Chapter 5
Jails

> You never really understand a person until you consider things from his point of view… until you climb into his skin and walk around in it.—Harper Lee

The fact that jails have become a key focal point for mental illness over the years is not inherently the central problem. This may be a semantical point, but it is an important one to think over. As discussed earlier, the history of caring for those with mental illness is fraught with horrors, stigma, abuse, and misunderstanding. Shifting the primary location of care for patients from the asylum to the communities they reside was quite intentional and, in part, driven by humanitarian interests. The perception of this shift is remarkable. What better way exists to "fix" a broken system than destroying it and freeing the tortured souls bound up in its clutches? Truly, these are almost identical interests that drove the creation of asylums in the first place just a generation before—recall our discussion of Dorothea Dix and her advocacy for these very reforms. While it is tempting to simply suggest that jails are no place for individuals with mental illness, the broader truth is that jails can perform a vital role in the continuum of treatment when tailored evidence-based programs are put into place. This brings us to *the* central problem: jails are utilized as the de facto focal point for mental illness largely without process, decisive action, and dedicated programming. Thus, shifting the responsibility of care effectively did little to solve the underlying issue of a broken continuum of care, with the operational word being *care*.

5.1 Know the Role

As a legal matter, the standard of care rests in how we have come to define a constitutionally acceptable level of care. What this boils down to, in most circumstances, is defining the absolute minimum level of care required to run a legally compliant jail. Yet, even this standard can be quite costly. For example, a Southwestern

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Louisiana jail administrator speculated that her costs run upward to $100 per day to care for an individual with mental illness at this standard. In all actuality, this estimate runs on the cheaper end of the spectrum across the United States; for example, an often cited report in *the Miami Herald* estimated that care for individuals with mental illness in the Broward County, Florida jail is about $130 per day compared to the $80 for an "average" inmate back in 2007 (Miller & Fantz, 2007). A Vera Institute report updated in 2014 has compiled similar situations across the country. In Harris County (Houston), Texas, the annual expenditure for mental health care reached $24 million dollars per year. In Northeast Ohio, over half of a jail's medical budget was spent on psychotropic drugs alone (Vera Institute, 2014). Again, most of these tallies cover just the bare necessities as required by the constitution.

This institutional mentality is beginning to thaw as justice professionals are increasingly acknowledging the failing logic of providing short-term care that only covers basic needs. Largely driven by the desire to tamp down cost, justice administrators have recently sought out ways to adapt their forced role of primary mental health-care providers for an at-risk population by partnering diverse array of community stakeholders to formulate a stronger continuum of care (and dispersing the costs involved to a wider range of players). As this innovation is taking place, the vast majority of jurisdictions are slow to respond, if at all. Major court decisions have driven reform in the past, and even these pressures brought about change slowly.

5.1.1 Constitutionally Acceptable Level of Care: The Status Quo

The basis for defining a "legal" level of care began with litigating perceived protections of incarcerated persons under the Eighth Amendment—"Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." In 1974, a prisoner in Texas named J.W. Gamble filed a civil rights action under 42 USC § 1983 by handwritten petition. While it seems that Gamble's primary objective was compensation for maltreatment, his case instead defined the first set of constitutional obligations of medical care for the incarcerated. Gamble's complaint described a back injury he sustained in 1973 while unloading a truck full of cotton bales as a part of his prison work duties. He continued to work but soon reported his discomfort to prison staff and was granted a pass to the medical unit at the facility. Gamble was evaluated by a medical assistant (with prescribing capabilities) for a hernia and was initially sent back to his cell. He continued to have problems and was able to go back to the medical unit—this time being seen by a nurse and a doctor. At this point, he obtained some medication for pain. The next day, he returned to the medical unit and was seen by another doctor, Dr. Astone, received a diagnosis of a lower back strain, and was placed on a treatment plan consisting of medication and cell restriction requiring Gamble to remain in his cell with the only

exclusion of showering. A few days later, Dr. Astone extended this treatment plan after reevaluation and further ordered that Gamble be assigned to a bottom bunk (an order the prison staff did not enforce). This sort of treatment carried on throughout the month of November under Dr. Astone's care, seemingly without improvement.

It was at this point things seemed to shift for Gamble. On December 3, 1974, Dr. Astone removed Gamble's cell restrictions, which also approved him for light work, despite continued pain and discomfort. As staff assigned work duties to him, his complaints to supervisory staff landed him in segregated housing as punishment. This issue was heard by a disciplinary committee days later resulting in a recommendation to be seen by medical staff; but they insisted that he be seen by a different physician. Dr. Gray treated Gamble for high blood pressure and pain, prescriptions were lost and delayed, and he remained in segregation for the entire month. This treatment stretched into January and came to a head in February. At this point, Gamble reported chest pains and "blank outs," yet staff were slow to respond, taking all day on February 4th to move him from segregation to the medical unit. He was hospitalized that evening and diagnosed with an arrhythmia yet soon sent back to segregation. When his symptoms reappeared, staff refused to bring him back to the medical unit—Gamble asked several times on February 7 and 8, and he was turned down repeatedly. Finally, on February 9th, he was again treated for his heart condition, and he wrote his petition to the courts on February 11th.

Initially, the district court dismissed his petition as the presiding judge did not view his case to have a clear legal claim. Typically, a judge at this level is trained to evaluate if a plaintiff can argue concrete, tangible harms have occurred and have been clearly documented. The appeals court was not moved by this logic and reinstated the complaint based on their finding of an insufficient levels of medical treatment. Soon, the Supreme Court would weigh in with an 8 to 1 decision:

> We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain," *Gregg v. Georgia, supra,* at 173 (joint opinion), proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs [n10]or by prison guards in intentionally denying or delaying access to medical [p105] care[n11] or intentionally interfering with the treatment once prescribed. [n12] Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983.

On first glance, it seems as though the Court was moved by Gamble's handwritten petition. Perhaps Gamble was able to lay out a claim based on the repeated times he was denied care, or his accounts of how his prescriptions were lost, or when the prison staff interfered with his treatment when they put him back to work or punished him by sending him to a segregation unit. The truth is the case is much more complicated than it appears:

> This conclusion does not mean, however, that every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment. An accident, although it may produce added anguish, is not on that basis alone to be characterized as wanton infliction of unnecessary pain….in the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton

> infliction of pain" or to be [p106] "repugnant to the conscience of mankind." Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency" in violation of the Eighth Amendment.

As it turns out, the Court believed the district court judge was correct in that Gamble did not have a § 1983 claim, at least against the medical director Dr. Gray. The majority opinion cited the repeated instances of treatment Gamble received by the prison medical staff—whether it was "good" treatment was not to be decided in this venue. Further, since the lower court of appeals' decision focused on the care of the physicians and medical staff under Dr. Gray, their decision outlining the lack of civil rights violations was limited to these individuals (particularly, absolving Dr. Gray). Instead of deciding the fate of the other litigants mentioned in the petition, like the warden of the prison and the Texas Department of Corrections leadership, the Supreme Court decided to push this back down to the lower courts to decide in light of their recent clarifications of the Eighth Amendment in this situation. The level of care may have amounted to malpractice, which would need to be litigated differently; however, the decision rendered that incarcerated persons were constitutionally protected against "wanton infliction of unnecessary pain." Gamble may have lost, but his case surely caused ripples in correctional medical care.

This was the legal foundation for all cases involving standards of medical care for incarcerated people that will follow; however, there has not been a landmark case on the level of Estelle v. Gamble to directly address mental health care for justice-involved individuals. One key exception exists from a stream of action in California. Advocates there took a different approach to address the emerging mental health deficiencies in jails and prisons beginning in the 1990s—focus on increasing sparseness of resources and personnel given an expanding incarceration population. It was these broadening deficiencies in adequate care that triggered § 1983 civil rights violations, infringing upon inmates' constitutional rights under the Eighth Amendment. The momentum for this conflict began to surge when a magistrate certified a class "consisting of 'all inmates with serious mental disorders who are now or who will in the future be confined within the California Department of Corrections'" (with limited exceptions) who together had volumes of stories of neglect and maltreatment. After years of litigation, this case—*Coleman v. Wilson*—was initially resolved in 1995 by appointing a special master to oversee a remediation plan to remedy the conditions in California prisons. Importantly, this special master was charged with holding the California Department of Corrections accountable for six components of mental health treatment to meet minimal constitutional requirements:

> The six components are: (1) a systematic program for screening and evaluating inmates to identify those in need of mental health care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a

> sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide. *Balla v. Idaho State Board of Corrections,* 595 F.Supp. 1558, 1577 (D.Idaho, 1984)

This case references precedent that originated out of Texas (*Ruiz v. Estelle,* 503 F.Supp. 1265 (S.D.Tex.1980)), which was expanded upon further in a case against the Idaho Department of Corrections in 1984. These six components defining the minimal constitutional level of mental health care would eventually become further tested at the Federal District Court level when California failed several times to resolve Coleman v. Wilson under the appointed special master. This new case, Coleman v. Brown, sought to bring California into compliance with Coleman v. Wilson almost 10 years later in 2013. Yet again, a judge sided with the plaintiffs, arguing that California needed to continue to provide relief to the class of mentally ill inmates under the care of the California Department of Corrections.

These key features of legal precedents, as many others across the country, can also be found interwoven in the accreditation standards of the corrections industry. In fact, the evolution of best practices (again, geared to ensure a *minimal* array of services to be constitutionally acceptable) can be easily gleaned from each edition of industrial standards released by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). For example, the ACA Performance-Based Standards for American Correctional Association (2001) mandate the following: round-the-clock emergency health care with on-site crisis intervention, emergency rooms or other appropriate health facilities, and on-call mental health professional services with an emergency health facility that is not located nearby (Standard 4-ACRS- 4C-03); a training program to be in place for *care worker* staff to recognize signs and symptoms of mental illness, substance use disorder, and intellectual disability (Standard 4-ACRS- 4C-04); mental health screening by trained professionals that covers mental health problems and suicide attempts/ideation, substance abuse, and direct observation of behaviors (Standard 4-ACRS- 4C-06); and a written suicide prevention and intervention program with dedicated training that covers all staff who supervise inmates. These standards have become commonplace throughout American corrections. Yet, given the fact that more individuals with mental illness remain untreated rather than receive treatment in jails should give us pause. Perhaps these standards provide a safety net for the most seriously ill; however, it appears that they are ineffective for the vulnerable population en masse.

5.1.2 Common Interactions

For generations now, vocations that care for individuals with mental illness have suffered from a lack of prestige, pay, desirability, and so on. Jobs within jails certainly fall in this category. A quick search for information on these jobs reveals high

turnover, issues with burnout, and, at times, a lack of further career opportunities. Yet, as mentioned earlier, jails have become a critical focal point for mental health crises—roughly 15% of male and 30% of female jail inmates have a serious mental illness, and the vast majority do not receive any treatment (NAMI, 2017). Further, most correctional officers have little training in mental health and substance abuse awareness and treatment (Stohr, Self, & Lovrich, 1992). A majority of jails across the country thus heavily depend on their treatment staff to identify mental illness, develop a treatment plan, and help to ensure the six components of mental health care are provided to meet constitutional standards.

Jail correctional officers, in particular, play a critical role in promoting a healthy environment for both fellow staff and inmates. The recent stories brimming from the Orleans Parish Prison (the New Orleans jail ran by the Orleans Parish Sheriff's Office) and Riker's Island Prison Complex (the New York City jail ran by New York City Correction Department) offer allegories as to the serious behavioral health consequences of staffing issues among other organizational failures. For example, in New Orleans, just months after opening a state-of-the-art jail complex, the Orleans Parish Sheriff's Office reported 200 inmate-on-inmate altercations, 44 instances of use of force on inmates by state, 16 assaults on staff, 3 rapes, 29 inmates transferred to the hospital for injury or sickness, and 16 suicide attempts—all within the first 3 months (McCampbell et al. 2017; Sledge, 2017). In New York, tales of correctional staff retaliating against inmates who attempt suicide at Riker's Island have surfaced, depicting just how brutal the jail environment has become (Rayman, 2016). Both failing jails are now notorious for high turnover, leading to the stagnation of the critical changes needed to promote a safe and therapeutic environment. While these are extreme cases, it is important to note that line correctional officers are often only equipped to identify suicide risk by a matter of policy and receive little more training pertaining to mental health. Their jobs are wrought with low job satisfaction, little autonomy, and inadequate pay. Mental health seems to be a low priority for line officers who spend the most interface time with inmates, by far.

The key players involved in the postarrest phase of a potential justice-based intervention include jail intake and medical/treatment staff, line correctional officers, public defenders, prosecutors, and judges, with the heaviest burden on intake and medical/treatment staff to flag potential inmates for services and assistance. Robust research has only begun to evaluate the systemic breakdown in counties and parishes across the country to successfully capture mental illness and explore effective interventions. As such, we do not have a deep understanding of the everyday interactions of these key players and inmates with mental illness. Of particular importance here, the Stepping Up Initiative (2017) is the leading movement for change at the local level. This Initiative is a partnership of the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation, which partnered to offer a structured guide, training, and seed funding to reduce the number of people with mental illness in jails beginning in 2015. As of this writing, 365 counties have passed resolutions through local leadership to join this initiative, the first step of which is to engage in a comprehensive system-wide evaluation of just how individuals with mental illness

are processed and captured (or not captured) by the current system. The Initiative also serves to assist localities in building a diverse partnership of key stakeholders who have been deemed essential to creating successful models for change.

5.1.3 Common Problems

As the Stepping Up Initiative prepared to launch, its advertising campaign to counties and parishes identified the following commonplace problems in jails across the United States: (1) prevalence of serious mental illness was three to six times higher in jails relative to the general population, (2) three out of four of these individuals have co-occurring disorders, (3) once in jail, these individuals tend to experience longer stays in jail relative to individuals without mental illness, and (4) these individuals are at a much higher risk of recidivism upon release relative to individuals without mental illness (Council of State Governments Justice Center, 2014; Haneberg, Fabelo, Osher, & Thompson, 2017). Certainly, this list is not exhaustive, but it captures the failing logic of the current systems in place across the country—it depicts a system that has recurring failures as an intervention for people with mental illness. The analogy to a revolving door has become apt.

Perhaps the systemic failure is most punctuated by an examination of suicide ideation, attempts, and completions in jails; as indicated earlier in this text, the risk of suicide tends to be the highest in jails. According to the Bureau of Justice Statistics, suicides among jail inmates have been on the rise, with the most current rate being 46 per 100,000 inmates as of 2013 (Noonan, 2015). Compare this to a national average of roughly 12 per 100,000, the difference in jails is about four times higher than the general population (Centers for Disease Control and Prevention, 2017). Existing data on suicide ideation and attempts among jail inmates is scant and much older. However, the underlying patterns of crisis still emerge.

One of the first briefs coming from the Stepping Up Initiative leadership summarizes a growing body of knowledge on what, exactly, our failures are in the jail setting. It begins by outlining the changes that have occurred in services for individuals with mental illness over the last decade: a mass proliferation of specialized police response teams and programs, specialized programming to divert low-level offenders with mental illness from the mainstream justice system, broader use of specialty courts, and enhanced mental health services in jails to name a few. Even with these innovations in place, the brief describes four barriers preventing gains. First, and primarily, most locales suffer from the lack of adequate data to identify a targeted population and monitor it effectively. For example, having access to basic information such as the total number and identities of individuals with mental illness arrested and who currently in the local jail is important. Additional relevant information about this population is also crucial, such as the length of stay in jail, bond status, whether individuals have previously received treatment or are currently being treated, and the ability to follow rearrest. Without adequate data tools, developing a system-wide response to any underlying problem becomes problematic.

Second, many programs that are in place lack an evidence-based services, tools, and programming, and critically, "community-based behavioral health-care providers are rarely familiar with (or skilled in delivering) the approaches that need to be integrated into their treatment models to reduce the likelihood of someone offending" (Haneberg, Fabelo, Osher, & Thompson, 2017). Third, due to scarce resources, innovation has been small in scope and scale, thus blunting any ability to create sustained systemic changes. Finally, and related to the first barrier, many innovations have lacked adequate tracking to determine their impact. Did the initiatives reduce arrests for individuals with mental illness, reduce the length of time these individuals spend in jail, and/or increase treatment options, connections, and adherence to treatment regimes? These barriers translate into underdiagnosis/lack of diagnosis, continued exasperated behavioral problems, overpopulation through recidivism, and continued vulnerability for individuals with mental illness in potentially problematic and unhealthy jail environments.

The services offered to inmates within jails continue to be in line with constitutional minimums, yet change is afoot. Oftentimes, only one mental health professional is dedicated to provide services for an entire jail of hundreds of inmates. While prisons offer programs for education, vocational training, etc. that help with mental health and behavioral change, jails have consistently lacked the same breadth of scope of programs for inmates in many jurisdictions. Further, jail inmates usually serve a shorter sentence than those in prison; this lack of time does not afford the chance for long-term treatment services or programming. Thus, this highlights the importance of a collaboration between jails, courts, probation, and community players to shore up a continuum of care to break this cycle. This is exactly what the Stepping Up Initiative lays out.

5.1.4 Preventable Tragedies

Unfortunately, death of inmates inside jails and prisons are real possibilities. Even further, inmates with mental illness are more likely to suffer harm while incarcerated according to many studies. One report published by the University of Texas School of Law Civil Rights Clinic (2016) called "Preventable Tragedies" discusses the deaths of ten different inmates in county jails, all with mental health concerns—such as Terry Borum in Swisher County Jail, Gregory Cheek in Nueces County Jail, and Amy Lynn Cowling in Gregg County Jail. The first part of the report describes each of the deaths in personal detail to highlight the "cracks" in the county jail system in Texas and its real impact on human lives. An interesting point to note here is that each of these deaths took place under very different circumstances and in different county jails. These tragedies were all easily preventable in many ways. This report also goes on to provide 12 recommendations for Texas county jails based on national standards to help improve care for inmates with mental illness, which the authors truly believe would serve to prevent each of the tragedies listed in this study.

Similar recommendations were also provided by the Stanford School of Law in their study on mental health in jail inmates (more on this study in Chap. 7; Steinberg, Mills, & Romano, 2017).

Each of the stories provided in the "Preventable Tragedies" report sheds light on a different problem with the county jail system, specifically in Texas. Earlier in this text, the statistics on jail settings were discussed which included the elevated number of inmates, increasing number with mental health diagnoses, lack of funding, lack of access to care, etc. The trends that these statistics depict also are typical in Texas, and the evidence supporting this claim is provided with each case in this report. For example, the story of Terry Borum is alarming in that his severe alcoholism was known prior to his incarceration by jail staff and the Sheriff, but no action was taken to care for him until his case became an emergency situation. Terry had a history of depression that resulted in his alcoholism, and when a minor altercation led him to the county jail, his symptoms reached a breaking point. His past suicide attempt complicated his mental health history and should have been one of the first reasons to prioritize medical treatment to ensure his care was appropriate. As the report details the story, treatment did not happen at all, and after he went into delirium tremens that included hallucinations and seizures, he fell inside his jail cell causing a serious head injury. It was at this point that medical care was initialized and Borum was fully evaluated. Yet, it was too late; due to the lack of nutrition, the haphazard care provided, and the jail's unwillingness to use their medical care budget on Terry, he was not able to survive a survivable injury and died in a nearby hospital.

In another case within the "Preventable Tragedies" report, Gregory Cheek was arrested after breaking into a home and painting the walls blue and yellow. At the time of his arrest, he was covered in blue paint and suffering from delusions. Despite this, his intake assessment reported no medical issues, no mental health issues, and no medications prescribed at the time. Gregory was seen by the jail's psychiatrist who recommended he be transferred to the state hospital on more than one occasion. Additionally, a magistrate judge ordered that Gregory be transferred to the state hospital, but none of these instructions were followed. After suffering the beginning signs of hypothermia, Gregory died in jail from a bacterial infection that was left untreated. A review of his case after his death reveals that the jail psychiatrist ignored reports from the medical staff to follow up on Gregory's medication while inadequate medical care and follow-up attention was paid to a worsening physical condition. It turns out that Gregory succumbed to Waterhouse-Friderichsen syndrome—a severe bacterial infection of the adrenal glands causing gland failure and bleeding. In this case, neither Gregory's physical nor mental health was attended to, which can be surprising to some as his mental health symptoms were severe and readily recognizable, as was his signs of his failing physical health, specifically his rapid weight loss and chronic hyperthermia in days nearing his death.

Amy Lynn Cowling's story was similar to Terry Borum above in that her death is attributed to the complications of withdrawal. Yet in Cowling's case, several prescriptions meant to treat her mental health illnesses (Seroquel and Xanax) and

substance use disorder (methadone) were discontinued due to the Gregg County Jail's strict policy on drugs in the jail. While the jail's physician would have ordered an alternative course of medical treatment to fit the jail's policy and keep Amy's treatment from slipping, she never had the chance to see the doctor. The reason—the doctor only makes visits to the jail on Wednesdays and Amy was booked on a Friday. After her medication was discontinued, Amy's physical and mental health rapidly decompensated, and she was moved to an isolation cell with orders to be closely watched. Yet, the correctional officers on watch that evening decided to falsify the observation logs and could not account for why Amy was found unresponsive on the day she died.

These stories are just three of the many across the country of individuals with mental illness dying in county jails. The stories of Terry and Gregory are different, but both show the results of improper care while incarcerated. Terry's illness was known to jail officials, but they chose to ignore his needs as well as use the budget of the jail as an excuse not to seek medical treatment. In Gregory's case, he was initially treated as though he was perfectly healthy and later evaluated. Upon evaluation, the mental health professionals and even a judge decided he needed more treatment than the jail could offer, but no one chose to uphold the orders. It seems like a comedy of errors has led to the deaths of these ten people—Terry Borum, a 53-year-old grandfather who lived by and maintained traditional country values; Gregory Cheek, a young artist and surfer, husband and father to a young girl; and Amy Lynn Cowling, a 33-year-old mother of three who was in recovery for her opioid addiction.

The stories of deaths in county jails are alarming and unsettling, and they happen with a frequency that surely can be reduced. Yet, this seems difficult when considering the level of care inherent in what is deemed as constitutionally acceptable. The authors offer the following areas of improvement to aid in reform while maintaining this very same standard: (1) increase diversion from jail for low-risk individuals with mental illness, (2) improve screening and assessment tools to ensure adequate care and informed decision-making, (3) arm the judiciary with the results of screening and assessment to aid in diversion, whenever appropriate, (4) evaluate and refine suicide prevention programs with partnerships that include mental health professionals, (5) increase and strengthen collaborations with mental health professionals and local agencies, (6) ensure the ability to continue medication treatment regimens with appropriate medications or their alternatives, (7) develop and update medical detoxification programming, (8) consider adding peer support specialists, (9) improve monitoring programs and ensure that jail staff are accountable for monitoring inmates with mental health concerns, (10) reduce the use of restraints and isolation cells, and (11) limit the use of force and consider the use of force only as a last resort. While these steps are a good start for jail administrators, these recommendations remain quite inward-looking and fail to address some of the broader concerns that impact the jail that are outside of its control. The following section addresses some of the most promising approaches in recent years to address the issues the "Preventable Tragedies" report unearths.

5.2 Evidence-Based Solutions

The state of the art for local, system-wide reform has deftly been outlined by the Stepping Up Initiative materials, to be customized to each location through local partnerships all focused on providing better care for individuals with mental illness (Haneberg et al. 2017). The initial call to action outlines six steps to structure progress: (1) assemble a team of local leadership across multiple agencies and key stakeholders and decision-makers throughout the community committed to change, (2) invest in an ability to identify individuals with mental illness and gauge their risk of recidivism and further identify the needs of these individuals, (3) assess treatment and service capacity in the local area, (4) create a plan with measurable outcomes, (5) implement an approach with a scientific research design to ensure quality assurance and accountability of each partnership, and (6) track the progress using data and make data-informed decisions to ensure continued success. Each step along the way, any interested county/parish partnership can access a large resource pool supported by the National Alliance on Mental Illness, Major County Sheriffs' Association, National Association of County Behavioral Health & Developmental Disability Directors, National Association of State and Drug Abuse Directors, National Association of State Mental Health Directors, National Council on Behavioral Health, National Sheriffs' Association, and Policy Research Associates, among many more.

The first step provides the backbone of change. It requires a wide range of stakeholders to "put skin in the game" to address the problems of justice-involved mental health individuals. Typically, each entity signs onto a memorandum of understanding defining its commitment to this team, its role, and its responsibilities. Primarily, this gets all of the key players in the same room to begin discussing strengths and weaknesses, resources and gaps, and problems and solutions. A key advantage of having these partnerships is that it helps to avoid blind spots in planning; each partner brings a unique perspective and experiences to aid in building a strategy to problem solve.

5.2.1 Step Two: Latest Generation Assessment and Screening Tools and Data Capacity

After assembling a team, many locales realize that their tools for identifying individuals with mental illness being processed through the justice system are old and outdated and perform poorly, and jails are often at the center of this process. Further, the team may also realize that their local jails do not have a definition of mental illness and serious mental illness consistent with the state and/or local health officials' definitions—a serious issue if these jails are the primary centers for mental health screening for the area. This lack of definition would critically pose problems when trying to connect individuals to care in the community for follow-up care. Following

Table 5.1 Evidence-based screening tools, adapted from SAMHSA

Mental disorders	Substance use disorders	Co-occurring disorders	Motivation and readiness	Trauma history and PTSD	Suicide risk
Brief Jail Mental Health Screen (BJMHS)	Texas Christian University Drug Screen-V (TCUDS-V)	Mini International Neuropsychiatric Interview Screen (MINI-Screen)	Texas Christian Motivation Form (TCU-MotForm)	Trauma History Screen (THS)	Interpersonal Needs Questionnaire (INQ) combined with Acquired Capacity for Suicide Scale (ACSS)
Correctional Mental Health Screen (CMHS-F or CHHS-M)	Simple Screening Instrument (SSI)	BJMHS combined with TCUDS-V	University of Rhode Island Change Assessment Scale-M (URICA-M)	Life-Stressor Checklist (LSC-R)	Beck Scale for Suicide Ideation (BSS)
Mental Health Screening Form-III (MHSF-III)	Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	CMHS-F or CMHS-M combined with TCUDS-V		Life Events Checklist for DSM-V combined with Post-traumatic Stress Disorder Checklist for DSM-V (PCL-5)	Adult Suicidal Ideation Questionnaire (ASIQ)

the establishment of a consistent definition of mental illness across the local system (including substance use disorders), the team can move on to select validated screening tools for mental illness and substance use disorders to proficiently flag individuals with potential mental illness and substance abuse disorders that fit this definition (see Table 5.1). Subsequent to screening, any flagged concerns must be further evaluated by mental health professionals using validated and reliable assessment techniques. Just like the instruments embedded into the population surveys of jail and prison inmates that are used to identify individuals with mental illness, the tools described in Table 5.1 provide reliable and accurate information about potential mental health and substance use disorder diagnoses. In fact, these tools were designed to be given by any trained personnel, not just mental health professionals or sworn officers.

Importantly, screening and assessment do not equate to a diagnosis or diagnoses that can, in turn, inform treatment. All flagged individuals must then be seen by a mental health professional to confirm or refute the screening result and, if appropriate, begin an individualized treatment plan. Many times, the mental health

professional assessment is done after release, thus requiring communication and data sharing between the jail and community mental health partners. Or, as mentioned earlier, initial mental health assessments may require follow-ups to continue to define and/or refine diagnoses. In that, meaning not all diagnoses are black or white—there often exists gray area. For some, diagnosis requires time and more than one evaluation or a second option for another doctor. For others, mental illness develops slowly over time, so it may not be an easy diagnosis right away, or a change may need to be made. Either way, the screening and assessment tools described in Table 5.1 can be performed expeditiously, with the intent that it can easily be integrated with jail intake.

Further, latest generation risk and need assessment tools provide users with the ability to prioritize treatment for individuals who, after screening, are identified as high risk and high need. In other words:

> With mounting research that demonstrates the value of science-based tools to predict a person's likelihood of reoffending, criminal justice practitioners are increasingly using these tools to focus limited resources on the people who are most likely to reoffend. At the same time, mental health and substance use practitioners are trying to prioritize their scarce treatment resources for people with the most serious behavioral health needs….when [a] person is assessed as being at moderate to high risk of reoffending, connection to treatment is an even higher priority, along with interventions such as supervision and cognitive behavioral therapy to reduce the risk of recidivism. (Haneberg et al. 2017)

Thus, having a well-defined screening and assessment process, equipped with the latest generation actuarial tools (many of which are in the public domain), introduces vast improvements in the efficiency of mental illness interventions. This makes a broad catchment system possible and is the foundation for change while preserving precious resources for optimal results. While the ideal goal for each locale would be to provide services for each individual with a mental health diagnosis, a realistic goal would be to provide an individualized treatment plan for each individual while providing direct services for those with the highest risk and needs.

Having such a process also enables local partnerships to monitor change. For example, while planning its local Stepping Up Initiatives, the partnerships in Bexar County, Texas (e.g., San Antonio) realized they did not have a reliable accurate count of just how many individuals in the Bexar County Jail have mental illness on any given day. Their solution was to explore and establish a universal screening process for mental illness together as a partnership. Other important baseline data may be sought during this planning stage, such as length of stay, connectivity to treatment after release, and a reliable method to measure recidivism. All of these metrics rely on the ability to accurately and reliably identify individuals with mental illness and need to be put into place to measure successes and inefficiencies in the system being put into place.

The Stepping Up Initiative literature identifies four key data tools that need to be constructed for optimal success: (1) a tool to track the number of people with mental illness (and/or serious mental illness) passing through intake at the jail (e.g., being booked); (2) a tool that tracks the length of stay of all individuals, with the ability to compare the length of stay of those with mental illness (and/or serious mental

illness) to the overall average or, more importantly, to individuals without mental illness; (3) a tool that tracks connections to treatment, in particular, *successful* connections to treatment; and (4) a tool that tracks recidivism based on an accepted definition by the team. A reflection on these data tools suggests that jail staff and leadership shoulder the effort to create and maintain these resources; in the team context, any barriers the jail leadership may face in development and maintenance of these tools can, indeed, be troubleshooted by the team in good faith. However, the jail remains a core conduit of change.

5.2.2 *Defining a Sequential Intercept Model and Notating Gaps in Services*

A tool that has promulgated in counties/parishes considering change is the Sequential Intercept Model. Initially developed by Munetz and Griffin (2006), the Sequential Intercept Model is a visualization of the flow of individuals with mental illness into and out of the criminal justice system, beginning with law enforcement and first responder contact and entry into jail, and follows each of the various pathways of criminal justice processing through eventual release and termination of justice involvement (Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015). These models are customized to each locality, with the emphasis of finding what Munetz and Griffin call points of interception at which an intervention can be developed for qualifying individuals; these intervention points commonly occur at initial contact with first responders, at initial detention and preliminary hearings, during a stay in jail, interface with the courts (e.g., public defenders, prosecutors, and judges), or upon psychiatric evaluation, at reentry back into the community, and with interface with community corrections (e.g., probation and parole officers). As this is a visual tool, an example can be found with Fig. 5.1.

The Stepping Up Initiative literature states that local teams should look beyond the Sequential Intercept Model and include an exhaustive community model for mental health crisis. This extra step will allow for proactive measures to be taken to potentially intervene before justice involvement even begins. After each point of interception has been defined, teams can then evaluate local resources available to intervene at each point, identify the training necessary for the players involved at point to effectively intervene, perhaps identify additional personnel who can make intervention possible, and so on. For example, if a law enforcement agency has the capacity to train its officers to differentiate potential misdemeanor cases involving individuals experiencing potential mental health symptoms (see above), then there stands a chance to divert potential mental health consumers out of the criminal justice system before criminal processing begins. In this case, the intervention involves not only players in the criminal justice system but providers in the community that can work cases brought to them by law enforcement while ensuring public safety.

In other words, the Sequential Intercept Model, or a broader, detailed process analysis, gives the ability to map out failures or inefficiencies in the system that

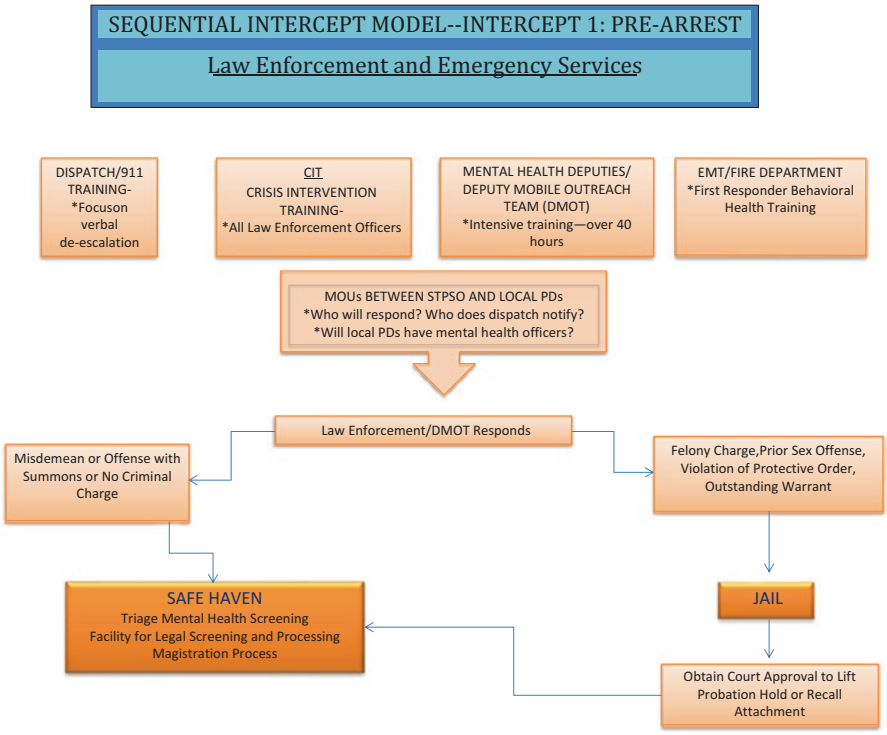

Fig. 5.1 The refined Sequential Intercept Model, Pre-Arrest, for the 22nd Judicial District Court of Louisiana and its local partners (Courtesy of Judge Peter G. Garcia and Diane Dicke)

require priority attention by the team. Here is an example—a Stepping Up Initiative team discovered that a large number of individuals with serious mental illness were being processed for probation revocations due to technical violations and new crimes. Upon this discovery, the team (including representatives from probation) identified that did not have any specialized probation supervision services available for individuals with severe mental illness and high risk of recidivism. Solutions can be designed, installed, measured, and further refined, if necessary.

5.2.3 Prioritize and Implement New Policies, Practices, and Improvements and Then Track Progress

After a complete introspection of local needs, strengths, and gaps, the team can begin prioritizing improvements to the local system. For jails, emphasis is typically placed on ensuring successful reentry back into the community as well as connectivity to treatment and/or court programs customized for individuals with mental illness (specifically, customized for different types of individuals based on risk and

need). As mentioned earlier, jails shoulder the burden of developing and maintaining the data tools to inform decision-making in a data-driven way and—most importantly—serve as the hub for mental health screening and assessment. These initiatives often are identified as an immediate goal by the group; the Stepping Up Initiative literature also recommends for each locale to prioritize further goals into short-term and long-term categories, based on an agreed-upon logic (e.g., need and/or initiatives that hold promise for broad impacts). After the foundational tools and processes have been put into place during the planning period, the team is free to work with one another to determine its priorities; recommendations are available by the Stepping Up partnerships; however, determinations should be driven by local decision-making. It is likely that one or a few parties on the team will take lead on one of several chosen initiatives, perhaps forming subcommittees for each task/implementation plan. Thus, regular progress updates should occur as a team that includes robust evaluation components to determine impact and to identify room for improvement and quality assurance. Strong communication and partnerships are key to success.

Finally, each initiative *must* be monitored to track progress. For example, the team may ask, is training needed? If so, was the training successful? To determine success, the team may partner with a local university and/or researcher to study the knowledge gained from training and/or ability to successfully put training into use. This may require a pretest, posttest design—giving trainees an exam before they are trained and upon successful completion of training to determine knowledge gained—and/or it may require observation of trainees after successful completion of training to determine whether someone who received training is using the skills and knowledge gained in their jobs. Each evaluation should be customized to the location, its partners, the situation, and so on. However, the key point here is that each initiative should be devised in a way that allows for adequate evaluation with a robust research design to ensure wise investment of funds and optimal success.

5.3 Bureau of Justice Assistance: A Source of Support

The Bureau of Justice Assistance, a child agency within the United States Department of Justice (Office of Justice Programs), has been the leading funding agency to support Stepping Up Initiatives across the country. Key funding streams for jail initiatives include opportunities under the Second Chance Act such as Targeting Adults with Co-occurring Substance Abuse and Mental Health Disorders, Adult Mentoring, and Adult Offender Reentry Demonstration, as well as opportunities under the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008, primarily the Justice and Mental Health Collaboration Program. Historically, these funding streams have aided jails in adopting, piloting, and troubleshooting screening assessment tools and processes, provided training, and have aided local partnerships in developing and adopting *evidence-based* programs and services with the intent that these initiatives are sustainable if deemed successful.

5.4 National Registry of Evidence-Based Programs and Practices and CrimeSolutions.gov

The National Registry of Evidence-Based Programs and Practices, or NREPP, is an extremely useful resource created in 1997 by SAMHSA: "The purpose of NREPP is to help people learn more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP is one way SAMHSA is working to improve access to information on evaluated interventions and reduce the lag time between creation of scientific knowledge and its practical application in the field" (SAMHSA, 2017). In other words, the NREPP repository provides practitioners with a list of scientifically vetted programs and services (as well as programs/services not quite making the cut) to serve as a guide for potential solutions for initiatives calling for mental health and substance use interventions. To accomplish this, the NREPP has provided independent assessments, by certified assessors, of the existing research on each intervention since its inception. Each assessment is designed to generate easy-to-use ratings (currently being: effective, promising, ineffective, and inconclusive) of various components of the intervention to summarize the volumes of research examined an assessment team. In July of 2017, the NREPP hosted 466 interventions, with the ability to narrow potential programs/services by easy-to-use criteria based on the target population to receive this program/service.

For example, a jail professional can use the NREPP search tools to look for interventions specific setting, in this case, correctional facilities—which narrows down the field to ten reviewed interventions as of July 2017. One of these interventions, Trauma Affect Regulation: Guide for Education and Treatment (TARGET), is cleanly summarized in an easy-to-read Program Snapshot (see Fig. 5.2). Upon a quick glance, any NREPP end user can determine that TARGET has been proven effective in treating anxiety disorders and symptoms as well as trauma- and stress-related disorders and symptoms, improving coping behaviors, improving general functioning and well-being, and helping individuals who internalize their problems. Yet, TARGET has been proven ineffective in allaying depression and depressive symptoms as well as improves self-concept but shows promise in assisting with self-regulation and social connectedness. If end users wish to wade through the research reviewed for each rating provided, easy-to-follow links are provided to enable a deeper assessment. Within minutes, any team seeking high-quality, scientifically proven programming and services to best serve their clients can rely on the information found within the NREPP to begin the selection process with confidence.

Similar to the NREPP, CrimeSolutions.gov, developed by the National Institute of Justice and launched in mid-2011, offers repository of independently assessed programs and practices to aid in informed initiative development and implementation—just with exclusive focus on programs with justice-involved individuals and with a slightly more simplistic *overall* rating scale (e.g., effective, promising, and no effects, with only one finding per program and practice; National Institute of

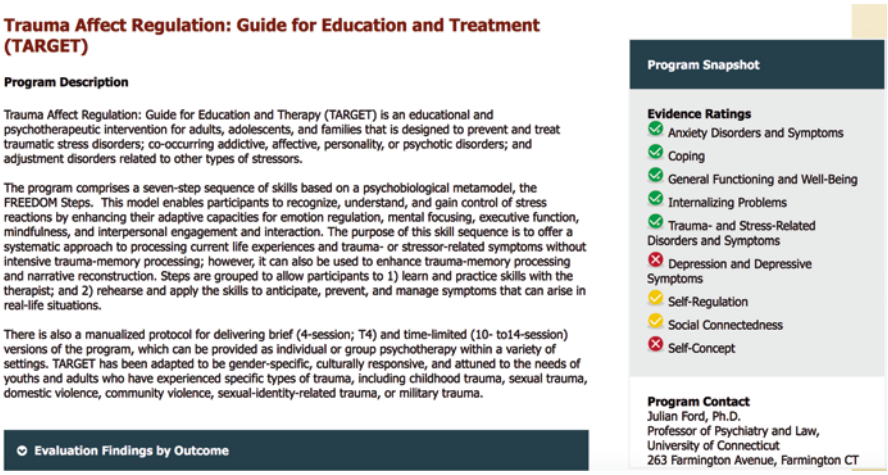

Fig. 5.2 National Registry of Evidence-Based Practices; results displaying the summary of Trauma Affect Regulation: Guide for Education and Treatment (TARGET)

Justice, 2017). As of July of 2017, 471 programs (e.g., "a specific set of activities carried out according to guidelines to achieve a defined purpose") and 58 practices (e.g., "a general category of programs, strategies, or procedures that share similar characteristics with regard to the issues they address and how they address them") have been assessed by CrimeSolutions.gov. Diving deeper, if an end user were to search for specific programs tailored specifically to individuals with mental illness in correctional facilities (excluding substance use disorder), CrimeSolutions.gov displays just four promising programs and no practices for review (as of July 2017). At this time, the vast majority of jail-based programs reviewed relating to mental health are substance use disorder-specific, with 1 effective program (Project BUILD), 12 promising ones, and 8 with no effects found. Likewise, jail-based practices relating to mental health *only* exist for substance use disorders, with two effective practices (Incarceration-based Therapeutic Communities for Adults and Motivational Interviewing), two promising ones, and three with no effects.

Thus, a great deal of work needs to be done to explore meaningful interventions in jails and within partnerships with jails. Part of the point of the Stepping Up Initiative is for counties/parishes to take bold steps to implement initiatives that can build on our collective knowledge of what works, what is promising, and what is flat out ineffective or counterproductive. As of this writing, more than 600 awards have been given by the Bureau of Justice Assistance under the Second Chance Act programs and 168 awards under the Justice and Mental Health Collaboration Program; many of these funded projects will aid in furthering our knowledge, which will expand the information found in the NREPP and CrimeSolutions.gov.

5.5 The Role of Jails in the Future

The original core intent of jails are twofold: (1) to *strategically* hold individuals in confinement awaiting trial, with public safety as the chief concern when considering decisions to detain, and (2) as a sentencing option for minor offenses that do not require prison time. For a litany of reasons but primarily due to the lack of evidence-based data tools, jails have not been able to aid in strategically holding individuals who pose a public safety risk while helping to release individuals who do not. Further, jails do not have the capacity or have limited capacity to offer the necessary services to help individuals with mental illness, which will remain to be the case in the foreseeable future. Jail professionals are increasingly accepting their roles within a broader partnership of local community stakeholders to best serve individuals with mental illness, with key emphasis remaining on services rendered in the community. This ideal, to deliver care in the least restrictive environment, has become renewed with an understanding that jails are a critical catchment point to *begin* or *restart* behavioral health interventions.

Therefore, jails of the future will need be better connected with community and agency partnerships, particularly relating to shared communication and critical data sharing. Jails will become a primary referral service for individuals, with an emphasis on connecting individuals with evidence-based care tailored to their needs. Jail professionals will take the lead on identifying the vast majority of individuals needing care in these improved local catchment systems. Therefore, they will become a major player and have a central for implementing change. Individuals who have historically needed care and have been cycling through the justice system due to lack of care, being underserved, or just receiving services proven to have no evidence to effect change will begin to get the care they deserve.

5.5.1 Drain the Jail: Customized Specialty Courts

One intervention option for jails is to establish a partnership with the local criminal court in the creation of a mental health court, particularly if individuals with mental illness tend to have longer jail stays relative to those without mental illness. Mental health courts, which will be expanded on in the next chapter, allow for individuals with mental illness to be released from jail into a program supervised by a team—typically, a judge, case manager, treatment provider, probation officer, prosecutor, and defense attorney. The court then takes lead in connecting their clients with appropriate evidence-based treatment; monitors progress, treatment compliance, and setbacks; and ensures public safety.

The jail continues to be a key partner in two primary ways. First, jail professionals continue to take in identifying individuals who may have mental illness to be potential clients. Ideally, this should be accomplished through validated screening

and assessment tools; however, if the jail simply does not have the resources to upgrade their data tools, mental health court case managers can be trained to go into jails to provide these services to identify potential clients. If the latter work flow is chosen, the jail-court partnership may invest in training of key staff to better identify signs and symptoms of mental illness (e.g., Mental Health First Aid) in order to assist case managers in identifying individuals to be screened and assessed as often individual case managers will not have the capacity to review every individual booked into jail. While not ideal, it is a step in the right direction in the absence of a central screening and assessment process.

Second, jails often serve as a behavior modification tool for mental health courts. Specifically, these programs commonly employ jail sanctions for noncompliance with program rules or treatment protocols, with this sanction type being the most punitive short of dismissal from the program. Typically, this happens when a client fails a drug screen, repeatedly misses treatment sessions, and so on. There is a stream of research that attempts to estimate the number of days jail sanctions should last for positive change in light of noncompliance; it should be noted that too lengthy of a stay can backfire and cause problems, so great care must be taken in partnership with the jail to ensure the success of this measure.

5.5.2 Avoid the Jail: Safe Haven

Instead of intercepting individuals as they pass through jail, and perhaps, as described above, partner with the court as a primary referral source, an initial catchment point could be set up with first responders to capture individuals with potential mental illness before they go to jail. In other words, for individuals who are having a mental health crisis but may not be engaging in illegal behavior, first responders should have a resource available to them to affect an intervention. A model called Safe Haven, developed in San Antonio, serves as a leading model across the country for this very situation. Safe Haven has been developed to be a centralized hub and shelter for the care of individuals in crisis, with staffing by key agencies and personnel most apt to help—mental health professionals (including substance use), housing specialists, law enforcement (including probation and parole), and education and career development professionals, among others.

While intended to serve the homeless, a Safe Haven can offer screening and assessment with referral out to services just like a jail can, yet at an earlier point of intercept (e.g., before arrest or hospitalization) is imminent. Much more coverage on this model will be offered in the chapter on community-based services. Jails should often be included as a partner in these projects as data sharing can become critical. For example, if an individual released from jail and ends up homeless, any effort to connect this individual to treatment or any screening and assessment performed by the jail may be extremely valuable to a Safe Haven.

5.5.3 *Use the Jail: Expand Available Services, Case Management, and Use of Reentry Plan*

Jails with resources may have the ability to adopt evidence-based programs and services to act on the findings of screening and assessment immediately. This becomes important for inmates serving time in a jail. In fact, recent research suggests that individualized treatment that begins prior to release and continues into aftercare post-release is most likely to be successful (Travis & Visher, 2005; Osher, 2006; Osher, 2007). As such, jail reentry programs will continue to grow and proliferate in the upcoming years.

Seeking Safety is one such program designed for individuals (men and women) with post-traumatic stress disorder symptoms or diagnosis co-occurring with substance use disorder (Najavits, 2001). This flexible program is designed to provide clients with effective coping skills and psychoeducation. To do so, the program focuses on defining safety as one's primary goal in one's relationships, thinking patterns, behaviors, and emotions while addressing PTSD symptoms along with substance use simultaneously. The Hampton Roads Regional Jail in Portsmouth, Virginia, is currently piloting this program with local funding with hope to expand on its evidence-based in the local area through external grant funding. Many jails across the country are engaging in similar strategies as they search for a pool of funding to rely on to sustain these initiatives.

Holistic reentry programs designed to treating substance use disorder, not specifically mental illness, are much more commonplace and routinely funded. One excellent example is the Allegheny County Jail-Based Reentry Specialist Program. This program begins in the jail with 5 or more months of programming that includes case management, education (literacy and GED classes, tutoring, basic education, and pre-apprenticeship training), structured job readiness classes, relapse prevention, cognitive behavioral therapy, and gender-specific drug treatment for substance use disorder, housing support services, parenting classes, and much more. Upon release, clients can receive up to 12 additional months of programming, with many of the same offerings available in the community. This model is becoming increasingly popular, and jails are increasingly working with community partners to ensure the continuity of programming and services upon release. At some point in the near future, this model will be customized for individuals with mental illness to provide services for individuals that must serve time in jail and who may not be a good fit for alternative programs available, such as diversion or mental health court.

5.5.4 *Out-of-the-(Pizza)-Box Innovations*

Chicago's Cook County Jail is using a new and innovate approach to fund programming within the jail (Babwin, 2017; Janssen, 2017). Rather than using taxpayer dollars to fund their version of a work release program called "Recipe for Change," they

have turned to an internal solution. The inmates at Cook County Jail are creating and selling pizzas inside the jail. According to media interviews, jail staff are using the pizza system as a means to treat inmates humanely while affording inmates an opportunity to learn skills that may be helpful upon release from jail. Additionally, this pizza program is used as a behavior incentive. If any inmate is involved in disruptive behavior, they are immediately transferred out to Division 11 cell block where the Recipe for Change program is housed, thus resulting in the loss of pizza privileges.

Participating inmates attend classes 5 days each week, just like many other jail culinary program. Classes are taught on different topics related to the foodservice industry, such as food safety and sanitation, as well as preparation techniques and cooking skills. There is a set menu daily, which always includes a pizza that uses fresh ingredients from the nearby Cook County Sheriff's garden (Freeman, 2017).

Sheriff Tom Dart suggests that this program has already begun to show an immediate positive impact on inmates. The plan in the future is to obtain a food truck so that the pizzas can be sold to a nearby courthouse, creating additional revenue to self-fund this training program. The Recipe for Change program is just one small step in positivity within the jail system and the community. Jail inmates are finding a bit of humanity among good food. Upon return to their community, their skills in the kitchen are transferable. Yet, it should be noted that it seems as though the program lacks an evidence-based for broad impact. The out-of-the-box revenue generation concept of the program can fund solutions to resolve this gap. At times, solutions such as these are easier to come by as taxpayers are often wary of increasing their burden.

5.6 Conclusion

In the United States, our jail system continues to be a large provider of mental health services. This fact is both alarming and concerning in that there is a need to have those services be both adequate and documented. Budget cuts and funding concerns have led to understaffing and overcrowding in most local jails. Additionally, recidivism and lack of alternative resources in community only help to fuel the fire of increased inmates and struggles. Slowly, communities are coming together to work toward a better way to handle these issues for those in their area. In later chapters, some of those resources will be discussed with the hopes of bringing to light success stories. Those success stories can continue to the process of creating change.

As it stands now, there is a lack of adequate research on the jail system and how inmates are treated both physically and mentally. Specifically, there is a lack of baseline knowledge about training of correctional officers from one state to another, much less within the counties/parishes in each state. This is significant because this lack of information does not allow for proper comparisons. Without proper comparisons, there is no baseline evidence to support positive or negative outcomes. Thus, improvement becomes nearly impossible, particularly jails within major cities like Los Angeles and New York that have documented problems with mental health services. If there does not exist standardized information on training

of corrections officers, how would a researcher be able to compare? If officers in both California and New York were required to have a specific certificate, research could be done to establish success or failure. Additionally, comparisons could be made to say that certain trains or methods work better than others, thus improving the system as a whole. All in all, these changes could allow for a more comprehensive approach to overcoming obstacles within the jail system and the treatment of those incarcerated.

Moving on, as discussed many times with recidivism, typically a person who is incarcerated without programming to help in change, will return to jail or prison. Going along with that thought, it could be safe to say that those in these jail systems may very well enter the prison system eventually. Why is this important? Research about short-term stays within the jail system could lead to significant information as it relates to the prison system. Therefore, having states work together for better standards or even just within a state system could vastly change outlooks for the criminal justice system of the United States.

Another note regarding the lack of research, if a community has no information on the number of individuals with mental illness within their jail system, then there would be no initiative to treat those individuals. Often these jails have known that there were individuals within the system with mental health, but no knowledge was known of the extent of the number. Luckily, this has prompted some communities to take action.

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