

Chapter 2

Size and Scope of Justice-Involved Mental Illness



Research on mental health epidemiology shows that mental health disorders are common throughout the United States, affecting tens of millions of people each year, and that, overall, only about half of those affected receive treatment.—National Institute of Mental Health (2018).

Before starting a discussion on just how many justice-involved individuals have a diagnosable mental illness, what those diagnoses tend to be, their severity of symptoms, and their rates of relapse, it will be helpful to keep a few caveats in mind. First, diagnosing mental illness can prove difficult as it impinges on the full cooperation of the patient. This cooperation may be influenced by stigma; varying levels of acceptance of mental health care by gender, race, and culture; and, likely, the “us versus them” relationship of medical staff to inmate, probation and parole officer to client, drug court case manager to client, and so on. Second, there is evidence of moderate amounts of malingering in the justice-involved population; in other words, justice-involved individuals are known to feign illness, including mental illness, if doing so will provide a benefit, such as getting out of assigned work duties, obtaining higher-quality meals, to get out of their jail or prison cell, to be able to be in an air-conditioned facility, or just to feel the reward of gaining a privilege or advantage, no matter how trivial it is to an average person. Last, there is considerable variation in applying mental health screening tools in professional circles, and, further, there can be dynamic differences in how mental health professionals apply diagnoses over time, by place or region, or given other factors (that will be discussed later). To make the long story short, there is a substantial amount of gray area when trying to estimate the *prevalence* of mental illness among the justice-involved population. This chapter will discuss the most current prevalence estimates—or the overall rate of mental illness among each segment of the justice-involved population.

2.1 What We Know: It's Complicated

To begin, and most importantly, there has been no comprehensive record keeping of mental illness for justice-involved individuals. Further, the epidemiological tracking systems on mental health for all Americans are addressed by the Centers for Disease Control; yet, the organization only recently began its first deep assessment in 2011 by piecing together data from several of its monitoring programs (Center for Disease Control and Prevention, 2017a). Ideally, one centralized source would build the capacity to collect data on the extent of mental illness in the United States as well as within the subpopulation of justice-involved individuals; but instead, existing data on the topic comes from a series of special governmental reports, state reports, and sporadic independent research endeavors. This persistent problem was, in fact, acknowledged by the Twenty-First Century Cures Act. For example:

- Section 14015, entitled “Improving Department of Justice Data Collection on Mental Illness Involved in Crime,” requires the US Attorney General to gather and report data on homicides (including homicides of police officers), serious injuries, assaults, serious injury or death by law enforcement officers “with respect to the involvement of mental illness in such incidences, if any.”
- Section 14016, entitled “Reports on the Number of Mentally Ill Offenders in Prison,” includes a mandate to the Comptroller General to estimate the cost of imprisoning individuals with “serious mental illness by the Federal Government or State or unit of local government.”

While these efforts of expanding our tracking systems are ongoing and are beginning to be fleshed out, it is important to understand our most current tools. As a helpful resource, William Reeves (2013) of the Centers for Disease Control offers a comprehensive summary of the American mental health surveillance systems. Reeves begins by defining seven key public health functions of these systems, which underscores the importance of this section. First, the public health surveillance systems are put into place to inform interventions with the benefit of data to help shape decision-making. In other words, the systems are set up in a way that allows for trends to be monitored, providing an easy mechanism to discover, identify, and describe changes—or potential signs of problems—and act on them. Second, these systems provide a way to estimate the impact of health conditions, including mental illness. Third, surveillance provides an ability to experts to follow the progression of health conditions and how our responses and treatments shape outcomes. This “natural history” offers a learning tool to help professionals refine future responses and treatments. Fourth, they aid in providing a big picture description of how conditions are distributed in society and how often they occur. Fifth, and related to the second function above, these systems provide structure for hypothesis creation and seeds research ideas. Sixth, they further allow for the evaluation of prevention efforts and control measures. Last, they help professionals plan programs strategically.

As Reeves describes it, surveillance is accomplished through a diverse multilayered approach deployed in unison to give us “a complete mosaic” of the health issues being explored. Specifically, three broad types of surveillance systems exist that collected data on mental illness: population surveys, health-care surveys, and vital statistics. Each provides a slice of information that assist in the *triangulation* of data. According to George Rutherford and his colleagues, “public health triangulation is a process for reviewing, synthesizing, and interpreting secondary data from multiple sources that bear on the same question to make public health decisions” (Rutherford, McFarland, Spindler, White, Patel, Aberle-Grasse, Sabin, Smith, Tache, Calleja-Garcia, & Stoneburner, 2010). In fact, triangulation goes deeper than this; in other words, surveillance systems use different research methodologies and/or sampling strategies to access information in unique ways. The key triangulation is to look for convergence and divergence in the data for further exploration.

2.1.1 Population Surveys

Population surveys examine health issues of *all* citizens (or a subpopulation) through the use of representative samples of the American public at the national, regional, state, and local levels. This survey technique relies heavily on self-reported information to determine the occurrence of mental illness in the wider population. While there is not any one population survey that solely deals with mental health, the US Department of Health and Human Services embeds an array of mental health surveillance into a suite of ongoing programs. For example, the National Survey of Drug Use and Health (NSDUH—administered by SAMHSA) has been tracking mental health since 1994; this survey tool is an annual, nationally representative, self-report survey of Americans aged 12+ designed to capture a broad array of data on substance use and abuse as well as general and mental health. It has become a leading tool for surveillance and has led to an array of special governmental reports and independent research on overall mental health trends in the United States. As such, it can easily be considered the flagship mental health population survey tool at this time. Specifically, it was equipped with the ability to track two key mental illness measures in 2008, both at the state and national level: (1) severe mental illness and (2) any mental illness (SAMHSA, 2013). The drive for this upgrade to the NSDUH in 2008 was, in fact, made over 15 years earlier when Congress passed the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, thus showing how slowly innovation can occur after policy shifts.

The NSDUH currently utilizes sets of questions, called scales, to determine whether a survey respondent has severe mental illness or any mental illness. Such scales include psychological distress and functional impairment, which largely makes up the clinical interview section of the survey—the Structured Clinical Interview (SCID-I/NP; includes mood, anxiety, eating, impulse control, substance

use, and adjustment disorders as well as a screen for psychotic symptoms). In addition, the NSDUH includes questions on thoughts of suicide and depression within the last year, and these questions help shape the estimations of both severe mental illness and any mental illness in the population. Using the most up-to-date methods available, the survey estimated that 4% of American adults have a serious mental illness (17.9% have any mental illness) in 2015 (SAMHSA, 2017). Importantly, this prevalence is not impacted by diagnoses—that is, this information is gathered in a way that does not require a diagnosis if the scales deployed in the NSDUH have been vetted properly and are sufficiently reliable. Ongoing research is being done to ensure that these estimations are reflective of the American reality of mental illness. In fact, these most recent estimations were recently recalibrated in the 2011 edition of the NSDUH in a collaboration project between SAMHSA and the National Institute on Mental Health (NIMH). These recalibration efforts will continue to be ongoing as our understanding of mental illness evolves. For example, in October 2015, the American Psychiatric Association released its newest Structured Clinical Interview (First, Williams, Karg, & Spitzer, 2016). As such, it is important to remember that there will be a lag of ability to receive the latest intelligence of mental health prevalence on the American population using population surveys. It is also important to remember that the diagnostic criteria for many mental illnesses do not change substantially over the years. In other words, there will be relatively negligible amounts of error in the population data collected. It still is important to note the shortcomings of each data type, especially when trying to account for changes in mental health conditions over time (Fig. 2.1).

Additionally, it is also important to note that the NSDUH reaches respondents who have a physical address. While this can include some “noninstitutional group quarters” such as shelters, boarding houses, university dorms, migrant worker camps, and halfway and quarter houses, NSDUH *does not* reach many homeless or transient Americans who do not consistently seek shelter. Most importantly for the current discussion, NSDUH further excludes individuals in jails and prisons, nursing homes, state mental health hospitals, and individuals in long-term care facilities. In other words, it excludes a wide swath of the vulnerable populations we are interested in studying. These vulnerable populations must be accounted for in some other way; but, we also should consider the prevalence of mental illness will always be underestimated when reviewing the findings of the NSDUH results each year.

To expand and refine mental health surveillance further into states, and more importantly, down to the county level, the Centers for Disease Control and Prevention have relied on the Behavioral Risk Factor Surveillance System (BRFSS). This effort began in 1984 to annually interview a representative sample of Americans in all states to record and track information on health-related risk behaviors, chronic health conditions, and the use of local preventative services. It has since become one of the largest routine health surveys in the world with over 400,000 participants each year. In regard to mental health, the BRFSS has historically used some core questions to ascertain number of mentally unhealthy days and has since 2007 included optional modules (with states given the option to opt-in) for anxiety and depression as well as mental health and stigma. For the areas that

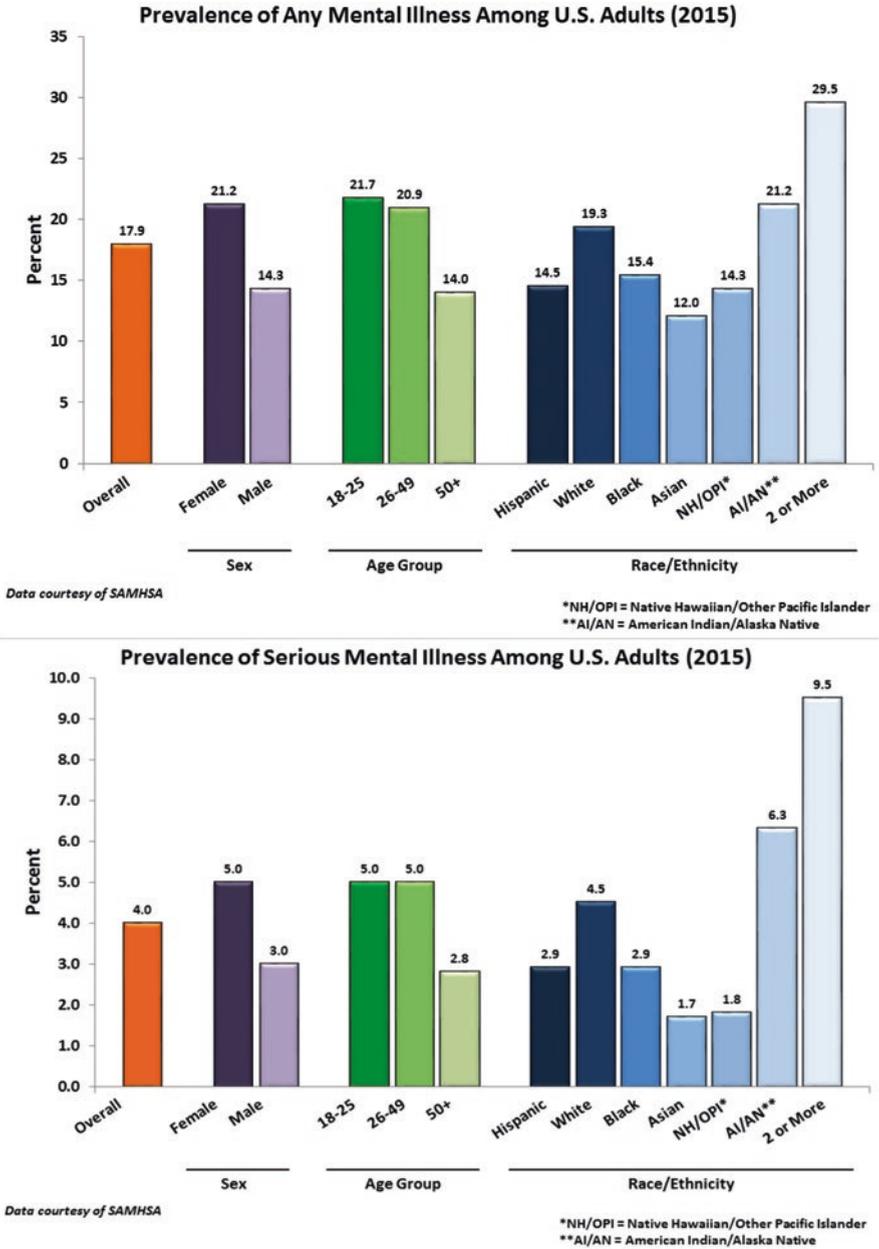


Fig. 2.1 Latest prevalence of mental health and serious mental health illnesses in American adults, reported in 2015 by SAMHSA

Table 2.1 Prevalence of mental health problems among prison and jail inmates (James & Glaze, 2006); note the levels of individuals with mental health problems

Selected characteristics	Percent of inmates in —			
	State prison		Local jail	
	With mental problem	Without	With mental problem	Without
<i>Criminal record</i>				
Current or past violent offense	61%	56%	44%	36%
3 or more prior incarcerations	25%	19%	26%	20%
<i>Substance dependence or abuse</i>	74%	56%	76%	53%
<i>Drug use in month before arrest</i>	63%	49%	62%	42%
<i>Family background</i>				
Homelessness in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27%	10%	24%	8%
Parents abused a alcohol or drugs	39%	25%	37%	19%
<i>Charged with violating facility rules^a</i>	56%	43%	19%	9%
Physical or verba: Assault	24%	14%	8%	2%
<i>Injured in a fight since admission</i>	20%	10%	9%	3%

^aIncludes items not shown

opt-in to examine mental health issues, the BRFSS can provide basic information about the prevalence of mental health issues at the local level. It can also assist mental health professionals in realizing the capacity of services in the local area or estimate the numbers of underserved individuals needing mental health care. This will become important for justice-involved populations as states and communities begin seeking alternatives to jails and prison and need the data to inform change. In 2007, the BRFSS mental health module was delivered in almost half of the United States: Alaska, Arkansas, California, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, and Wyoming. In 2009, only eight states opted-in to receive follow-up data.

Reeves (2013) further points out that additional in-depth population surveys occur sporadically, typically at near 10-year intervals. Examples of these include the National Comorbidity Surveys and the National Epidemiologic Survey on Alcohol and Related Conditions. This also includes the special editions of surveys performed by the Bureau of Justice Statistics to expand this surveillance into the justice-involved population, the 1996/2002 Survey of Inmates in Local Jails, and the 1997/2004 Survey of Inmates in State and Federal Correctional Facilities. The most recent special editions of these surveys mimic the methodology of the NSDUH by utilizing a modified clinical interview (for the DSM-IV). The findings, not surprisingly, are very different from the general public. About 56% of state prisoners, 45% of federal prisoners, and 64% of local jail inmates indicated any mental health problem, with many symptoms being severe in nature (James & Glaze, 2006). The latest surveys also disentangled substance dependence (or abuse) from mental health problems. When doing so, the results show just how enmeshed these problems are (Table 2.1).

The special report (James & Glaze, 2006) entitled “Mental Health Problems of Prison and Jail Inmates” provides a summary of the findings from the special editions of the Survey of Inmates in Local Jails (2002) and Survey of Inmates in State and Federal Correctional Facilities (2004). The modified clinical interview in these surveys reliably estimated 23% of state prisoners and 30% of jail inmates had symptoms of major depression, and 15% of state prisoners and 24% of jail inmates had symptoms of a psychotic disorder. Notably, while a substantial portion of prisoners and inmates had a recent history of mental illness (24% of state prisoners, 21% of jail inmates, 14% of Federal prisoners), many more exhibited symptoms of mental illness (49% of state prisoners; 60% of jail inmates; 40% of Federal prisoners). More troubling, very few receive services to address these issues (33% of state prisoners who exhibited mental health problems, 17% of jail inmates who exhibited mental health problems, 24% of federal inmates who exhibited mental health problems). Much more detail will be provided in subsequent chapters on the nature of these findings:

- Roughly one in four of state prisoners and jail inmates with a mental health problem served three more prior incarceration periods relative to state prisoners and jail inmates without mental health issues.
- Female inmates exhibited higher rates of mental health problems relative to male inmates (73% of female State prisoners compared to 55% male; 75% of female jail inmates compared to 63% male).
- State prison inmates who exhibited a mental health problem were about twice as likely to experience homelessness relative to those without a mental health issue.

These issues are central to this text and will be explored into great depth. At this point, consider the value of this type of research and surveillance tool in understanding mental illness, particularly within vulnerable populations.

2.1.2 Health-Care Surveys

Health-care surveys are only recently gaining more significance in the surveillance of mental illness. The reason for this is that the data comes directly from health-care and insurance providers; historically, mental health professionals use the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM, to diagnose a patient whereas hospitals, medical providers, and insurance companies use the *International Statistical Classification of Diseases and Related Health Problems* as managed by the World Health Organization or ICD. The latest edition of the DSM—the DSM-5—has only recently been aligned with the ICD, which is now in its 10th revision (ICD-10). While mental health is yet to be effectively tracked in this manner, it is only a matter of time before the professions adjust to report on more indicators than it has been able to reliably track in the past. To date, suicide is one of the few reliable indicators being tracked by this system of surveillance (Reeves, 2013).

Table 2.2 Primary diagnosis at office visits, classified by major disease category in 2013 (NAMCS; Center for Disease Control and Prevention, 2017b)

1. Supplementary classification (follow-up care, including routine care)	18.2%
2. Diseases of the musculoskeletal and connective tissue	10.1%
3. Diseases of the circulatory system	9.0%
4. Symptoms, signs, and ill-defined conditions	8.4%
5. Diseases of the nervous system and sense organs	8.1%
6. Diseases of the respiratory system	8.1%
7. Mental disorders	6.7%

One prime example of a health-care survey is the National Ambulatory Medical Care Survey, again led by the CDC. This survey, conducted annually since 1973, randomly selects physicians providing direct patient care to participate. It has since been expanded to cover community health centers in 2006. Specifically, the survey tool asks physicians to provide information on roughly 30 patient visits in a randomly selected 1-week time frame. Mental health-related questions have been asked in a few different ways since the 2001. Other examples of health-care surveys include the National Hospital Discharge Survey and the National Nursing Home Survey (Table 2.2).

To date, there has not been any survey to medical providers in jails or prisons that replicates these surveillance techniques. Even if most of these providers wanted to engage in a surveillance program, the lack of resources proves to be a significant roadblock in doing so. For example, medical records may not be kept electronically, or if they were, the systems in which the information is kept may be out of date and incompatible with modern surveillance systems. It is for these reasons that reports of this nature are limited to states with well-resourced criminal justice systems.

2.1.3 Vital Statistics

Vital statistics generally include births, deaths (and fetal deaths), marriages, and divorces. For the current discussion, deaths are the important component of public health surveillance. Suicide is the leading mental health indicator that can easily be tracked by current surveillance methods. As of 2016, suicide is the second to accidents as the leading cause of death for Americans aged 15–19 and the tenth leading cause of death in all Americans (Center for Disease Control and Prevention, 2017c). Another notable indicator that can be included among vital statistics is substance use disorder. For example, medical examiners or coroners can determine that substance abuse contributed to a decedent's cause of death, such as in a case of a long-term cocaine abuser who died from a heart condition. It could very well be determined that this user's heart was damaged by chronic cocaine use, which is very possible with the stimulant family of drugs. Yet, it is important to note here that death investigation systems are quite varying across the United States. It is true that

the vast majority of deaths (99% according to the CDC) are recorded, not every jurisdiction has equal access to a comprehensive death investigation system. As such, many deaths may not be classified correctly or completely. In the same example of a long-term cocaine abuser, it may be that his death is simply recorded as cause of death, myocardial infarction (immediate cause), and manner of death, natural without any mention to cocaine dependence as a mechanism of death. Thus, the heart attack would not be noted as a direct consequence of the long-term cocaine use on a death certificate and in vital records.

Suicide has been the leading cause of death for jail inmates for quite some time (deaths in custody was first tracked by the Bureau of Justice Statistics in 2000, so certainly since then, Noonan, 2015). About one-third of jail inmate deaths are attributed to suicide (or 46 suicides per 100,000 inmates), with deaths from heart disease close behind. Compare this to 5.5% of prison inmate deaths attributed to suicide (or 15 suicides per 100,000 prisoners), and the vulnerable population becomes clear—much more about this will be discussed in later chapters.

2.1.4 Putting It All Together: A Summary of Mental Health in America Today

The National Alliance of Mental Illness, a leading advocacy organization for mental health, keeps an array of easy-to-follow briefs on the most up-to-date compilation of mental health statistics available to aid in spreading its message. For example, in their most recent *Mental Health Facts in America* infographic, the following facts are the most salient:

- 43.8 million American adults experience mental illness in any recent year; that is one in five adults in the United States.
- A subset of these Americans—ten million, or close to 1 in every 25 adults—lives with a serious mental illness.
- Half of all chronic mental illness begins to occur by age 14, with the average delay between the onset of symptoms and initial intervention being 8–10 years.
- Depression is the leading cause of disability worldwide.
- Serious mental illness is estimated to cost the United States \$193.2 billion in earning losses each year.
- 90% of those who commit suicide have an underlying mental illness; suicide is the tenth leading cause of death in the United States.
- The majority of adult American living with mental illness—60%—did not receive mental health services in the previous year; half of youths (aged 8–15) with mental illness did not receive services in the previous year.
- Black and Hispanic Americans are half as likely to seek and use mental health services compared to their white American counterparts; Asian-Americans utilize mental health services even less, about 1/3 the rate of their white American counterparts.

In their most recent *Mental Health Facts: Multicultural* infographic, these points are also crucial to summarize here:

- American Indian or Alaskan Native adults have the highest prevalence of mental illness at 28.3%, almost three in every ten adults, followed by white adults (19.3%), black adults (18.6%), Hispanic adults (16.3%), and Asian adults (13.9%).
- Individuals who identify as LGBTQ are more than twice as likely to have a mental health condition relative to those who identify as straight/heterosexual; LGBTQ youth are two to three times more likely to commit suicide than straight youth.

This information largely draws from the National Institute of Mental Health resources and is updated frequently to promulgate the latest intelligence on mental health in the most user-friendly way.

2.2 What We Don't Know

With only five targeted population surveys on justice-involved individuals, the two most recent being much more comprehensive than the previous ones, we still may not know the “true” size and scope of justice-involved mental illness. Also disconcerting, the latest available data dates to 2004—over a decade ago—and much has changed since then. In particular, a steady stream of Federal investment in evidence-based practices and programming has shown the potential to ameliorate the issues being discussed here; on the other hand, a perfect storm was also brewing for massive cutbacks in criminal justice and mental health within the same time frame: (1) the level of mass incarceration crested at a peak of 506 inmates and prisoners per 100,000 citizens in 2007–2008. (2) This coincides perfectly with a substantial economic recession, the so-called Great Recession, beginning December 2007. Consider these findings from a recent SAMHSA, (2016) review of behavioral health spending and use: the broad trend in mental health spending from 1986 to 2014 indicated a deeper divestment in inpatient and residential treatment coinciding with an increase in the use of and expenditures in outpatient treatment; during the same time frame, Medicare, Medicaid, and private insurance use increased, while out-of-pocket expenditures decreased; conversely, decreases in Medicaid (26 to 25%) and local spending (16 to 14%) occurred from 2008 to 2014. If one were to dig deeper into these expenditures, they would find a mix bag of successes and failures—with the successes masking the failures when observing this summary data.

For example, the National Alliance on Mental Illness (2015) published its results of an annual survey on state legislation on, and investment in, mental health. In this study, NAMI cites a loss of \$4.35 billion in state cuts to mental health-care systems since the recession. From the initial results of this survey published in 2013, many states have begun to reinvest in these systems upon recovery, yet some states have been unable to reform, while others have been in decline. Perhaps more troubling, the results in 2015 show slowed growth and progress relative to previous years for

states that were able to make headway. Alaska, North Carolina, and Wyoming are cited by NAMI to be in states of steady decline, with signs of problems occurring in Kentucky, Arkansas, Iowa, Kansas, Ohio, and the District of Columbia. While not mentioned directly in the narrative of the study's findings, Louisiana also has been struggling to reform; in fact, its state constitution will only allow for cuts to higher education and health care during non-budget legislative sessions (e.g., every other year). While other states may not be so restrictive, mental health and criminal justice are often higher on the chopping block for cuts than other essential services.

Thus, information about the level of need that exists for mental illness and substance use disorder treatment, or both, is ill defined. What is clear is that the number of individuals in jails and prisons who requires treatment far exceeds the number who receives it—the latest justice-involved population surveys verified this. Specifically, “over 1 in 3 State prisoners and 1 in 6 jail inmates who had a mental health problem received treatment since admission” (James & Glaze, 2006). In other words, *66% of prisoners and 83% of jail inmates do not get the mental health treatment that they need according to the most up-to-date and comprehensive investigation into the justice-involved mental health population.* Remember, these bleak figures were obtained before mental health systems were further stressed by the recession.

Not knowing much more beyond this is a barrier to progress. Recall that Reeves (2013) describes seven key functions of public health surveillance systems: (1) to inform interventions with the benefit of data, providing an easy mechanism to discover, identify, and describe changes—including signs of problems—and act on them, (2) to estimate the impact of health conditions, (3) to provide a natural history of health conditions and how our responses and treatments shape outcomes, (4) to provide a big picture description of how conditions are distributed in society and how often they occur, (5) to structure hypothesis creation and seeds research ideas, (6) to enable thorough evaluation of prevention efforts and control measures, and, perhaps most importantly, (7) to help professionals engage in strategic planning. Without further investment into mental health surveillance, these functions become much more difficult to achieve. One truth in all of this is that, historically, the United States has prioritized mental illness behind other matters.

2.3 What We Know We Don't Know: Hidden Mental Illness

It is entirely possible—in fact, it is very probable—that not all illnesses are addressed, while an individual is incarcerated. Further, these illnesses may not be addressed in time to help the patient, fully addressed in the best way possible, or diagnosed in a way to offer the best treatment. On that last point, proper diagnosis may require several visits and observations by a mental health professional, all of which may benefit greatly by comprehensive medical records for the current provider to understand prior assessments, treatments, and so on. Often, for many reasons, a person's medical history may be disjointed and/or lack current information.

Consider visiting a doctor as an adult and being asked for a complete medical history from childhood. Even for a person with little to no medical history, it may be difficult to recount all that is needed for a current report. Now, imagine this scenario again from someone who has felt stigmatized many times for a mental health concern and criminal history. The mental illness alone may have prompted denial or a reluctance to report symptoms. Add in a criminal history, all the more reason for a person to fear stigma. Further, the chain of information is broken after incarceration and return to society. Often, this continues to repeat again and again resulting in stagnation for the individual in the process of recovery and health.

Broadly speaking, inmates may not disclose their illness for fear of discrimination, negative treatment, or just plain lack of knowledge. Often, individuals feel shame surrounding their mental health. Mental health concerns are often seen as a sign of weakness—a label that is perhaps one of the most problematic for inmates—which only further perpetuates the stigma. Masking the signs and symptoms of depression or anxiety, or any other psychological disorder, can be a major setback for a person as these issues will go untreated, potentially leading to significant problems, decompensation, and higher risks of bad outcomes (e.g., suicide, drug overdose, violent confrontations, and so on). Seeking help as soon as symptoms arise is important to the health of the person affected, yet this has not historically been the case for jail inmates or prisoners, thanks largely to the effects of stigma. Additionally, knowing one's own triggers is essential for future prevention and proactive efforts to remain healthy.

Taking that ideal a step further, mental illness in a male prison, there is less likelihood of disclosure of mental illness and seeking of treatment. According to the World Health Organization (2017), there are differences in both prevalence of mental health and substance abuse as well as reporting by gender. This gap is supported by a stream of literature; for example, Doherty and Kartalova-O'Doherty (2010) published their analysis of the HRB National Psychological Wellbeing and Distress Survey in 2010. The data in this telephone survey revealed significant gender differences between males and females that influence seeing general practitioners for mental health concerns. In particular, an array of sociodemographic and psychological factors (such as feelings of limited physical activity and social activity, educational level, employment status, marital status, self-reported physical health, self-reported quality of life, and whether these men live in a rural or urban setting) influenced male visits to general practitioners, while females were only influenced by social factors (e.g., feeling like mental health limits social activities) and access to health care (e.g., price), thus leading to broader differences among the genders in seeking mental health help from practitioners. The main point here is that we generally know less about individuals who do not seek help or are not willing to seek help and that the rate of untreated mental illness is likely higher in some groups relative to others, gender being a prime example.

Another issue surrounding the idea of prisons or jails as it relates to mental health is time. The intake process is limited, and only a small amount is spent addressing the immediate needs of the incoming inmate as well as acclimating them to the policies and procedures of the prison. Also, keep in mind the mindset of the individual

being brought into the facility. Obviously, none of this is ideal for the typical psychosocial interview. In a hospital setting, a trained mental health professional would complete a psychosocial interview upon intake with a patient. This interview would include questions regarding background and history on both physical and mental health in order to gain a baseline for the individual. This allows the treatment staff to have somewhat of a comparison for behavior. Additionally, this information is kept in the patient's medical record for future use if needed. If the same patient returns for treatment, the staff would then be able to review past notes and information to best treat the person. Jails and prisons, however, do not have similar processes in place (oftentimes), leading to an utter lack of knowledge about the people within these facilities. Thus, mental health diagnoses often remain undiagnosed, yielding to a lack of ability to adequately describe the issues within justice-involved populations. Other than the few major surveys of jail and prison inmates, which offer limited glimpses into the "true" picture of mental health within these facilities, there is a major disadvantage in the lack of ability to track issues over time, track the emergence of new problems, understand the impact of policies on mental health, and so on.

2.3.1 Marginalized Groups and Cultural Differences

Marginalized groups struggle within the criminal justice system as they do in regular society. Persons of different races, religions, sexual orientation, etc. often experience difficulties in seeking help, maintaining treatment regimes, or even being considered for treatment services (e.g., in the case of justice-involved transgender individuals). These groups often experience higher rates of victimization, isolation, stigmatization, and so on and often are less likely to report mental health concerns and seek treatment. Without knowing the full picture and extent of these issues with relevant data, it is difficult to intervene in the lives of these vulnerable individuals. This certainly can add to their trouble receiving help. Without factual information to support the need, most facilities cannot justify providing further programming—particularly when trying to justify costs. And unfortunately, with little to no information and data being collected on these vulnerable subpopulations (let alone, on individuals with mental illness, generally), it is difficult to assess the extent of the problem(s) in the first place. Part of the lack of information lies in the lack of understanding of different marginalized groups or cultures even outside of the criminal justice system. Even further, without research and information, it is also difficult to determine any further disparities that may exist; most research suggests this to be the case.

For example, recent stories of violence against transgender persons have emerged as a widely publicized issue in late 2016 and early 2017. With recent national attention on issues of this population, advocates are helping to aid in equality for transgender persons in criminal justice settings as well by tapping into this surge of attention. The National Center for Transgender Equality (NCTE)—a leader in this

movement—“continues to press for stronger protections and accountability and create new tools for advocacy focused on transgender and gender non-conforming people’s interactions with the criminal justice system with local, state and federal law enforcement officials and public at-large” (2017). Within the literature found on their website, the NCTE makes reference to the daily humiliation, increased risk of physical and sexual abuse, and fear of harm if individuals use legal solutions to report these problems. In particular, the Prison Rape Elimination Act (PREA) was designed specifically to include dedicated provisions to help protect incarcerated transgender individuals against sexual assault. However, prisoners (and staff) often lack respect for the PREA process, with many left thinking that it could be considered “a joke” or just a window dressing on the realities of prison life (Khey, unpublished research).

Mental health professionals are trained on cultural competencies to work with different cultural groups, particularly with an understanding of the issues described above to encourage sensitivity to the deficiencies primarily caused by the social realities of vulnerable populations. The dilemma, as mentioned many times within in this book, often rests with a lack of professional staffing to accommodate all inmates within a jail or prison. This means, that despite adequate training for mental health professionals, there being one person for an entire jail or prison means that there may not be the means to assess all inmates to ensure proper care and adherence to cultural etiquette. At that point, administrators tend to focus their efforts on meeting and maintaining what is currently understood as the constitutionally acceptable level of mental health services. Much more on this concept will be explored in subsequent chapters; however, it is important to understand that typical levels of mental health services throughout American corrections tend to only allow for crisis care and exigent problems as they may present themselves. Vulnerabilities can often be magnified in criminal justice settings, including those inherent in cultural differences.

To be sure, there are many various cultural barriers that may exist within society that also are relevant within the criminal justice system. For example, language barriers can be difficult to overcome in everyday life, let alone the difficulties that language barriers can present when entering a jail upon arrest. A language barrier can particularly exacerbate the issue of obtaining proper and accurate information (of special note: health information). Also, it is further important to recognize that certain cultures are far less likely to adhere to American cultural norms. Some people of Asian descent tend not to make eye contact, which to some may be perceived negatively or disrespectful—or more notably in this instance—may be a sign of deception for some trained law enforcement and corrections personnel. In addition, in some Asian cultures, as well as in others such as Orthodox Hasidim, it is wholly inappropriate to have any interaction between females and males who are not married. With this in mind, consider the harsh environment of a jail or prison; if a male inmate were to be approached by a female corrections officer and who subsequently avoids eye contact and does not respond, there could be potential trouble (e.g., insubordination). The inmate would be doing this as a sign of respect to his culture, but for the officer and other staff, this would be viewed as disrespect and could lead

to possible infractions inside the jail/prison. Furthermore, different races, religions, and other cultural subgroups may have other barriers and specific behaviors. Consider differences among Islamic inmates, women of color, American Indians, and so forth.

On a final note, it is often important to consider one's perceived social status when discussing mental health outcomes. In other words, it may not be enough only to consider membership in a vulnerable subpopulation or class (e.g., transgender male prisoner) in isolation. Importantly, mental health problems may be attenuated by one's own perception of being marginalized. In research published by Friestad (2010), male Norwegian prisoners were surveyed to understand how perceived social status in prison affected potential inequalities in health (and mental health). As expected, prisoners who perceived that they were marginalized exhibited increased odds of experiencing mental health problems. More work needs to be done in this area to better understand the impacts of vulnerable individuals, particularly at the point when these individuals are set to reenter society.

2.4 Conclusion

Many professionals suspect that most mental illnesses are underreported. In fact, this chapter remains brief as the American epidemiological understanding of mental illness continues to take a back seat to other, less- or non-stigmatized problems. This is truly the result of the lack of investment in mental health research relative to other American priorities. There appears to be a shift in this trend, however. The twenty-first Century Cures Act was recently enacted into law; it sharply responds to this problem through policy, by earmarking funds, and by shifting governmental agencies in a way that will enable progress in this area. While it is not exactly clear when these changes will start producing results, changes have already started to occur to ensure transformation in America's struggle with mental health.

One key issue that is not always discussed or even thought of in regard to the lack of mental health treatment options is the waste of the resources earmarked for this purpose. This waste can take many forms. Consider then, like any other illnesses, the effect of prolonging/delaying treatment in that this can often result in an increase the cost/investment necessary to achieve a healthy outcome. Further, the traumatic experiences of incarceration, one of America's primary responses to mental health diagnosis, often serves to only push vulnerable people toward further or compounding negative outcomes. Therefore, if treating the person in the community early in the disease process could be given a certain dollar amount, it most certainly would be monumentally less than the amount necessary when the cost of incarceration is factored in for those individuals that fall in the cracks of this safety net. Incarcerating a person in need of treatment has placed a large financial burden onto the criminal justice system, thus creating a different problem. To date, this problem has been largely ignored; yet, progress is slowly occurring in the form of broad partnerships and fresh ideas to address this problem.

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