Chapter 6. Barriers to Prevention, Screening, and Treatment—and Overcoming Them

The previous chapter demonstrated that it would be cost effective and, in some cases, save money to initiate or expand programs to prevent, screen for, and treat a number of communicable and chronic diseases among inmates. Even when it is not possible to demonstrate that prevention or treatment would be cost effective—as with mental illness—prisons and jails should improve their efforts to address these conditions because of the large number of inmates who suffer from them and because of constitutional obligations of correctional systems to provide adequate health care.[1]

Despite the compelling reasons for improving the prevention, screening, and treatment of disease among inmates, significant barriers make it difficult for prisons and jails to improve these services. This chapter identifies some of these barriers and discusses how they can be overcome, using examples of successful correctional health care programs.

Barriers to Improved Prevention, Screening, and Treatment

As summarized in "Selected Barriers to Improved Prevention, Screening, and Treatment of Inmates" and discussed below, the four principal barriers to improved correctional health care for inmates are the following: obstacles related to lack of leadership, the logistics of operating a prison or jail, limited resources, and correctional policies regarding treatment and security.

Lack of leadership

Some corrections administrators may not believe that inmates are entitled to the level of health care that this report suggests is needed. Other administrators are unaware of the need for improved care or of how it could save them or their communities money in the long run. Many administrators may still be reluctant to consider that protecting public health through comprehensive medical and mental health care is a correctional responsibility.

Similarly, some public health officials may not believe that it is their mission to advocate and work with prison and jail administrators to improve correctional health care, may not understand that such improvements can more effectively protect public health in their communities, or may feel they do not have the resources to provide assistance.

Logistical barriers

Very short periods of incarceration are a serious barrier to identifying jail inmates with health problems, particularly communicable diseases. Many jail inmates are held for no more than 48 hours pending a probable cause hearing. Others are jailed a few days until they can post bond.[2] Short stays create three impediments to effective disease screening and treatment in jails:

- Even in facilities with routine screening policies, screening may be delayed for up to 14 days after intake. Correctional health care staff lose the opportunity to treat inmates who are released before they can be tested.
- Because certain tests, such as TB skin tests, take time to show results, inmates may return to the community without ever learning the results—and may therefore be unaware that they are infected and need treatment.
- Inmates who are screened and diagnosed may be released before a course of treatment can be initiated or completed.

A concrete example illustrates the potential seriousness of these problems. A study found that of 93 inmates with latent tuberculosis (TB) infection who were released from the San Francisco County Jail in 1994 before their prescribed isoniazid therapy was completed, only 3 went to the public health TB clinic for more medication in the month after their release.[3] The public health implications of this lack of followup are serious. Incomplete TB treatment may result in increased transmission of latent TB

Selected Barriers to Improved Prevention, Screening, and Treatment of Inmates

Lack of leadership

- Lack of awareness of need for improved health care services.
- Reluctance to consider improving public health as a correctional responsibility.
- Unwillingness of public health agencies to collaborate or become advocates for improved corrections health care.

Logistical barriers

- Short periods of incarceration.
- Safety-encumbered administration procedures for distributing medications.
- Difficulty coordinating discharge planning.
- Inmate difficulties attending to health problems after release.

Limited resources

- High cost of health care services.
- High cost of some medications.
- Lack of sufficient space.

Correctional policies

- Failure to specify minimum levels of required care in contracts with private health care vendors.
- Requirements that inmates be escorted to medical treatment.
- Poor communication between public health agencies and prisons and jails.
- Lack of adequate clinical guidelines.

infection and active disease, and the development of drug-resistant strains. The cost to the Nation of failure to control the spread of TB can be high. Efforts to control the resurgence of TB in the early 1990s cost New York City alone more than $1 billion.[4]

There are logistical barriers to the efficient distribution of medications in prisons and jails. Medication administration schedules and inmates' inability to go to a pharmacy or telephone a physician can impose extra steps in securing approval for a medication.[5] "Pill lines"—prescribed times during the day when inmates pick up their medicines—can prevent proper administration of medications that must be taken at specific times (e.g., with meals).

The rapid and unpredictable manner in which jail inmates are typically processed limits a jail's ability to provide meaningful discharge planning that would help ensure a continuum of care for inmates after release into the community. In many instances, jail health care personnel do not know when an inmate will be released. By the time they find out, it may be too late to develop effective linkages with community providers.

Providing case management and discharge planning in prisons can also be difficult to coordinate. Because prisons are often located in rural areas far from the cities that are home to many inmates, prison health care staff may have difficulty establishing close ties

with health care providers in inmates' home communities, and these providers may be unable to visit the prison to establish relationships with inmates who are nearing release. Of all the potential problems that prisons and jails may encounter in discharge planning, one of the most difficult to negotiate is continuity of mental health treatment, particularly providing uninterrupted medication.

Many inmates require not only ongoing medical and mental health treatment after release but also other community-based services, including substance abuse treatment and assistance with housing, child care, and public assistance programs. Ex-offenders often find it very difficult to obtain these services. Problems in these other areas of their lives can hamper releasees' motivation and ability to attend to their health problems after release. Compounding these personal problems, inmates released from prisons and jails—even with help from corrections staff—often encounter serious bureaucratic obstacles to becoming eligible for Medicaid after release, delaying their access to immediate and ongoing treatment.

Limited resources

Correctional systems often face serious resource limitations in providing inmate health care services. Meeting inmate health care needs can be expensive. Inmates have high rates of many diseases that require medical attention. In part, this is due to the lack of health care they have typically received before incarceration. Changes in inmate demographics—an aging population and increasing numbers of substance abusers—also create greater demands for correctional health care services (see chapter 1, "Introduction").

Current correctional budgets are often too small to pay for the staff, equipment, medicines, or space needed to provide all the prevention, screening, and treatment services that should be made available or to provide all these services in the recommended manner. Among the problems encountered are the following:

- The Centers for Disease Control and Prevention (CDC) recommends that staff directly watch inmates with tuberculosis disease or latent TB infection swallow each dose of medication.[6] Given that up to 9 percent of inmates may be infected with TB, thousands of inmates per year would be candidates for directly observed therapy. In part because of the cost of this approach, compliance with this CDC recommendation has been inconsistent.
- Many correctional systems may find it expensive to provide all eligible inmates all the medications that current U.S. Public Health Service guidelines recommend for treating HIV,[7] and must therefore make difficult budgeting choices.
- The current standard of treatment for hepatitis C (combination therapy with interferon and ribavirin) costs about $12,000 per patient per year. As a result, potential treatment costs for correctional systems with large numbers of eligible patients may be extremely high. Given the uncertainties regarding the treatment's efficacy, few correctional systems have instituted widespread treatment for hepatitis C.
- A relatively new class of medications known as selective serotonin reuptake inhibitors (SSRIs), such as sertraline, paroxetine, and fluoxetine, has been shown to be more effective than older medications in treating some mentally ill patients. Some correctional systems cannot afford the higher cost of these newer medicines, resulting in inferior treatment for many mentally ill inmates.

Because of the high cost of treating every inmate who is found to have a treatable medical condition, correctional administrators (including some health care managers) may prefer to avoid screening inmates for some medical and mental conditions. Administrators know that, once an inmate has been found to have a disease, case law and professional ethics require them to provide treatment that meets community standards.

Because of limited resources, some correctional facility medical departments are cramped. With insufficient space, maintaining confidentiality is difficult, and the environment may not be conducive to adequate care.

Policy barriers

Some correctional systems have rules or policies that interfere with providing proper health care to inmates.

Many correctional systems prohibit inmates dually diagnosed with both a substance abuse problem and a mental illness from participating in drug treatment programs. These programs frequently require complete abstinence from all drugs, including prescription medications these inmates may be taking for their mental illness. As a result, these inmates are precluded from participating.

An increasing number of correctional systems are contracting with private vendors for inmate medical care. Some systems do not explicitly include in their request for proposals all the minimal requirements for services that every bidder must agree to provide. As a result, the successful bidder may cut costs by reducing inmate access to medical staff, minimizing disease screening, or excluding newer, more expensive medications from their formularies of approved drugs.

Understandably, correctional agencies' first priorities are facility security and staff safety. Some systems require two correctional officers to accompany every inmate on every visit to an outside hospital or clinic for special testing or treatment. Other departments require that inmates be transported individually in agency vans. Typically, correctional officers must escort inmates moving within a facility. Some correctional systems require that two or three officers accompany high-risk inmates for medical screening or treatment within a prison or jail. The limited number of available correctional officers or vehicles may create long delays if more than one or two inmates need to be transported for medical care at the same time.

Some correctional systems have policies that impose unpleasant requirements on inmates with certain conditions, making them reluctant to disclose that they have the diseases. Courts have upheld the right of correctional systems to segregate inmates with AIDS in separate housing.[8]

Correctional systems' lack of appropriate policy or practice protecting the confidentiality of inmates' medical status also discourage disclosure and acceptance of testing.

Correctional systems' lack of clinical guidelines or inadequate guidelines for prevention, screening, and treatment practices can result in inadequate medical care. Few of the 41 State departments of corrections surveyed as part of *The Health Status of Soon-To-Be-Released Inmates* project (see chapter 2, "History of the Project") submitted complete and up-to-date clinical guidelines for HIV, hypertension, diabetes, asthma, or mood-altering medications for treating mental illness. Only five States returned guidelines for treating HIV, none of which had been updated to reflect current standards for combination therapies. Four of the thirteen States that submitted guidelines for diabetes did not require annual eye examinations, which are well known to help prevent blindness in diabetics. Only one State submitted clinical guidelines for prescribing mood-altering medications for mental illness.

Public health agency policies may also hamper effective treatment. When county health departments test or screen inmates for communicable diseases, poor interagency communication may prevent inmates from learning their test results. Jail inmates may have left the facility by the time the public health department communicates the test results, and correctional health care staff may be unable or may not try to locate releasees to provide the results.

Ethical dilemmas related to providing correctional health care can present correctional and public health administrators with difficult choices in attempting to provide inmates with adequate services. Issues in correctional health care that may present ethical dilemmas include mandatory clinical testing and forced treatment of inmates; cost-based formulary decision making; pharmaceutical company sponsorships; recruitment of inmates in clinical research; use of health care professionals whose credentials may not meet community standards; and the role of correctional clinicians in decisionmaking by reentry courts and parole boards.

Solutions

Most of these barriers to improved health care for inmates can be overcome. As discussed below:

- Position statements on appropriate health care for inmates developed by professional organizations can encourage correctional administrators to eliminate barriers to proper care.
- Correctional systems should not have to shoulder the burden alone for filling gaps in inmate health care, but should collaborate with public health agencies and community-based organizations to improve the prevention, screening, and treatment of diseases among inmates.
- "Success stories" provide models for how communities can overcome barriers to improving inmate health care services.

Correctional health care position statements

A number of professional groups have developed guidelines describing appropriate health care for inmates. These position statements can be used as leverage to encourage correctional administrators to find ways of resolving barriers to providing adequate care. The National Commission for Correctional Health Care has prepared guidelines for the administrative management of HIV-positive individuals in correctional facilities.[9] The American Correctional Association Delegate Assembly passed a resolution in 1999 supporting nonsmoking facilities and smoking cessation classes for both inmates and correctional staff. The American Psychiatric Association and the American Public Health Association have also developed guidelines for inmate health care (see chapter 4, "Improving Correctional Health Care: A Unique Opportunity to Protect Public Health").

Linkages among corrections, public health care agencies, and community-based organizations

Collaboration between correctional agencies and public health agencies can help overcome the lack of funds and staff that make it difficult for many prisons and jails to address adequately the health care needs of all inmates. Public health departments may be willing to contribute funds, staff, and expertise if they understand that this use of their resources can advance the cause of public health in their communities. Correctional agencies have a stake in convincing public health officials and other government decisionmakers of the public health importance of improving the prevention, screening, and treatment of diseases among inmates. Community-based organizations and community providers may be qualified and interested in working with inmates and releasees.

Public health and correctional agencies are already working together to improve the health care of inmates and, at the same time, the health of the larger community. This was the finding of a 1997 survey conducted jointly by the U.S. Department of Justice's National Institute of Justice and the Centers for Disease Control and Prevention to learn about the extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, sexually transmitted diseases, and TB.[10] According to the study, almost all correctional systems collaborate to some extent with public health agencies. Some jurisdictions have established extensive collaborations to help fill gaps in the prevention and treatment of these diseases.

The collaborations have found ways to overcome many of the barriers that make it difficult for prisons and jails to provide these services by themselves. In particular, the partnerships helped to overcome correctional departments' lack of resources by involving public health departments
in initiating or expanding the following:

- Testing and screening of inmates.
- Prevention and treatment programs in prisons and jails.
- Following up inmates after release to ensure a continuum of care.

Researchers visited six States and five cities or counties with promising approaches to collaboration. The researchers found that several factors facilitated collaboration:

- The availability of data on the prevalence of diseases among inmates and in the community, or dramatic events, such as outbreaks of disease that demonstrated the need for collaboration.

- Legislation or regulatory requirements that make public health departments responsible for providing health care services in corrections facilities or for reporting disease among inmates.
- Correctional system willingness to open its facilities to outside organizations.
- Sensitivity on the part of correctional administrators and public health staff to each other's missions, challenges, priorities, and perspectives.
- Health department funding of programs in correctional facilities.
- The presence of health department personnel in correctional facilities and liaison staff in correctional and public health agencies, formal agreements for collaboration, and the development of interagency relationships over time.
- Frequent communication and information exchanges, such as serving on joint committees, holding meetings at leadership and operating levels, and exchanging important databases and information about patients.

State and local public health agencies and service providers are the most appropriate and likely collaborators in any effort designed to improve inmate health care. Barriers to inmate health care can be addressed still more effectively if collaborative efforts include other organizations, such as probation and parole agencies, community-based organizations, academic medical centers and universities, and substance abuse treatment programs and other service providers. As the following section suggests, some communities have established broader based collaborations.

Two collaborations that have overcome barriers

The State of Rhode Island and Hampden County, Massachusetts, have established partnerships that illustrate how joint endeavors can overcome many of the barriers to improving correctional health care services for inmates.

Collaboration in Rhode Island.[11] Rhode Island has developed a collaboration among the State Department of Health, the State Department of Corrections, an academic medical center (Miriam Hospital, affiliated with Brown University), and approximately 40 community-based organizations and service agencies. In addition to regular meetings, the partners work together on disease surveillance; inmate disease prevention services; discharge planning; and policies, legislative proposals, and union issues related to health care issues.

The Department of Health provided much of the initial funding for staffing the program. Over time, however, the Department of Corrections has picked up an increasing share of the personnel costs, funding two public health educator positions from its regular budget.

The collaboration initially focused on treatment and support services for inmates with HIV and on continuity of care between providers in prison and in the community. Pretest and posttest counseling, discharge planning, transitional services, and community linkages for HIV-infected inmates were added later. The collaboration has added sexually transmitted diseases and tuberculosis to its purview.

The collaboration's focus on prerelease planning and followup is especially important in light of the failure of most prisons and jails to provide continuity of care. The following steps have been established:

- Inmates with HIV are treated in prison by the same physician who will treat them after they return to the community.
- The Rhode Island Department of Corrections notifies the State health department's TB unit when an inmate with active or suspected TB, or an inmate receiving TB therapy, is being released, so that continuity of care can be arranged.
- Postrelease services for inmates with HIV infection and inmates at risk for HIV infection include housing, substance abuse treatment, job development, psychosocial support, and long-term case management.
- At a weekly case assignment meeting, program staff involved in the collaboration meeting discuss community linkages and placements for inmates nearing release. The four community-based organizations that participate in these meetings are mentors to employable women

who are being released and arrange services for cocaine- and alcohol-involved releasees, long-term sex workers, injection drug users, and HIV-infected releasees.

- A disease investigation specialist, funded by the Department of Health and based in the prison, locates HIV-positive individuals who have been released to the community before they received their test results to link them to services at Miriam Hospital or another equally qualified provider of HIV services.

Compliance with postrelease medical and other appointments for services increased dramatically as a result of the collaboration. Evaluation results suggested that recidivism among female inmates who participated in these postrelease programs was lower than in a comparison group who did not participate.[12]

Collaboration in Hampden County, Massachusetts.[13] The Hampden County Correctional Center, which serves Massachusetts' second largest metropolitan area, has developed a public health model of correctional health care that focuses on disease screening, patient health education, prevention, treatment, discharge planning, and continuity of care for releasees. The program costs about $6 per inmate day, or 9 percent of the facility's budget.

Significant features of the program include the following:

- Based on ZIP Code of residence, inmates with HIV/AIDS and other serious medical and mental health conditions are assigned to one of four health teams that work jointly in the correctional center and in four community health centers. (Eighty percent of the inmates come from the catchment areas of these four community health centers.) In 1997 more than 70 percent of releasees with HIV/AIDS kept their first appointments with their assigned community health center.
- Case managers who work in both agencies provide case management and discharge planning services for all inmates with HIV/AIDS and serious mental health problems. A discharge planning nurse at the facility provides similar services for inmates with chronic diseases.
- Releasees are linked with community-based agencies that address issues of family reintegration, housing, employment training and readiness, and benefit programs.

The Hampden County program serves a metropolitan area of 500,000. Because 80 percent of metropolitan areas in the United States have populations of between 100,000 and 1 million, the Hampden County model should be replicable in many other communities. The Massachusetts Department of Public Health is using a CDC grant to establish case management, discharge planning, and community linkage programs in other Massachusetts county jails. These programs will also serve HIV-positive inmates being released from State prisons.

The success of the Rhode Island and Hampden County models depended on the political will, commitment, and leadership of correctional and public health officials in these jurisdictions.

Promising practices in jails for treating mental illness

A number of programs in jails provide comprehensive mental health services.[14] Erie County, Pennsylvania, has developed an integrated network of criminal justice and mental health professionals to create a community-based forensic program. The program provides a continuum of care that begins during incarceration in the county prison and extends to the community upon discharge or parole.[15] Some jails appear to have incorporated innovative features of a comprehensive mental health care system:

- Two jails contract for psychiatric services with the community psychiatry program at their local medical school. The medical college's community psychiatry rotation includes assignments at the local jail. This arrangement ensures that trained medical personnel are in the jail on a regular basis.[16]
- A number of jails employ crisis intervention specialists or teams. The primary responsibilities of these specialists and teams are to stabilize inmates experiencing mental health crises as quickly as possible, house them appropriately,

and provide them with direct mental health services. Providing crisis intervention specialists in the jail frees correctional officers from having to handle difficult situations and allows for timely and appropriate solutions.[17]

Local policymakers have worked with officials in the Maryland Department of Health and Mental Hygiene and other State officials to establish the Maryland Community Criminal Justice Treatment Program, a multiagency collaboration that provides shelter and treatment services to mentally ill jail offenders in their communities.[18] Operating in 18 of the State's 24 jurisdictions, the program includes the following features:

- Case management services, such as crisis intervention, screening, counseling, discharge planning, and followup in the community.
- Services for mentally ill offenders who are homeless or have a substance abuse problem.
- Routine training for criminal justice and treatment professionals.
- Diversion after booking for qualified mentally ill defendants.

Criminal justice and treatment professionals credit the program with improving the identification and treatment of jailed mentally ill individuals, increasing communication between mental health and corrections professionals, improving coordination of in-jail and community-based services, and reducing disruption in local jails.

The Fairfax County (Virginia) Jail has also overcome the pervasive barriers to discharge planning for mentally ill inmates.[19] The jail uses a private nonprofit organization to link detainees with mental health-related services upon release and to maintain the detainee's family ties while the inmate is incarcerated. This affords the inmate a source of additional support after release. The organization's eight staff also:

- Provide transportation and housing assistance to mentally ill releasees upon release.
- Provide emergency services for releasees without plans at release.
- Teach, mentor, and tutor classes in the facilities.
- Teach life skills that inmates will need after release.
- Provide group therapy for inmates and their families.
- Arrange support groups for families and close friends of inmates.
- Offer families emergency funds for food and clothing while their providers are in jail.

The jail provides discharge planning for every inmate, but detainees with mental illnesses work with the same staff person from intake through discharge.

A review of seven programs developed in State and Federal prisons for mentally ill inmates who also have a substance abuse problem (the "dually diagnosed") found that the programs' key components included an extended assessment period, motivational activities, psychoeducational groups, cognitive-behavioral interventions (such as restructuring of criminal thinking errors), self-help groups, medication monitoring, relapse prevention, and transition into institution or community-based aftercare facilities.[20] Many programs used therapeutic community approaches that had been modified to provide greater individual counseling and support, less confrontation, smaller staff caseloads, and staff cross-training. Capsule descriptions of two of these programs follow.

- The Alabama Department of Corrections, with funding from the U.S. Department of Health and Human Services' Center for Substance Abuse Treatment, established a separate dormitory for the dually diagnosed in the Venteress Correctional Facility. Treatment includes group therapy, psychoeducational groups, 12-step groups, AIDS prevention and education activities, psychiatric medications, relapse prevention training, and community reentry services including development of an aftercare treatment plan. The program's highly regimented schedule of activities includes several core modules drawn from the facility's 8-week treatment program combined with 10 weeks of additional treatment services to address management of emotional problems.

- The Delaware Department of Corrections' Chronic Care Program, located in the State's maximum security facility, houses 25 dually diagnosed inmates. A private vendor provides treatment services 7 days a week. Treatment includes individual and group therapy, drug education, medications, psychoeducational groups, AIDS prevention education, relapse prevention, and individual case management and planning for community reentry. Inmates participate for 8 weeks in a "Medication/ Mental Illness" group designed to help them to understand their mental illness and their psychotropic medications. Behavioral reinforcement is provided through a system in which inmates progress to higher levels of responsibility and privilege based on compliance with treatment goals and community rules.

Conclusion

This chapter has identified several barriers to improving health care for inmates in prisons and jails. With political will and commitment from corrections and public health administrators, most of these obstacles can be overcome. The policy recommendations for improving correctional health care provided in the following and final chapter recognize that improving prevention, screening, and treatment in prisons and jails will not be easy. The recommendations represent feasible steps correctional systems can take and that, as described above, at least some prisons and jails have already implemented.

Notes

1. *Estelle* v. *Gamble*, 429 U.S. 97 (1976), held that "deliberate indifference" (not mere medical malpractice) to "serious medical needs" of inmates violates the eighth amendment's prohibition against cruel and unusual punishment.

2. The U.S. Department of Justice, Bureau of Justice Statistics (BJS), does not collect information regarding length of stay of presentenced inmates. A BJS survey of more than 6,000 sentenced inmates from 431 jails found that the median length of stay for sentenced inmates was 5.7 months. Because the data on time served were restricted to persons in jail, the data overstates the median time served. Persons with shorter sentences leave jail more quickly, resulting in a longer average sentence among persons in the inmate sample. Harlow, C.W., *Profile of Jail Inmates 1996*, Special Report, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, April 1998, NCJ 164620.

3. Tusky, J.P., M.C. White, C. Dawson, T.M. Hoynes, J. Goldenson, and G. Schecter, "Screening for Tuberculosis in Jail and Clinic Followup After Release," *American Journal of Public Health* 88 (1998): 223–226.

4. Satcher, D., "Tuberculosis—Battling an Ancient Scourge," *Journal of the American Medical Association* 282 (1999): 1996.

5. Greifinger, R.B., and M. Horn, "Quality Improvement Through Care Management," in M. Puisis, (ed.), *Clinical Practice in Correctional Medicine*, St. Louis, MO: Mosby, 1998.

6. Centers for Disease Control and Prevention, "Prevention and Control of Tuberculosis in Correctional Facilities," *Morbidity and Mortality Weekly Report* 45 (RR–8) (1996): 1–27.

7. U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents*, Washington, DC: Public Health Service, January 28, 2000.

8. See, for example, *Onishea* v. *Hopper*, 126 F.3d 1323 (11th Cir. 1997).

9. See appendix E, "Information About NCCHC and Its Position Statements." The current copy of the position statement on the Management of HIV in Correctional Facilities can be accessed at: http://www.ncchc.org.

10. Hammett, T.M., *Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB*, Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, July 1998, NCJ 169590.

11. Ibid.

12. Vigilante, K.C., M.M. Flynn, P.C. Affleck, J.C. Stunkle, N.A. Merriman, T.P. Flanigan, J.A. Mitty, and J.D. Rich, "Reduction in Recidivism of Incarcerated Women through Primary Care, Peer Counseling, and Discharge Planning," *Journal of Women's Health* 8 (1999): 409–415.

13. Hammett, T.M., P. Harmon, and L.M. Maruschak, *1996–1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities,* Washington, DC: U.S. Department of Justice, National Institute of Justice, July 1999, NCJ 176344.

14. Carr, K., B. Hinkle, and B. Ingram, "Establishing Mental Health and Substance Abuse Services in Jails," *Journal of Prison and Jail Health* 10 (2) (1991): 77–89; Nielsen, E.D., "Community Mental Health Services in the Community Jail," *Community Mental Health Journal* 15 (1) (1979): 27–32; Dvoskin, J.A., "Jail-Based Mental Health Services," pp. 64–90 in H.J. Steadman (ed.), *Effectively Addressing the Mental Health Needs of Jail Detainees,* Washington, DC: National Institute of Corrections, June 1990, NCJ 151850: 80–83.

15. Amann, A., J. O'Keefe, and P. Kovacs, "Interdisciplinary Approach to Managing Mentally Ill Offenders," *Corrections Compendium* 23 (8) (1998): 4–6.

16. Morris, S.M., H.J. Steadman, and B.M. Veysey, "Mental Health Services in United States Jails: A Survey of Innovative Practices," *Criminal Justice and Behavior* 24 (1) (1997): 3–19.

17. Ibid.

18. Conly, C. *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program,* Program Focus, Washington, DC: U.S. Department of Justice, National Institute of Justice, March 1999, NCJ 177397.

19. Morris, Steadman, and Veysey, "Mental Health Services in United States Jails" (see note 16).

20. Edens, J.F., R.H. Peters, and H.A. Hills, "Treating Prison Inmates With Co-Occurring Disorders: An Integrative Review of Existing Programs," *Behavioral Science and Law* 15 (4) (1997): 439–457.