National Institute of Corrections
Jails Division

Large Jail Network Meeting

July 7–9, 2002
Longmont, Colorado

Table of Contents

Meeting Highlights Large Jail Network Meeting July 7-9, 2002 **1**

Cost Containment for Inmate Health Care **5**

Rebecca Craig, Director, Standards and Corrections Health Care, Institute for Medical Quality, California Medical Association *5*

Taming the Cost of Health Care in Detentions:What Works in San Diego County **11**

William Sparrow, Medical Services Administrator, San Diego County Detention Services Bureau *11*

Confronting Costs for Medical Care: Open Forum Discussion **15**

Increased Medical Costs: Managed Care and Private Contracts **19**

David Parrish, Hillsborough County, Florida *19*

Dennis Williams, Escambia County, Florida *23*

Public Health and Jails:Challenges and Current Activities **25**

Roberto Hugh Potter, Corrections and Substance Abuse Unit, Centers for Disease Control *25*

Dennis Andrews, Superintendent, Cook County (Chicago) Department of Corrections *29*

Succession Planning: Mentoring and Training Future Middle Managers **31**

Rocky Hewitt, Orange County, California *31*

Al Johnson, Training Manager, St. Louis County Department of Justice Services *33*

Preventing Jail Suicides **37**

Jim Babcock, Sacramento County, California *37*

Update on Large Jail Issues **41**

Topics For the Next Large Jail Network Meeting **43**

Richard Geaither, Correctional Program Specialist, NIC *43*

Appendix 1: Meeting Agenda **45**

Appendix 2: Participant List **51**

MEETING HIGHLIGHTS

LARGE JAIL NETWORK MEETING

JULY 7-9, 2002

These proceedings summarize a meeting of NIC's Large Jail Network held in Longmont, Colorado, on July 7-9, 2002. Approximately 60 administrators of the nation's largest jails and jail systems attended the meeting. Twenty-three of the attendees were first-time participants in a Large Jail Network meeting.

The meeting focused on several issues affecting jail operations:

- Containing costs for inmate medical care
- Succession planning for future jail leaders
- Preventing jail suicides

HIGHLIGHTS OF MEETING SESSIONS

- **Addressing the Issue of Cost Containment: An Introduction.** The opening speaker for this Large Jail Network meeting was **Rebecca Craig**, Director of Standards and Corrections Health Care for the Institute for Medical Quality, California Medical Association. She presented a broad perspective on the issue of cost containment for medical services and pointed to hidden costs, such as the shortage of nurses, facility operations that hinder access of medical staff to inmates, and the under-utilization of health care staff in jails. She emphasized the importance of gathering and analyzing data to identify the costs of services per inmate per day in order to make decisions about health care based on real knowledge. It is also crucial, she pointed out, for jail administrators to make all decisions about medical services jointly with medical administrators.

- **Taming the Cost of Health Care in San Diego County. William Sparrow**, Medical Services Administrator for the San Diego County Detention Services Bureau, presented some specific cost containment strategies that were successful in San Diego. These included: competitive contracting; bringing physicians from the University of California, San Diego into the jail; developing an internal case management system; reviewing pharmacy practices; enhancing the skills of nursing staff; establishing competitive bidding for laboratory services; and collaborating with county counsel to review reimbursement rates for non-contracted hospitals.

- **Managed Care and Private Contracts. David Parrish**, Hillsborough County, Florida, summarized that county's experiences in developing contract medical care. He pointed to a variety of benefits of the contract, but noted that the

county's long-time vendor had suddenly demanded an extraordinarily large increase in compensation and then terminated the contract when the Sheriff's Office refused to comply. In response, the Sheriff's Office has been reviewing the possibility of operating medical services itself and comparing that option with the potential benefits of contracting. A consultant negotiated an interim agreement with the current contractor and helped develop a new RFP. Depending on the proposals received in response, the county will determine whether to exercise the self-operation alternative or contract for services. **Dennis Williams**, Escambia County, Florida, highlighted recent changes in Escambia County's approach to health care. As a result of working in partnership with a new health care provider to develop an effective cost containment program, costs have declined significantly and are capped. Positive changes that have occurred since Williams assumed responsibility for the jails in April, 2001, include a new cooperative attitude between security and medical staff, increased community awareness of on-site medical capabilities, line staff involvement in decisions, and an innovative "Keep on Person" Self-Medication program that allows inmates to self-administer certain medicines.

- **Public Health and Jails**. **Roberto Hugh Potter**, from the Corrections and Substance Abuse Unit of the Centers for Disease Control, pointed to the importance of cooperation between jails and public health. He noted that because inmates have disproportionately high rates of a variety of infectious diseases, jails offer an excellent venue for disease screening, initial treatment, and prevention education of high-risk individuals. Summarizing current CDC projects involving corrections, he highlighted lessons learned from those ventures and pointed to steps that jails could take to involve public health in their activities. **Dennis Andrews**, Superintendent of the Cook County (Chicago) Department of Corrections, summarized the advantages that county has experienced because its medical services are operated entirely by the county health department. Because of the large inmate population, the department has the largest hospital and mental health facility in Illinois.

- **Succession Planning: Training Future Managers.** Two jail administrators summarized their county's approaches to developing future correctional leaders. **Rocky Hewitt**, Orange County, California, emphasized the role of present administrators in fostering appropriate attitudes, behaviors, and values. He then summarized Orange County Sheriff's Department's leadership training program. **Al Johnson,** Training Manager of the St. Louis County Department of Justice Services, described that county's Leadership Development Program, which is based on the core values of the county and uses an Experiential Learning Model. He offered some specific tips to agencies considering a leadership development program.

- **Preventing Jail Suicides.** The Sacramento County Jail had several recent suicides and, in response, undertook a review of its suicide prevention policies. **Jim Babcock,** Sacramento County Sheriffs Office, summarized the work of its Suicide Prevention Task Force in addressing jail suicides. He also presented a number of recommendations for improving the county's suicide prevention

efforts made by an NIC consultant, Lindsay Hayes, a national expert on jail suicides.

- **Update on Large Jail Issues.** This session gave meeting participants the opportunity to raise issues of concern or to request assistance from other attendees. The following issues were discussed at this session: staff tracking sheet; a candidate for Congress who is familiar with jail issues; an update of activities of the American Jail Association; staff absenteeism; RFP issues; and cooperation with the Centers for Disease Control.

- **Topics for the Next Meeting. Richard Geaither,** NIC Correctional Program Specialist, led participants in a discussion of issues to be addressed at the next meeting of the Large Jail Network in February 2003. The group agreed on the following topics for the meeting: future trends in the nation; legislation, grants, and other funding available for jails; management accountability and professional standards; and an update on legal issues.

COST CONTAINMENT FOR INMATE HEALTH CARE

REBECCA CRAIG, DIRECTOR, STANDARDS AND CORRECTIONS HEALTH CARE, INSTITUTE FOR MEDICAL QUALITY, CALIFORNIA MEDICAL ASSOCIATION

COST CONTAINMENT: INMATE HEALTH CARE

There are several reasons why jail administrators need to invest time and energy on this topic:

- **Fiscal responsibility**. In your position as jail administrator, you have a duty to be fiscally responsible.
- **Political climate.** It is often difficult to convince those in power that jail inmates need good medical care.
- **Constitutional requirements.** The Constitution makes clear that there are requirements related to quality care in jails.

It is important to recognize that having quality health care in your facility does not necessarily cost more. You can keep the overall cost down without reducing the quality of care.

COMMUNITY ENVIRONMENT

It is helpful to look at jail health services in the context of the community environment because external forces affect jail operations. One reason for public debate is that health costs in the general community are now increasing 10% or more a year. In addition, pharmaceutical costs are increasing 15%-25% annually, and they will outpace hospitalization costs by the end of this year.

REASONS FOR COST INCREASES

- **Aging of the general** population. This means that Baby Boomers are now facing rising costs for prescription drugs.
- **New technologies.** New technologies have made it possible to create new medications, for which companies can charge what they choose as long as the copyright is in effect.
- **Consumer knowledge.** Consumers know more about what is available; therefore, they expect more.
- **Reduced fiscal margins and reserves.** Past cost-saving measures have already removed the excesses from medical services budgets.

COMMUNITY COST CONTROLS

Health organizations in the larger community have put in place a number of cost control measures that should also be used in the jail setting. These include defined benefit packages; competitive bids for service; set reimbursement rates; an established formulary that defines covered diseases; control of providers to limit the number of hospital days; and control of health care utilization.

One result of these controls, however, is that large segments of society have less access to health care. With the rising cost of insurance premiums, small businesses are often unable to afford the cost of insurance for their employees.

Insurance companies can increase premiums, but government entities such as jails have no way to shift costs except through requiring co-payments for care. Increasingly, jails have instituted the practice of charging inmates co-payments for medical care; the number of jails doing so has grown in recent years. The negative aspect of co-payments, however, is that it may discourage inmates from seeking needed medical care. If you decide to charge co-pays, you must be sure to exempt conditions such as tuberculosis or pregnancy. In addition, it is important to remember that if an individual has no money for the co-payment, the jail must still provide services to that individual.

CORRECTIONAL HEALTH CARE

What all this means to jails is that they must think and plan smarter. You need to start doing what insurance companies are doing: developing mechanisms to define the scope of benefits—that is, identify what health care services will be provided in the jail. This definition can give you a good first cut at controlling costs. Then use technologies to monitor and document your approach.

ANALYSIS OF THE SYSTEM: AN OVERVIEW

Analyze your medical system to answer the following basic questions:

- What is the cost of the current program?
- What are the deficiencies of the current program?
- What services are currently provided; how, where, and by whom are they provided?

It is critical to do your own studies and evaluation, as there is too much variation among jurisdictions to rely on a study done by another jurisdiction. Results vary in terms of size, facility design, type of population, and the age of the population.

HIDDEN COSTS

Nursing shortage. The shortage of nurses has become a nationwide epidemic. By the year 2020, there will be 500,000–1 million vacant nursing positions. There is also a pervasive graying of the current nursing workforce; the average age of nurses is 47 years, and 56% are over 52 years old.

The nursing shortage is here to stay. What this means is that you are likely to face rising recruitment costs for nurses, and you may need to develop different ways of dealing with nurses than with other staff: When nurses are being courted as they are today, there is no reason why any nurse should stay in a hostile work environment. The attitudes of administrators and line staff toward health staff are crucial. It is up to you as an administrator to ensure that the work environment for health services staff is very positive.

The crucial elements that create nursing satisfaction are flexibility and the ability to control their work shifts. You may have to be more open to part-time shifts and offer more money, but perhaps fewer benefits.

Access to inmates by medical staff. Remember that time is money, so it is important to look at your operations carefully to be sure they are not creating problems of access to medical services. Sometimes custody practices such as lockdown affect medical staff costs by creating large blocks of time when medical staff's access to inmates is limited. The result is that you need additional staff to cover health care needs.

Utilization of health staff. Support staff in health services are often under-utilized. They need to be given real responsibilities as well as training to carry them out. I am a strong proponent of using medical assistants to work under nurses who are leaders of a unit. Look at the tasks that are being done by a nurse but could be done by a medical assistant. I would never replace a registered nurse with an assistant, but you don't need an RN to do pill call for housing units, answer phone calls, or get medical records. In many places, nurses are doing these things.

UTILIZATION DATA

Use data to help you manage better. Data to answer the following questions should be collected monthly and summarized annually:

- How frequently are specific services being utilized? Include specialty clinics.
- What services are provided on site?
- How many and what kinds of off-site referrals are being made? You need to know trends in referrals for services such as dermatology, orthopedics, and pregnancy in order to develop a good RFP and evaluate responses. You also need to include costs of transportation such as cost per mile, depreciation, and staff.

COST VARIATIONS

It is critical to perform your own studies and evaluations. The cost of care varies significantly from county to county. Reasons for the variability include contractual arrangements for paying outside health services, the extent of on-site clinical services, and the distance from and availability of services.

MEDICAL COST ANALYSIS

Use a standard formula to determine the medical cost per inmate day:

- Average daily population x 365 days = total inmate days
- Compile the cost for a specific service
- Divide the cost by total inmate days = cost per day

A medical cost analysis helps you gain an understanding of the system and make decisions based on real knowledge. Knowing the cost per patient per day lets you estimate what the increase in cost will be for an increase in the inmate population. In addition, understanding how the system works protects you from "giving away the farm" to your medical provider.

DEFICIENCY ANALYSIS

An analysis of deficiencies should be part of the medical cost analysis to help identify weaknesses in the management processes. Deficiencies can be determined by reviewing the trends in grievances. Divide grievances into categories and identify how many involve medication errors, including the wrong prescription or the wrong person. Examining deficiencies also helps you determine the medical service provider's attitude. Compare records of events across custody, mental health, and medical units.

PLANNING

Use your completed analysis of the system to develop a plan. Define the "benefit package," that is, the scope of services to be provided. Also look at where services will be provided; will they be centralized or decentralized? Based on cost and utilization data, identify the appropriate on-site services. For off-site services, look at frequency data as well as security needs.

ORGANIZATION OF SERVICES

Most jail systems now provide:

- Chronic care clinics
- Dental services
- Medical/mental health housing

SCOPE OF SERVICES

Services must meet community standards of care and address both medical and mental health needs. Look at community resources for help in decreasing your costs. The decision of the 9th Circuit Court in the Wakefield case emphasized the importance of continuity of mental health care. It is difficult to provide this continuity with fewer dollars, but partnerships with public health can help.

SUMMARY

Jails reflect the communities they serve. The cost savings initially seen as a result of cost-cutting techniques may be impossible to repeat. If you hit a wall, look again at the numbers with your medical staff. Examine medical practices to be sure that physicians are not over-prescribing expensive medications. It is critical to make decisions jointly with your medical administrators. Remember that you are all on the same team.

For additional information, contact Rebecca Craig, Director, Standards & Correctional Health, Institute for Medical Quality, 221 Main Street, San Francisco, CA 94105; 415-882-5132; rcraig@img.org

OPEN FORUM DISCUSSION: COST CONTAINMENT

- ***Medical and mental health staff are reluctant to pass on records to custody staff. This means that thousands of classification decisions are being made without access to medical and mental health records.***

Custody staff do not have the right to read the actual medical records, but they have a right to information needed to make decisions. In many cases, medical and public health staff are afraid to pass on the HIV status of an individual or information about active TB out of a concern that the individual will be penalized. However, some kinds of information are crucial to custody staff. Records of past suicidal behavior, withdrawal, seizures, diabetes, and other things need to be tagged. Custody and health staff need to work these things out together.

TAMING THE COST OF HEALTH CARE IN DETENTIONS:WHAT WORKS IN SAN DIEGO COUNTY

WILLIAM SPARROW, MEDICAL SERVICES ADMINISTRATOR, SAN DIEGO COUNTY DETENTION SERVICES BUREAU

DIAGNOSING THE PROBLEM

When I came to the San Diego County Detention Services Bureau, there was a medical services provider. What was most striking to me, coming from a managed care environment, was that the sheriff was paying retail for everything in a remarkable wholesale environment. Community providers saw keeping inmates in the hospital as a cash cow. The medical staff were unresponsive and costly. The first week I was there, a physician did an unauthorized vasectomy on a patient in unsanitary conditions. I had to go to the county's Board of Supervisors to settle the subsequent lawsuit.

COST CONTAINMENT STRATEGIES

I first cancelled the contract with the private provider and then made other changes, including new equipment and staff. Ultimately, we did develop a set of cost containment strategies. Following are the areas we looked at for potential cost savings:

- Competitive contracting;
- Case management;
- Pharmacy management;
- Medical supervision and staff skills enhancement;
- Laboratory monitoring; and
- County counsel collaboration.

COST CONTAINMENT STRATEGY: COMPETITIVE CONTRACTING

- **Approach:** We developed a competitive RFP to create an integrated health care system across the county. It addressed primary care physicians in the jail, access to accredited hospitals, and a hospital-based case management component. The minimum selection criterion for hospitals is that they provide a case management approach that moves inmates through the system as effectively as possible.
- **Cost Containment Results:** The competitive process reduced inmates' length of stay in the hospital and the overall budget. The cost for a contracted hospital is now $950 per day as opposed to $5,000 per day for a non-contracted hospital.

UCSD CONTRACT/MSO FUNCTION

- **Approach:** Physicians from the University of California, San Diego (UCSD) now provide on-site jail clinics and specialty clinics in the jail.
  - **Cost Containment Results:** In 2000-2001, a UCSD nurse and the medical director reviewed 5,455 referrals, with a resulting cost savings of at least $270,000.
  - Appointments and transportation were a big cost concern, but there is now an on-site team, which has eliminated the problem. There is never more than a 30-minute wait for an inmate to see a physician.
  - In-service training to address operational issues has improved the morale of the nursing staff. Enhancing the skill level of nurses and giving them more responsibility has created positive changes.

COST CONTAINMENT STRATEGY: INTERNAL CASE MANAGEMENT SYSTEM

- **Approach:** The case management focus emphasizes coordination of care. The full-time medical director, who has practiced 20 years in San Diego County, has begun to take a focused, hands-on approach to case management. The case management system makes it possible to review cases and collaborate with contracted hospitals from admission to release, ensuring that inmates return to the jail as quickly as possible. The medical director and nurse supervisor for case management track inmates' release dates, identify those with private insurance, and oversee timely transfers of inmates to contract hospitals. The establishment of a consistent policy and procedure governing the administration of "watch take" medicines and development of criteria to identify "outliers," who are using a disproportionate share of the medical budget, have also been part of the case management approach.
- **Cost Containment Results:** In six months, the total cost avoidance has been $451,000. The average length of inmates' stay in hospitals has been reduced to 3.1 days.

COST CONTAINMENT STRATEGY: PHARMACY PRACTICES

- **Approach:** To affect pharmacy costs, you must mount an offense of some magnitude. San Diego County reviewed:
  1. Drug formulary (the medications physicians are encouraged to use)—Although we have encouraged physicians not to order "designer" psychotropic medications, we have not taken the step of ordering them to prescribe specific medications.
  2. The drug alternatives list—Physicians have been encouraged to prescribe certain anti-psychotic medicines.
  3. The I.V. program—They had been sending inmates to hospitals for I.V. therapy, which required an inpatient day at the hospital and transportation. They have enhanced the skill level of the jail nursing staff, so they can now do I.V. therapy on site.

4. Solid medications—Doctors have been encouraged to prescribe solid rather than liquid medications.
5. ADAP billing—The Aids Drug Assistance Program (ADAP) has been billed for HIV and AIDS medications.
6. Performance Guarantee Program—The program has been used to obtain the anti-psychotic medicine Risperdal through the pharmaceutical company Janssen.

- **Results:** A study by the University of California San Diego identified dramatic cost savings in the area of pharmacy practices:
  1. IV Program—Annual savings of $969,486
  2. Solid medications—Annual savings of $323,090
  3. Preferred antipsychotic drugs—Annual cost avoidance of $50,000
  4. ADAP billing—Collected $144,474 for HIV and AIDS medications
  5. Performance Guarantee Program—Cost avoidance of $157,143.

COST CONTAINMENT STRATEGY: INCREASED MEDICAL SUPERVISION AND STAFF SKILLS ENHANCEMENT

- **Approach:** A reduction in the number of inmates sent out for care resulted from improved clinical care provided in-house. Increased medical supervision of the nursing staff and training programs to increase staff competency (including psychiatric, pain management, alcohol and drug withdrawal, and medication classes).
  1. **On-Call Physician** Program—The Sheriff's Department implemented a 24-hour-a-day on-call emergency physician available for consultation to jail nursing staff by telephone. The On-Call Physician can determine whether options of care could be used, including transport by deputy car or provision of care by nursing staff and follow-up at the jail's medical clinic.
  2. **Results**—the On-Call Program reduced the total number of 911 ambulance transports from 30.1 runs per month to 9.1 runs per month (a 69.8% reduction.

- **Results:** Ultimately, a cost containment strategy comes down to an indirect effect. San Diego County has experienced a greatly reduced liability as a result of its cost containment efforts: from 25 settlements of lawsuits in 1997 to 10 settlements in 2001. This reduction has been the result of better care, including medical staff's increased time with patients.

COST CONTAINMENT STRATEGY: LABORATORY CONTRACT

- **Approach:** San Diego County established competitive bidding for laboratory services, participated in a state reimbursement program, and audited billing.
- **Results:** There was a $20,000 reduction in lab costs.

COST CONTAINMENT STRATEGY: COLLABORATION WITH COUNTY COUNSEL

- **Approach:** In collaboration with county counsel, the Sheriff's Department is reviewing the issue of the rate of reimbursement for non-contracted hospitals and the point at which they take custody of an offender.

SAN DIEGO'S STRATEGY

The county's strategy has left no stone unturned in working to identify ways to contain medical costs in the jail. The cost of health care is projected to increase 22% nationally and 29% in California. These rapidly rising costs mean that San Diego can contain costs, but likely will not be able to reduce them.

For additional information, contact William Sparrow, Medical Services Administrator, San Diego County Sheriff's Department, 9621 Ridgehaven Court, San Diego, CA 92123; 858-974-2291.

CONFRONTING COSTS FOR MEDICAL CARE: OPEN FORUM DISCUSSION

How do you get any leverage with non-contract hospitals?

If the federal and state governments can define rates of reimbursement for Medicare and Medicaid, why can't the sheriff's office promulgate its own rate of reimbursement? All hospitals depend heavily on Medicare for their income, so we have a plan to pay the Medicare rate of reimbursement. The San Diego County Sheriff is extremely powerful and has been very supportive. The hospital would obviously not like to see an article saying that the sheriff is paying twice what others pay for care. It is also helpful to get the County Board of Supervisors to buy in. Hospitals are likely to take a reasonable rate of reimbursement rather than go to court.

How do you react to the demands of the district attorney or public defense bar for specific medications?

We do get bizarre orders as a result of public defenders sometimes. However, they recognize how much the standard of care in the jail has improved, and their support has increased. The Alliance for the Mentally Ill is a strong group and originally was in opposition to the sheriff, but the group is now among our strongest advocates. The introduction of Patient Advocates has contributed to this good will. Social workers have also improved our relationships with this very proactive community. We give numerous talks in the community, which is an investment we believe will pay off in the long run.

What kinds of inpatient care does the university provide?

Primary care, emergency room, internal medicine, and family practice physicians from the university provide care. These physicians are the gatekeepers and refer inmates to specialists. We pay these university doctors $180 an hour to do a four-hour shift in the jail, but we have much higher patient satisfaction with them.

Do you have a policy regarding inmates being released on psychotropic medications?

Yes. Those on psychotropic medicines are given a 30-day supply when they are released. Having a social worker to facilitate discharge planning and aftercare at a community clinic has resulted in less recidivism from the mentally ill in our community. We also give medicine for seizures or heart disease on discharge, as well as any other reasonable medication.

How are you measuring success?

We are discharging about 15% of inmates on psychotropic medication. We have a $5 million grant to study the effects of active case management for this population. The inmates in this group who are released get a ride from the jail to their residence and are

initially seen every day. In the study group, they are not reoffending and are getting jobs. We have hard data that demonstrates that focused case management keeps people out of jail.

What are the I.V. treatments? Do you have your own infirmary?

We have a medical observation unit and an acute psychiatric unit. We can provide such treatment as dialysis and maintenance therapy on antibiotics in-house rather than sending inmates to the hospital. Investing in the skill level of nurses has been our best move.

What medications must security staff watch an inmate take?

"Watch take" medications include psychotropic medicines, narcotics, and AIDS drugs. We found that inmates would cheek them and use them later. It is not the nurse's job to be sure the inmate is taking the medication, so a security staff person checks the inmate's mouth.

Do you have a drug maintenance program?

No. There are detox programs but no methadone maintenance program.

How about dialysis?

We can now do dialysis in the jail through the university. The new jail was built with the capacity of providing dialysis, because we calculated the cost of taking inmates off site for dialysis was over $100,000.

Do you use telemedicine?

No. We have considered it, but our on-site care is reasonably developed, and telemedicine does not seem necessary.

We all use the concept of a case manager, but we don't necessarily have someone with that title. Are there advantages?

We have found that having a specific case manager works best. When someone gets sent to the hospital, a physician or nurse finds out the admitting diagnosis, expected length of stay, and educates staff in hospitals about what capability the jail has. If a person could be released with a home health aid, they can be released to the jail. A case manager specialist for medical services can cut down on costs.

What is really the ideal model for providing services?

It is impossible to answer that question, as there are too many variables from county to county. Ultimately, decisions regarding medical services come home to the sheriff. San Diego has a public-private partnership with the university, but the Sheriff's Department monitors it. Some combination of approaches may be good, but monitoring is always required. The whole point is: are you getting the service you believe you should have? Is there a degree of understanding? If you are working with a public agency and you are satisfied, stay with it. Successful systems have a medical director very high in the command structure. Any model can work fine, but ultimate responsibility rests with the director or sheriff.

An important issue is how you fund health care in the community.

Right now, health departments are suffering severe cuts, and sheriffs' departments are likely to be cut as well. If you separate yourself from the issue, your budget is likely to become just another entity for the chopping block. The public health clinic in a community can be shut down, or the sheriff's department can support the health department through its large numbers of inmates, which may be the wiser approach.

In Pittsburgh, the health department created a nonprofit agency overseen by a medical board. The profit that used to go to private provider now comes back into the system.

Another advantage of the nonprofit model is the opportunity it provides for getting grants as well as contracting for pharmaceuticals.

If you charge a co-pay, don't you lose money on the cost of staff to track payments?

Sometimes. Another possible reason for not using co-pays is that we don't want to create disincentives for inmates to seek care.

INCREASED MEDICAL COSTS: MANAGED CARE AND PRIVATE CONTRACTS

DAVID PARRISH, HILLSBOROUGH COUNTY, FLORIDA

"*MEDICAL SERVICE IN HILLSBOROUGH COUNTY: A TWENTY-YEAR LEARNING CURVE*"

BACKGROUND

In 1973, jails run by the Board of County Commissioners, Tampa Police Department, City Sanitation Department, and Hillsborough County Sheriff's Office were consolidated by a Special Act of the Florida Legislature and placed under the administration of the Sheriff. The Special Act required the Hospital Authority to provide medical service (at no charge) to any inmate who was hospitalized. This resulted in a policy of "observation and referral." If an inmate required more than aspirin, we sent him to the hospital.

In 1981, unfortunately, a new Special Act split the Hospital Authority into the Tampa General Hospital (TGH) and Public Assistance. As a result, TGH began to charge for all inmate hospitalizations, while Public Assistance refused to finance inmate health care except for indigents. In fact, they never paid for any inmate services. Faced with a $600,000 medical care budget and $1,800,000 in projected expenses, we were forced to look at an alternative form of service, contract medical care.

First, we examined the private service program in Broward County, which had the only contract program in Florida. In July 1982, we awarded a contract to Prison Health Services for $1.2 million.

We allowed the existing nurses to remain on as county employees so that there would be staff left in the event that the contractor was unable to perform. This was a catastrophic mistake! Based on past practice, the existing staff equated good medical care with hospitalization, while the basis of the contract was to save money by providing services in the jail. The result was a medical staff that worked against itself. The best advice to anyone contemplating contract medical care is to convert all positions to the vendor.

CONTRACT ADVANTAGES

We immediately experienced a number of advantages under the contract, including:

- The employment of new personnel was expedited by eliminating Civil Service bureaucracy.
- Although the Sheriff's Office gives final hiring approval, day-to-day recruiting and screening became the responsibility of the contractor.
- National Commission on Correctional Health Care accreditation was assured, as it was a condition of the contract.

- The fiscal officer, sheriff, and Board of County Commissioners expected an annual increase in the medical budget because the contract contained an escalator clause based on the (medical) consumer price index.

However, the escalator clause turned out to be a major problem, as health care costs rose compared to increases in the offender population.

THE CONTRACT

Contracts run for three years, with the possibility two 2-year extensions, for a maximum of 7 years before they must be re-bid. During that time period, it is essential to periodically test the market to ensure that contract costs remain competitive.

Contract compliance is an essential part of a successful contract. A full-time monitor, preferably with hands-on nursing experience, can serve as the liaison between the county and the company.

Positive benefits of the contract included:

- A reduction in hospitalizations, as many more inmates are treated in-house; and
- A reduction in emergency room visits.

At the same time, the total number of medical contacts increased dramatically.

IMPACT OF CORPORATE RESTRUCTURING

In the late 1990s, corporate takeovers changed the landscape in the private health care business. The two major players, Prison Health Services (PHS) and Correctional Medical Systems, resemble the companies they were a few years ago in name only. They have been absorbed or bought out by larger corporate entities. In fact, the founder of PHS is now an employee of the same company, having spent several years in a non-compete status after PHS was bought out. This restructuring resulted in a significant change in corporate policy. The bottom line became the primary consideration.

Our vendor of 12 years suddenly demanded a $700,000 increase in compensation—on top of the $500,000 increase that had been approved as a condition of the contract only two months before. When we refused to comply, the vendor simply exercised the "120-day notice for contract termination" clause, and we faced a crisis. This practice has become commonplace for private health care companies. Faced with less competition due to corporate takeovers, coupled with increased medical costs, they routinely play hardball rather than negotiate.

SELF-OPERATION

In Hillsborough County, we decided to consider operating medical services again rather than agree to an unfounded increase or reduced service. The only way to do that was through a combination of private enterprise flexibility and government service stability. Civil Service agreed to create the necessary positions and authorized 1/3 of them to be

unclassified, which increased our ability to set salaries and hire and fire as necessary without the bureaucracy.

A line-by-line budget analysis concluded that self-operation was competitive with private enterprise because the higher cost of benefits was offset by the corporate overhead/profit margin. Medical staff were receptive to the plan because of its potential for job stability and a secure benefits package. The proposal ran into its biggest opposition from Legal and Recruitment and Screening departments. Concerns over liability were countered by a supplementary insurance policy. Recruitment and screening staff were placated by our agreement to continue the advertising and interviewing process as under the private system.

NEW RFP

Rather than proceed with only one option, we hired a medical consultant who helped negotiate an interim agreement with the current vendor and assisted in development of a new request for proposal (RFP) package, which included three major changes:

Instead of a catastrophic limit per inmate, an aggregate was computed for all inmates. This gave a financial incentive to the vendor to keep expenses below the aggregate cap. The Sheriff's Office purchased catastrophic insurance to cover expenses over the cap.

1. The term "position" was eliminated from all documents and replaced by "post." For 20 years, we had used the terms interchangeably, but they do not mean the same thing. Vendors saw "position" as a person, while we were referring to a spot in the facility. To rectify the problem, we now include a duty roster by shift for each facility instead of FTEs as the standard for staffing compliance.
2. Performance-based standards became the basis for evaluating the level of contract compliance. Ten aspects of care were delineated:

    - Intake
    - Sick call
    - Histories and physicals
    - Infirmary
    - Referral logs
    - Chronic care clinics
    - Specialty consults
    - Medical records management
    - Pharmacy
    - Off-site referral

CONTRACT COMPLIANCE

The ten aspects of care mimic quality assurance studies and accreditation standards; they do not represent anything new for the medical staff. Each aspect has a subset of measures. If the monthly sampling does not reflect at least 80% compliance, a $1,000 penalty is assessed, up to a monthly maximum of $10,000. This represents a major shift from the old method of measuring contract compliance, which was a 200% penalty for the value of each position/post left vacant. Now the contract simply provides for non-payment for the value of services (staff) not provided.

After going through a tedious and complex bidding process, we are about to see whether or not there will be any competition between the available vendors. Depending on the proposals we receive, we may or may not opt to exercise the self-operation alternative.

For additional information, contact David Parrish, Colonel, Hillsborough County Sheriff's Office, P.O. Box 3371, Tampa, FL; 813-247-8310; dparrish@hcso.tampa.fl.us

DENNIS WILLIAMS, ESCAMBIA COUNTY, FLORIDA

BACKGROUND: THE SITUATION IN APRIL 2001

I assumed responsibility for Escambia County's three jails and 1500 inmates in April 2001. At that time, it was clear that health care costs were out of control. Direct costs were $4.8 million, and indirect costs were another million dollars. It was difficult to tell exactly what was happening, however, as there were no good statistics on costs.

I called in a consultant, who spent 30 days on site. Although sheriffs in Florida are not obliged to use an RFP process, there is political pressure to do so. However, the consultant contacted a single health care provider and gave the company 30 days to define what they company would do if it took over operations. For the sake of the inmate population and the community, we decided to lay off all current employees.

The single biggest problem with the existing health care system was that there was no accountability, not even the records on an inmate that you would expect to find in a health file. Over 40% of the inmates were on psychotropic medications. The situation was surprising because Escambia County had been sued in the late '70s and early '80s, and this served as a catalyst for the development of good regulations for jails in Florida and the later development of jail standards.

THE PICTURE TODAY

Today, health care costs are down to $3.6 million and are capped. By working in partnership with our health care provider, we have created an effective cost containment program. The provider met with local hospitals to negotiate cost structures for our inmates. Our standing within the community has improved, and the inmate population is more settled as a result of being treated more fairly.

When I arrived, health care costs were over $9.00 per inmate, and they are now $5.00 per inmate. Despite this reduction in cost, the quality of health care has gone up considerably.

WHAT HAS CHANGED

- **Partnership with medical services.** It is important to make clear to security staff that contract medical staff are part of the facility staff. The security structure in Escambia County has been changed in relation to medical services. Previously, security staff were inclined to send problem inmates to health services staff. We have been successful in changing the staff's attitude to emphasize fair treatment of inmates and in building a partnership with medical services staff.

- **Community awareness.** We have brought doctors from the community into our facilities to help them understand our capabilities. It has been important to do this without being critical of prior practices.

- **Line staff involvement.** We have involved line staff from every shift in decisions and given them a real voice.

- **Innovative program.** Our "Keep On Person" (KOP) Self-Medication Program allows inmates who meet certain criteria to self-administer certain prescription and over-the-counter medications. It has eliminated the need for one full-time nurse.

For additional information, contact Dennis Williams, Escambia County Sheriff's Office, P.O. Box 18770, Pensacola, FL 32523; 850-436-9822; dwilliams@escambiaso.com

OPEN FORUM DISCUSSION: MEDICAL SERVICES

Was there resistance to the Keep On Person policy?

Yes, we spent 30 days training staff about the KOP policy. When we first put it in place, we were comfortable with the program's design, enforceability, and impact, but we needed to hear what staff were thinking. On the basis of their responses, we made some changes. Initially, they were afraid of liability issues, but once they understood the idea, there was no resistance. If polices are well-grounded, take into account good correctional practice, and are sanctioned by the health care provider, they can withstand challenges.

How does the officer know what to leave and what to take when doing searches?

Deputies are educated on what to look for. Participants wear a green ID band on their wrists while they are on the KOP regime. We haven't had a problem with either stealing or hoarding.

Per diems and co-pays are sometimes seen as a moral issue because the poorest of society are being required to pay, and sometimes they are seen as an issue of inmate responsibility.

Until and unless we start requiring accountability, there won't be any changes. Populations in jail are underprivileged, but that is the result of the fact that all of us have failed to address social issues adequately.

Does the Keep On Person program address issues of bartering or theft?

The kinds of medications allowed will not benefit someone else. We had to educate inmates on what types of medicines are being carried, so that they would realize there is no benefit to them. Normal over-the-counter medicines like aspirin are not even included. The program has been effective in reducing staff time devoted to administering medications.

PUBLIC HEALTH AND JAILS:CHALLENGES AND CURRENT ACTIVITIES

ROBERTO HUGH POTTER, CORRECTIONS AND SUBSTANCE ABUSE UNIT, CENTERS FOR DISEASE CONTROL

INCARCERATED POPULATIONS: THE BURDEN OF DISEASE

Inmates have disproportionately high rates of infectious diseases, substance abuse, high-risk sexual activity, and other health problems. Thousands of former correctional inmates return to the community each month, especially from jails. Inmates often have a history of trauma, including physical abuse and violence, as well as chronic illness in their lives, and they are likely to have had poor access to health care prior to incarceration.

- The rate of AIDS is five times higher in incarcerated populations than in the general public; 17% of all those with AIDS in this country have passed through a correctional setting.
- Sexually transmitted disease (STD) rates range from 5%-35% in some jails; up to 35% of STD cases are found in jails.
- Eliminating syphilis in jails may be the key to eliminating the disease in the general population.
- Approximately 80% of inmates are involved in some aspect of substance use and abuse.

CORRECTIONS AND THE COMMUNITY

The problem is not a corrections problem. The diseases enter jails from the community, in part because of a lack of public health programs, including street-level health care workers. However, jails offer an excellent venue for disease screening, initial treatment, and prevention education of high-risk individuals.

It is important to recognize that the problem is the fault of public health, not corrections, but this failure can become a crisis for jails. We do not want to see the health status of inmates returning to the community perpetuate a public health crisis. Therefore, effective corrections/community public health collaborations are needed. The question is: how do we work together to break the cycle?

The Centers for Disease Control (CDC), in partnership with the Health Resources Services Administration, currently has a 5-year demonstration project that involves California, Florida, Georgia, Illinois, Massachusetts, New York, and New Jersey. The project provides counseling and testing, medical treatment, discharge planning, and continuity of care for HIV positive inmates. Many of the funded programs are in jails.

LESSONS LEARNED

- Corrections and public health are both part of the community.

- The health of the community impacts corrections, which, in turn, impacts the community.
- Public health enhances public safety.
- Most prisoners will return to the community.
- Incarcerated populations as a whole are unhealthy.
- Incarcerated populations represent a good opportunity to improve community health.
- Correctional facilities are critical settings for:
  - Early intervention and care;
  - Prevention education and risk reduction; and
  - Behavioral intervention.

"INTEGRATING PUBLIC HEALTH AND CORRECTIONS: PREPARING FOR THE NEW MILLENIUM"

A meeting a year ago in Chicago that included 18 of the largest jail systems in the country focused on public health and corrections collaborations. Teams from various jurisdictions came together to plan collaborative approaches in their communities.

The original plans of the jurisdictions were as follows:

- 8 jurisdictions planned to do disease screening/counseling & testing;
- 6 jurisdictions planned to establish linkages with community providers to do discharge planning or case management; and
- 2 jurisdictions planned to provide disease-related (especially STDs and HIV/AIDS) educational programs for inmates.

Most of the participating jurisdictions did establish some kind of cooperative program, but not necessarily the one they had planned.

WHAT WAS LEARNED ABOUT COLLABORATION

- **"Contextual Factors"—**Contextual factors influencing the degree of success in the collaborative efforts included the following:
  - The bureaucratic complexity of the organizations involved;
  - Prior collaborative experiences, especially in "outbreak" situations;
  - "Champions" within the organizations, especially from the corrections side; and
  - Rapid inmate turnover.

- **"Implementation Factors"**—Implementation factors involved in public health-corrections collaborations included the following:

- The need to think different about each other than in the past;
- The difficulty of dealing with different missions of public health and corrections entities;
- Conflict among participating agencies;
- Local realities;
- Turnover among team members; and
- The ability to involve community-based organizations in the project.

HEALTH POLICY

Public health needs corrections to be actively involved to develop:

- Continuity of care
- Standardized health services
- Ways to conquer recidivism
- Harm reduction inside and outside
- Improved community sentiment
- Elimination of disparities
- Profiles of the economic benefits of interventions
- Collaboration between public health and corrections must support: early detection v. the "Ostrich approach"; early treatment v. "Band-Aid approach"; prevention; education; and continuity of care through case management.

CDC'S ROLE

CDC can provide information on the following:

- Disease surveillance
- Disease treatment/case management
- Behavioral intervention
- Discharge planning/continuity of care (a CDC focus right now)
- Technical assistance and cross training
- Guidance documents

SUPPORTIVE INFRASTRUCTURE

An infrastructure to encourage public health-corrections collaboration would help with the exchange of communications and information between the two sectors. It would also assure corrections of a prominent role in program development, create liaisons with medical staff and between public health and corrections. Such an infrastructure would also promote the value of collaborative services and programs.

STEPS FOR SUCCESS

Corrections agencies should look to the Centers for Disease Control for funding. We hope to develop cooperative agreements with NIC and to work with NIC to define areas of need. At present CDC can only directly give money to public health departments rather than directly to jails. We hope that this will change.

The following are steps for success in involving public health in your activities:

- Include both medical and security in medical services planning.
- Orient and train public health staff on corrections dynamics and procedures.
- Conduct a pilot to troubleshoot potential problems.
- Provide to correctional staff an overview of collaborative projects and their potential impact on detainees and the community.
- Build an infrastructure to sustain programs in the absence of grant funding.
- Learn from other successful collaborations.

For additional information, contact Roberto Hugh Potter, Corrections and Substance Abuse Unit, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, Atlanta, GA 30333; 404-639-8011; rhp3@cdc.gov

OPEN FORUM DISCUSSION: PUBLIC HEALTH AND JAILS

How can we get Health and Human Services to change the rules so that money can go directly to jails?

Someone would probably need to convince the Secretary of Health and Human Services to make the change.

What are some concrete steps to take in establishing public health and corrections cooperation?

Training of public health personnel on corrections is certainly needed. We currently train corrections people on public health issues, but we need to do the reverse, and there is no organized effort at present. It would be useful for you to get involved in national health care organizations.

DENNIS ANDREWS, SUPERINTENDENT, COOK COUNTY (CHICAGO) DEPARTMENT OF CORRECTIONS

BACKGROUND: HEALTH SERVICES AT COOK COUNTY DEPARTMENT OF CORRECTIONS

The Cook County health department runs our department's medical services and is in charge of our medical staff. All employees are county employees. The Chicago Board of Health is also involved. We operate under the Board's budget. Our health services administrator is not a physician.

With our large inmate population, we run the largest hospital and mental health facility in the state of Illinois. There is a 180-bed hospital on the jail compound, which is directly under the Cook County Hospital and offers 24x7 coverage. It includes an emergency room. A range of services is offered in the jail. Mental health staff are on site 24 hours a day. Testing for sexually transmitted diseases is done at intake. Psychiatric patients are given on-site evaluations for treatment.

HANDLING PROBLEMS

Most problems are easy for us to handle. If I get a call from a family or a judge, I simply send it over for medical services to deal with. Essentially, we only have to deal with security issues.

- **Medications.** We were having problems within divisions with having nurses hand out medications. We moved all inmates on prescribed medications to the same units in each facility, which cut down on the time it takes to pass out medications.
- **Changes in** policy**.** We have a committee composed of medical and command staff to talk over any prospective changes. They work together.
- **Aftercare.** The medical services staff can do anything they want to, as they are on their own budget. However, I hired two nurses to educate inmates in AIDS and STDs. We are doing preventive work and also talking about aftercare. A list of homeless shelters is provided to those who are discharged.

For additional information, contact Dennis Andrews, Superintendent, Cook County Department of Corrections, 2700 S. California Ave., Chicago, IL 60608; 773-869-6870.

OPEN FORUM DISCUSSION

How long has the arrangement in Cook County been in place?

The Cook County Health Department has run jail medical services since 1978.

How many of you regularly provide Hepatitis C vaccine to inmates? (a question from CDC)

The CDC is currently working on a plan, which will go to Congress, to fund the purchase of Hepatitis C vaccine to enable the CDC to inoculate high-risk adults. Those under age 19 can already get free vaccines from their local health department, but the CDC wants to vaccinate high-risk people. We'd like you to think about whether you would be willing to vaccinate those coming through your jail. We plan to send a letter to the 50 largest jails in the country about this.

What are the important issues related to health care that should be considered in leadership planning?

Correctional administrators should train their successors on the important issues related to health services. They need to understand risk management and Constitutional issues, especially, if litigation is to be avoided in the future.

SUCCESSION PLANNING: MENTORING AND TRAINING FUTURE MIDDLE MANAGERS

ROCKY HEWITT, ORANGE COUNTY, CALIFORNIA

LEADERSHIP QUALITIES

As a leader, you must establish the "Pygmalion effect" by selling your vision, your expectation, and your values. You want new mangers to value honesty, sensitivity, and cooperation. It is also important for you to set an example of ethical behavior. Take care of your people and make sure that everyone understands that doing the right thing is what is important. Expect your people to be committed and loyal.

ORANGE COUNTY SHERIFF'S DEPARTMENT SUPERVISORS TRAINING

We offer two 16-hour blocks of training in leadership, a total of 32 hours. The training program begins with a breakfast meeting with the sheriff. The remaining 10 training modules cover at least the following topics:

- **Personal philosophy:** Ethics, Leadership, Transitional Change, Motivating Others, and Loyalty.
- **Orientation:** Performance Evaluations, Attendance/Punctuality, Probation, Investigation/Discipline, Medical Restrictions/Workers' Comp, ADA, Family Leave, FLSA Issues, Sexual Harassment, Employee Assistance, Time off for School Activities, and Payroll/Timekeeping.
- **Operational Issues:** Housing Issues, Inmate Classification, Disciplinary Action/Hearings/Appeals.
- **Use of Force:** Use of Restraints, Contraband Search Policy, Allegations of Misconduct, and Strip/Body Searches.
- **Practical Application:** Peer Relations, Briefings, Staff Work/Projects, Performance Evaluations, and Merit Increases.
- **Resources:** Guide to Resources.
- **Panel Discussion.** This discussion includes staff from different areas of the facility.
- **Management Responsibilities.** Watch Commander Responsibilities, Facility Management, Personnel Acquisition, Budget, Labor Relations, Professional Involvement, and Management Performance Plan.
- **Facility Orientation.** Less Lethal Weapons and Feedback/Evaluation.

The program is designed to instill a "can-do" attitude among managers. One of its messages is that you need to be loyal and accept the sheriff's values—or go elsewhere.

For additional information, contact Rocky Hewitt, Assistant Sheriff, Orange County Sheriff's Department, P.O. Box 449, Santa Ana, CA 92702; 714-953-3092; rockhewitt@ocsd.org

AL JOHNSON, TRAINING MANAGER, ST. LOUIS COUNTY DEPARTMENT OF JUSTICE SERVICES

SUCCESSION PLANNING: BACKGROUND

I am Chair of our Training and Development Committee, and the committee and I spent six months reading everything we could find on succession planning. You may be asking, "What is in succession planning for me?" To determine this, you need to ask yourself the following questions:

- Do you have a clearly defined mission?
- Do you believe in and support that mission?
- Do you have a plan in place to ensure that the mission is achieved after you leave or become unable to perform?

One thing we discovered in our research is that raising the issue of succession planning creates resistance on the part of those who will be succeeded. There are a number of reasons for this:

- Current leaders may feel, "It's not my problem; I don't have to deal with it."
- People fear being exposed or criticized.
- Leaders don't like the notion of someone replacing them.

I hope to eliminate some of that resistance. I also intend to guide you along our "hero's journey" and share some of the lessons we learned along the way. A few disclaimers first: what I'm describing is not the only way, and it is not necessarily the best way. We all have different needs, resources, and motivations.

THE HERO'S JOURNEY

The hero's journey is a quest undertaken after an agency has decided to:

- Address an issue or problem;
- Face the challenge and obstacles presented; and
- Resolve the issue and secure a victory over the problem.

In St. Louis County, we took this journey for a variety of reasons. We were faced with massive retirements, with 30% of our executives retiring within the next five years. Our constituency was changing rapidly, as people moved from the city to the county, and our demographics were also changing.

FACING THE CHALLENGES

In designing our Leadership Development Program, we looked at a number of options, including providing the program internally or bringing it in from outside. The literature seemed heavily in favor of internal programs, so we decided to develop our own.

Our core values were the starting point of the program. These values are:

- Integrity;
- Excellence;
- Innovation;
- Valuing people; and
- A focus on results.

We then identified the business outcomes desired and the core competencies needed to reach those outcomes. We also understood very well that leadership could not be taught in the classroom.

GUIDING METHODOLOGIES

Our training is based on an Experiential Learning Model, which uses guided training along with hands-on projects that are directly related to desired outcomes for our organization. However, the following methods are also useful: executive coaching; 360° feedback, in-basket exercises, management development seminars, and job rotations.

CORE COMPETENCIES

Department directors identified six key competencies that are required to support our core values. They are:

- Business knowledge and skills;
- Collaboration;
- Communication;
- Customer focus;
- Managing a diverse workforce; and
- Visioning.

THE TOUGH QUESTIONS

Several questions must be answered and a number of decisions must be made before starting a Leadership Development Program:

- How much will the program cost?
- How will we pay for it?
- Who will coordinate it?
- Who is eligible?
- What is the curriculum?
- Who is eligible for the program?
- What commitment must participants make?

- Will training be done during working hours or after hours?

Answers to these questions will take you a long way toward developing your program.

THE PILOT PROGRAM

Thirty high performers were nominated by their supervisors to participate in the program, which will be 12-18 months long. Every participant must sign a professional development plan, which requires them to assess their strengths and opportunities. Each will develop a portfolio designed to demonstrate the competencies they have learned.

Each participant will be assigned to an advisor as well as to a number of coaches who provide expertise in specific competencies.

CONTINUING THE JOURNEY

Program graduates will keep their portfolios updated and ensure that their skills continue to be used in their work assignments. They will also be expected to serve as advisors, coaches, or instructors in future leadership development programs.

If you are considering taking the journey into leadership development, here are some basic tips:

- Begin with your organization's business outcomes and purposes in mind.
- Identify the competencies required to reach your business outcomes and purposes.
- Provided guided practical training and experience on real-world projects related to your business purposes and outcomes.

Remember that you don't need to do something on a grand scale. Ensure that someone who might succeed you is trained a bit at a time. Delegate, oversee, guide, and support someone who might take your place.

For additional information, contact Al Johnson, Training Manager, St. Louis County Department of Justice Services, 100 South Central, St. Louis, MO 63105; 314-615-4329;al_Johnson@stlouisco.com

OPEN FORUM DISCUSSION: LEADERSHIP TRAINING

One problem is that managers often don't recognize their own abilities. How do you select coaches?

They are chosen for their expertise in specific areas and have been nominated by department heads.

What happens to very competent staff who are not nominated for the program?

They will not participate in the pilot program but may be selected for a later program.

***Is it possible your program is suppressing the dissident—the individual who is extraordinarily competent but who falls outside the mainstream and is unlikely to be selected*?**

There will be later opportunities. Even a dissident has to "play ball," of course, but there will always be participants on whom you are taking a chance.

PREVENTING JAIL SUICIDES

JIM BABCOCK, SACRAMENTO COUNTY, CALIFORNIA

BACKGROUND: SUICIDES IN THE SACRAMENTO COUNTY JAIL

We had a suicide in the jail last fall, which seemed an unremarkable, isolated incident. We did a post-morbidity review and then moved on. Because the county coroner is now the chief administrator of jail medical systems, we developed a Memorandum of Understanding with an adjacent county, so that county's coroner would handle any in-custody death.

In January, we had two more suicides, making three in a fairly short period of time. In February, a notorious inmate committed suicide in the jail. He had been in custody for several months and was not seen as a suicide risk. His suicide created a media stir, including an editorial in the local paper, the *Sacramento Bee,* and coverage by CNN. One issue was that the public defender had filed a motion in court to prevent the jail from giving psychotropic medications to the inmate, and this was publicized as the jail's failure.

We realized how much these suicides were likely to start costing the jail. In response, we set up a Suicide Prevention Task Force to see how we could improve our approach to suicide prevention. Shortly after that, we had another suicide, which was traumatic for custody staff and taken very seriously by mental health staff. I contacted NIC for help, and the agency sent Lindsay Hayes, a national expert on jail suicides, to Sacramento.

SACRAMENTO COUNTY JAIL

The Sacramento County Jail consists of two facilities, holding a total of 3500 pretrial detainees and sentenced individuals. Jail psychiatric services are provided through a contract with the University of California, Davis, School of Medicine. We attract Fellows from around the world, who come to Sacramento to get expertise in forensic psychiatry. The program has a reputation for recruiting and retaining high quality staff.

SUICIDE RATES IN JAILS

Suicide rates are 9-16% higher than in the general population. Nationally, suicide is the leading cause of death in jails. Over 95% of suicides are from hanging. Most suicides take place within the first 24 hours of confinement.

UPDATE ON RECENT SACRAMENTO JAIL SUICIDES

The only common characteristics of the recent suicides in the Sacramento County jail were that they were all male and all deaths were secondary to hanging. There was no other common thread.

SUICIDE PREVENTION TASK FORCE

The Task Force reviewed trends in facility suicides over the past ten years. They conducted an extensive, multi-organizational, multi-disciplinary review of the organization. The Task Force's areas of focus were as follows:

- Screening;

- Training;
- Inmate monitoring (not only by custody staff but by every facility employee);
- Environment/milieu—to identify possible methods for committing suicide;
- Incident training—to improve reporting and documentation;
- Emergency response—to improve intervention;
- Management interventions—the philosophy from the top town; and
- Policies and procedures—to see what needed to be revised.

NIC TECHNICAL ASSISTANCE

The NIC consultant, Lindsay Hayes, did a three-day intensive review of the facility. He supported our current suicide prevention efforts and made recommendations to the Suicide Task Force. The Task Force will remain in effect. Hayes recommended the following steps to improve our suicide prevention efforts:

- **Staff Training**—Train everyone in the facility, not just the custody staff.
- **Intake Screening**—This is a critical step, as it gives the first clues to a potential problem.
- **Communication Between Staff**—Staff must communicate across disciplines. Bring them together to start team-building and sharing information.
- **Safe Housing**—Examine the physical plant to identify opportunities for suicides. Make the plant as safe as possible.
- **Frequent Observation/Supervision**—How often is someone looking in cells? Make sure that they are doing their job and walking around.
- **Prompt Intervention**—Keep emergency medical supplies on the housing unit. Make every effort to save a life.
- **Reporting**—You need to document incidents and keep good records.
- **Mortality Review**—Do a review immediately and use it as a learning tool. Involve all disciplines and all staff levels in a discussion about how to prevent future events.

For additional information, contact Jim Babcock, Chief Deputy, Sacramento County Sheriff's Office, 711 G Street, Sacramento, CA 95814; 916-874-5686.

OPEN FORUM DISCUSSION: JAIL SUICIDES

What training was given to front line staff?

We have built in a formal procedure to train all staff on suicide prevention. It includes annual training as well as updates in alternate months.

We hold an informal meeting every Friday morning to identify inmates who may have made suicide attempts in the past. This has solved a lot of problems.

It is also important to include nurses and doctors in these briefings. The commitment must go all the way to the top, as well. I have recently started holding weekly staff meetings with captains, the medical director, and the mental health director.

The inmate profile seems to be changing. They are in the facility longer and the proportion of Latinos has increased. I'm not sure what is happening, but we may need a new national study of the suicide problem.

The Australian Institute of Criminology has good data on suicides, including related factors in Australian jails and prisons. They are also looking at self-harm in jails and prisons. Perhaps we should ask people if they feel like doing themselves any harm rather than if they ever feel like committing suicide. There is an increase in self-mutilations among inmates, as a form of para-suicide and for some kind of gratification. We may be overlooking this as a good indicator of potential suicides.

Was there anything in the high-profile case that should have stood out?

Not really. When he was admitted, because of the notoriety of the case, mental health staff immediately assessed him. He was put on a suicide watch early on. When he was arraigned, the public defender tried to keep us from giving any kind of medications. There was an incident after he had been in the facility a couple of weeks, however. He jumped from a tier and fractured his heel, but he refused medical attention. In retrospect, we should have noted this more carefully. When he committed suicide, he was in a single cell that happened to have a video camera in it, but the area where he committed suicide was out of view of the camera.

What do you do for staff after suicides? How do you support them?

We do a number of things. Employees can seek confidential counseling through the Employee Assistance Program. We also have on contract psychologist trained in crucial incident debriefing. We also have a law enforcement chaplaincy program staffed by a number of well-trained chaplains who respond to such incidents. There are also built-in protocols in our policies and procedures. It is important to debrief in a non-threatening way. We also debrief staff after a successful intervention into a suicide attempt.

Have you changed your approach to the media?

We try to be very open with legitimate press representatives, but we have a policy of not talking to some members of the press. We have tried to emphasize the proactive steps we have taken, such as bringing in technical assistance and developing a Task Force. We also like to have good relations with the Grand Jury, so we bring them into the facility for a tour. After the notorious case, I called the foreman and offered to provide any information. Instead of starting a counter-productive investigation, the Grand Jury heard about our new direction from our mental health director and from me.

UPDATE ON LARGE JAIL ISSUES

This session provided an opportunity for meeting participants to make general announcements or ask questions and for presenters to provide any summarizing comments they wished to make. Following is a summary of remarks.

- David Parrish, Hillsborough County, Florida. We produce a single staff tracking sheet that is modified daily. It announces the number of vacancies and gives staff a clear picture of the situation with respect to the entire staff.

  On another point: We need a voice in Congress, and I wanted you to know that Gail Raye, Sheriff of Davidson County, Tennessee, is running for election to Congress. She is on the NIC Advisory Board, and she has a real understanding of jail issues.

- Tim Ryan, Orange County, Florida. I wanted to give you a brief update on the American Jail Association. Milwaukee did a very good job at the recent AJA conference, at which there were more than 2000 attendees. The next conference will be in Albuquerque, and if you have never attended an AJA conference, you should consider coming. AJA is different from the American Correctional Association because its focus is only on jails. AJA is beginning to look at the possibility of developing a national jail administrator's academy. Other AJA news:

  - "Who's Who in Jail Management"—a new edition will be out in a few months.
  - The new AJA headquarters in Hagerstown, Maryland, will be completed in the spring.
  - AJA is having budget problems. Staff will face salary reductions, workshops may be cut from two speakers to one, and <u>American Jails</u> may not be as big as in the past. We are looking at the issue.
  - Stephen Ingley, Director of AJA, is considering putting a page in each issue of <u>American Jails</u> on issues that have come up on the LJN Network listserv—which would include nothing that is a security issue. Would you object? (Participants indicated that they would not object.)

- Grace Smith, Jefferson County, Kentucky. I am looking for help in dealing with staff absenteeism. Our employees are increasingly absent from work, and nothing that we do makes a difference. I would appreciate any assistance you can offer.

- Ronald Malone, Milwaukee, Wisconsin. I need help in developing an RFP for food services, including the issues that should be addressed.

- Hugh Potter, CDC. It is clear that CDC needs to work more closely with jails. I intend to start trying to build the relationships that will help both of us. I also wanted to follow up on the topic of suicide. We need to remember that what goes on outside of the facility has tremendous impact on inmates. It is important to control the internal jail environment, but we also need to take account of external pressures on inmates.

TOPICS FOR THE NEXT LARGE JAIL NETWORK MEETING

RICHARD GEAITHER, CORRECTIONAL PROGRAM SPECIALIST, NIC

Richard Geaither led a discussion among meeting participants of potential topics for the next meeting of the Large Jail Network, to be held in early February, 2003. The following topics were suggested:

- Legal issues
- Staff training on ADA issues
- Legislation, grants, and available funding for jails
- Role of jails in counter-terrorism
- MIS in jails
- Juveniles in adult facilities
- Future trends in the U.S.
- Professional standards
- Management accountability for negative supervision
- Assessing the culture of your organization
- Using telephone revenues
- Working with citizens
- Reintegration programs
- Emergency management

Meeting participants selected the following as principal topics for the next meeting:

1. Future trends in the U.S.
2. Legislation, grants, and available funding for jails
3. Management accountability for negative supervision and professional standards
4. Legal issues

For additional information, contact Richard Geaither, Correctional Program Specialist, NIC Jails Division; 1960 Industrial Circle, Longmont, CO 80501; (800) 995-6429; rgeaither@bop.gov

APPENDIX 1: MEETING AGENDA

APPENDIX 2: PARTICIPANT LIST