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A SURVEY OF SELF-REPORTED MENTAL ILLNESS AMONG ADULT INMATES IN NEBRASKA

A Thesis Presented to the

School of Social Work

and the

Faculty of the Graduate College

University of Nebraska

In Partial Fulfillment

of the Requirements for the Degree

Masters of Social Work

University of Nebraska at Omaha

by

Cristin B. O'Rourke

September, 2004

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THESIS ACCEPTANCE

Acceptance for the faculty of the Graduate College, University of Nebraska, in partial fulfillment of the requirements for the Masters of Social Work, University of Nebraska at Omaha.

Committee

Allen Weber PhD

Ph.D.

Chairperson Ann Coyne, Ph.D.

Date 9/29/04

Acknowledgements

I want to thank all of my friends, colleagues, and family members who have offered their support, encouragement, and advice during this thesis. Special thanks to my big brother Kevin, whose kindness and generosity enabled me to pursue grad-school plans in Omaha, and a very special thanks to my dear husband, Peter, whose love enables me to pursue life-long dreams.

Additionally, I extend my sincere appreciation to Dr. Ann Coyne, Dr. Gary Marshall, and Dr. Gwen Weber for their patient assistance with this project.

TABLE OF CONTENTS

A SURVEY OF SELF-REPORTED MENTAL ILLNESS AMONG ADULT INMATES IN NEBRASKA

Cristin B. O'Rourke, M.S.W.

University of Nebraska, 2004

This study used the results of mailed surveys to estimate the number of adults incarcerated in Nebraska prisons that have mental illness. It explored possible associations between the variables of gender, race, and mental illness. Survey questions, as well as the criteria for determining the presence or absence of mental illness, were based on a Bureau of Justice Statistics (BJS) Special Report (Ditton, 1999). In this survey sample (S=421), approximately 58% of incarcerated adults identified themselves as mentally ill (according to BJS criteria), a percentage significantly higher than the 16% reported by the BJS. Several possible reasons for the discrepancy in these estimates are presented. No conclusions could be drawn about associations between the variables of gender and mental illness because of the small number of females among survey respondents. No conclusions could be drawn about associations between mental illness and race (when

using five categories) due to the small number of respondents from the Asian, Hispanic, and Native American members of the population. When the number of racial categories was collapsed from five to three (including only African American, Caucasian, and Other), there were still no significant associations. Implications for policies regarding incarcerated mentally ill are discussed and suggestions for future research in this area are presented.

Introduction

Since the deinstitutionalization of mental hospital patients in the 1950s, criminal justice facilities have seen a steady increase in the number of mentally ill individuals in their custody (Kupers, 1999). In the United States, over a quarter of a million individuals with mental illness were incarcerated in mainstream correctional institutions in midyear 1998 (Ditton, 1999). While it may be tempting to live by the axiom, "Out of sight, out of mind," and ignore this information, it is important that we acknowledge its significance. Every year, approximately 12 million prison and jail inmates return to our communities. Of those released, an estimated ten percent are mentally ill (Sigurdson, 2000).

In this study, I attempted to estimate the total number of adult inmates in Nebraska prisons who are mentally ill according to criteria presented in a Bureau of Justice Statistics (BJS) Special Report (Ditton, 1999). I also wanted to determine whether or not there are any relationships between the variables of gender, race, and mental illness among these inmates.

Because there has not been a previous study on the prevalence of mental illness among incarcerated adult

prisoners in Nebraska, I based my hypothesis about the prevalence of mental illness among inmates on the most recently reported national data (Ditton, 1999). This BJS Special Report estimated that 16 percent of state prison inmates nationwide are mentally ill.

A recent survey of the fifty states and the District of Columbia revealed that Nebraska's percentage of mentally ill adults (non-incarcerated) was 7.47%, whereas the national mean was 7.51%. Given the reported standard deviation of 0.815, the percentage of non-incarcerated Nebraskan adults reporting mental illness falls within the median national cohort (Wright, 2003). Since the percentage of non-incarcerated mentally ill Nebraskans is close to the national average, and because I utilized the same survey questions and the same criteria for determining mental illness as did the BJS researchers, I hypothesized that the proportion of Nebraska prison inmates with mental illness would be similar to Ditton's reported results, or approximately 16 percent.

Two large-scale studies (Ditton, 1999; Substance Abuse and Mental Health Services Administration [SAMHSA], 2002) found that females, both those incarcerated and those in the general population, had higher rates of mental illness

than males. In the general population, the percentage of females with mental illness was 8.8%, while the percentage of males with mental illness was 5.6% (SAMHSA, 2002, p.69). Ditton (1999), in her report on a survey of incarcerated adults, found the highest rates of mental illness among white females in state prison (29%). Given this information, I hypothesized that there would be a positive association between being a female (of any race) and having a mental illness, and that white females should have higher rates of mental illness than other race-gender cohorts. I did not anticipate any other relationships between the variables of gender, race, and mental illness based on the existing research (Ditton, 1999; SAMHSA, 2002).

After presenting the survey results, this paper discusses policy implications and concludes with recommendations for future research in this area.

Literature Review

"[M]entally ill offenders are an easily forgotten and ignored population. They have been effectively removed, not only from their lives in the community, but from public and professional awareness as well" (Sigurdson, 2000, para. 6). In the past, the term *mentally disordered offender* generally referred to those individuals in forensic hospitals, i.e., those judged not guilty by reason of insanity (NGRI); guilty but mentally ill (GBMI); incompetent to stand trial (IST); or mentally disordered sex offenders (MDSO). Now, as the research clearly shows, individuals with mental disorders are found within the populations of mainstream correctional facilities. Jails and prisons contain large numbers of individuals who are either diagnosed with serious mental illness and/or are in psychiatric crisis (Dvoskin & Patterson, 1998). "[T]he inmate population of mentally impaired people has been growing for nearly 30 years. National trends indicate that these populations will continue to grow during the next decade before leveling off" (Stahl & West, 2001, para. 5).

Over a quarter of a million individuals with mental illness were incarcerated in the United States in midyear 1998 (Ditton, 1999). Because "American society has the

world's highest per-capita imprisonment rate" (Meyer, 1992, p. 1), and the numbers of those incarcerated continue to grow, one can only assume these numbers are even higher today. According to Metzner, Cohen, Grossman, and Wettstein (1998), the actual prevalence of mental illness among incarcerated offenders is unknown. The various estimates that have been calculated are based upon available research data, which, in many cases, are subject to methodological limitations. University of New Mexico psychologist Roger Paine asserts, "There is really no way to produce an accurate picture of mental illness in prisons. Requesting numbers on mentally ill inmates from prisons or jails results in fictitious numbers because most do not have adequate measures to determine who has a mental illness or not" (as quoted in Jones & Connelly, 2002, para 63).

The most recently reported research by the Bureau of Justice Statistics (BJS) (Ditton, 1999) indicates that approximately 16 percent of the corrections population is mentally ill. Regarding the Bureau of Justice Statistics estimate, the Executive Director of the American Correctional Association writes, "[I]f you speak with your colleagues or simply spend time at the facilities, you will

realize this number represents a floor rather than a ceiling" (Gondles, Jr., 2000, para. 4). "It is estimated that between 20 and 30 percent of individuals in jails or prisons have diagnosable mental illnesses. Moreover, between 60 to 80 percent of offenders have significant drug and alcohol abuse problems" (Jones & Connelly, 2002, para. 37).

The research generally does not count the number of offenders who have personality disorders, conditions which can significantly impede their functioning. "Further, because of head injuries, substance abuse and other afflictions to the brain, a significant number of inmates have subtle dementia that impairs their ability to make rational decisions and formulate plans" (Taylor, 2001, para. 2). Other studies and clinical reports indicate that 8-19% of prisoners have significant psychiatric or functional disabilities which will require treatment, and that an additional 15-20 percent of prisoners will require some form of psychiatric intervention during their incarceration (Metzner, Cohen, Grossman, & Wettstein, 1998).

The available empirical evidence suggests that the incidence of mental illness among inmates is approximately

four times higher than the incidence of mental illness among the general population. "[T]he prevalence of alcohol, drug, and combined alcohol/drug problems is between five and eight times greater among imprisoned offenders than among the general population" (Pallone, 1991, p. 148). The incidence of mental retardation in incarcerated offenders exceeds that of the general population by 50 percent (Kupers, 1999). Pallone (1991) therefore argues that the intervention of mental health professionals is required in correctional facilities, minimally for "efficient management," i.e. for prisoner and staff safety, regardless of whether or not such treatment reduces recidivism rates (p. 148).

The U.S. Census Bureau conducted the 1997 Survey of Inmates in State Correctional Facilities (SISCF) for the Bureau of Justice Statistics between June and October, 1997. Out of the 1,409 State prisons that met participation criteria (facilities had to be listed in the 1995 Census of State and Federal Adult Correctional Facilities and opened before June 30, 1996), 280 were selected for the survey sample. Overall, a total of 14,285 interviews at two hundred-twenty male facilities and sixty female facilities were completed by investigative personnel

(Bureau of Justice Statistics [BJS], 2000). Regarding the sampling of state facilities,

> the 13 largest male prisons and the 17 largest female prisons were selected with certainty. The remaining 1,265 male facilities and 261 female facilities were stratified into 14 strata defined by census region (Northeast except New York, New York, Midwest, South except Texas, Texas, West except California, and California). (BJS, 2000, p.69)

No additional information about facilities was provided, so it is not known whether any facilities in Nebraska were included in the sample.

The researchers used computer-assisted personal interviewing (CAPI) to conduct the hour-long interviews with inmates. "An interviewer asked the questions presented on the screen and entered the responses. Many of the tasks involved in conducting a survey interview, like skipping to another question, were performed automatically by the computer" (BJS, 2000, p. 1). CAPI additionally facilitates the research process by enabling the interviewer to ask follow-up questions that are tailored to the inmates' preceding answers. "[I]nmates were interviewed about their current offense and sentences,

criminal histories, family and personal backgrounds, gun possession and use, prior drug and alcohol use and treatment, educational programs, and other services provided while in prison" (BJS, 2000, p.69). It is unclear from the description of the SISCF survey methodology whether or not the inmates were able to request clarification of any of the questions.

The data from this survey, alone and/or in combination with data from other surveys, were used to compile reports about various aspects of the criminal justice population (see Bonczar, 2003; Chaiken, 2000; Ditton, 1999; Greenfeld & Henneberg, 2001; Greenfeld, & Smith, 1999; Harlow, 1999; Harlow, 2000; Harlow, 2001; Harlow, 2003; Maruschak, 1999a; Maruschak, 1999b; Maruschak & Beck, 2001; Mumola, 2000a; and Mumola, 2000b). However, the only report that specifically addresses the prevalence of mental illness among state prison inmates is by Ditton (1999).

In her report, "offenders were identified as mentally ill if they met one of the following criteria: they reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program" (Ditton, 1999, p.2). According to Ditton, the original SISCF survey authors included the

question about past admission to a mental hospital as a measure of mental illness "[t]o take into account underreporting of current mental or emotional problems" (1999, p.2).

The SISCF items that generated the data in Ditton's report (1999) appear in Section 1 (Individual Characteristics) of the questionnaire. The interviewer asks, "Do you have a mental or emotional condition?" (BJS, 1999, p.110). Later in the survey, the interviewer continues,

> Now I am going to ask you about services you may have received for emotional or mental problems, other than those related to drug or alcohol abuse. Because of an EMOTIONAL OR MENTAL PROBLEM, have you EVER--
>
> Taken a medication prescribed by a psychiatrist or other doctor?
>
> Been admitted to a mental hospital, unit, or treatment program where you stayed overnight?
>
> Received counseling or therapy from a trained professional?
>
> Received any other mental health services?
>
> (BJS, 1999, pp.149-150, uppercase in original)

The SISCF questionnaire does not solicit any detailed information about the inmates' alleged mental or emotional condition and is not designed to be a diagnostic tool. Thus, Ditton's report (1999), based on an analysis of answers to these questions, provides general prevalence rates only. In this sense, her work differs from other research about mentally ill incarcerated offenders that provides data about inmates' symptoms (i.e., psychotic or nonpsychotic disorders) or about specific diagnoses (i.e., schizophrenia, depression, bipolar disorder, etc.) (Metzner, Cohen, Grossman, and Wettstein, 1998).

Research indicates that the rates of serious mental disorders are generally higher among inmates in jails than in prisons (Ditton, 1999; Guy, Platt, Zweling, & Bullock 1985; Steadman, Fabiask, Dvoskin, & Holohean, 1987; and Teplin, 1990). Jails are often temporary holding facilities for inmates awaiting trial, or for those offenders serving sentences less than one year. On the other hand, prisons represent the end of the adjudication process, housing those inmates who have been convicted of more serious crimes with longer sentences. Often, by the time an inmate has been convicted and incarcerated in a prison, "many severely mentally ill inmates have already

been hospitalized or treated on a pretrial basis, diverted to the mental health system, adjudicated NGRI [not guilty by reason of insanity], had their charges dismissed, or placed on probation" (Metzner, Cohen, Grossman, & Wettstein, 1998, p. 230).

Since prisoners are by definition, socially deviant, it is not surprising that the incidence of psychiatric deviance is higher among this population than in the criminally non-deviant population (Pallone, 1991). Additionally, since prisoners are by virtue of their incarceration, distinctly different than the general population, it may seem meaningless to compare prevalence rates of mental disorders between these two populations. Acknowledging this situation, researchers have looked to other institutionalized populations for more valuable comparisons.

When the incidence of mental disorders has been compared between incarcerated offenders and mental hospital patients, the following results were found: 1) there was no significant difference in the prevalence of alcohol use disorders, or in the prevalence of anxiety, somatoform, and dissociative disorders; 2) there was a significantly higher incidence of drug abuse problems and personality disorders

(especially those of psychopathic deviation) among prisoners than among patients; and 3) there was a significantly higher incidence of schizophrenia among patients than among prisoners (Pallone, 1991).

Many authors discuss possible reasons for the high prevalence of mentally disordered inmates (see for example, Gondles, Jr., 2000; Kupers, 1999; Metzner et al., 1998; Meyers, 1992; Stahl &. West, 2001; and Pallone, 1991). "[B]etween 1955 and 1995, the number of patients cared for in public mental institutions plunged from 559,000 to 69,000" (Stahl & West, 2001, para. 2). The deinstitutionalization of mentally ill patients in the 1950s and reduced resources in the public mental health system, combined with "the criminalization of poverty" (Kupers, 1999, p. 11) have caused more mentally disordered individuals to be on the streets and subject to arrest. Local businesses often exert pressure on the police to get rid of undesirables, including those suffering from untreated mental disorders. Especially in tourist towns such as New Orleans, the police are well known for arresting all vagrants and homeless persons (Treatment Advocacy Center, n.d.[a], para. 12).

The Associate Commissioner for Forensic Services in the New York State Office of Mental Health, Dr. Joel Dvoskin, stated, "The most prolific mental health worker in the United States is the police officer and there's not even a close second" (as quoted in Meyer, 1992, pp. 1-2). The police often implement so-called *mercy bookings*, where they arrest persons who appear to be suffering from the severest forms of psychiatric illnesses, in order to protect these individuals. "This is especially true for women, who are easily victimized, even raped, on the streets" (Treatment Advocacy Center, n.d.[a], para. 11).

People with severe mental illnesses are sometimes arrested and jailed because their families find it is the most expedient means of getting the person into treatment. As the public mental health system in the United States has become increasingly under funded, it gives priority for treatment services to persons against which criminal charges are pending. So, for a family seeking treatment for an ill relative, having the person arrested may be the most effective way to accomplish their goal (Treatment Advocacy Center, n.d.[a]).

Additionally, changes in the legal and criminal justice systems have contributed to the high prevalence of

incarcerated individuals with mental disorders. New laws and courtroom proceedings prevent the diversion of offenders with mental disorders into non-correctional treatment programs. Evidence shows that police arrest mentally ill persons more often than they arrest the general public (for committing the same crimes). Additionally, in some communities, law enforcement agencies are considered more capable of handling mental health crises than is the local mental health system (Sigurdson, 2000).

> By default, the responsibility of caring for inmates suffering from mental illness has fallen on federal, state, and local correctional facilities across the country. Policy-makers who closed state-run mental facilities in the 1960s never envisioned a mass transfer of patients from hospitals to correctional facilities; nor did corrections officials. (Stahl & West, 2001, para. 23)

The public mental health system has failed to provide adequate treatment for the deinstitutionalized population. Many of these individuals are now incarcerated. States are closing down public hospitals, yet community mental health centers are frequently ill-equipped to treat the seriously

mentally ill consumer (Kerle, 1998). Some mentally ill individuals are held in jails on emergency detention without criminal charges. Seventeen states allow jails to hold mentally ill persons without charges under certain conditions (Kerle, 1998). In too many cases, the criminal justice system has become a last-resort caregiver for persons with mental illness (Gondles, Jr., 2000).

"Considering the history and present status of mental health services and the criminal justice system, it is important that we recognize that prisons were never designed to be primary providers of mental health care" (Jones & Connelly, 2002, para 61). However, due to the deinstitutionalization of state mental hospital patients, there has been a shift in responsibilities to the correctional community. Unfortunately, when the hospitals were emptied, the money necessary to care for patients with severe mental illnesses did not usually follow them into their communities. Essentially, prisons, and jails especially, are becoming the new state hospitals but are functioning without the financial resources to do so (Jones & Connelly, 2002).

Dr. Chris Sigurdson, staff psychiatrist at the US Department of Justice Federal Bureau of Prisons, writes,

"The United States currently has more mentally ill men and women in jails and prisons than in all state hospitals combined" (2000, para. 5). For perceived cost savings and increased civil liberties, our policy makers moved large numbers of severely mentally ill men and women from mental hospitals, the public institutions designed for their care, into correctional facilities, the public institutions designed for the containment of offenders (Sigurdson, 2000). In spite of these facts, it is only recently that mental healthcare for offenders became an important topic for criminal justice and correctional professionals. To these personnel, incarcerated offenders with mental disorders were not considered a significant problem. The issue of psychiatric rehabilitation was considered secondary to retribution (Jones & Connelly, 2002).

Researchers have tried to elucidate the relationship between incarceration and mental illness. "Much of the evidence suggests that those inmates with mental illness are more prone to commit crime, are at a greater likelihood for arrest, are more likely to commit violent crimes, and have the highest rates of recidivism of any offenders (NIJ, 1991, Sigurdson, 2000)" (Jones & Connelly, 2002, para. 15). While it is obvious that criminal behavior is not a direct

result of mental illness, it is also obvious that a large percentage of those who commit crimes are mentally ill. The issue is further complicated when one looks at arrest rates and conviction rates for mentally ill versus "normal" offenders. For example, when committing the same crimes, people with mental illness are 64 percent more likely to be arrested than those without a mental illness (Jones & Connelly, 2002). Also, examination of police records often reveals "a direct relationship between the person's brain disorder and the behavior that led to the apprehension" (Treatment Advocacy Center, n.d.[a], para. 10).

There are many reasons why major mental illnesses can make individuals vulnerable to incarceration. Untreated, these illnesses impair thinking, judgment, and mood. Individuals may not be able to find or maintain employment, may not be able to access community mental services, and may not have contact with their natural support systems, such as family and the church. Criminal behavior may result when a paranoid individual attempts to right misperceived wrongs or attempts to defend against misperceived threats. Finally, individuals with limited insight, delusions, and disorganized thinking may be easily led into criminal activity (e.g., as runners for drug

organizations) (Sigurdson, 2000). "Regardless of the relationship between mental illness and incarceration, we must recognize that the need for mental health treatment does not disappear with imprisonment" (Sigurdson, 2000, para. 32).

It is important for law enforcement and mental health personnel to acknowledge cultural traditions when considering whether or not an offender is mentally ill. Some offenders have been brought up in cultures where it is normal to see and hear things. "These are not necessarily symptoms of psychosis, nor should they be dismissed as simple malingering. It is the professional's duty to sift through all the factors to determine whether there is a legitimate problem. It is not the patient's job to convince the health care professional that he or she is sick" (Taylor, 2001, para. 24).

Some offenders develop psychological disorders which arise as a function of the stress related to confinement. Confinement-specific stress can "exacerbate many forms of mental disorder which preexist the experience of incarceration, particularly among those prisoners undergoing a first experience of confinement" (Pallone, 1991, p. 118). An early artifact of incarceration appears

to be deterioration of mental health as measured by MMPI (Minnesota Multiphasic Personality Inventory) scores on admission and after 115 days of confinement. The greatest stress appears to be felt by first-time inmates who anticipate serving long sentences. Repeat offenders and those inmates serving shorter sentences had lower stress levels as measured by behavioral manifestations of stress reactions (Pallone, 1991).

Some of the factors involved in confinement-related stress include the loss of liberty, loss of personal space, loss of control, violence, overcrowding, and lack of purposeful activity (Pallone, 1991). Features of present-day prisons that increase the levels of traumatic stress during incarceration are as follows: "Pervasive racism, inattention to the special needs of women, sexual harassment by staff, the horror of rape, staff insensitivity toward rape victims, lack of quality contact with loved ones, and a frighteningly high rate of suicide behind bars" (Kupers, 1999, p. 89).

Prisoners with mental disorders may choose to remain in their cells as much as possible to avoid potential trouble. Mental illness can lead to deterioration in social skills, making this population extremely vulnerable

to altercations with other inmates. Isolation often contributes to increased depression and a worsening of psychotic symptoms. Alternatively, prisoners with mental disorders are sent to lock-up (the "hole" or solitary confinement) following altercations with other prisoners. Many prisoners with mental illness lack impulse control and may "strike out at the least provocation" (Kupers, 1999, p. 29). The stress and isolation of solitary confinement often exacerbates the symptoms of mental illness.

Illogical thinking, delusions, auditory hallucinations, and severe mood swings frequently lead to bizarre behavior by individuals with severe brain disorders who are in jails and prisons. Such behaviors are disquieting to other "normal" inmates who often react with violence against those with mental illness and other brain disorders. Life behind bars can be a particularly brutal experience for this population (Treatment Advocacy Center, n.d.[a]). Additionally, institutionalization (of any kind) commonly causes an erosion of independent living skills, leaving the released individual less capable of caring for him- or herself than he or she was at the time of admission (Dvoskin & Patterson, 1998).

"For people with serious brain disorders, the effects of being in jail or prison are occasionally positive, but more often negative. Interestingly, many of those who claim that it was positive, do so because they found being incarcerated was the only way they could get psychiatric treatment" (Treatment Advocacy Center, n.d.[a], para. 19). Such cases are the exceptions because incarceration usually exacerbates psychiatric symptoms. As mentioned above, individuals with serious brain disorders are often placed in solitary confinement. In addition, they are not always given the necessary medication to control their symptoms (Treatment Advocacy Center, n.d.[a], para. 20). When resources are limited, treatment becomes restricted to the most severely mentally-disturbed inmates. The rest of the offenders with mental disorders receives little more than "token clinical attention" (Kupers, 1999, p. 69).

The effective delivery of mental health services in correctional facilities is complicated by fiscal constraints, including funding shortfalls and budget cuts, the increasing size of the population of incarcerated offenders with mental illness and/or substance abuse issues, and legal decisions that obligate the state to treat seriously mentally ill offenders (Wilkinson, 2002).

Additional issues that have plagued prisons and jails trying to provide proper care and treatment to offenders with mental health disorders are inadequate services, under-trained staff, lack of interagency collaboration, and the management of diverse populations, i.e. juveniles, racial minorities, and elderly offenders (Jones & Connelly, 2002).

There are a multitude of ethical and legal issues surrounding the treatment of mentally ill incarcerated offenders. One of the most basic concerns is the philosophy of the criminal justice system. Is the goal of incarceration punishment or rehabilitation? Are these goals mutually exclusive? For those that view correctional facilities as institutions whose purpose is to deter and punish, it makes little sense (fiscally or otherwise) to use limited resources on rehabilitation. On the other hand, prisoners are legally guaranteed mental health care as a necessary health service. Correctional facility administrators do not want to risk lawsuits or governmental sanctions for failing to provide required services to their inmates. Inmates convicted of sexual offenses are often mandated to receive mental health treatment as a condition of their release or transfer. While the effectiveness of

correctional rehabilitation treatment for sexual offenses is controversial at best, these treatment programs often "dissipate limited mental health resources (Dvoskin, 1991)" (Metzner et al., 1998, p. 246).

Specific legal issues involving mentally ill inmates have generally focused on the following three aspects of treatment decisions: "a right to treatment, a right to refuse treatment, and the acceptable parameters of the treatment programs provided" (Hafemeister, 1998, p. 55). Based primarily on the Eighth Amendment, courts have ruled since the mid-seventies that inmates have a right to medically necessary treatment for illness, whether physical or mental in nature. Courts, at both the Federal and State levels, have generally not supported a patient's right to refuse treatment. These decisions focused on the subject of dangerousness (to the other inmates, staff, and potentially, to the community), and placed the importance of ensuring the safety of others above the right of inmate self-determination (Hafemeister, 1998).

Courts are also involved in evaluating the appropriateness of treatment programs. The following four issues are given main consideration during the evaluation process: 1) whether the treatment program is being used

more for punishment than potential rehabilitation; 2) whether or not there is empirical evidence to support the potential effectiveness of the treatment programs (courts consistently agree that treatments should *not* be experimental); 3) whether or not the treatment program is overly intrusive (i.e., electro-convulsive therapy [ECT], psychosurgery, medication); and 4) whether or not informed consent has been obtained from the inmates (Hafemeister, 1998). One could argue that by virtue of their incarceration, inmates are unable to be truly voluntary patients.

When the state of mental health care today is reviewed, several paradoxes are evident. First, while scientists, in the last thirty years, have made unprecedented advances in the recognition and treatment of severe mental illness, society has simultaneously engaged in the regressive practice of returning large numbers of mentally ill persons to prisons and homeless shelters (i.e., poor houses). Second, government officials say that our society cannot afford to treat the mentally ill in our communities, yet incarcerating the mentally ill always costs more than providing appropriate community care. Finally, "[w]e generously fund care and treatment for

individuals with other, irremediable, brain illnesses but frequently ignore more easily treated human suffering due to mental illness" (Sigurdson, 2000).

There is a disproportionate incidence of neurogenic mental disorder among the poor and the nonwhite. Societal institutions have failed to identify and treat "neuropsychological and neuropsychiatric anomalies, especially among the poor and nonwhite, before they ever 'mature' into criminal behavior" (Pallone, 1991, p. 140). For many poor and nonwhite citizens, a "traumatizing referral by police or the courts" (Pallone, 1991, pp. 140-141) is their first encounter with the mental health system.

American policy makers have thus far chosen not to make sure that mental health services are available, accessible, and attractive to these vulnerable segments of the population before the criminal justice system becomes involved. And, within the criminal justice system, "the standards for mental health care in the prison are inadequate both in terms of ratios between care-givers and care-recipients and in terms of the character of care-givers professionally prepared to provide professional service to offenders whose mental disorders are those

characteristically associated with male, nonwhite, and lower socioeconomic status populations" (Pallone, 1991, pp. 148-149).

One of the major impediments to developing public policy and designing appropriate services for persons who intersect the criminal justice and mental health systems is a lack of descriptive data. This may be due, in part, to the difficulties society has in determining what behavior is deviant, what behavior is psychiatrically deviant, what behavior is criminally deviant, and especially, what criminal behavior is excused by mental illness (Pallone, 1991). Social value systems, both transient and long-term, affect judgments as to whether a person is abnormal. "In most societies there is substantial overlap between judgments of mental abnormality and criminal behavior; that is, the same specific behavior may receive either label, depending on who is doing the labeling" (Meyer, 1992, p. 14).

Dr. Chris Sigurdson (2000) writes,

> We need to review our social policies regarding mental illness and incarceration. If, in so doing, we decide that prison is where we want to house a large number of our severely mentally ill, we must then fund our

> jails and prisons accordingly. The right of inmates to adequate mental health and medical care has been consistently upheld by the Supreme Court. The denial of care is not an option. It is also not wise. More than 12 million people are released from jails and prisons each year. At least 10 percent of them will be mentally ill. (para. 33)

Various authors have recommended policy changes for the criminal justice system. Sigurdson (2000) suggests that more correctional funds be diverted to mental health programs so greater attention can be focused on upgrading resources and ensuring that inmates receive appropriate treatment. Barr (2002) recommends improved discharge planning and argues that successful discharge plans lead to greater continuity of care, higher rates of medication compliance and attendance at follow-up appointments, and less recidivism for those mentally ill offenders who are released from correctional facilities.

Sigurdson (2000) suggests that correctional administrators should reevaluate the roles and responsibilities of their mental health personnel, ensuring that they understand their function(s) within the institution. He asserts that the treatment and care for

mentally ill offenders must be conducted by properly trained and licensed staff. In order to accomplish this, he advises that facilities provide an increased amount of pre-service and in-service training for correctional staff and specialized mental health training for designated staff members (Sigurdson, 2000).

Several authors recommend that criminal justice systems work with communities in order to create alternatives for offenders with mental illness who have not committed violent crimes (Barr, 2002; Goldcamp, & Irons-Guynn, 2000; and Kupers, 1999). One such option is mental health courts. These courts are patterned after drug courts and are based on the concept of therapeutic jurisprudence. Mental health courts "attempt to prevent criminalization and recidivism by providing critical mental health services" (Watson, Hanrahan, Luchins, and Lurigio, 2001, p. 477).

While models differ somewhat by jurisdiction, the basic concept of all mental health courts is that non-violent mentally ill offenders can have their sentences remanded if they agree to undergo treatment. In order for these courts to be successful, it is imperative that communities provide appropriate and accessible mental

health services. As of late 2000, there were only twelve mental health courts in existence; however, this number is likely to have increased since the passage of Public Law 106-515 in November, 2000. This law directs the attorney general to issue grants for the establishment of 100 state and local demonstration mental health courts (Watson, Hanrahan, Luchins, & Lurigio, 2001).

As mentioned above, successful mental health courts require adequate community mental health services. Funding for community health services should be increased not only to ensure that mentally ill offenders have access to services in lieu of punishment, but also so that mentally ill citizens can access treatment prior to encountering the criminal justice system. If mental health services were more accessible, then harmful delays in the treatment of individuals with severe mental illnesses could be avoided (Sigurdson, 2000). Wilkinson (2000) argues that community mental health centers should be required to provide comprehensive care and supervision, including the use of clinics, hospitals, day treatment, residential programs, and assertive case management.

Laws should be developed that enforce mandatory treatment for mentally ill individuals before a far more

restrictive commitment, i.e., to prison, is the only option. Mandatory treatment can include inpatient hospitalization, partial hospitalization programs, day treatment, and/or residential treatment facilities (Sigurdson, 2000). As discussed above, it costs less to treat a mentally ill individual in the community than it does to treat him or her inside a correctional facility.

Resolution to the problem of how to handle mentally ill incarcerated offenders will come only when there is cooperation among correctional security and treatment staff, parole officials, community providers, mental health treatment advocates, and elected officials who determine funding streams (Maue, 2001). "Effective communication and the establishment of collaborative partnerships between those working in the mental health and criminal justice fields are critical. Such partnerships...are the key to success in addressing the needs of the mentally ill impacted by the criminal justice system" (Wilkinson, 2002, para. 38).

Method

Subjects

The Nebraska Department of Correctional Services (DCS) has eleven facilities throughout the state of Nebraska. The following three facilities were excluded from this study: 1) Hastings Correctional Center, because the inmates are primarily non-English-speaking detainees of the Immigration & Naturalization Service (INS); 2) Work Ethic Camp-McCook, because the participants are probationers, rather than prisoners; and 3) Nebraska Correctional Youth Facility, because the inmates are not adults.

As of 10/08/2003, the total adult inmate population in Nebraska prisons (minus the INS detainees at Hastings Detention Center and 287 inmates with release dates prior to January 1, 2004) was 3,573, or approximately 4,000. In order to select an appropriate sample size, I consulted R.V Krejcie and D.W. Morgan's, "Determining Sample Size for Research Activities" (1970). Their work indicates that a sample size of 351 is required for a population of 4,000. Subjects were chosen by random selection from a list provided by the Nebraska DCS. This list of adult inmates included name, gender, race, facility, and proposed release

date (used to exclude inmates who might be released before the surveys were distributed).

Procedure

Permission to conduct this research was given by the warden or superintendent at each DCS facility, as well as by the director of the Department of Correctional Services, Harold W. Clarke. Approval was also granted by the University of Nebraska Medical Center Institutional Review Board (IRB) prior to the onset of any data collection.

A total of 995 surveys were mailed in bulk to inmates at the following eight DCS facilities: Community Corrections Center-Lincoln, Diagnostic & Evaluation Center (Lincoln), Lincoln Correctional Center, Nebraska Correctional Center for Women (York), Nebraska State Penitentiary (Lincoln), Omaha Correctional Center, Community Corrections Center-Omaha, and Tecumseh State Correctional Institution.

The surveys were distributed in three separate mailings consisting of 498 surveys on October 15, 2003, 247 surveys on November 15, 2003, and 250 surveys on December 15, 2003. Ten of the December-mailed surveys were returned unopened, as the designated recipients had been paroled. A

total of 430 surveys were returned (see Results section for more details about response rates).

Inmates received written instructions to complete the survey (see below) and to return the survey in a pre-addressed, postage paid envelope that was provided by the investigator. There was no contact between the investigator and the inmates.

The variables in this study are nominal and qualitative. They are listed as follows: 1) Gender (2 categories): Male or Female; 2) Race (5 categories): African American, Asian, Caucasian, Hispanic, and Native American ("Other" is not included as only 0.1% of Nebraska inmates fall into this category); and 3) Mental Illness (2 categories): present or absent.

Because the purpose of this research project was to estimate general prevalence rates of mental illness, and to compare the results with those reported by Ditton (1999), I used the same SISCF questions and the same criteria for determining mental illness that Ditton did. If an inmate answered "yes" to survey question # 1 ("Do you have a mental or emotional condition?") *or* answered "yes" to survey question # 3 ("Because of an emotional or mental problem, have you ever been admitted to a mental hospital,

unit, or treatment program where you stayed overnight?"), then he or she was considered to have a mental illness for the purpose of this study.

The estimate of the total number of Nebraska adult inmates with mental illness was obtained by multiplying the ratio of inmates identified as having mental illness ($\mathbf{P}_{NEB}$) by the total number of adult inmates in Nebraska as reported by the DCS web-site.

Materials

The materials required for this study included IRB approved adult informed consent forms, IRB "Rights of Research Participants" forms, surveys, and pre-addressed, postage-paid envelopes. The computer software program SPSS, Student Version 11.0, was used for statistical analyses of the data. The survey used in this research project is reproduced in Figure 1 below (please see Appendix A for the BJS report survey questions):

Figure 1. Survey mailed to inmates

Please answer the following questions and return in the envelope provided. Thank you for your participation.

1. Do you have a mental or emotional condition? [ ] Yes [ ] No

2. Because of an emotional or mental problem, have you ever taken medication prescribed by a psychiatrist or other doctor? [ ] Yes [ ] No

3. Because of an emotional or mental problem, have you ever been admitted to a mental hospital, unit, or treatment program where you stayed overnight? [ ] Yes [ ] No

4. Because of an emotional or mental problem, have you ever received counseling or therapy from a trained professional (do not include drug or alcohol treatment)? [ ] Yes [ ] No

5. Because of an emotional or mental problem, have you ever received any other mental health services? [ ] Yes [ ] No

* * * * * * * * * * * *

Please indicate your gender :

[ ] Male
[ ] Female

Please indicate your race:

[ ] Caucasian
[ ] African American
[ ] Hispanic
[ ] Native American
[ ] Asian

Adapted from Bureau of Justice Statistics, July 1999, NCJ 174463

Results

Quantitative Data

Gender Breakdowns of Survey Recipients & Survey Respondents

The gender breakdowns of the survey recipients and the survey respondents are compared below (see Table 1.1) to the most recent gender breakdowns of the Nebraska Department of Correctional Services (NDCS) adult inmate population (NDCS, 2004a). If the survey sample corresponded exactly with the gender cohorts of the inmate population, then I would have expected 40 females and 381 males to respond. As reflected below, females were over-represented in the final sample even though they were actually under-represented in the recipient pool.

Table 1.1. Gender breakdown of inmates, survey recipients, and survey respondents

	Nebraska Inmates		Survey Recipients		Survey Respondents	
	Number	Percentage	Number	Percentage	Number	Percentage
Male	3,703	90.4%	909	91.4%	368	87.4%
Female	354	9.6%	86	8.6%	53	12.6%

Racial Breakdowns of Survey Recipients & Survey Respondents

Table 1.2. Racial breakdown of inmates, survey recipients, and survey respondents

	Nebraska Inmates		Survey Recipients		Survey Respondents	
	Number	Percentage	Number	Percentage	Number	Percentage
African American	1,003	24.7%	233	23.4%	76	18.1%
Asian	27	0.7%	7	0.7%	2	0.5%
Caucasian	2,382	58.7 %	580	58.3%	276	65.6%
Native American	200	4.9%	59	5.9%	34	8.1%
Hispanic	433	10.9%	116	11.7%	33	7.8%
Other	2	0.1%	N/A	N/A	N/A	N/A

The racial breakdowns of survey recipients and respondents are compared above in Table 1.2 to the most recent racial breakdowns of the NDCS adult inmate population (NDCS, 2004a). If the survey sample corresponded exactly to the race cohorts of the inmate population, then I would have expected 104 African American inmates to respond, 3 Asian inmates to respond, 247 Caucasian inmates to respond, 21 Native American inmates to respond, and 46 Hispanic inmates to respond. As reflected

above, Caucasians and Native Americans were over-represented in the final sample, while all other racial classifications were under-represented in the respondent population.

Response Rates

A total of 995 surveys were mailed out. Ten of the selected survey recipients were paroled before they received their surveys, reducing the number of inmates who could potentially respond to 985. A total of 430 inmates returned surveys. The overall response rate was equal to 43.2 %. I excluded nine of the returned surveys from data collection because the respondents either did not indicate their race or gender (n=2), or the respondents indicated more than one race (n=7). These exclusions lowered the response rate of useable surveys to 42.3 %.

Among the survey recipients, female inmates had a response rate of 61.6%, while their male counterparts had a response rate of 40.5%. Native American inmates had the highest response rate among racial categories (57.6%), followed by Caucasian inmates (47.6%), African American inmates (32.6%), Asian inmates (28.6%), and Hispanic inmates (28.4%).

Frequency of Inmates with Mental Illness

The number of respondents who described themselves as mentally ill, according to the stipulated criteria, was 242, or 57.5% of the survey sample. Therefore, $\mathbf{P}_{NEB} = .575$. Based on the current adult inmate population provided by the NDCS (2004a) (excluding the INS detainees at Hastings), the total number of incarcerated adults in Nebraska with mental illness is equal to ($\mathbf{P}_{NEB}$) x 3846, or approximately 2211 persons.

Associations between Gender, Race, and Mental Illness

There were no significant associations between the variables of gender and mental illness or race and mental illness among the survey sample. Cramer's V for gender and mental illness was 0.022. Cramer's V for race (5 categories) and mental illness was 0.075, while Cramer's V for race (3 categories) and mental illness was 0.074. Collapsing the racial categories from five categories into three categories did not change the level of association between the variables.

Mental Illness within race-gender categories

Among African American survey respondents (N=76), approximately 52% of males and 57% of females identified themselves as mentally ill. Among Caucasian survey

respondents (N=276), approximately 60% of males and 62% of females identified themselves as mentally ill. Asian, Hispanic, and Native American respondents were grouped together into one category, *Other*, in order to increase sample size (N=69). Among *Other* survey respondents, approximately 52% of males and 56% of females identified themselves as mentally ill.

Qualitative Data

Over twenty-seven inmates included unsolicited information along with their returned surveys. Most wrote additional material on the survey itself, giving explanations for, or clarification of, their answers to the questions. Some wrote comments in the blank space at the bottom of the questionnaire, while others enclosed an additional page or pages with their surveys (please see Appendix C for all of the responses).

Six of the inmates requested further correspondence from me, espousing the virtues of communication, especially for those who are incarcerated. Three of these asked for photographs of their future "Pen Pal". One respondent invited me, as well as the three members of my thesis committee, to a 12-Step meeting at the Correctional Center in Lincoln. Five different respondents indicated that they

would like to know the results of the study, and one inmate was interested in the response rate.

Some common themes emerged in the unsolicited responses. Several inmates noted that they took part in mental health treatment only because it is required for parole. Respondents indicated that the services, while needed, were often inadequate and inappropriate due to a lack of staff and the limited number of programs available.

A number of inmates commented about psychotropic medications. One wrote, "There (sic) answer to everything is pills," implying that medications may be over-prescribed. Another indicated that medicine may be mis-prescribed, writing, "When 5 of us are seen by the Dr. we all end up with identical prescriptions." Regarding the use of psychotropic medications, another inmate complained, "I can't aford (sic) pills on the street, so why take them? Plus people only take them to get high."

Finally, several inmates expressed thoughts about how incarceration affects people. "Prison is like death because you can't be there for those who need you," wrote one inmate. Another commented, "I hate to say this so casually, but <u>everyone</u> in prison has a mental or emotional condition. 100% of persons incarcerated suffer both

emotional and mental problems... Once Free Will is taken from a person, it's all downhill from there" (underlining in original).

Discussion

Prevalence of Mental Illness among Inmates in Nebraska

My hypothesis that the proportion of Nebraska prison inmates with mental illness would be close to the 16% reported by the BJS (Ditton, 1999) was not validated by the results of this study. Among survey respondents, a significantly higher percentage (57.5%) of inmates classified themselves as mentally ill than did the respondents in Ditton's report (1999).

One of the potential reasons for this discrepancy is that different data collection procedures were used in the two studies. The current study collected inmate responses via mail, while the BJS study used data that was gathered during face-to-face interviews. It is possible that subjects were more honest (more willing to divulge potentially embarrassing information) when their responses were collected anonymously. In the presence of an authority figure, actual or perceived, inmates may have been reticent to label themselves "mentally ill." Collecting responses by mail may generate higher prevalence rates than collecting responses by in-person interviews.

In the current study, investigative personnel were not immediately available to inmates to explain potentially

unclear terminology. As mentioned above, survey respondents were classified as "mentally ill" if they reported a current emotional or mental condition or if they reported an overnight stay in a mental hospital or treatment program. If inmates misunderstood the questions and had no one on hand to clarify them, then inmates may have been more likely to answer "yes," thus generating an inaccurately high prevalence rate.

For example, one inmate answered "yes" to survey question number one ("Do you have a mental or emotional condition?") and added, in writing, "I have an anger problem." In response to the same question, another inmate wrote, "Yes, meaning prison is like death because you can't be there for those who need you." Because of their "yes" answers, both respondents were deemed "mentally ill" for the purposes of the study.

Another potential reason for the discrepancy in the mental illness prevalence rate found in this study and that reported by Ditton (1999) is that the sample in this research study may not have been random. While the author used random selection to determine the survey recipients, the author cannot guarantee that those inmates who received surveys were the same ones who filled them out and returned

them. One inmate wrote that he didn't get the survey in the mail, but rather from another inmate.

It is possible that survey recipients redistributed their surveys to other inmates who they thought would be better suited for the topic under investigation. For example, imagine that one inmate received a survey because he or she was chosen by random selection. This inmate sees the words "mental illness" in the title of the research project and thinks, "I'm not mentally ill, but I know someone who is. I'll pass this along to him (her)."

The sample was no longer representative of the population as soon as any of the randomly selected survey recipients gave their surveys to other inmates. If inmates passed on their surveys to those who they perceived as being mentally ill, then the prevalence rate would be falsely inflated. The author has no way of knowing how many surveys were redistributed by the selected recipients.

The author also has no way of knowing whether or not certain facilities were over- or underrepresented in the respondent sample since the author did not ask respondents to identify their facilities on the surveys. It is possible that certain facilities had higher response rates than others, again altering the randomness of the sample.

It would have been interesting to compare the response rates of survey recipients within the various facilities, as well as to compare the prevalence rates of mental illness of inmates within the various facilities. These results could impact funding decisions if it was indicated that certain facilities house a higher proportion of mentally ill inmates than others.

Researchers have suggested that the harsh conditions within correctional facilities can cause individuals to develop and display symptoms of mental illness which were not apparent prior to their incarcerations (Kerle, 1998; Kupers, 1999; Meyer, 1992; Sigurdson, 2000). It is possible that inmates develop what they perceive as an emotional or mental condition due to the negative effects of incarceration. If this is true, then the rate of mental illness among a group of prisoners should become higher as the length of incarceration increases for the group.

This reasoning leads to a third potential reason for the high prevalence of mental illness among Nebraska inmates. Nebraskan inmates as a group might serve longer sentences than their counterparts nationally, giving them more time to develop symptoms of mental illness. According to the Nebraska DCS website (2004b), the average length of

stay for an inmate in Nebraska is 25.5 months, well below the national average of 30.6 months. Therefore, length of stay does not seem to be a factor in the elevated rate of mental illness among Nebraskan inmates.

A fourth possible reason for the higher prevalence of mental illness among Nebraska prison inmates is that this state locks up a higher percentage of its mentally ill citizens than does other states. During the fiscal year 2001, Nebraska was ranked fortieth out of fifty states on a measure of total mental health dollars spent. The state ranked slightly lower (forty-second) when per-capita expenditures were measured (National Mental Health Information Center, n.d.). By failing to provide adequate funding for community mental health services, Nebraska has made its prisons and jails the de facto primary psychiatric treatment centers.

Associations between Gender, Race, and Mental Illness

My hypotheses that there would be associations between gender and mental illness were neither supported nor invalidated by the results of this study. The number of females in the sample (S=53) is too small to adequately represent the population of females (N=354) incarcerated in Nebraska prisons (Krejcie & Morgan, 1970). I was unable to

determine whether being a female (of any race) increased the likelihood of being mentally ill or to determine whether being a Caucasian female (S=37) increased this likelihood even more.

My hypothesis that there would be no other associations between the variables of gender, race and mental illness was neither supported nor invalidated by survey results. Again, the small sample sizes of several racial categories make statistical findings insignificant. Even when the five racial categories were collapsed into three categories (African American, Caucasian, and Other), the sample size of the *Other* category was still too small to be representative of the population. While the respondent demographics approximated the inmate demographics, the sample sizes were insufficient to adequately represent each racial and gender stratum (Krejcie & Morgan, 1970).

Methodological Considerations

"[E]pidemiological studies of mental disorders have come to rely on investigative methods that fall short of approximating the professional diagnostic process" (Pallone, 1991, p. 16). In research whose purpose is to plan treatment facilities and services, the importance has

often been placed on identifying those persons within the population who suffer from *any* mental disorder, rather than trying to pinpoint the prevalence of specific disorders through differential diagnoses.

This methodology, called a "gross screen" by Pallone (1991, p. 18), includes the standard epidemiological technique of "subject self-reports in response to an interview schedule administered by non-clinicians" (p.46). He argues that direct examination of subjects by mental health professionals utilizing reliable and valid scientific instruments would yield mental disorder ratios in the correctional population much higher than the median figure of 19%.

Utilizing professional mental health practitioners to conduct full-scale diagnostic interviews would be too labor-intensive and cost-prohibitive for this study. It also presents security issues for both the mental health practitioners and the correctional facilities. These factors led this investigator to utilize the self-report survey items based on the questions used in Ditton's 1999 BJS Special Report.

Limitations of Survey Questions

In Ditton's report (1999) and in this study, inmates were considered to be mentally ill if they answered yes to either of the following two questions:

1) "Do you have a mental or emotional condition?"
2) "Because of an emotional or mental problem, have you ever been admitted to a mental hospital, unit, or treatment program where you stayed overnight?"

This investigator found several problems with these questions.

The first question ("Do you have a mental or emotional condition?") may be measuring something other than mental illness. Based on some of the unsolicited responses, it appears that inmates interpreted *emotional condition* in a variety of ways. For instance, one inmate wrote, "I have an anger problem," and answered "yes" to question number one. Another inmate commented, "Everyone in prison has a mental or emotional condition..." When the terms *emotional condition* are understood in the common vernacular, rather than in professional terminology, more people will answer "yes" to question number one.

Additionally, persons with conditions that affect their mental status, such as developmental disorders,

learning disabilities, substance-induced brain damage, or head injuries, would most likely report that they have a mental condition. However, their *mental condition* is not necessarily synonymous with mental illness.

The second question ("Because of an emotional or mental problem, have you ever been admitted to a mental hospital, unit, or treatment program where you stayed overnight?") was included as a measure of mental illness "to take into account underreporting of current mental or emotional problems" (Ditton, 1999, p. 2). Including this measure makes several assumptions that may or may not be true.

First, this measure assumes that persons are only admitted to mental hospitals because they have a mental illness. All fifty states allow for the involuntary commitment of persons to mental health facilities for behavior that deems them dangerous to themselves or others, when they fail to provide for their basic needs, such as food, clothing, or shelter, or when they fail to seek or avail themselves of treatment for a life-threatening medical condition. Persons falsely accused of such behavior, such as those involved in acrimonious divorces or custody disputes, may be held (minimally) overnight until

they can be seen and evaluated by a mental health practitioner (Treatment Advocacy Center, n.d.[b]).

Second, this measure assumes that once a person is mentally ill, then he or she is always mentally ill. Research shows that persons can and do recover from certain mental illnesses, especially adjustment disorders and situational depressive disorders (American Psychiatric Association, 2000). An inmate who answered "yes" to the second question might have been admitted to a psychiatric facility in the past, even as a child, and is no longer suffering from a mental or emotional condition. Including past admissions may falsely elevate prevalence rates, especially when research personnel are not immediately available to clarify responses.

Limitations of Survey Methodology

There are several drawbacks to using written surveys as tools for data collection. Beyond the fact that research personnel are not available to clarify terminology and/or answer questions for the recipients, there are several additional concerns. First, and most obviously, recipients who are illiterate are unable to read the survey. Second, like the illiterate recipients, non-English speaking recipients are unable to read the survey.

Finally, some recipients may be able to read, but not at an educational level high enough to comprehend the survey questions without clarification. These limitations could be particularly relevant to the minority survey recipients in the inmate population.

Recommendations for Policy

The results of this study indicate that over half of adult inmates in Nebraska suffer from mental illness. According to the Nebraska Department of Correctional Services (NDCS) website, a total of 48.5 mental health staff is employed to serve the entire adult inmate population.

> In addition to the Director of Mental Health, there are 7 Clinical Psychologists and 4 Psychologist Associates. There are 29.5 Masters Level Practitioner positions, and 6 clerical and 1 administrative support staff who serve the 10 Nebraska Department of Correctional Services institutions. On a monthly basis, Mental Health staff provides services to approximately 50% of their respective institution's inmates from Nebraska's 93 counties, as well as those inmates placed in the care of the NDCS through interstate transfers. The Mental Health Department

> makes services available to all inmates, either upon their request or staff referral. (NDCS, 2004b)

If the Director of Mental Health, as well as the clerical and support staff, is excluded from the number of mental health staff providing treatment, then there are approximately forty mental health treatment practitioners available to serve the 2,211 inmates who identified themselves as mentally ill in this study. These numbers result in a staff to inmate ratio of approximately one to fifty-five. An obvious policy recommendation for the state of Nebraska would be to increase funding to the Department of Correctional Services (DCS) so it can hire additional mental health practitioners and offer additional treatment services to its mentally ill inmates. The Nebraska DCS must have adequate financial resources to offer to mentally ill inmates treatment services that meet national minimal standards of care.

Minimal standards of care for mental health treatment services within correctional facilities were established in 1980, following a class action lawsuit in Texas. These nationwide standards are as follows: 1) a systematic screening process; 2) treatment that entails more than segregation and supervision (i.e., personnel do more than

separate and watch); 3) treatment that involves an adequate number of mental health professionals to provide services for all eligible inmates; 4) clinical records that are adequate and confidential; 5) treatment that includes a program for identifying and treating suicidal inmates; and 6) a system for the accurate monitoring of those inmates who are prescribed potentially dangerous medications (Kupers, 1999).

These standards are only a minimum and many prison systems still fail to provide quality care to the large number of inmates in need of psychiatric treatment. "Too little attention is given to identifying mentally disturbed inmates. There is a deplorable lack of access to inpatient facilities, and there are huge gaps in terms of 'intermediate levels of care'" (Kupers, 1999, p. 67).

A comprehensive mental health program within a correctional facility should include the following components: 1) Crisis intervention programs, with infirmary beds available for short term treatment (less than ten days); 2) Acute care programs; 3) A chronic care program or special needs unit (unit within the general prison population which houses chronically mentally ill that require a therapeutic milieu, but not psychiatric inpatient

treatment); 4) Outpatient treatment services; 5) Consultation services (consulting with the prison's management and/or providing training to corrections personnel); and 6) Discharge/transfer planning that provides services for inmates who are being transferred to another facility or discharged into the community (Metzner et al., 1998).

A second policy recommendation for the Nebraska DCS is to eliminate the gaps and overlaps in the delivery of mental health and substance abuse treatment services within the state prison system. Currently, mental health services and substance abuse services are considered to be separate programs within the Nebraska DCS (NDCS, 2004b). Research indicates that almost thirty percent of persons with a mental illness have a coexisting substance use disorder (National Mental Health Association, 2004). It would make sense, both in terms of cost-savings for the DCS and treatment efficacy for the inmates, to combine the two service branches. The utilization of treatment programs for dually diagnosed inmates should be integrated into the DCS.

A third policy recommendation for the state of Nebraska is for the legislature to supply more state mental

health funds to the correctional system. Based on the results of this study, it appears that a large proportion of Nebraska's incarcerated adult prisoners are mentally ill. The mental health dollars allocated for these citizens should follow them out of the community and into the criminal justice system, if we expect the criminal justice system to provide treatment for them.

Suggestions for Future Research

Given the dramatic difference in mental illness prevalence rates between Ditton's (1999) results and the results of this survey, it would be advantageous to duplicate the SISCF survey, utilizing the face-to-face interviews, in Nebraska's prisons. This would determine whether the 57.5 % rate of mental illness found in this study is an artifact of research methodology or a true reflection of the number of incarcerated mentally ill offenders in Nebraska.

To determine current rates of mental illness in Nebraska's prisons, research could be conducted that separates inmates according to whether they answered "yes" to survey question #1, survey question #3, or both. This would enable researchers to determine form the data if the inmates classified as mentally ill have a *current* emotional

or mental condition, *had* a condition in the past, or *had and still have* an emotional or mental condition. Unfortunately, this investigator did not record the data separately and destroyed the original surveys.

Regarding this written survey, research could be conducted in Nebraska's DCS that is related to literacy and English-competency rates. Within race-gender cohorts, it could be determined whether or not response rates were impacted by inmates' ability to read, in general, and their ability to read English, in particular. Survey response rates, as well as survey responses, could be impacted by inmates' ability to comprehend English, as measured by years of schooling. Also, with regard to race-gender cohorts, it could be determined whether or not cultural differences influence response rates and/or answers to survey questions. Researchers could examine how different cultural groups define mental illness and/or how different cultural groups define treatment services.

Another suggestion for future research in Nebraska is to increase the number of female and minority inmates sampled so that the data collected would be an accurate representation of the population strata. Increasing the sample size of female and minority inmates would enable any

relationships found between the variables of mental illness, race, and/or gender to be statistically significant, rather than mere depictions of individual differences.

Within Nebraska's DCS, research could be collected for prevalence rates of mental illness among each facility. Once facility prevalence rates are established, these rates could be compared to the number of mental health staff working at each facility, as well as to the amount of mental health treatment services provided at each facility. This data would enable researchers to assess potential relationships between prevalence rates and treatment services.

With regard to treatment services, researchers should develop evidence-based strategies to test the efficacy of existing mental health and substance abuse programs within Nebraska's DCS. Additionally, researchers should examine success rates of current dual-diagnosis treatment services being utilized in any other criminal justice facilities to assess the possibility of implementing these programs in Nebraska prisons. Finally, research should be done on alternative treatment models, such as community mental-health sponsors for inmates identified as being mentally

ill, and the introduction of advocacy, education, and support groups, such as National Alliance for the Mentally Ill (NAMI) into criminal justice facilities.

Nebraska is a state that consists of many rural areas. As of January, 2002, twenty-eight counties were without any licensed mental health practitioners in their communities (Nebraska Health & Human Services System, 2002). Therefore, another research suggestion for Nebraska is to determine if a relationship exists between the number of mental health workers in each county and the number of mentally ill incarcerated offenders with residence in that county.

In counties without mental health workers, local law enforcement personnel are often the first responders to individuals in mental health crises. These professionals determine whether a person enters the mental health system or the criminal justice system. A suggestion for research in Nebraska is to examine the educational training on mental illness that is currently provided to Nebraska's local law enforcement personnel. Besides evaluating the adequacy and appropriateness of the training itself, comparisons could be made between the amount of training provided to law enforcement personnel in each county and

the number of mentally ill incarcerated offenders from that county.

Research on incarcerated offenders is complicated by the difficulty of defining and measuring the construct of mental illness. The variations among existing research clearly demonstrate that differing definitions of mental illness, as well as different means of measuring it, will produce a wide range of results regarding the prevalence of mentally ill inmates among incarcerated offenders. Locally, and nationally, mental health professionals should work with research experts to develop reliable, valid, user-friendly, and inexpensive tools so that correctional personnel can accurately measure the number of mentally ill inmates confined within their facilities at any one time.

Some specific suggestions for larger-scale, national research are as follows: 1) Compare, on a state-by-state basis, the number of incarcerated mentally ill citizens to per-capita expenditures on community mental health services; 2)Develop evidence-based strategies to test the efficacy of current mental health and substance abuse treatment programs within the criminal justice system on state and local levels; 3)Examine existing mental health court models and compare effectiveness between the various

models; and 4) Conduct research that examines the deleterious effects of incarceration that may cause a previously non-ill inmate to develop a mental disorder.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Barr, H. (2002). Prisons and jails: hospitals of last resort; the need for diversion and discharge planning for incarcerated people with mental illness in New York [Electronic version]. Monograph published by the Open Society Institute of New York. Retrieved September 15, 2002, from http://www.soros.crime/MIRep main.htm.

Bonczar, T. P. (August, 2003). Prevalence of imprisonment in the U.S. population, 1974-2001. *Bureau of Justice Statistics Special Report, NCJ 197976*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Bureau of Justice Statistics (BJS). (July, 1999). The survey of inmates in state correctional facilities, 1997 [Electronic version]. Representation of the computerized questionnaire. Retrieved April 10, 2004, from http://www.ojp.usdoj.gov/bjs/pub/pdf/ sisfcfq.pdf.

Bureau of Justice Statistics (BJS). (November, 2000). Correctional populations in the United States, 1997; Section 4: Surveys of state and federal inmates, 1997 [Electronic version]. Retrieved April 10, 2004, from http;//www.ojp.usdoj.gov/bjs/pub/pdf/cpus9704.pdf.

Chaiken, J. (2000). Correctional populations in the United States, 1997. *Bureau of Justice Statistics Special Report, NCJ 177613*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Ditton, P. M. (1999). Mental health and treatment of inmates and probationers. *Bureau of Justice Statistics Special Report, NCJ 174463*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Dvoskin, J.A., & Patterson, R.F. (1998). Administration of treatment programs. In R.M. Wettstein (Ed.), *Treatment of offenders with mental disorders* (pp. 1-43). New York: The Guilford Press.

Goldcamp, J.S., & Irons-Guynn, C. (2000). Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage [Electronic version]. *Crime and Justice Research Institute*

Monograph, NCJ 182504. Washington, DC: United States Government Printing Office.

Gondles, J. A., Jr. (2000). Special needs offenders—Everyone's concern [Electronic version]. *Corrections Today, 62*(7), 6.

Greenfeld, L. A., & Henneberg, M.A. (2001), Victim and offender self-reports of alcohol involvement in crime. *Alcohol Research and Health, 25* (1), 20-31.

Greenfeld, L.A., & Smith, S. K. (1999). American Indians and crime. *Bureau of Justice Statistics Special Report, NCJ 173386*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Guy, E., Platt, J.J., Zwerling, I., & Bullock, S. (1985). Mental health status of prisoners in an urban jail. *Criminal Justice & Behavior, 12*(1), 29-53.

Hafemeister, T.L. (1998). Legal aspects of the treatment of offenders with mental disorders. In R. M. Wettstein (Ed.), *Treatment of offenders with mental disorders*, 44-125. New York: The Guilford Press.

Harlow, C.W. (1999). Prior abuse reported by inmates and probationers. *Bureau of Justice Statistics Special Report, NCJ 172879*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Harlow, C.W. (2000). Defense counsel in criminal cases. *Bureau of Justice Statistics Special Report, NCJ 179023*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Harlow, C. W. (2001). Firearm use by offenders. *Bureau of Justice Statistics Special Report, NCJ 189369*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Harlow, C.W. (2003). Education and correctional populations. *Bureau of Justice Statistics Special Report, NCJ 195670*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Jones, G., & Connelly, M. (2002). Mentally ill offenders and mental health care issues: An overview of the research. *Maryland State Commission on Criminal Sentencing Policy*. Retrieved December 31, 2002, from: http://www.msccsp.org/publications/mental.html.

Kerle, K.E. (1998). *American jails: Looking to the future*. Boston: Butterworth-Heinemann.

Krejcie, R.V., & Morgan, D.W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement, 30*, 607-610.

Kupers, T.A. (1999). *Prison madness: The mental health crisis behind bars and what we must do about it*. San Francisco: Jossey-Bass Publishers.

Maruschak, L. M. (1999a). DWI offenders under correctional supervision. *Bureau of Justice Statistics Special Report, NCJ 172212*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Maruschak, L.M. (1999b). HIV in prisons, 1997. *Bureau of Justice Statistics Special Report, NCJ 178284*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Maruschak, L.M., & Beck, A.J. (2001). Medical problems of inmates, 1997. *Bureau of Justice Statistics Special Report, NCJ 181644*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Maue, F.R. (2001). An overview of correctional mental health issues [Electronic version]. *Corrections Today, 63*(5), 8.

Metzner, J., Cohen, F., Grossman, L.S., & Wettstein, R.M. (1998). Treatment in jails and prisons. In R. M. Wettstein (Ed.), *Treatment of offenders with mental disorders*, 211-264. New York: The Guilford Press.

Meyer, R.G. (1992). *Abnormal behavior and the criminal justice system*. New York: Lexington Books.

Mumola, C. J. (2000a). Veterans in prison or jail. *Bureau of Justice Statistics Special Report, NCJ 178888*. Washington, DC: United States Department of Justice, Office of Justice Programs.

Mumola, C. J. (2000b) Incarcerated parents and their children. *Bureau of Justice Statistics Special Report, NCJ 182335*. Washington, DC: United States Department of Justice, Office of Justice Programs.

National Mental Health Information Center. (n.d.). *State mental health agency, mental health actual dollar & per capita expenditures, 2001*. Retrieved February 18, 2004, from http://www.mentalhealth.org/databases/databases_exe.asp?D1=DC&Type=PC&Myassign=list.

National Mental Health Association. (2004). *Substance abuse - dual diagnosis fact sheet* [Electronic version]. Retrieved May 21, 2004, from http://www.nmha.org/infoctr/factsheets/03.cfm.

Nebraska Department of Correctional Services (NDCS). (2004a). *Inmate population*. Retrieved January 25, 2004, from http://www.corrections.state.ne.us/statistics/inmate.html.

Nebraska Department of Correctional Services (NDCS). (2004b). *Institutions/Programs*. Retrieved May 23, 2004, from http://www.corrections.state.ne.us/statistics/programs.html.

Nebraska Health and Human Services System. (2002). Map of licenses per county. Retrieved September 30, 2004, from http://www.hhs.state.ne.us/crl/mhcs/mental/map.pdf.

Pallone, N. J. (1991). *Mental disorders among prisoners: Toward an epidemiologic inventory*. New Brunswick, CT: Transaction Publishers.

Sigurdson, C. (2000). The mad, the bad, and the abandoned: The mentally ill in prisons and jails [Electronic version]. *Corrections Today, 62*(7), 70-78.

Stahl, E., & West, M. (2001). Growing population of mentally ill offenders redefines correctional facility design [Electronic version]. *Corrections Today, 63*(5), 72-74.

Steadman, H.J., Fabisiak, S., Dvoskin, J., & Holohean, E.J. (1987). A survey of mental disability among state prison inmates. *Hospital and Community Psychiatry, 38*, 1086-1090.

Substance Abuse and Mental Health Services Administration. (2002). Results from the 2001 National Household Survey on Drug Abuse: Volume I. Summary of National Findings (DHHS Publication No. SMA 02-3758, NHSDA Series H-17). Rockville, MD: Author, Office of Applied Studies.

Taylor, E.R. (2001). Using algorithms and protocols in diagnosing and treating offenders with mental health disorders [Electronic version]. *Corrections Today, 63*(4), 80-84.

Teplin, L. A. (1990). The prevalence of severe mental disorder among urban jail detainees: Comparison with the epidemiologic catchment area program. *American Journal of Public Health, 80,* 663-669.

Treatment Advocacy Center. (n.d.[a]). Fact sheet: Criminalization of Americans with severe mental illness [Electronic version]. Retrieved September 25, 2002, from http://www.psychlaws.org/GeneralResources/Fact3.htm.

Treatment Advocacy Center. (n.d.[b]). Standards for assisted treatment: State by state summary [Electronic version]. Retrieved, April 20, 2004, from http://www.psychlaws.org/LegalResources/state-chart.htm.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders [Electronic version]. *Psychiatric Services, 52*(4), 477-481.

Wilkinson, R.A. (2002, June 1). Written testimony on the criminal justice system and mentally ill offenders, submitted to the United States Judiciary Committee Hearing. Retrieved December 31, 2002, from: http://www.drc.state.oh.us/web/Articles/article71.htm.

Wright, D. (2003). *State Estimates of Substance Use from the 2001 National Household Survey on Drug Abuse: Volume I. Findings* (DHHS Publication No. SMA 03-3775, NHSDA Series H-19). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Appendix A

Bureau of Justice Statistics Special Report Survey Items:

Survey items used to measure mental illness

Do you have a mental or emotional condition?
(prison and jail inmates only)

[ ] Yes [ ] No

Have you ever been told by a mental health professional such as a psychiatrist, psychologist, social worker, or psychiatric nurse, that you had a mental or emotional disorder? *(probationers only)* *

[ ] Yes [ ] No

Because of an emotional or mental problem, have you ever—

Taken a medication prescribed by a psychiatrist or other doctor?

[ ] Yes [ ] No

Been admitted to a mental hospital, unit or treatment program where you stayed overnight?

[ ] Yes [ ] No

Received counseling or therapy from a trained professional? **

[ ] Yes [ ] No

Received any other mental health services?

[ ] Yes [ ] No

(Ditton, 1999, p.2)

*This question was not included in my survey items because I did not distribute any surveys to probationers.

**This question was modified in my survey items because the author of the BJS report (Ditton, 1999) wrote, "Respondents were asked...whether they had ever received treatment for a mental or emotional problem, *other than treatment related to drug or alcohol abuse*" (p. 2, italics added).

Appendix B: Descriptive Statistics

Table B.1. Frequency table for gender of survey respondents

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	368	87.4	87.4	87.4
	Female	53	12.6	12.6	100.0
	Total	421	100.0	100.0	

Table B.2. Frequency table for race (five categories) of survey respondents

Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	African American	76	18.1	18.1	18.1
	Asian	2	.5	.5	18.5
	Caucasian	276	65.6	65.6	84.1
	Hispanic	33	7.8	7.8	91.9
	Native American	34	8.1	8.1	100.0
	Total	421	100.0	100.0	

Table B.3. Frequency table for race (three categories) of survey respondents

Race Collapsed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	African American	76	18.1	18.1	18.1
	Caucasian	276	65.6	65.6	83.6
	Other	69	16.4	16.4	100.0
	Total	421	100.0	100.0	

Table B.4. Frequency table for mental illness of survey respondents

Mental Illness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Absent	179	42.5	42.5	42.5
	Present	242	57.5	57.5	100.0
	Total	421	100.0	100.0	

Table B.5.1. Crosstabulation of mental illness and gender

Mental Illness * Gender Crosstabulation

			Gender		
			Male	Female	Total
Mental Illness	Absent	Count	158	21	179
		% within Gender	42.9%	39.6%	42.5%
	Present	Count	210	32	242
		% within Gender	57.1%	60.4%	57.5%
Total		Count	368	53	421
		% within Gender	100.0%	100.0%	100.0%

Table B.5.2. Measures of association between mental illness and gender

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.022	.648
	Cramer's V	.022	.648
N of Valid Cases		421	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Table B.6.1. Crosstabulation of mental illness and race (5 categories)

Mental Illness * Race Crosstabulation

			Race					
			African American	Asian	Caucasian	Hispanic	Native American	Total
Mental Illness	Absent	Count	36	1	110	16	16	179
		% within Race	47.4%	50.0%	39.9%	48.5%	47.1%	42.5%
	Present	Count	40	1	166	17	18	242
		% within Race	52.6%	50.0%	60.1%	51.5%	52.9%	57.5%
Total		Count	76	2	276	33	34	421
		% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table B.6.2. Measures of association between mental illness and race (5 categories)

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.075	.672
	Cramer's V	.075	.672
N of Valid Cases		421	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Table B.7.1. Crosstabulation of mental illness and race (3 categories)

Mental Illness * Race Collapsed Crosstabulation

			Race Collapsed			
			African American	Caucasian	Other	Total
Mental Illness	Absent	Count	36	110	33	179
		% within Race Collapsed	47.4%	39.9%	47.8%	42.5%
	Present	Count	40	166	36	242
		% within Race Collapsed	52.6%	60.1%	52.2%	57.5%
Total		Count	76	276	69	421
		% within Race Collapsed	100.0%	100.0%	100.0%	100.0%

Table B.7.2. Measures of association between mental illness and race (3 categories)

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.074	.312
	Cramer's V	.074	.312
N of Valid Cases		421	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Table B.8. Crosstabulation of gender, mental illness, and race (5 categories)

Mental Illness * Race * Gender Crosstabulation

Gender				Race					Total
				African American	Asian	Caucasian	Hispanic	Native American	
Male	Mental Illness	Absent	Count	33	1	96	16	12	158
			% within Race	47.8%	100.0%	40.2%	53.3%	41.4%	42.9%
		Present	Count	36		143	14	17	210
			% within Race	52.2%		59.8%	46.7%	58.6%	57.1%
	Total		Count	69	1	239	30	29	368
			% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Female	Mental Illness	Absent	Count	3		14		4	21
			% within Race	42.9%		37.8%		80.0%	39.6%
		Present	Count	4	1	23	3	1	32
			% within Race	57.1%	100.0%	62.2%	100.0%	20.0%	60.4%
	Total		Count	7	1	37	3	5	53
			% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table B.8.1. Measures of association within gender of mental illness and race (5 categories)

Symmetric Measures

Gender			Value	Approx. Sig.
Male	Nominal by Nominal	Phi	.106	.392
		Cramer's V	.106	.392
	N of Valid Cases		368	
Female	Nominal by Nominal	Phi	.340	.191
		Cramer's V	.340	.191
	N of Valid Cases		53	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Table B.9. Crosstabulation of gender, mental illness, and race (3 categories)

Mental Illness * Race Collapsed * Gender Crosstabulation

Gender				Race Collapsed			
				African American	Caucasian	Other	Total
Male	Mental Illness	Absent	Count	33	96	29	158
			% within Race Collapsed	47.8%	40.2%	48.3%	42.9%
		Present	Count	36	143	31	210
			% within Race Collapsed	52.2%	59.8%	51.7%	57.1%
	Total		Count	69	239	60	368
			% within Race Collapsed	100.0%	100.0%	100.0%	100.0%
Female	Mental Illness	Absent	Count	3	14	4	21
			% within Race Collapsed	42.9%	37.8%	44.4%	39.6%
		Present	Count	4	23	5	32
			% within Race Collapsed	57.1%	62.2%	55.6%	60.4%
	Total		Count	7	37	9	53
			% within Race Collapsed	100.0%	100.0%	100.0%	100.0%

Table B.9.1. Measures of association within gender of mental illness and race (3 categories)

Symmetric Measures

Gender			Value	Approx. Sig.
Male	Nominal by Nominal	Phi	.076	.344
		Cramer's V	.076	.344
	N of Valid Cases		368	
Female	Nominal by Nominal	Phi	.056	.920
		Cramer's V	.056	.920
	N of Valid Cases		53	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Appendix C: Qualitative Data

Unsolicited Responses from Survey Respondents:

The following were written on surveys themselves or on attached pages sent to the investigator (individual responses are separated by bullets):

- "I take mental health counseling due to my incarceration. It is a requirement for eligibility for parole for 90% of all inmates."
- "The counseling was inappropriate to the situation."
- "Your study is very much needed in the Department of Correction. Most inmates achieve the goal of completing mental health only because most inmates are forced to attend and complete the mental health program for parole. Correctional mental health program is not a voluntary program for inmates. The program is used by the Department of Correction to gain government funds, not as a means to help inmates. The Department of Correctional Mental Health Program do (sic) not help inmates. The program do (sic) not consist of any mental growth, no pondering of thoughts, no inspiration of succeeding, no power that can reverse the fortunes of mental state, no teaching

in any form to help a person prevent recidivism. The Department of Correctional version of Mental Health Program simply do (sic) not help inmates and do (sic) not help inmates prepare for inovation (sic) back into the social community. I attended the Mental Health Program and did not receive any mental progress from the program."

- "[I]n prison one can only find help from within because the mental health staff isn't truly qualified or constant enough to truly see or help anyone."
- "Incarcerated felons cannot send mail without their name on the return address--I doubt you get many back. Sorry."
- "I received therapy counseling for a mental dysfunction from 92-95. Now because I admitted I needed help back then I've become a victim of the judicial system. I was married, living a normal life when I was falsely accused."
- "I need help and would like to talk to someone about my problems."
- "Medication is not controlled by a physician after the initial rx [prescription]. Any need to adjust a

medication (or stop) must wait for up to 4 months to be seen again by the psychiatrist. There is no therapy in hope of reducing medication, the reductions are just made. Non medical staff (case managers) do (sic) ask questions about medications and therefore must be influenced by the information."

- "Most programs in prison are shut down, but Administration claim (sic) to have many programs. No self-help groups (AA, NA, Relapse Prevention, Religious-Church). Main goal of administration is to house only."
- "There are no mental health programs for seg [solitary confinement] inmates. The control units don't allow them. All mental health do (sic) is stop by and ask me if I feel like hurting myself, am I suicidal, am I eating, sleeping? That's all!"
- "My mental condition is depression. I take Zoloft, Prozac, Ritalin, and Paxil."
- "This is my second incarceration for theft, forgery related crimes. I'm sure mental illness is a 'huge' part of that! (Not to mention stupidity!)"

- "Please include in your thesis that we as an inmate population have very little access to any mental health treatment or programs and when 5 of us are seen by the Dr. we all end up with identical prescriptions."
- "I am a drug addict."
- "I'm not ashamed of the way I aim (sic)--I'm getting help."
- "Mental health classes here are bull sh--, they don't do anythig (sic), and there (sic) anser (sic) to everything (sic) is pills. I can't aford (sic) pills on the street, so why take them? Plus people only take them to get high."
- "Prison is like death because you can't be there for those who need you."
- "I hate to say this so casually, but <u>everyone</u> in prison has a mental or emotional condition. 100% of persons incarcerated suffer both emotional and mental problems. after (sic) a certain amount of time in prison, some of these problems become irreversible. Once Free Will is taken from a human being, it's all downhill from there."

- "These are very 'wide open' questions that will produce the stats I'm sure your (sic) asking for. I mean, you wanted me to answer "Yes" anyway, right? I make race cars out of my poopie everyday. Does that make me crazy?"
- "I have an anger problem."
- "This wasn't sent to me, but someone else. I hope its (sic) okay that I filled it out."
- "Blow me and don't bother me again with this sh--."
- "I think you need money for vocational school, not more shrinks. I don't believe medicating a problem helps. It makes the problem worse. People get so medicated in here that they don't know what's going on. I think the shrinks are full of sh--. Hope this helps: train them to do something, don't sedate them."
- "They have a program here but its (sic) an all for one class. When you are in here for what I am and have to talk about your crime its (sic) not good."
- "Thank you for wasting my time. My time is valuable. Please send girls, dope, or money and I'll participate."