

STUDY REVEALS THAT MORE

BY MICHAEL P. MALONEY, MICHAEL P. WARD AND
CHARLES M. JACKSON

According to the Bureau of Justice Statistics, local jails housed an estimated average daily population of 567,079 inmates as of mid-1997. This represented a 92 percent increase since 1987 (population 295,873). The trend continues as reflected in an increase in an average daily population of 9.4 percent in the single year from mid-1996 (population 518,492) to mid-1997. During the decade from 1985 to 1995, the number of jail inmates per 100,000 U.S. residents nearly doubled on a per capita basis from 108 to 193 — a 79 percent increase.

While data clearly indicate an ongoing increase in the number of people incarcerated in county jails, the number of these individuals who suffer from a significant mental disturbance remains unclear. Different studies on this issue result in very different estimates. The National Alliance for the Mentally Ill and the Public Citizen's Health Research Group sponsored a frequently cited survey conducted by E. Fuller Torrey titled *Criminalizing the Mentally Ill*. This study concluded that more than one in every 14 jail inmates, or 7 percent, suffered from serious mental illness. Based on a cursory review of the literature, it is clear that there is a steady increase in the number of

inmates with mental disorders detained in county jails. However, there are little data regarding exact prevalence and the specific characteristics of these inmates. Such data are essential before questions regarding program development, appropriate treatment and disposition can be addressed.

PROVIDING MENTAL HEALTH CARE

All jails have a constitutional mandate to provide at least minimum mental health or psychiatric care to detainees. Most jail systems are ill-equipped to provide such services, with many inmates receiving little or no treatment or experiencing long delays in the delivery of even minimal services. Further, while jail treatment is mandated, the exact nature and extent of such services is not legally clarified. Professional and accrediting bodies have attempted to provide relevant guidelines. The American Psychiatric Association, the National Commission on Correctional Health Care and the American Correctional Association generally agree that what constitutes minimum care would include some form of inmate screening and resultant identification of those with significant mental disorders. Treatment would include a range of care options that incorporates crisis intervention, ongoing psychiatric treatment (with the use of psychotropic medication when indicated), as well as availability of appropriately trained mental health staff and an ongoing staff training program.

Provision of even minimal treatment for jail inmates with mental illnesses can be a vexing problem that is extremely costly. In many cases, the availability of mental health services in the community has decreased and jails are basically used as an adjunct to the mental health system. This problem has developed insidiously over time, and services, when they are provided, have been offered on a hit-or-miss basis. Thus, the need for mental health treatment in jails appears to be growing, but the response has been limited and frequently ineffective. Contributing to the problem, and thwarting solutions, is a sometimes confusing array of data regarding such basic factors as the actual prevalence of mental disorders in jails, the types of mental disorders most often encountered and demographic characteristics of specific inmate populations.

The current study sought to provide relevant data regarding the prevalence of mental illness in a large county jail population. Because of a number of unique logistical features and the sheer volume of inmates, the Los Angeles County jail system provides an ideal, albeit complicated, arena for conducting such an investigation.

JAIL BOOKING OPERATIONS

The L.A. County jail system is comprised of eight separate detention facilities with an average daily census approaching 20,000. All new inmate bookings take place in the inmate reception center, which is located in the Twin Towers Correctional Facility in the general downtown area of Los Angeles. The center is the largest inmate booking operation in the United States, processing an average of slightly more than 500 inmates daily (84 percent male and 16 percent female). There are little data available regarding specific population characteristics of county jail inmates that would be pertinent to the identification and treatment of mental disorders. Collecting such data is extremely difficult since large local detention facilities are confronted with the task of processing huge numbers

of inmates in a timely fashion. In addition to the need for basic screening and classification, as well as the need to keep the sexes segregated, immediate assignment of inmates to appropriate housing is also necessary. The entire process usually takes place in the span of several hours. Consequently, the "window of opportunity" for data collection is extremely limited.

DATA COLLECTION

In 1998, the reception center processed 175,158 inmates (148,004 males and 27,154 females), with an average of 480 per day. The actual number of inmates booked in a 24-hour period varies greatly, depending on the day of the week. For example, the average number of bookings on weekend days is low (Saturday=89.3; Sunday=99.4), while early weekdays are quite high (Monday=754.7; Tuesday=714.9). The range is extreme with a low number of bookings of 36 and a high of 1,093. Such a high-volume operation presents a significant problem in terms of obtaining a representative sample for purposes of developing an appropriate "base rate" for clinical planning (mental health and custody staffing, screening, treatment and housing).

Data collection, which included a clinical interview and administration of screening tests, was conducted by two senior psychologists and a post-doctoral fellow with a combined clinical experience of more than 50 years and took from approximately 35 minutes to an hour per inmate. Data collection must be done in such a way that it does not result in security risks and, more important, it does not interfere with custody operations. This became the most critical factor in sampling design.

As a result of reception center logistics, a decision was made to employ a modified stratified time sampling approach. Reception center operations were broken down into days of the week (by number of inmates seen) and different shifts (time of day). An attempt was made to obtain a sample that would proportionately represent the flow of inmates being booked. The point of subject selection (booking front) occurred immediately after the inmate was searched and before being sent to the large booking or classification cells. The possibility of contamination (influence from other inmates) was considered minimal at this point. Sampling was conducted during all days of the week and during all time shifts. Data collection was conducted over an eight-month period (September 1998 through April 1999). It is believed that this sample procedure conducted during a significant number of months combined with a large sample size (N=1,000) effectively eliminated any significant systematic bias in the process of subject selection.

Each inmate was informed that participation was voluntary and anonymous and that it would have no anticipated effect on any ongoing legal involvement (e.g., anticipated trial, etc.). The overall sample consisted of 1,000 inmates. No attempt was made to convince inmates to be involved. Mental health risk data were obtained on 170 of the women (88 percent) and on 738 of the men (92 percent). Sufficient data for the present analysis were obtained on 908 subjects. Subjects not included in this analysis were limited to those who were unable to speak English with sufficient fluency for interview purposes (54 subjects eliminated), those who refused to be interviewed or were unresponsive (N=20), and people who

were under the influence, in severe withdrawal or removed by custody for security reasons (N=18).

The sample breaks down into 194 females ages 18 to 55 (mean age=33.51, standard deviation=8.54) and 806 males ages 15 to 75 (mean age=33.64, standard deviation=10.63). Of the sample, 25.6 percent were 25 or younger and nearly 77 percent were 40 or younger. None of the women were older than 55, but 2.5 percent of the men were 56 to 75. The sample included four juveniles, all males, three of whom were being tried as adults after previously being determined unfit by the juvenile court. The sample also included one blind inmate (male) and one deaf inmate (female).

SCREENING FOR MENTAL DISORDERS

As set forth by the American Psychiatric Association, identification of people in need of mental health treatment in jails can be seen as a three-step process that first involves routine and universal screening at the time of booking. Second, people identified at this initial screening as having a sufficiently high probability of suffering a serious mental illness are seen for a more in-depth mental health assessment. Finally, if deemed necessary, a full-scale psychiatric or psychological examination is conducted.

Screening is the critical starting point in this process. As stressed earlier, in an operation such as the reception center, screening must be effective (i.e., actually capable of identifying inmates suffering from genuine mental illness) while not being cumbersome, excessively time-consuming or a significant interference in custody operations.

A review of the relevant literature suggests, simply, that there is no single non-interview procedure or test that can effectively be implemented as a mental health screening device. The mental health problems presented by the jail population are extremely diverse and demand a more multifaceted approach than is commonly described in many studies. Additionally, the use of such terms as mental disorder and mental illness is variable and adequate definitions are frequently lacking. Jail mental health screening procedures must identify inmates who currently manifest symptoms of mental disturbance requiring immediate treatment, as well as those inmates who are at risk of developing such problems during the course of their incarceration.

In the present study, a concept called “risk of mental disorder” was employed to identify inmates who were currently suffering from a clear mental disorder or who were considered a high risk for emergent psychological problems that would necessitate fairly immediate further evaluation or treatment. An inmate was considered at-risk if he or she met one or more of the following criteria.

1. Evidence of current suicide ideation: Data regarding this criterion were obtained by direct interview. This criterion was met if the inmate positively indicated current thoughts of suicide/self-destruction.
2. Mental status examination findings suggest a probable mental disorder combined with elevations on the Brief Psychiatric Rating Scale: Inmates were scored as positive on this criterion if they manifested obvious symptomology of a major mental disorder. Symptoms most frequently suggested affective disorders with depressive and manic or hypomanic-like features or clear evidence of atypical thought content, logical processing difficulties and report of sensory abnormalities. Low intelligence was not rated unless there was clear evidence of dementia.
3. History of significant suicide attempt within the past two years: Data were obtained through interviews. This factor was scored as positive only if the inmate reported a behaviorally overt suicide attempt. Previous suicidal ideation was not scored. The two-year period was strictly adhered to and responses suggestive of an ambiguous time frame (e.g., “a couple of years ago, maybe more”) were not scored.
4. History of multiple suicide attempts during the past five years: This factor was scored as positive only if there was a report of two or more behaviorally overt suicide attempts in the past five years.
5. Treatment with major psychotropic or antidepressant medication during the past year: Use of so-called “minor tranquilizers” and anxiolytics was not scored as positive on this factor.
6. Psychiatric hospitalization within one year of arrest.
7. More than two psychiatric hospitalizations during the past five years.
8. Intensive psychiatric treatment in a jail or prison during the past five years: A five-year period was used on this factor since these inmates typically serve a significant time in prison, and additionally, only the more severely disturbed inmates are placed in intensive treatment within a prison. This criterion also included inmates who had been hospitalized in a penal-code locked psychiatric facility (e.g., Atascadero State Hospital in California).

TABLE 1. RISK OF MENTAL DISORDERS BY CRITERIA 1-8 (SEE ABOVE FOR CRITERIA LIST.)

Criteria	1	2	3	4	5	6	7	8	AT-RISK*
MALES									
(N=738)	37	157	33	20	95	28	19	16	207
PERCENTAGE	5.0	21.3	4.5	2.7	12.9	3.8	2.6	2.2	28.0
FEMALES									
(N=170)	12	36	14	5	29	13	6	4	52
PERCENTAGE	7.0	21.2	8.2	2.9	17.1	7.6	3.5	2.4	30.6
TOTAL									
(N=908)	49	193	47	25	124	41	25	20	259
PERCENTAGE	5.4	21.3	5.2	2.8	13.7	4.5	2.8	2.2	28.5

*At-risk means the number of people who qualify with one or more criteria.

RESULTS

The results of this study indicate that approximately 28 percent of the males and 31 percent of the females booked into the L.A. County jail system were rated at-risk on at least one of the above factors (see Table 1). The majority of risk for males and females related to current problems or symptoms. Twenty-one percent of both male and female inmates were rated at-risk as a result of observed symptoms upon the mental status exam at the time of booking. Also, 5 percent of the males and 7 percent of the females reported having thoughts of committing suicide at the time of booking. Again, these are inmates exhibiting symptoms of mental disorder or difficulties requiring immediate intervention. Seventy-eight percent of the males and 73 percent of the females considered at-risk had current problems. The remaining risk factors essentially refer to individuals with past psychiatric problems who may require psychiatric services during their incarceration. For example, the stress of incarceration and legal problems may result in decompensation in inmates who had previously suffered problems related to mental illness. These data would suggest that mental health screening in jail settings should incorporate some method for assessing current symptomatology and that this is the most critical variable to be considered in planning and designing screening procedures for newly booked jail inmates.

CONCLUSION

Society in general, and the criminal justice system in particular, has long struggled with the issue of incarceration of the mentally ill. Existing data are inadequate and confusing. The current study represents a large-scale, systematic attempt to more precisely describe and define the basic nature and some of the parameters of this problem. A wide variety of demographic, clinical and cognitive/educational data were obtained from a representative sample of 1,000 newly booked male and female inmates in the L.A. County jail system on a stratified, time-sampling basis. One of the main features of this study was a specific attempt to operationalize some of the issues, particularly the concept of being at-risk for mental illness. Readers can make their own judgment of this attempt at operationalization and the resultant findings. There are many more people with serious mental health problems entering jails than was previously thought. Further, they are bringing a whole host of other problems and deficiencies with them (e.g., substance abuse, homelessness and low intelligence). Like it or not, jails are becoming a critical mass in the treatment of the mentally ill, with no solution in sight. This mandates that more and better screening and treatment programs be used in jail settings. The current study provides some of the necessary foundation and perspective for that effort.

Michael P. Maloney, Ph.D., ABFP, is the program head of women's mental health and Michael P. Ward, Ph.D., is acting mental health clinical program head at the Los Angeles Department of Mental Health at the Twin Towers Correctional Facility. Charles M. Jackson is acting chief of the Correctional Services Division of the Los Angeles County Sheriff's Department.