U.S. Department of Justice
National Institute of Corrections

Proceedings of

A NATIONAL FORUM

on

CREATING JAIL MENTAL HEALTH SERVICES

for

TOMORROW'S HEALTH CARE SYSTEMS

November 9-10, 1994

San Francisco, California

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Proceedings of

A National Forum on

Creating Jail Mental Health Services for Tomorrow's Health Care Systems

Sponsored by

National Institute of Corrections
and
Center for Mental Health Services

November 9 - 10, 1994
San Francisco, California

U.S. Department of Justice

National Institute of Corrections

1960 Industrial Circle, Suite A
Longmont, Colorado 80501

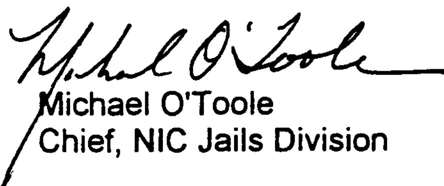
March 30, 1995

Dear Participant:

Enclosed you will find proceedings from the National Forum on *Creating Jai/ Mental Health Services for Tomorrow's Health Care Systems* held in San Francisco, California from November 9-10, 1994. This program was jointly sponsored by the National Institute of Corrections (NIC) and the Center for Mental Health Services (CMHS) as part of a series of joint programs addressing the issues of individuals suffering from mental illness who are in jail.

I want to thank you for making this forum a success and for supporting NIC and CMHS programs.

Sincerely,



Michael O'Toole
Chief, NIC Jails Division

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Introduction: Objectives of the Forum

This National Forum is one of several projects made possible by a Memorandum of Understanding between the National Institute of Corrections and the Center for Mental Health Services. Other projects include providing technical assistance to support jurisdictions in their efforts to improve their mental health services, developing a quarterly newsletter on mental health and corrections issues, and establishing Jail Resource Centers for Mental Health in Toledo, Ohio, and Alexandria, Virginia.

These efforts result, in part, from a strong concern on the part of the National Institute of Corrections Advisory Board about the numbers of mentally ill persons in correctional facilities. The Advisory Board's statement on this issue is presented on the inside cover of these proceedings.

We hope this forum is the first annual event to bring together people who are working with the mentally ill in corrections. The intention of the meeting was to bring together a wide array of people representing various parts of the country, various parts of the system, and various sizes of communities. It was based on the concept that the participants themselves are the experts and can learn from one another. The forum was not designed to be a day and a half to map out the federal initiatives nor a training workshop in which experts will provide their insights.

The proceedings

These proceedings are based principally on tape recordings and notes from each session of the meeting. Part I, which also includes draft texts of papers prepared for the meeting, summarizes presentations made on the first day of the forum. These include descriptions of San Francisco Jail programs that address mental health needs and a discussion of women's mental health needs.

The second day of the forum was devoted to small work groups' discussions of key issues surrounding the general topic of mental health services in jails. The second day's activities also provided an opportunity for all audience members to participate in an open mike session at which they could comment or ask questions. Part II of the proceedings includes a summary of the work group discussions and concluding comments from the audience and consultants.

Welcome: Morris Thigpen, Director, National Institute of Corrections

This an important forum. As all of you from the various disciplines represented here are aware, correctional facilities are housing many individuals who need mental health services. The situation we are faced with today hasn't happened overnight, however. Between 1970 and 1990 the number of psychiatric beds in this country was reduced almost by half During this period, the number of private psychiatric beds increased, but most of the individuals we are dealing with obviously can't afford private mental health and psychiatric services. For this reason, we have seen many individuals who have been moved out of mental health hospital settings into the streets. Because of the difficulties they still have, many of these people end up in our jails.

The National Alliance for the Mentally Ill, a public citizens health research group, completed a study in 1992, which included the following findings:

- one in fourteen inmates in our nation's jails suffer serious mental illness
- 29% of the jails in 45 states detain mentally ill individuals who do not have criminal charges against them.
- The study went on to conclude that the situation, instead of getting better, seems to be getting worse. That is why I am glad that NIC, in collaboration with the Center for Mental Health Services, is sponsoring this forum to look at this problem, to network, to do what we can to increase services for the mentally ill in our nation's jails.

You represent a select group, and I wish you great success as you undertake a difficult subject-but one that plays very heavily on the minds of all of us.

Opening Remarks: Dr. Raymond Patterson, Director, Demonstration Division, CMHS

Good morning. I bring you greetings from Dr. Bernard Arons, Director of the Center for Mental Health Services. Dr. Arons very much regrets that he was not able to be here this morning. It is a great honor for me to have the opportunity to speak in his place at this landmark national forum-the first of its kind.

I should also mention that we are particularly pleased to have had the opportunity to join with the National Institute of Corrections and the San Francisco Sheriffs Department in sponsoring this important meeting of criminal justice and mental health professional, consumers, family members and advocates. We in Washington have much to learn from you and audiences like you. We have looked forward to this gathering and anticipate that the discussions will be

enlightening and worthwhile. Now, I would like to acknowledge the work of two key people-Susan Salasin from the Center for Mental Health Services and Linda Wood from the National Institute of Corrections for their outstanding efforts in putting this meeting together.

Somebody once said that they were "in favor of progress, as long as nobody changes anything." But simply staying the course and acting as though that is progress is not adequate. We need change and we need improvement in the way that mental health services are organized and delivered nationwide. This audience is working to effect change in an area where change, particularly innovation, is essential-mental health services within the criminal justice system. Your work is absolutely crucial to forging new linkages and improving the quality of car for those who so very much need it.

I can't say too much about how important the efforts of the National Institute of Corrections are to this field. NIC's efforts have been critical in helping to building new bridges between mental health and criminal justice, as have the efforts of its sister agency, the National Institute of Justice.

Building new bridges is also what the Center for Mental Health Services is all about--bridges with advocacy organizations; bridges with other Federal agencies; bridges which address the complex issues of people with w-occurring mental illnesses and substance use disorders; bridges with family members, consumers and jail and prison officials who are committed to providing the best possible care for incarcerated individuals with mental illnesses-really, bridges among all "people-serving" organizations.

As many of you may know, the Center for Mental Health Services, was created by the US. Congress in 1992 to provide national leadership in mental health services and policies. It is a component of the Substance Abuse and Mental Health Services Administration, one of eight US. Public Health Service agencies within the Department of Health and Human Services.

We've given each of you an information kit which summarizes the Center's programs. And well be telling you about our specific activities to promote coordination between the mental health and criminal justice systems in just a few minutes. But to give you the big picture of what the Center does, we see our task as three-fold.

First, we keep the mental health services delivery system operating and functioning well. We do this by directing programs that support infrastructure development at the community level. For example, our Community Mental Health Services Block Grant, supports comprehensive, community-based services for adults with severe mental illnesses and children with severe mental disturbances. And our Clinical Training and Human Resource Development Program encourages more people to become mental health providers through awarding training grants to states and universities. We also have a special training program focused on mental health services for people with HIV/AIDS.

After building infrastructure, we push the system forward by funding innovative demonstration programs to test different approaches for services. Since the Center's inception, we have launched three new such programs: one for children with severe emotional disturbances; one for homeless persons with severe mental illnesses, who may also have a substance abuse problem; and one for people with HIV/AIDS.

Finally, we facilitate the application of scientific findings and practice-based knowledge for treating mental disorders, by supporting a variety of knowledge exchange activities, like this meeting. Other activities include our Mental Health Statistics Improvement Program which works with state, local and consumer groups to develop standards for quality statistical information. And our National Reporting Program for Mental Health Statistics is the only national information source focusing on services and clients. We also fund several technical assistance center, and are working to establish a CMHS clearinghouse for us by consumers, families, professionals and policy makers.

Overall, the Center is working diligently to promote the development of new service systems that are:

- high quality,
- comprehensive,
- integrated,
- community-based,
- tailored to individual needs,
- accessible,
- sensitive to cultural differences, and that
- encourage consumer and family participation.

We've had an exciting and productive first two years of existence. But there is still so much left to do. In reflecting on the enormity of the task before us, I am reminded of an anecdote, said to be true, about Albert Einstein when he was a child. It seems that, for all of his incredible intelligence, the young Einstein did not speak his first words until a relatively late age. His parents were quite worried about this. Then, one night at the dinner table, young Albert broke his long silence and spoke his first words. His parents, greatly relieved, asked him why he had never spoken until that moment. And young Albert said, "Because up to now, everything was in order."

I share this story because, until fairly recently, too little has been said, and too little has been done, about mental health services. Everything is not in order and it doesn't take the brilliance of an Einstein to recognize it.

We know that the need is great. To cite a few statistics relevant to criminal justice:

- It is estimated that more than 6 percent of men and 14 percent of women admitted to jails have acute symptoms of severe mental disorders.
- According to the US. Department of Justice in 1987, suicide is the second most frequent cause of death among jail detainees, accounting for 39 percent of all inmate deaths. We know what a high priority suicide prevention has been for you, and we salute your programmatic effort to reduce this number in every jail.
- And, in a recent study funded by the National Institute of Mental Health, one researcher examined detainees in a large county jail system and found that only one-third of the subjects with severe mental illnesses (psychosis or major mood disorders) were given treatment within a week of jail entry

For these and a host of other reasons, we in the Center for Mental Health Services have joined with the National Institute of Corrections in a number of activities to look at how local jails and prison systems can better interact with communities to improve services for offenders with mental illnesses. We are eager to play a part in facilitating the productive interaction among criminal justice professionals, providers, consumers, family members, advocates and policy-makers at different levels of government--Federal, State, municipal and local--that is essential to leaming how effective jail mental health services may best be provided.

In closing, I am reminded of something that legendary Texan who also happened to be the 36th President of the United States, Lyndon Johnson said: "There are plenty of recommendations on how to get out of trouble cheap and fast. Most of them come down to this: deny your responsibility." The efforts of this audience bear testimony that not only have you not denied your responsibility, but you have embraced it. We very much look forward to working with you as we forge ahead. We have much to learn and to benefit from each other.

Susan Salasin, Director, Mental Health/Criminal Justice Program, Center for Mental Health Services

The collaboration between NIC and CMHS has been very productive. Our work together has been extremely open, goal-oriented, and problem-solving. This collaborative effort was initiated in about 1992, when three streams of events came together and pulled CMHS into the area of services for the mentally ill who are in jails and prisons:

- The first was the legislation that created SAMHSA our parent agency. The bill required a report to Congress that identified issues, problems, and barriers faced in the provision of services to the mentally ill who are involved in the criminal justice system.
- That requirement for that report was there as a result of dynamic efforts on the part of the organization for the families of the mentally ill, the National Alliance for the Mentally Ill (NAMI). The group had released a ground-breaking report, "Criminalizing the Mentally Ill," earlier in 1992, which had emphasized that many people are in jail simply because they are mentally ill. NAMI, a strong advocacy group, was influential in getting CMHS involved in this effort.
- At about the same time, NIC's Advisory Board had become concerned about the numbers of mentally ill in correctional facilities and had directed the agency to investigate collaboration with CHMS. The result was a Memorandum of Understanding that involves NIC, CMHS, and the National Institute of Justice (NIJ). This MOU has been the basis of several specific inter-agency agreements.

This forum is one result of the collaboration. We hope it will be a yearly event to bring together people who are working with the mentally ill in corrections. We have also developed two resource centers-in Alexandria and Toledo--to demonstrate viable mental health linkages with jails, sponsored training workshops, provided technical assistance to enable people to visit innovative sites, and funded consultants' assistance to jails interested in improving their mental health services.

This has been the first cross-fertilization between two agencies. In effect, we are trying to model at the Federal level what we hope you will do at the local level, which is encourage collaboration between two cultures that have often not worked together and have different ways of approaching things. Once they begin working together, however, they often find common ground.

In the course of this collaboration, we wanted to pay attention to the numbers of mentally ill in jails who are also substance abusers. A number of studies have found that 80-90% have problems in both areas, and we hope to highlight this issue in our future work. Our work is also emphasizing the problems of women in

jails. In this context, we supplemented a grant from NIJ on jail management practices to fund a study of how the-seriously mentally ill are being handled in jails around the country. We also have a strong multi-cultural focus, recognizing that a number of ethnic groups make up jail populations.

We are all here to network. I hope you see faces here that you don't know and some that you do know. The basic tenet of this meeting is that you can provide technical assistance to one another. We hope you will all give us the benefits of your wisdom and challenge the ideas presented. Finally, we hope you will go home re-energized from your time here to start something new or develop further something that has already begun.

The Jail as a Community Institution: Walter Thomas, Under-sheriff, San Francisco Sheriff's Department

On behalf of Sheriff Michael Hennessey and the entire staff of the San Francisco Sheriffs Department, I want to extend our welcome and to thank both NIC and CMHS for sponsoring this national forum. During the next two days you have the chance to spend time with each other discussing how to make the interaction of the current mental health and jail systems more relevant.

Most of us in this room are painfully aware of the history of the incarceration of the mentally ill both in England and America in the course-of the past hundred years. It is certainly the case that we have come a long way in improving services to these individuals, but there is also much that remains to be done.

Both Sheriff Hennessey and I energetically support the goals of this forum. We hope that you all have the courage and the energy to tackle the challenges ahead of you to find answers to the compelling questions facing us in terms of mental health issues in our jails.

Dr. Henry Steadman, Policy Research Associates

One of Congress' requirements is that CMHS report on mental health services for offenders. The new Congress will get this report, which we at Policy Research Associates helped to develop. The "concept paper" included on the following pages is a distillation of what we expect will go in the report. It addresses more than jail mental health services, but it provides an idea of what that report will look like.

Dr. Henry Steadman, Policy Research Associates

Congress required that CMHS develop a report on mental health services for offenders. The new Congress will get this report, which we at Policy Research Associates helped to develop. The "concept paper" below is a distillation of what we expect will go in the report.

Concept Paper for "A National Forum on Creating Jail Mental Health Services for Tomorrow's Health Care Systems'*

Introduction

The legislation that established the Center for Mental Health Services (CMHS) on October 1, 1992, required that CMHS provide a report to Congress within 18 months of that date on the ..."most effective methods for providing mental health services to individuals who come into contact with the criminal justice system., including those individuals incarcerated in correctional facilities (including local jails and detention facilities), and the obstacles to providing such services." This report, "Double Jeopardy: Persons with Metal Illnesses in the Criminal Justice System," is currently under internal review by SAMHSA staff The report will synthesize the research and state of knowledge on mental health services and systems interactions with police, jails, prisons, probation and parole to address the issues presented in the CMHS legislation.

The following paper presents some ideas and principles that have been drawn together as a result of this effort. The content reflects many of the issues discussed during the development of the CMHS Report to Congress and represents what may be many of the core elements of that document. While this National Forum focuses on jail settings, the content of the Congressional Report and this paper reflects all criminal justice settings, including law enforcement activities, jails, prisons and community corrections.

Background

In 1991, there were approximately 3,353 jails in the US. From 1980 to 1992, the number of persons in jail on any given day in the United States increased form 158,394 to 444,584 (United States Department of Justice, 1993). Further, US. currently process approximately 10.1 million admissions per year. In 1990, US. jails were functioning a 111 percent capacity overall. Fully 142 jurisdictions (28% of all jurisdictions containing jails with 100 or more capacity) had at least one jail under court order to reduce inmate population (United States Department of Justice, 1992).

Jail overcrowding is at epidemic proportions throughout the US. Not only are large numbers of jails antiquated and barley able to meet minimal standards of card, but also jail populations are exploding.

Among the burgeoning populations in US. jails are increasing numbers of persons with mental illnesses. A recent survey of male jail admissions in Cook County, IL, found that 6.1 percent had a current psychotic illness and were in need of treatment services (Tephn, 1994). Among female Cook County detainees, the estimates of metal illness were even higher. Fully 14 percent of the female detainees had a current mental illness of schizophrenia or affective disorder (Teplin, unpublished). In the same study, Abrams and Teplin (1991) found that 58.3 percent of the persons with major mental illnesses were currently alcohol abusing/dependent, while 33.3 percent had current w-occurring drug abuse/dependence.

On a national level, this would indicate that nearly 700,000 admissions to US. jails in 1990 were individuals with acute and severe mental illnesses, and a significant proportion of these requires specialized substance abuse services.

In addition, there were 1,239 prisons in the US. in 1990. The Bureau of Justice Statistics reported that on June 2, 1994, there were nearly 945,000 inmates in US. prisons; a 300 percent increase since 1980. Despite the increase in expenditures and the expansion of physical plants, at the end of 1990, state prisons were operating at 18 to 29 percent over capacity, while Federal institutions were 51 percent over capacity.

Clearly, the prison population is different from the jail population in terms of seriousness of offense and length of confinement. However, like jails, a sizable portion of prison inmates have mental illnesses. Estimates of severe metal disorders among prison inmates generally range from 6 to 15 percent (Monahan and Steadman, 1983; Steadman and Cowzza, 1993). In addition, co-morbidity is an important factor in the management of persons with mental illnesses in prison. While arrests for all crimes have increased by 27.7 percent over the past decade, arrests for drug related crimes have increased by 125.9 percent (United States Department of Justice, 1991). Further, 79 percent stated that they had used drugs, excluding alcohol, in the past, and 62 percent said they used drugs on a regular basis.

Of the more than 4 million Americans under correctional supervision in 1990, 3.2 million were in the community. Based on jail and prison estimates, a significant number of persons under community corrections are mentally ill and in need of ongoing mental health treatment services in the community.

Correctional populations represent one of the most underserved populations of persons with metal illnesses in the US. And it is one of the fastest growing.

Important Distinctions and Concepts

A diverse group. People come into contact with the criminal justice system for many reasons. Only a portion of them have acute mental disorders, but this group demands disproportionate attention, both because of their special needs and because of the problems they pose for criminal justice system personnel and for the proper administration of the criminal justice system

Persons with mental disorders are a heterogeneous group. The effects of their mental illnesses range from psychosis, to severe disruptions in emotions, to functional impairments in the ability to relate to others or sustain work. They represent different ages, cultural and ethnic backgrounds, and sexual preferences. They include a disproportionate number of males, but also a significant and growing number of women. They have a wide range of experiences and abilities, and they live in metropolitan, suburban and rural areas. A few have been violent; most have not. All of these factors must be considered when developing mental health programs in the community and in the criminal justice system.

Most persons with mental illnesses are not violent. One of the most prevalent myths about persons with mental disorders is that most of them are prone to violence. Typically, this fear is based on the fact that an individual has a psychiatric diagnosis, has received treatment or has been hospitalized for a mental illness. These fears persist despite the facts that persons with mental illnesses are no more likely than the general population to commit violent acts. In fact, persons with metal illnesses are more likely to be held without criminal charges and are more likely to be charged with minor crimes.

Persons with special needs. Persons with mental illnesses who come into contact with the criminal justice system have special needs. Further, within this group there are subgroups that warrant particular attention. These include persons with co-occurring substance use disorders, women, ethnic minorities, homeless persons, persons with HIV/AIDS, and youth.

Diversity of points of contact. Just as persons with mental illnesses have diverse needs, those needs will vary depending on the point at which they are in the criminal justice system. A person whose acute psychiatric crisis brings him or her to the attention of the police may need immediate stabilization, while a prison inmate with severe mental illness may require long-term treatment and support.

Clearly, the responsibilities of the criminal justice system for persons with mental illnesses will differ at each stage, as well. An individual may be detained in jail for a short period of time, so that jail staff may focus primarily on maintaining continuity of any community-based services the person is receiving. Personnel responsible for individuals with mental illnesses on probation or parole in the community may act as case managers to broker a full range of health, mental health, housing, and social services for their clients.

Key issues at Various Points of Contact

Police. Effective police response to citizens with mental illnesses requires cooperation and the exchange of knowledge, resources, and services between law enforcement, mental health, and social agencies. Without such cooperation, police may resort to the inappropriate use of arrest or the emergency psychiatric hospitalization.

In particular, the efforts of local police are bolstered when:

- 24-hour mobile mental health crisis response is available.
- Police training programs emphasize learning to identify symptoms of mental illnesses and knowing the operation of the local health system.
- Mechanisms sensitive to both client privacy and service system information needs are developed.

Jails/Lockups. Because jails have a constitutional duty to provide metal health treatment to individuals who require it, and a responsibility to provide a safe and secure environment for both staff and inmates, it is in the best interest of all concerned to stabilize persons who have mental illnesses. Effective mental health services can reduce security risks by helping persons with mental illnesses control their psychiatric symptoms and by educating staff to interact in a more positive way with these individuals.

Jail mental health services can be most effective when:

- The jail, as a community-based facility, functions as an integral part of the social and health services system.
- Diversion programs are developed to avoid inappropriate detention of persons with mental illnesses.
- The essential mental health services of screening, evaluation, crisis intervention, and discharge planning are available to persons who are not appropriate for diversion.
- Mental health professionals are encouraged to spend a specific amount of time in on-site training in jails.

Prisons. Consistent with the concept of a “community metal health system,” prisons should provide a full array of mental health services, beginning with screening and evaluation and crisis intervention at the “front door,” through psychotropic medication and monitoring, individual and group therapy, case management, and specialized housing in prison, to discharge planning and referral at the “back door.” In non-prison communities, the use of outpatient services can significantly enhance an individual’s ability to live and function in the community.

With similar help, inmates with mental illnesses can learn to function in the prison general population.

Prison mental health services are most effective when:

- States encourage continuity of mental health services both upon entry into the prison from jail and upon release from prison via either parole or direct discharge.
- Case-finding in prisons is continued throughout an inmate's stay to detect the possible onset of mental disorders that may occur at any time.
- Crisis beds and beds in special Residential Treatment Units are available to avoid unnecessary inmate transfers to psychiatric facilities and to promote integration of inmates with mental illnesses in the prison.
- Collaboration is promoted between State departments of corrections and state mental health agencies.

Probation and Parole. Individuals with mental illnesses on probation and parole, like other community members with similar problems, require the availability of a full range of mental health services that are accessible, appropriate, and relevant to their needs. Mental health treatment may be a condition of probation or parole for some individuals; for others, participation in such services is voluntary.

Effective strategies for dealing with persons with mental illnesses on probation and parole include:

- Intensive case management that focuses on connecting the individual to community-based services.
- Development of general policies of progressive sanctions that decrease the probability that technical violations of the conditions of probation/parole will result in a return to jail/prison and increase the likelihood of continued community living.
- The development of policies that respect an individual's right to privacy and freedom when community supervision involves forced treatment.

Diversion Programs. While some persons with mental illnesses who commit serious offenses and/or have previous histories of non-appearance for court dates warrant correctional detention, other individuals clearly don not belong in jail. When persons with mental illnesses can be appropriately diverted from the criminal justice system, it helps reduce jail overcrowding and promote the smooth operation of jail programs. The best diversion programs recognize that without assistance to overcome the barriers created by fragmented services, the nature of

mental illnesses, and the lack of social supports and other resources, many individual with mental illnesses, may return to jail.

In particular, diversion programs are most effective when:

- Services are integrated at the community level, and involve corrections, local courts and probation, mental health substance abuse services and social services, such as housing and entitlements with a high level of cooperation among all parties.
- Regular meetings of all the key players occur to encourage coordination of services and sharing of information.
- Boundary-spanners are selected for the program who can directly manage the interactions between jail, court and mental health staff.
- Strong leadership exists that is able to involve all key players and put all of the necessary pieces into place.
- There is early identification of detainees with mental health treatment needs who meet the division program's criteria.
- Case managers are culturally and racially diverse and familiar with both the criminal justice and mental health systems.

Special Populations. Persons with mental illnesses who come into contact with the criminal justice system have special needs, as compared to other detainees. Yet even within this group of persons with mental illnesses, there are subgroups that warrant particular attention. These include persons with co-occurring substance use disorders, women, ethnic and racial minorities, homeless persons, persons with HIV/Aids, and youth.

The needs of these special groups can best be addressed when:

- Specialized services are available to all persons with mental illnesses who have special need when they come into contact with the criminal justice system.
- Cultural competence training is available to all mental health and criminal justice staff
- Specialized training for the management of persons with mental illnesses who have w-occurring disorder, such as substance abuse, HIV/AIDS, and other special treatment conditions, is emphasized for both mental health and criminal justice staff

Some principles for Successful Mental Health Services in Criminal Justice Settings

Based on a series of meetings with diverse groups of stakeholders, review of the existing research and feedback on earlier ideas, we are suggesting six core principles to guide what needs to happen to significantly improve the lives of

persons with mental illnesses who come into contact with the criminal justice system. They are:

- Access to targeted, appropriate, and flexible mental health services should be available to all persons with mental illnesses.
- Creative use of existing resources can accomplish many of the needed changes to the crimmal justice and mental health systems without the need for a massive infusion of new resources.
- Mental health services targeting the co-morbidity of severe mental illnesses with alcohol and drug use disorders should be a priority.
- Cross-training of mental health, law enforcement, and corrections personnel is crucial.
- The identification of need and the provision of metal health services should take cultural differences into account.
- Developing more detailed mental health care standards and promoting existing ones as an effective change strategy.

Respects for Federal (CMHS) Initiatives

Emerging from many discussions and meetings with CMHS staff and representatives from key constituencies are a number of ideas for how CMHS may be able to impact the primary issue of providing quality mental health services in the criminal justice system.

Federal Working Group on Persons with Mental Illnesses in the Criminal Justice System.

The creation of a working group composed of representatives of Federal agencies, mental health service providers, correctional and law enforcement professionals, consumers, family members, and researchers who have responsibilities either directly or indirectly for the care of persons with metal illnesses who come into contact with the criminal justice system is a first step toward solving the multiple problems of this population. Such a group could build on existing efforts sponsored by the Center for Mental Health Services, the National Institute of Mental Health, and it could target and coordinate efforts between department to facilitate the improvement of mental health services. The activities of this group might include:

- Developing Memoranda of Understanding between key Federal agencies to create training, education, research, and resource partnerships.
- Encourage research demonstration projects at CMHS, NIMH, and NIJ to expand the current knowledge base of effective programs.

Promote Systems Integration. Adequate care for persons with mental illnesses who come into contact with the criminal justice system requires an integrated system of care. While jail, prison, and probation/parole mental health systems often do not interact at all with community-based mental health providers, coordinated and integrated programs clearly increase the likelihood of uninterrupted car, better psychiatric outcomes and lower recidivism. Services integration might be encouraged by:

- Including mental health services to persons in the criminal justice system in the State comprehensive mental health planning process.
- Technical assistance to provide communities with information, such as how to convene interagency community planning teams, develop contracts or letters of agreement, or implement specific programs.

Generate and Disseminate Knowledge and Information. The establishment of a comprehensive information gathering and knowledge dissemination plan should be considered to provide necessary information and technical assistance to the people, agencies, and communities that can best use it. This plan may include:

- Integrating key information, including essential components of jail/prison mental health services, specific road maps for localities to implement these services within correctional facilities, and fact sheets and brochures describing how programs have been developed in other areas.
- Continuing to fund technical assistance centers and consultants to help States and localities implement service programs.

Stimulate Advocacy for Persons with Mental Illnesses in the Criminal Justice System. Persons with mental illnesses who come into contact with the criminal justice system are doubly stigmatized. Of all persons with special needs, they are the ones most likely to be forgotten. They are usually shuffled between the mental health and criminal justice systems with few advocates including family, consumer, and professional groups, must continue to work diligently in order to guarantee that appropriate mental health services remain a priority.

Advocacy groups should be encouraged to increase their focus on mental health/criminal justice issues. Federal agencies can help by:

- Requesting the participation of both consumers and family members in task forces and work groups related to issues of policy, program design, and research on persons with mental illnesses in the criminal justice system.
- Supporting the information needs of these groups.

Dr. Jay Stone Rice, Consultant, San Francisco

Reclaiming Lives: San Francisco's New Genera&on Approach Towards Treatment and Training

In 1990, I decided to study the San Francisco's Sheriff's Department's New Generation Program Facility. I was particularly interested in the Department's innovative Jail Horticulture Program. Inmates who are in the jail predominantly for drug or drug related charges are taught to grow things without chemicals. This concrete and symbolic intervention strategy called to mind the words of Wendell Berry, the noted essayist and Kentucky farmer. Berry proposes that our primary ecological task is to recognize the heretofore overlooked value of what has been labeled waste and reclaim these lost resources, be they material or human. These noble sentiments have pragmatic implications for the viability of our criminal justice system and the health of our society. For without effective treatment, people in jails and prison become more toxic and pose a greater threat to our communities when they are released.

The Sheriff's Department's new generations programs combine intensive custodial staff training with ecologically sensitive inmate programming. The Department's unwavering commitment to comprehensive treatment contributed to the development of the Jail Horticulture Program. Examining the evolution of the Department's treatment philosophy provides a useful context for evaluating this program's effectiveness.

In this paper I am going to discuss the genesis of the Sheriff's Department's treatment philosophy and its manifestation in new generation programs. I will then describe the Jail Horticulture Program and present the results of its evaluation.

Sheriffs Department Philosophy

Department History

The Department's approach to treatment has developed over 20 years of experimentation through three distinct periods. The Sheriff's Department began a Rehabilitation Department in 1973 utilizing VISTA Volunteers. I was a member of this group, along with Assistant Sheriff Michael Marcum. This program sought to make the jail more humane by providing case work services. Caseworkers helped inmates communicate with family members, researched and resolved sentencing questions, connected inmates to community services, and represented inmates in conflicts with the custodial staff The Rehabilitation Department was aided by the San Francisco Jail Project' a legal assistance program for indigent county jail inmates. This project was started by a young attorney, Michael Hennessey, who has been San Francisco's Sheriff since 1979. The Rehabilitation

Department had virtually no budget at its inception and advocated opening the jails to community agencies so that they could provide essential inmate services.

The next phase of the Sheriff's Department's development emerged from its realization that while the rehabilitation program made jail time fairer and more humane, inmates essentially remained unchanged. At the end of the VISTA program, the Rehabilitation Department was renamed Prisoner Services to reflect this assessment of its initial efforts. The Prisoner Services Division placed greater emphasis on enhancing the inmate's economic viability by developing expanded educational and vocational programs. The Work Furlough Program was developed to reduce jail overcrowding and help keep offenders connected to their families and communities.

The desire to help minimize incarceration's impact on the family led to monthly family meetings at the work furlough facility. Offenders and family members would discuss the difficulties created by incarceration, as well as the problems that would likely arise upon release.

At the end of this period, the Department opened a new generation Program Facility. The new generation jail model was developed by jail administrators working with architects, and psychologists, to serve the dual functions of custody and treatment. Michael Marcum was named the Department's first civilian facility commander.

Approximately twenty classes and treatment programs are available on a daily basis in the Program Facility. These include tutoring' reading, ESL and GED classes, auto mechanics, printing and video production' parenting and domestic violence classes, twelve-step groups, drama, and the horticultural therapy program.

Walking through the hallways of the Program Facility, one sees abundant evidence of a commitment to building self-respect and a sense of community. The walls are tastefully covered with framed works of art and poems produced in creative arts classes. Regularly scheduled cultural awareness programs foster identity, pride, and respect for the cultural diversity of the Bay Area. An environmental ethic is expressed through the boldly marked and prominently placed recycling containers.

The third and current phase of the department's evolution entails the integration of security and treatment through the development of a direct supervision facility. Custodial staff are extensively trained in direct supervision and are encouraged to take responsibility for the running of the facility and the success of educational programs and treatment interventions. In the Program Facility, the Department has shifted from a hierarchical structure to one in which the front-line deputies are given authority and support for fostering inmate development.

John Bush (1990) notes that "Standing alone, both punishment (e.g. arrest and incarceration) and treatment are ineffective in changing established patterns of criminality." (p. 1). To be transferred to the Program Facility, inmates must sign

an agreement pledging an exemplary standard of behavior. They agree to non-violence, no glorification of crime or drug usage' and no verbal expression of racism or sexism. Failure to comply with these standards may result in being returned to the other locked facilities. Treatment and educational staff are trained to integrate personnel responsibility and accountability into their classes and programs.

Social Ecology

The new generation approach reflects an understanding of social ecology. Urie Bonfenbrenner (1979), a noted psychologist and researcher, defines social ecology as the overlapping spheres of influence which contribute to human development. Social ecological spheres of influence on inmate development include the health of the family, quality of schooling' availability of economic opportunity, and community viability. Sheriff Hennessey (1987) notes the importance of social ecological interventions when he states,

> "Jails and prisons do not ultimately stop crime. Sound family structures stop crime; jobs stop crime; having a stake in society stops crime. Over the years, longer sentences and tougher laws haven't put a dent in the crime rate, which continues to grow in relation to the population"(p.3).

The Jail as a Community Institution

The Sheriff's Department has creatively fostered a unique and growing relationship with people of San Francisco through education, collaboration with other community institutions, creative art projects, and community service. Perhaps the most significant commitment to creating a community institution has been the Department's aggressive recruitment of custodial and treatment staff that reflect the make-up of the jail population

The department utilizes community college instructors for its classes, community agencies for its treatment programs, and local foundation grants to operate its programs. Local artist, writers, and musicians have contributed their time and talents to the creation of the jail arts program, County jail inmates have performed theater pieces and poetry readings and art exhibits in San Francisco.

Inner city residents endure shame by virtue of their association with an environment considered ugly by the larger community. The Department has responded to this by channeling offender labor towards improving their own communities. The Sheriff's Work Alternative Program (SWAP) has been designed to serve the communities where most of the inmates live and where most of their crimes are committed. The vast majority of county jail inmates come from seven lower income San Francisco neighborhoods that are characterized by noise, density, physical deterioration' and inadequate city services.

Program Evaluation

The Garden Project

I chose to study the Jail Horticultural Program because it is one of the Department's most representative ecological treatment interventions and community service projects. The goals of this program are to transmit meaningful work skills while cultivating a heightened awareness of self in relation to community and nature. Cathrine Sneed, who began this program in 1983, will tell you more about it during her presentation this afternoon.

Description of Inmates

The new generation program facility was opened in 1989 and currently houses 372 inmates. In July, 1991, a random one-day snapshot demographic profile was determined for the approximately 330 inmates in the program facility as of the survey day. About 40% of the facility population was under the age of 25 and 84.5% were male. African Americans constituted 34.5 % of the population; 18.2% were Caucasian; 34.5%, Hispanic; 8.2%, others. This can be compared to the 1990 San Francisco census which found that the adult work force contained 8.2% African Americans and 12.8% Hispanics. The over-representation of minority groups in San Francisco's Count Jails mirrors the jail and prison populations nationally.

Inmates had been sentenced predominantly for drug or drug related offenses. Sentences range form 30 days to six months with the average being three months.

Study Design

County jail inmates who volunteered to participate in this study were given a series of questionnaires. These instruments were designed to gather comprehensive socio-demographic and family information, along with histories of trauma, substance abuse, and criminal activity. Inmates were also evaluated for depression' hostility, and their desire for help (Maclan & Pearhnan, 1992; Remy, 1991; Simpson 1991).

Baseline data was collected from 57 inmates incarcerated at the Program Facility. Forty-eight inmates were randomly assigned to the Jail Horticulture Program or other new generation jail programs. All inmates were assessed at discharge and most were assessed at approximately three months post-release.

Results

Family Instability

As children, county jail inmates experienced repeated losses and adjustments to new living situations. By adolescence, over one-fourth of the subjects no longer lived with their mothers. By the age of seven, one-third did not live with their fathers; by adolescence, this grew to almost two-thirds. About one-fifth lived with foster parents and others before the age of six; by adolescence this increased

to almost one-third. Serial step-parents often contributed to the experience of instability and loss.

In summary, by the time they reached adolescence, a significant proportion of the inmates had lost the support of their mother, their fathers, and their extended family. As children they did not receive the continuity of care they needed to grow and thrive. As a result, their ability to value themselves, trust others, and form healthy relationships has been seriously compromised.

Childhood Abuse and Neglect

Family instability was causally linked to childhood sexual and physical abuse, beatings, and injuries. The variables here included receiving cuts or bruises, having to be treated by a physician, and being threatened or injured with weapons. Childhood physical abuse was reported by 63% of the inmates studied, and 30% reported being sexually abused. Almost one-half of inmates saw their parents physically hurt each other. Children who see their parents abusing each other are more likely to become abusers as adults than children who experience abuse directly.

Childhood neglect was also prevalent for the subjects. Approximately 42% experienced periods of having no adult to care for them. food was unavailable at times for 28% of the respondents and 28% reported being kept home from school.

These self-reported figures are likely an undercount of what might be reported by social service agencies working with these families. For example, physical abuse was determined by the inmate's response to being asked if they had ever been hit harder than they deserved. Many inmates reported that they were only hit when they deserved it. When asked what they were hit with, some said broom sticks, electric cords, brushed, golf clubs, or bullwhips. It is likely that violence towards children has been normalized in these families.

Some national studies indicate that about 1 in 6 boys and about 1 in 3 girls are sexually abused (Finkelhor, Hotaling, Lewis, & Smith, 1990) and that rates are higher in multi-problem families. The true rate of sexual abuse histories doubtless is higher than reported here. the under-reporting may point to difficulty subjects have admitting to being sexually abused, particularly in a jail population where a premium is place on strength and where vulnerability can be exploited.

One subject's response to a query regarding who had sexually abused her was, "Everyone, my uncles, older cousins, stepfather, and brother." This woman was in jail for prostitution. Silbert (1980) found histories of childhood sexual abuse to be universal among San Francisco prostitutes. Most of the women in this sample were arrested for prostitution.

Substances Used

Inmates were asked what substances they had ever used and which ones they had used in the year and month before arrest. They were reassessed for substance use at the three month follow-up. they reported using from 2 to 17 substances at baseline. The average number reported was 9.61. Women were more likely than men to have used cocaine, heroin, and heroin mixed with cocaine. Whites were more likely than African Americans to have used every class of drugs.

The quality of family life played a prominent role in substance abuse. Given the level of early trauma and loss experienced by the respondents, substance use may represent a maladaptive attempt to numb emotional pain and hold oneself together. The illicit drug trade also provides economic opportunities which are sorely lacking in low income inner city neighborhoods.

At three months post-release subjects in both conditions had decreased the variety of drugs they used, and those in the garden reported the greatest decrease in drug use. This effect increased with the length of sentence.

Depression

This study found that inmates who scored high on the depression scale were likely to have mothers who were detached, i.e., emotionally distant from their children, Female inmates who had detached mothers, had poor current family relations, and who had committed more crimes were the most depressed at the initial interview. They became less depressed after participating in either the horticulture program or other new generation jail programs. The greatest rate of change was shown by subjects in the horticultural therapy program. At discharge, subjects in the garden condition who had detached mothers were not significantly different from subjects with good mothers, and this was sustained at follow-up.

Hostility

This study found that inmates' hostility was causally related to their experience of childhood injury and sexual abuse. Subjects who had been injured and or sexually abused, who used fewer drugs, and committed more crimes were more hostile. Inmates who had never been injured in childhood had lower hostility scores, and there was no change over time for those subjects. All the change was in those who had been injured. Injured white subjects in the garden became significantly less hostile by discharge and returned to baseline levels at follow-up. Injured African Americans in the garden were slightly more hostile at discharge and significantly less hostile at follow-up, particularly in comparison to African Americans in the control condition.

Desire for Help

Desire for Help explored the inmate's recognition of their substance abuse problems, as well as their interest and readiness for treatment. Subjects who were incarcerated at a young age and had violent parents exhibited less desire for help. Subjects in the standard treatment steadily decreased their desire for help, while

subjects in the garden maintained their desire for help throughout the study period. Participants in the Jail Horticulture Program successfully maintained their desire for help regardless of the childhood victimization histories. The tragedy is that continued help was available for so few inmates upon release.

Discussion

Political debates on crime and criminals are too often characterized by emotionally divisive and simplistic solutions. San Francisco Sheriff's Department recognizes that all county jai inmates eventually return to the community. Sheriff Hennessey believes the department has a responsibility to the people of San Francisco to develop comprehensive inmate programs. Their new generation approach, reflecting 20 years of dedicated effort, combines personal accountability wit positive role modeling and treatment interventions with enhanced living skills. Subjects participating in all the new generation programs showed improvement, with the greatest change observed in those working in the garden.

The Jail Horticulture Program, which has been the focus of this study, cultivates growth and development by fostering a relationship between humans and nature. The inmates learn how to amend depleted soil naturally, plant seeds with care, and weed to accentuate healthy growth. In organic gardening, growth is a function of labor aligned with natural cycles. Inmates are concretely shown healthy growth takes time and considerable effort. Regardless of the root causes of their current problems, they are taught to take responsibility for their own growth and development.

The majority of San Francisco county jail inmates are incarcerated for substance abuse related charges. This study determined that the reduction in the number of types of drugs used post-release was greater in subjects who were in the garden project. This suggests horticultural therapy may be a particularly relevant jail treatment intervention for this population.

Subjects participating in the horticultural program were less hostile and depressed. However, some gains shown by subjects participating in the garden were not retained at follow-up. This indicates subjects require transitional support and assistance post release.

This study suggests county jail inmates often carry forward psychological scars from family instability, early trauma and loss, The term rehabilitation does not adequately describe the task at hand in providing treatment to this population. Many jail inmates have not developed stable and healthy self structures. Many of them would benefit from comprehensive mental health and case management services. These inmates can best be served in the community mental health and criminal justice systems recognize that they are serving the same clientele and develop coordinated treatment interventions.

Our current crime rate and burgeoning criminal justice system engenders pervasive hopelessness within both jail inmates and society at large. This study determined that subjects participating in the Jail Horticulture Program sustained

their hope and desire for help throughout the treatment and follow-up period. Without hope, it would be difficult for inmates to stop abusing drugs and alcohol and work through the painful realities of their lives. Media accounts of this program, often including images of inmates caring for plants, also convey hope to the community at large. Without a vision of hope and the possibility of renewal, a community is unlikely to commit the resources necessary to accomplish the task at hand. The Sheriff's Department believe its new generation programs can provide an important first step in helping inmates break free from the criminal justice system.

REFERENCES

Berry, W. (1987). Home economics. San Francisco: North Point Press.

Brand, D. (1987, November 9). In Massachusetts: Theater therapy. Time, 12-16.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Bush, J. (1990). Security and treatment: Dichotomy or unity.

Finklehor, D., Hotaling, G., Lewis, I.A, & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. Child Abuse and Neglect, 14 (l), 19-28.

Gettinger, S. (1984). New generation jails: An innovative approach to an age-old problem}. Washington, DC: National Institute of Corrections, US. Department of Justice.

Hennessey, M. (1987, April/May). The bottom line in jail funding. The Incident Report, p.3.

Herman J.L. (1992). Trauma and recovery: The aftermath of violence-from domestic abuse to political terror. New York: Basic Books.

Maclan, P. S., & Pearlman L. A (1992). Development and use of the TSI Life Event Questionnaire. Treating Abuse Today: The International Newsjournal of Abuse. Survivorshin and Therapy},2 (l), 9- 11.

McCann I. L., & Pearlman L.A. (1990). Psychological trauma and the adult survivor: Theory. therapy. and transformation. New York: Brunner/Mazel.

Remy, L. L. (1991) Intensive family reunification project: Program evaluation and design}. Unpublished manuscript. Mill Valley, CA: Loring

Rice, J. S. (1993). Self development and horticultural therapy in a jail setting. Unpublished doctoral dissertation, Professional School of Psychology, San Francisco.

Rice, J. S. & Remy, L. L. (1994). Evaluating horticultural therapy: The ecological context of urban jail inmates. Journal of Home and Consumer Horticulture, 1 (2/3), 203-224.

Silbert, M. H. (1980). Sexual assaults of prostitutes. San Francisco: Delancey Street Foundation.

Simpson, D. D. (1991, March). TCU forms manual: Drug abuse treatment for AIDS-risks reduction (DATAR) Fort Worth: Texas Christian University, Institute of Behavioral Research.

Panel Discussion: Mental Health Services in San Francisco Sheriff's Department Facilities

Jo Robinson, Program Director, Jail Psychiatric Services, San Francisco Sheriff's Department

Many jail mental health programs began with suicide prevention or crisis responses teams. As community resources dwindled and community mental health became a scarce-and not particularly user-friendly-commodity, more mentally ill individuals began showing up in the jail system.

Increase in Inmates Needing a Mental Health Evaluation

During the fourteen-year period between 1980 and 1994, bookings at the San Francisco Sheriff's Department increased by approximately 4 percent; during the same period., the number of individuals needing a mental health evaluation increased by 186 percent. The number of actual interventions during that fourteen year period increased 106%; last year, we saw 4,542 individuals. It doesn't take a mathematical genius to figure out that something is very wrong with this picture.

It is also important to point out that the criteria for doing a mental health evaluation did not change during that period. Our policy is to see anyone who verbalizes or exhibits emotional distress or anyone who has a history of psychiatric disorder. The referral sources are many--from attorneys, families, from medical or custodial staff.

After an inmate has been evaluated, we determine if ongoing treatment is needed. If so, we do crisis intervention, individual therapy, group therapy, psychiatric or other specialized housing, psychiatric hospitalization, psychiatric medication, milieu therapy, and community placement.

With more individuals in our jails demonstrating signs of serious mental illness, we have had to increase services with no corresponding increase in our budget. Some of these attempts have been successful and others have failed badly.

Diversion Attempts

When we started looking at this issue, the most sensible approach seemed to be to identify efforts that successfully reduce the number of mentally ill who are incarcerated in the system. Proposals were made to the police department to teach officers to distinguish between symptomatic behavior and criminal behavior, with the strong suggestion that those with symptomatic behavior be taken to the psychiatric hospital and not arrested and brought to jail. Not surprisingly, the hospital and community mental health system raised objections to this, saying they had no place to put these people in their already overcrowded system. So, sadly, this effort went nowhere.

Our other attempts have also been only marginally successful. In an attempt to get the incarcerated mentally ill out of custody, either as a diversion from jail or as a placement after completing a jail sentence, we developed a jail aftercare program. Once again, we got resistance from community mental health people, who told us that these were criminals who belonged in jail.

However, it really depended on which door these people had entered--whether it was the criminal justice door or the community mental health treatment door. Therefore, we began to try to educate community mental health providers, to teach them not to be afraid of someone simply because he or she had been arrested. These people were no different from others in the mental health facility; in fact, they may have seen these same people a month or two earlier. In addition, we agreed to do case management for the people we placed in the community for up to six months after their placement. We also funded dedicated treatment beds in a community program. It was an additional advantage that the community program selected decided to hire one of our jail staff members to run the program. But even with these things in our favor, transitioning clients to the community is still an ongoing challenge. We have many successful community placements each month, but we would like to see more.

Pilot Case Management Project

The Sheriff's Department Jail Fines Money, received because of overcrowding, has recently funded a pilot project that allows a mental health case manager to work with twenty mentally disordered people who are frequently incarcerated and who are high users of the jail psychiatric service system. This clinician provides intensive case management while these people are in the community. This is an aggressive kind of case management, in which they go to homes, take the clients to appointments, make sure that they register for SSI. Its goal to keep these people stable and out of jail. The project is about seven months old. So far, it has been successful, in that not one of these regular clients has been reincarcerated.

While not giving up on the struggle to reduce the total number of mentally ill people incarcerated, we still have the ongoing task of tryins to deliver clinically appropriate services to the people who are in jail. We see not only those with serious psychiatric impairment but also those with personality disorders as well as those in situational distress. The reality is, however, that most of our time and money are spent on those with serious mental disturbance.

Need for Priority Setting

I have the wonderful experience of working with an exceptionally caring group of mental health professionals. And I have the difficult task of reminding them that we have limited resources-that we have to develop priorities for whom we will see. A co-worker once stated that the fifty-minute “isn’t my office beautiful” therapy certainly isn’t a reality in the jail. It has been my experience that a large number of those in jail have needs that are nearly unquenchable because of a history of trauma, abuse, and neglect, as well as bad choices. Again I have the

frustration of watching the money and letting mental health staff know that they cannot give these people the treatment they need and are entitled to.

Conclusion: Need for Services

I strongly believe that most incarcerated people could benefit from some form of therapy, but we do not have the resources to make this possible. At times it seems that the best we can do is plant a seed that gives people hope that things can change. We can teach more coping skills, model better ways of relating, and provide substance abuse and education groups to a limited number of people. But we don't harbor the illusion that this touches the problem.

We often feel very inadequate. At other times, we are seen as a lubricant to the system, a way of helping things run smoothly. The group of people in the San Francisco jails are just beginning to work together, to pool our resources and let go of our territorial natures-to establish a team approach that will provide the best possible treatment for the mentally ill individuals who are in jail. This can only help to make the transition to the street more productive for the person and safer for the community.

Working together means preventing money from being spent simply for warehousing these individuals. It means providing treatment and programs for those who are incarcerated so that they can return to the community a better citizen, and it means providing comprehensive services for them back in the community. I know that our agency can't do it alone, but with the collaboration of all the agencies that work in the San Francisco jail system, we have a chance.

Sandra (Sunny) Schwartz, Program Administrator, Direct Supervision Program Facility

I am interested in making both correctional facilities and neighborhoods healthier. The programs that exist today at the San Francisco County Jail are the culmination of twenty years of heroicaction. In the past, we had many elective courses. Although well-intentioned, our programs were not working. Essentially, we were engaged in baby-sitting, getting people out of their cells, hoping to impact a few of them, but not comprehensively addressing prisoners' deficiencies.

Inmates' Needs

We know from both intuition and our own research that 80% are substance abusers. Even if they are not there for an offense related to substance-abuse, it is still a problem. We also know, from the learning specialist from Skyline Community College that approximately 65-75% have a fourth to sixth-grade reading level. A significant number have impulse control problems.

Approach to Providing Services

About five years ago, we held a "think tank" at which the sheriff, the undersheriff, the facility director, and sung and unsung community activists got together to

devise a strategy to deal with those inside who would eventually be our neighbors. We agreed that time in the county jail should be productive, dignified, and responsive to people's needs. Therefore, we began to mandate classes, requiring everyone to be in class. It was an enormous undertaking. We were dealing with a population that already feels ashamed about education, but we agreed that this was the responsible, political, and sound jail management approach to programs.

We designed a contract that prisoners must sign and take very seriously: The contract includes language about respect and accountability. We also developed very strong Affirmative Action principles in hiring. We wanted to hire people who could be role models and join us in holding people responsible for their behavior.

We also created subcommittees within the Sheriffs Department. The subcommittee on operations included programs because programs were recognized as a significant aspect of jail operations-not an afterthought. Another subcommittee of sworn and civilian personnel created a mission statement; another addressed discipline, that is, how to hold people accountable in a meaningful way. I want to underscore that these groups included both civilian and sworn personnel, and high ranks as well as low.

Mandatory Programs

Based on the deficiencies of prisoners--education, substance abuse, impulse control-we developed mandatory programs. We knew that it was just a beginning. We also had dorm meetings with prisoners and required them to be up and ready to go at 8 a.m. For people who are often used to being up all night, this was an incredible exercise in itself. Teachers hold people accountable, act as important role models, and provide individual program plans. The focus is to address the deficiencies of prisoners, as well as crime and crime prevention.

Importance of Staff Involvement

It is important to create an environment that is healthy for everyone. Staff must be genuinely involved. I believe that most staff really want to do more, and we work at getting civilian and deputized staff truly integrated. They are there all together at morning muster, at staff meetings, at supervisors' meetings, at subcommittee meetings. Eventually, this approach breaks down the traditional barriers.

Finally, I want to emphasize the importance of post-release services, which are a critical missing link. I am sometimes haunted by the fact that, however much we do for them in the jail, these people are released into the community, where there is not much support. At times people have violated so that they can get extra help. I don't believe that extra money is needed to fill this missing link. It is really a matter of rethink& reorganizing, humbling ourselves, and acknowledging how we have failed. Although we have a few post-release programs, many more are needed.

Cheryl Simmons, Director of Treatment, SI.S.T.E.R Project

The Sister Project is a demonstration project located in the San Bruno County Jail. It represents an important model linkage between the federal government, a local criminal justice agency, and a local treatment provider. It is sponsored by the Center for Substance Abuse Treatment (CSAT), a federal agency; the sheriff's department; and Walden House, a major treatment provider in the city and county of San Francisco.

We provide an in-custody treatment program for sixty-two women. The grant was designed to support the program in providing services for addicted women in the criminal justice system. This population has traditionally been invisible and mostly misunderstood. Once we began we realized that the task was far larger than we had originally conceived. In order to provide meaningful services, we realized that we had to join hands with other providers such as social services, parole, probation, educators, district attorneys, medical providers, and mental health providers. We have been knocking on many doors to invite many groups to sit at the table with us, to make a difference in the lives of these women. I have passion for this work because I know the women need this attention.

We teach them the tools to understand and deal with their addiction. We offer an array of services to help them to deal with all the trauma in their lives. We also try to teach them to begin to love themselves. It is impossible for them to care in a meaningful way for their children unless they love themselves. These women have suffered from an absence of role models and from an absence of love, of unconditional regard. The underlying glue on which this project is built is something that people don't talk about--unconditional love. We are able to tell the women that we care deeply about them, that we want nothing in return that we will not exploit them, will meet them where they are. I do not expect them to see the world through my eyes; I only hope that, through their own eyes, they will recognize their own empowerment.

We plant the seeds of hope. We work the garden. We help them understand that they have to get rid of the rocks and debris, the narcotics paraphernalia. We have to get rid of the pain and abuse and despair. When we take the women through the process, they begin to have hope. The hardest thing is to see a women who is being released and is crying. She is crying because she is saying "who is going to help me now?"

The program will continue to help these women by calling on many groups. The days of a single application from a single discipline are past. These problems must be treated through a holistic approach that requires commitment and participation from many groups. We share the planet together. Unfortunately, if we do not save our sisters, who will save the children?

We know that institutions cannot be built fast enough, that they are tilled while their plans are still on the drawing board. If we help a woman to heal, to feel

better about herself so that she can return to the world and lead a life of direction, we will have done us all a favor. Such a woman will be able to care for own children and keep them from the same fate. It doesn't always take more dollars to do this. It takes commitment, it takes a belief that we can make a difference. What we try to do is to change a harvest of shame to a harvest of hope. If they get nothing else while they are in our program, they leave with hope.

However, I am concerned about the continuing care options upon their release. We need to establish treatment options that would welcome women, that would help them establish a culture of their own within the larger culture so that they begin to validate themselves and understand that goodness and glory rests within them. We need the community to step forth, to bring whatever resources they can so that we can create an ambiance that promotes health and harmony. We need to give the children something to look forward to so that we don't have to see mothers and grandmothers and children in custody. I want to break this cycle. And I want you all to help me.

Cathrine Sneed, San Francisco Jail Horticulture Project

In working for the Sheriff's Department for sixteen years I saw that women didn't have the skills to change their lives. Like most women in jails elsewhere, many left the jail and went back to the same corner they started on. The result was that the cycle continued.

I think discouragement with this situation was partially responsible for my getting a serious kidney disease. While making slow progress toward recovery I was inspired to read The Cranes of Wrath, which made clear the importance of people's connection with the land. I realized that the San Francisco Jail sits on 145 acres of wonderful land. In 1982 we began the garden project, which was expanded to bring out more prisoners every day.

The project was successful, but inmates were reluctant to leave the jail because of the garden. They didn't want to go back to the same comer. On hearing this, the sheriff encouraged us to go into the neighborhood where many of the jail inmates come from and to create a garden there. So we now have both an in-custody program and a post-release program.

The garden is a job training site. It is also a beautiful organic garden. We have revenues of $2500 a month from produce grown on half an acre. Chez Panisse is one of our biggest customers. The project has received a great deal of support from foundations and other sources. It has been featured in a number of articles. I have been around the country talking about the program, which I know keeps people out of jail. I know the people working in the garden aren't committing crimes.

The city of San Francisco has committed almost $600,000 to a new project that will let us plant and care for all the trees for the city.

There are 120 in the jail garden program. They are divided into classes, and sixty workers come to the jail garden every two hours. These workers are not paid. In the post-release garden, we currently have 28 on parole, but we have had as many 125. My goal is to have as many working there as want to participate. Those in the garden are paid $5.00 an hour for four hours a day. Those in the tree corps are paid $8.00. Funding comes from various sources.

An important part of the program's success is having good role models. I have brought with me our head gardener, Timothy. Timothy wanted to work in the garden and was very persistent in trying to do so. He is a marvelous role model for other young people in the community. When he says he is making a living in the garden, it is very influential. He has made a choice and can talk about it. This is extremely important to the success of the project.

Timothy, headgardener, San Francisco Garden Project: There is some magic about the garden. I have been there for six months; I rang the phone off until I got the job. Now I am taking classes in gardening at a community college. There are many people looking up to me, and I hope the qualities they see in me will rub off on them.

Kadiya, San Francisco Garden Project: The garden is serene, it is a family away from family. I ran way from responsibilities and hurt a lot of people, but now I am sober. I am back to myself I have returned to the community to try to be a role model. I have respect; even police officers help me now. The question I ask others is: Do you want to do time or harvest time?

Special Mental Health and Substance Abuse Issues for Women in Correctional Facilities

Susan Salasin, Director of the Mental Health and Criminal Justice Program and the Women's Mental Health Program at the Center for Mental Health Services

When we formed the Center for Mental Health Services in 1992, we recognized our responsibility to proceed both in the criminal justice area and in the area of women's mental health. What we have found is that these issues have converged in interesting ways. When we looked at the population of seriously mentally ill women, we wanted to identify their most important needs for services.

What we found was that, to address these women's highest priority needs, we had to take into account the following issues:

- Physical and sexual abuse were often present in the lives of women diagnosed with serious mental illness. Often this abuse begins in childhood, and these women leave home early. They often engage in prostitution. They also have children at a young age. These women bring that background and that set of issue to jail.
- Another issue we examined was the role of these women as mothers and the kinds of supports they needed to keep their families together. More than two-thirds of seriously mentally ill women in jail lose their children to some other form of care. Their needs seem to revolve around inadequate preparation for motherhood, the effects of psychotropic drugs during pregnancy, and, especially, crisis hospitalization or confinement and its impact on the mother and the rest of the family.

Having established these two priorities, the CMHS last summer sponsored a conference that looked seriously at the issue of women's' mental health in the context of the needs I have described and tried to explore some possibilities for providing services. A principle focus of that meeting was mentally ill women in jails and prisons.

The two women I have with me today have both made large contributions to these efforts. We recently sponsored a policy workshop to bring together people to talk about the issues facing women with mental illnesses in the criminal justice system. Bonnie Veysey will brief you on the results of that conference. Cassandra Newkirk has been a leading force in focusing on the needs of women in jails and on special populations.

Dr. Ronnie Veysey, Senior Research Associate, Policy Research Associates, Inc

The Mental Health Services Needs of Women in the Criminal Justice System

Introduction

In February 1993, Policy Research Associates contracted to produce a report to Congress on mental health services to persons who come into contact with the criminal justice system. The development of this report was supported by Center for Mental Health Services (CMHS) funds provided to the National Institute of Justice (NIJ) through an interagency Memorandum of Understanding. This report, "Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System" synthesized the research and state of knowledge on mental health services and systems interactions with police, jails, prisons, probation and parole. A major focus of this report was the need for specialized mental health services for specific populations, including women, youth, persons of color, homeless people, and persons with HIV/AIDS.

As part of the Memorandum of Understanding between the Center for Mental Health Services, the National Institute of Justice and the National Institute of Corrections, Policy Research Associates convened a meeting of experts with experience in women's issues in correctional settings as a first step toward developing appropriate mental health services for women.

The meeting was held on September 21,1994, in Arlington, Virginia. Experts on women in correctional settings attended, including federal representatives of Substance Abuse and Mental Health Services Administration (SAMHSA), CMHS, the National Institute of Mental Health (NIMH), Center for Substance Abuse Treatment (CSAT), NIJ, the National Institute of Corrections (NIC), Jails and Community Corrections Divisions; administrators of jails, prisons and community corrections; mental health services providers; researchers; and consumer advocates.

With an eye toward developing a monograph on the issues facing women with mental illnesses in the criminal justice system, this one-day planning meeting discussed what we know about women's special needs when they come into contact with police, and when they are in jails, prisons, and community supervision and how mental health services can be provided to women with mental illnesses in these settings.

Background

Although women represent only a small percentage of jail and prison inmates, between 5 and 10 percent, studies show they are more likely than men to be

diagnosed with an affective disorder, which is easier to overlook since it is less often associated with disruptive behavior.

Because women represent a small proportion of jail and prison populations, many facilities do not provide a full range of mental health services, or appropriate housing options, for female inmates/detainees. Further, services that are offered are often based on the needs of men.

Compounding the problems of women with mental illnesses in the criminal justice system are issues that are not common or are non-existent among men. Among these concerns that may require special attention are pregnancy and primary responsibiity for minor children a history of being survivors of domestic violence and early childhood physical or sexual abuse, and inadequate mental health treatment and housing in jails and prisons.

In 1991, 67 percent of women in prisons had one or more children under 18, and 6 percent of all women who entered prison that year were pregnant. This represents 56,000 minor children for the 38,462 women incarcerated in US. prisons. Approximately 70 percent of these women lived with their minor children prior to being incarcerated (Bureau of Justice Statistics, 1993).

Some women who are pregnant and/or who have minor children will also have mental illnesses, and women separated from children or who are pregnant are under increased stress and may require mental health services targeted specifically to these issues. These additional stresses often can be reduced by policies in jails and prisons that allow children to visit and programs that offer parenting courses.

Mental health and substance abuse treatment programs that are offered to women in jails and prisons should assess and provide additional services to women with histories of physical or sexual abuse. Among persons with mental illnesses in general, women are more likely than men to be victims of abuse, particularly sexual abuse (Carmen, Rieker, and Mills, 1984; Jacobson and Richardson, 1987).

In addition, histories of abuse are common among incarcerated women. Rann (1993) found that 50 percent of female jail detainees had been victims of physical or sexual abuse at some point in their lies. More than 70 percent of women with drug or alcohol abuse problems were victims of violence, including domestic assault by adult partners, rape and incest (National Council on Alcoholism, 1990).

Points of Contact

The overall goal of this project is to explore the issues relating to women, violence, and mental illness at all stages of the criminal justice system, including contact with law enforcement, incarceration in jails or prisons, and supervision by probation or parole. General points include:

- There is a general lack of emphasis on women's services. Among the strategies that may be used to remedy this general lack are: (1) the use of standards or mandates in all criminal justice settings, (2) an acknowledgment of the differences between men and women, particularly interpersonal relationship styles, types of crimes committed, and skills and resources, and (3) the use of "strengths" v. deficit models in program activities.
- In order to design appropriate mental health programs for women, it is important to encourage the participation of the women for whom the services are designed at all levels of development.
- Throughout the criminal justice and mental health systems, there is a pressing need for cultural awareness and competency training.
- In addition, there are specific issues that cut across the criminal justice system that must be considered, including: (1) establish mechanisms to identify and overcome barriers between systems to avoid turf conflicts, (2) education, including developing cross-training curricula, and resources and strategies to educate the general public, (3) services integration, particularly substance abuse/mental health services with natural community resources.

Police

The issues facing law enforcement officers when interacting with women perpetrators of crimes, women victims of crimes, and women who are suspected of being mentally ill may involve different types of legal responses and interpersonal interactions with the individual, the need for specialized training of officers, and community options and resources appropriate for women, particularly victims.

Special attention should be given to:

- Developing emergency services and alternatives to arrest. Specifically, mental health crisis teams have been found to be useful for managing women, if staff are:
    - well-trained in women's issues
    - able to listen to the individual
    - know about what services are available to women in the community
    - accountable to someone in the community
- Services that police can access that provide emergency housing for women *and their children* are very important.

- Special needs facing pregnant women or women with responsibilities for minor children who also have a mental illness that must be considered are:
    - the reaction of women who are pregnant when they are taken off psychotropic medications,
    - options for care for minor children, other than Child Protective Services, when a woman is taken into custody,
    - the use of court-ordered or required treatment through probation or diversion are difficult for women who have responsibility for minor children if the terms of the agreement require women to participate in programs during daytime hours or for long periods of time.
- Police use of mandatory arrests of the batterer, when there is evidence that the women is a victim of “domestic” violence.

Jails

Jails, as short-term detention facilities, face different issues, including providing minimal mental health care at least on parity with men’s services, screening for history of sexual or physical assault, co-morbidity of substance abuse, separation from minor children and the need for visitation and parenting skills programs.

Special attention should be given to:

- Profiling women and sub-groups of women as a stage in the designing of mental health programs to determine
    - characteristics/contexts of women’s lives
    - the types of crimes women commit
    - the mental health and other service needs
- Parenting training as a necessary component of services to women, because most women plan to parent after release. In addition, policies for visitation with minor children and in-jail nurseries for newborns must be considered.
- Many women in jail did not have a “conventional lifestyle” at the time of arrest. To assist women integrate into the community after release, a change from a medical model to a rehabilitative model is necessary.
- Need to identity and properly diagnose mental health problems stemming from physical or sexual abuse

- Language and understanding of subcultures are important for accurate assessment and the provision of appropriate mental health and other services.

Prisons

In comparison to jails, prisons are much more likely to have mental health services in place that address women's needs. Similarly, as long-term facilities with larger numbers of women confined in the same facility, they are much more able to provide on-going care. In addition, research indicates that higher percentage of women utilize mental health services than men in prison. The issues facing jails also are present in prisons, including providing minimal mental health care at least on parity with men's services, screening for history of sexual or physical assault, co-morbidity of substance abuse, separation from minor children and the need for visitation and parenting skills programs.

Special attention should be given to:

- Developing a diagnostic process that is sensitive to the differences between men and women. The instruments currently used are not appropriate for women. Specifically, screening forms are not tailored for women, particularly in regard to histories of abuse.
- A classification process (i.e., assignment of security levels) must be designed for women.
- Mental health evaluations using well-trained clinical staff, who are experts in women's issues to ensure an appropriate diagnosis and to identify less disruptive, but serious mental illnesses, such as depression.
- Developing mental health/medical standards that are appropriate for women. Currently the standards are the same for men and women, except OB/GYN. Given that women represent 5 percent of the population in prison, yet use 50 percent of the health care, interventions must be holistic and targeted to problem patients.
- Behavioral modification strategies that appear to show great promise with women offenders. In addition, all programs need to be more empowering. Thought should be given to peer support programs, especially for women with substance abuse issues and with histories of abuse.
- The possibilities for continued abuse. Specifically, clinical staff need to be sensitized to trauma to avoid re-traumatization, and need to be aware of the pervasiveness of sexual abuse by staff

Community Corrections

Community supervision (probation and parole) is an area where there is a tremendous potential for intervention for women offenders with mental health

problems. With social pressures for courts to keep women in the community and wit their children, attention should be given to supervision strategies for women with mental illnesses, women victims of domestic abuse, and women perpetrators of violence, such as child abuse. Many female offenders require comprehensive services to assist them in remaining in their communities, including housing, mental health, health and substance abuse services, job skills training and placements, assistance with sexual victimization/abusive relationships, life skills training (including parenting, nutrition, budgeting, problem-solving, parenting skills and child care, and social supports).

Special attention should be given to:

- The standards applied to release decisions for men and women that place additional burdens on women being released from prisons. Structural obstacles, such as the lack of family-based community housing, can prevent a woman's release or cause her terms of release to be violated.
- Developing staff training curricula to prepare probation/parole officers to manage women's needs. In addition, supervision must consider the costs of technical violations and build in flexibility around relapse.
- The use of Intensive Case Management programs that show great promise for use in conjunction with probation or parole.
- In designing mental health intervention strategies for probation or parole, consideration must be given to rural/urban differences and the availability of resources. If at all possible, services should be imbedded in geographic communities.
- Primary concern among women is financial support for themselves and their families. often conditions of release require women to participate in programs or report during daytime hours. This means they cannot work and report or use services. Similarly, acquiring safe and cheap child care to report or participate in services is difficult.

Special Topics

In addition to the priorities listed above, other special topics deserve attention, including:

- A discussion on the impact of race/ethnicity and class on the provision and the receipt of services. This topic requires specific focus and discussions should attend to the unique characteristics of African Americans, Hispanics, and Asians
- Lesbian and bi-sexual issues

- The role of consumer self-help groups in the recovery process
- Special issues faced by youth in adult settings

Major Tasks and Timeline

To complete this project in a timely fashion, the following timeline is proposed:

Tasks	Month
Convene a 10 member Steering Committee in Washington,DC	1
Confirm monograph contents and select chapter authors	2
Authors write chapters	2-6
Dr. Veysey conducts site visits to 5 selected innovative programs	2-4
Chapters submitted to Dr. Veysey for editing	7
Steering Committee designees review chapters	7
Authors revise chapters	8-9
Final edits	10
Production	11-12

Cassandra Newkirk, M.D., Deputy Commissioner, Offender Services, Georgia Department of Corrections

I am a forensic psychiatrist and have worked as psychiatrist in a number of correctional settings. I want to talk today about some of the specific problems of incarcerated women with mental health, substance abuse, and physical and sexual abuse issues. I would like also to point to some ways we can begin to address these problems.

Role of Physical and Sexual Abuse

Approximately 80% of women who come into a prison or jail have been physically or sexually abused at some time in their lives. This is an estimate because few studies have been done to gather real data on this issue. In fact, there is a lack of information on physical and sexual abuse in the community at large. Very few psychologists, nurses, or doctors ask the question, “Have you ever been physically or sexually abused?” Those of us who are therapists know that it may take a year or two to recognize the symptoms of physical or sexual abuse histories. This points to the need for training for all health care professionals on the issue of physical and sexual abuse.

Other Problems

Other problems of women in the criminal justice system include the following:

- Eighty percent of women entering the criminal justice system are also substance abusers.
- A much larger percentage of women than of men are seriously mentally ill. Again there has been very little research in this' area but we are hopeful now that data can be collected on this issue.
- Approximately 75% of women entering the criminal justice system also have at least one child.

A study done by a North Carolina researcher asked all women coming into the prison what their major life problems were. The most common problems were depression and substance abuse. Much of the depression was related to a substance abuse history, to being away from their children, or to having been physically or sexually abused.

When a woman enters the door of a jail or prison, what we are looking at it is someone who is likely to have been physically or sexually abused, may have been a prostitute, is likely to have children, likely to have a sexually transmitted disease or other health problems, and is probably depressed.

Importance of Accurate Assessments

One important issue in corrections is accurate assessments of inmates. Because 90% of women in jails never come into the prison system, physical and psycho-social assessment in jails is especially important.

Although women make up a smaller percentage of jail and prison populations than men, they take up a larger portion of health care services. They go to physicians more quickly than men do. The will also ask for access to mental health services more often than men. Women's demands for health and mental health services do have an economic impact on your facility. If you adequately treat them, however, you can decrease your costs because they will stop coming to sick call so regularly.

Obstacles to doing accurate assessments of women include the following:

- Many sick calls are for vague physical complaints, but that these are usually symptoms of a somatic problem, often depression. The typical response is to give a woman some aspirin or Tylenol, which doesn't help the problem, so the women keep coming back with vague complaints. It is important to remember that many sick calls have a large psychological overlay. Many small jails do not have their own mental health services, so they must refer inmates to community mental health centers. Regular physicians sometimes give jail inmates

psychotropic medications to keep them quiet, but this doesn't really address their problems.

- Substance abuse issues are sometimes hard to identify. At intake, we need to identify the types of substances inmates were taking. The usual question at intake is, "Do you use drugs?" The answer is often "no," whatever the truth is. As professionals, we have to learn how to get the histories we really need.
- Sexual abuse histories are even more difficult to obtain. We are often uncomfortable asking about sexual abuse histories, so we have no idea of the dimension of the problem. At one point I asked the seriously mentally men I was counseling if they had ever been sexually abused as a young person; I was shocked when 50% indicated that they had. We often don't think to ask this question but it has important implications for treatment.

In dealing with women, it is often hard to know what you are seeing unless you have been specially trained. I have had first-hand experience of this difficulty. When I first worked in a women's prison I was used to seeing psychotics, so I had to ask colleagues what I was looking at in women inmates. I was actually watching women dissociate before my eyes, and I also saw more post-traumatic stress disorder. When experts in these problems began to treat these women, the number of disciplinary reports and the number of sick calls rapidly declined.

One woman had been locked down for long periods or placed in restraints because she would become extremely combative. Although I saw a video tape of an episode in which she beat and injured six correctional officers, she didn't remember the incident. This had been a consistent pattern. She had a history of being sexually abused as a child, had used cocaine as an adult, been physically abused as a woman and had three children. She also had difficulty sleeping, was anxious, depressed, and didn't remember things. I realized that her chances of parole were beginning to look bad, but that she was actually dissociating. We took her out of restraints, gave her a bit of psychotropic medication, and got her sleeping. Since that time, there have been no other episodes.

We finally realized what was happening, and this helped us recognize that we didn't deal adequately with the physical and sexual abuse of incarcerated women. Many things we do in correctional facilities are considered part of day-to-day operations. When women become agitated, we lock them down. In doing so, we are often re-traumatizing them, forcing them to relive the trauma of childhood sexual abuse. Run-of-the mill operations can be very disturbing to these women.

Responding to Women as Mothers

What can we do about the problem of women being taken away from their children? One answer is to develop parenting programs. I recently met an ex-offender who has established a program called "Parenting at a Distance" that includes a curricuium to teach women to stay in contact with their children while

they are incarcerated. It includes such simple things as developing forms to send to children's' teachers, which the teacher can send back to the mother to let her know how her child is doing. Rule #l is not to lie to children but to tell them where their mother is. The ex-offender developed the program because it is what she would have wanted herself She has graduated her first class of offenders and is working in the prison as volunteer. A study will be done to follow these women because the of disciplinary reports and sick call requests in the prison have gone down dramatically just as a result of this program. We need to keep in mind the importance of non-traditional approaches to dealing with incarcerated women's problems.

We have to keep in mind that women tend to express their emotions much more freely than men do. If you ignore them, they will do almost anything to get the attention they need. We often see agitated behavior because they haven't been taught to put into words what they are feeling.

Importance of Women Treatment Staff

It is important to have women on the treatment staff in correctional settings. There are often few women, except nurses, in prisons. Most psychologists in prisons tend to be men. When I began to work with women in prison, I was inundated because the inmates had never seen a woman psychiatrist, let alone a black woman psychiatrist. The result was that I got a lot of history that others hadn't heard. I had to pass the women's tests, but they were more willing to talk to me than to male psychiatrists. You cannot staff a female institution or unit the same way you do a male institution.

Conclusion

To summarize: As you plan services for women who are chronically and severely mentally ill in jails, you must be sensitive to the differences between men and women. You must also understand the need for educational components in your program because it is important to educate women about their mental illness and about other issues such as prenatal care. Look for help from special groups that address female offender issues. You might also want to seek a technical assistance grant from NIC to help you develop a diagnostic classification system specifically for female offenders. If you can do an accurate assessment at intake, it can save you many problems as the women move through the system.

Work Group Discussions

A major purpose of this National Public Forum was to provide the opportunity for participants to meet in small groups based on the size of the jail with which they are most closely associated. Croups comprised of those who work in or with small, medium, or large jails met on the second day of the forum to discuss important issues related to mental health services in jails.

Questions Addressed by Work Groups:

- **What is the basic set of mental health services a jail of this size needs?**
- **What does linkage to community-based services really mean in communities of this size?**
- **Who are the players in the community who need to be involved?**
- **What should the jail's response be to the special needs of women detainees?**

Group Facilitators. A facilitator led each work group in addressing these questions. Croup facilitators were: Judy Regina, Small Jails; Dr. Lois Ventura, Medium Jails; and Michael O'Toole, Large Jails.

Group Recorders. Recorders acted as co-facilitators in each group and recorded the major highlights of the group's discussion. The recorder's notes on each session were the basis of brief reports to all meeting participants. Croup recorders were: Ray Coleman, Small Jails; Mike Jackson, Medium Jails; and Connie Fortin, Large Jails.

Work Group Summary. Following is a summary of the points emphasized by participants in the three work groups on each topic. The summary is based on: recorders' notes; group report-outs; tape recordings of each group's discussion; and individual participants' notes collected at the end of each work group session.

Under each question, the points made in all three work groups are summarized. Following these are specific points that distinguish additional concerns of small, medium, and large jails. In some cases, while the same general idea emerged in all three work groups, the focus, specificity, or comprehensiveness of the response to a question may have varied depending on the size of the jail under discussion. For example, while those in all the groups identified the need for better communications, only those in the group on large jails focused on the need for communicating with other agencies through effective MIS or telecommunications systems.

Topic #1: What is the basic set of mental health services a jail of this size needs?

What hind of information is important for determining the mental health services that are needed in the jail? (eg., how many detainees are admitted to the jail, how many need mental health services, what specifically do they need?)

General categories of information needs identified by all groups:

- Population being served
- Levels of service needed
- Information on community services

Specific information needs identified by small jails:

- Who will provide various mental health services
- Sources of funding for services

Specific information needs identified by medium jails:

- Demographics of community
- Community knowledge of mental health needs
- Information on pre-trial and post-trial diversion programs
- Information on who needs to be in jail and who can be safely and effectively diverted
- Offender's mental health needs and previous treatment
- Offender's history of substance abuse
- Offender's arrest history and current charge
- Community resources available on release

Specific information identified by large jails:

- An understanding of the legal mandates for dealing with mentally ill inmates

- A shared recognition of the common mission of corrections and mental health and the shared goals under that mission
- Research and reliable data on inputs and outcomes of various mental health treatment models
- Common definitions of mental health disorders that are understood by everyone working in the jail

What are the particular mental health service components that need to be in place?

Service components identified by ail groups:

- Screening mechanisms
- Crisis intervention
- Behavior management
- Community linkages
- Cross training of mental health, corrections, and law enforcement Staff

Additional service components identified by small jails:

- Safe environment
- Medical management of the mentally ill
- Referral services

Additional service components identified by medium jails:

- Systematic approach to screening--at intake, at medical, or at classification
- Ability of security staff to identify mental health problems and make appropriate referrals
- Dedicated mental health staff positions in the jail
- Substance abuse treatment services
- Suicide intervention program
- Ability to house and treat mentally ill offenders appropriately--in segregation, a special living unit, or in the general population
- Case management services

- Liaison with families
- Assistance in making the transition to the community effective

Additional service components identified by large jails:

- An instrument that screens for mental health that is part of the ongoing objective classification process
- Access to inpatient care through jail services that parallel services in the community
- Multi-disciplinary approach to providing services to the mentally ill
- Group or individual counseling
- Need for good communications through MIS and telecommunications systems for transmitting information
- Continuum of care, in which case management and discharge planning are essential elements
- Community resource liaison position in the jail
- Advocacy and family groups involvement

Topic 2: ***What does linkage to community (based services really mean in communities of this size?***

What are the hey agencies needed to &liver these services?

Key agencies identified by all groups:

- Key agencies are social services, substance abuse, housing services
- Courts--judges and prosecuting and defense attorneys
- Probation and parole agencies
- Local businesses
- Consumer advocate organizations
- Families

What are the incentives to develop mental health services for the jail?

Incentives identified by all groups:

- Reduced exposure to liability and litigation
- Improved safety for inmates and staff
- Cost savings resulting from better use of scarce resources
- Jail population reduction
- Humanitarian concerns

Additional incentives identified by small jails:

- An interest in professional management

Additional incentives identified by medium jails:

- Reduction in recidivism if the mentally ill are given effective treatment
- Improved staff morale and reduction of staff stress

Additional incentives identified by large jails:

- Returning stabilized inmates to the community should result in a safer community and fewer police resources devoted to the mentally ill
- An improved public image for everyone working with these difficult offenders

What are the barriers to providing mental health services for the jail?

Barriers identified by all groups:

- Stigma attached to being mentally ill, substance abusers, and offender
- Limited resources
- No group will take ownership of the problem
- Turf protection
- Lack of community awareness
- The public mandate for law and order
- The mentally ill in jails are not part of the national agenda

Additional barriers identified by small jails:

- Outdated definitions of mental illness
- Mentally ill are held only occasionally in small jails
- Lack of program space in small jails
- Lack of policies and philosophy to guide staff
- Down-sizing of mental health but no accompanying community services

Additional barriers identified by medium jails:

- Client confidentiality issues

Additional barriers identified by large jails:

- Different finding streams create gaps in service

Topic 3: Who are players in the community who need to be involved?

Key players identified by all groups:

- Judges, prosecutors, public defender
- Sheriff
- County commissioners
- Line officers
- Mental health administrators
- Mental health providers
- Families
- Consumer support groups
- Victim advocacy groups
- Citizens
- Prosecutors, public defender
- Charitable groups
- Clergy
- Law enforcement -- state, county, municipal
- Local protection and advocacy agencies
- Agency or persons in county dealing with ADA issues
- Training academies for law enforcement and corrections officers

Additional players identified by small jails:

- Local physician especially in small communities
- Rural health centers

Additional players identified by medium jails:

- The media

What are the successful strategies that have been used to get people/agencies to buy in?

Strategies identified by all groups:

- Use of a task force or coalition of all the players
- Steering committees focused on specific issues
- Involvement of families and advocacy groups
- Lawsuits are effective in getting parties to come together.
- Access to reliable information provides a mutual understanding of problems

Additional strategies identified by small jails:

- Involvement of influential persons and key elected officials--sheriff is often pivotal person in small communities
- Use of Federal resources, e.g., NIC Jail Center, Information Center, Academy, CMHS, NIJ)
- Educating citizens, taxpayers
- Use of mental health and jail standards

Additional strategies identified by medium jails:

- Demonstrating effectiveness of successful programs
- Breaking down turf protection

Additional strategies identified by large jails:

- Inter-agency memoranda of understanding
- Education sessions for legislators
- Integration of all community services in the jail (including social services, education, public health, as well as mental health)
- Joint tracking of clients by mental health and corrections
- Continuum of care and case management models

Topic 4: What should the jail's response be to the special needs of women detainees?

What are the special mental health needs of women in jail?

Women's needs identified by all groups:

- Self esteem
- Caregiver issues--children, elderly
- Identity issues
- Co-dependency
- Feelings of not being worthy
- History of abuse
- Depression
- Substance abuse
- Need for housing
- Medical problems specific to women, including pregnancy
- Poor life and social skills
- Fewer services for women in jail
- Isolation, separation, and loss
- Dissociative reactions

Additional needs identified by small jails:

- Small jails may hold women only occasionally
- Lack for female staff in small jails
- No access to existing programs, which are solely for men
- If male-female separation is not possible, it is difficult to provide services

Additional needs identified by large jails:

- Although there are fewer women in jail, they have a greater need for services

- Different biomedical makeup
- Social connections, based on relationships both inside and outside jail, are key to wellness
- Classification systems that are based on traditional male profiles create problems in terms of access to services

What has been done in the jail to respond to the special mental health needs of women?

Responses to women's needs identified by all groups:

- Create special programs for women focusing on issues such as self-esteem, parenting, abuse counseling, wellness, parenting, health education, and women's co-dependency.
- Provide access to existing programs, e.g., education, mental health, and vocational-industry.
- Training in independent living skills,
- Provide linkage to housing.

Additional responses identified by small jails:

- Collaboration with the community to develop services in the jail
- Develop linkages to after-care services
- Some small jails contract out their housing for women. If so, they still have to provide services.

Additional responses identified by medium jails:

- A graduation ceremony for women who complete special programs
- Mentoring and role model programs

Additional responses identified by large jails:

- Many large jails have co-housing in which males and females are housed together in supervised settings
- Look at women from a "whole client approach"
- Find ways, while women are still in the jail, to maintain and improve the roles women will assume when they leave

Wrap-Up

Closing Comments from Audience:

- ***The incarcerated mentally ill need to be ma& a high priority.*** The work groups made clear the strong link between incarcerated mentally ill and the overall lack of support for persons with mental illness. We also heard that lack of funding is not the whole problem, that lack of support and treatment for the mentally ill population is perhaps even more important. We have to make this population a high priority; since it is the population that is most difficult.
- ***Federal role in encouraging collaboration between mental health and corrections.*** There is excellent collaboration in some jurisdictions between the mental health system and corrections, but, unfortunately, this is an exception not the rule. One group suggested that perhaps we need to encourage the Federal government. to attach more requirements to the receipt of block grants, to compel that there is a collaborative effort. This is perhaps one way to encourage what we are all seeking. Recent Federal legislation develops a Mental Health Planning Council in each state which must include representation of other state agencies, including the state corrections agency. This, we hope, will encourage inter-agency collaboration.
- ***Involuntary treatment.*** Even if services are available, some clients will not avail themselves of them unless forced to do so. The mental health system is not accustomed to coercing people into treatment. Most states have strict civil commitment standards and even stricter involuntary medication standards. However, there has to be a way short of imprisonment to force people into treatment, to medicate them long enough, under involuntary provisions, that they will get hooked so that they will participate voluntarily.

  Pennsylvania has particularly restrictive civil commitment laws, and public defenders vigorously oppose hospitalization of the mentally ill. If you succeed in hospitalizing someone, they will remain there as short a time as possible. I wonder whether or not it is possible to have something that is half a jail, half a hospital, with a whole range of services, with court-mandated treatment. In Philadelphia, jails are increasingly full of people who are there because they are mentally ill and, often, as a result of restraining orders obtained by their families because they can't get them to cooperate with ongoing treatment. If they are diverted back into the civil stream they will not get treatment.

Response flank Steadman): No one has tried a third system. It has an intuitive appeal, but it is not clear how it would work in our existing civil and criminal law. Given the rights of the individual and society, it is hard: to conceive how it would work. How would it be different from involuntary civil commitment except that criminal charges are pending. How would we set up a system to treat for mental illness, that would, under the pretext of a criminal charge, enforce treatment? It is hard to conceive.

Response (Ray Patterson): This is a complex issue, which tends to have strong advocates on both sides. Some advocates maintain on principle, that there should not be involuntary treatment, medication, or hospitalization. Family members-who have had to deal with the consequences when the system fails and who can't get any help for a family member until something negative happens--often are in favor of mandatory treatment. There is no easy answer. Criminal justice and mental health systems may have very different criteria for involuntary treatment. Thirty-seven states have outpatient civil commitment, but only 15 or 20 actually use it to any significant degree. Dealing with this issue is a difficult balancing act that requires weighing, on the one hand, individual freedom and individual rights against, on the other, societal protection and family rights. I don't have an answer. Where you stand depends on where you sit.

Response (audience): There is legislation in Oregon on this issue that makes sense. A mentally ill person who is doing well can sign a form that says, in effect, "You have permission to give me medicine at a time when I can't make this decision." When the person is rational and everything is going well, he/she has the opportunity to make a good decision, rather than waiting until they are unable to make a responsible decision.

Response (Hank Steadman): This is an evolving area of law, called "substituted judgments." It is important to those with dementia, Alzheimer's, and a whole array of service needs. This may be quite applicable to the kinds of clients we encounter in jails.. Not many states have developed this type of legislation, but the whole issue of substituted judgment has a lot to offer.

Response (Ray Patterson): CMHS is looking at this issue the same way in terms of an "advanced directive." The impetus to do so has come from consumer groups and families. There are questions, however, about the issue of competence to waive. If one has signed an advanced directive for a medical illness saying they do not want to resuscitated, they still have the opportunity to change their mind.

The question is, what happens when a psychotic individual changes his mind and refuses medication? The legal system then gets involved in the issue. But the approach is certainly appropriate to look at.

Response, (Hank Steadman): A variation is for the mentally ill person to identify a person who will make the decision about medication for him or her at a point when the mentally ill person is incapable of doing so.

Comment (audience): As a consumer advocate, I also want to say something about forced treatment. The idea for advanced directives comes from the consumer movement. It is easy to say that if we could only treat everyone 100% of the time, we wouldn't have to deal with these people in the criminal justice system. But everyone here has probably heard about abuses of treatment in the system, such as the situation in Florida and Texas, where for-profit motivations caused people to be committed against their will. There is a fine line between the needs of the individual and the needs of society. We would all hope to have the right not to be incarcerated against our wills without someone judging what we have actually done, not what we might conceivably do.

Comment (audience): We really haven't given the system a chance before deciding that we need to so something else. Community services haven't been given a chance, haven't been funded adequately to engage people who end up in the criminal justice system. We haven't provided the kind of services that have any meaning to these people. So we have a lot of work to do in terms of community-based services.

Closing Comments: Hank Steadman

One of the things that is exciting but at the same time frustrating about the people who are here is that the reason people get invited is that 1) they have a good program that a funding agency is interested in having them talk about or 2) they are committed to doing something good in their system. In other words, this is not a random sample of those running jails or mental health systems. It is very helpful to listen to one another, but these are the good programs represented here.

Recently at a meeting on mental health in South Carolina, the head of the South Carolina Sheriff's Association noted a resolution passed by the association that said, "South Carolina Sheriff's Association believes that there should be no mentally ill persons in South Carolina jails." This is very far from being committed to providing an array of services; they just want people out of the jail. There are many people in corrections who feel this way, and we have to keep this in mind. The people at this meeting aren't the ones who need encouragement.

Jail Standard Must Exceed Community Standard

A factual point: I have heard several times at this meeting comments about the "community standard" and how the jail needs to meet it. My understanding of the law is that the jail has a higher standard than the community. Having deprived someone of liberty, the jail is required by the Constitution to meet standards higher than those in the community.

The Public Health Model

What do we mean when we talk about the public health model? The phrase has found its way into jail-mental health services meetings, but my sense is that people use it without knowing what it means. I think, in fact, that the public health model is the single best model. I first heard about it in the early '80s at a conference in which the jail was referred to as a "public health outpost." I have always been intrigued by the concept because all community health problems are in fact found in the jail in a concentrated form. The jail is a wonderful place to provide a focus for public health or mental health services. The only problem is that the community doesn't see prisoners as worthy.

The concept of a public health outpost takes us away from thinking about treating a single individual. The public health model deals with groups of people. That concept is easier to sell than the case of a single individual who may have serious crimmal conduct. In the public health model, you are dealing with a medical model in which the idea is to identify the germ agent, then treat the symptoms. This moves us toward treating the next generation as well as the person.

We are not good at identifying distinctive treatment issues or effective treatment. The treatment modality for a person who is detained must be adapted to deal with

the physical plant, the pharmacy available, and so forth. A public health model would commit us to doing research on effective treatment in the jail setting.

Functional Disabilities Important in Setting Treatment Priorities

I believe that the only people we have resources to treat are those who have active symptoms and are dysfunctional in the jail environment. We don't treat based on lifetime symptoms of those coming into the jail. The point is how they can function in jail. There is no such thing as effective treatment in jail; all jail treatment is preparation for treatment. The reality is that, given short stays in jail, you can only prepare people for doing something long-term in the community. A diagnosis of dysfunction or depression is relevant to the community, but, given your limited resources, it is not relevant to the jail. Therefore, jails need to emphasize functional rather than diagnostic issues.

Families an Asset in Obtaining Resources

Family members and consumers are an important asset in seeking funding. They have political weight that those in the system often do not have. It is important to involve family members in developing treatment programs, but, they are even more valuable in terms of helping you obtain resources. They are often well known in the community and have invaluable experience that can help you get money from the county or local government.

Confidentiality and Information Exchange

Another area that has emerged at this meeting is information exchange. One of the things we hear from treatment providers is their frustration at getting information on the last time a person was in jail, what kind of community treatment the person was getting, or how to get information from the jail to prison on treatment. This is consistent with mental health theories of continuity of care, but there is another side to the issue. I have heard from a number of consumers that they don't always want the information to follow them into the community, that it is stigmatizing. One reason to have consumer representation on local coalitions is to listen to their point of view and figure out how to respond to it. These people may feel very vulnerable and don't want anyone to know they were in the mental health unit last time. We need to recognize this alternate point of view, and think about how to balance information and security needs against the rights of the consumer to privacy.

Use Resources Made Possible by NIC-CMHS Collaboration

Finally, an unsolicited testimonial: The cooperation of these two service-based agencies, NIC and CMHS, provides important support for developing programs and resources for localities that don't have capability but do have the interest. You should use these resources and also use your own political clout to get to ensure that these agencies continue to get resources. We're a constituent group to those agencies. I encourage you to use the technical assistance support and to take advantage of the opportunities provided by this collaboration.

APPENDIX

CREATING JAIL MENTAL HEALTH SERVICES
FOR TOMORROW'S HEALTH CARE SYSTEMS

sponsored by

The National Institute of Corrections

and

The Center for Mental Health Services

Holiday Inn Union Square
480 Sutter Street
San Francisco, California 94108

November 9 - 10, 1994

AGENDA

Wednesday. November 9, 1994

2:00 pm **Welcome** . . . . *Morris Thigpen, Director, NIC*

2:15 pm Opening Remarks . . . . *Dr. Raymond Patterson, Director*
Demonstration Division, CMHS
. . . . *Walter Thomas, Undersheriff*
San Francisco Sheriffs Department

2:45 pm Forum Objectives . . . . *Susan Salasin, Director*
Mental Health Criminal Justice Program, CMHS
. . . . *Dr. Hank Steadman*
Consultant

3:00 pm Creating a Healthier Jail Environment
Through Training and Programs . . . . *Michael Marcum*
Asst. Sheriff, San Francisco Sheriff's Department

3:30 pm San Francisco's New Generation Program . . . . . . *Dr. Jay Stone Rice*
Consultant

3:45 pm Panel Discussion . . . . *Dr. Jay Stone Rice*

con 't.

4:30 pm San Francisco's Garden Project . . . . ***Cathrine Sneed***
San Francisco Sheriff's Department

5:00 pm Special Issues for Women in Jail . . . . Susan ***Salasin, CMHS***
. . . . ***Dr. Bonnie Veysey***
Consultant

5:45 pm Overview of Workgroups . . . . ***Dr. Hank Steadman***

6:00 pm Reception

<u>Thursday. November 10, 1994</u>

8:30 am Workgroup 1

- Small Jails . . . . ***Judy Regina***
Consultant
. . . . ***Ray Coleman***
Consultant

- Medium Jails . . . . ***Dr. Lois Ventura***
NIC Resource Center
. . . . ***Mike Jackson***
Consultant

- Large Jails . . . . ***Michael O'Toole***
Chief, NIC Jails Division
. . . . ***Connie Fortin***
Consultant

10:30 am Workgroup 2

- Small Jails . . . . ***Judy Regina***
. . . . ***Ray Coleman***

- Medium Jails . . . . ***Lois Ventura***
. . . . ***Mike Jackson***

- Large Jails . . . . ***Michael O'Toole***
. . . . ***Connie Fortin***

12:00 pm Lunch

con't.

1:15 pm	Group Reports . . . . ***Dr. Hank Steadman***
2:30 pm	WrapUp . . . . ***Dr.HankSteadman***
3:00 pm	Open Mike. . . . . *Dr. Raymond Patterson* . . . . *Linda Wood* *Correctional Program Specialist, NIC*
5:00 pm	Adjourn

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CENTER FOR MENTAL HEALTH SERVICES

Holiday Inn Union Square
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