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PROCEEDINGS OF THE LARGE JAIL NETWORK MEETING

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Proceedings of the Large Jail Network Meeting

January 24-26, 1993

Denver, Colorado

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LARGE JAIL NETWORK MEETING
January 24-26, 1993

This meeting of the NIC-sponsored Large Jail Network focused on the problem of air-borne and blood-borne pathogens--including HIV, tuberculosis, and hepatitis B--in jails.

In 1989, Dr. Louis Sullivan, the Secretary of Health and Human Services, set 2010 as the target date for the total elimination of tuberculosis in the United States. However, it has become clear in recent years that this goal cannot be reached. On the contrary, the incidence of tuberculosis has increased, making it a major public health problem in this country. Jails--especially crowded, poorly ventilated jails--provide a perfect environment for the spread of TB.

Although CDC (Centers for Disease Control) has produced a series of guidelines to assist correctional institutions in dealing with AIDS, tuberculosis, and Hepatitis B, the focus of these recommendations has been prisons rather than jails. Because jails and their populations are very different from the prisons for which these guidelines have been developed, this meeting of the Large Jail Network was designed to provide information specifically relevant to large jails.

Following are highlights of each topic addressed in the meeting:

How Medical Units are Dealing with Blood-borne and Air-borne Pathogens

- "Know your enemy" and "Know yourself." That is, use everything known about the enemy, infectious disease, in establishing a plan. "Knowing yourself" emphasizes the ways in which jails are different from prisons. In this context, Dr. John Clark, Medical Director of the Los Angeles County Sheriff's Department, reported that The Centers for Disease Control (CDC) have agreed to develop separate guidelines for dealing with infectious diseases in jails. This significant development means that CDC is at last recognizing the fact that jail populations differ from those of prisons and, consequently, different guidelines are needed for jails.

- Ensure that jail inmates testing positive for TB continue to take their medication. If an infected person takes Isoniazid (INH) for a prescribed period of time, a full-blown case of TB can usually be avoided. However, incomplete therapy fosters the development of multi-drug resistant strains of the disease. Medical units should use directly observed therapy and work closely with local health departments to continue to track inmates with TB after they are released.

- It is important to screen and test both inmates and staff. Although most jails use skin tests for inmates, this may not be the best approach to testing because results aren't available for seventy-two hours--beyond the time some offenders are in jail. Using mini-xrays or testing only those with apparently active cases may be

preferable. Education can help overcome staff resistance to being tested.

- Isolate infected inmates. A TB patient needs isolation, not acute care. A well-ventilated room, especially one with UV lights, is useful for treating TB patients in the jail.

Exposure Control Plans for Blood-borne and Air-borne Pathogens

- In addition to screening for and treating infectious diseases, jurisdictions' exposure control plans should address universal precautions in handling and disposing of bio-hazardous wastes, including spills of blood and other potentially contaminating substances.

- Equipment and protective clothing should be provided for officers and inmates who must deal with contaminated substances.

- Most facilities have exposure control plans. However, those planning for new facilities may not have recognized the need for special areas as negative pressure chambers or equipment such as ultraviolet lights.

Training Programs on Infectious Diseases

- It is important to train civilian staff as well as the sworn officers who may receive training as new recruits through an academy program.

- Staff training can prevent misunderstandings about infectious diseases. Without training, staff can cause panic to spread throughout a facility.

- Despite their training, however, under the pressure of a real situation officers may still put themselves at risk. It is therefore important to reiterate constantly the importance of following guidelines.

Dealing with Rising Health Care Costs in Jails

- One reason jail administrators might choose to contract health care services is to save money. Another is to protect the jail from liability.

- It is important to re-bid contracts every few years to bring competition into the process.

- Setting a population figure in the RFP may help save money. The RFP must be clear and succinct in defining the size of the population and the services to be provided.

- "Dumping inmates," i.e., finding a way to release seriously or chronically ill inmates from the jail, is a common practice that does save money but can also lead to a lawsuit.

- Some states have passed legislation that makes it possible for counties to charge inmates for medical services.

- One question is whether the public will be willing to pay for special medical provisions in jails. As jails must, increasingly, compete for public dollars with highways, schools, and other public needs, "cost" is no longer simply a dollar amount but involves an assessment of what a community must forego in order to spend money on something else.

The NIC/NASA Project

- The NIC/NASA project is investigating the following NASA-developed technologies for use in correctional settings: 1) VIPER, a non-invasive drug screening mechanism; 2) technology for contraband detection; and 3) a literacy tutor. NASA has done preliminary testing on the first and third NIC is tracking the progress of technology for drug screening that is being developed by U.S. Customs.

The National Institute of Justice

- NIJ has several initiatives that are relevant to jail administrators. The most important is the agency's recent survey on AIDS and tuberculosis, which included jails as well as prisons.

- Preliminary results of the NIJ survey are available, except for data on numbers of cases of AIDS and TB.

- NIJ, like CDC, is only now recognizing the differences between jails and prisons in its approach to survey design. Future surveys will address these differences.

Discussion: Health Care in Jails

- Finally, an important discussion focused on the relationship of health care services in jails to the larger issue of health care in the United States. The two medical directors of large jail systems at the meeting addressed the issue partly in terms of contracting.

- Dr. Williams, from Orange County, California, commented on the ways in which contracting for health care puts the focus on the bottom line and tends to ignore inmates' welfare. He also expressed the opinion that jails' health services should

be the responsibility of a health care administrator rather than the insurance companies that seem to have taken over this country's health care system without really addressing health problems.

- Dr. Clark, from Los Angeles, stressed that the issue is not with how corrections provides medical services but that health care should be seen as a right for everyone as opposed to a commodity. He disagreed with Dr. Williams to some degree, making the point that contracting's appropriateness may depend on the size and location of the facility.

- Jail administrators at the meeting agreed that, although important, cost is certainly not the only determinant in choosing a contractor, that quality of services is crucial.

- Mike O'Toole pointed out that public administrators must constantly balance public policy issues with the need for real-life implementation. What is important--and increasingly difficult--is to maintain the balance between these endeavors.

Session #1: TB and Infectious Diseases

Dr. Randall Reves, Denver Metro TB Clinic, Department of Public Health

Dr. Reves' presentation provided a basic framework for the entire meeting by addressing the following: what tuberculosis is, how it is transmitted, how transmission can be interrupted, and how health care workers and inmates can be protected from the disease.

- *History of the disease.* TB has been around for a long time but has only been understood since the late 19th century. After steadily declining for a number of years, the number of tuberculosis cases has been growing since 1984. There are now more than 20,000 new cases each year in this country.

- *Features of tuberculosis.* Although the disease can involve any organ, 85% of cases involve the lungs. Although not highly infectious, TB has the potential for prolonged latency and can be present in an individual for years.

- *Transmission.* The disease is usually transmitted through the air via microscopic droplets from infectious cases. Other means of transmission, including close contact and surgery, are rare. The droplets, which can remain suspended in a room for hours, can be produced by coughing, sneezing, or talking. Droplet nuclei then bypass natural defenses in the body to reach the alveoli, the primary site of infection.

- *Detection of infection.* Infection can be detected through a Mantoux tuberculin skin test within two to ten weeks. A positive skin test shows the presence of the infection but does not indicate an active case of TB.

- *Risk factors for active cases among those infected.* Following exposure to an infectious case, risk factors for getting the disease include: age (peaks at about five and nineteen years), exposure intensity, time since infection, size of reaction and exposure history, lung lesion, HIV infection, and other immuno-suppressed states. Minor risk factors include gender (an 18% higher risk for women) and ethnicity (Asians and Blacks are at higher risk).

- *TB among corrections populations.* According to 1984-85 data for twenty-nine states, the one-year case rate among corrections populations was 30.9 per thousand as opposed to 1.0 among non-corrections populations.

- *Multi-drug resistant TB.* Outbreaks of multi-drug resistant (MDR) TB commonly occur in hospitals, correctional facilities, homeless shelters, residences for AIDS patients, and nursing homes.

- *Actions to reduce risk.* Improve ventilation so that there is a total exchange of air

in room six times an hour. Ultraviolet (UV) light, properly designed, can produce the equivalent of thirty air exchanges an hour.

All HIV+ individuals and those with undiagnosed pulmonary disease should be suspected of having TB and isolated to prevent others' exposure. Patients should cover their mouths when coughing and continue taking medication.

- *Screening.* Screening recommendations from the Centers for Disease Control are designed for prisons, not jails; however, CDC recommendations are relevant for employees. The skin test is not ideal for jails, as results are not known for two to three days. It is important to x-ray those with coughs and use sputum smears to screen those with abnormal x-rays.

- *Involvement of the health department.* Jails should have a good system for communicating with the local health department when someone in the jail is identified as having TB because that person is a risk to family and other close contacts.

- *The First Maxim for a Jail Screening Program:* Don't start a screening program unless you are prepared to do follow-up, including therapy for the prevention and treatment of the disease.

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Session #2: How Medical Units are Dealing with Blood-borne and Air-borne Pathogens

Dr. John Clark, Medical Director, Los Angeles County Sheriffs Department, and
Dr. Ernest Williams, Medical Director, Orange County, California, Sheriffs Department

The responsibility for screening, diagnosing, and treating TB is increasingly landing at the door of the correctional reception center. In this session, directors of two sheriffs departments' medical units describe their jail systems' approaches to dealing with the problem of tuberculosis.

Background

We think of tuberculosis as a disease of the past, but there has been a strong resurgence of the disease in this country. Los Angeles County, for example, has 2,000 TB patients and spends $4 million each year on the disease.

New York City and Los Angeles now lead U.S. cities in the numbers of TB cases. Los Angeles has a large number of victims among the following groups: children under six--the number doubled in the past year; the homeless--about one half have TB; drug abusers; immigrants--60 percent of TB patients are immigrants from Southeast Asia and south of the U.S.

border. The county is fortunate that it didn't dissolve its TB health system when the disease seemed to be dying out.

In Los Angeles, one of ten patients has multi-drug resistant TB. The result is that what should be a six-month treatment at $10,000 costs ten times that. Because patients can contract multi-drug resistant TB if they don't continue taking medication, L.A. is now providing incentives to the homeless--including food, lodging, and transportation--to get treatment. To get patients' cooperation in taking their medication, there is even a move to quarantine some patients.

The Circle of Infection

To pass the disease from one person to another, the circle of infection must remain unbroken. This circle requires a point. of entry, a host, a point of exit, a reservoir, and a portal of exit. Also needed is a mode of transmission, a method of spreading the disease from host to host, which can be either: 1) direct (touching, biting, kissing) or direct projection (coughing, sneezing) or 2) indirect (the infectious agent is deposited on inanimate items that are transported to a host). Tuberculosis uses both direct and indirect means of transmission, as it is passed through coughing, sneezing, or indirectly through air systems. To keep the disease from being passed on, you must break the circle.

"Managing TB in Short Term Correctional Facilities: Strategies for Guerilla Warfare," Dr. John Clark, Los Angeles, California

Principle #I: Know Thy Enemy.

The epidemiology of tuberculosis is well known. We know that TB is caused by a bacterium that is spread through airborne droplets. Although most people who are exposed never develop active tuberculosis, there are some circumstances that make an infected individual (i.e., one with a positive skin test) more likely to develop the active disease. These include suppression of the immune system; chronic diseases (liver disease, alcoholism, diabetes, etc); intravenous drug use; homelessness, malnutrition, and/or other factors associated with lower socioeconomic status; and institutionalization.

Principle #2: Know Thyself

It is important to know the nature and characteristics of short-term correctional facilities and to recognize that they are different from prisons. Jails are unique in terms of their population and the transient nature of that population. Jail inmates are very different from prison inmates, for whom most guidelines have been developed. At long last, however, in a significant acknowledgement of this difference, the Centers for Disease Control have recently agreed to develop separate recommendations for jails.

- *Surveillance and Reconnaissance.* It is important to maintain data on communicable diseases in the jail in order to track changes year to year and make comparisons with other communities in the state. Such trend analysis helps determine how to use your existing resources. For example, the L.A. County Jail was not taken by surprise by the growth in TB because the medical unit has been tracking its gradual increase for years.

- *Screening.* All new employees, both sworn and civilian, must have documented proof of a TB skin test. All medical employees and all custody staff assigned to medical units should be evaluated annually for TB. Every inmate is screened by x-ray, which requires 800-1,000 tests a day in Los Angeles. The department uses mini x-rays rather than skin tests, which aren't final for 72 hours. A radiologist reviews the mini x-ray by the next morning, so inmates with TB can be receiving medication within twenty-four hours.

- *Diagnosis/isolation/treatment.* The x-ray is only an initial screening device. Those with positive x-rays are given additional tests to determine if they are infected.

  Isolation: A TB patient needs a place to be isolated, not acute care. Counties could avoid the $1,000 a day it costs to keep a TB patient in the hospital by keeping inmates with the disease in an isolated place in the jail.

  Treatment: Use directly observed therapy (DOT). Inmates with active cases of TB must be observed taking their medication. On principle, you must watch all inmates take TB medication, although a compliant individual might prove him/herself responsible enough to be on self medication. Directly observed therapy is essential during the first two weeks of treatment in respiratory isolation and the first two weeks of treatment out of respiratory isolation. DOT is also recommended for the next four weeks.

  UV Light has been shown effective in treating TB, although there is some concern regarding its harmful effects on eyes. Los Angeles is planning to put portable UV units in the jail's housing areas.

- *Other Issues:*

  Air flow systems--You must have an effective air flow system and good ventilation to prevent the spread of the disease. A negative air flow chamber is desirable.

  Training--Staff training is crucial.

  Notification of the county health department--It is extremely important to notify staff of the county health department as soon as you have a suspected case. This cooperation is important because the county may have already identified the individual and be tracking him/her. In L.A., two county health department employees actually work at the jail.

Managing TB in Orange County. Dr. Ernest Williams, Orange County Sheriffs Department

It is especially important for smaller jails to work closely with the public health department. In Orange County, the jail's medical staff meets regularly with the county public health staff.

It seems to be most cost-efficient to screen with x-rays when there is one intake location for medical screening in the county jail system. Orange County used to x-ray inmates; because x-ray machines cost up to $300,000, medical staff are having difficulty convincing the public health department to return to this approach. Instead, nurses now survey everyone at intake and note symptoms suggesting the possibility of TB. Those suspected of having the disease are isolated and tested earlier than other inmates, who are given a skin test after fourteen days.

Because health staff often don't know when inmates are released, one way to encourage them to continue taking medication is to include in infected inmates' property a packet containing two weeks supply of medication. This practice may reduce the chance that the same inmate will return to the jail with an active case.

Orange County received funding last year for a pilot study on testing custody staff. Of 1100 staff tested, 9.6% were found positive. As expected, the highest rate was among staff at the inmate reception area, and the lowest rate was at the newest facility, probably because its air exchange system and environment are not conducive to transmission.

Highlights of Group Discussion, Session 2

- *Confidentiality issues.* Some states' laws prohibit the medical staff from divulging outcomes of medical tests. There was some discussion, however, about the fact that the jail is inextricably linked to the community and thus should divulge test results as a matter of public safety.

- *Employee issues.* Staff and unions often resist mandated testing. Some jurisdictions require a skin test at hiring but do not insist on follow-up testing after that. Do employees request transfers if they are working in areas where exposure is likely?

- *Working with the public health department.* It is useful to combine the files of the jail, the health department, and other local human services agencies. In some jurisdictions, jail are now competing for resources with public health.

- *Shortage of health services staff.* Limited resources and staff make it very difficult to follow suggested guidelines, especially regarding employee testing.

- *Hepatitis B.* Several agencies provide testing and treatment for hepatitis B but have been less concerned about tuberculosis, in part because there are more federal regulations related to hepatitis than to TB.

Session 3: Exposure Control Plans for Blood-borne and Air-borne Pathogens

Administrators of large jails are becoming increasingly aware of the need to protect both staff and inmates from the risks posed by blood-borne and air-borne pathogens. Some jurisdictions have followed federal guidelines in developing policies, while others have initiated their own approaches.

Milwaukee County's Exposure Control Plan
Richard Cox, Milwaukee County, Wisconsin

Milwaukee County is in the process of making the transition into its new jail. The jail, which is under the sheriff's department, houses pre-trial inmates only, while the House of Correction holds only post-adjudication inmates. There is currently a plan to create a single department of corrections in Milwaukee County, thereby eliminating the duplication involved in having two separate jurisdictions.

The state of Wisconsin adopted OSHA's guidelines for blood-borne pathogens, except for those addressing the timing of training. Thus, Milwaukee County's exposure plan specifically addresses only air-borne pathogens. Highlights of the plan are as follows:

- Surveillance--The county closely monitors staff and inmates to identify cases of TB.

- Education--The health services unit provides education on exposure control to staff when they are hired and annually thereafter. It is very important to provide good information to staff, who may spread panic when they don't understand. All health services unit staff are also county employees.

- Screening--Inmates are screened by a nurse prior to admission. The screening, which includes a physical examination and screening for TB, takes place at the sallyport before the inmate actually enters the jail. Employees are screened by a separate health services unit in the jail.

- Isolation--On the advice of a consultant, the new jail has three isolation cells to hold inmates with TB symptoms. If there is no other option, they are taken to the hospital.

- Chest x-ray--Those with a positive skin test are x-rayed to evaluate their need for preventive therapy.

- Case reporting--All cases of TB are reported immediately to the Milwaukee Public Health Department.

- Close contacts investigation--To contain the spread of the disease, the department checks on all those in contact with positive cases.

- Regular treatment--The public health TB nurse sees inmates who are on treatment monthly.

- Continuity of care--The public health department is given as good an address as possible when an inmate with TB is released.

Milwaukee County has also had one case of legionnaire's disease. An anomaly, the case involved a healthy male. No one else in the housing unit had symptoms. The facility management contacted the manufacturer of the mechanical air system to correct the air flow in the facility.

Jefferson County's Exposure Control Plan
Joe Payne, Jefferson County, Kentucky

Jefferson County's Plan provides for:

- Vaccinations--All employees are vaccinated against Hepatitis B.

- *Training--The* county invited OSHA's Office of Health Compliance Assistance to look at the agency's training format, policies and procedures, noise control, and treatment of blood-borne pathogens. OSHA inspected the facility and wrote a letter defining all shortcomings they identified. OSHA also helped the county formulate its policies and procedures.

- *Universal* Precautions--Jefferson County assembles a packet of protective clothing for officers to wear in case of a blood spill. The packet is provided in all vehicles and on every floor of the jail. The county buys the materials in bulk and assembles the packet at a cost of about five dollars per packet.

The county found the following documents helpful in developing its exposure control plan:

Core Curriculum on Tuberculosis, Centers for Disease Control.

Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard, 29 CFR 1910.1030,OSHA.

Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers, Centers for Disease Control.

Hillsborough County's Exposure Control Plan
David Parrish, Hillsborough County Detention Facility

In June 1992 Hillsborough County established a committee of sheriff's office employees to put in place procedures to deal with blood-borne pathogens. The committee was initially developed in response to the needs of officers on the street who wanted procedures to follow in dealing with evidence or in notifying the county after the possibility of contamination. It then became clear that this was also an important issue for the jail system.

The county's plan addresses the following:

- *Inoculation*-- Important considerations include who gets inoculated and who pays? Will everyone be inoculated or only those who have contact with inmates? How do you deal with refusals? (This problem can be handled through education, but you need a procedure to deal with it.)

- *Training--Include* two to four hours initially for everyone, initially, not as part of the inservice training cycle. Following that, provide annual training for all sworn and unsworn officers alike. The person selected to do the training should know the topic well and be able to give very simple explanations. In Hillsborough, a psychiatric nurse practitioner who also handles workers compensation provides the training. Legitimate claims under workers compensation should be covered that way.

- *Equipment--The* county has equipment similar to Jefferson County's as well as materials needed for clean-up. It is crucial to include gloves, which are often all that are needed.

- *Disposal of bio-hazardous* waste--The facility provides special red bags and dumpsters for disposal. They worry about anything sharp and anything contaminated, even laundry. This is not just a medical issue, but applies to the kitchen, the laundry, everything you deal with on a day-to-day basis. Although the facility usually emphasizes recycling, this is an important exception, a whole new industry.

- *Standard Operating Procedures--Policies* and procedures are often complex, too long, and hard to understand. It is important for them to be comprehensive and detailed, but it is best to keep them simple.

Highlights of Group Discussion, Session 3: Exposure Control Plans

- *Model Plan.* Is there a model plan providing basic information on how to deal with specific risk situations and identifying the equipment and materials needed?

- *Timing of screening.* This is an important issue. Is the arresting officer still there when the inmate is screened? Is the offender already inside the jail?

- *"Dumping" inmates.* Attempting to get inmates released when they are critically ill or pregnant to avoid paying for their treatment is a common practice, but a lawsuit can result.

- *Risk Management Teams.* Self-insured states often have risk management teams that focus on liability; their purpose is to identify where you will lose money if something goes wrong. Risk Management Teams can spearhead facility modifications, purchases of special equipment, and training. County risk managers need to understand the importance of funding effective control plans.

- *Need for special equipment.* Exposure control plans are not new, nor is the need for training or some types of equipment. However, those planning for new facilities may not have thought of the need for such things as negative pressure chambers or UV lights, although they seem to be important.

- *Liability.* Even if it is impossible to insulate your facility from staff complaints or eventual lawsuits resulting from exposure, training and use of protective devices are mandatory. What happens if inmates actually do the clean-up? What is the liability in such cases?

- *Use of protective equipment.* There may be some over-reaction in using the protective suit. Gloves may be all that are necessary. Common-sense precautions such as washing one's hands are also obvious. Training is needed on when to use protective clothing. Even with training programs, special equipment, etc, at the moment of emergency, officers often put themselves at risk.

- *Public acceptance.* How far will the public go along with hermetically sealed facilities? Prohibitively expensive, such facilities will be competing for public dollars with highways, schools, and other needs for public dollars. Because of budget restrictions, the cost is no longer simply the dollar cost, but what the community has to forego to spend the money in a certain way.

- *Cost-saving measures.* All facilities should have exposure control plans, but there are ways to save money. For example, kitty litter can be used to pick up blood and body fluids. Rather than buy special biohazard containers, it is possible to meet the standard by using what you have.

Session 4: Training Programs on Infectious Diseases

Special equipment and policies addressing infectious diseases are ineffective unless staff are trained. Without training, staff can misuse equipment and spread misinformation, even panic, among those in the facility. This panel described two jurisdictions' approaches to training on infectious diseases.

Las Vegas Metro Police Department's Training Program.
Paul Conner, Las Vegas.

In addition to training, Las Vegas takes the following steps to protect staff from infectious diseases:

1. maintains a record of vaccinations for each employee;
2. provides personal protective equipment to employees; inmates are also provided with equipment;
3. provides a quick reference guide identifying three levels of exposure;
4. uses an acceptance/refusal form to get staff to agree to vaccinations;
5. uses a model procedure for exposure notification.

Las Vegas initially had to train 1500 employees in three months. Fifteen volunteers with EMT training provided two days of training to all employees.

Training is provided for new officers. Civilians employees present the biggest problem because they are put on the job immediately, while sworn officers go through the training academy. Civilians are also at risk and need training.

It is also important to notify officers of the need for a second shot. Eighty percent of Las Vegas' officers have had shots, at a cost of $27,000 for vaccine. Street officers go to the jail for their shots.

Sacramento County's Training Program
Robert Denham, Sacramento County Sheriff's Department

Sacramento became concerned about communicable diseases because, along with New York, California had the largest number of HIV/AD cases in the country. The purpose of Sacramento County's training programs is to provide accurate information to help employees deal with hazards on the job.

It is clear, however, that training may not prevent officers from acting. Under the pressure of the situation, they are still liable to put themselves at risk and maintain, during debriefing, that they "did what they had to do." For this reason, it has been important to emphasize constantly the importance of following the guidelines.

Our training begins in the academy for new recruits. The Sacramento Area Red Cross and local fire fighters have together developed a guidebook for fire, law enforcement, police, corrections, and ambulance personnel. In addition to producing a manual that includes modules on every topic the group also provided twenty-four hours of training for trainers.

A four-hour block in the annual training for officers is devoted to infectious diseases. Sacramento also does debriefing following all incidents of exposure. The medical staff meets with those who were involved to evaluate what was done during the incident. They also counsel and provide information to those who were exposed.

Highlights of Group Discussion, Session 4: Training Programs on Infectious Diseases

- *Training.* In Contra Costa County, the union went to bat with the county board of supervisors to get training, but it is often hard to get funding for training. Could NIC fund regional presentations for health workers, staff, and administrators?

- *Rumor* control. Training is important to control rumors and stem potential panic among both staff and inmates.

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Session 5: Dealing With Rising Health Care Costs in Jails

Although the problems addressed by previous panels are clearly soluble, the question is how do jails address this increasing mandate within fixed--or shrinking--resources for which other mandated activities are competing. Members of this panel face this question in a variety of ways: by contracting for services, by attempting to get seriously ill inmates released, and by charging inmates for their medical care.

Everett Rice, Sheriff, Pinellas County Corrections Bureau, Largo, Florida

The first question a jail administrator asks is whether you really save money by contracting part or all of your health care services. The answer, unfortunately, is that it's not clear. Under a tight time schedule, after contracting for ten years, we tried to figure out what it would cost to run our own health services.

I believe that if you approach contracting correctly, you save money. There are, in any case, two other advantages to contracting: 1) you don't have the burden of running the health care unit, and 2) you can contract away most liabilities. Even government entities that are self-insured can avoid medical malpractice liability through contracting. Through the indemnification clause of our current contract, for example, the health care provider will have to assume responsibility for the recent death of an inmate.

It has also occurred to me that it is not really the sheriff's responsibility to deal with sick people--that the county or the health department ought to take responsibility for the health services contract. Although, because of political considerations, there was no way to arrange this in Pinellas, I think jail administrators should seriously consider getting completely out of the health services loop.

Nevertheless, following are some things we have learned:

- *It is important to re-bid contracts.* Because there are plenty of companies ready to compete for your business, reopen the bidding to make sure you are getting the best bargain. Otherwise, things seem to ease up and coverage goes down.

- *Make sure the contract is accurate.* In general, health care providers are responsible. Nevertheless, even though most major companies are trying to do a good job and satisfy their clients, the contract must be right.

- *Monitor the contract. You* must monitor the contract carefully to make sure the contractor is doing the job right. You need to have a reliable person on-site who works for you to ensure the contract is going well.

- *Set a population figure in the contract.* This has saved us a lot of money. We figured out what our average daily population ought to be and used that as a line in the contract. The contractor has to refund a per diem for each inmate below that number; if it goes over that figure, we pay. Because our population seems to be going down, this approach has saved us about $60,000 since August.

I may be wrong, but my philosophy is that it is the responsibility of the medical industry, not jails or county government budgets, to take care of sick people who can't afford health care. If we get a very sick person, the first thing we do is try to figure out a way to get him or her out of custody so the person is not the jail's responsibility.

After three or four contracting experiences, Pinellas County has finally removed the kinks from our contracts. I am convinced that contracting health care is the best way both to reduce costs and avoid liability.

Don Amboyer, Macomb County Jail, Mt. Clements, Michigan

Macomb County is located in southeastern Michigan and is part of the tri-county area that makes up metropolitan Detroit. The county population is about 850,000; the capacity of the Macomb County Jail is 1100, probably one of the smallest jails represented here.

Over the last twelve or thirteen years, the jail has expanded rapidly. When I started at the jail, a father and son were physicians in the jail. All of a sudden, we were inundated with a great number of lawsuits. This, in fact, was what caused us to look seriously at contracting.

At that same time, we 'were building a 640-bed addition to our facility. During that process we developed a unique contract with the Michigan Department of Corrections, which didn't have the space for additional beds. Under that contract, the state loaned our county $6.5 million to add four floors to a high-rise tower in the facility. Our agreement with the state was that we would house up to 216 state prisoners until that amount was amortized--which took about four years and two months. Following that, we continued to house state prisoners for two more years at $56 a day, an important revenue source for us that saved county taxpayers a lot of money and another reason we thought it incumbent on us to look at contracting medical services at that time.

My comments today center on three issues: the RFP process; what we call "court cooperation" (and in Florida is called "dumping"), and our prisoner reimbursement program.

- *The RFP Process.* We put our health services out for bid on a three-year basis, which keeps the current contractor on its toes. The RFP itself must be succinct and spell out clearly the level of services to be provided. We've become very stringent in defining what is and is not included because we have learned that we are very likely to have to refer back to the RFP later. Perhaps the most critical aspect of our RFP was that we requested bids for all categories for all sizes of population. This made it possible to compare bids accurately and in terms of exactly the same things.

  Macomb County selected the county hospital as contractor. Although the hospital's bid was actually higher than that of some private contractors, other contractors didn't project costs of some services. We are also using the county hospital to provide mental health services because their bid was lower than that of the county mental health department. The county does not have a contract monitor; instead, the county internal audit bureau reviews hospital records and does audits.

- *Court Cooperation.* Offenders are not in the sheriff department's custody until arraigned; in the meantime, they are in the custody of the police. It is not unusual for a judge to arraign a person in the hospital in order shift the cost to the county from the municipality.

  Unfortunately, our county judges are not inclined to release offenders on any kind of pre-trial basis, whether through lowered bonds or RORs. Nevertheless, the jail administration tries to identify those in jail who could be better served in the community because it would save money. We try to have these offenders released on their own recognizance or, if the offender has already been sentenced, we try to convince the judge to suspend the balance of the sentence. Some judges say they can't legally release these offenders, while others will do so after a show of cause hearing.

- *Prisoner Reimbursement.* A Michigan statute allows counties to recover the cost of housing and medical care of inmates. We charge sentenced inmates $35 a day for housing and, in addition, we bill them for medical services.

Everyone receives services whether they can pay or not; no one is ever denied services. But, as we all know, some incarcerated individuals are in fact quite wealthy and have the ability to pay for services. Those are the people we are concerned about. Everyone is billed, but the county does not actually collect from everyone. The Macomb County Jail is accredited, so all inmates receive a physical at no charge within the first fourteen days of incarceration. For every additional visit to a medical provider, the inmate must pay. The result has been that fewer go to sick call because they will be charged.

When inmates receive outpatient care, the hospital itself bills the inmate patient for three months after he/she has been released. The hospital also bills third party insurance carriers, where applicable. If they haven't received payment within ninety days, the hospital bills the county, the "payer of last resort." In cases where the inmate is wealthy, the county has used writs of attachment, wage garnishment, and the interception of income tax refunds to collect money owed by previous prisoners. Last year, Macomb County received $776,000 in housing reimbursements and $135,000 for medical services.

Politically, this is a very popular program. The sheriff ran for a fifth term on the issue of prisoner reimbursement and won hands down. The idea is that prisoners are held accountable, not only for their actions, but for some of the expenses borne by taxpayers.

Highlights of Group Discussion, Session 5: Dealing with Rising Health Care Costs.

- *Interval between RFPs. Three years* seems a short time for review. Hillsborough County built in optional extensions up to four years, which gives the vendor an incentive to continue to perform well.

- *Vacant positions.* Some jurisdictions include a provision in the contract that they will not pay for a position that is vacant. If a position is not staffed during a shift, this might also be considered a material breach of contract.

- *Flat price for population.* How do you know you are looking at comparable services? How do you ensure quality?

- *States allowing reimbursement. You* need to know if there is enabling legislation for charging for housing or medical care in your state. Despite broad commonalities among states, varying legislation and legal frameworks limit change or provide different possibilities.

- *Contract monitor.* If you use the county auditor, you must still pay by the hour for work for the jail. Although one agency uses an MD for internal review, no counties represented at the meeting use an MD as contract monitor.

- *Liability insurance.* In some instances, the contractor provides medical malpractice

insurance and the county provides civil liability. In Macomb, the hospital indemnifies the county, but the county pays additional premiums for medical malpractice.

- *Inmate dumping.* Participants expressed caution about inmate dumping, although it is common practice to try to remove sick inmates from the jail's responsibility through a pretrial release program, ROR, or reduced charges.

- *Contracting for health services.* There was an important discussion on this issue. Dr. Williams, from Orange County, noted that he was against contracting for health services for three reasons:

  1. When you focus on the bottom line, you don't look at quality, which sooner or later affects what happens to the inmate population. Health care in jails is part of the larger social issue of health care.

  2. In addition, the accreditation process for contractors is usually wired. All a contractor has to do is call downtown or the central office to get information needed to pass the accreditation process.

  3. Finally, health care provided for those in jails should be the responsibility of a health care administrator as opposed to the insurance companies that have now taken over the health care system and don't really address the health problems in this country.

Administrators responded that price is not the only determinant of choice of providers, that quality is an issue. Dollars are important, but they aren't everything.

Dr. Clark commented that the "bottom line" is the inherent problem with our health care system in the United States. The problem is not with how we provide medical services in corrections, but that health care <u>should</u> be seen as a right for everyone as opposed to a commodity.

In terms of contracting, Dr. Clark said that there is room for a combination of approaches. Its success may depend on the location and size of the facility. With facilities holding 2,000 or more inmates, the efficiency and effectiveness of contracting may start to go down. In L.A., most medical services staff are employed by the sheriff's department. However, services are contracted for a small facilities located in a remote area of the county because it is logistically impossible to staff a facility eighty-five miles away. Contracting is also useful for certain kinds of services, such as dialysis, diagnostic radiological services, MRIs, catscans.

Session 6: The NIC/NASA Project
Susan Hunter, Chief, NIC Prisons Division

The NIC/NASA project grew out of a series of meetings in 1990 in which NIC and NASA discussed the tremendous technological needs in corrections and NASA's mandate to use space technology to benefit society. As a result of those discussions, the two agencies developed an inter-agency agreement to work together.

NIC began the project by having to learn about NASA's technology and the technology transfer process. To identify corrections' needs, NIC met with technical utilization groups in various states and brought together practitioners in prisons, community corrections, and jails to talk about their needs. Two meetings were held, one on each coast, between NASA scientists and correctional practitioners to identify problems in corrections that might be addressed through technology and to hone in on potential technologies that might be applicable to corrections.

In mid-1991, a group of correctional practitioners met to identify specific priorities for this project. The resulting priority areas were:

1. High priority: contraband detection, drug use detection, and computerized literacy tutor (because NASA had the technology);

2. Medium priority: perimeter security, electronic monitoring;

For each area, the groups developed problem statements that were sent to all nine NASA stations to identify what technologies might be available to address the priority needs. Following this, NIC funded feasibility studies on each technology NASA identified as applicable. The result was a plan for how the technology could be applied to the correctional issue, what the cost would be to develop it, and its likely benefits.

If a technology was found feasible and affordable, the next step was to develop a working model of the technology as it would apply to corrections. Following that, NASA was to find a vendor to develop it, test market it, and put it out on the market. NIC's approach was the most economical possible, as the Institute served as catalyst to encourage others to develop the technology.

The following technologies are under now investigation:

*VIPER (Visual Identification and Processing **of** Eye Responses):* a non-invasive drug screening mechanism. Like a viewfinder at the drivers' license bureau, VIPER scans eyes to determine drug/alcohol use within the past forty-eight hours or so. VIPER is not in itself a test but a quick-screening device that indicates drug or alcohol use. If drug use is indicated, an actual test is performed.

VIPER has gone through several stages of development. A working model is currently

being tested by the Monrovia Police Department, Monrovia, California. NASA is also currently looking for a vendor. When one is found, VIPER will be available for purchase within the next year.

Contraband Detection. Finding a technology to help corrections agencies detect contraband has been the greatest challenge. The search is for an inexpensive, non-invasive way to screen for contraband. The goal is to be able to identify any non-body substance in or on the body, perhaps by having the individual go through a special door frame equipped with a scanning device.

Although magnetic residence imaging (MRI) seemed promising originally, NASA's Pasadena lab did a feasibility study that determined it would take at least $1 million to develop MRI for corrections' use. NIC tried to work with the larger state and county corrections departments to come up with the million dollars needed to develop the technology. However, potential contracts with California and New York collapsed because of the states' economic problems. The prospect of following through on MRI still exists, but the money isn't available at the present time.

U.S. Customs is working on a similar technology called nuclear magnetic resonance, however. The technology involves a light that would blink to indicate the presence of a non-body substance in or on a body. NIC is tracking the progress of this technology and has also contracted other federal labs to identify other work being done in this area.

Literacy Tutor. Unlike most literacy tutors, the one being developed by NASA is both interactive and voice-activated. The benefit of voice activation is that it will enable illiterate inmates to start the tutor and begin to learn basic skills even before they are able to use the keyboard. The literacy tutor will also provide specific evaluation feedback, analyzing inmates' problems to let teachers know exactly what kinds of mistakes are being made. Correctional education specialists, who indicated that this technology would be useful, are working with NASA to make the software relevant to correctional settings.

The model is ready for preliminary testing, and NIC hopes to have it available at the ACA meeting in Nashville this summer. NASA is also looking for a vendor for this product. When one is identified, it will take about a year for the literacy tutor to be available for the market.

Telemetered Drug Detection. This technology looks for traces of drugs in skin or sweat. The feasibility study has been completed, but the technology will take a year to two years to develop. As the technology involves detecting drugs, NIC is looking to the drug czar's office for possible funding.

Kevin Jackson, who has responsibility for the NIC project, is available either at NASA or at NIC.

Session 7: NIJ's Involvement in Jails Issues and the Survey on AIDS and Tuberculosis

Virginia Baldau, National Institute of Justice

The National Institute of Justice (NIJ) is charged with research and development on the prevention and control of crime and the improvement of the administration of justice. NIJ addresses the full spectrum of the criminal justice system.

Current NIJ initiatives of interest to jail administrators include the following:

- *Drug Use Forecasting (DUF)* -- tracks levels and types of drug use among arrestees in twenty-four major metropolitan areas; quarterly and annual reports are produced.

- *Jail industries -- an* early effort, some of it done in collaboration with NIC; the agency will publish five case studies of jail industries programs and a marketing workbook.

- *Boot camps in jail settings* -- a study done by NCCD.

- *Drug treatment in jails -- NCCD* is evaluating drug treatment in Santa Clara, Contra Costa, the women's facility in Los Angeles, New York City, and Westchester County; the study looks at the interaction of offender characteristics with program elements to determine effective combinations. To be published early in 1994.

- *Construction Directory* -- NIJ-ACA listing of new construction; a third issue on new construction will be ready by the American Jail Association meeting in May. NIJ also provides referrals and information from a construction database.

- *Post-occupancy studies* -- An NIJ Fellow, Carol Knapel, is doing research on post-occupancy; the results will be incorporated into NIC training.

- *Technology* -- recently developed interagency agreements with national labs and professional justice associations;

- *National Assessment Program* -- a family of surveys of seven different sub groups in corrections, including jail administrators. We send the survey to the 275 largest counties and a stratified sample of smaller counties. The survey addresses needs, priorities, workload, staffing. Administrators will receive the survey this spring and are encourage to respond, as NIJ will use results to plan programs, training, and dissemination activities.

Sherry Crawford, NIJ AIDS Project

NIJ has done annual surveys on AIDS in correctional facilities. Results have made it clear that state correctional systems and some large jail systems sponsor AIDS educations

programs for inmates. NIJ's video tape on issues related to maintaining a drug-free lifestyle is the first step in a larger project. NIJ is also producing a case management manual to assist jails and community services agencies in providing referrals to housing, drug treatment, and other services needed by repeat offenders.

Because of budget constraints, NIJ did not conduct an AIDS survey in 1990-91. The survey was started again FY '92 and added questions on tuberculosis. This meeting has made clear other health care issues of concern, including some that are specific to jails.

Ted Hammett, Preliminary 1992 Findings from NIJ's Aids Survey

NIJ hopes to make future versions of the survey more responsive to jails, as previous versions paid insufficient attention to the particular problems of these types of facilities. The meeting has been enlightening, especially in pointing out the rapid turnover in jails, and the implication of this for controlling HIV and TB in these settings.

The following data are based on forty of the fifty state and federal corrections systems and on seventeen city/county jails of the thirty-seven who received it. Data on numbers of cases of AIDS or HIV infection are not yet available.

Preliminary Findings on AIDS:

Education--Topics most commonly addressed include sex practices and drug injection equipment. Jails are also addressing these issues. Slightly over half of responding agencies provide materials in Spanish.

Testing--No jails have mandatory HIV testing, although some test on a voluntary basis. The debate over testing in correction facilities has shifted. Because AZT is effective in preventing AIDS, the emphasis is now on intervention for the disease rather than, as in the past, on preventing transmission.

Notification--This is still a controversial issue. The inmate himself is notified, but unions are pressuring for notification of officers. Almost 60 percent of jails have policies notifying victims.

Housing--The predominate policy is to house asymptomatic inmates with the general population and to treat those with AIDS on a case-by-case basis based on their behavior and security concerns.

Availability of therapies--AZT is usually made available; experimental drugs are rarely used.

Preliminary findings on TB:

TB is an area of growing concern in jails; MDR TB was documented in eight of forty state/federal systems and in two of seventeen city/county jail systems.

Screening - - The survey asked only about skin testing, but Dr. Clark's point on turnover indicates that skin tests may not be the best approach. It might be preferable to identify active cases of TB rather than screen for infection.

Housing--Among jails, 77 percent isolate those with active cases.

Treatment - - Most facilities are following CDC recommendations of nine months for those who are HIV+ and six months for HIV-. Directly observed treatment is important to prevent Multi-drug resistant TEL INH being used to prevent development of active cases of TB; preventive therapy given to those in the following categories: with positive TB test; all HIV+; all HIV+ need to have anergy testing to determine accuracy of skin test because of their suppressed immune systems.

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Final Session: Brief Presentation on National Academy of Corrections and Wind-up

Dr. Dianne Carter, *President, National Academy* ***of*** *Corrections*

The Academy's Program Plan lists training programs for this year. Topics relevant to this group include: state jail inspectors; quality assurance in corrections medical systems; a systems approach to mentally ill offenders. The red schedule shows eligibility for participation. Next year, the Academy will have a program on treatment strategies for tuberculosis.

Michael O'Toole, Chief, Jails Division

Mike O'Toole noted that ADA hearings for detention facilities will be held throughout February and March; interested administrators are encouraged to attend.

Participants suggested the following possible topics for the next meeting:

- Women's health issues;
- Female inmates in general;
- Advice on equipment, and food, medical, laundry services;
- Classification of female inmates;
- Other special needs offenders (geriatric, mental health)
- Transition to new facilities-composition of teams
- Innovative legislative provisions addressing jails
- Correctional industries

APPENDIX

NATIONAL INSTITUTE OF CORRECTIONS
JAIL CENTER

LARGE JAIL NETWORK MEETING

RED LION HOTEL
DENVER, COLORADO *JANUARY 24-26, 1993*

AGENDA

SUNDAY	***JANUARY 24, 1993***	
6:00 PM - 8:00 PM	INFORMAL DINNER	
	Welcome	Larry Solomon Michael O'Toole
	Introductions and Program Overview	*Michael O'Toole*
MONDAY	***JANUARY 25, 1993***	
7:30 AM - 8:30 AM	BREAKFAST	
8:30 AM - 9:45 AM	TB and Infectious Disease	*Dr. Randall Reves* *Denver Metro TB Clinic*
	Questions and Answers	
9:45 AM - 10:00 AM	BREAK	
10:00 AM - 11:45	How Medical Units Are Dealing With Blood-borne and Air-borne Pathogens	*Dr. John Clark* *Los Angeles County* *Dr. Ernest Williams* *Orange County*
	Group Discussion	

11:45 AM - 1:00 PM	LUNCH	
1:00 PM - 3:15 PM	Exposure Control Plans for Blood-borne and Air-borne Pathogens	
	o Richard Cox	*Milwaukee County, WI*
	o Joe Payne	*Jefferson County, KY*
	o Colonel David Parrish	*Hillsborough County, FL*
	Group Discussion	
3:15 PM - 3:30 PM	BREAK	
3:30 PM - 5:00 PM	Infectious Diseases Training Programs	
	o Paul Conner	*Las Vegas, NV*
	o Robert Denham	*Sacramento County, CA*
	Group Discussion	
6:00 PM - 7:00 PM	DINNER	

TUESDAY *JANUARY 26, 1993*

7:30 AM - 8:30 AM	BREAKFAST	
8:30 AM - 10:00 AM	Dealing With Rising Health Care Costs in Jails	
	o Dr. Donald Amboyer	*Macomb County, MI*
	o Major John Wolf	*Pinellas County, FL*
	Group Discussion	
10:00 AM - 10:15 AM	BREAK	
10:15 AM - 10:30 AM	Update on NASA Project	*Susan Hunter*

10:30 AM - 11:00 AM	Survey: AIDS and Correctional Institutions Issues and Options	*Virginia Baldau NIJ*
11:00 AM - 11:30 AM	RECAP AND CLOSEOUT	*Michael O'Toole*

NATIONAL INSTITUTE OF CORRECTIONS
JAILS DIVISION

Large Jail Network Meeting

Red Lion Hotel
Denver, Colorado **January 24-26, 1993**

- PARTICIPANT LIST -

Timothy Ryan, Alameda County Sheriff's Department
5325 Broder Boulevard
Dublin, CA 94568 (510) 551-4940

Richard Franklin, Alaska Department of Corrections
2200 East 42nd Avenue
Anchorage, AK 99508-5202 (907) 561-4426

Charles Kozakiewicz, Allegheny County Jail
440 Ross Street
Pittsburgh, PA 15219 (412) 255-0100

Tom Faust, Arlington County Sheriff's Office
1400 North Courthouse Road, Room 214
Arlington, VA 22201 (703) 358-4466

Pepe Lucero, Bexar County Adult Detention Center
200 North Comal
San Antonio, TX 78207 (512) 270-6219

Charles Barnes, Broward County Sheriff's Department
2600 South West Davie Boulevard, D-114
Fort Lauderdale, FL 33315 (305) 765-8900

- PARTICIPANT LIST -

L.L. Gross, Cobb County Sheriff's Office
1825 County Farm Road
Marietta, GA 30060-4013 (404) 499-4200

Thomas White, Connecticut Department of Corrections
340 Capitol Avenue
Hartford, CT 06106 (203) 566-3717

Larry Ard, Contra Costa County Sheriff's Dept.
1000 Ward Street
Martinez, CA 94553 (510) 646-4497

Robert Pace, Cuyahoga County Corrections Center
1215 West Third Street
Cleveland, OH 44113 (216) 443-6002

Lonnie Lawrence, Dade County Correction & Rehab. Dept.
1500 Northwest 12th Avenue, Suite 722
Miami, FL 33130 (305) 547-7385

Bob Knowles, Dallas County Sheriff's Office
133 North Industrial, Room C-13
Dallas, TX 75207-4313 (214) 653-2901

Robert Wayne Melton, DeKalb County Sheriff's Department
3630 Camp Circle
Decatur, GA 30032 (404) 294-2405

- PARTICIPANT LIST -

Randall Reves, Denver Disease Control
605 Bannock
Denver, CO 80204

Walt Smith, Denver Sheriff's Department
P. 0. Box 1108
Denver, CO 80201 (303) 375-5614

Michael Berg, Deputy Director Jail and Prisons Division
Office of the Sheriff
P.O. Box 2070
Jacksonville, FL 32202 (904) 630-2124

Alma R. Cornish, Escambia County Corrections Division
P. 0. Box 17789
Pensacola, FL 32522 (904) 436-9813

Carl Peed, Fairfax County Sheriff's Office
10520 Judicial Drive
Fairfax, VA 22030 (703) 246-4432

Edward Sobach, Florida Department of Corrections
2601 Blairstown Road
Tallahassee, FL 32399-2500 (904) 488-5021

Mark Barrett, Franklin County Corrections Center
370 South Front Street
Columbus, OH 43215 (614) 462-3310

- PARTICIPANT LIST -

Mike Quinn, Harris County Sheriff's Department
1301 Franklin Street
Houston, TX 77002 (713) 755-5321

Ellena M. Young, Hawaii Department of Public Safety
677 Ala Moana Blvd., Suite 1000
Honolulu, HI 96813 (808) 587-1342

Michael Jalma, Hennepin County Sheriff's Office
Room 36, Courthouse
250 South 5th Street
Minneapolis, MN 55418 (612) 348-8358

David Parrish, Hillsborough County Sheriff's Office
P.O. Box 3371
Tampa, FL 336019 (813) 247-8310

Charles Megerman, Jackson County Department of Corrections
1300 Cherry Street
Kansas City, MO 64106 (816) 881-4231

Joe Payne, Jefferson County Corrections
730 West Main Street
Louisville, KY 40202 (502) 574-2167

John Clark, Los Angeles County Sheriff's Department
441 Bauchet Street
Los Angeles, CA 90012 (213) 974-4901

- PARTICIPANT LIST -

Paul Myron, Los Angeles County Sheriff's Department
441 Bauchet Street
Los Angeles, CA 90012 (213) 974-4901

Paul Conner, Las Vegas Metro Police Department
330 South Casino Center Blvd.
Las Vegas, NV 89101 (702) 455-3951

Donald Amboyer, Macomb County Jail
43565 Elizabeth Road
Mt. Clements, MI 48043 (313) 469-5024

Russell Pearce, Maricopa County Sheriff's Office
102 West Madison Street
Phoenix, AZ 85003 (602) 256-1801

Larry Wendt, Maricopa County Sheriff's Office
102 West Madison Street
Phoenix, AZ 85003 (602) 256-1801

Richard Cox, Milwaukee County Criminal Justice Center
949 North 9th Street
Milwaukee, WI 53233 (414) 226-7050

John Schweitzer, Multnomah County Sheriff's Department
1120 Southwest 3rd Avenue, Room 307
Portland, OR 97204 (503) 248-5088

Jerry Krans, Orange County Sheriff's Department
550 North Flower Street
Santa Ana, CA 92702 (714) 647-1802

- PARTICIPANT LIST -

Ernest Williams, Orange County Sheriff's Department
550 North Flower Street
Santa Ana, CA 92702 (714) 647-1802

Ed Royal, Orange County Corrections Division
P. 0. Box 4970
Orlando, FL 32802 (407) 836-3564

David Bosman, Pima County Sheriff's Department
P.O. Box 910
Tucson, AZ 85702 (602) 741-4711

Everett Rice, Pinellas County Sheriff
P.O. Drawer 2500
Largo, FL 34649 (813) 587-6204

John Wolf, Pinellas County Corrections Bureau
14400 49th Street North
Clearwater, FL 34620 (813) 530-6336

Milton Crump, Prince Georges County
Department of Corrections
13400 Dille Drive
Upper Marlboro, MD 20772 (301) 952-7014

Albert Gardner, Intake Service Center
Rhode Island Department of Corrections
P.O. Box 8249
Cranston, RI 02920 (401) 464-3802

Kenneth Golden, Riverside County Sheriff's Department
P.O. Box 512
Riverside, CA 92501 (909) 275-2413

- PARTICIPANT LIST -

Robert N. Denham, Sacramento County Sheriff's Department
711 -"G" Street
Sacramento, CA 95814 (916) 440-5686

Phil Danna, San Bernardino County Sheriff's Department
655 East Third Street, 2nd Floor
San Bernardino, CA 92415-0061
(714) 387-3636

James W. Painter, San Diego County Sheriff's Department
9621 Ridgehaven Court, 2nd Floor
San Diego, CA 92123 (619) 974-2266

Roy Mueller, St. Louis County Jail
7900 Forsyth
Clayton, MO 63105 (314) 889-2114

Alice Pollard, St. Louis Municipal Jail
124 So. 14th Street
St. Louis, MO 63103 (314) 622-4741

Alan J. Croce, Suffolk County Sheriff Correctional Facility
One Center Drive
Riverhead, NY 11901 (516) 852-2207

Pat Howell, Tarrant County Jail
350 West Belknap
Fort Worth, TX 76196-0196 (817) 884-1547

Richard Bryce, Ventura County Sheriff's Department
800 South Victoria Avenue
Ventura, CA 93009 (805) 654-2383

- PARTICIPANT LIST -

Mike O'Malley, Vermont Department of Corrections
103 South Main Street
Waterbury, VT 05671-1001 (802) 241-2276

Terry Moore, Volusia County
Department of Corrections
1300 Red John Drive.
Daytona Beach, FL 32020 (904) 254-1552

Joseph M. Stancari, Westchester County DOC
P.O. Box 389, Elmwood Hall
Valhalla, NY 10595 (914) 347-6011

Virginia Baldau, National Institute of Justice
633 Indiana Avenue NW
Washington, DC 20531
(202) 514-6204

Cheri Crawford, National Institute of Justice
633 Indiana Avenue NW
Washington, DC 20531
(202) 514-6210

Ted Hammett, Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138
(617) 349-2734

NIC Staff

Larry Solomon

Susan Hunter

Pete Nacci

Sharla Rausch