- *Suicide protocols for inmates could be informed by state-of-the-art policy regarding seclusion and restraint.*
- *Jails would benefit from relying on triangulation—screening tools, observations of arresting officer and observing/booking officer, and self-report—to identify inmates at risk of suicide. Casual observation by even a trained jailer usually will not identify a suicidal individual.*
- *All jails should have suicide smocks and blankets to provide to inmates at risk of self-harm. Such inmates should also have ready access to a toilet. If jail officials deem that having a toilet in the cell presents a drowning or other hazard to the inmate, then they should be prepared to safely escort the inmate to a toilet upon the inmate's request.*
- *Inmates at extreme risk of self-harm should be taken to a more appropriate treatment setting, such as an inpatient facility, as soon as possible. (See discussion of barriers to hospitalization below.)*

A serious issue faced by those with MI or MR/DD is the stigma attached to the disorders. Inmates identified as having MI or MR/DD are at risk of victimization, ridicule, and rejection by fellow inmates. Therefore, privacy and confidentiality are essential if inmates are to feel safe enough to self-identify as having MI or MR/DD.

- *Jails would benefit from having a private place for the intake screening, so that inmates can be fully honest about suicidality, MI, and/or MR/DD without fear of stigma.*
- *Jails could consider ways to provide medication that are private or non-identifying. For example, jails may wish to consider distributing a multivitamin to all inmates once a day along with any other needed medication, so that individuals needing medication will not be singled out.*

Our study found great variation in inmate access to mental health providers for the purposes of assessment, medication evaluation, and service provision.

Rapid access to assessment and needed treatment is essential to minimize psychiatric crises.

- *Whenever possible, jails should ensure that one of the medical staff they hire/contract with is a trained mental health professional*
- *If hiring or contracting with in-house mental health professional is not possible, 24/7 access to consultation from a mental health professional in the community is needed.*
- *LMEs can play a central role in working with jails to identify providers to go to the jails for the purposes of assessment and treatment.*

Access to psychotropic medications is also central to crisis prevention/management. Jails reported significant challenges in providing medication to inmates without substitution because of the cost, for which they are responsible. They also reported varying processes and timeframes for getting medications to inmates.

- *Streamlined procedures to check medications that inmates bring with them to jails would help ensure they are able to continue taking their medication uninterrupted.*
- *Streamlined procedures to provide medication evaluations and new prescriptions to inmates who need them, either via in-house mental health professionals or through consultation with community-based providers, would also be of great benefit.*
- *Jails need additional resources from their counties to cover the cost of psychotropic medications. In addition, arrangements with pharmaceutical companies, philanthropic foundations, and other sources of support should be explored to help defray the cost of medications.*

During times of psychiatric crisis, rapid response is essential. However, a number of jails reported cumbersome and time-consuming processes when trying to get an inmate hospitalized.

- *LME mobile crisis teams should provide care to inmates in crisis in the jail whenever they exist in the community.*
- *Jails could negotiate with local hospitals to provide emergency services and hospitalization to inmates, reducing the need for long trips to the state psychiatric facilities*
- *Streamlined processes are needed across the state for inmate hospitalization at both the state psychiatric facilities and Central Prison Safekeeping.*

Inmates with MI or MR/DD move in and out of jail; they frequently have a community provider prior to incarceration and always need one upon release. Continuity of care between jail and community is essential.

- *Jails and LMEs need quick and frequent communication, such as sharing of daily arrest logs, so that inmates with MI or MR/DD who receive services from the public system can be identified quickly.*
- *Communication should include information to the jail about the inmates' community-based prior treatment and medications, as well as any other*

relevant information that would help jail staff with the individual while incarcerated. Communication should also include information about date of inmate release

- *Inmates should be released with an appointment made at a community provider. Given that some communities have multiple resource options for individuals with MI or MR/DD, all jail inmates could be given a list of community resources upon release. Alternately, this list could be included in the jail manual received at admission.*
- *LMEs could be of tremendous help to jails if they would provide rapid screening, triage, and assessment for inmates who are citizens of their catchment areas.*
- *Written agreements between jails and LMEs to establish and streamline communication and collaboration would be of great benefit.*

Many jails expressed concern and frustration with what they experienced as a worsening of mental health services in their area, both in terms of difficulty accessing services for inmates and in terms of lack of community-based services, which result in increased rates of incarceration. Mental health reform is seen as resulting in negative outcomes for many with MI or MR/DD and criminal justice involvement.

- *A comprehensive evaluation of mental health reform's impact on incarceration rates and access to services while in jails for individuals with MI or MR/DD is needed.*

Jail is an inappropriate setting for many with MI or MR/DD, whose “crimes” are a result of their disability and who cannot receive adequate care while in jail.

- *Jail diversion programs are needed across the state, to prevent unnecessary incarceration of individuals with MI or MR/DD*

One of the great challenges in addressing the issues identified in this report is the fact since jails are local entities, changes will be required at 93 different locations. In addition, many of the recommendations made above will require coordination among agencies both within the county and across the state. It seems a poor use of resources to “reinvent the wheel” and have each jail work independently to identify screening tools, streamline processes for working with psychiatric hospitals, etc.

- *A “Jail Inmates with MI or MR/DD” ad hoc Task Force is needed at the State level to make and disseminate recommendations of ways in which county, regional, and state-level efforts can ensure that jail inmates with MI or MR/DD are better served. This Task Force could have representation from jail administrators, LMEs, county commissioners, the Department of Corrections Safekeeping, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, advocates and primary consumers in MI and MR/DD, provider groups, and other relevant representatives.*
- *This Task Force could identify other groups or organizations in the community who have examined the issue of people with MI or MR/DD in*

jails and develop collaborative relationships, so as not to “reinvent the wheel.”

- *One possible avenue for change could be in revision to NC Administrative Rule requiring some of the changes recommended above.*

Only through a concerted effort of all involved, supported by the political will of the counties and state, will the needs of individuals with MI or MR/DD in North Carolina jails be addressed.

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Appendix A

Literature review

Rates of people with mental illnesses or MR/DD in jails and prisons are very high

A significant number of jail and prison inmates in the United States have a mental illness, according to a report released by the U.S. Department of Justice in September 2006 (James & Glaze, 2006). The report, based on interviews with 479,900 jail inmates and more than 775,000 inmates of state and federal prisons, states that 64% of jail inmates have symptoms or recent history of a mental health problem. (Prevalence rates for federal and state prison inmates are slightly lower, hovering around 50%.) The report states that 24% of jail inmates reported at least one symptom of a psychotic disorder, 77.5% reported at least one symptom of mania, and 77.2% reported at least one symptom of a major depressive disorder. In contrast, the percentage of the U.S. adult population (age 18 or older) suffering from a diagnosable mental disorder during a given year is estimated to be between 21% and 26%, according to figures released by the U.S. Surgeon General (1999) and the National Institute of Mental Health (2006). Approximately 6% of the general population has a serious mental illness such as schizophrenia or bipolar disorder, the NIMH says (2006).

Persons with developmental disabilities and/or mental retardation [DD/MR] are also overrepresented in jails and prisons. According to researcher Joan Petersilia (1997), the prevalence of DD/MR in the prison system is between 4 and 10%, compared to 1-2% in the general population; the incidence is estimated to be even higher in jails (Petersilia, 2000).

People with mental illnesses are often arrested for minor offenses or for unwittingly taking part in a crime

Almost without exception, persons who are arrested in North Carolina are taken to a county jail operated under the auspices of the county sheriff's department. Persons are held in jail until they post bond or until their trial date. Most persons with a mental illness or MR/DD who are arrested have not committed a violent crime (according to the Bureau of Justice, 70% of persons with mental illness in local jails have not committed a violent crime; Ditton, 1999); many may have not committed a crime at all. In a recent study of arrests of persons with mental illness, researchers found that the most common reason for arrest was public disturbance. Researchers Fisher et al (2006) tracked a cohort of nearly 14,000 adults who received intensive public mental health services in the state of Massachusetts for a 12-month period in 1991 and 1992. Subjects were tracked for 11 years. Researchers found that 28% of subjects were arrested at least once, most commonly for crimes against public order. Since the early 1970s, researchers and consumer advocates have written extensively about the "criminalization of the mentally ill" —prejudicial arrest and detention, in lieu of treatment—of persons with mental illness who commit minor or "nuisance"

offenses (Abramson, 1972; Steadman et al, 1978; Teplin, 1984; Hochstedler, 1986; Lamb and Wenberger, 1998).

The literature on crime and arrest rates of persons with DD/MR is inconclusive. Some data shows that people with DD/MR are more likely than others to commit many types of crimes, from theft to assault (Hodgins, 1992; Holland et al, 2002), while advocates for persons with DD/MR suggest that members of this population are often not guilty of the offenses for which they are accused (Perske, 2000, 2004). However, it is well-known that this population is overrepresented in the criminal justice system. One British study (Gudjonsson et al, 1993, as quoted in Kebbell and Davies, 2003) found that 33.7% of male suspects in police custody and awaiting interview had an IQ of 75 or less. A study of Australians and New Zealanders being brought to trial found that between 23.6% of defendants had an IQ below 70 and thus could be diagnosed with mental retardation; another 14.9% of defendants were found to have borderline intellectual functioning (i.e., IQ between 70 and 79) (Hayes, 1997).

Jail can be an inappropriate and even dangerous place for people with MI or MR/DD

While jail diversion programs, such as those found in a number of cities in North Carolina, work to prevent persons with a mental illness and other disorders from serving lengthy jail terms, they can solve only part of the problem. As a result, many persons with mental illness are arrested and sent to jail, which all too often is a frightening and even hostile environment that few are equipped to handle. Unfortunately, persons with a mental illness are more vulnerable than most, researchers say. According to a report released by Human Rights Watch (2003) about mental illness in prisons, prisoners with a mental illness are more likely to be abused by fellow prisoners than their non-mentally ill counterparts. Also, the conditions of incarceration are likely to exacerbate symptoms of mental illness, and the violence and aggression that can result are often punished by prison staff, the report said.

Persons with DD/MR are also more likely than their non-disabled counterparts to be victimized by fellow inmates and jail staff (Lindsay, 2002). They also face other challenges. For example, persons with DD/MR who get arrested are often unable to understand even basic law enforcement and legal terms (Erikson and Perlman, 2001), and they are likely to receive harsher treatment from the criminal justice system. In one study, Australian researcher Judith Cockram (2005) tracked more than 3,200 offenders through the criminal justice system over an 11-year period. She found that more than a third of her subjects with DD/MR who were charged with a criminal offense were sentenced to time in jail, and nearly 5% were held without bail while awaiting trial, compared to 13% and 2%, respectively, of those without disabilities.

Persons who go to jail – especially those who are there for the first time – are at significantly increased risk for suicide, which remains a problem for jails in the United States. While jail suicides have declined from a rate of 129 per 100,000

inmates in 1983 to 47 per 100,000 inmates in 2002, according to the U.S. Dept. of Justice (Mumola, 2005), suicide still accounts for 32% of all jail deaths in the U.S. There is a much higher rate of suicide in small jails (i.e., those with an average daily census below 50). Persons who kill themselves in jail also tend to do so soon after being taken into custody: 48 percent did so in the first week of custody, with nearly 23 percent doing so the day of admission or the next (Mumola, 2005).

Statistics regarding rates of attempted and completed suicide in North Carolina jails are beyond the scope of this report. All 80 North Carolina jails that participated in the present research reported that they consistently screen for suicide risk.

Despite jails' best efforts, mental health treatment is not readily available in jail

Most jail inmates with a mental health problem do not receive treatment while in jail, even if they were receiving treatment in the community before admission. According to recent federal statistics (James and Glaze, 2006), 22.6% of jail inmates with a mental health problem received mental health treatment (medication, therapy, or hospitalization) at least once during the year prior to arrest, but only 17.5% of them received treatment while they were in jail.

While all persons in jail face difficulty obtaining appropriate mental health treatment, many populations face additional barriers, including female inmates and inmates with a dual diagnosis of mental illness and a substance abuse disorder. The number of females incarcerated in U.S. has risen dramatically in recent years—nearly 50% between 1995 and 2003 (McLean et al, 2006)—and a significant percentage of these women struggle with mental health problems that are complicated by poor physical health, poverty, and abuse. The prevalence of mental health disorders is greater in incarcerated women than their male counterparts (75% vs. 63%, Veysey, 1998). Men and women inmates have similar rates of severe mental illness (SMI), but female inmates are far more likely than their male counterparts to have major depression (14% vs. 3%), and 22% of female inmates have post-traumatic stress disorder, according to Veysey. In another study, a survey of 100 female jail inmates found high levels of trauma exposure (especially interpersonal trauma) and clinically significant levels of substance abuse, depression, and PTSD (Green et al, 2005). Women also need a more complex net of medical and social services than do men, as women occasionally enter jail while pregnant and are far more likely than male inmates to be the sole care providers for children under 18. Many jails are not equipped to handle these demographic changes. Jail officials are trained to recognize symptoms of mental health problems in males but not those for females (Veysey, 1998). Also, they are not trained or equipped to recognize and accommodate an inmate with PTSD (Veysey, 1998), despite its high prevalence among female inmates.

A large percentage of persons with MI are diagnosed with a co-occurring substance abuse disorder, a phenomenon known as dual diagnosis. One study (Hartwell, 2004) found that 62% of more than 700 prisoners in Massachusetts fit the criteria for dual diagnosis and that such individuals are at higher risk for recidivism and homelessness upon release than persons with only MI. Unfortunately, many dually diagnosed jail inmates do not respond well to traditional treatment methods for either condition but instead need specialized treatment, which is rarely available in jail settings (Swartz & Lurigo, 1999). Evidence-based practices for this population rely on an integrated approach in which both conditions are addressed simultaneously. The literature on the incidence and treatment of dual diagnosis is extensive and beyond the scope of this report. If readers are interested, an excellent summary can be found at the SAMHSA website, <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>.

While the literature is scant on the availability of services for jail inmates with MR/DD, one study stated that persons with this condition are rarely even identified, much less provided services, by at least one large, urban jail. Researchers Nelson et al (1994) found that the King County Correctional Facility in Seattle did not screen for MR/DD in a timely manner and often did not screen at all; that requirements for detention officer training about MR/DD were ignored; and that information about accommodations for persons with MR/DD were omitted from jail policy.

There are effective screening tools to identify people with MI or MR/DD during jail intake, though these instruments are not fail-proof

A variety of brief and inexpensive instruments are available to screen for each of these conditions. Mental illness screening options include the Correctional Mental Health Screen (Ford and Trestman, 2005), an 8-item test (12 items for females) to be administered by non-specialists that has been used successfully in clinical trials in prison settings. Another available instrument is the Brief Jail Mental Health Screen (Steadman et al, 2005), a verbal test which takes about 2 ½ minutes to administer and which correctly detected mental illness in male inmates 73.5% of the time in clinical trials and failed to identify existing mental illness in 14.5% of male subjects. The test was less successful in detecting mental illness in female inmates; only 61% of females tested were correctly identified as having a mental illness, while more than a third (34.7%) of sufferers were missed. This screening is available for free on the website of The National GAINS Center, the research and policy arm of SAMHSA. (See www.gainscenter.samhsa.gov/html/resources/MHscreen.asp.)

The presence of MR/DD can also be detected with the proper screening tools. One such tool is the Hayes Ability Screening Index [HASI] (Hayes, 2002), a 5-10 minute test which consists of several self-report questions, a spelling subtest, a 'join the dots' puzzle, and a clock drawing subtest. The test, which can be administered by a lay person, was 100% successful at predicting intellectual

disability in clinical trials, and 82% successful at excluding those without intellectual disability. While the length of this test may make it impractical for use with all incoming inmates, it could be used for a subset of inmates who report being in special education classes in school or some other reasonable proxy for having below-average IQ.

Unfortunately, the HASI and similar tools test only for IQ, which by itself is not a reliable indicator of risk, according to Bogacki et al (2005). Low IQ alone is not a good indicator of high-risk activity, they state; in fact, their studies found that the potential for high-risk behavior actually *decreases* with lower IQ. Instead, they found that high-risk behavior is most likely when an individual's adaptive functioning is significantly lower than his/her IQ. They created the Developmental Disabilities Risk Inventory [DDRI] to assess and compare an individual's IQ and adaptive functioning.

The IQ also fails to measure verbal memory skills, according to Powell et al (2002). Thirty adults with DD/MR were given a battery of four tests measuring IQ, reading and spelling, receptive vocabulary, and verbal memory. While scores on the IQ, reading and spelling, and receptive vocabulary tests were highly correlated, correlation with verbal memory test results was only moderate. This finding is significant, because verbal memory is required during all phases of the criminal justice process, from the reading of the Miranda rights to following jail officials' orders to understanding and participating in a criminal trial.

There are effective models of treatment for people with mental illnesses or MR/DD who go to jail

While limited research has been done to determine what methods are most effective in mental health treatment for jail inmates, experts have suggested that cooperative transition planning is the key component of success. In other words, the jails that find the greatest success in treatment inmates with mental illness—and indeed, inmates with any chronic and complex health or mental health condition—are those that have formed relationships with the officials and agencies that will be working with jail inmates after they are released from custody.

Inmates rarely stay in jail for more than a few weeks, and many are released within 72 hours of arrest. Thus, jails rarely provide long-term mental health services. Instead, often the best they can do is to identify that an inmate has MI or MR/DD and then work with community mental health providers to ensure that the inmate can receive services in the weeks and months to come. This transition planning can be difficult, because it requires the coordination and cooperation of officials from law enforcement, the court system, community mental health, and social service organizations.

The model most cited in the literature is the APIC Model (Osher et al, 2003). This model, which can be adapted for use by jails and communities of all sizes, is outlined below:

- **Assess** the inmate's clinical and social needs, and public safety risks
- **Plan** for the treatment and services required to address the inmate's needs
- **Identify** required community and correctional programs responsible for post-release services
- **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services

Transition planning for jail inmates is just one of 46 recommendations and policy statements contained in the detailed and comprehensive Criminal Justice/Mental Health Consensus Project Report released in 2002 (CSG, 2002). The report, a combined effort by criminal justice officials, mental health experts, and community leaders, examines how to best respond to persons with MI who end up in the criminal justice system. The report contains recommendations and policy statements pertaining to each step of the criminal justice process, from arrest through judicial proceedings, detention and incarceration, and release. The report also cites a number of model programs. Though many of the programs cited – such as the Cook County Jail's comprehensive Threshold Program for repeat offenders with MI – are affiliated with large, urban jails, others can be easily adapted for use by even the smallest jails. In Chicago, for example, mental health providers are notified electronically when their service recipients go to jail and when they are released, while jail officials in Rockville, Md., post a daily list of inmates that can be accessed by mental health providers. Other model programs are designed to capture persons with mental illness before they end up in jail. The Chapel Hill, N.C., Police Department has a Mobile Crisis Unit in which specially trained officers respond to volatile situations involving a person with a mental illness; similar units operate in other small and medium-sized cities such as Broken Arrow, Okla., and Lee's Summit, Mo. (For more information about the project and to read the complete report, see <http://consensusproject.org>).

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Appendix B

Jail Study Advisory Board

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**Experiences of Consumers with Mental Illness and
Developmental Disabilities and their Collaterals in the
Jails of North Carolina**

Conducted by

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*A study funded by the North Carolina Governor's Advocacy Council for
Persons with Disabilities*

Executive Summary—UNCG Study

Purpose and Procedures

This study aimed to explore the experiences of people with mental illness (MI) and developmental disabilities (DD) and their collaterals in the jails of North Carolina. Collateral contacts included family members, jail personnel and local management entity (LME) workers. Participants were interviewed by study personnel using semi-structured interviews consisting of questions formulated by the researchers and the study advisory committee.

Results

Jail Participant Summary

Jail personnel:

- In general voiced concerns about overcrowding, jailing for petty theft, excess stays and general population issues.
- Focused their concerns primarily pertained to MI versus the DD population
- Did not feel the local Mental Health Centers/LMEs were able to help them, often due to closing or workload, in some cases due to lack of interest.
- Were aware of a multiplicity of needs of this population, and were primarily concerned they are not getting treatment
- Reported very few successes
- Were an excellent source of recommendations for change, focusing mostly on increased training for officers, pre-booking jail diversion and onsite crisis workers.

LME Participant Summary

LME participants:

- Shared Jails' concerns regarding overcrowding and petty crimes but focused more on lack of trained evaluators in jails
- Also felt DD consumers were affected by lack of training of jail personnel, but, like the jails, did not see it as a big problem
- Cited mental health reform and lack of personnel as well as work overload as problems for mental health centers working with incarcerated inmates
- Were a rich source of information for defining consumer special needs. Their focus was on housing, transitioning back into community, and medication monitoring
- Reported few successes
- Ideal changes consisted of partnerships, task force development and increasing training of jail personnel and communication among all concerned.

Family and Consumer Summary

Families and Consumers:

- Reported challenges throughout the process of arrest, incarceration and discharge and transition back into the community.
- Voiced much frustration with the barriers to getting their loved ones' needs met especially in lack of communication and need for enhanced procedures for communicating with family members
- Identified proper, skilled assessment as a glaring need, especially at intake but also during the jail stay
- Identified lack of adequate discharge planning and inability of consumers to meet even basic needs upon discharge (filling prescriptions, renewing benefits, having a place to live) as consistent areas of concern.
- Largely described the local mental health entities as either under-responsive and/or overworked

Recommendations

- Conceptualize care at all stages of incarceration process
 - Improve assessments of **incoming** inmates (evidenced based screening tool) by increasing access to trained evaluators
 - Increase access to treatment/crisis intervention **while incarcerated**.
 - Increase **discharge/transition planning** and follow-up, linkage to LME
- Involve family when possible, rework privacy procedures
- Increase skills for working with treatment resistant population throughout process

Purpose

This study aimed to explore the experiences of people with mental illness and developmental disabilities and their collaterals in the jails of North Carolina. Collateral contacts included family members, jail personnel and local management entity (LME) workers.

This study is a sister study of *Identification and Treatment of Individuals with MI or MR/DD in NC Jails* conducted by Anna Scheyett and Jennie Vaughn in the School of Social Work at the University of North Carolina, Chapel Hill. Both studies were sponsored by the North Carolina Governor's Advocacy Council for Persons with Disabilities (GACPD) and shared an Advisory Council made up of mental health consumers, family members, and advocates. The Advisory Council was involved in crafting the study purpose and procedures, and had direct input into study questions.

Study personnel from both studies collaborated on the annotated bibliography (Appendix A included in the Chapel Hill report), therefore, a review of the literature will not be repeated in this report.

Procedures

The UNCG study sought to meet the study's purpose by conducting qualitative interviews with consumers and family members, jail personnel and local management entity (LME) workers. It was the hope of the researchers that this strategy would complement that of the Chapel Hill study by giving more of a voice to those involved in incarceration of persons with mental illness and developmental disability in the jails of North Carolina. Study procedures and all study documents were approved by the UNCG Institutional Review Board for the Protection of Human Subjects prior to participant recruitment and data collection.

Recruitment—Consumers and Families

Recruitment emails and postcards were sent to advocacy groups throughout North Carolina. These groups included, Traumatic Brain Injury Association, Autism Society of North Carolina, Association of Retarded Citizens (ARC) Chapters of North Carolina, North Carolina Alliance for the Mentally Ill (NAMI) Chapters of North Carolina, various mental health consumers' organizations in North Carolina; and finally, word of mouth through email lists and social networks of study participants and advocates.

Local Management Entity (LME) and Jail Personnel Recruitment

All LME's in North Carolina were contacted either by phone or email to participate. Multiple attempts were made when there was a lack of response. About half of the LME's responded with interest in participating. At that point, major jails in each of the LME cachement areas were recruited.

Respondent Numbers

This population, particularly family and consumers, proved difficult to access. It is unclear whether this was due to the difficult topic, the possibly painful memories associated with revisiting it, or a failure in recruitment strategies. So while interview numbers were not as high as expected, information shared particularly by family members, was very rich and adds an invaluable, personal dimension to what we know about the experiences of people with mental illness in jails.

- Ten jail interviews were conducted by phone. A member of the research team (*a.t.*) spoke with jail personnel at various levels with different jail functions, (i.e., nurse, captain, guard, etc).
- Five LME interviews were conducted by phone. While ten LME personnel agreed to talk initially, by the time the interview dates were set up, only 5 LME's participated. This may be attributable to the fact that there is a high

level of turnover in the current “mental health reform” context and some LME’s have gone out of business and/or consolidated.

- Nine family members/consumers were interviewed by phone, though they were all given the option of meeting face to face with the interviewer (*m.f.t.*). Of these, one had a member jailed in Pennsylvania and one was unusable. These interviews were extensive, often exceeding fifteen pages transcribed. Three consumers participated but one was as a family member.

Question Formulation

Interview questions were formulated by the researchers in conjunction with the GACPD Advisory Team. LME and jail personnel were asked versions of the same questions which included:

- What do you see as special challenges for jails in your area related to inmates with mental illness? (Challenge question MI)
- What do you see as special challenges for jails in your area related to inmates with developmental disabilities? (Challenge question DD)
- What special challenges exist for your mental health centers in providing services to jailed inmates? What do you attribute these to? (Challenge LME question)
- What special needs do consumers in your area have? (Special Needs question)
- Are there any successes in your area related to providing services to MI/DD consumers who are jailed that you would like to share? What do you attribute these to? (Success Question)
- What would you like to see happen in your area when a person with MI/DD comes into contact with police for an infraction of the law? (Dream Question)

Families and consumers were asked the following questions:

- What are some challenges that you/your loved one faced in relation to their mental illness/DD during their jail experiences? (Challenge question)
- What were some barriers to getting their/your needs met? What do you attribute those barriers to? (Barrier question)
- In general, what should happen to consumers who come in contact with police officers for infractions of the law? (Should question)
- What should not happen? (Should not question)
- What would you change about your experience if there were anything you could change? (Change question)
- What were some successes, if any, during the process? (Success question)
- Did you have any experiences with the local mental health center during the process? (LME question)

- Do you think there are ways to pre-plan for this type of event, such as an advanced psychiatric directive? Have you tried this? (Pre-plan question)
- Have you ever called the police to press charges against your loved one? What happened? (Police question)

All interviews were audio-taped over the phone and then transcribed by the research teams. Families and consumers were given the option of being interviewed in person but tended to prefer the phone method. Interviews were semi-structured around the questions listed, however the family and consumer interviews were more “free form” and tended to last longer, with an emphasis on allowing the participants to “tell their story.”

Results

After transcribing, all responses were open-coded under each question. **NOTE: Strong themes emerged across questions and respondents and are condensed and summarized below. Themes are bolded and strong interview quotes are listed in bold italics.**

Selected Jail Results

- **What do you see as special challenges for jails in your area related to inmates with mental illness?**
 - We’ve become a **holding place**, no one really knows what to do with them
 - **Growing** population of mentally ill, volume
 - More coming in for minor **infractions**
 - What do we do with them?
 - Inmates don’t know what meds they are on
 - **Need more trained** staff to assess these inmates
 - ***I think we need someone here to evaluate these inmates when they come in. These officers are not trained to do that. They see them as just another crazy person that they have to deal with.***
- **What do you see as special challenges for jails in your area related to inmates with developmental disabilities?**
 - **I don’t work with DD**
 - We’ve become a holding place
 - Everyone picks on them back there and that makes them act worse.
 - Need staff that is better trained, **really do not see a lot of inmates with DD though.**
- **What special challenges exist for your mental health centers in providing services to jailed inmates? What do you attribute these to?**

- They can no longer bill so contact has stopped
 - **They really don't come here**
 - A lot of these centers are closing
 - ***What mental health centers? All the ones here are going out of business. They don't have anyone to come and provide any types of services to these inmates once they are picked up. I think we have gotten ourselves into a mess with these centers shutting down and it seems like everyday it gets worse.***
 - We have someone who comes about once a week but that does not really do us any good
 - ***All these centers are closing down. I am not sure what they expect these people to do. This is already a vulnerable population and all the places they could go for help are shutting down. Soon there will be no one left to provide any type of treatment.***
- **What special needs do consumers in your area have?**
 - **Financial** needs
 - When they come to jail their **disability gets cut off**
 - **No place to go**
 - No source of income and a criminal record
 - ***We put them in there with all the other inmates and it is like they are putting on a show...They are back there hooping and hollering and we can't keep them calmed down. It is like they want everyone in here to see them.***
 - **Just need treatment**, we're not doing anything besides babysitting them
 - Need a lot of attention
 - So many...they are not getting any medication in here...need some sort of counseling...a lot of times we don't have the medications to give them or they don't even know what they are supposed to take.
 - Shutting down the centers...have no where to go for help
 - ***I keep seeing the same ones coming and going here. We really need to get these people some help from somewhere.***
 - **Are there any successes in your area related to providing services to MI/DD consumers who are jailed that you would like to share? What do you attribute these to?**
 - Oh God, I **don't have time** to do that
 - Some get the medication they need and they seem to be better
 - I **can't think of anything** right now to tell you the truth
 - Um, let me think...I really can't think of anything
 - ***Honey, not that I can think of.***
 - No, I can't think of one right now.

- (Laughter) No, unfortunately I cannot think of one.
 - Hmm...I can't think of one right now.
 - Ummm. Can I call you back about that (laughter)
 - I cannot think of one right offhand.
 - ***I know that this probably does not sound good but I cannot think of one.***
- **What would you like to see happen in your area when a person with MI/DD comes into contact with police for an infraction of the law?**
 - **More training** for police officers
 - Needs to be somewhere they can go first to **get evaluated for hospitalization versus jail**
 - Someone come out here and evaluate them
 - ***I have no idea. I know what we got going on here right now ain't working. I can't tell you how to make it better though.***
 - ***I do not think this is the best place for them and they need to go somewhere they can get some help. Help from people who are trained for this kind of thing. They do not need to be caged in here with these other animals.***
 - A lot need to **be in the hospital and not here**
 - Stop seeing them with **regular population**, get picked on and more agitated
 - These people need treatment
 - ***I think they just need treatment. We are not doing anything with them at the jails besides babysitting them. Once they get back on the streets they are on their own. More than likely they will end back up in here too before too long.***

Jail Personnel Summary

Jail personnel in general voiced concerns about overcrowding and that they did not know what to do with the large numbers of people with mental illness who were being arrested. Many were concerned about the number of inmates with mental illness who were being jailed for minor infractions of the law and then were staying longer than average. Several voiced concerns about mixing people with mental illness and developmental disability in with the general population as they stated they felt this made the symptoms worse. Though, most jail personnel stated they did not see individuals with developmental disability very often.

Jail personnel did not feel the local Mental Health Centers were able to help them, often due to closing or workload, but in some cases due to lack of interest and inability to bill for their time. One jail personnel stated real concern for what would happen to individuals with mental illness once the

centers all closed and that they then “wouldn’t be able to build jails fast enough to hold them all.”

Jail personnel seemed very aware were aware of a multiplicity of needs of this population, and were primarily concerned with lack of treatment. They were also aware that benefits are cut off when jailed and that people are often released with nowhere to go.

There were very few successes to report. Several participants laughed when asked.

These participants were an excellent source of recommendations for change, focusing mostly on increased training for officers, pre-booking jail diversion and onsite crisis workers. They were clear in stating that if jail could be avoided in lieu of the hospital, that this should happen.

LME Results

- **What do you see as special challenges for jails in your area related to inmates with mental illness?**
 - **Lack of trained** personnel to properly **evaluate**
 - **Large number** consumers arrested for **petty** crimes
 - **Lack of trained evaluators** on intake
 - Not having trained staff to screen for MI
 - Consumer may not feel comfortable **revealing**
 - So many consumers arrested for small infractions
 - **Jails overcrowded**
 - ***In my opinion, the jails are just becoming an inpatient facility for people with mental illness. With the lack of mental health services in NC right now so many individuals are getting arrested for minor infractions of the law.***

- **What do you see as special challenges for jails in your area related to inmates with developmental disability?**
 - **Lack of qualified personnel**
 - **Not aware of DD** in jails in our area
 - Not having enough trained staff
 - We really **do not have our DD consumers being incarcerated**

- **What special challenges exist for your mental health centers in providing services to jailed inmates? What do you attribute these to?**
 - **With mental health reform** there tends to be **gaps** in services.
 - **No communication** from the jail
 - Consumer does not reveal they are a client of the LME

- **In and back out** before anyone knows
 - Honestly, just **lack of time**,
 - *...with the closing of so many mental health centers there are simply not enough people to provide services. The few practitioners that are left have such high case loads they are not readily available to go visit consumers while incarcerated*
- **What special needs do consumers in your area have?**
 - So many, need more in depth counseling, medication monitoring, assistance getting prepared for release.
 - Released with **nowhere to go**
 - End up back on the streets in the same predicament
 - They need **someone to advocate** for them. A lot of time our consumers are not aware of their rights and they need someone they can trust to advocate for them.
 - *They need more treatment. They also need someone who can speak out on their behalf. I also do not believe they should be held in cells with all other inmates. I think they need to be handled with much more caution than other inmates due to the nature of their mental illness.*
- **Are there any successes in your area related to providing services to MI/DD consumers who are jailed that you would like to share? What do you attribute these to?**
 - I can't think of one in particular but I have seen individuals go into the criminal justice system and get clean from the substances making their MI worse. Some have relapsed but a few have remained clean and gotten on the right track
 - Unfortunately, I can't think of one at this time.
 - I really do not have the time to try and think of that right now.
 - I can think of a few people who have done well but I think it was just *“getting out and seeking the help they needed. Not waiting for someone to come along and help them but by being proactive and seeking help.”*
 - *I am sure there have been some successes however I cannot think of one at this time.*
- **What would you like to see happen in your area when a person with MI/DD comes into contact with police for an infraction of the law?**
 - *“I would like to see a trained professional on staff at every jail in order to screen individuals for MI so these individuals can get some of the services they need put in place while they are incarcerated.”*
 - **More communication** on everyone's part.

- Everyone just does their jobs and does not think about the picture as a whole.
- I also think everyone could benefit by **attending some trainings together** on dealing with mental illness in the jail system.
- **More of a partnership** between the MH Centers and the jails.
- A lot of consumers are **arrested over and over again**. I would like to see some sort of **partnership or task force** determine ways to deal with the recidivism of these consumers.
- We really need a **trained clinician at every jail** to assist these consumers after they are released, to make sure they have a place to go and they get the services they need after being released.

LME Participant Summary

In general, the LME participants shared many of the jails personnel's concerns regarding overcrowding and petty crimes but focused more on lack of trained evaluators in jails, both at intake, during incarceration and at release. They also felt that consumers with developmental disability were affected by lack of training of jail personnel, but, like the jails, did not see it as a big problem.

In discussing their own ability to meet the challenges of providing services to person's who are incarcerated and mentally ill, they cited mental health reform and a lack of personnel as well as work overload as problems. Like the jails, the LME participants were clearly aware of consumer special needs. These participants tended to focus on housing and transitioning back into the community, as well as medication monitoring.

They also had few successes to report.

When asked what they would like to see happen they brainstormed partnerships, task force development and increased training of jail personnel and better communication among all concerned.

Family and Consumer Results

These interviews tended to much longer and less linear than the LME and Jail interviews, many were over fifteen single spaced pages transcribed. There are, therefore, more themes under each question. Below are questions with themes and supporting quotes.

- What are some challenges that you/your loved one faced in relation to their mental illness/DD during their jail experiences? (Challenge question)
 - Very trauma of arrest
 - ***He is more ill than a criminal***
 - ***I mean, just crying...sobbing. No matter how much I tried to tell the jail nurse, "Something's wrong. This isn't normal." Phone calls to me, he'd say, "Mom, something's wrong with me. I'm going crazy."***
 - ***We went to visit him. He cried hysterically, you know, through the window.***
 - Difficulty transitioning from hospital/LME's to courts, attorneys, jails
 - ***The judicial system really did not know what to do with someone who had mental illness.***
 - ***There was nobody at the jail who understood mental illness***
 - Social problems from other inmates
 - Lack of Treatment while there
 - They stuck him in a chair, they put him in confinement... that made his illness worse.***
 - Because it's not their fault that they're mentally ill. And it's not okay for the jail not to have someone there who's trained to understand that these are mental...symptoms of mental illness, and not somebody acting up.***
 - By the time they got him to XXX at XXX Prison, and the doctor called me, he said he was in the deepest form of psychosis you could be in. Because what they had done is pushed him farther and farther into that psychosis. He was to the point where he would go to the bathroom on the floor and smear it all over his body, which is a really deep form of psychosis. Which should not have happened.***
 - Lack of Transition/Follow-up
 - ***He was discharged to a homeless shelter***
 - ***He would have been released into the community with no medicines and no place to live***
 - ***No way to fill prescriptions***
 - ***Lost benefits while in jail***

- **What were some barriers to getting their/your needs met? What do you attribute those barriers to? (Barrier question)**
 - So many people involved
 - ***Worst experience with the attorney***
 - ***I was never treated like I was believable, it was just like I was an inadequate parent.***
 - Lack of care in jail
 - ***In with general population at ages 16-18.***
 - ***All they kept doing was punishing him.***
 - ***Isolation is not good for mental illness***
 - Lack of communication with family
 - ***He was missing for seven days and ended up being two miles away in the county jail.***
 - ***... Never bothered to get any background information from his family***
 - Lack of understanding of mental illness
 - ***There's not an understanding of schizophrenia as a biological illness.***
 - ***Especially difficult if untrained staff and noncompliant inmate: "They will tell you they are fine."***
 - ***They've never admitted to having the illness, they've never admitted to having voices. And they will sit there and tell you that everything is fine. Well, somebody who's not trained isn't going to understand...***
 - ***that nurse, at times,[reports] about my son's condition were extreme opposite of what was really going on. When you leave the jail and get to the hospital, he was in extreme psychosis. But if I would call and ask the nurse, she would say "Oh he's great."***
- **In general, what should happen to consumers who come in contact with police officers for infractions of the law? (Should question)**
 - Proper Assessment with History
 - Revision of Privacy Rules

-I think, if you know that there is something wrong with this person and...even though they are adults I think that they need, at least their family members need to be notified.

- Liaison in jails with mental health center and families
- Reduction of stigma through education
- Jail diversion when possible
- Proper treatment and crisis monitoring in jail

- **In general, what should not happen to consumers who come in contact with police officers for infractions of the law? (Should question)**
 - Jail, if possible not to
 - Lack of follow-up
 - Poor treatment by police
 - *I hate the way they treat them*
 - No place to go
 - *I just wish there was a place for him to go*

- **What would you change about your experience if there were anything you could change? (Change question)**
 - More communication with consumer/more treatment opportunity
 - *He was literally a captive audience.*
 - Their treatment by LEO's, nurses, guards
 - More communication with family members.

- **What were some successes, if any, during the process? (Success question)**
 - Police were helpful domestically
 - Angel List
 - *Of people who have “just heard me when I say, ‘Okay my son has schizophrenia. He is not a criminal...I need to get him out of jail and into the hospital.’”*
 - Giving medicine on time (consumer)
 - They believed me (parent)
 - Someone did actually diagnose him

- **Did you have any experiences with the local mental health center during the process? (LME question)**
 - Positive
 - Things best when we had a good relationship with the county
 - Fabulous nurse but “so overworked,” “just fried,” “I felt sorry for her.”
 - Negatives

- Varies from county to county
- Lack of involvement
- **Do you think there are ways to pre-plan for this type of event, such as an advanced psychiatric directive? Have you tried this? (Pre-plan question)**

The majority of participants had no experience with advanced directives though medical guardianship was being explored in one case. Another family described an identification card system that police could find in a consumer's wallet: ***“being members of NAMI, we had printed up a little card that our loved ones, or the consumers can carry, saying ‘My name is so-and-so. Please contact so-and-so. This is my doctor, I’m on these drugs, I have a mental illness.’”***

- **Have you ever called the police to press charges against your loved one? What happened? (Police question)**
 - Most had experience with this
 - Generally positive views regarding police in the home, de-escalation skills. Especially true of specially trained officers.
 - Concerns regarding the embarrassment of having police at their homes repeatedly.
 - ***“We were humiliated time and time again. And that shouldn’t happen, the over reaction. I mean, it should be taken seriously, but at the same time, you shouldn’t bring out the whole force...with lights blaring and embarrassing you in front of your neighbors and humiliating you in front of your friends.”***

Family and Consumer Summary

Family members provided rich data in the form of personal stories and “expert” suggestions based on their own struggles. The majority of the family members interviewed were mothers of sons. There were also two significant others (both also female) who were interviewed. One met the criteria of being both consumer and family member. Additionally, two male consumers participated in the interviews.

Families reported challenges throughout the process of arrest, incarceration and discharge and transition back into the community. They voiced much frustration with the barriers to getting their loved ones’ needs met. Lack of communication and need for enhanced procedures for communicating with family members emerged as a strong theme across interviews. Proper, skilled assessment was also seen as a glaring need, especially at intake but also during the jail stay as

some family members stated that their loved one would deny mental illness at first but would then deteriorate markedly while incarcerated. Finally, lack of adequate discharge planning and inability of consumers to meet even basic needs upon discharge (filling prescriptions, renewing benefits, having a place to live) were consistent areas of concern. Families largely described the local mental health entities as either under-responsive and/or overworked though there were some bright spots, especially those professionals who went out of their way, who stepped outside the rigid guidelines of blanket confidentiality for example, or who really listened to the family members.

The researchers were also interested in whether or not family members had experience with advanced directives but none did. All were fairly familiar with calling the police on their loved one and most felt the police did great at stabilizing the situations and calming their consumers while the situation remained domestic. The families were not as satisfied with law enforcement's reactions when there were actual laws broken.

Discussion

Much useful information was received from LME's and jails, in addition to that received from the families and consumers involved in this study of jail experiences of people with mental illness and developmental disability in North Carolina. It became clear that inherent in the responses were concerns about the treatment of people with mental illness at **all phases** of the jail experience.

Initial Phases

The **importance of proper intake and assessment** of individuals with mental illness was reported again and again. Interestingly, people with developmental disability were not seen as a big issue by any of the study participants, leading to the possibility that persons with developmental disability are possibly going unidentified when incarcerated in North Carolina. Another issue that emerged from the family data was the concern that a consumers who are reluctant to identify as mentally ill are being taken at "their word" during brief intakes and therefore are being allowed to seriously decompensate once they are processed. This concern underlines the importance of specialty training with treatment-resistant or reluctant mental health consumers. **Increasing evaluation skills** may also lead to the result that many participants hoped for, **reducing incarcerations in favor of hospitalization and/or outpatient treatment whenever possible.**

Middle Phases

In addition to the importance of intake, participants voiced concerns about medical management while incarcerated in the form of proper medication being

provided. They also underlined the importance of access to crisis management while in jails since some consumers came in appearing stable and then decompensated due to the stress of the jail environment, lack of medication and/or emerging mental illness. Also emphasized was the need for specialized services in jail such as isolation from the general population and flexibility of rules (allowing more activity, allowing books for reading, etc).

Exit Phases

The exit phase of the jail experience for persons with mental illness was emphasized again and again as a crucial step in maximizing (or, more likely, undermining) consumer stability. The lack of transition planning seemed to be a common experience. One family member described her consumer walking all the way from jail (in another county) to her house when released, with prescriptions and no way to get them filled. Another stated that she isn't mentally ill but had difficulty navigating all the social systems to get benefits reinstated when her loved one was released. Commonly voiced was the dilemma of consumers having nowhere to go upon discharge and no linkage to follow-up to mental health services. All participants worried that the overworked mental health centers were not able to devote the time needed to work with these consumers and that, for this reason, many consumers would be back in jails again.

Limitations of the Study and Future Directions

This study, in many ways, represents a "first look" at people with mental illness and developmental disability in North Carolina's jails. There were limitations to the study and the study methodology that should be considered when weighing the results. Additionally, future studies would benefit from less reliance on self-report and broader recruitment strategies, especially in the area of developmental disability.

Lack of information about Developmental Disability in North Carolina.

There were very few responses that pertained to developmental disability on the parts of LME and jail personnel. Additionally, no consumers with developmental disability, or family members of persons with developmental disability participated in the study. It is impossible to say what this means, but it should definitely not be taken as a sign that people with DD are *not* incarcerated in North Carolina jails.

Difficulty accessing consumers and family members and relatively small sample size

As stated earlier, efforts by the research team to contact consumers and family members for recruitment failed to net a substantial sample size. In the case of LME workers, the small sample size is likely due to the chaotic state of many county LME's due to privatization issues in mental health reform. The study

recruitment method of going through advocacy organizations needs revision, since a substantial number of persons with the jail experience were not accessed. Future studies may also consider the use of a toll-free number where consumers and their families can call in for free. One consumer advocate stated that this may have been a barrier to more consumer participation, since prospective participants had to call the researcher to indicate their interest.

Reliance on self-report and recollection

In future it will be important to actually view people with mental illness in the county jails of North Carolina. The reliance on self-report and recollection could be mitigated with first-hand observation. Additionally, self-serving bias on the part of jails and LME personnel would be decreased with direct observation of procedures.

Inability to factor out the turbulent mental health reform context.

The current mental health context in North Carolina, fraught as it is with privatization hurdles and confusion regarding new procedures, as well as a decrease in available mental health beds, makes it difficult to understand how well the jails would be functioning if this were not the case.

Final Recommendations

Recommendations emerging from the UNCG Interview Study complement and underline those from the UNC Chapel Hill Survey Study and include:

- There is a need to conceptualize care of inmates with mental illness and developmental disability at all stages of the incarceration process
 - Improve assessments of **incoming** inmates (evidenced based screening tool) by increasing access to trained evaluators. This could lead to increased incidents of **jail diversion**.
 - Increase access to treatment/crisis intervention **while incarcerated**.
 - Increase **discharge/transition planning** and follow-up, linkage to LME, access to **discharge medications**
- Involve family when possible, rework privacy procedures to enable this to happen
- Increase skills for working with treatment resistant population throughout all phases.

Appendix Z

Important Study Quotes

I think they just need treatment. We are not doing anything with them at the jails besides babysitting them. Once they get back on the streets they are on their own. More than likely they will end back up in here too before too long.

--Jail personnel

What mental health centers? All the ones here are going out of business. They don't have anyone to come and provide any types of services to these inmates once they are picked up. I think we have gotten ourselves into a mess with these centers shutting down and it seems like everyday it gets worse.

--Jail personnel

I keep seeing the same ones coming and going here. We really need to get these people some help from somewhere.

--Jail personnel

We put them in there with all the other inmates and it is like they are putting on a show... They are back there hooping and hollering and we can't keep them calmed down. It is like they want everyone in here to see them.

--Jail personnel

I know what we got going on here ain't working. I can't tell you how to make it better though.

--Jail personnel

I do not think this is the best place for them and they need to go somewhere they can get some help. Help from people who are trained for this kind of thing. They do not need to be caged in here with these other animals.

--Jail personnel

I think we need someone here to evaluate these inmates when they come in. These officers are not trained to do that. They see them as just another crazy person that they have to deal with.

--Jail nurse

All these centers are closing down. I am not sure what they expect these people to do. This is already a vulnerable population and all the places they could go for help are shutting down. Soon there will be no one left to provide any type of treatment.

--Jail personnel

If we think it is bad now, wait until all these mental health centers close and we won't be able to build a jail fast enough to hold everyone.

--Police captain

They need someone to advocate for them. A lot of time our consumers are not aware of their rights and they need someone they can trust to advocate for them.

--LME worker

I would like to see a trained professional on staff at every jail in order to screen individuals for MI so these individuals can get some of the services they need put in place while they are incarcerated.

--LME worker

There are so many consumers being arrested right now for small infractions of the law. The jails are already filled to capacity and now with the influx of people with mental illness it is only getting worse.

--LME personnel

I called the hospital and I say, "My son's in jail and he needs to be in the hospital," and she says, "We don't take criminals."

--Family member

We were humiliated time and time again. And that shouldn't happen, the over reaction. I mean, it should be taken seriously, but at the same time, you shouldn't bring out the whole force...with lights

blaring and embarrassing you in front of your neighbors and humiliating you in front of your friends.

--Family member

Going through mental health or some kind of rehab is better than just...if I had of got the help I needed then and somebody had of helped me discover the help that I needed maybe I'd still have my family...we'd still be together. But that took 16 years of my life away.

--Consumer

Well, I think they should investigate them and...try to get them some help, you know, first. 'Cause putting people in jail ain't always the answer.

--Consumer

They stuck him in a chair, they put him in confinement, they did all these things that made his symptoms worse. Mainly because there was nobody at the jail who understood mental illness, who could see that this was surfacing.

By the time they got him to xxxx at xxx Prison, and the doctor called me, he said he was in the deepest form of psychosis you could be in. Because what they had done is pushed him farther and farther into that psychosis. He was to the point where he would go to the bathroom on the floor and smear it all over his body, which is a really deep form of psychosis. Which should not have happened.

Because it's not their fault that they're mentally ill. And it's not okay for the jail not to have someone there who's trained to understand that these are mental...symptoms of mental illness, and not somebody acting up.

We went to visit him. He cried hysterically, you know, through the window. I mean, just crying...sobbing... No matter how much I tried to tell the jail nurse, "Something's wrong. This isn't normal." Phone calls to me, he'd say, "Mom, something's wrong with me. I'm going crazy."

--Mother

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She has consulted and trained in adult health and mental health services and engaged in both quantitative and qualitative research in the areas of serious mental illnesses, case management, psychiatric advance directives and HIV. On July 1, 2007 Anna will assume the role of Associate Dean for Academic Affairs at the School of Social Work.



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Throughout her practice career, she worked in direct service settings, primarily with persons who have serious mental illness, substance abuse issues, or both. She has recently published articles related to social work values in practice, involuntary treatment, jails and mental illness, and families and substance abuse practice. She is beginning a four year term as Undergraduate Social Work Director beginning August 1, 2007.



Melissa Floyd Taylor

About the North Carolina Governor’s Advocacy Council for Persons with Disabilities

The Governor’s Advocacy Council for Persons with Disabilities (GACPD) is part of a nationwide system of protection and advocacy (P&A) agencies. It is committed to ending all disability-based discrimination experienced by North Carolina citizens with disabilities.

Currently, GACPD is a division of the N.C. Department of Administration and is overseen by a 21-member board of volunteers appointed by the state’s top leaders in government.

The PAIMI Act requires that each state have a PAIMI (Protection and Advocacy for Individuals with Mental Illness) Advisory Council to advocate for the rights of people with mental illness and to advise the protection and advocacy system about the needs of people with mental illness. In North Carolina the PAIMI Advisory Council is part of GACPD.

In addition to working on individual cases of discrimination, GACPD offers technical assistance to legislators and rule-making bodies of government to ensure that persons with disabilities receive equal opportunities in every aspect of community and institutional life. GACPD can also provide technical assistance to service providers and businesses by providing guidance on accessibility issues.

If you are a person with a disability and need help speaking or acting to protect your rights, North Carolina’s P&A may be able to help by providing information, advocacy services or legal representation. See our website at www.gacpd.com, or contact us toll-free at 1-877-235-4210.
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