

# On Language and Limits; Missions and Mental Health

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## Introduction

Temporally speaking, this article is an outcome of time spent with large jail managers at a meeting sponsored by the National Institute of Corrections in the fall of 2012. But philosophically speaking, this article is the product of many years of working in jails, in mental health agencies, and in academia, as well as many years of living in communities where persons with acute, chronic, and serious mental illnesses are found. As anyone reading this article knows, the boundaries between the mental health system and the jail system have blurred in the last two decades, leaving jail systems in particular scrambling for a fix—or at least for a patch to fill the hole left by an underfunded community mental health system and its increasingly limited array of services offered to persons with mental disorders.

Jails are one service provider in a community of service providers. Their core role and mission is in providing safe and secure custody of persons who must and can be legally confined. This article contrasts the specialized roles of jails and the community mental health system. It then suggests actions that jail administrators can take when they want to define the jail's mission—and the boundaries of that mission—while contributing to the development of true solutions for their communities.

One of my earliest social work jobs was in an outpatient community mental health setting, where I provided individual, family, couple, and group counseling to a wide swath of the Colorado Springs, Colorado community. Even though at the time (the 1970s and early 1980s) we lamented the government's refusal to keep its promise of adequate funding and support for an array of community-based services, even the most cynical among us would now agree those were the glory days of community mental health. Those were the days when one's first client of the day might be someone in need of immediate hospitalization for her first episode of psychosis, the next client might be a colonel in the Air Force seeking help for his marriage, and the last might be an 18 year old mother referred by social services for the parenting classes and counseling required before her children would be returned to her physical custody.

Indeed, those were the days when *everyone* came to the local mental health center for services. Not that stigma didn't exist; it did. But even in the face of it, the word and meaning of *community* mental health meant that it was a place of, in, and for the community; a place where anyone could be seen, and at a reasonable cost as well. Those were the days of the International Classification of Diseases—the

ICDA-8<sup>1</sup>, the standard diagnostic manual and coding system at the time, which was followed by the Diagnostic and Statistical Manual (DSM) II, listing a mere 182 disorders—a far cry from the 297 disorders found in the latest version, the 2000 DSM IV TR (text revision).<sup>2</sup>

I went to work in the local jail in 1983, in anticipation of a consent judgment (related to a series of completed and attempted suicides in that jail) that would require the hiring of a licensed mental health professional. I stayed for more than 7 years and watched the jail system morph from a linear design to a modular design, from indirect to direct supervision, from some 225 inmates in a jail built for many fewer to more than 800 inmates housed in two facilities. I worked closely with the community mental health center—the same center where I used to be employed—exchanging information as necessary to maintain individuals' health and safety (clearly a part of the security function) and working with community mental health professionals to access state hospital beds for persons in acute and life-threatening crises.

Over the years, as the allocation schemes and supply of psychiatric hospital beds became more restricted, I valued the support of judges, attorneys, and wise mental health colleagues who understood one critical, indisputable truth: the jail was not and never would be a division of the community mental health system. What we didn't understand at the time was another critical, indisputable truth: If you build it, if you boast about it, they will come. Somewhere between these truths we all lost our focus.

Though we are unable to change history, we can learn from it and work to change what happens next. Indeed, many changes have occurred in mental health systems and in jails over the last 45 years—some carefully planned, others accidental. An example of the former is the development of direct supervision management strategies and the physical environments to complement them. An example of the latter is the status of jails as the largest single provider of custodial services for persons with mental illnesses. We can learn from our mistakes and our successes, and it all starts with clarity of language and steadfastness of mission.

In the face of recent tragic, almost unfathomable events involving persons who appear to have (had) some form of diagnosable mental disorder, the nation is beginning an examination of the need for a different (but not new) kind of domestic security. The three ideas most frequently floated for the prevention of mass murders have to do with gun control, preventive mental health services, and incarceration.<sup>3</sup> Perhaps this is the moment when viable alternatives take shape and when incarceration becomes the least relied upon alternative. If we are to learn anything from history, let it be that no good comes from mission creep.

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<sup>1</sup> World Health Organization. (1968). ICD-8, Adapted: International statistical classification of diseases and related health problems. (8th Revision). New York, NY: Author.

<sup>2</sup> American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

<sup>3</sup> See, for example, <http://www.nytimes.com/2013/01/11/us/politics/biden-to-meet-with-gun-advocates-including-nra.html>

## The History

An examination of how our society responds to mentally ill persons in crisis and the appropriate role of jails must address the history of both the jail and the community mental health systems.

**Jail Systems.** The nature and function of the jail system is established and documented in state legislation, but its historical development is less than clear. Though often joined at the literary hip with prisons, the specific catalysts of the jail's evolution over the centuries are not as well identified. Whether the changes in roles and functions of the jail have occurred at the will of the state, of the local governing body, or of the elected official in charge is also unclear, though chances are all three forces have had their effect. And one cannot forget that the federal government, in all its branches, has played a critical role as well. Civil rights legislation, Supreme Court decisions, and executive actions have all influenced, and continue to influence, jail change.

In every state there is some legislative authorization for the detention of citizens and other persons found in the state. Following are examples of the jail's statutory mandate in three states.

In Kansas, Chapter 19 of the Revised Statutes reads:

Jail at county seat. There shall be established and kept at every county seat, by authority of the board of county commissioners, at the expense of the county, a jail for the safekeeping of prisoners lawfully committed. (K.S.A. 19-1901).

In California, the State Penal Code governs, and as to jails it reads:

The common jails in the several counties of this state are kept by the sheriffs of the counties in which they are respectively situated, and are used as follows:

1. For the detention of persons committed in order to secure their attendance as witnesses in criminal cases;
2. For the detention of persons charged with crime and committed for trial;
3. For the confinement of persons committed for contempt, or upon civil process, or by other authority of law;
4. For the confinement of persons sentenced to imprisonment therein upon a conviction for crime.
5. For the confinement of persons pursuant to subdivision (b) of Section 3454 for a violation of the terms and conditions of their post release community supervision. (Cal. Penal Code § 4000).

And in Florida, similar authorization is found:

County and municipal detention facilities; definitions; administration; standards and requirements.

(1)(a) “County detention facility” means a county jail, a county stockade, a county work camp, a county residential probation center, and any other place except a municipal detention facility used by a county or county officer for the detention of persons charged with or convicted of either felony or misdemeanor. (Fla Stat. § 951.23 (1)(a))

The common theme of these authorizing statutes seems to provide at least a broad definition of local jails’ mission, which is to provide for the detention and confinement of persons charged with a crime or civil infraction and/or to otherwise ensure their appearance in court. Most state detention-related statutes also speak to the need to treat people humanely, to attend to their physical and emotional health, and in some states, to do so “in a manner which promotes their reform.” (K.S.A. 19-1919).

**Community Mental Health Systems.** The evolution of the community mental health system is well documented. Outraged by the enormity of state hospital systems and convinced that mental health care provided in one’s home community would be more fiscally and morally sound than the wholesale institutionalization of persons with severe mental illnesses and other disorders, Congress in 1963 passed the Community Mental Health Services and Construction Act (“the Act”).

This was not simply a spontaneous governmental act of altruism; it was clearly the product of a confluence of events:

- The development of new medications that promised to better control some of the positive (that is, the more evident) signs of severe mental disorders;
- The cost to the federal government of funding state mental institutions, which in the mid-1950s housed close to 600,000 people;
- The outcry of the public—family members who yearned for a more humane form of and milieu for treatment; and
- The political will of President John F. Kennedy, whose personal, familial experience with mental illness no doubt served as a driving force behind the Act<sup>4</sup>.

The Act promised the development of comprehensive community services, including acute hospital beds; step-down or short-term emergency services, often delivered in crisis units; day treatment programs; outpatient services; and consultation and education services. Based on the recognition that mental illness strikes in all social and economic strata, the spirit of the Act was an inclusive one: everyone would be able to physically and financially access the services available in their communities.

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<sup>4</sup> Kennedy’s comments to Congress prior to introducing the Act are particularly interesting and relevant, and one might substitute the word “jail” for the words “hospital” and “institution” and find wonder in the parallels. <http://www.presidency.ucsb.edu/ws/?pid=9546>

As is often the case with best intentions, however, the reality differs from the vision. Not all of the services contemplated in the Act were funded. Over time and as a result of evolutions in both political and fiscal will, the nature and objectives of the services that were implemented at the community level changed. Funding streams and schemes and reimbursement formulas, both public and private, forced community mental health centers to redefine and prioritize their target populations and problems. These agencies often identified for priority services persons with serious mental illnesses, children, and members of other special population groups, such as adolescents, older adults, persons with dual diagnoses of mental illness and chemical dependency, and, in some cases, forensically involved persons. Curiously, many of these people make up the very same populations that jails are now struggling to serve. How did this happen?

## What Happened.

There are many theories about why so many persons with mental illnesses are incarcerated. The conjectures of Lionel Penrose<sup>5</sup>, a British psychiatrist, often are cited. After studying criminal justice data, Penrose pointed to an inverse correlation in the size of the populations in psychiatric hospitals and in prisons: as one rises, the other falls. Penrose suggested that the rise and fall of these populations were related to political will and, by extension, to the funding that accompanies that will. When mental health treatment is valued, the availability of beds in psychiatric facilities increases and imprisoned populations decrease, and vice versa.

Closure of state hospitals and increases in the number of prisoners with mental illnesses reinforced the power of Penrose's theory. This phenomenon was once thought of as "transinstitutionalization," but in recent decades it has been reframed as the "criminalization" of mental illness. The expediency of transporting a person in an acute state of distress to jail rather than to a mental health facility is well known. For the most part, jails, acting outside of their mission of providing safe and secure custody of persons lawfully detained, have been willing participants in this criminalization process. Jails have been inclined to help law enforcement officers to resume their patrol duties—even though in doing so, they assume custody of a person in the throes of a health crisis.

## How Many People Are We Talking About?

Over the last 20 years, various studies have generated information about the number of persons incarcerated in U.S. jails who have a diagnosable mental illness. The numbers have varied widely depending on the methodology used. Overall estimates of the extent of mental illness within jail populations range between approximately 14 to 17 percent when including both men and women and reach as high as 31 percent when focusing solely on women. When substance use and dependence disorders are also examined, we learn that 68 percent of the jail population has a substance use

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<sup>5</sup> L. Penrose, Mental disease and crime: outline of a comparative study of European statistics, *British Journal of Psychiatry* 1938;18:1–15.

disorder. The proportion of mentally ill jail inmates who have a co-occurring substance use disorder exceeds the 70 percent mark.<sup>6</sup>

In the free world, in any given year, about 20 percent of the adult U.S. population reports having any type of mental illness, a percentage that has been stable since 2008. In 2011, 5 percent were reported to have a serious mental illness, which is slightly higher than the 4.5 percent reported in 2008 but equal to that reported in 2009 and 2010. Among free persons with serious mental illness, 25 percent had a co-occurring substance use disorder—much lower than the prevalence among seriously mentally ill jail inmates.<sup>7</sup> Looking at this from the opposite angle, among adults who had a substance use disorder in 2011, about 42 percent also had a co-occurring mental health disorder.<sup>8</sup>

Thus, while the overall percentage of people with some type of mental disorder is comparable in and outside of jail, there are many more people found in jail with co-occurring substance use and mental health disorders. This is not surprising given the criminalized nature of drug possession and use.

Finally, lifetime rates of mental illness are significant. Approximately 50 percent of persons in the U.S. develop a diagnosable mental health or substance use disorder over their lifetimes, a percentage that has risen over the years. Many of these diagnosed disorders are first observed in childhood and adolescence. When our scope is limited only to mental disorders, the lifetime occurrence rate is nearer 30 percent.<sup>9</sup>

## Resources and Responses

As we have seen, in and out of jail, the numbers of persons with diagnosable mental illnesses and co-occurring disorders in this country are notable. It is not hard to imagine the human and fiscal resources challenges that arise from this demand. For public and community mental health services, these challenges have meant a narrowing of target service populations and intervention offerings. The result has been an ongoing redefinition of the nature and purpose of the public mental health system. Federal and state government policies have set the pace for the makeover by changing funding schemes,

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<sup>6</sup> For a good recent summary of the research and other relevant information, see Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggelston, A. (2012). *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. The Council of State Governments/Justice Center and the Criminal Justice/Mental Health Consensus Project. Available at [http://issuu.com/csgjustice/docs/behavioral\\_framework\\_v6\\_full/1](http://issuu.com/csgjustice/docs/behavioral_framework_v6_full/1)

<sup>7</sup> Ibid.

<sup>8</sup> Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

<sup>9</sup> See <http://www.cdc.gov/Features/MentalHealthSurveillance/> and Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the national comorbidity survey replication. *Arch Gen Psychiatry*, 62, 593-602. Available at [http://www.ph.ucla.edu/epi/faculty/detels/PH150/Kessler\\_DSMIV\\_AGP2009.pdf](http://www.ph.ucla.edu/epi/faculty/detels/PH150/Kessler_DSMIV_AGP2009.pdf)

Medicaid reimbursement formulas, state hospital bed allocations, definitions of forensic populations and services, and criteria for accessing emergency psychiatric evaluation and treatment.

Jails have met similar and in many ways largely invisible challenges in connection with mental illness. The target population for the jail includes everyone whose custody is assumed by the jail—everyone and anyone. And it is well documented that many of the people who enter the jail enter with significant risk factors for the development or exaggeration of mental illness, stemming from having lived lives of poverty, having poor or inadequate education, being subject to un- or underemployment, coming from or living in disrupted families, and having been exposed to incarcerated first-degree relatives and friends. Many of these detainees have substance use and dependence disorders. Some have histories of mental illness, symptoms of which have been aggravated in part because of the lack of adequate systemic interventions<sup>10</sup>. Some are acclimated to the jail environment where the daily pressures of basic survival no longer exist, at least not in the same form, and, in the case of those with mental illnesses, where the pressures to take medications and submit to assessments and clinical demands are probably not as immediate.

Even when these people are released from jail with treatment plans and mental health appointments in place, they are returning to live in communities where, when their symptoms rage, it is still easier for them to be taken to jail than to a crisis center or emergency room. Despite many years of innovative work around the country to develop alternatives to incarceration for persons with significant mental illnesses—alternatives such as pretrial services, jail diversion programs, crisis intervention teams, mental health courts, and specialized probation and case management services—the impact on jail systems seems as intense and enormous as ever.

Indeed, the fact that the mental health challenges facing jails are invisible is a double-edged compliment. The number of people managed, the problems they have and the challenges they present, the movement of people through these systems (both the physical environs of the jail and the judicial system), and the human and fiscal costs of these challenges—all are typically invisible to the community. They are invisible in part because, as a whole, jails are doing more than their fair share of managing persons with mental illnesses, and they are managing them well over lengthy and expensive periods of time.

As the reach of community mental health services has diminished, that of the local jail has expanded. In the twenty-first century, jails are frequently referred to as the “largest mental institutions” in the

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<sup>10</sup> For an excellent overview of the evidence supported relationships between poverty and other social-psychological conditions, including mental illness, see [Murali, V., and Oyebode, F. \(2004\). Poverty, social inequality and mental health. \*Advances in Psychiatric Treatment\* \(2004\) 10: 216-224 doi: 10.1192/apt.10.3.216 F.](#) Available at: <http://apt.rcpsych.org/content/10/3/216.full>

country.<sup>11</sup> Really? How does that language—that definition of the jail’s function—affect the jail’s essential mission? And what about the term “mental institution”—what image does that conjure up in your head? I see a monolithic, poorly managed, oppressive, insensitive, anti-humanistic cuckoo’s nest (to recall the Ken Kesey novel and motion picture)—an image much different than that of most twenty-first-century jails.

What is the language used in your county to describe what is going on in your jail with regard to caring for persons with mental illness? Do your neighborhoods’ residents know how many persons with serious mental illnesses and/or co-occurring disorders are in the jail? Do they know what the jail’s monthly bill is just for psychotropic medications? I suspect not. What about the administrators and staff at the community mental health center in your area—do they know? Probably not.

How about the members of the executive branch of your government and other movers and shakers in your community—do they know how local agencies respond when a mentally ill person comes into contact with law enforcement? How about the police chief? The juvenile detention director? The school board? Your public health officer? The director of the Chamber of Commerce? How about your college and university leaders, including the administrators and staff of your state’s medical and allied health schools? These are all people affiliated with organizations that “feed” the jail population. So, why don’t they and everyone else in your community know about whom you are managing and the work entailed in managing so many people with mental illnesses?

Your answer may be that this is old news, that everyone knows about the inundation of jails with persons with special mental health needs and substance use and abuse conditions. If that is your belief, I invite you to test it out. Call a few people—the police chief, the school superintendent, your public health director. Ask them if they know what is happening in your community’s jail—not the Los Angeles County Jail or the Cook County Jail; your jail. The gap in knowledge about your own community’s experiences and response may surprise you.

The truth is, contrary to popular opinion, the Los Angeles County Jail is not the largest “mental institution” in the country. Neither is the Cook County Jail nor Rikers Island<sup>12</sup>, no matter what the media say. These are not mental institutions—they are jails. They may provide more mental health services than any other single provider in the area, but still they are not mental institutions. What is important for the public to understand is that the jail system is the largest single provider of *custodial services* for persons with mental illnesses in your area. Note this difference well: not mental health treatment; custodial services.

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<sup>11</sup> For example, see [http://www.upi.com/Health\\_News/2010/07/12/Jails-are-top-mental-health-institutions/UPI-27621278982109/](http://www.upi.com/Health_News/2010/07/12/Jails-are-top-mental-health-institutions/UPI-27621278982109/); <http://www.npr.org/templates/story/story.php?storyId=93581736>; <http://www.pbs.org/wgbh/pages/frontline/social-issues/cook-county-jails-impending-mental-health-crisis/>; and <http://www.npr.org/2011/09/04/140167676/nations-jails-struggle-with-mentally-ill-prisoners>

<sup>12</sup> as above

## Changing the Language and Embracing the Mission

How a problem, challenge, or responsibility is framed linguistically—and who frames it—has a lot to do with how it will be solved, met, or assigned. The following ideas are offered in line with the core jail mission of providing safe and secure custody of persons: (a) whose appearance in court has been lawfully commanded, (b) who have been sentenced to serve time for a criminal conviction in the local county jail, and/or (c) who have been sentenced for a criminal conviction and await transfer to a state penal institution.

Providing safety and security includes seeing that inmates' health needs are met in a way that stabilizes or improves their well-being and the well-being of those around them. The legal mandates for mental health interventions in jails are well known: jails must provide timely assessments including crisis intervention services and, where indicated, a care plan, follow-up, and discharge planning services. The provision of safe housing is a jail management and inmate classification responsibility to which every inmate is entitled. Some jails create what they call "special needs units" as a way to provide a separate, specialized, and lower-stress environment, but the legal and ethical mandate is simply for safe housing. In operation a dedicated unit can provide space for a particular kind of service, such as mental health care, to be adequately delivered.<sup>13</sup> Unless an agency operates a licensed mental health facility within the jail, there is no specific mandate for a dedicated mental health housing unit, though they certainly and commonly are found in jails across the country.

**Clarity of Language.** Admittedly there are many days it seems so, but *the jail is not a mental institution*. Resolve to disabuse people of that notion.

The jail is what it is: a custodial criminal justice institution that at present is likely to house a disproportionate number of persons with mental health and/or substance related challenges. If you call yourself a mental institution, then the problem of housing persons with mental illnesses is minimized—because, after all, they belong there, don't they? If you call yourself a custodial institution, then we have to wonder why so many people with serious, acute mental illnesses are there and not in psychiatric hospitals where they can be properly treated. Once a jail calls itself a mental institution, it has created a natural place for law enforcement and courts and others to send persons who are acutely psychotic.

Change the language and the way the issue is framed. Doing so will not necessarily stop others from using you as they have, but it may pave the way to changing how you see yourself and your trajectory and allow you to control both.

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<sup>13</sup> See Collins's (2007) still timely summary of legal issues and mandates for jails at <http://static.nicic.gov/Library/022570.pdf>

**Clarity of Mission.** The mission of the community mental health system is constantly evolving, dependent on fiscal and human resources and on the will of government. But the community mental health system has done one thing very well: it has become more focused and less tolerant of waste. Initial and ongoing assessments are designed to identify a client's problems and create responsive plans for dealing with them. When the problems are outside the scope or capabilities of community mental health, clients are referred for specific services, or services may be denied.

The jail's mission is a bit more circumscribed. *Once custody is assumed by the jail*, and the inmate's freedom to seek assistance elsewhere is curtailed, the jail assumes the responsibility for that inmate's wellbeing. The jail must see that adequate and ongoing assessment, response, and (where indicated) care are provided for any health or mental health issues that challenge the safety and security of the inmate, others with whom s/he interacts, and the facility. The jail's obligation is to treat symptoms, not necessarily to cure the illness (though we know that jail health care staff do so all the time), and to do so in a way that comports with best practices in health/mental health care in the community. That obligation takes hold at the moment the detainee is accepted into the jail.

This is the hard part. Nowhere in the jail's mission does it say that the jail is responsible for the lack of services available in the community, for law enforcement's exercise of its arrest powers, or for the lack of pretrial, crisis intervention, or jail diversion programs in the jurisdiction. Indeed, the jail's responsibility is limited to people lawfully admitted into the jail.

If the jail is not a mental institution, then those persons brought to the jail who show acute symptoms of a behavioral health (read: mental health) disorder should be referred to a psychiatric facility. There they can be assessed, given a clear diagnostic workup, and provided with a plan of action, and only then be cleared for custody in the non-therapeutic environment of the jail—if such custody is warranted given the circumstances under which the person was taken into custody by law enforcement. And, no matter the paint color, the porcelain toilets, the single cells, the moveable furniture, and what the housing unit is called, jails can't create the same level of therapeutic environment that psychiatric facilities can. Despite the notable work being done in many facilities, the essential jail environment can never be truly therapeutic. This reality should be communicated to the public, who, on hearing the terms "mental health unit," "forensic division," or "behavioral health pod," enjoy dreamy thoughts of comfortable, peaceful, and nurturing environments.

Most governing legislation in fact requires jails to accept persons who have been lawfully detained, and refusing someone pending the completion of a psychiatric assessment doesn't mean you'll never see that person again. What it does mean is that the detainee will be seen by a mental health professional—one who has access to the same resources as, or perhaps even more resources than, jail personnel and whose mission and expertise is to assess, diagnose, and create a treatment plan for the individual seen. The detainee may end up in the jail, and indeed, may well deserve to be in jail, but in most cases no

detainee should be incarcerated until everyone with a need to know understands the reality and implications of his/her condition.

A wise and capable institutional manager will stop short of taking on the roles and responsibilities of the community mental health and state psychiatric hospital systems. These roles are clearly outside the scope of the jail's mission. As frustrated as one can be with how these entities function, or fail to function, I find it helps to remember that public mental health care is the victim of political interlopers who continuously raid this system, once designed to catch and support everyone with significant mental health needs. It is an expensive system of care, one that is forced to rely on the private pharmaceutical industry and still largely dependent on the expensive medical model when responding to persons in need.

Before expanding your jail's role, think about your jail's monthly pharmacy bill for psychiatric medications. Imagine assuming responsibility for a system where a day in an inpatient psychiatric hospital bed costs a minimum of \$1,000. Imagine the numbers, the credentials, and the salaries and benefits of staff who would have to be hired, and consider the cost of their malpractice insurance. Consider the emotional, social, and fiscal costs of fending off litigation for allegations of malpractice, negligence, and conditions of confinement.

The alternative? Find ways to work with the public health system. It is less expensive and more productive to assign an officer to the outpatient clinic or the hospital emergency room than to try to circumvent the system by billing the jail as a mental institution or even as a primary provider of mental health care. Are the jail's actions and decisions backed up with orders for competency and sanity evaluations? Your advocacy efforts toward securing legislation that authorizes these evaluations to be done in the jail or on an outpatient basis would be a fruitful endeavor.

I will offer one last suggestion about language, mission, and the idea of influencing legislation and policy. This is critical time in our country, when as a result of recent mass shootings there is renewed commitment to take action—be it by legislation or executive order—to prevent the kind of violence that results in mass tragedy. Policy options will be examined that involve actions and responses by law enforcement, community mental health systems, and jails. It is important that you, as a public safety professional, speak out for enhanced mental health funding, for the underlying research and development efforts needed to create better crisis and violence assessments, and for ways of encouraging and facilitating the public's interest in seeing that all people get the mental health care they need—when they need it, and where they need it. Clearly define the jail's mission as a custody provider, not a primary treatment provider. Be wary of the suggestion that preventive detention is the only option for preventing violence. And if preventive detention is to become mandated in your state or locality, advocate for legislation requiring that community mental health services be delivered in jails while the person is incarcerated.

## Considering Your Options Inside the Jail

Whatever your agency's aims are over the long term for responding to the needs of detainees with mental illnesses, most jails are likely to be providing some level of mental health services and will continue to do so. Take the time to think through the implications of certain operational decisions you are making now.

**Personnel.** Why let someone else hire your critical personnel? Insist on interviewing and on exercising the right of refusal of any candidate applying for the position of mental health director in your facility, no matter who that person's direct employer will be. Don't miss the opportunity to find out if the mental health director shares, and will act to further, your philosophy about the jail's mission and purpose in the community. This person is your face to the public and private mental health system, and the message that originates in your institution should be consistent with your custodial responsibilities: no drama; no mission creep.

Hire a substance abuse treatment coordinator. Substance use and dependence disorders are common in the jail environment, and they are mixed up in and aggravate the diagnosis and treatment of mental health disorders. Though you run neither a mental institution nor a chemical dependency treatment center, assessing every inmate for his/her need for such treatment and choosing from a range of evidence-based interventions to get it going<sup>14</sup> is a great place to put energy.

Insist, when a detainee is admitted who is known to the community mental health system, that community mental health serve that detainee while s/he is incarcerated. You can do this by promoting legislation or by presenting the argument during budget negotiations. Encourage the reality of a seamless system of community care, as originally articulated in the components of the Community Mental Health Act. Reassert the mission of the jail: to provide safe and secure custody. Make the case for what the jail needs in order to do so—that is, the ongoing involvement of the experts who have seen and will see the detainee when the criminal or civil actions against him/her are resolved.

**Services.** If assessment, crisis intervention, development of a treatment plan, case management/follow up, and discharge planning are the fundamentals of jail-based mental health programs, consider how and how well these are accomplished in your facility. Keep in mind that there is no mandate for jails to provide psychotherapy. Also consider that interventions based on cognitive

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<sup>14</sup> Start here, at the Substance Abuse and Mental Health Services Administration's (SAMHSA) website for evidence based practices: <http://www.nrepp.samhsa.gov/>

behavioral approaches appear to fare better, in terms of their ability to improve offender outcomes, than insight-oriented methodologies.<sup>15</sup>

**Environ.** Maybe you need a special needs unit in the jail to house persons with mental illnesses; maybe you don't. Designating special units can be helpful in terms of making targeted staff deployment decisions and creating a space where clinical work can be accomplished on site, minimizing the movement of disruptive people in the jail itself. But these units can also be a burden. Wasted bed-space often is a problem. Lack of clarity about who can authorize admissions and discharges to the unit creates tension and can also result in housing gridlock. How the unit is used also makes a difference. If, for example, the unit is used both for special watches and for housing certain inmates who require more acute-care supervision, how might one function influence the other?

There is nothing magical about a special needs unit. If there is magic to be had, it comes from how it furthers the mission of the jail while enabling the jail staff to provide for the very special and particular needs of some of the inmates in it.

If the community mental health provider is to deliver services in the jail, working collaboratively with jail staff also might create some magic. Think of it: experts, committed to two different missions, working together to usher people through the boundaries of their separate institutions so that each can deliver what is called for in their mission. In other words, it looks like this: a special needs unit that supports and enhances the safety and security of the institution, while providing a more focused opportunity for professionals to work together to help stabilize a person with a mental disorder. That's it; that's the goal, is it not?—the co-existence of purpose without the dangers of mission creep.

## Taking the First Steps

Sheriffs and jail commanders might read this and think that all of these suggestions will take too long and will prove to be impossible to implement. But the truth is that there are several actions that can be taken this very day to make a difference.

First, *call a meeting to reassert your mission* in discussion with the community agencies with which you interact frequently, including law enforcement agencies and community mental health. Give them the facts about the challenges you face in managing persons with mental illnesses. Ask them to join you in your efforts to get back to the basics of jail function and form. Tell them your ideas about how you will

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<sup>15</sup> See, for example, Andrews, D.A., and Bonta, J., *The Psychology of Criminal Conduct*, 5th ed. Cincinnati, OH: Anderson, 2010; Milkman, H., and Wanberg, K., *Cognitive-Behavioral Treatment: A Review and Discussion for Corrections Professionals*. Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, 2007. Available at <http://nicic.gov/Library/021657>

accomplish this return to your mission, and give them a timeline to prepare. This is not a negotiation or a problem-solving session—this is an information session.

Beginning on a date you choose and have communicated in advance, and after providing jail staff refresher training that especially focuses on identifying the common behavioral symptoms of mental disorders, *refuse for admission any persons who evidence acute symptoms of mental distress until they are cleared for custody and have a treatment plan for care.* Acute mental illness in a detainee is no different from chest pains: obtaining expert care takes precedence. Jails must stop accepting people in mental distress without evaluations. Your aims in refusing to admit a mentally ill person in crisis are two: to gain expert guidance about how to care for the persons whose custody you ultimately assume, and to help move law enforcement toward better arrest decision-making. It may be helpful if you pool resources with law enforcement and mental health and post an officer at the local crisis intervention center or in hospital emergency rooms for just these kinds of situations. By doing so, you may help calm these partners' fears of having to evaluate an aggressive or otherwise disruptive person in a public space.

*Invite community mental health to provide ongoing services to their clients in the jail.* Trust your interviewed and hand-picked mental health director and your substance abuse treatment coordinator to shepherd this process as it unfolds. Expect resistance, but insist on performance. Perhaps that occurs by revisiting the county's funding agreement with the community mental health agency or by pursuing court orders or making other kinds of advocacy efforts. It is true that community mental health is operating under tight budgets and restrictive reimbursement structures. You will surely feel their pain when you hear that it is unlikely that they will be reimbursed for services delivered in the jail. But there is some hope for change, as the recent interpretation of measures under the Affordable Care Act suggests that health coverage for nonconvicted offenders is a part of the package<sup>16</sup>. So, there may well be a future in joining together to advocate for change in reimbursement rules and formulas—but for today, the only thing that matters is their assistance in the jail.

*Get out in front of the violence reduction discussions currently underway.* Any scheme that relies principally on detention for preventing violence is against your best interests. Detention may in fact be one part of the community's response to threats or of its prevention efforts, but you must articulate why detention cannot be the sole response. Talk with your legislators. Make sure your constituents know that the essential mission of the jail is thwarted by solutions that call for removal of a person from his/her community and nothing more.

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<sup>16</sup> Cardwell, A., and Gilmore, M., *County jails and the affordable care act: Enrolling eligible individuals in health coverage*. Washington, D.C.: National Association of Counties, Community Services Division. Available at [http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare\\_WebVersion.pdf](http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf)

These are just the beginning steps. Nothing here should dissuade you from continuing to partner with others to develop jail diversion programs and crisis centers, to ensure that crisis intervention training occurs in your jurisdiction, and to seek technical assistance to improve the quality of your jurisdiction's and jail's mental health program. Indeed, the central lesson here is that it takes the jail and your community working together to make a difference in the management of persons with serious mental illnesses.

The articulation of the jail's mission—and its related boundaries and limitations—is a piece that often is lost in the rhetoric that confuses the jail with a mental institution and that conjures up ideas of detention as being the chief solution to horrific violence. The notion of the jail being one service provider in a community of service providers has never been more important. Embrace that idea and let everyone in your community know it.

Document available at:

[http://community.nicic.gov/blogs/national\\_jail\\_exchange/archive/2013/01/18/on-language-and-limits-missions-and-mental-health.aspx](http://community.nicic.gov/blogs/national_jail_exchange/archive/2013/01/18/on-language-and-limits-missions-and-mental-health.aspx)

*The National Jail Exchange is an ongoing electronic journal focusing on providing information to jails practitioners and is sponsored by the National Institute of Corrections (NIC). The contents of the articles, the points of view expressed by the authors, and comments posted in reaction to the articles do not necessarily reflect the official views or policies of the National Institute of Corrections.*

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