

Frequently Asked Questions about New Study of Serious Mental Illness in Jails

1. *Has the percentage of people with mental illnesses in jails gone up? Do these estimates suggest the problem is getting worse?*

Previous studies draw on widely varying methodologies, settings, and definitions of mental illness, which makes comparisons and trend analyses difficult. Still, some comparisons indicate that the percentage has, at minimum, not decreased in more than 20 years; when compared to studies with similar methodological rigor, it has increased. The bottom line is that these estimates confirm what jail staff already knows to be true: the volume of people with mental illnesses entering jails is substantial and these individuals require complex treatment, services, and supervision strategies that jails were not designed or equipped to provide.

2. *Why are these figures different than those cited by government agencies?*

As stated above, prevalence estimates of mental illnesses in jails vary widely depending on methodology, setting, and the definition of mental illness used by researchers. Two important and widely cited studies from the Bureau of Justice Statistics (BJS) illustrate this variation. In 1999, BJS surveyed people in jails and asked if they had either a “mental condition” or an overnight stay in a mental hospital during their lifetime—16.3 percent self-reported that they met these criteria. This study was helpful in establishing the large number of persons who have had previous mental health contact in the community but did not identify those who had not accessed services. In 2006, BJS again surveyed people in jails and asked if they had a “mental health problem,” defined as any symptom of any mental illness (such as persistent anger or insomnia)—64 percent self-reported that they met this criteria. This study was helpful in identifying the wide range of symptoms that people in jails experience and emphasized the need for careful screening and assessment.

The estimates in the current study are not based on self-reported responses to surveys, but rather were generated from a validated screening instrument (the Brief Jail Mental Health Screen) and a “gold standard” diagnostic interview conducted by trained clinical researchers (the Structured Clinical Interview for DSM-IV). As such, these figures are more accurate and rigorous than those generated by self-reports. Furthermore, the figures cited in this study estimate the prevalence of *serious mental illnesses*, defined as the presence of one or more of the following diagnoses in the past month: major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified. The study figures capture only those individuals with the most extensive, ongoing mental health treatment and service needs.

Responses to these frequently asked questions are drawn heavily and liberally from Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., and Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6) and from various CSG Justice Center publications. Information from other sources is cited in the “Notes” section.

3. *Why should we focus on “serious mental illnesses”? Aren’t “less serious” mental illnesses a problem?*

The study focused on “serious mental illnesses” because this population has the greatest need for comprehensive and continuous treatment, both inside the jail and after release. People with serious mental illnesses typically meet state and federal criteria as a “priority population” to receive publicly funded mental health services. The needs of people with less serious mental illnesses and mental health problems should not be ignored, and do present significant challenges for jail management; however, people with serious mental illnesses should be the focus of comprehensive program packages and prioritized for specialized responses that require the most intensive resources.

4. *What is driving these numbers? Do cuts in mental health services have an impact? What about the closure of state psychiatric hospitals?*

The reasons why people with mental illnesses wind up in jail are complex, but there are a number of common explanations:

1. People with mental illnesses may be more visible to law enforcement because of behaviors stemming from lack of treatment, often in combination with a substance use disorder (for example, public disturbance, public intoxication, or other “nuisance” offenses).
2. People with mental illnesses are at increased risk of developing a substance use disorder over the course of their lifetimes, and arrests for drug offenses have skyrocketed since 1980. Research has found that nearly three-quarters of men and women with mental illnesses in jails also have a co-occurring substance use disorder.¹
3. Third, nearly one-third of people who experience homelessness have serious mental illnesses, and their homelessness may make them the subject of calls to law enforcement.²
4. Limited access to over-burdened community-based treatment may make individuals with untreated symptoms more likely to be arrested, increase delays in release from jail, and may limit individuals’ ability to successfully reintegrate into their communities. As such, cuts in mental health services have an impact on the prevalence of mental illnesses in jails insofar as they make it more difficult for treatment providers to dedicate resources, time, and treatment slots to this population. These providers already face long queues of people with no involvement in the criminal justice system, and are thus hard-pressed to develop collaborative, specialized interventions for a population with complex supervision and treatment needs.

Once in jail, people with mental illnesses tend to stay longer, and are less likely to be placed on probation or some other form of community-based supervision in lieu of incarceration, than others charged with similar offenses.³

Some observers have suggested that there is a causal relationship between the closure of state psychiatric hospitals (“deinstitutionalization”) and the high numbers of people with mental illnesses in jails. Studies do not support that 1) there has been a transfer of individuals from state hospitals to jails, or 2) people who are hospitalized and people who wind up in jail are demographically or clinically similar groups.⁴

5. Are you suggesting that people with mental illnesses do not belong in jails?

There is no doubt that many individuals who have mental illnesses commit crimes for which they should serve time in jail or prison. It is important for public safety that persons with mental illness who commit serious crimes be held responsible for their actions. But many individuals with mental illnesses who wind up in jails have committed low-level, nonviolent crimes, often as a result of their untreated mental illnesses or co-occurring substance use disorders. For these individuals, contact with the criminal justice system starts a cycle of arrest, incarceration, release, and re-arrest that poses nearly insurmountable challenges to recovering from their mental illnesses. Furthermore, many jail officials agree with community-based treatment providers that the jail environment is not the best treatment setting for individuals with mental illnesses—in fact, this environment can exacerbate mental illnesses in a manner that poses risks to the individuals, the general jail population, and jail staff.

6. Why are these estimates lower than those my county jail has reported?

There are three main reasons why these estimates may be lower than those reported by your county jail.

1. Jail personnel classify mental illnesses primarily to ensure the safety of all individuals under their supervision, and these classifications do not always match up with the diagnostic categories used by researchers or treatment providers. For example, many jails count all individuals who have been prescribed psychotropic medications as having mental illnesses. Furthermore, some jails may not use validated screening instruments.
2. As discussed in question 3, a number of mental disorders that do not meet state and federal definitions of “serious mental illness” were excluded from this study, including anxiety disorders (e.g., post-traumatic stress disorder) and adjustment disorders. If such disorders were included in the study, the corresponding prevalence estimates would be higher, but less precise.
3. Many people experience acute reactive psychiatric conditions, such as suicidal thinking, which also represent significant jail management concerns. The identification of persons at-risk for suicide is a critical screening function within jails, and while those at-risk to harm themselves may not have a serious mental illness as defined by this study, they still require significant assessment and treatment.

7. Did all the jails participating in the study have similar prevalence figures?

Yes. While some variation was noted across the five jails included in the study, estimates were consistent among the jails and over time.

8. Did the estimates vary by race?

Differences or changes in the racial composition of the jails included in the study did not explain the variation in prevalence estimates that was noted across jails; however, the relationship between race and mental illness in jails was not explicitly examined.

9. Why are the estimates so much higher for women than for men?

While disparities in the prevalence of mental illnesses among men and women in jail have been well documented, the size of the disparity found in this study is appreciably greater than figures reported elsewhere—the proportion of women is double that of men. The study itself does not explain the causes of this disparity, but clearly indicates the need for future research to explore this issue. Some observers have speculated that early childhood experiences and higher rates of trauma exposure (not necessarily leading to PTSD), may explain some of this phenomenon. This finding is particularly important because the proportion and number of women in jails has increased.⁵

10. Can these figures be applied to my county jail?

The prevalence figures in this study can be applied to your county jail to yield a reasonable estimate for planning purposes. However, the size of your jail (either larger or smaller than study sites) or its location (e.g., rural vs. urban) may introduce significant variation in actual prevalence figures. That said, jail administrators can likely anticipate that the prevalence of *serious mental illnesses* will be between 11 and 18.9 percent among men and between 21.7 and 42.1 percent among women.

11. Don't these individuals pose a risk to public safety? Aren't they more violent than other people?

Popular beliefs about violence and mental illness are not consistent with the research. Studies have shown that there is a weak statistical association between mental illnesses and violence.⁶ Serious violence by people with serious mental illnesses appears concentrated in a small fraction of the total number, and especially among those who use alcohol and other drugs and those without access to effective services. Indeed, the vast majority of people with mental illness are not violent; they are more likely to be victims of crime than they are likely to harm others.⁷

12. Can anything really help these individuals? What can policymakers do to address this problem?

Yes. Research shows that community-based treatment works for the vast majority of people with serious mental illnesses, and the vast majority of people with serious mental illnesses have no contact with the criminal justice system. For those who are involved with the criminal justice system, specialized responses have been shown to increase access to treatments and services and some interventions show promise in reducing recidivism. Communities have established such promising practices as police-based interventions that divert people with mental illnesses into treatment in lieu of arrest when appropriate, problem-solving court-based models (such as mental health courts) that mandate treatment in return for charge-reduction or dismissal, enhanced transition planning from jail and prison to the community, and specialized probation and parole supervision models that aim to reduce recidivism rates for this population post-adjudication. Many of these collaborative efforts have been prioritized and supported at the federal level by the Mentally Ill Offender Treatment and Reduction Act and the Justice and Mental Health Collaboration Program grants authorized by that legislation.

13. When is it appropriate to divert people with mental illnesses from jails into specialized community-based treatment?

The Council of State Governments Justice Center has developed a library of publications that provide recommendations for jurisdictions interested in creating diversion programs for this population. In general, such efforts are appropriate when key stakeholders representing the criminal justice and mental health systems collaboratively identify a target population and jointly design and implement a specialized response. Target populations and program designs differ from locale to locale, but in every jurisdiction where such a program has been developed, there is buy-in from change agents in multiple systems, including law enforcement, the courts, jails and prisons, probation and parole, district attorneys, public defenders, treatment and service providers, and people with mental illnesses and their families. For more information, please visit <http://www.consensusproject.org>.

Notes

1 Abram, K. M. and Teplin, L. A. (1991) Co-occurring disorders among mentally ill jail detainees. *American Psychologist*, 46. 1036-1045.

2 Osher, F. C. and Steadman, H. J. (2007). Adapting Evidence Based Practices for Persons with Mental Illness Involved with the Criminal Justice System. *Psychiatric Services*, 11 (58), 1472-1478, 2007.

3 For example, in Pennsylvania, a study conducted by the Pennsylvania Board of Probation and Parole found that offenders on Department of Corrections "Psychiatric Review Team Roster" received parole approval upon meeting their minimum sentence date at a rate of 21 percent, individuals on the "Mental Health Active Roster" received parole approval at a rate of 37 percent, and individuals on the "Mental Health Inactive Roster" received parole approval at a rate of 44 percent, compared with a rate of 61 percent for offenders in the general population. Pennsylvania Board of Probation and Parole. (2007). Internal Data. Internal Data. See also Circuit Court of the Eleventh Judicial Circuit of Florida, *Final Report of the Miami-Dade County Grand Jury*, 2004.

4 Trestman, R. L., Zhang, W., and Wiesbrock, V. (2007). Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *Journal of the American Academy of Psychiatry and the Law*, 35, 490-500; Pinta, E. (2009). Letter to the Editor: Psychiatric disorders and repeat incarcerations: is there an epidemic? *The American Journal of Psychiatry*, 166, 489-a-490.

5 Sabol, W. J., & Minton, T. D. (2008). *Jail Inmates at Midyear 2007*. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, as cited in Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., and Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6).

6 Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55, 393-401.

7 Teplin L. A., McClelland G. M., Abram K. M., et al. (2005). Crime victimization in adults with severe mental illness. *Archives of General Psychiatry* 62:911-921.