

Mentally Ill Offenders Involved With the U.S. Criminal Justice System: A Synthesis

SAGE Open
July-September 2013: 1–11
© The Author(s) 2013
DOI: 10.1177/2158244013497029
sgo.sagepub.com


Christine M. Sarteschi¹

Abstract

This paper sought to synthesize what is currently known about mentally ill offenders in American jails and prisons based upon the most recent government and congressional reports and relevant literature review. The primary goal is to provide a detailed picture of the status of mentally ill offenders—including prevalence, basic demographic information, bio-psycho-social status, mental health, and family histories—and also to identify the problems, conditions, and obstacles faced while under the jurisdiction of the criminal justice system. Mentally ill offenders are constitutionally guaranteed basic mental health treatment. A review of the literature indicates that this constitutional guarantee is not being adequately fulfilled. Implications and suggestions for change are discussed.

Keywords

mentally ill offenders, mentally ill inmates, serious mental illness, mental illness in jails, mental illness in prisons, mentally disordered offenders

Introduction

On May 23, 2011, the U.S. Supreme Court ordered the release of 33,000 prisoners from California prison facilities. According to *Brown v. Plata* (2011), California state prisons had operated at 200% capacity for more than a decade. As a result of severe overcrowding, prisoners were routinely denied medical and mental health treatment. In the view of Supreme Court Justice Kennedy, these conditions were a serious violation of the cruel and unusual punishment clause of the Eighth Amendment of the U.S. Constitution. California's prison system is in disarray, but it is unclear if these conditions mirror other correctional institutions across the country. The primary goal is to provide a detailed picture of the status of mentally ill offenders—including prevalence, basic demographic information, bio-psycho-social status, mental health, family and trauma histories—and to also identify the problems, conditions, and obstacles faced while under the jurisdiction of the criminal justice system. Implications and suggestions for change are discussed.

Prevalence

Accurate prevalence rates of mentally ill prisoners are difficult to gauge (Toch, 2007; Veysey & Bichler-Robertson, 2002). Rates often depend on the report consulted (Brandt, 2012; Toch, 2007). The latest Bureau of Justice Statistics (BJS) survey of mentally ill prisoners by James and Glaze (2006) is the “only national source of detailed information on . . . offenders who have mental health problems” (p. 11).

Their report showed that 1,264,300 inmates, not including individuals on probation or associated with community corrections, had mental health problems. Those estimates represent 45% of federal offenders, 56% state offenders, and 64% jail inmates (James & Glaze, 2006). For comparison, Ditton found in a 1999 report that there were approximately 283,600 mentally ill inmates in federal (7.4%), state (16.2%), and local jail (16.3%) correctional facilities, and a total of 831,600 of individuals on probation (16%) are included. In the Ditton survey, inmates were considered “mentally ill” if they reported a mental health or emotional condition or had an overnight stay in a hospital or a treatment facility. Data for the 2006 BJS report were based on two earlier BJS surveys conducted in 2002 and 2004. In the estimation of James and Glaze, nearly 50% of all federal inmates and a majority of inmates in state and jail correctional facilities have mental health problems. It is important to note that inmates who were in mental health institutions at the time of the 2006 survey were not included in the sample nor is there information available in that report regarding whether offenders had more than one psychiatric diagnosis.

¹Chatham University, Pittsburgh, PA, USA

Corresponding Author:

Christine M. Sarteschi, Chatham University, 001 Falk, Woodland Rd., Pittsburgh, PA 15232, USA.
Email: csarteschi@chatham.edu

Journal Articles

Journal articles have slightly differing estimations of prevalence rates. A 1999 “call to action” commentary by Dr. Erik Roskes, for example, estimated that there are approximately 600,000 to 900,000 (10%-15%) mentally ill inmates in U.S. jail and prison facilities (Roskes, 1999). Lamb, Weinberger, Marsh, and Gross (2007) cited a similar statistic. As of June 2004, Lamb et al. estimated that nearly 321,884 (15%) of the then 2.1 million prisoners had a severe mental illness. A study of 9,245 offenders in Utah’s state prisons, between 1998 and 2002, found that 23% met the criteria for a serious mental illness (Cloyes, Wong, Latimer, & Abarca, 2010). In another study, Adams and Ferrandino (2008) described the ever-increasing rates of mental illness among inmates of Florida correctional facilities. They reported that the number of inmates classified as “severe,” with regard to their mental illnesses, doubled (402-812) between 2002 and 2006.

Investigations by Teplin and colleagues in Cook County, Illinois, have continued to document the epidemiology of mental health and substance use disorders in correctional settings for both adolescents and adults. So too have other researchers. Trestman, Ford, Zhang, and Wiesbrock (2007) assessed the rates of psychiatric disorders among a sample of 508 newly incarcerated men and women in five Connecticut jails. They found that the majority, nearly 70%, met criteria for at least one lifetime psychiatric disorder. A more recent prevalence estimation by Steadman, Osher, Clark Robbins, Case, and Samuels (2009) found that in a sample of 822 jail inmates, 14.5% of males and 31% of females qualified as having a serious mental illness. Extrapolating those estimates to the entire U.S. jail population, they estimated that 17.1% of males and 34.3% of females, or 51.4% of jail inmates in 2007, were considered to be seriously mentally ill. The latter statistic, by Steadman and colleagues, is less than the 2006 figure cited in the 2006 James and Glaze survey which found that 64% of jail inmates had mental health problems. The difference in rates could be explained by the inconsistent definition of mental illness in government surveys and clinical studies. For instance, Steadman et al. utilized the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association [APA], 1994), an assessment tool considered to be the gold standard in diagnosing clinical and personality disorders (Lobbestael, Leurgans, & Arntz, 2010). The James and Glaze (2006) survey define “mental health problems” by two main factors: (a) a recent history of a mental health problem or (b) having symptoms of a mental health problem. Symptoms are based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; APA, 2000a) of mental health disorders. Both are measures of mental illness but provide discrepant results.

Non-Peer-Reviewed Reports

Estimates of prevalence are also available in non-peer-reviewed publications. A 2003 Human Rights Watch (HRW) report titled “Ill Equipped: U.S. Prisons and Offenders With Mental Illness” estimated that two to four hundred thousand individuals housed in correctional facilities were mentally ill. Not all states have psychiatric diagnostic information for inmates available (Soderstrom, 2007). Among the states that do provide such information, California for example, conservatively estimates that 10% to 15% of its inmates are mentally ill (Nieto, 1999). A 2009 joint legislative audit of mental health care among Wisconsin inmates found that 20.1% of inmates had mental health needs and another 10.1% were considered seriously mentally ill (Wisconsin Department of Corrections, 2009). The Wisconsin inmate population only grew approximately 4% from June 2006 to June 2008 but the rate of mentally ill inmates nearly tripled during that period. In another instance, a 2010 study of 618 Michigan inmates, using the interRAI Mental Health assessment tool, found that 20.1% of males and 24.8% of females had severe psychiatric symptoms (Fries, 2010). Finally, in a report published in 2010, the Treatment Advocacy Center and the National Sheriffs Association gathered the prevalence rates of mentally ill offenders for 16 states. After examining state and national surveys, they determined that between 15% and 20% of the inmates in jails and prisons had a serious mental illness (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

Diagnosable mental illnesses rates generally range from approximately 10% to 30%. Another common finding is that inmates residing in federal facilities have lower rates of mental illness than inmates residing in state facilities (National Commission on Correctional Health Care [NCCCHC], 2002). Local jail inmates have the highest rates of mental illness, when compared with state and federal inmates (James & Glaze, 2006). Local jail inmates seem to have the highest rates of mental health problems, when compared with state and local inmates in correctional facilities (James & Glaze, 2006). After reviewing the existing surveys and the most recent clinical studies in the literature, determining accurate prevalence rates remains difficult. A commonly accepted estimate of prevalence would indicate that half or more of all incarcerated prisoners have mental health problems.

Prevalence by Diagnosis and Symptoms

In 2002, the NCCCHC investigated the prevalence of mental illnesses among prisoners nationwide. Volume 1 data for their report was primarily retrieved from a Steadman and Veysay (1997) article. Volume 2 consisted of a secondary data analysis of information extrapolated from the National Comorbidity Survey. Volume 1 of the studies showed that anxiety disorder was the most common diagnosis reported for inmates in federal, state, and local jail facilities. Volume 2 of their study found that both antisocial personality

disorder (APD) and anxiety disorder were found to be the two most common diagnoses among inmates in federal, state, and local jail facilities, and for individuals involved in community corrections. Posttraumatic stress disorder (PTSD) was also quite common among state inmates. Twenty-two percent to 30% met criteria for that diagnosis. In addition, 15% to 19% of individuals involved in community corrections met the diagnostic criteria for major depression.

The BJS survey by James and Glaze provided information about three main psychological diagnoses: (a) major depressive disorder, (b) psychotic disorder, and (c) mania symptoms, the latter associated with bipolar disorder (*DSM-IV-TR*; APA, 2000a). Of particular interest was the fact that nearly half of the inmates in federal, state, and local facilities reported experiencing between one and four symptoms of major depressive disorder. Nearly 60% of inmates in state and jail facilities had between one and three mania symptoms. Another surprising finding of that survey was that nearly 24% of jail inmates reported having at least one or two psychotic symptoms. Castillo and Fiftal Alarid (2011), in their study of rates of recidivism among 307 mentally ill offenders in jail or on probation, found similarly high rates of bipolar disorder (36.3%), severe depression (22.5%), and psychosis or schizophrenia (18.6%).

Rates of substance use, abuse, and dependence are also very high among mentally ill offenders (James & Glaze, 2006). The BJS 2006 survey shows that more than 80% of mentally ill offenders in federal, state, and jail correctional facilities reported regularly using alcohol or drugs. A little more than 62% of federal inmates with mental health problems, and nearly three quarters of state and jail offenders with mental health problems, reported being alcohol or drug dependent. Nearly half of all inmates surveyed were under the influence of alcohol or drugs during the commission of their crimes. In the month before being arrested, the three most commonly reported illicit drugs used by inmates in federal, state, and jail correctional facilities were marijuana or hashish, cocaine or crack, or methamphetamines, respectively. Generally, inmates identified as having mental health problems have higher rates of substance dependence or abuse than do those without mental health problems (James & Glaze, 2006). Similar findings are reported in the literature (Soderstrom, 2007).

Prevalence by Gender, Race, and Age

Females have higher rates of mental illness than do males in federal, state, and jail correctional facilities. James and Glaze (2006) found that females generally have higher rates of affective disorders than males. Male inmates however, were 3 times more likely than female inmates to be diagnosed with APD according to the NCCHC study (2002). Similarly, Trestman (2000) found that nearly 40% of males in their jail sample met criteria for antisocial personality disorder (ASD)

(compared with 27% among females). Blitz, Wolff, Pan, and Pogorzeiski (2005) investigated behavioral health disorders in 10 New Jersey state prisons. Of the 10 prisons included for investigation, 18% of the incarcerated inmates were classified as having special behavioral health needs. Women were more likely than men to be identified as having special needs. Female inmates were also more likely to have psychotic and depressive disorders.

Caucasians seem to have higher rates of mental illness than do Blacks or individuals of Hispanic origin (James & Glaze, 2006). Hartwell (2001) reported a similar finding in her study of 169 Massachusetts mentally ill inmates. It was her impression that Caucasian inmates were disproportionately identified as being mentally ill. Blacks have higher rates of mental illness than Hispanics, in federal, state, and jail correctional facilities. Volume 2 of the NCCHC (2002) report found that both Blacks and Hispanics were more likely than Caucasians to be diagnosed with schizophrenia or a related disorder. Hartwell also found that Hispanics and Blacks were more often diagnosed with thought disorders when compared with their Caucasian counterparts.

With regard to age, the 2006 BJS report found that individuals age 20 or younger had the highest rates of mental illness in federal, state, and jail correctional facilities. The second highest rate of mental illness was found among individuals ages 25 to 34. The lowest rate of mental illness occurred among individuals ages 55 and older with the exception of inmates in local jails (52.4%). The limited research available about older mentally ill offenders is consistent with the latter finding. One study of 83 mentally ill male offenders, in a New York City jail, above the age of 62 found that a high (relative to the general U.S. population) percentage (40%) had psychotic disorders (Paradis, Broner, Maher, & O'Rourke, 2000).

Prevalence Rates of Probationers and Community Corrections

Prevalence rates for mental illnesses among probationers or in other community correctional settings are limited (Skeem, Emke-Francis, & Eno Loudon, 2006). It was noted in the NCCHC (2002) Volume 2 report that there are "no estimates" (p. 58) of prevalence that exists for individuals in community corrections. It was also reported that "no scientifically rigorous prevalence study has been conducted with this population" (NCCHC, 2002, p. 58), though a 1995 study by Boone showed that approximately 3% to 23% of parolees had a mental illness. Both BJS surveys by Ditton (1999) and James and Glaze (2006) contain data about individuals on probation but that information is limited to three main categories: (a) substance abuse histories, (b) employment status, and (c) whether an individual was the recipient of mental health treatment while incarcerated.

The 1995 study by Boone also estimated that approximately 6% to 9% of individuals involved with community

corrections needed mental health treatment. Solomon, Draine, and Marcus (2002) more recently studied individuals who were involved in a probation or parole service. They found that of the 327 clients who were screened for major depression, mania symptoms, or schizophrenia, 78% qualified for one or more diagnoses. The majority of probationers or parolees in their study were male, were African American, were taking psychiatric medication, and had a mean age of approximately 35 years. Approximately, one third of their sample had been incarcerated within 15 months of the initial study interviews. In addition, one third had reported receiving psychiatric crisis services and nearly 70% had reported receiving some type of therapy (individual, family, or group). Almost 40% had received substance abuse treatment and a little more than a third had utilized intensive case management services. A later study by Crilly, Caine, Lamberti, Brown, and Friedman (2009) reported that individuals who had been on probation within the past year were characteristically younger, male, non-White; had used drugs; and were significantly more likely to have symptoms of psychosis, mania, and PTSD when compared with individuals who had not been on probation in the past year.

Current Bio-Psycho-Social Status of Mentally Ill Offenders

Physical Health Status

Overall physical health information for inmates is readily available from national surveys. However, there is limited physical health information which pertains to only mentally ill inmates. Cuddeback, Scheyett, Pettus-Davis, and Morrissey (2010) attempted to address this knowledge gap. In their study, they compared the medical histories of individuals with a serious mental illness, who had a history of at least one incarceration within a 5-year period, to the medical histories of mentally ill individuals who did not have an incarceration history. Individuals with a serious mental illness and an incarceration history were significantly more likely than those without an incarceration history to have infectious diseases, skin disorders, blood disorders, and injuries. Overall, the authors found that among individuals who had both a serious mental illness and an incarceration history, there is a 40% increased likelihood of having a general medical problem and 30% increased chance of having multiple medical problems.

Employment Status and Sources of Income

Generally, there is limited information contained in national surveys about the employment and financial situations of mentally ill offenders prior to and after incarceration. A study by Sneed, Koch, Estes, and Quinn (2006) assessed the employment status of mentally ill offenders involved in a

Mental Health Court (MHC) program. It was found that 75% of the 94 participants were unemployed both at the time of intake and 12 months after entering the program. The 2006 BJS survey is consistent with that finding. When compared with inmates without mental problems, mentally ill offenders have “low rates of employment, high rates of illegal income” (James & Glaze, 2006, p. 5). That survey also shows that federal inmates report “illegal sources” as being their source of income 28% of the time. This may be related to the fact that a greater number of white-collar offenders are incarcerated at the federal level (NCCCHC, 2002) when compared with inmates at state and local levels.

Homelessness/Housing Status

Government surveys indicate that in the year prior to being arrested, mentally ill inmates are more likely and in some cases twice as likely (James & Glaze, 2006) to be homeless when compared with nonmentally ill inmates (Ditton, 1999). A study by Kushel, Hahn, Evans, Bangsberg, and Moss (2005) of 1,426 homeless and marginally homeless individuals assessed rates of prior imprisonment. The researchers found that nearly one quarter of the homeless individuals involved in the study had been incarcerated in a state or federal prison at some point in their lives. A more recent study by Greenberg and Rosenheck (2008) showed that among adult jail inmates, the rate of homelessness was very high (15.3%) and according to the authors was 7.5 to 11.3 times higher than that found in the general population. They also found that homeless inmates, relative to other inmates, were more likely to be incarcerated for a property crime; have more prior criminal justice system offenses, both nonviolent and violent; have more mental health and substance abuse problems; have a higher unemployment history; were more likely unmarried; have lower incomes; less education; and fewer personal assets. Greenberg and Rosenheck concluded from their data that prior incarcerations were a major risk factor in homelessness and thus may have resulted in the cycling between public psychiatric hospitals, jails and prisons, homeless shelters, and the street.

Mental Health and Treatment History

The 2006 BJS survey by James and Glaze reported information regarding five different aspects of mental health history, 1 year prior to incarceration: (a) recent history of mental health problems, (b) diagnosed with a psychiatric disorder by a mental health professional, (c) had an overnight hospital stay, (d) used prescription medication, and (e) had professional psychotherapy. In each of the aforementioned categories, the rates among females were twice, and in some cases nearly 3 times, as high as their male counterparts. Female mentally ill inmates were more likely to have a history of mental health problems and to have received either

psychotherapy or medication. A small percentage of inmates in federal, state, and local correctional facilities—2.1%, 5.4%, and 4.9% respectfully—reported having had an overnight hospital stay prior to incarceration.

Not all studies in the literature are consistent with the James and Glaze BJS 2006 report. One such example is a study by Fisher et al. (2002). They investigated the lifetime psychiatric hospitalization histories of 94 mentally ill male inmates in a Massachusetts jail. In their study, mentally ill jail inmates were 3 times more likely to report a history of psychiatric hospitalizations when compared with a nonincarcerated comparatively similar sample. Given those results, having included female inmates in the study might have yielded higher rates for previous hospitalization.

In another example, a study by Quanbeck et al. (2004) found that 49 of the 66 Los Angeles County jail inmates identified as bipolar had been hospitalized in the month prior to their arrest (as cited in Quanbeck, McDermott, & Frye, 2005). Even higher psychiatric hospitalizations were found in a later study by Way, Sawyer, Lilly, Moffitt, and Stapholz (2008). Way et al. (2008) found that among the newly admitted inmates to the New York State prison system, 6% were identified as having a serious mental illness and 97% had a prior psychiatric hospitalization. In addition, 62% had prior serious suicide attempts, and nearly 60% had prior inpatient treatment for substance abuse. Government surveys and clinical studies seem to indicate that a majority of mentally ill offenders have long psychiatric histories.

Physical and Sexual Abuse History

With regard to the mental health histories of female offenders, the findings of James and Glaze (2006) are consistent with nongovernmental surveys (see Sarteschi & Vaughn, 2010). In addition to the high rates of mental illness often found among female offenders, female offenders are much more likely to report having a physical or sexual abuse history. The 2006 BJS survey showed that between 17% and 24% of individuals in federal, state, or local correctional facilities report having been physically or sexually abused. When these figures are examined by gender, females are in some cases 4 times more likely than males to have a history of sexual abuse and approximately twice as likely to report having been physically abused (Ditton, 1999). Studies in the literature consistently find that female offenders in general are more likely than males to have endured some type of physical or sexual abuse throughout their lives (Sarteschi & Vaughn, 2010).

Family History

The majority of mentally ill inmates, in state and federal prisons, report having a family member who has been incarcerated (James & Glaze, 2006). Mentally ill offenders in state

and federal prisons were 3 times more likely to report having had an incarcerated father than an incarcerated mother. Mentally ill inmates in federal correctional facilities were 6 times more likely to report having had an incarcerated brother rather than an incarcerated sister. The rate was slightly lower (5 times) among mentally ill state offenders. One third to nearly half of mentally ill inmates, in correctional facilities, reported having received public assistance while growing up. Finally, more than half of mentally ill inmates reported living with only one parent or parental figure for the majority of their childhood.

Researchers are beginning to more thoroughly investigate the histories of the incarcerated, but there seems to be a relative lack of information with specific regard to the psychosocial histories of mentally ill inmates. The 2006 BJS James and Glaze study appears to be one of the first governmental surveys to provide such information. A review of the general offender literature revealed a study by Novero, Booker Loper, and Warren (2011) that analyzed self-reported childhood adversities of first- and second-generation inmates. Forty-four percent of the study population reported being exposed to at least four types of childhood adversities compared with a little more than 6% of the nonincarcerated adult population. It was also found that inmates who had an incarcerated parent had “extraordinarily” (Novero et al., 2011, p. 12) high levels of negative early life experiences. Second-generation inmates, having had incarcerated parents, were more likely to display anger, be perpetrators of violence, and break prison rules. Novero et al. asserted that the increased difficulties faced by second-generation inmates can be best explained by psychological theories of attachment, maladjustment, strain, and stigma.

Criminal History and Type of Offense

According to the 2006 BJS report, the majority of mentally ill inmates in federal, state, and local correctional facilities have had prior incarcerations. Approximately one third of federal, state, and local inmates reportedly have had 3 to 10 prior incarcerations and slightly less than 7% of all three groups have had more than 11. The majority of state and local inmates have had a current or past violent offense. There are a greater number of violent recidivists in state facilities than in federal and local correctional facilities. For instance, 11.6% of the inmates in state correctional facilities, according to the James and Glaze 2006 report, have committed homicide compared with slightly less than 3% of inmates housed in federal or jail correctional facilities. There are an estimated 60,787 violent inmates in jail facilities and 328,670 violent inmates in state correctional facilities. Forty-eight percent of the federal mentally ill inmates have been charged with drug trafficking crimes. There is a roughly equal percentage of violent (32%) and nonviolent recidivists (33%) in jail facilities.

Confinement Conditions for Mentally Ill Offenders

Access to Mental Health Treatment Once Incarcerated

The 2006 BJS report states that approximately one third of inmates in state correctional facilities reported receiving mental health treatment. Percentages are lower in federal correctional facilities (24%) and are at their lowest in jail facilities (17.5%); the majority of the latter group were offered medication only; 7% received professional counseling or therapy. When compared with federal, state, and local inmates, higher percentages of parolees reported receiving prescribed medication or counseling or therapy. Finally, the majority of federal and state inmates, and inmates on parole with mental health problems, report receiving at least some mental health services, but it is not clear what those treatments were.

A 2003 HRW report described U.S. prison services as “woefully deficient” (p. 1). Seriously mentally ill prisoners were neglected, and their behavior was often considered to be “malingered” (p. 1). Other reports show similarly inadequate access to inmate mental health services. In 2006, the Department of Justice (DOJ) investigated the confinement conditions of Taycheedah Correctional facility, a women’s prison in Wisconsin. The DOJ, in a 2006 report, concluded that psychiatrist staffing was “grossly inadequate” (p. 3). Two part-time psychiatrists were available for approximately 600 inmates. The DOJ ultimately summarized that Taycheedah “violated inmates’ constitutional rights by failing to provide for inmates’ serious mental health needs” (p. 2). A more recent study of 618 Michigan inmates by Fries (2010) determined that 65% of the 618 inmates who were identified as having severe psychiatric symptoms had not received mental health treatment in the past year (U.S. Department of Justice, Civil Rights Division, 2006).

Detention Conditions

In the *Brown v. Plata* (2011) opinion, Justice Kennedy provided a description of the treatment of mentally ill inmates in California facilities. Inmates with a serious mental illness lacked “minimal, adequate care” (p. 5). The wait time for receiving mental health services can be up to 12 months. Awaiting those services, many mentally ill inmates are subjected to segregation and enforced isolation. Some commit suicide while waiting to receive treatment. Seventy-two percent of the suicides were deemed, by an appointed special master, to be “foreseeable” and/or “preventable” (p. 6). Inmates threatening suicide are placed in small telephone-booth-sized cages for prolonged periods of time and denied access to bathroom facilities. In one

case cited in the opinion, a mentally ill catatonic inmate was caged for almost 24 hr standing in a pool of his own urine. We “had no place to put him” (p. 5) was the response of prison officials. Experts have described California’s prison conditions as “inhumane,” “appalling,” and “unacceptable” (p. 6).

Detention conditions are also known to exacerbate illness symptoms or cause psychotic episodes (Arrigo & Leslie Bullock, 2008; HRW, 2003). Recent prison reports show that inmates with serious mental illnesses are prone to unjustified segregation, solitary confinement, self-mutilation, rage, violence, and suicide attempts (and completions), and are easy targets for abuse (Vera Institute of Justice, 2006). It is not uncommon for segregation units to be 50% occupied by the mentally ill inmates (Vera Institute of Justice, 2006). There is evidence that on occasion, mentally ill inmates may be utilizing segregation units as a form of protection and escape from other inmates (National Prison Rape Elimination Commission, 2009).

Disciplinary Problems While Incarcerated

Mentally ill inmates present challenging disciplinary problems. The 2006 James and Glaze reports shows that inmates with mental health problems are much more likely to be charged with breaking facility rules or verbally or physically assaulting correctional staff when compared with nonmentally ill populations. They are also more likely to refuse to leave their cells, set fires, destroy property, smear human excrement on prison walls, and engage in self-mutilation when compared with nonmentally ill inmates (Arrigo & Leslie Bullock, 2008). Inmates with Axis II disorders are particularly prone to self-injurious behaviors (Appelbaum, Savageau, Trestman, Metzner, & Baillargeon, 2011). In addition, mentally ill inmates are vulnerable to attacks by other inmates (Treatment Advocacy Center, 2007). The National Prison Rape Elimination Commission (2009) noted that inmates with serious mental illness are particularly vulnerable and are at an increased risk for sexual abuse. Adams and Ferrandino (2008) pointed out that the aforementioned issues have long been understood yet little has been done to address them.

Others have expressed concerns about the correctional officers who work with the mentally ill within the criminal justice setting (Soderstrom, 2007). Generally, correctional officers are trained to maintain an authoritative relationship with inmates unlike mental health officials, who attempt to negotiate compliance (Soderstrom, 2007). The differing ideologies may present a clash between correctional officers and mental health staff. A related concern is that because the majority of prison systems provide only minimal mental health training to correctional officers, they have difficulty distinguishing between inmates who are acting out due to their mental illness and inmates acting

out for non-illness-related reasons (Fellner, 2006). Many correctional officers tend to assume the latter (Fellner, 2006) and subsequently punish inmates by placing them in special housing units (SHU) where confinement conditions are particularly excessive and severe (Arrigo & Leslie Bullock, 2008; HRW, 2003). Olley, Nicholls, and Brink (2009) pointed out an alternative problem: An inmate, due to severe psychiatric symptoms, lacks the ability to recognize that mental health treatment is required and goes without care, possibly endangering himself or herself and others.

Sentence Length

Studies show that mentally ill offenders have a more difficult time getting released and are often kept for longer than necessary periods, sometimes held without formal charges (Torrey et al., 1992). Bureau of Justice's data show that individuals with a mental illness serve sentences on average 5 months longer than those without a mental illness (James & Glaze, 2006). Other studies have shown they have greater difficulty being granted parole (Feder, 1994; Lurigio, 2001) and serve a longer portion of their sentences when compared with the nonmentally ill inmates (Feder, 1994). Aside from the studies mentioned above, there seems to be a lack of additional or more nuanced information regarding the sentence length of mentally ill offenders.

Suicidality Among Mentally Ill Inmates

A review article by Daniel (2006) estimated that between 33% and 95% of suicidal inmates have a psychiatric diagnosis. Studies show that the most significant risk factors for suicide include depression, hopelessness, prior suicide attempts, having a history of psychiatric disorder, substance abuse, and recent psychosocial stressors. Borderline personality disorder can increase the risk for suicide primarily due to a lack of interpersonal skills, impulsivity, and emotional stability. Daniel also found that substance abuse is a risk factor for suicide. Individuals diagnosed with APD, schizophrenia, or bipolar disorder are more likely to abuse substances and therefore, have a higher suicide risk than nonsubstance abusing inmates. In addition, Daniel reported that being transferred to a new correctional facility heightened the suicide risk for the mentally ill inmates. The author speculated that the reason for the increased risk was difficulty adjusting to the new facility. Suicide was found to be much greater among inmates deemed criminally insane and being held both in inpatient hospital settings and in super maximum-security facilities. Finally, the three most common methods of suicide (in order of most to less frequent) are hanging, overdosing on psychiatric drugs, and self-immolation, the latter being victims who tend to be female inmates with severe psychopathology.

An Ecological Perspective on Mentally Ill Offenders: Implications and Suggestions for Change

Systems thinking or ecological thinking emphasizes assessing a phenomenon in its broader context rather than looking at each of its components individually (Berben, Dobbels, Engberg, Hill, & De Geest, 2012). Public health and related disciplines recognize the importance of the ecological approach in part because it avoids placing blame squarely on individuals (Mittelmark, 2012). As applied to mentally ill offenders, their justice system involvement may be a function of their choices, the environment in which they were raised, the community in which they live, and the number of available and affordable mental health programs. The ecological perspective approach requires interventions that target interpersonal, institutional, community, and public policy changes.

At the interpersonal level, some inmates receive mental health services yet others are grossly underserved. It is unclear what accounts for this discrepancy. Terry Kupers suggests that the short supply of mental services are reserved for those who prove to be the most worthy (Toch, 2007), perhaps referring to those who are the sickest or those who the prison staff do not perceive as malingering. Rotter and Carr (2011) identified promising intrapersonal therapeutic approaches for mentally ill offenders. Those included cognitive-behavioral therapy (CBT), and problem-solving skills training programs such as Thinking For a Change, Moral Reconciliation Therapy (MRT), Lifestyle Change, and Reasoning and Rehabilitation (R and R). They also noted that Dialectical Behavioral Therapy (DBT) has been effectively utilized with offenders diagnosed with borderline personality disorder.

Institutionally, many mentally ill offenders currently reside within a criminal justice system which is ill-prepared to handle their needs. For instance, a federal investigation concluded that a Western Pennsylvania correctional institution violated the constitutional rights of inmates and those with intellectual disabilities by keeping them in solitary confinement for 22 to 23 hours a day. The Justice Department found that the State Correctional Institution at Cresson "often permitted its prisoners with serious mental illnesses or intellectual disabilities to simply languish, decompensate, and harm themselves in solitary confinement for months or years on end under harsh conditions, in violation of the Constitution" (The Associated Press, 2013). It is expected that the Justice Department will expand its investigation to include all Pennsylvania state prisons. In another instance, a Jackson Mississippi private prison was found to be infested with rats (Le Coz, 2013). A federal class action lawsuit, filed in May 2013, alleges that prisoners sold the rats to the mentally ill inmates for them to keep as pets or to use as currency for cigarettes.

This author joins a small but growing chorus of journalists (i.e., Andrew Cohen of *The Atlantic* and Solitary Watch) and other human rights activists, urging the federal government to independently investigate and properly monitor the incarceration conditions of mentally ill offenders. A May 2013 Government Accountability Office report revealed that there is “little publicly available information on the BOP’s [Bureau of Prisons] use of segregated housing units” (p. 2). Nor have they “studied the impact of segregated housing on inmates, staff, and institutional safety” (p. 41) because of, according to the BOP’s Office of Research and Evaluation (ORE), “competing priorities related to studying impacts of prisoner reentry, drug treatment, and recidivism” (p. 38). Correctional institutions should be mandated to collect and publish data on their solitary confinement practices. Mentally ill offenders are disproportionately held in solitary confinement, conditions that exacerbate their illness symptoms (Arrigo & Leslie Bullock, 2008; HRW, 2003; Vera Institute of Justice, 2006). Oversight is desperately needed.

At the public policy level, it is important to have accurate numerical estimates of mentally ill offenders. While statistics tell us little about the cost in human suffering, of incarcerated mentally ill offenders, accurate estimates would help us to identify the scope of the problem. A noteworthy limitation of governmental surveys of mentally ill inmates is that they are dated. The latest government study published in 2006 was based on data from 2002 and 2004. Government studies are also in part based on self-administered symptom checklists (Toch, 2007) which may lead to an under- or overestimate of mentally ill offenders. Accurate prevalence data are essential to identifying the most effective interventions.

Community stakeholders, policymakers, and mental health and criminal justice system professionals, must focus on two key areas: (a) preventing individuals with serious mental illnesses from being involved in the criminal justice system and (b) diverting criminal offenders with serious mental illnesses from prison and into treatment. Though not everyone agrees, the criminalization hypothesis suggests that individuals who are disproportionately involved in the criminal justice system are committing crimes due to their untreated illness symptoms (Fisher, Silver, & Wolff, 2006). If true, the mental health system must intervene before an individual becomes too sick to control his or her behavior. Programs that address other powerful risk factors associated with the propensity to commit crimes, including poverty, homelessness, and substance abuse, are also needed (Draine, Salzer, Culhane, & Hadley, 2002).

Finally, diversion into treatment rather than incarceration should be available for all mentally ill offenders. Problem-solving courts, especially mental health courts, have shown great promise but they are not available in all communities (Sarteschi, Vaughn, & Kim, 2011). Monies should also be invested in the training of both law enforcement and emergency responders, to better handle mentally ill offenders. In some communities, they have become the front-line

responders in dealing with individuals who are experiencing a mental health crisis (Teller, Munetz, Gil, & Ritter, 2006). Solomon et al. (2002) believed that police utilize the jail psychiatric facilities as a measure to prevent illness decompensation or possible danger to others within the community. If better trained about the nature of mental illnesses and how to intervene in crisis situations, fewer individuals with mental illnesses may be arrested. Two community-based, intensive intervention programs to consider include crisis intervention team (CIT) training (Skeem & Bibeau, 2008) and assertive community treatment (ACT; see DeMatteo, LaDuke, Locklair, & Heilbrun, 2013). CIT programs provide intensive training to first-responders about how to respond in mental health crisis situations (Teller et al., 2006) ACT is a model of intensive case management that utilizes a team approach to meet the behavioral health needs of individuals with serious mental illnesses who chronically cycle in and out of the justice system (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003). Both programs are empirically supported and have the potential to reduce the number of mentally ill individuals involved in the justice system.

Conclusion

This article is intended to provide a summary of the status of mentally ill offenders associated with U.S. correctional facilities. The most common types of psychological disorders found among inmates, according to government and congressional surveys and data collected from studies in the literature, include anxiety, affective, thought, and substance abuse disorders. PTSD is a common psychiatric diagnosis (NCCHC, 2002) and APD is also thought to be prevalent (Trestman, 2000), especially among male inmates (Trestman et al., 2007). This is a slightly broader range of psychological conditions than what the APA (2000b) cited as being the three most common: (a) schizophrenia, (b) bipolar disorder, (c) and depression. Females have higher rates of mental illness than males. Generally, Caucasians have higher rates of mental health disorders than Blacks or Hispanics (Soderstrom, 2007). The latter two groups are more likely to be diagnosed with thought disorders when compared with Caucasians. In addition, mental illnesses affect inmates in every age range but generally tend to be more prevalent among inmates under the age of 34. Relatively little is known about the mental illness rates of individuals on probation and parole (also known as community corrections) but the few studies done report characteristics similar to federal, state, and local jail inmates housed in correctional facilities.

Mentally ill offenders, when compared with nonmentally ill offenders, also seem to be in poor physical health, have experienced high levels of unemployment, have been homeless, have long histories of both prior psychiatric hospitalizations and prior incarcerations, have significant histories of physical and sexual abuse, and the majority have a family member who has been incarcerated. Once incarcerated, they

have minimal access to mental health treatment, and are subjected to isolation, confinement, and abuse, often at the hands of less than adequately trained correctional officers, a finding consistent with a recent review of treatment of persons with mental illness in the criminal justice system (Brandt, 2012). Finally, mentally ill offenders are more likely to attempt and commit suicide than their nonmentally ill counterparts, and are at significant risk of being sexually abused by other inmates.

The contribution of this literature review is that it provided a portrait of the current status of mentally ill offenders. Undoubtedly, attention and resources from both the criminal justice and mental health systems must be devoted to improving the conditions of mentally ill offenders. Their living conditions are dire, and in some cases even barbaric. Mentally ill offenders are constitutionally guaranteed basic mental health treatment. A review of the literature indicates that this constitutional guarantee is not being adequately fulfilled. More must be done to protect this vulnerable population.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research and/or authorship of this article.

References

- Adams, K., & Ferrandino, J. (2008). Managing mentally ill inmates in prisons. *Criminal Justice and Behavior, 35*, 913-927. doi:10.1177/0093854808318624
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000a). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2000b). *Psychiatric services in jails and prisons* (2nd ed.). Washington, DC: Author.
- Appelbaum, K. L., Savageau, J. A., Trestman, R. L., Metzner, J., & Baillargeon, J. (2011). A national survey of self-injurious behavior in American prisons. *Psychiatric Services, 62*, 285-290. doi:10.1176/appi.ps.62.3.285
- Arrigo, B. A., & Leslie Bullock, J. (2008). The psychological effects of solitary confinements on prisoners in supermax units. *International Journal of Offender Therapy and Comparative Criminology, 52*, 622-640. doi:10.1177/0306624X07309720
- The Associated Press. (2013, June, 1). *Pennsylvania prison misused solitary confinement for mentally ill inmates, feds say*. Retrieved from http://www.pennlive.com/midstate/index.ssf/2013/06/pennsylvania_prison_misused_so.html
- Berben, L., Dobbels, F., Engberg, S., Hill, M. M., & De Geest, S. (2012). An ecological perspective on medication adherence. *Western Journal of Nursing Research, 34*, 635-653. doi:10.1177/0193945911434518
- Blitz, C. L., Wolff, N., Pan, K., & Pogorzeiski, W. (2005). Gender specific behavioral health and community release patterns among New Jersey prison inmates: Implications for treatment and community reentry. *American Journal of Public Health, 95*, 1741-1746. doi:10.2105/AJPH.2004.059733
- Boone, H. B. (1995). Mental illness in probation and parole populations: Results from a national survey. *Perspectives, 19*, 32-39.
- Brandt, A. L. S. (2012). Treatment of persons with mental illness in the criminal justice system: A literature review. *Journal of Offender Rehabilitation, 51*, 541-558. doi:10.1080/10509674.2012.693902
- Brown v. Plata, 563 US 09 (2011)
- Castillo, E. D., & Fiftal Alarid, L. (2011). Factors associated with recidivism among offenders with mental illness. *International Journal of Offender Therapy and Comparative Criminology, 55*, 98-117. doi:10.1177/0306624X09359502
- Cloyes, K. B., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior, 37*, 175-187. doi:10.1177/0093854809354370
- Cosden, M., Ellens, J. K., Schnell, J. L., Yamini-Diouf, Y., & Wolfe, M. M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences & the Law, 21*, 415-427. doi:10.1002/bsl.542
- Crilly, J. F., Caine, E. D., Lamberti, J. S., Brown, T., & Friedman, B. (2009). Mental health services use and symptom prevalence in a cohort of adults on probation. *Psychiatric Services, 60*, 542-544. doi:10.1176/appi.ps.60.4.542
- Cuddeback, G. S., Scheyett, A., Pettus-Davis, C., & Morrissey, J. P. (2010). General medical problems of incarcerated persons with severe and persistent mental illness: A population-based study. *Psychiatric Services, 61*, 45-49. doi:10.1176/appi.ps.61.1.45
- Daniel, A. E. (2006). Preventing suicide in prison: A collaborative responsibility of administrative, custodial and clinical staff. *Journal of American Academy of Psychiatry and the Law, 34*, 165-175. Retrieved from <http://www.jaapl.org/cgi/content/full/34/2/165#R1>
- DeMatteo, D., LaDuke, C., Locklair, B. R., & Heilbrun, K. (2013). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts and reentry. *Journal of Criminal Justice, 41*, 64-71. doi:10.1016/j.jcrimjus.2012.09.002
- Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers* (Bureau of Justice Statistics Special Report NCJ 174463). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Draine, J. D., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services, 53*, 565-572. doi:10.1176/appi.ps.53.5.565
- Emily Le & Coz, E. (2013, May, 30). *Private prison in Mississippi allegedly put inmates "barbaric" conditions*. Retrieved from http://www.huffingtonpost.com/2013/05/31/private-prison-mississippi-barbaric-conditions-_n_3362596.html?ncid=edlinkusaolp00000003
- Feder, L. (1994). Psychiatric hospitalization history and parole decisions. *Law and Human Behavior, 18*, 395-410. doi:10.1007/BF01499047

- Fellner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights–Civil Liberties Law Review*, 41, 391-412. Retrieved from http://www.law.harvard.edu/students/orgs/crcl/vol41_2/fellner.pdf
- Fisher, W. H., Packer, I. K., Banks, S. M., Smith, D., Simon, L. J., & Roy-Bujnowski, K. (2002). Self-reported lifetime psychiatric hospitalization histories of jail detainees with mental disorders: Comparison with the non-incarcerated national sample. *Journal of Behavioral Health Services & Research*, 29, 458-465. doi:10.1007/BF02287351
- Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 554-557. doi:10.1007/s10488-006-0072-0
- Fries, B. E. (2010). *Independent study of mental health and substance abuse: Final report*. State of Michigan Department of Corrections. Retrieved from http://www.michigan.gov/documents/corrections/2010_Boilerplate_302_Final_Version_316653_7.pdf
- Greenberg, G. A., & Rosenheck, R. A. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59, 170-177. doi:10.1176/appi.ps.59.2.170
- Hartwell, S. (2001). An examination of racial differences among mentally ill offenders in Massachusetts. *Psychiatric Services*, 52, 234-236. doi:10.1176/appi.ps.52.2.234
- Human Rights Watch. (2003). *Ill equipped: U.S. prisons and offenders with mental illness*. Retrieved from <http://www.hrw.org/reports/2003/usa1003/>
- James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (Bureau of Justice Statistics Special Report NCJ 213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Kushel, M. B., Hahn, J. A., Evans, J. L., Bangsberg, D. R., & Moss, A. R. (2005). Revolving doors: Imprisonment among the homeless and marginally housed population. *American Journal of Public Health*, 95, 1747-1752. doi:10.2105/AJPH.2005.065094
- Lamb, R. H., Weinberger, L. E., Marsh, J. S., & Gross, B. H. (2007). Treatment prospects for persons with severe mental illness in an urban county jail. *Psychiatric Services*, 58, 782-786. doi:10.1176/appi.ps.58.6.782
- Lobbstaël, J., Leurgans, M., & Arntz, A. (2010). Inter-rater reliability of the structured clinical interview for DSM-IV Axis I disorders (SCID I) and Axis II disorders (SCID II). *Clinical Psychology & Psychotherapy*, 18, 75-79. doi:10.1002/cpp.693
- Lurigio, A. J. (2001). Effective services for parolees with mental illnesses. *Crime & Delinquency*, 47, 446-461. doi:10.1177/0011128701047003009
- Mittelmark, M. B. (2012). From associations to processes. In B. Wold, & O. Samdal (Eds.), *An ecological perspective on health promotion systems, setting and social processes* (pp. 11-16). Dubai, United Arab Emirates: Bentham Books.
- National Commission on Correctional Health Care. (2002). *The health status of soon-to-be-released inmates: A report to Congress, Volume 1*. Washington, DC: U.S. Department of Justice.
- National Prison Rape Elimination Commission. (2009). *National Prison Rape Elimination Commission final report* (Bureau of Justice Statistics Bulletin NCJ 226680). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Nieto, M. (1999). *Mentally ill offenders and California's criminal justice system*. California Research Bureau. Retrieved from <http://www.library.ca.gov/crb/99/02/99002.pdf>
- Novero, C. M., Booker Loper, A., & Warren, J. I. (2011). Second-generation prisoners: Adjustment patterns for inmates with the history of parental incarceration. *Criminal Justice and Behavior*. Advance online publication. doi:10.1177/0093854811406637
- Olley, M. C., Nicholls, T. L., & Brink, J. (2009). Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behavioral Sciences & the Law*, 27, 811-831. doi:10.1002/bsi.899
- Paradis, C. M., Broner, N., Maher, L., & O'Rourke, T. (2000). Mentally ill elderly jail detainees: Psychiatric, psychosocial and legal factors. *Journal of Offender Rehabilitation*, 31, 77-86. doi:10.1300/J076v31n01_05
- Quanbeck, C. D., McDermott, B. E., & Frye, M. A. (2005). Clinical and legal characteristics of inmates with bipolar disorder. *Current Psychiatry Reports*, 7, 478-484. doi:10.1007/s11920-005-0070-z
- Roskes, E. (1999). Offenders with mental disorders: A call to action. *Psychiatric Services*, 50, 1596. Retrieved from <http://psychservices.psychiatryonline.org/cgi/reprint/50/12/1596>
- Rotter, M., & Carr, W. A. (2011). Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches. *Community Mental Health Journal*, 47, 723-726. doi:10.1007/s10597-011-9391-z
- Sarteschi, C. M., & Vaughn, M. G. (2010). Double jeopardy: A review of women offenders' mental health and substance abuse characteristics. *Victims & Offenders*, 5, 161-182. doi:10.1080/15564881003640728
- Sarteschi, C. M., Vaughn, M. G., & Kim, K. (2011). Assessing the effectiveness of mental health court: A qualitative review. *Journal of Criminal Justice*, 39, 12-20. doi:10.1016/j.jcrimjus.2010.11.003
- Skeem, J., & Bibeau, L. (2008). How does violence potential affect crisis intervention team responses to emergencies? *Psychiatric Services*, 59, 201-204. doi:10.1176/appi.ps.59.2.201
- Skeem, J. L., Emke-Francis, P., & Eno Loudon, J. (2006). Probation, mental health and mandated treatment: A national survey. *Criminal Justice and Behavior*, 33, 158-184. doi:10.1177/0093854805284420
- Sneed, Z., Koch, D. S., Estes, H., & Quinn, J. (2006). Employment and psychosocial outcomes for offenders with mental illness. *International Journal of Psychosocial Rehabilitation*, 10, 103-112. Retrieved from http://www.psychosocial.com/IJPR_10/Employment_and_Offenders_with_MI_Sneed.html
- Soderstrom, I. R. (2007). Mental illness in offender populations: Prevalence, duty and implications. *Journal of Offender Rehabilitation*, 45, 1-17. doi:10.1300/J07634501_01
- Solomon, P., Draine, J., & Marcus, S. C. (2002). Predicting incarceration of clients of the psychiatric probation and parole service. *Psychiatric Services*, 53, 50-56. doi:10.1176/appi.ps.53.1.50
- Steadman, H. J., Osher, F. C., Clark Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761-765. doi:10.1176/appi.ps.60.6.761

- Steadman, H. J., & Veysey, B. M. (1997). *Providing services for jail inmates with mental disorders* (Research in Brief, NCJ 162207). Washington, DC: U.S. Department of Justice, National Institute of Justice.
- Teller, J. L. S., Munetz, M. R., Gil, K. G., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57*, 232-237. doi:10.1176/appi.ps.57.2.232
- Toch, H. (2007). Prevalence estimates: The numbers game. *Correctional Mental Health Report, 8*, 67-68. Retrieved from http://www.civicresearchinstitute.com/pdfs/CMHR805_web.pdf
- Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons in jails and prisons than hospitals: A survey of the states*. Treatment Advocacy Center. National Sheriffs Association: Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
- Torrey, E. F., Stieber, J., Ezekiel, J., Wolfe, S. M., Sharfstein, J., Noble, J. H., & Flynn, L. M. (1992). *Criminalizing the seriously mentally ill: The abuse of jails as prisons*. Washington, DC: Health Research Group and National Alliance for the Mentally Ill.
- Treatment Advocacy Center. (2007, April). *Criminalization of individuals with severe psychiatric disorders*. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/criminalization_of_individuals_with_severe_psychiatric_disorders.pdf
- Trestman, R. L. (2000). Behind bars: Personality disorders. *Journal of American Academy of Psychiatry and the Law, 28*, 232-235. Available from <http://www.jaapl.org/>
- Trestman, R. L., Ford, J., Zhang, W., & Wiesbrock, V. (2007). Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *Journal of American Academy of Psychiatry and the Law, 35*, 490-500. Available from <http://www.jaapl.org/>
- U.S. Department of Justice, Civil Rights Division. (2006). *Investigation of the Taycheedah Correctional Institution*. Retrieved from http://www.justice.gov/crt/about/spl/documents/taycheedah_findlet_5-1-06.pdf
- U.S. Government Accountability Office. (2013, May). *Bureau of Prisons: Improvements needed in Bureau of Prisons monitoring and evaluation of impact of segregated housing* (Publication No. 13-429). Retrieved from <http://www.gao.gov/assets/660/654349.pdf>
- Vera Institute of Justice. (2006, June). *Confronting confinement: A report of the commission on safety and abuse in America's prisons*. New York, NY. Retrieved from http://www.prison-commission.org/pdfs/Confronting_Confinement.pdf
- Veysey, B. M., & Bichler-Robertson, G. (2002). *Prevalence estimates of psychiatric disorders in correctional settings*. In Health Status of Soon-to-be Released Inmates Report to Congress, Vol. 2. Chicago, IL: National Commission on Correctional Health Care.
- Way, B. B., Sawyer, E. A., Lilly, S. N., Moffitt, C., & Stapholz, B. J. (2008). Characteristics of inmates who received a diagnosis of serious mental illness upon entry to the New York State prison. *Psychiatric Services, 59*, 1335-1337. doi:10.1176/appi.ps.59.11.1335
- Wisconsin Department of Corrections. (2009). *An evaluation: Inmate mental health care*. State of Wisconsin: Author. Retrieved from <http://legis.wisconsin.gov/lab/reports/09-4full.pdf>

Author Biography

Christine M. Sarteschi, PhD, LCSW, is an assistant professor of social work and criminology at Chatham University. Her research interests lie in social work research, mental health courts, mentally ill offenders, youth offenders and the intersection of U.S. mental health and criminal justice systems.