

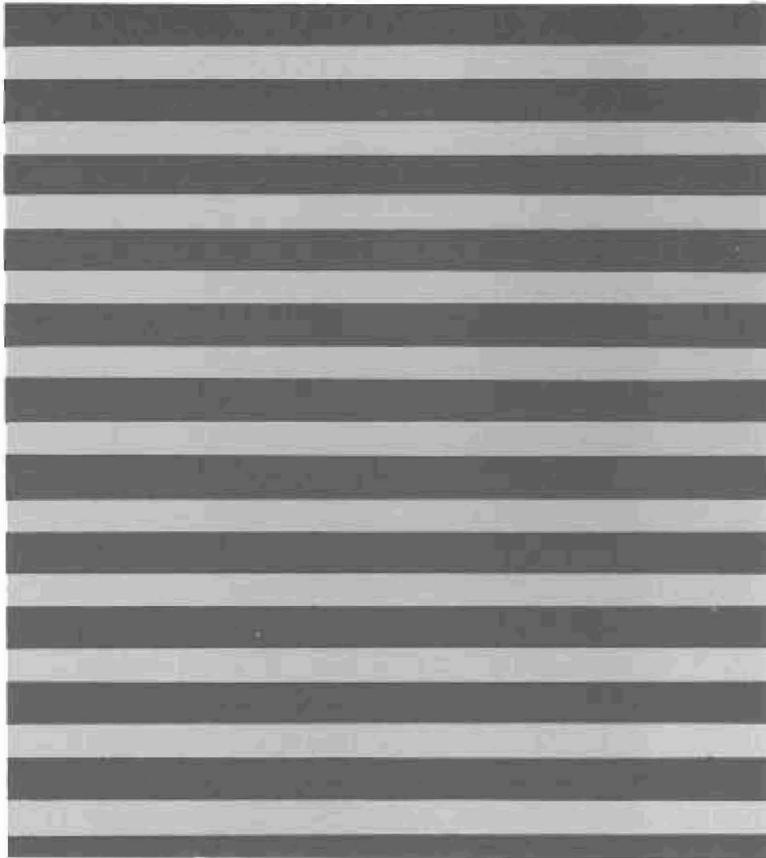
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## Inpatient psychiatric treatment in a county jail

BY J. REID MELOY, PH.D.

A SPECIAL REPRINT



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*Inpatient psychiatric services within large metropolitan jails are a new treatment phenomenon in the United States. The author describes one such program in San Diego County, California. Particular attention is focused upon the description of the services and the admitted patients. Psychological and social dynamics unique to an inpatient staff within a custody setting are discussed. The problem of patients' rights in such a setting and several working solutions are addressed. Finally, the impact of an inpatient psychiatric unit within a jail upon the reliability and validity of mental disability defenses is noted.*

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The growing need for readily available acute inpatient services to incarcerated mentally disordered individuals is being increasingly recognized.<sup>1</sup> Steadman and Morrissey have written that the local jail is the "front line detention site" and research is badly needed to measure the impact of deinstitutionalization on the local jail.<sup>2</sup> They and others have preferred to call this phenomenon the "transinstitutionalization" of the mentally ill.<sup>3</sup> It has been shown that the mentally disordered have a 20% greater probability of being

AUTHOR'S NOTE: *The views expressed in this article are the author's own and do not necessarily reflect the philosophy or policies of the San Diego Department of Health Services.*

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arrested for the same crime than the normal population.<sup>4</sup> In a 1983 review of the available literature, Monahan and Steadman analyzed six studies that investigated prevalence rates of mental disorder among jail inmates. They concluded that the true prevalence rate of psychoses in local jails ranged from 1% to 7% and the rate for less severe forms of mental disorder varied between 15% and 20%.<sup>5</sup> In a subsequent article, Steadman noted that given the deficit of mental health services available, the problem was significant.<sup>6</sup>

Outpatient psychiatric services in the nation's jails, where most acute psychiatric emergencies arise by virtue of the immediate legal "holding environment" of any local jail, are barely adequate. Psychiatric inpatient facilities within the nation's jails are virtually nonexistent. The usual procedure is the belated transport of a psychotic jail inmate to the local public mental health facility, whereupon he may be injected with a neuroleptic medication, be additionally diagnosed as psychopathic, and be returned to the jail, oftentimes to a cell isolated from other inmates. The law enforcement decision to transport a psychotic inmate for treatment is usually the consequence of behavioral management problems rather than clinical need.

As of July 1, 1985, there were four acute inpatient psychiatric facilities located within California county jails and designated as involuntary treatment facilities by the State Department of Mental Health.<sup>7</sup> These facilities represent an innovative and much-needed approach to the acute treatment of the locally incarcerated and psychotic individual.

I will describe in detail the operation of one such California facility, the Psychiatric Security Unit in the San Diego County Jail. Particular attention will be paid to the description of the program and the patient population that it treats. Psychological and social dynamics unique to an inpatient

psychiatric unit in a county jail will be noted; and legal issues, particularly concerning patient's rights, competency, and insanity will be addressed.

### **Program description**

The San Diego County Sheriff's maximum-security detention system for males consists of one central and three regional centers and houses approximately 2,000 inmates. Located on the sixth floor of the San Diego County Central Detention Facility, the Psychiatric Security Unit is designed to provide a viable therapeutic atmosphere within a maximum-security setting. The psychiatric inpatient unit is composed of an office area, much like a small clinic with conference and interview rooms, a medication room, three large activity rooms, a patient dormitory area with 24 beds, four beige-colored seclusion cells that include a bed, a table, and a stainless steel sink and toilet, and two additional padded isolation rooms with no fixtures or furniture. The inpatient unit is surrounded by a hallway, or catwalk, that allows visual access to the patient areas.

Security is an equal priority with treatment. All psychiatric staff wear sensor alarms when in the patient areas, and there is an additional wall alarm system. The two-tiered system provides both a graduated and immediate response by jail deputies in situations of imminent physical danger to both patients and staff. The unit itself, contrary to other areas of the jail, is brightly painted in pastel shades, and patients are allowed to display their artwork on the walls of the unit. Three times the floor space (50 square feet per patient in the activity areas) is provided per individual when compared to other areas of the jail. These central elements of the patient milieu, space and color, provide immediate therapeutic benefits to many acutely psychotic and disorganized inmates upon admission.

The program staff consists of 26 individuals: 3 part-time psychiatrists, a part-time physician, 16 nurses, a psychiatric social worker, recreational therapist, mental health specialist, 2 clerical staff, and myself, the clinical psychologist-program director. The program is designed to provide three services to the detention facility. First, the inpatient program, designated a 24-hour care, involuntary detention facility, has a capacity for 24 patients. The inpatient census averages 21 patients at a cost of \$110.00 per patient-day.<sup>8</sup> Twenty-four-hour nursing is provided, and activities address the acute needs of the inpatient population, including twice-weekly group psychotherapy, daily medication rounds, recreational activity, individual counseling, psychodiagnostic testing, and unstructured time for television or music.

The average length of inpatient stay is 34 days, ranging from 1 day to 4 months. The longer durations of stay are usually limited to those patients previously found not guilty by reason of insanity (NGRI) who are returning to San Diego County from the regional state hospitals to seek restoration of sanity judgments in the superior court of the county. These patients, due to the 1978 California court decision *In re Lee*, usually have a right to detainment in a mental health facility for the length of their commitment.<sup>9</sup>

The second aspect of the program is the outpatient service to mentally disordered inmates not in need of acute inpatient treatment. Inmates are seen during morning "sick call" by a psychiatrist five days a week in the central facility and once per week in the regional facilities, and are evaluated for continued medications, additional group psychotherapy, or inpatient admission. The system generally provides a reliable method of identifying inmates in need of psychiatric treatment and triaging them to the appropriate level of care. The program treats 20 outpatients per day.

The third service is emergency consultation and evaluation of inmates in the central jail by members of the mental health staff, and court-ordered Penal Code 4011.6 evaluations when there is probable cause to believe an inmate is a danger to self, others, or grave disability exists.<sup>10</sup>

The entire program is administered by the mental health division of the San Diego County Department of Health Services. Services of the physical plant of the program (namely, food, clothing, and shelter for the patients) are funded by the San Diego County Sheriff's Department.

### **The inpatient population**

The Psychiatric Security Unit seeks to identify the most acutely disturbed individual in custody. Usually presenting symptoms are acute psychoses, although homicidal and suicidal individuals are admitted to the unit in the absence of psychosis. Sixty-five percent of the patients are a subtype of schizophrenia with a chronic history of psychotic episodes due to medication noncompliance and a lack of adequate treatment support in the community. In addition to the primary, usually Axis I, diagnosis, there is a personality disorder in 50% of the inpatients, often not identified until the psychosis has remitted and the individual's maladaptive behavior in relation to others becomes obvious. Personality disorders are usually the antisocial, narcissistic, borderline, and histrionic types.

I have also observed that many male borderline personality-disordered patients who have no motivation for outpatient treatment in the community will find their way to the county jail masked as alcohol or polydrug abusers. A recurrent history of depression is often uncovered in these individuals once they are forced to detoxify in jail and are then evaluated. Major affective disorders, both bipolar and unipolar, that have been self-medicated for years with illicit drugs or

alcohol will not be immediately apparent in this population unless a careful affective history is taken.

The accompanying table is a cross-sectional one-day sample of inpatients admitted to the Psychiatric Security Unit. The mean age of the all-male population is 32 years, with a range of 19 to 55 years. The majority of the population is Caucasian, with representation from the Black, Hispanic, and Asian racial/ethnic groups.

The legal bases for patients being in the unit are represented in this random sample: 43% (10) are voluntary inpatients; 30% (7) are patients found NGRI; 13% (3) are conservatees; 4% (1) were found incompetent to stand trial; and the remaining 9% (2) were civilly committed for initial 72-hour detention or 14-day certification.

Only the primary diagnosis is listed. Forty-three percent of the patients have paranoid schizophrenia. An Axis II primary diagnosis of personality disorder is represented by one patient. A secondary diagnosis of personality disorder, as noted earlier, occurs in 50% of the sample. Substance abuse, usually mixed, is documented in the psychiatric histories of 80% of the inpatients.

The criminal charges are of questionable validity since 52% are charges at the time of arrest and only 48% are charges at the time of conviction. It is useful to note, however, that the majority of crimes involve physical harm or the threat of imminent physical harm to a victim.

In a previous article I have empirically defined and elaborated three general patient types that are admitted to the inpatient program.<sup>11</sup> The first type is called the "sunshine chronic," an individual who is schizophrenic, has a lengthy but misdemeanor criminal history, and is often booked on charges such as trespassing, petty theft, or defrauding an

Random sample of acute psychiatric inpatients, Psychiatric Security Unit, San Diego County  
central detention facility (n = 23)

<u>Patient</u>	<u>Age</u>	<u>Race/Ethnic</u>	<u>Legal Status</u>	<u>Length of Stay (days)</u>	<u>Primary Diagnosis</u>	<u>Criminal Charge</u>
1.	42	black	NGRI <sup>a</sup>	18	mixed substance abuse	attempted murder
2.	23	white	NGRI	124	schizophrenia, paranoid	vehicular manslaughter
3.	23	black	VOL. <sup>b</sup>	20	major depression	robbery
4.	34	white	CONS. <sup>c</sup>	49	schizophrenia, undif.	attempted grand theft battery on an officer
5.	31	black	VOL.	8	schizophrenia, para.	grand theft person
6.	48	white	VOL.	55	schizophrenia, para.	2nd burglary
7.	33	white	VOL.	42	amphetamine abuse	attempted murder kidnap
8.	25	white	VOL.	26	borderline person. dis.	possession of stolen prop. unlawfully taking vehicle
9.	49	black	NGRI	7	schizophrenia, para.	assault with deadly weapon
10.	58	white	VOL.	85	schizophrenia, para.	arson
11.	25	white	VOL.	93	schizophrenia, undif.	felony vandalism
12.	25	white	CONS. <sup>d</sup>	60	schizophrenia, para.	robbery
13.	28	white	CERT. <sup>d</sup>	6	schizophrenia, para.	burglary
14.	43	white	VOL.	48	schizophrenia, undif.	attempted arson

<u>Patient</u>	<u>Age</u>	<u>Race/Ethnic</u>	<u>Legal Status</u>	<u>Length of Stay (days)</u>	<u>Primary Diagnosis</u>	<u>Criminal Charge</u>
15.	37	white	NGRI	5	schizophrenia, para.	attempted murder
16.	29	hispanic	NGRI	12	schizophrenia, undif.	assault with deadly weapon
17.	33	white	NGRI	20	schizophrenia, para.	solicitation of murder
18.	33	white	VOL.	14	major depression	unlawful fire
19.	31	hispanic	VOL.	28	schizoaffective	threatening with weapon
20.	28	white	NGRI	5	schizophrenia, undif.	auto theft
21.	19	white	72-hr DET <sup>e</sup>	1	factitious disorder	arson auto theft
22.	24	white	INCOMP. <sup>f</sup>	36	schizoaffective	burglary
23.	21	asian	CONS.	25	schizophrenia, para.	assault with deadly weapon

a Not Guilty by Reason of Insanity  
c Conservatee  
e 72-hour Detention

b Voluntary  
d 14-day Certification  
f Incompetent to Stand Trial

innkeeper. This individual has a long history of noncompliance with medication and is usually quite content to live as a transient. He has slowly drifted to the bottom of the socioeconomic ladder, but knows how to “survive on the street.” He is most likely to abuse alcohol. When the inpatient program has first contact with him, he is usually psychotic, gravely disabled, and harmless. He has no contact with family or relatives, and has usually never been married.

The second type is the “mentally disordered offender.” He also has an Axis I diagnosis of schizophrenia or bipolar disorder, but additionally has a personality disorder. He is much younger than the sunshine chronic, usually in his twenties. He has a criminal history beginning in adolescence and is arrested on felony charges such as burglary or assault with a deadly weapon. He tends to abuse sympathomimetics such as crystal methedrine, cocaine, and phencyclidine. He is noncompliant with prescribed medications, and, when not psychotic, is a major behavioral problem in any treatment facility. He is unmotivated for treatment and will resist attempts to alter his generally narcissistic orientation to reality once his acute symptoms have remitted. If still in contact with his parents, they are oftentimes terribly angry and hurt by his successful manipulation of them.

The third type of inpatient is the “failed schizophrenic.” I use *failed* to emphasize that both the mental health system and the patient himself are responsible for his failure. He is young, usually in his twenties, diagnosed as schizophrenic, and is in jail because of inadequate treatment support in the community. His family is intact, he has an intermittent work history, a high school and perhaps junior college education, and is most inclined to abuse marijuana. He does not have a personality disorder. He is a tragic figure because he could have led a tolerable existence prior to his arrest. The failed schizophrenic is charged with a wide variety of alleged criminal acts, but by and large does not have a criminal

history. Crimes may range from trespassing to murder of his parents or spouse. He has come to the attention of law enforcement for one of two reasons: either he has acted out publicly to seek the treatment heretofore denied by the community, or he has acted delusionally in response to his decompensating condition. The "failed schizophrenic" would characterize most of the paranoid schizophrenic individuals who commit "sudden murder."<sup>12</sup>

### **Psychological and social dynamics**

The most difficult problems that needed to be solved in the development of an inpatient facility within a county jail arose because of the triangular relationships that necessarily coexist in such a setting; namely, the interaction among the patient-inmate, the deputy, and the mental health professional. This is in contrast to the usual dyadic relationship that is present in most inpatient and outpatient psychiatric settings between the patient and the therapist.

Two metaphors are quite apt. First, transactional analysis provided a vehicle for the conceptualizing of Karpman's triangle, the shifting roles that can exist in a triadic relationship among the persecutor, the victim, and the rescuer.<sup>13</sup> In a setting such as the one described, these roles can be pathologically expressed by the jailer, the jailed, and the helping professional. This can be a source of intense emotional conflict if it is not addressed educationally and therapeutically. In Orange County, California, it signaled the demise of the jail inpatient psychiatric program because the mental health staff allied with the patient-inmates against the perceived "persecution" by the jailers, and were eventually removed from the facility by the jail commander.

A second metaphor is the Oedipal myth. Law enforcement provides a limit-setting and oftentimes punishing male parent figure for the inmate. It is a figure that is both

depended upon and at times hated. Nevertheless, the authority of the jailer must be followed by the inmate. This "punishing father figure" is always absolute and virtually always masculine. In the second corner of the Oedipal triangle is the mental health professional. Again, by both self-selection and fortuity, 80% of the Psychiatric Security Unit staff is female. These individuals provide a limit-setting and protective role for the severely psychiatrically disturbed patient-inmate. It is a role that engenders the respect of most patient-inmates and the passionate, unrequited love of a few, yet may rekindle feelings of hostility and fear toward the father-jailer. The patient-inmate is, of course, the child in the Oedipal drama. Consciously seeking the freedom of the community, he is unconsciously caught in a hostile-dependent relationship and, sometimes, a repetitively compulsive liaison with the punitive father-jailer.

With the advent of the inpatient program in 1982, it was predicted by a few that the female psychiatric staff would be assaulted, raped, perhaps even taken hostage. Much of the behavior of the deputies was motivated by a wish to protect the predominantly female staff and to maintain security and control of the facility. The expression of these behaviors was often paternalistic, angering the more feminist members of the staff; but as their catastrophic fantasies were not acted out by the patient-inmates, respect and cooperation improved. A few cynics, however, still continue to perceive the inpatient program as coddling inmates who are only malingering to gain attention.

Designation of the inpatient program as an involuntary detention facility eight months after the unit began treating patients gave the mental health staff an authority to act that won immediate respect from many deputies. No longer subject to the whims of an entirely voluntary inpatient population, the involuntary treatment option allowed for the pharmacological management of the more difficult, violent, and psychotic inmates in the jail.

The triadic relationship also provided fertile ground for certain psychiatric staff members to evidence their own defensive splitting. They would alternately ally themselves much too closely with the patient-inmates, believing their protestations of innocence and angrily criticizing law enforcement; and then oscillate to a position of strong identification with the deputies and respond in a too-distant, punitive manner toward the patient-inmates. The very few staff members who themselves functioned at a more primitive psychological level were removed from the program when it became evident that the precipitating stressors of this new environment exacerbated their own characterological predispositions to project, split, and deny their own perceived realities.

### **Legal issues**

As a designated involuntary detention facility, the Psychiatric Security Unit has the legal authority to treat people involuntarily if they present a danger to themselves, others, or are gravely disabled as a result of a mental disorder.<sup>14</sup> The California Welfare and Institutions Code defines five periods of involuntary treatment: an initial 72-hour detention and 14-day certification under any one of the three commitment criteria, and a 14-day extension for danger to self only. Additionally an individual who is "a demonstrated danger" may be committed to involuntary treatment for 180 days beyond the initial 17-day period of commitment. The fifth period of time involves the establishment of a temporary 30-day conservatorship for grave disability following the 17-day initial commitment period.<sup>15</sup>

When an inmate is admitted to the Psychiatric Security Unit on a 72-hour detention, he is under two legal holds, a civil and a criminal one. If the latter criminal charges are dismissed, a psychiatric decision must be made as to whether

the civil commitment should continue. If the civil hold continues, the patient cannot remain within a criminal setting<sup>16</sup> and is transported by the Sheriff's Department to an involuntary detention facility outside of the jail. There are 17 such facilities within San Diego County. At the point of contact between the patient and the screening psychiatrist or psychologist of the involuntary treatment facility of destination, a decision will be made to either continue the involuntary civil commitment or release the individual.<sup>17</sup> A patient-inmate who remains in criminal custody but no longer meets the criteria for involuntary treatment could have the choice of giving voluntary informed consent for treatment or returning to the main-line jail population.

This entire procedure is quite confusing to a patient-inmate already in marginal contact with reality. The notion of being identified as both a mental patient and a criminal in a setting that is both a psychiatric facility and a jail might approach an Orwellian nightmare for the psychotic individual.

Several patient's rights provisions of the California Welfare and Institutions Code are modified for this involuntary detention facility to operate within a maximum-security criminal setting.<sup>18</sup>

- a. Patients are denied the right "to wear [his] own clothes."<sup>19</sup> Inmates are issued cotton clothes throughout the facility to ensure identification and discrimination from other civilian staff.
- b. Patients are denied the right "to see visitors each day."<sup>20</sup> Patient-inmates are allowed visits certain days of the week in accordance with visitation policy throughout the detention facility. Security staffing patterns and limitations would not allow the daily transport of patient-inmates to and from the visitation areas.
- c. Patients are denied the right to "receive confidential calls."<sup>21</sup> Patients do have "reasonable access"<sup>22</sup> (in the Psychiatric Security Unit, 16 hours per day) to a collect call-only telephone.

- d. Patients are denied the right to "mail and receive unopened correspondence."<sup>23</sup> All mail entering and leaving the county jail is searched for contraband and may be read by law enforcement personnel. Members of the attending psychiatric staff are not allowed to open or read correspondence by the patient-inmates unless specifically requested to do so by the latter.

All other legal and civil rights of persons involuntarily detained within the Psychiatric Security Unit are protected. When disciplinary actions have been initiated by the law enforcement personnel against a patient-inmate within the unit, I have advocated that a distinction be made between patient privileges, such as television and music, and patient rights. Disciplinary actions, with few exceptions, have been jointly agreed upon by the security and psychiatric personnel and have resulted in the suspension of patient privileges. Patient's rights within a jail setting, however, remain the major statewide unaddressed legal problem in attempting to provide mental health care to inmates. Counties have been left to resolve these issues at the local level.<sup>24</sup>

The use of seclusion or restraint is problematic in an inpatient psychiatric setting within a jail. The 1983 consolidated standards of the Joint Commission on Accreditation of Hospitals specify that a patient can only be secluded and/or restrained to prevent injury to self or others, or to prevent serious disruption of the therapeutic environment.<sup>25</sup> Seclusion and restraint must be ordered and a clinical assessment documented in the patient record by a physician.<sup>26</sup> They shall be time-limited and not exceed 24 hours.<sup>27</sup> P.R.N. orders (orders prescribed on an as-needed basis) shall not be used to authorize restraint or seclusion.<sup>28</sup> Appropriate and documented attention shall be paid every 15 minutes to a patient in restraint or seclusion.<sup>29</sup>

Uses of seclusion and restraint in jails have historically been much less restrictive, and are generally used for medical observation, including danger to self and others.<sup>30</sup> Another

involuntary psychiatric treatment facility in a jail in California has taken the position that inmate (patient) seclusion is solely the responsibility of the security staff and, therefore, does not require daily psychiatric approval for the seclusion of an inmate.<sup>31</sup> It is my opinion that this attitude severely compromises the authority of the psychiatric staff and may result in "inpatient treatment" being nothing more than pharmacological management of psychotic inmates housed in isolation.

To strictly adhere to the civil commitment statutes concerning restraint and seclusion within a jail setting, as the Psychiatric Security Unit does, raises two other problematic issues. Who will physically restrain the patient-inmate when necessary, the nursing staff or security personnel? And what forms of restraint will be allowed within the psychiatric inpatient setting?

Specific, detailed policy and procedural formulations have resulted in a legal and effective process for the seclusion and restraint of patient-inmates that protects their rights as mental patients and ensures facility security.<sup>32</sup> Patient-inmates are physically restrained by security personnel in the *presence* and with the *supervision* of psychiatric nursing staff. The application of conventional psychiatric restraints (leather restraints, soft helmet) is done by the nursing staff while the patient-inmate is being physically controlled by the security staff. Other forms of restraint commonly used by law enforcement (metal restraints, pain-inducing control techniques, carotid restraint) are prohibited within the inpatient psychiatric setting unless all conventional psychiatric restraints fail and an imminent security risk to staff is present.

The Psychiatric Security Unit has the capacity to seclude six patient-inmates at any one time. Most often these isolation cells are used without the need for physical restraint and

with the judicious use of pharmacology as a form of "chemical restraint." Conventional leather restraints are used approximately once a week. I attribute this to the physical security of the unit, including visual observation and control of patient areas; and the ability of the mental health staff to provide a consistent atmosphere of respect and limit-setting with all patients. There have been two minor assaults against staff by patients in the first three years of operation. Patient-against-patient assaults average one per week. There has been one suicide by asphyxiation within the inpatient setting.

The inpatient program has found most useful a procedure I have called "graduated therapeutic containment." An individual's level of impulse control, whether it is characterological or due to psychosis, determines where he is secluded, each area more confined and less amenable to positive reinforcement. As the patient-inmate's behavior improves, he is moved to a relatively larger area. This form of graduated containment allows the staff to assume some ego control that is momentarily absent, yet provides the patient-inmate with some freedom to affectively express. Only in cases of intractable violence toward self and others is large muscle movement completely restricted with leather restraints. Such a treatment protocol must be supported by a highly secure physical milieu, one that perhaps only exists within a maximum-security setting. Probably the most apt psychological metaphor is Wilfred Bion's notion of the "container" in which the patient's affective-fantasy expression is both reflected and reinterpreted by the self-object to which he is relating.<sup>33</sup> The self-object in this inpatient setting is both human (psychiatric staff) and nonhuman (physical structure of each gradually less restrictive seclusion area).

The primary purpose of the Psychiatric Security Unit is to provide treatment to severely disturbed inmates, not to provide forensic psychological and psychiatric evaluations to the court. Yet the inpatient program's role at the junction of

the criminal justice and mental health systems has improved the reliability and validity of the clinical data base of defendants when there is a legal question of mental disability.

Defense decisions to enter a motion of incompetency to stand trial<sup>34</sup> are often made in consultation with the psychiatric staff and are based upon evaluation and treatment of the inmate in the jail setting.

Patient-inmates found incompetent to stand trial returning to the jail from the regional state hospital are closely followed to ensure retention of competency until so judged by the court. In California a person is considered gravely disabled if he is found incompetent to stand trial and has been charged with a serious felony.<sup>35</sup>

A 24-hour per day clinical data base, from day of admission to discharge, is available on all inpatients entering pleas of NGRI. Oftentimes these records begin within a day of the alleged offense due to the acute psychiatric needs of the defendant at the time of arrest and his admittance to the inpatient program at the time of custody. In such cases the inpatient records may provide the most reliable and valid psychiatric information on the defendant by virtue of the temporal proximity to the criminal act and the treatment, rather than adversarial, purpose of the data gathering.

## **Summary**

The provision of inpatient psychiatric services within a large metropolitan jail is a new treatment phenomenon in the United States. I have described in detail such a program, the Psychiatric Security Unit, located in San Diego County, California. Particular attention has been focused upon the

description of the inpatient program and a cross section of patients admitted to the program. Psychological and social dynamics unique to an inpatient staff and program within a custody setting have been discussed. The problem of patient's rights in such a setting and several working solutions have been addressed. Finally, the impact of an inpatient psychiatric unit within a jail upon the reliability and validity of mental disability defenses has been noted.

#### Notes

1. E.V. Valdiserri, "Psychiatry Behind Bars," *Bulletin of the Am. Acad. of Psychiatry and Law* 12(1):93-99, 1984; H.R. Lamb, R. Schock, P.W. Chen, and B. Gross, "Psychiatric Needs in Local Jails: Emergency Issues," *American Journal of Psychiatry* 141(6):774-777, 1984.
2. H.J. Steadman and J.P. Morrissey, "The Impact of Deinstitutionalization on the Criminal Justice System: Implications for Understanding Changing Modes of Social Control" (Paper presented at Simon Fraser University, Vancouver, British Columbia, April 5, 1984).
3. *Id.*; also see speech delivered by Michael O'Connor, M.D., Director of California Department of Mental Health, to National Alliance for the Mentally Ill, Irvine, California, July 7, 1984.
4. L.A. Teplin, "Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill," *American Psychologist* 39(7): 794-803, 1984.
5. J. Monahan and H.J. Steadman, "Crime and Mental Illness: An Epidemiological Approach," in N. Morris and M. Tonry, eds., *Crime and Justice: An Annual Review* (Chicago: University of Chicago Press, 1983).
6. J.P. Morrissey, H.J. Steadman, and H.C. Kilburn, "Organizational Issues in the Delivery of Jail Mental Health Services," *Research in Community and Mental Health* 3:291-317, 1983.
7. Inpatient psychiatric facilities within California may apply for designation as involuntary detention facilities if they meet the statutory requirements of the Lanterman-Petris-Short Act (California Welfare and Institutions Code div. 5, pt. 1, §§ 5000-5466) and the California Administrative Code tit. IX, subch. 4, §§ 800-868.

8. This figure does not include support services provided by the San Diego County Sheriff's Department, including the physical plant, meals, clothing, and security personnel (Sheriff's deputies). The major portion of the figure cited is the cost of psychiatric staff.
9. *In re Lee*, 3 Cal. App. 3d 9452 (1978). This case law was modified by statutory law on Jan. 1, 1985. The new provision allows an NGRI individual to be housed in a jail setting if the mental health staff is reasonably certain that he will not present a danger to himself or other inmates and he will continue his prescribed medication.
10. California Penal Code § 4011.6 orders the transport of a criminal to an involuntary psychiatric detention facility for evaluation of his or her mental state. It does not mandate treatment.
11. R. Meloy, "Rapid Identification of the Functionally Psychotic Individual in Custody," *Criminal Justice and Behavior*, in press.
12. D. Lunde, *Murder and Madness* (New York: W.W. Norton, 1980).
13. S.B. Karpman, "Fairy Tales and Script Drama Analysis," *Transactional Analysis Bulletin* 7(26):39-43, 1968.
14. California Welfare and Institutions Code § 5150.
15. California Welfare and Institutions Code §§ 5151-5157, 5250-5309, 5350-5371.
16. California Welfare and Institutions Code § 5325.1(a) states: "Treatment should be provided in ways that are least restrictive of the personal liberty of the individual."
17. Each designated involuntary detention facility retains the authority to continue or terminate a civil commitment regardless of the facility's affiliation with a larger public mental health service.
18. California Welfare and Institutions Code art. 7, § 5325, "Legal and Civil Rights of Persons Involuntarily Detained."
19. *Id.* § 5325(a).
20. *Id.* § 5325(c).
21. *Id.* § 5325(d).
22. *Id.*
23. *Id.* § 5325(e).

24. A statewide Jail Mental Health Standards Committee was convened by various professional groups in January 1985 to address these difficulties.
25. *Joint Commission on the Accreditation of Hospitals Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities* 19.2.1, 1983.
26. *Id.* 19.2.2, 19.2.2.1.
27. *Id.* 19.2.3.
28. *Id.* 19.2.5.
29. *Id.* 19.2.10, 19.2.10.1.
30. California Administrative Code tit. 15, subch. 4, "Minimum Standards for Local Detention Facilities."
31. Personal communication with staff members of the Santa Clara jail inpatient program.
32. San Diego County Sheriff's Department, "Manual of Policies and Procedures."
33. W.R. Bion, *Seven Servants* (New York: Jason Aronson, 1977). See also H. Searles, *The Nonhuman Environment* (New York: International Universities Press, 1960).
34. California Penal Code § 1367: "as a result of a mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner."
35. California Welfare and Institutions Code § 5008(h): "the indictment or information pending against the defendant at the time of the commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person."