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"It's Not Like Therapy": Patient-inmate perspectives on jail psychiatric services

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Abstract

Jails may serve an important public health function by treating individuals with psychiatric problems. However, scholars debate the service qualities that can best achieve this aim. Some suggest the possibility of comprehensive psychiatric services in jails, while others recommend a narrower focus on basic elements of care (assessments, medication management, and crisis intervention). To date, this debate remains uninformed by service recipients. This qualitative study addresses this gap by illuminating patient-inmate perspectives on jail psychiatric services. Patient-inmate experiences indicate that the jail environment is incongruent with the provision of comprehensive psychiatric services. Thus, program administrators would best serve patient-inmates by strengthening basic services and connections to community-based providers who can provide comprehensive and effective care.

Keywords

mentally ill offenders; standards of care; mental health services; jails; inmates

Background

In the United States, jails are places of containment for accused criminals awaiting trial, and places of punishment for low-level offenders serving brief sentences. For inmates with serious mental health challenges, these facilities are also required to be places of treatment. Given the high proportion of under-resourced and high-need individuals who comprise jail populations, practitioners and researchers posit that jails have public health and therapeutic potential (American Psychiatric Association, 2007; Dumont, Brockmann, Dickman,

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Alexander, & Rich, 2012). However, factors inherent to the jail context may limit this potential. Below, we describe the jail environment, characteristics of jail inmates, and jail psychiatric services. Our review suggests that the overrepresentation of people with mental health problems in jails has earned these facilities the title of "the new mental hospital" (Torrey, 1995). However, the contextual features of jails and insufficient services provided within jails contradict this designation. Furthermore, despite increasing awareness that patient perspectives provide critical insight for developing relevant psychiatric services and informing valid measures of success (Ware, Tugenberg, & Dickey, 2004), jail-based research has largely neglected the experiences of service recipients. Thus, research on the potential for and realities of jail-based psychiatric services remains incomplete.

The Cultural and Structural Context of Jail

Correctional facilities are notoriously difficult institutions to penetrate. Prison ethnographies from the mid-20th century inform much of what we know about the structure and culture of these institutions (see, e.g., Clemmer, 1940; Cressey, 1959; Sykes, 1958). An elegant review of this literature by Melanie Jordan (2011) highlights the way in which prison structures are characterized by complexity, routine, and isolation, and the way in which prison culture is characterized by discipline, hierarchy, social stratification, and toxic masculinity. In addition, the occupational culture of correctional officers, branded by cynicism, suspicion, group solidarity, and hyper-masculinity, contributes to an overall air of hostility within these institutions.

While theories of prison culture can likely be extrapolated to jails, important distinctions in population and structure also exist. In one seminal study, John Irwin (1985) argues that jails are predominately used to manage disreputable members of society; their inmates are typically not serious criminals, but those who are largely poor and disruptive. Because "the rabble," as Irwin labels them, are presumed guilty, their "malign neglect" by the jail is then justified (1985, p. 45). Through such malign neglect, jails disorganize and demoralize, degrade, and further cultivate deviance among inmates. Combined with the rapid turnover of inmates, and the simultaneously constraining and chaotic jail environment (e.g., smaller cells, no access to the outdoors, absence of natural light, noisiness and dirtiness; Irwin, 1985; Wacquant, 2002), these processes make jails even more punitive than prisons and present potential structural and cultural barriers to mental health service delivery.

Patient-inmates in Jail Contexts[1]

Correctionally-involved individuals with mental health challenges are overrepresented in jails and constitute a high-need and under-resourced population. Estimates suggest one out of every seven men and one out of every three women in jail has a serious mental health problem (Steadman, Osher, Robbins, Case, & Samuels, 2009), the sum of which likely compromises over one million of all yearly jail admissions (Minton & Zeng, 2015). [2] The

[1]The authors borrow the term "patient-inmate" from Jordan (2012), who uses the label to symbolize the dual role these individuals embody in correctional contexts as both psychiatric patients and correctional institution inmates.

[2]Serious mental disorder diagnoses commonly include major depressive disorder, depressive disorder not otherwise specified (NOS), bipolar disorders, schizophrenia spectrum disorder, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, delusional disorder, and psychotic disorder (NOS) (American Psychiatric Association [APA], 2000; Kessler, Chiu, Demler, & Walters, 2005).

majority of these individuals face serious substance abuse problems, homelessness, and unemployment, making it unsurprising that they are re-arrested more often and more quickly than their relatively well counterparts (Castillo & Fiftal Alarid, 2011; Baillargeon et al., 2010; Cloyes, Wong, Latimer, & Abarca, 2010; James & Glaze, 2006; Porporino & Motiuk, 1995).

While detained, individuals with serious mental health problems face additional challenges. Extrapolating from research on prison contexts, the aforementioned structure and culture can lead to confusion, frustration, boredom, isolation, stress and vulnerability (Jordan, 2011, 2012; Nurse, Woodcock, & Ormsby, 2003). Within such environments, patient-inmates are often less able than other inmates to follow procedures and navigate inevitable, stressful social interactions. These individuals are more likely to receive infractions or be placed in isolation cells, to be physically and sexually assaulted, and to self-injure while in custody (Fellner, 2006; Felson, Silver, & Remster, 2012; Kaba et al., 2014). Thus, patient-inmates are not only a sizeable population, but also one that begs for additional accommodations and protections during detainment (e.g., separate units, additional supervision, and de-escalation).

Psychiatric services in Jail: Expectations and Realities

To address the needs of patient-inmates, case law and professional associations have outlined the necessity for and required characteristics of correctional psychiatric services. Jails are constitutionally obligated to provide mental health care (*Bowring v. Godwin 551 F. 2d 44*, 1977, *Estelle v. Gamble 429 U.S. 97*, 1976). Furthermore, these services must be adequate, as indicated by inclusion of assessment and screening, treatment beyond seclusion and observation, provision by mental health professionals, record keeping, safe provision of psychotropic medications, and suicide prevention efforts (*Ruiz v. Estelle, 553 F. Supp. 567*, 1982). Additional mandates include the documentation of psychiatric histories, the extension of care beyond psychotropic medications, adequately trained and sufficiently large staff to permit individualized treatment, and systems for ensuring standards of care (*Langley v. Coughlin, 715 F. Supp. 522*, 1989, *Madrid v. Gomez, 889 F. Supp. 1146*, 1995). Professional associations have also outlined standards for services in correctional facilities. The American Psychiatric Association (APA) has six principles for the provision of adequate mental health care in jails and prisons (APA, 2007). These principles encourage a level of care equivalent to that in the community, simultaneous priorities of security and treatment, clinical leadership with authority to create a therapeutic environment, and adequate staffing. Despite these substantial mandates, the provision of mental health care in jails appears variable, at best.

It is difficult to describe the way in which jail psychiatric services currently do and do not meet existing legal and professional standards, as existing federal surveys fail to collect data with enough specificity to do so. Several surveys conducted during the 1990's suggest that most jail facilities have the infrastructure to provide at least some mental health service to inmates (Goldstrom, Henderson, Male, & Manderscheid, 1998; Steadman & Veysey, 1997). These capacities typically include crisis intervention, medication management, intake screening, and follow-up evaluation. Less commonly available services include formal

mental health treatment or therapy, case management or reentry planning, in-patient or specialized psychiatric units, and collaboration with external providers or support system members. The extent to which inmates actually access services, and whether or not provision is sufficient for impact remains less clear. However, evidence suggests many mental health needs go undetected; fewer than 10% of all inmates receive any mental health service at all, leaving at least 30% of those with the most serious of mental health problems untouched (Steadman & Veysey, 1997; Teplin, 1990). Service provision and receipt appears highly dependent upon facility size and community context, as well as inmate age and race. Facilities that are small or located in politically conservative communities provide few services (Goldstrom et al., 1998; Helms, Gutierrez, & Reeves-Gutierrez, 2016). Inmates who are Black, Latino, and young receive few services (Kaba et al., 2015). In light of service limitations, some scholars recommend narrowing expectations for jail mental health care to essential services of detection, crisis intervention and stabilization, and referral, while enhancing community-based mental health care (Steadman, McCarty, & Morrissey, 1989; Steadman & Veysey, 1997).

Studies capturing provider perspectives help illuminate the realities of correctional psychiatric services. In relation to the perceived impact of services, providers in prisons prioritize some domains (e.g., symptom awareness and management, medication adherence, and institutional functioning) over others (e.g., emotion management, re-entry planning, or criminogenic risks and needs; Bewley & Morgan, 2011). Some acknowledge that harsh environments, institutional goals of containment, and values of obedience may conflict with therapeutic efforts to empower inmates, while impeding collaboration between correctional officers and mental health staff (des Cruser & Diamond, 1996; Kita, 2011; Nurse et al., 2003; Wright, Jordan, & Kane, 2014). Structurally, staffing limitations can hinder care continuity, critical access to clinicians in times of crises, and therapeutic relationships (Nurse et al., 2003; Wright et al., 2014). Despite these barriers, the serious needs of patient-inmates often motivate scholars and practitioners to search and advocate for the potential in correctional psychiatric services. These optimists suggest that, if correctional culture can be shifted and collaboration between correctional and clinical staff promoted, services can address core mental health challenges and aid in successful re-entry (see, e.g., des Cruser & Diamond, 1996; Jordan, 2012; Kita, 2011)

Patient-inmate perspectives—Psychiatric services research in the general population has increasingly recognized the importance of patient perspectives to informing and evaluating care (Hoy, 2014; Ware et al., 2004). Some of this research also indicates that preferences for services are dependent on the social circumstances of recipients and the context of care. Ware and colleagues (Ware et al., 2004, p. 555), for example, suggest the importance of “a sense of connection based on shared humanness” to recipients of public psychiatric services. This finding highlights the way in which non-traditional aspects of mental health care (e.g., provision of material benefits) are necessary in achieving this connection with members of socially and economically marginalized groups. Despite the importance of patient perspectives and their contextual specificity, these authors know of no prior study capturing jail inmates’ perspectives on psychiatric services.

A small body of research on the needs and preferences for mental health care in prisons, however, does exist. This research suggests that medication management and individual counseling may be valued components of care among patient-inmates, and that fewer barriers to accessing care may exist than commonly hypothesized (Bowen, Rogers, & Shaw, 2009; Jordan, 2012; Morgan, Rozycki, & Wilson, 2004). One small-scale qualitative study of prisoners (n=4), suggests patient-inmates perceived several benefits from counseling, including emotional release, a sense of understanding, and empowerment (Jordan, 2012). However, inmates were interviewed in the presence of their clinicians, potentially reducing candor. In addition, one survey of prisoners (n=418) found that participants desired individual counseling and, with the exception of a predilection for self-reliance, faced no significant barriers to care (Morgan et al., 2004). In this study however, responses were confined to researcher-defined items, which may have excluded barriers that reflect patient-inmates' experiences. Thus, aside from the importance of medication management, much remains unclear regarding patient-inmate perspectives on correctional mental health services, especially in jail contexts.

In summary, existing literature suggests three things about the provision of mental health care in jails. First, legal and professional standards demand extensive comprehensive services from jails. Second, the degree to which and variety with which administrators deploy jail psychiatric services indicates a stark departure from these demands. Third, cultural and structural characteristics of jails may be incongruent with service delivery goals and procedures. In the face of these realities, scholars and practitioners have two divergent responses. Some remain optimistic about the opportunities and potential for comprehensive care in jails, while others suggest a narrower focus on essential psychiatric services in jails and recommend strengthening community-based care. This study contributes to this debate by asking for the first time how the recipients of these services conceptualize jail mental health care, including the benefits of and limits to service provision. Results may ultimately inform service delivery and deepen our understanding of what can reasonably be expected from psychiatric services in jail contexts.

Methods

Mental health service consumer perspectives are critical to both informing services and standards of care (Hoy, 2014; Ware et al., 2004). This study seeks to illuminate service recipient perspectives on jail mental health care, asking: how do patient-inmates conceptualize jail psychiatric services, including the perceived benefits of and limitations to these services? While other researchers have evaluated jail psychiatric services using interviews with or surveys of administrators and clinicians, they have failed to capture the perspective of service recipients. In addition, the only studies examining the perspectives of patient-inmates occurred in prison (not jail) and either interviewed participants in the presence of their clinicians or used expert-informed, top-down categories to define service preferences and potential barriers to care (Jordan, 2012; Morgan et al., 2004). This study addresses this gap by conducting in-depth interviews with patient-inmates (n=19) on their experiences of and preferences for care. By using an inductive qualitative approach, we privilege the elements of care most salient to participants, while obtaining a unique perspective on service potential and limits. To achieve these aims, we use techniques from

two analytic approaches- Interpretive Phenomenology (Benner, 1994) and Constructivist Grounded Theory (Charmaz, 2006). We operationalize our strategy below as we describe the study site, sample, data, and analysis.

Study Site

In 2013, one of the authors conducted fieldwork in a large social service organization. Located in the urban center of a large West Coast city, the organization provides services to a significant proportion of the city's indigent adults with diagnoses of serious and persistent mental illness. The first author recruited participants from a program within this organization, which provides services to justice-involved individuals (i.e. who are under community or mental health court supervision, or who have histories of repeated incarceration).

The jail system within which these participants had been recently detained has several facilities and houses approximately 1,300 inmates at any given time.[3] Within these facilities, the local Department of Public Health (DPH) directly administers health services, including administration of psychotropic medications. DPH sub-contracts provision of other mental health services to a non-profit agency. A nurse informally screens inmates for mental health problems at intake, and may or may not refer a detainee for further assessment from the mental health team. The mental health team is comprised of approximately 14 full time equivalent staff. Psychiatric social workers occupy a majority of these positions, and services are overseen be a psychologist. About 35% of inmates in this system receive any mental health service and 6% receive psychotropic medications. Of those seen by mental health providers, one third have only one contact. The jails have procedures for suicide prevention, risk assessment at intake, suicide watch cells, and staff training on risk assessment and suicide prevention (Bureau of Justice Statistics, 2002). The jails also have some capacity to provide psychological counseling, alcohol and drug counseling, psychotropic medications, and connection to community-based psychiatric services upon release. However, these jails do not provide assessment at times other than intake or 24-hour mental health care, as is standard in most jail facilities in the United States.

Sample

We used purposeful (typical and criterion) sampling strategies (Palinkas et al., 2015), with the following inclusion criteria: 1) having a psychiatric diagnosis, and 2) having at least two experiences of jail detainment in the county, with at least one occurring within two years of the interview. To recruit these individuals, we used a three-pronged strategy, including announcement in social service organization community meetings, dissemination of flyers via case managers, and a drop box in the social service organization's waiting room. The sample size (n=19) was selected to permit detailed analysis of individual experiences, as well as saturation within emerging theme categories. While on the small end of recommended ranges, the sample is reasonable given the narrow study aim, specificity of

[3]These data are gleaned from a regional audit of this jail system. Institutional Review Board requirements, however, prohibit the disclosure of the exact study site to protect participant anonymity. Thus, in accordance with this restriction, we omit this reference.

participant experiences, and the strong quality of dialogue (Malterud, Siersma, & Guassora, 2016).

The sample is demographically similar to the local county jail population with respect to ethnoracial identity and gender, with men and Black/African American individuals overrepresented in comparison to the city's general population (see Table 1). The diagnostic profile of participants also reflects that of the organization within which our fieldwork was conducted, with the majority of interviewees reporting a diagnosis of schizophrenia, schizoaffective, or bipolar disorders. All interviewees were indigent and reliant on public income support, with the exception of one individual who was in the process of obtaining these benefits. The majority of individuals had long histories of involvement with the criminal justice system, with more than half of the sample reporting involvement in the juvenile justice system and 14 of 19 participants reporting ten or more arrests in their adult lives.

Data Collection and Analysis

Data sources include interviews with participants conducted by the first author, as well as memos containing descriptive and meta-observations of interviewees and procedures. Interviews moved from open-ended (e.g., "tell me about the last time you were in jail"; "what was the mental health care like?"), to focused (e.g., "what was helpful to you?"), to analytic questions ("what recommendations would you make to improve services?"; Charmaz, 2006). Interviews averaged 1.25 hours (excluding breaks), and each was recorded and transcribed. Given the unique challenges faced by the sample population (e.g., symptoms of psychosis or inebriation), the first author took several measures to enhance communication, comfort, and rapport. Acknowledging the power imbalance inherent to the researcher/interviewee relationship, the first author made efforts to create a sense of reciprocity. Having prior clinical experience with the sample population, the first author also attended to participants' mental statuses throughout the interview process. On two occasions, the first author extended the option to pause or reschedule the interview due to the presentation of symptoms that seemed to delay or distract the participants. In both circumstances, the participants took a break and resumed the interview once symptoms had dissipated. Notably, prior research indicates that individuals with serious mental illness demonstrate strong reliability when reporting past traumatic, health-, and health service-related experiences (Goldberg, Seybolt, & Lehman, 2002; Goodman et al., 1999).

The first author, second author, and one research assistant analyzed transcripts using Dedoose, qualitative data analysis software, in three phases. First, using Grounded Theory techniques and within a phenomenological tradition, we coded data line-by-line and stayed as close as possible to participant testimonies. Next, we engaged in focused coding, wherein we identified three elements present in all interviewee conceptualizations of services: service administration (i.e., what and how services were administered), service effects (i.e., results of services for patient-inmates), and service contexts (i.e., relationship between services and jail conditions). Finally, we used memoing and theoretical coding to draw connections and distinctions between focused codes. During this process, we also constructed tables to organize data by participant and codes, facilitating identification of patterns against which

we could test thematic observations and identify illustrative quotes (Miles & Huberman, 1994). Finally, to enhance groundedness, we engaged in reflexive practices throughout data collection and analysis, did not conduct a thorough review of the literature on jail psychiatric services until data were analyzed, and utilized researcher triangulation (Charmaz, 2006; Ramalho, Adams, Huggard, & Hoare, 2015).

Results

Interviewees drew from their often lengthy and repeated periods of detainment when discussing jail psychiatric services. Providing detailed descriptions of jail psychiatric services, their perceived effects, and their contexts, each interviewee conceptualized services based on their utility and interpreted this utility in relation to the jail's larger structure and culture. Seven common components of care emerged based on service descriptions, with a majority of interviews exploring each component. Based on interviewees' contextualized perceptions of service utility, these seven components of care clustered into two categories: *primary service components* (medication management, psychosocial assessments, and crisis intervention) and *supplementary service components* (groups, providing goods, accommodation and advocacy, and connection).

Primary Service Components

Interviewee descriptions of jail psychiatric services commonly emphasized the importance of medication management, psychosocial assessments, and crisis intervention. Interviewees conceptualized these *primary service components* as fundamental elements of care, and essential to symptom management and safety.

Medication Management—Patient-inmates viewed the provision of psychotropic medication as a fundamental component of jail psychiatric service. The role of medication management was so central that, at times, the role of jail psychiatric services was reduced exclusively to the distribution of medication. For example, when asked about her experience with jail psychiatric services, one interviewee vaguely stated that they were "helpful with [her] bipolar." When probed on how jail psychiatric services were helpful with her bipolar she responded, "they gave me medications." Even for patient-inmates who refused medications, medication management remained central to descriptions of jail psychiatric services.

Ideal medication management, described as accessible and timely (particularly at initial assessment), could help manage psychiatric symptoms. In contrast, poor medication management, described as difficult to access, delayed, and involving unnecessary modifications to medication regimens taken in the community, led to withdrawal or symptom increase (e.g., paranoia and sleep disturbance). As one interviewee explained, "It's sad though because a lot of people come in and [clinical staff] mess with their meds and [staff] wonder why people are acting out or having a tough time because they're misdiagnosed and mismedicated." When psychiatrists augmented medication regimens from regimens taken in the community, patient-inmates were unclear as to why they could not continue taking the same medications they took in the community. As a result, they felt denial of these medications was mentally and physically harmful, as well as discriminatory.

Psychosocial Assessments—Interviewees identified the importance of compulsory and comprehensive psychosocial assessments. However, many failed to recall such assessment. In the absence of this primary service, patient-inmates reported being "overlooked" and needing to self-advocate for assessments in order to access medications. A lack of comprehensive assessment also left inmates feeling like clinical staff failed to understand them or their needs. One interviewee explained:

> [The psychiatrist] didn't analyze me…he didn't diagnose me, so he doesn't know exactly what is wrong with me. All he could do was read the file and that's what they tend to do, instead of actually talking to you. To me … if somebody just reads your file or whatever, they don't really know you.

Another inmate echoed this sentiment, asking simply, "how the hell can they analyze you, if they don't even talk to you?" Thus, patient-inmates conceptualized compulsory and comprehensive assessments as fundamental to care because these assessments allow access to appropriate and important medications and other services relevant to needs.

Crisis Intervention—Access to clinical staff in times of symptom escalation was another key service component. Because staff worked 9 AM to 5 PM and only on weekdays, clinicians were inaccessible for the majority of inmates' time in detainment. In some cases, significant problems arose when symptoms escalated outside of business hours and correctional officers were responsible for intervening. An interviewee describes one such experience:

> See these scars right here? I had slashed my wrists because I was feeling depressed and stuff…[the correctional officers] put you in a safety cell butt naked. They strip you and all that. Then they're supposed to slide you a garment…It velcros so you can't hang yourself with it. … They put me in there. I had blood all over me. I was in horrible shape and [the correctional officer] didn't give me a garment for the whole night. … He came around and was going, "oh, poor baby [in a baby voice]," which just makes it worse. The thing is, right before the psych staff came in the morning, he slid in [a garment]…If you're someone that is already traumatized, it makes it a thousand times worse…it's like a very hostile environment and it's scary, because you know you can't win…It's a very powerless feeling, and scary.

The importance of crisis intervention was particularly strong for patient-inmates who had such experiences. However, patient-inmates who bore witness to others in crisis echoed this sentiment. Because symptoms are indifferent to time and day and because correctional officers failed to appropriately respond to patient-inmates' needs, interviewees felt continuous access to clinicians was a necessity for psychological wellbeing and safety.

Supplementary Components of Care

In contrast to primary components, which interviewees viewed as necessary for safety and psychological stability, patient-inmates saw *supplementary components of care* as helping to mediate the effects of incarceration and, in some cases, enhance a general sense of wellbeing. Often discussed after primary components and as undermined by the jail context, patient-inmates largely framed supplementary components as unessential.

Group Activities—Comprised of psychotherapeutic and rehabilitation-focused groups, interviewees identified group activities as a component of psychiatric services with potential to disrupt the monotony, isolation, and solemnity of detainment. In their ideal form, they help pass the time, facilitate learning, and feel positive and goal directed. As one interviewee explained, "I enjoyed [the groups]. They passed the time [and] keep a positive direction." Another interviewee echoed this sentiment stating, "[The groups]…got you out of your cell…That's the best thing. [They] gave you something to do, gave you some stuff. You know, positive stuff." Two interviewees also highlighted the fact that some of the groups were facilitated by people who volunteered inside the jail. Perceived as trustworthy individuals, independent of any investment in or dependency on the jail institution, interviewees valued the presence of these volunteers.

The therapeutic utility of these groups beyond helping participants "pass the time", however, seemed limited. Participants had a general sense that while groups were positive in tenor, they didn't "get to the meat and bones" of patient-inmates' problems. For some, the use of physical restraints and lack of relevance hindered utility. One interviewee who avoided participation explained, "I know [patient-prisoners are] cuffed and shackled when they have those [group] meetings. Anyways, to me it would be pointless, because I wouldn't be able to focus on nothing… being shackled." In addition, some interviewees viewed participation in groups irrelevant to their needs, pointless or redundant, ultimately contributing to an overall negative perception of jail psychiatric services.

Provision of Goods—Patient-inmates reported few social supports and financial resources while in detainment. As such, providing intangible (e.g., information, linkage to external practitioners) and tangible goods (e.g., toiletries, snacks) was a valued clinician activity. Interviewees often viewed the provision of goods like candy superficially as a "treat." Material support could also help enhance a sense of connection to clinical staff, which one interviewee illustrated by stating, "even though they're so busy…I got to know [them] pretty good. One of them even used to bring me her books after she read them." Some interviewees also saw provision of the intangible good of linkage to trusted professionals outside of jail as key to accessing the support needed to endure incarceration, as one interviewee explained,

> They kept me together…therapists and the outside entities. Those were the ones that really kept me together because they kept everything positive, and always told me that, you know, it was 'gonna' be ok. You're not going to be here long, and there's bigger and better things on the outside for you.' I always trusted that. [I] trusted the process and I believed in what they were saying and came out.

In contrast, when clinical staff denied information (e.g., regarding their legal case) or goods (e.g., coffee) to inmates, interviewees perceived this as a symbol of neglect and deprivation reflective of the larger jail institution. This ultimately impaired rapport.

Accommodation and Advocacy—Interviewees identified accommodation of patient-inmate limitations and advocacy for patient-inmate needs as a valued clinician activity. For example, one interviewee explained how her symptoms made it difficult to follow the rules of the jail, stating, "It's not physical, but sometimes you can't do things that other people

can do at the time." While she felt correctional officers were unable to accommodate these limitations, clinical staff were able to "explain [the rules] in a way that makes sure you can relate." In other cases, when patient-inmates had difficulty advocating effectively for their needs (e.g., requesting a cellmate change), clinicians could advocate on their behalf. For a majority of patient-inmates, accommodations were best made when housed in a special unit for individuals with serious mental health challenges. Such additional supervision and separation could act as a buffer to the abuse and triggers present in the jail, as one interviewee explained, "Yea, I can relax [in the psychiatric unit] and just do my time… without being on guard. Somebody's ready to attack me in the general population. You don't have to feel like that over there." While another explained, "I didn't like being on the main line…there was a lot of beer" and "[inmates in the general population] would take your canteen."

Thus, because the larger jail system was unable to accommodate challenges and maintain safety, the ability of clinical staff to accommodate and advocate promoted a sense of wellbeing. However, patient-inmates felt that the ability of clinicians to advocate for patient-inmate needs was dependent on clinicians' degree of autonomy and authority within the jail structure. Patient-inmates often perceived clinicians as unable to separate themselves from larger institutional goals and practices, or unable to meet needs that potentially conflict with those of the larger institution, which in turn impaired clinicians' abilities to fulfill expectations.

Interpersonal Connection—Possessing a basic sense of interpersonal connection with clinical staff had the potential to reduce feelings of isolation, release negative emotions, and help inmates persevere through their detainment. This connection could be facilitated by simply "checking in" with or talking to patient-inmates. One interviewee noted, "I was able to … vent out a lot of shit, you know. And get a lot of stuff off my chest. And get some positive feedback at times. And that kind of made it easier to get through." No interviewee suggested such interactions with staff addressed ongoing psychiatric problems, but some indicated they could be grounding and humanizing within the otherwise disorienting and dehumanizing jail environment.

This sense of connection, however, was not a common experience and interactions did not extend beyond the superficial. Fluctuations in staffing and the perceived inability of staff to make time to talk with patient-inmates left the impression for some that clinicians "did not care." In addition, when patient-inmates perceived clinical staff as unable to assert their autonomy from, and authority within, the broader jail institution, the trust and rapport necessary for psychotherapeutic intervention was hindered. One interviewee explained the way in which the perceived lack of authority of clinical staff hindered the therapeutic alliance; he stated, "I felt like I could talk to [clinicians], but at the end of the day, they're going to do whatever the [correctional officers] tell them to do." Another interviewee illustrated the way in which the culture of the jail limited therapeutic potential, asserting:

> [Clinicians] have a different program and agenda and everything, but their attitude and demeanor changes. When a new [clinician] starts working, people [say], 'oh, we have a new [clinician]. They're cool.' And then in a few months they start

> taking on the ways [of the jail]; there comes the separation where it's no longer the human family and it's us versus them…They don't put any credence or value on what we say. Everything has to be triple verified because an inmate said it… Yea, everything there is just like the outward superficial stuff… It's not like therapy…I mean, if they're alright I might ask them to make copies for me or something, but it's not like you're working on inner issues or nothing.

In two cases, interviewees also acknowledged that they were unwilling to follow the clinical recommendations of jail staff, but later adopted similar recommendations that proved beneficial when made by community-based providers. Thus, perceived lack of autonomy and authority diminished the degree to which patient-inmates trusted staff, were able to develop a sense of connection with staff, and ultimately therapeutic benefit. As one patient-inmate concluded, "[talking to a clinician] was helpful, but it wasn't *really* helpful."

Discussion

Patient-inmates conceptualized jail psychiatric services as having seven components, each of which is defined by its impact on patient-inmates and is shaped by the context in which it is delivered. The first three of these components include psychosocial assessments, medication management, and crisis intervention. Perceived as central to jail psychiatric services and essential to symptom management and safety, these elements of service delivery comprise *primary service components.* The remaining four components include group activities, the provision of goods, accommodation and advocacy, and interpersonal connection. Perceived as generally beneficial and useful in mitigating the effects of detainment, but often superficial and less essential to jail psychiatric services, these elements of service delivery comprise *supplementary service components.*

Patient-inmates also clearly highlighted perceived benefits of and limits to primary and supplementary service components. The overarching benefits of primary service components, symptom management and safety, are realized by enhancing access to relevant services (especially medications), de-escalating crises, and preventing medication withdrawal and side effects. The ability to provide primary service components in a manner that achieves these aims is limited when assessments did not take place or were incomplete, staffing impeded continuous crisis intervention, and access to medications and existing medication regimens was impaired. In the case of supplementary service components, the overarching benefits of enhancing general wellbeing and mitigating incarceration effects are realized by decreasing monotony and isolation, softening the harshness and deprivation of jail, fostering connection to external supports and providers, and helping navigate and buffer negative influences in the jail environment. The ability to provide supplementary service components in a manner that achieves these aims is limited when services are irrelevant, material and immaterial needs are not met, and clinician autonomy and authority is not demonstrated.

While provision of comprehensive psychiatric services consonant with legal and professional standards may lead to positive effects, results indicate that structural and cultural factors inherent in the jail context can challenge the provision of primary service

components and prohibit the provision of supplementary services. Structurally, jails separate inmates from the broader society, and frequently have staffing patterns that provide limited access to clinicians. Although these factors make it difficult to maintain continuity in the provision of essential services (e.g., psychotropic medications, 24-hour crisis intervention), they are challenges that can be overcome by enhancing communication with community-based providers and expanding hours for jail-based providers. Given the perceived necessity of essential components of care to symptom management and safety, patient-inmates suggest such investments are warranted.

The cultural and structural barriers to the provision of supplementary services, however, appear less penetrable. Culturally, jails have a punitive ethos, and are characterized by deprivation. Structurally, they are hierarchical, rely on physical means to separate and contain, and have a constant ebb and flow of admissions. These attributes require the use of interventions such as shackles, situate clinical staff as deferential to correctional staff, and rely on dispossession, in turn contradicting patient-inmates' desire for connection, impairing the provision of highly tailored rehabilitative programming, and limiting the influence of, and trust in clinicians. While some of the needs addressed by supplementary services could be addressed by ensuring jails function properly (e.g., correctional officers maintain safety among all inmates) or by enhancing integration of external service providers, the aforementioned cultural and structural factors inherent in jails largely prohibit the provision of supplementary services by jail mental health programs.

Previous research indicates a contradiction between legal and professional expectations for mental health care and elements of jail structure and culture. Optimistic professionals advocate for a shift in jail culture, enhanced collaboration between correctional staff and clinicians, and increased awareness on how to access services among patient-inmates in order to reduce barriers to care (e.g., des Cruser & Diamond, 1996; Morgan et al., 2004). These authors also suggest the transformative potential of the therapeutic relationship in correctional settings (e.g., Jordan, 2012; Kita, 2011). The perspectives of patient-inmates captured in this study provide some clarification as to what jail psychiatric services can reasonably aspire. While efforts to create greater collaboration between clinical and correctional staff may promote improved operations, patient-inmates' experiences suggest such collaboration may further undermine trust and therapeutic alliance. In addition, interviewees failed to express any notion that lack of awareness was a significant barrier to care and, instead, highlighted structural and cultural barriers to engagement and provision. Finally, despite mandates for and practitioner interest in the provision of psychotherapy, no patient-inmate perceived this as a key component of jail-based psychiatric services. In contrast, jail-inmates viewed the structure and culture of the jail to be in direct conflict with the development of therapeutic rapport that is necessary to achieve this aim. Thus, echoing Steadman and colleagues (1989), patient-inmate perspectives indicate appropriate priorities for mental health service delivery are strengthening essential elements of jail mental health care, while integrating and ensuring post-release availability of community-based mental health providers and care.

First-hand perspectives of patient-inmates on jail psychiatric services are indispensable to understanding the potential for and limits to such care. While this study forefronts these

previously neglected perspectives, it does so with two limitations. First, the sample size precluded the ability to examine differences within sub-groups. For example, we were not able to test variation in conceptualizations by gender or ethnoracial group membership. Secondly, while some interviewees had experienced detainment in multiple locations, the study primarily focused on the experiences of service receipt within a single county. Thus, interviewees' conceptualizations of jail psychiatric services are likely limited to some degree to the way in which services are administered within the study site and findings are best extrapolated to other large jails with similarly robust (e.g., providing counseling, psychotropic medications, and connection to community-based providers) and structured (e.g., administered by a private agency) service systems. Future research should test the findings presented here by collecting data from a sample stratified by demographics and in counties with varying jail mental health service capacities and structures.

Conclusion

While jails may be popularly described as the "new mental hospitals," patient-inmate narratives contradict this title. Instead, patient-inmate perspectives suggest jails struggle to provide even the most essential components of care. To align with the needs of service recipients and recognize the impermeable cultural and structural constraints on care in jail contexts, practitioners, advocates, and institutional standards should focus on strengthening systems for providing assessments, psychotropic medications, and crisis intervention. In addition, program planners should employ methods through which medication management can be made more continuous, connection with community-based providers enhanced, and integration of community-based providers in a manner that maintains their autonomy increased. Finally, a patient-inmate informed research agenda for jail psychiatric services should investigate models through which these interventions are deployed and standards are met. In the absence of realistic, recipient-informed standards of care, interventionists will likely fail to address key needs, increase safety, or enhance psychological wellbeing in jail settings.

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Table 1

Participant demographic and social indicators, counts (unless otherwise noted)

Participant	***N=19***
Gender	
Male	15
Female	4
Age	
Median	45
Range	30–66
Sexual Orientation	
Gay or Bisexual	4
Heterosexual	15
Race/Ethnicity	
Black/African American	5
Hispanic/Latino	5
White	4
Native American	1
Multi-Racial	4
Mental Health Diagnosis	
Schizophrenia	8
Schizoaffective/Bipolar Disorder	6
Major Depressive Disorder	2
Other Diagnosis	3
Public Income Support	
Recipient/pending application	19