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Abstract

This article outlines and discusses five categories of information about individual jails that should be considered before making general statements about jails. These are (a) the process by which individuals come to and are processed through the jail, (b) the size of the jail, (c) the region of the country where the jail is situated, (d) classification/assessment techniques, and (e) architecture and supervision styles. It is hoped that this discussion will generate a better understanding of the complexity of jail systems across the nation and help public health professionals better target their research, programs, and policies directed at the jail/community health nexus.

Keywords

jails, public health, generalizability, policy

All jails are alike and no two are the same.

Potter, 2007

If you've seen one jail, you've seen one jail.

Rosenberg, 2009

Common wisdom in the public health world seems to be that if something works in one jail, it will work in all jails. A recent supplemental issue of the journal *Sexually Transmitted Diseases* (2009) and an article by some of the same authors in the *Journal of Correctional Health Care* (Harawa et al., 2009) provide exemplars of what might be called “vaccine thinking” about jails. That is, a “one-size-fits-all” approach to an environment characterized primarily by heterogeneity. There are more than 3,000 jail systems in the United States. This does not count the number of individual facilities across those systems. The *Sexually Transmitted Diseases* (2009) supplement reports on surveillance or program research based on fewer than 40 jails (i.e., less than 2% of all jail systems). The one exception is a statewide survey of STD services in Illinois (McIntyre, Studzinski, Beidinger, & Rabins, 2009). Concluding recommendations from some of the articles include general statements such as the following (emphases added):

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- Rapid HIV testing in jails identified a considerable number of previously undiagnosed cases of HIV infection. Rapid HIV testing should be available to **all inmates**, regardless of whether inmates reported HIV risky behaviors (MacGowan et al., 2009, p. S9; 4 states, multiple jails).
- Our findings support **universal Chlamydia testing of young women detainees**. . . . Risk factors reported here should inform the integration of prevention and treatment services in correctional settings and substance abuse treatment centers (McDonnell, Levy, & Morton, 2009, p. S29; one California county juvenile detention center).
- Modeling indicates that the intervention can avert many sexually transmitted infections at low cost and can save costs in a scenario in which inmates continue to engage in sexual activity as they do outside jail. **Modest success in efforts to promote condom use among inmates results in additional cost saving** (Tuli & Kerndt, 2009, p. S41; one special unit in one California jail).
- Young men in adult jails have a large burden of chlamydial infection. Correctional screening and treatment programs present an important opportunity to improve the health of inmates and interrupt disease transmission (Pathela et al., 2009, p. S58; New York Rikers Island jail system).
- Using arrest charge to target screening may efficiently increase HIV diagnosis in **jail inmates** where universal HIV screening is not possible (Harawa et al., 2009, p. 105; two units in one California jail, same jail as in Tuli & Kerndt, 2009).

In many research and recommendation documents, public health professionals have generalized from a small number of jails (and often prisons) to the totality of jails in the United States (e.g., *Morbidity and Mortality Weekly Report*; Centers for Disease Control and Prevention, 1989, 1996, 1997, 1999, 2003). Statements and recommendations such as these appear to suggest a lack of knowledge about how jails (and juvenile detention) operate. This lack of acknowledgment of the distinctions among systems makes the generalizability of the recommendations and statements weak.

In their classic text *Experimental and Quasi-Experimental Designs for Research*, Donald Campbell and Julian Stanley (1963, p. 4) note that “applied practice and scientific knowledge are seen as the resultant of selectively retained tentatives, remaining from the hosts that have been weeded out by experience.” In more simple terms, knowledge is evolutionary. It involves a process of refining evidence with “wise practice.” From this perspective, generalizability of evidence becomes a key issue. That is, knowing to what “populations, settings, treatment variables, and measurement variables” an effect or impact can be generalized (Campbell & Stanley, 1963, p. 5) is vitally important.

Generalization is rarely absolutely possible, Campbell and Stanley (1963, p. 17) pointed out. It requires knowing how closely the “populations, settings, treatment variables, and measurement variables” in the previous research match or differ from the setting in which you are going to use the evidence. In the case of most public health studies of jail populations, the key factors associated with the more than 3,200 jails in the country are generally glossed over. The remainder of this article addresses key elements of jails that “matter” when seeking to generalize knowledge about jails and their operations in relation to health practices and policies.

“Process Matters”: The Process of Incarceration

At its legal base, incarceration means to be confined in a correctional facility (detention center, jail, or prison). Exactly how long one must be confined to be incarcerated is an interesting question. Deaths in custody reporting programs in the United States and Australia (Joudo & Curnow, 2008; Mumola, 2007) begin counting deaths during the arrest phase (or “police operations”), including chase events.

There is wide variability across the nation in the process of incarceration, at least with relationship to the place of first detention. As shown in Table 1, there are more than 3,200 county jails (Sabol, Couture, & Harrison, 2007), which includes the 6 unified state jail/prison systems. Many

Table 1. Number of Jail Jurisdictions, 2000 and 2007

Jail Jurisdiction Size ^a	Number of Jail Jurisdictions, Midyear	
	2000	2007
Total	3,001	2,860
Fewer than 50 inmates	1,512	1,097
50-99	499	583
100-249	512	558
250-499	224	272
500-999	131	177
1,000 or more	123	173

Source: Sabol & Minton, 2008.

^a Based on the average daily jail inmate population.

counties across the United States have only one detention facility. In those counties, anyone arrested and in need of detention (not all those arrested are detained) is transported by police/deputies directly to the county jail (unless they need acute medical attention).

In larger counties with multiple law enforcement agencies that arrest and process individuals, the picture may be more complex. One may be arrested on the street or at home within the city limits of a jurisdiction and taken to a “lockup” or “holding cell” in the city police department while awaiting transfer to the county jail. In some instances, a local magistrate may be able to make the determination that an individual can be released, and that person returns to the community after only a few hours in the holding cell. In others, and for those accused of more serious crimes, it is likely that they will spend a few hours in the local lockup before being transported to the larger county jail. Multiple city lockups feed central jail facilities in many large counties across the nation. At present, there is no enumeration and location of the lockup facilities in the United States.

Once an individual is arrested, our legal process requires that a bond hearing to arrange bail be held within 24 hours of booking in most jurisdictions (for offenses that could result in a custodial sentence). Exceptions to the time limit are made for weekends, holidays, and where there are court orders that extend that period. The Eighth Amendment to the U.S. Constitution requires that bond not be excessive, as freedom to help plan one’s defense is a cornerstone of the criminal justice process.

Examining 10 years of pretrial release data from the 75 largest counties in the United States (accounting for more than half of all jail admissions annually), Cohen and Reaves (2007, p. 5) report that among those charged with felony offenses (i.e., the most serious crimes subject to prison sentences), 62% were released prior to case disposition (38% held until case disposition). Among the 62% released, 52% were released within 24 hours, 78% within 1 week, and 92% within 30 days of arrest. For misdemeanor offenders (less serious crimes), it is likely that releases may be faster or certainly no slower.

Those who were not released prior to trial were more likely to be charged with violent crimes (e.g., murder, sexual assaults, robbery), have a criminal record, and/or to be under some form of criminal justice control at the time of arrest (e.g., on bond, probation, or parole). In these data, males (40%) and Hispanics (any race; 45%) were less likely to be awarded bail than females and those of other ethnic groups. Among African Americans, 38% were not released prior to trial, compared to 32% of Whites. The amount of money required to make the bond also influenced release for those who were awarded bond. Cohen and Reaves (2007, p. 3) report a direct relationship between the amount of bail and the release of those who were granted bail. The higher the bail, the less likely they would be released. Once the bail topped the \$15,000 level, the likelihood of release dropped to 1 in 10. Those who remain in jail prior to a trial or sentencing hearing (because most cases are decided by plea) tend to be poorer, male, accused of serious violent crimes, or have prior

involvement with the criminal justice process. They are not representative of those who are arrested, and certainly not representative of the general public.

Once an individual who cannot make or is refused bail is classified and assigned to a jail unit, and following a guilty plea or trial conviction, the average length of stay in a county jail is about 2 weeks. The variability in range is extreme, partly because of how long some individuals stay in county jails while awaiting the outcome of a trial and appeals. But because most people are sentenced to probation, especially for misdemeanors offenses, incarceration in a jail is brief, on average (James, 2004).

Knowing the process of detention and release is especially important when talking about jails. Whether one is dealing with a "direct receipt" or a "fed" jail is also important in considering who actually winds up in the jail. Pre- and post-bail bond hearing status and whether one is dealing with a facility that holds primarily pre- or post-sentenced inmates is crucial to understanding the nature of the population held. These variables will affect the points at which one's data are generalizable, as well as the conclusions one can make about the overall health issues facing jail populations.

"Size Matters"

The diversity in jail size and the process by which individuals reach the jail make generalizations to the whole risky, at best. Yet few studies of health among jail inmates focus on more than a statistical handful of jails across the nation, mostly a handful of northern, Midwestern, and Western jails in large metropolitan areas. These are almost exclusively among the large jails or facilities that house 1,000 or more daily (or average daily population [ADP]). In 2006, this set of jails accounted for only about one third of the national jail population on census day, though their "flow" contribution may be up to three quarters of the total jail admissions annually.

Los Angeles County Jail, comprising three distinct campuses and at least 14 facilities, has had an ADP of 19,867 in 2002, rising to 21,184 in 2004, and returning to 19,062 in 2006 (Harrison & Beck, 2005; Sabol, Minton, & Harrison, 2007). To put this into perspective, only 23 state prison systems and the Federal Bureau of Prisons had populations of 20,000 or more in 2006 (Sabol, Couture, & Harrison, 2007). After Los Angeles, Rikers Island in New York and Cook County in Chicago topped the 10,000 ADP levels in recent years.

Little is gleaned from the published literature about health issues in small jails (i.e., < 250 ADP; about 50% of all jail systems, holding around 15% of jail inmates), or even how their medical services are delivered. Surveillance systems that record diagnosis information at the Centers for Disease Control and Prevention are rarely broken out by the size of a jail (or prison) where a diagnosis is made. The same holds for the vast majority of the medium-size jails, which comprise just over one third of all jail systems and hold around 35% of all inmates on a daily basis. We know almost nothing about health issues in tribal jails, even where Public Health Service staff provides medical care. Thus, it seems that to generalize to the remainder of the jails in the United States based on a study of a single or handful of large jails is neither methodologically sound nor the basis for evidence-based interventions.

"Region Matters"

Table 2 further divides the 2006 Bureau of Justice Statistics jail census data by region of the country where the jails are located. One of the first points to notice is that nearly half (49%) of jails are in the southern region. Among the 50 "large jail network" facilities, 23 are in southern states. There are proportionately few samples of jail health issues from the South, other than from a small set of urban areas. A disproportionate number of studies of jail populations are from the Northeast, the region with the fewest jails in the nation. These are followed by studies of a handful of jails in the West and Cook County (Chicago) in the Midwest.

Table 2. Jails by Region of the Country

Census Region	Number of Facilities	Percentage of Facilities ^a	Inmate Population Count ^a	Percentage of Inmate Population ^a
Northeast	221	6.81	67,504	13.06
Midwest	965	29.74	122,489	16.41
South	1,552	42.83	364,783	48.88
West	507	15.62	161,564	21.65
Total	3,245	100.0	746,340	100.0

Source: RTI International. (November, 2006). *National inmate survey - Year 1: Sampling plan for selection of facilities*. Paper presented Washington, DC.

Note. Does not include Connecticut, Delaware, Hawaii, Rhode Island, and Vermont—all treated as prison systems because they are unified correctional systems.

^a Based on only jails housing more than five persons daily.

Because crime patterns are not uniform across the nation (Federal Bureau of Investigation, 2009), one cannot assume that reasons for arrest are uniform across the nation, even among the largest jail systems. In the same vein, health problems are not uniform across the nation (Pappas, 2006), so one should not assume that the health problems encountered in jails are randomly distributed. Race/ethnic composition among the jail populations also varies across states, and because race/ethnicity exposes some of the greatest health disparities nationally, one must be cautious about generalizations from single or small sample jail studies.

The race/ethnic, socioeconomic status, urban/rural, and health disparities mix of the various geographical regions of the country require combining these with the size of jails in moving toward an evidence-based jail public health. Just as suicide rates vary in the general public by region of the nation (American Foundation for Suicide Prevention, n.d.), so too might risk of suicide in jails. Background rates of communicable diseases also vary by region, and so should considerations of the probability of jail-based disease transmission. It may be that unified systems in constrained geographical areas make surveillance and researching jail/prison populations easier, but it does not make them representative of jails in the rest of the nation.

“Classification Matters”: Static and Dynamic Risk Assessment

Just about every jail in the United States will use some form of risk assessment procedure to make decisions about housing for detainees and convicted inmates. Lowenkamp, Holsinger, and Latessa (2001, p. 544) differentiate between “clinical” and “actuarial” assessments. Clinical approaches are likely developed over a period of practice and are variable across those who use them. Actuarial approaches use “standardized, objective risk/needs” instruments developed through extensive research. Both approaches have developed over the past century.

To reduce the likelihood of a range of negative outcomes and increase the probability of a positive outcome, inmate classification science has been employed for several decades. Stinchcomb (2005, pp. 255–261) notes that the ideas of offender classification have their roots in the separation of children from adults in the first Quaker jails in America. More systematic classifications began to develop in the 1920s (Simourd, 2004). The advancement of “objective classification” schemes began in earnest during the early middle part of the 20th century and was associated with the “medical model” period of corrections, also known as the rehabilitative ideal. Sex offenders and “career criminals” spurred the discrimination of risk factors into two categories, “static” and “dynamic” or risk/need factors (e.g., Andrews, Bonta, & Hoge, 1990; Hanson & Harris, 2000; Lowenkamp et al., 2001; Schlager & Simourd, 2007).

Static risks are those correlates that cannot be changed, such as biological sex, race, and age. Dynamic factors (or risk/need), however, are those variable correlates, especially behavioral, that are subject to modification to improve a desired outcome. In their schema, “risk predictors are those factors identified through recidivism research that can be targeted and changed through correctional intervention” (Lowenkamp et al., 2001, p.544). Some instruments have also been shown to be effective in predicting rules violations during incarceration, correlates of the risks often cited in the public health literature such as sexual behavior and/or substance use.

In the past two decades, and in conjunction with the discussion of supervision (below), a variety of objective classification products have been developed (Austin, 1998) to allow jail workers to separate those who stay in a jail into a variety of risk categories, including potential offenders and victims. Although size of the jail matters, in most medium and large jails, those who are going to be housed will be objectively classified and housed according to risk and need, even when the length of stay is unpredictable. A more “clinical” or subjective approach may be used in pre-bond hearing detention. How inmates are classified and assessed becomes an issue for placement, supervision, and generalizability. This is especially true when a special or “vulnerable population” unit is the unit of analysis then generalized to the larger jail and/or all jails.

“Supervision Matters”

All jails do not share the same architecture, and this affects the way in which detainees/inmates are supervised. Stinchcomb (2005, pp. 135–140; see also Schmallegger & Smykla, 2008) provides a convenient analysis of how jail architecture affects supervision of inmates. She distinguishes three basic types of jail architecture/design and their associated supervision styles:

- “First generation,” sometimes termed “linear design,” was the traditional design of jails and prisons until the 1980s. Visuals of cells along a catwalk stretching down a corridor are accurate descriptions of this design. The type of supervision associated with this design is “linear remote (or intermittent) surveillance.” That is, officers cannot view all detainees/inmates at the same time, and most interactions occur when officers stand in front of the bars of an individual cell. This design has low visual and auditory access between inmate and officer.
- “Second generation,” otherwise known as the “indirect supervision design,” is often associated with a podular construction. In this setup, officers are housed in a somewhat central “control room” area with the ability to observe visually most of the cells and common areas in the pod. In many respects, this is a throwback to ideas of the original “panoptic” design for prisons developed by Jeremy Bentham in the 1700s. In fact, many health professionals would recognize it as a mainstay of current hospital nursing station design. This architectural form promotes indirect supervision through the separation of the officers from the inmates most of the time, with most conversations taking place through intercom devices. Increased visual supervision, but still limited interaction, is the hallmark of such a jail unit.
- “Third- (or new) generation jails,” sometimes referred to as “open plan,” are relatively new in the jail world. They bring an open central plan to a podular design, with no control room. They encourage a “direct supervision” approach to management of inmates by officers. In short, the officers are not physically separated from those they manage. Direct, continuous supervision with physical interaction between detained and supervisor is the way things operate. All services (except perhaps medical) are provided to the inmates in the pod. Many individuals who visit an “open plan” jail are surprised that there is relatively less violence in these settings. This is accomplished primarily by the continuous supervision and interaction of the officers with the inmates and the reduction of opportunities for rule violations.

Schmallegger and Smykla (2008, pp. 215–216) have introduced the “fourth-generation” jail concept for facilities that incorporate the architectural openness of the third-generation jail and add natural lighting with the provision of a range of active inmate services directly in the common area. They contrast this with the third generation’s need to remove inmates from the common area to obtain a variety of services.

Because nothing is ever simple with regard to jails, larger facilities that have developed over the course of several decades may well have a mixture of architectures, as well as a mixture of supervision styles. The Los Angeles County Jail system, for example, mixes two of these three designs and supervisory approaches in its downtown complex alone (the source of two articles mentioned earlier).

There is enough empirical evidence to suggest that the design of the facility and the style of supervision have a relationship to the problems and opportunities encountered in a jail to make them important in the consideration of risk. Therefore, knowledge of the structure and supervision in a jail setting is a necessary variable in attributing risk to a situation.

Putting It Together

How one arrives at the jail, either as a direct intake or as the result of a bond hearing filtration process, provides the first determinant of who winds up detained in jail. The filtration process is itself heavily determined by factors such as poverty, prior contact with the criminal justice process, and the seriousness of the alleged offense. This filtering will have implications for planning HIV/STD testing programs to reach this generally difficult population. If only about one third of the arrested population are reaching a jail after lockup, it may be necessary to plan to move the testing process back to the larger number of lockups to increase the number of potential tests performed.

Techniques of classification (objective vs. subjective, risk/need assessment) determine housing decisions in jails with adequate space, thus interacting with jail size and probably urban/rural location (region). Classification interacts with supervision level, which in turn, is heavily affected by architecture. Architecture and supervision interact to structure opportunities for behavioral and other risks. Detainees/inmates identified as higher risk are likely to be housed in more restrictive environments, with less access to nonmedical personnel for disease screening and/or prevention education programs. Intervention planners will be challenged to find ways to reach those who are considered more difficult to deal with in the jail setting.

All of these variables affect the “populations, settings, treatment variables, and measurement variables” to which an effect or impact can be generalized (Campbell & Stanley, 1963, p. 5). Therefore, they need to be considered before making any statements about general health conditions, policies, or practices across jail settings and populations.

Summary

Variability across U.S. jails is certainly a challenge to any researcher who wishes to establish data generalizable to all jails and populations held here. The same is true of those developing health-related interventions. In regard to generalizing from one or a sample of jails to the entire universe of jails in the United States, at least five factors need to be addressed:

- Nature of the intake process/flow
- Size of the jail system
- Region of the country and urban/rural county
- Classification/assessment procedures (objective vs. subjective)
- Design/supervision

Table 3. Jail Generalizability Grid

Variable	Intake Process	Size	Region	Classify	Design/Supervision
Intake process					
Size					
Region					
Classification					
Design/supervision					

Note. Coding elements: Intake = indirect (from lockup) or direct (from arresting officer); Size = small, medium, or large; Region = Northeast, Midwest, South, or West; Classification = “clinical” or objective; Design/supervision = first, second, third, or fourth generation.

Most of our current state of knowledge comes from studies in jails that are hardly representative of the jail universe in the United States. Placing one’s research in a grid of the five factors explored above (see Table 3) will allow one to discuss effectively what range of jails might be affected and how one’s research can inform practice in other jails around the nation. It will also garner credibility in the world of those who operate jails. To the extent that an “evidence-based” intervention is replicable in the larger world of jails, these five factors need to be addressed, at a minimum.

One size does not fit all those who enter the criminal justice process, and a one-size-fits-all approach will not fit all of the nearly 3,250 jails in the United States, either as risks or resources in improving community health. It is time to move beyond the “vaccine thinking” approach to the contextual factors that affect the health of those who pass through the jails, especially the communities from which they come. Only when we recognize that jails are a brief experience in the lives of most people will we begin to understand the nexus between communities, crime, and health.

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