The More Things Stay the Same: A Report on the Mental Health Problems of Inmates in America's Jails and Prisons

By: R. Christian Griffin

Abstract

Since the "incarceration revolution" of the 1980's, studies have consistently documented the disproportionately high rates of mental health problems found among jail and prison inmates in the United States. This paper presents in a summary manner the scope of the problem of mental illness among America's incarcerated population. Specific attention is given to historical precipitants of the problem as well as implications for social work practice.

Introduction

In recent years, a number of studies have documented the disproportionately high rates of mental health problems found among America's jail and prison inmates (Teplin, 1994; Ditton, 1999; James & Glaze, 2006). The incarceration of people with mental health problems has been precipitated in large part by the deinstitutionalization movement of the 1960's and the incarceration revolution of the late 20th century (Human Rights Watch, 2003; Harcourt, 2006). Though the courts have mandated treatment for mentally ill inmates (Teplin, 1994; White & Gillespie, 2005), the actual responsibility for identifying mentally ill offenders and implementing treatment programs has often been left to corrections officials who are not adequately trained to address the mental health needs of many incarcerated individuals (Teplin, 1990; White & Gillespie, 2005).

The purpose of this paper is to highlight the disturbingly high rates of mental illness that continue to plague so many jail and prison inmates. Specific attention is given to the need for social workers and mental health professionals to effect positive change through providing services to, conducting research on, and advocating policy improvements regarding inmates with mental health problems. It is hoped that by disseminating this information to professionals concerned with the dignity and worth of every individual (NASW Code of Ethics), social workers will demand the reduction of needless human suffering among mentally ill inmates and work to bring about more efficient correctional facilities and healthier, safer communities.

The New Asylums

By all accounts, detention facilities have become the United States' premier warehouses for people suffering from mental illness. However, primary data on the prevalence of mental illness in America's jails and prisons have been obtained by very few studies. In fact, Human Rights Watch (2003) reports, "there are no national statistics on historical rates of mental illness among the prison population" (p. 19). Over the past decade, the few studies that have produced data on persons with mental illness in America's jails and prisons have generated much discussion about the disturbingly high rates of mental illness, including severe mental illness such as psychosis, found among inmates. The mental health crisis that exists behind the bars of this nation's correctional institutions is an alarming phenomenon for which the data currently available to the public essentially speak for themselves. This report will begin with a presentation of those data in their purest form, along with a few methodological caveats and comments on the data by corrections and mental health professionals.

The most recent and most cited statistics on the mental health problems present among those in America's jails and prisons come from a study conducted by James and Glaze with the federal Bureau of Justice Statistics (BJS) entitled, "Mental Health Problems of Prison and Jail Inmates." Published in September 2006, the report enumerates a number of troubling findings regarding the mental health problems of inmates. One of the most alarming findings contained in the report is that "[a]t midyear 2005 more than half of all prison and jail inmates had a mental health problem" (p. 1). This population comprises "56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates" (p. 1).

Of course, rates of mental illness are largely a product of the way that mental illness is defined by researchers. In 1999, for example, Ditton found that only 16 percent of jail inmates and state prisoners were mentally ill. In her study, however, mental illness was assessed through the use of two rather narrow criteria: Inmates had to report either suffering from a mental or emotional condition at the time of the survey or previously being admitted overnight to a mental hospital or treatment program. As described in the Bureau of Justice Statistics' 2006 study, James and Glaze defined mental health problems by more capacious criteria than Ditton. In their study, a mental health problem was defined as "a recent history or symptoms of a mental health problem" (p. 1). A recent history of a mental health problem was operationalized as one's receiving a clinical diagnosis and/or treatment by a mental health professional within

twelve months of the study. Symptoms of a mental health problem were based on the diagnostic criteria of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Furthermore, only symptoms indicative of major depression, mania, and psychotic disorders were assessed. All information was obtained through detailed interviews with "systematically selected" inmates. The BJS reports that its inmate surveys, which are conducted every five to six years, "are the only national source of detailed information on criminal offenders, particularly special populations such as drug and alcohol users and offenders who have mental health problems" (p. 11).

Other notable findings from the Bureau of Justice Statistics' (BJS) 2006 report include the following: 43% of state prisoners and 54% of jail inmates "reported symptoms that met the criteria for mania. About 23% of state prisoners and 30% of jail inmates reported symptoms of major depression" (p. 1). Approximately "15% of state prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder" (p. 1). In terms of aggregated symptoms of the mental health disorders assessed by the BJS, "Jail inmates had the highest rate of symptoms of a mental health disorder (60%), followed by state (49%), and federal prisoners (40%)" (p. 3). Additionally, approximately 24% of state prisoners, 21% of jail inmates, and 14% of federal prisoners were found to have "a recent history of a mental health problem" as defined in the preceding paragraph (p. 2).

Subsequent to the publication of the Bureau of Justice Statistics' 2006 report, several journalists captured the reactions of mental health professionals to the ostensibly surprising findings contained in the report. Michael J. Fitzpatrick, the executive director of the National Alliance on Mental Illness, was quoted in the *Washington Post* as calling the report's findings "both a scandal and national tragedy" (Sniffen, 2006, para. 4). He also admitted, "The study reveals that the problem is two to three times greater than anyone imagined." The Bazelon Center for Mental Health Law told *The Nation's Health* that the report indicated the "numbers have increased significantly, with serious implications for taxpayers and public safety and for the lives of the individuals and their families" (Krisberg, 2006, p. 24). Yet, in the same article, Kim Krisberg observed, "While the [BJS'] report represents the first time in five years that such data has [*sic*] been available, the news that mental health problems abound inside the nation's correctional system is far from new" (p. 1).

Indeed, the Bureau of Justice Statistics' September 2006, report was definitely not the first study to find a disproportionately high rate of mental illness among jail and prison inmates. In fact, over the past decade, researchers have consistently documented a harrowing percentage of mentally ill individuals among those detained in America's correctional facilities. By 1997, the National GAINS Center had concluded that prisoners suffer from serious mental illness at "three to five times the rate" of people in the community and are approximately four times more likely than the average person to have schizophrenia (National GAINS Center, 1997). In 1999, Pinta conducted a meta-analysis of eight studies that had been rigorously designed to assess prevalence rates of mental illness among prisoners. The study found "on average that 18 percent of inmates have serious disorders such as schizophrenia, bipolar disorder, or major depression at some point in their lives and 15 percent have current (within the past year) disorders" (Hills, Siegfried, & Ickowitz, 2004, p. 4). In 2003, Human Rights Watch concluded that the Los Angeles County and Cook County jails had become "two of the largest mental health providers in the country." Likewise, the Council of State Governments (2002) reported, "The Los Angeles County Jail, the Cook County Jail (Chicago) and Riker's Island (New York City) each hold [*sic*] more people with mental illness on any given day than any psychiatric facility in the United States" (Fact Sheet).

> In 2006, the Commission on Safety and Abuse in America's Prisons included in its report, Confronting Confinement, that the "most conservative estimates of prevalence – 16 percent – means that there are at least 350,000 mentally ill people in jail and prison on any given day. . .Other estimates of prevalence have yielded much higher rates, even of 'serious' mental disorders – as high as 36.5 percent or 54 percent when anxiety disorders are included. . .These prevalence rates are two to four times higher than rates among the general public…They reflect what many witnesses told the Commission: *that prisons and jails have replaced state psychiatric hospitals as the institutions that house and care for persons with mental illness* (italics added)" (Commission on Safety and Abuse in America's Prisons, 2006, p. 43).

Similarly, White and Gillespie (2005) observed that "many experts argue that the criminal justice system is now the last resort provider for many hard-to-serve clients and is fast becoming the de facto mental health treatment resource for the nation's poor and disadvantaged" (p. 109). As one former corrections official succinctly stated the problem, "Detention facilities have, in

fact, become the new asylums" (Commission on Safety and Abuse in America's Prisons, 2006, p. 43).

One of the most glaring findings in the research mentioned above is the disheartening disparity in the prevalence of mental health problems among jail and prison inmates and the number of mentally ill inmates who have received treatment. In the study by James and Glaze (2006), for example, while approximately 60 percent of jail inmates and 50 percent of state prisoners reported "symptoms of a mental health disorder," only 21 percent of jail inmates and 24 percent of state prisoners indicated that they had a "recent history of a mental health problem," which would include contact with a mental health professional within the twelve months immediately preceding the study. These findings were consistent with a previous study conducted by the BJS which found that in 2000, only 10 percent of state inmates had received psychotropic medications and only 13 percent had attended some kind of mental health therapy or professional counseling (Beck & Maruschak, 2001). There is a clear need, then, for social workers to both provide direct services to inmates with mental health problems and advocate for improvements in the delivery of mental health treatment in America's jails and prisons.

From Institutionalization to Criminalization

Two major social movements have greatly contributed to the high rates of mental illness found among jail and prison inmates: the deinstitutionalization movement of the 1960's and the incarceration revolution of the late 20th century. The former included a drastic reduction of state psychiatric services as well as the failure of community mental health programs to effectively replace the psychiatric institutions that were being dismantled (Hills, Siegfried, & Ickowitz, 2004). Several factors precipitated the deinstitutionalization movement. Among them were the development of anti-psychotic medications, which introduced the prospect of successful psychiatric treatment taking place outside of mental hospitals, and increased litigation aimed at safeguarding the due process rights of persons involuntarily committed to mental hospitals (Human Rights Watch, 2003). Just before the deinstitutionalization movement began, approximately 339 out of every 100,000 Americans were institutionalized in a mental hospital. By 1998, the number had dropped to just 29 out of every 100,000 (Human Rights Watch, 2003). It would be a mistake, however, to assume that the abrupt decrease in the number of persons committed to mental hospitals represented a similarly abrupt drop in the overall number of institutionalized persons with mental illness.

As Harcourt (2007) observes, "Over the past 40 years, the United States dismantled a colossal mental health complex and rebuilt – bed by bed – an enormous prison. During the 20th century we exhibited a schizophrenic relationship to deviance" (A15). In other words, as Americans became increasingly "tough on crime," many individuals with severe mental health problems were shifted from state hospitals to jails and prisons. In 2006, Harcourt conducted a study that examined aggregate rates of institutionalization in the United States from 1928 to 2000. In it, he combined the number of people institutionalized in asylums and mental hospitals with the number of those incarcerated in state and federal prisons in order to posit a rate of aggregated institutionalization. The aggregated rate yields a more accurate representation of historical rates of institutionalization than examining either mental hospitalization or incarceration alone. Harcourt found that while an abrupt spike in incarceration has occurred since the "incarceration revolution of the late 20th century…the highest rate of aggregated institutionalization during the entire period [from 1928 to 2000] occurred in 1955 when almost 640 persons per 100,000 adults over age 15 were institutionalized in asylums, mental hospitals, and state and federal prisons" (Harcourt, 2006, p. 1751). Stated simply, although the incarceration revolution did yield a precipitous increase in the number of incarcerated Americans, resulting in the highest rate of incarceration in the world, by 2002, the aggregated rate of institutionalization had only risen to just below the aggregated rate for 1955. These figures suggest that "individuals who used to be tracked for mental health treatment are now getting a one-way ticket to jail" (Harcourt, 2007, p. A15).

Other researchers have similarly observed that mentally ill offenders are often arrested and detained because of behaviors caused by their mental disorders. Watson, Hanrahan, Luchins, and Lurigio (2001) observed that mentally ill individuals who interact with the police are more likely than other individuals to be arrested. Some police officers, often under pressure from local businesses, are even known to "clean the streets" of people who display certain undesirable behaviors (Treatment Advocacy Center, 2007). "Mercy bookings" are also somewhat commonly practiced by the police and are ostensibly done for the protection of severely mentally ill individuals (Treatment Advocacy Center, 2007).

Clearly, the deinstitutionalization movement and the incarceration revolution have led to the criminalization of many people suffering from severe mental health problems. This outcome is an unfortunate leap from the promises of those who advocated for and encouraged deinstitutionalization. Proponents of the deinstitutionalization movement envisioned a system of

community mental health programs as ensuring the successful transition of persons with mental illness from mental hospitals to their communities (Human Rights Watch, 2003). This vision, however, has never been fully realized. In fact, America's current mental health service and delivery system is notoriously fragmented and seemingly unable to address the needs of many of the most vulnerable Americans with mental illness. In its 2003 report to President George W. Bush, the New Freedom Commission on Mental Health stated, "…the mental health delivery system is fragmented and in disarray…lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration" (p. 3). Similarly, Michael J. Fitzpatrick of the National Alliance on Mental Illness laments, "The mental health system is failing long before people enter the criminal justice system and after they leave it" (Sniffen, 2006, para. 5).

The New Freedom Commission (2003) attributes the ineffectiveness of the current mental health delivery system to such problems as stigma surrounding mental illness, unnecessarily long periods of time between the discovery of effective forms of treatment and the implementation of the treatment into routine patient care, a lack of coordination between primary care physicians and mental health professionals, and high unemployment and other disabilities that often accompany the presence of a mental illness. These and other problems perpetuate the fragmentation of community mental health care systems, with the result that "all too many people who need publicly financed mental health services cannot obtain them until they are in an acute psychotic state and are deemed to be a danger to themselves or others" (Human Rights Watch, 2003, p. 21).

Human Rights Watch (2003) reports that "there is a direct link between inadequate community mental health services and the growing number of mentally ill who are incarcerated" (p. 23). People with mental illness are often left untreated and unhelped for so long that they experience severe mental deterioration and consequently become entangled in the criminal justice system (Human Rights Watch, 2003). Where criminal behavior is the result of mental illness, access to adequate community resources may act as a buffer between an individual with mental illness and the criminal justice system.

In recent years, economic factors have also contributed to the high levels of mental illness among jail and prison inmates. Restrictive insurance and managed care plans prevent some people from receiving needed mental health services (Hills, Siegfried, & Ickowitz, 2004). Furthermore, persons with severe mental disorders are over-represented in America's homeless population–approximately 20 to 33 percent of homeless people have a severe mental illness–and are thus too poor to access even the most basic mental health services (Human Rights Watch, 2003). Additionally, many states may encounter economic incentives that encourage them to deal with severely mentally ill offenders through the correctional system rather than state hospitals (Human Rights Watch, 2003). Treating individuals in state hospitals is much more expensive than detaining them in prison. For some severely mentally ill people, prison may even provide an alternative to homelessness and a rare opportunity for mental health treatment.

The factors that have precipitated our nation's jails and prisons becoming the new asylums are complex and must be addressed through policies aimed exclusively at the hope of recovery for the severely mentally ill. As articulated in Confronting Confinement (2006), "Our jails and prisons should not have to function as mental institutions. As a society, we need to expand and improve community-based treatment for persons with mental illness" (p. 46). The following section will examine the reasons social workers and other mental health professionals should urge policy-makers to address the needs of incarcerated persons with mental illness. It will also review some recent actions taken to address the problem of severe mental illness among jail and prison inmates.

For Them and For Us: Why We Should Care about the Incarcerated Mentally Ill

In recent years, a number of diversion programs aimed at reducing the incarcerations of offenders with mental illness and/or substance abuse problems have burgeoned across the United States. These programs have been developed in large part because of the public's growing awareness of the expenses associated with the incarceration of non-violent offenders (Human Rights Watch, 2003). Drug courts, for example, have been established across the country to preclude the incarceration of low-level drug offenders and channel the offenders into substance abuse treatment programs. By 1997, there were more than 300 drug courts in 48 states, and the courts had produced promising results through the reduction of criminal behavior, drug use, and costs (Watson et al., 2001).

Subsequent to auspicious results produced by drug courts, several communities began to consider ways of diverting mentally ill offenders from jail and prison (Watson et al., 2001; Harvard Mental Health Letter, 2006). In 1997, Florida established the first mental health court, and currently, there are more than 100 mental health courts in the United States (Harvard Mental Health Letter, 2006). While mental health courts vary from state to state, they all share several basic features. As outlined by Watson and her colleagues (2001), all mental health courts:

> handle only cases involving offenders with mental disorders. The judge, prosecutor, defense attorney, and other court staff often have special training in and are familiar with community mental health services. Court staff collaborate with community providers to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training, and psychosocial rehabilitation. Defendants can have their charges or jail sentences deferred if they agree to participate in services. The goal is to prevent criminalization and recidivism by providing critical mental health services (p. 477).

Evaluations of mental health courts have yet to produce conclusive results. While some studies of mental health courts have yielded promising findings, none have been controlled studies with random assignment (Harvard Mental Health Letter, 2006). As mental health courts continue to grow, there is much hope that they will be an effective tool in the diversion of low-level offenders with mental illness.

It is beyond the scope of this paper to further evaluate the varied attempts by policy-makers and legal and mental health professionals to prevent the incarceration of mentally ill offenders. Moreover, however successful they may be, diversion programs do not address the disproportionately high rate of mental health problems experienced by currently incarcerated jail and prison inmates. There are several reasons social workers, as well as the general public, should be concerned with the plight of the extant incarcerated mentally ill. These reasons can be divided into two groups–"for them" and "for us"–though there is clearly a good deal of overlap between the two.

For Us

Incarcerating people with mental illness is expensive. According to the Council of State Governments (2002), mentally ill offenders "stay in jail longer than other people do… [are] extremely expensive to keep [there] … and after release they are likely to return to incarceration" (Fact Sheet). In Orange County, Florida, for example, the average inmate stays in jail for 26 days, but the average stay for an inmate with mental illness is 51 days (Council of State Governments [CSG] Fact Sheet, 2002). In Los Angeles County, 90 percent of mentally ill inmates are repeat offenders, and approximately 31 percent of mentally ill offenders "have been incarcerated 10 or more times" (CSG Fact Sheet, 2002).

Similarly, in 2006, James and Glaze found that state prisoners with mental health problems reported receiving sentences that were on average five months longer than state prisoners without mental health problems. They also reported that 25 percent of state prisoners with a mental health problem and 26 percent of jail inmates with a mental health problem "had served 3 or more prior incarcerations" (p. 8) compared with 19 and 20 percent of prison and jail inmates, respectively, without mental health problems. A fact sheet provided by the Treatment Advocacy Center (2007) corroborates the staggering expenses associated with the incarceration of persons with mental illness by pointing out that it costs approximately $50,000 to incarcerate inmates identified as suffering from a psychiatric disorder. In contrast, the average cost of incarceration in the state of California is $30,929 per inmate per year (Aker, 2006). In Pennsylvania, the daily cost of incarcerating an identified mentally ill inmate, including medications and mental health treatment, is almost double the daily cost of incarcerating an inmate without a mental illness (Human Rights Watch, 2003). Given the proclivity of inmates with mental illness to re-offend at higher rates than other inmates, and since incarcerating offenders with mental illness is disproportionately expensive, American taxpayers clearly have much to gain by providing mentally ill inmates with treatment options aimed at permanently ameliorating their mental health problems.

Another reason that Americans should be concerned about the mental health of jail and prison inmates is that the vast majority of them will return to their communities after completing their sentences. Hills, Siegfried, and Ickowitz (2004) state that 95 percent of all prisoners return to the community. The health and safety of America's communities, then, are linked to the rehabilitative options offered to inmates with mental illnesses. As described by the Council of State Governments (2002), "Screening inmates for mental illness, delivering effective services, providing appropriate housing, and developing a comprehensive treatment plan improve the likelihood that an inmate with mental illness will return to the community (and to his or her loved ones) healthy and safely" (p. 127). Ensuring that mentally ill offenders receive much-needed mental health services during their incarcerations helps to ensure the eventual safety and health of the communities to which those inmates will return.

For Them

Inmates with mental illness face a disproportionately high number of obstacles in jails and prisons. These obstacles interfere with both the inmates' person-

al lives and the ability of corrections officials to operate detention facilities well. Addressing the unique problems encountered by inmates with mental illness, then, affords Americans the opportunity to reduce needless human suffering and increase the capacity of corrections officials to meet the goals of incarceration–ensuring security and safety.

James and Glaze (2006) report that inmates with a mental illness are more likely than inmates without to be charged with rule violations and injured in fights. For example, 19 percent of jail inmates with a mental health problem, compared with 9 percent of those without, reported having been charged with violating a facility rule. Since their admissions, 9 percent of jail inmates with a mental health problem, compared to 3 percent of jail inmates without a mental health problem, "had been injured in a fight" (p. 10).

Similarly, in 2003, Human Rights Watch found that mentally ill prisoners are often vulnerable to abuse by other prisoners. They also note that "male and female mentally disordered prisoners are disproportionately represented among the victims of rape" (p. 57). In its report, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, Human Rights Watch concluded that the mental illnesses of many prisoners cause their behavior to be interpreted as incompliant and/or defiant by corrections officials. "Prisoners with mental illness may find it difficult, if not impossible, to comply consistently with prison rules. Some exhibit their illness through disruptive behavior, belligerence, aggression, and violence" (p. 59). Inmates with a severe mental illness such as schizophrenia often "display predictable deficits in behavioral and emotional control" (p. 59). However, "such rule violations, even if the result of mental illness, are routinely punished…Numerous studies report that the mentally ill have higher than average disciplinary rates" (p. 59).

Inmates with mental illness may also present a heightened risk of suicide (Commission on Safety and Abuse in America's Prisons, 2006; White & Gillespie, 2005). As observed by the Commission on Safety and Abuse in America's Prisons (2006), mentally ill prisoners frequently display behaviors construed by corrections officials as necessitating segregation from the general inmate population. Segregation, however, is particularly difficult for inmates with severe mental illnesses to cope with. "In fact, many completed suicides occur in segregation and are committed by offenders with mental illness" (White & Gillespie, 2005, p. 109). A national study of U.S. jails in 1986 found that two-thirds of suicides in the jails examined were committed by inmates detained in a control unit (Commission on Safety and Abuse in America's Prisons, 2006).

The above-mentioned findings all underscore the significant personal difficulties encountered by detainees with mental health problems. They also depict a correctional environment in which the dignity and worth of mentally ill offenders are severely compromised. For social workers, whose code of ethics specifically recognizes the "dignity and worth of the person," (NASW Code of Ethics, p. 1) the personal effects of detention facilities on detainees with mental health problems present a salient impetus to work for change. While conceding that some offenders deserve to be incarcerated and in fact must be held in detention facilities in order to protect the public, social workers must also responsibly stand for the dignity and worth of every mentally ill offender and demand that attention be given to the reduction of needless human suffering.

Social Work Implications

With respect to professional obligations, the implications of social workers' concern for the dignity and worth of inmates with mental health problems spans all levels of practice. Perennial threats to funding for mental health treatment in jails and prisons, for example, provide opportunities for social workers to advocate for inmates at the macro-level. Since policy-makers regularly review and occasionally bolster extant treatment programs, social workers must intervene at the policy level to demand the proper treatment of mentally ill detainees. Organizations committed to human rights, such as Human Rights Watch, often act as media for the entrance of social workers into the world of policy-making. At the mezzo-level, social workers may address the problem of mental illness among inmates by becoming involved in programs that currently exist to meet the needs of detainees. Extant treatment programs in jails and prisons are chronically under-staffed, leaving an unfortunate dearth of competent, caring mental health professionals. Given their comparatively broad training, social workers are well situated to "fill the gaps" that often plague treatment programs in correctional facilities.

The problems faced by inmates with mental illness should not only cause concern for social workers, however; they should concern Americans from every community and profession. As mentioned above, the mental health of those detained in America's jails and prisons is inextricably tied to the values of all Americans and the safety of their communities. Yet despite all of the obvious reasons to provide adequate mental health treatment in America's jails and prisons, only 34 percent, 24 percent, and 17 percent, respectively, of state prisoners, federal prisoners, and jail inmates with a mental health problem report receiving any kind of mental health treatment since their admissions to correctional facilities

(James & Glaze, 2006). Of those who do receive treatment, the most common form of treatment is taking a prescribed medication (James & Glaze, 2006). Sadly, only 22.6% of state prisoners and 7.3% of jail inmates reported receiving some kind of professional mental health therapy since being admitted to the facilities where the surveys were conducted (James & Glaze, 2006).

The Council of State Governments (2002) has enumerated several recommendations for improving the mental health treatment of inmates with mental illness. These recommendations include improving screening for mental illness upon admission, bolstering individualized treatment plans, and periodically evaluating inmates for signs of mental health problems. These recommendations provide a good framework for the implementation of more effective mental health treatment programs in jails and prisons.

Specialized mental health units such as intermediate care programs within jails and prisons also provide policy-makers and corrections officials with a way to address the mental health problems of inmates (Hills, Siegfried & Ickowitz, 2004). These therapeutic communities allow mentally ill inmates to be sheltered from harmful conditions of confinement while receiving intensive mental health services. Research on specialized mental health units has yielded promising results regarding their effectiveness in reducing institutional problems and improving the lives of mentally ill inmates.

Conclusion

In conclusion, research on the mental health problems of America's jail and prison inmates over the last couple of decades has made one thing very clear: The more things stay the same, the more social workers must demand change! For social workers, addressing the mental health problems of America's detainees presents a unique opportunity to work for change at all levels – micro, mezzo, and macro – of practice. For all of the reasons given above, there is much at stake in this work. Like all epic struggles, the perennial foes (e.g., bureaucracies, financial restraints) are ever present in this battle. Also present, however, are those ideals that have guided social workers since the inception of their profession, including our belief in the dignity and worth of every human being. From providing direct clinical service to conducting rigorous research evaluating treatment programs, social workers must spearhead the call for policy-makers and corrections officials to implement practices that fully embrace the dignity and worth of America's detainees with mental health problems.

Christian Griffin completed the MSW program at Loyola University Chicago in May 2007. During his second year of the program, he worked as an intern at the Federal Defender Program in Chicago, Illinois, where he assisted attorneys in the discovery and documentation of relevant psychosocial information as mitigation in clients' sentencings. In the fall of 2007, he will begin law school at the University of Denver.

References

Aker, E. (2006, July 5). The Business of Punishment. *Policy Today*. Retrieved on April 23, 2007, from www.policytoday.com/index.php?option=com_content&task=view&id=79&Itemid=40

Beck, A.J., & Maruschak, L.M. (2001). *Mental health treatment in state prisons, 2000*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Commission on Safety and Abuse in America's Prisons. (2006). *Confronting confinement*. Washington, DC: Vera Institute of Justice. Retrieved on February 3, 2007, from www.prisoncommission.org/pdfs/Confronting_Confinement.pdf

Council of State Governments. (2002). *Criminal justice/Mental health consensus project*. Retrieved on February 17, 2007, from http://consensusproject.org/topics/the_report

Council of State Governments. (2002). *Fact Sheet: Mental Illness and Jails*. Retrieved on February 17, 2007, from http://consensusproject.org/downloads/facts_jails.pdf

Ditton, P.M. (1999). *Mental health and treatment of inmates and probationers.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Harcourt, B.E. (2006). From the asylum to the prison: Rethinking the incarceration revolution. *Texas Law Review, 84,* 1751-1786.

Harcourt, B.E. (2007, January 15). The mentally ill, behind bars. *New York Times*, p. A15.

Harvard Mental Health Letter. (2006). *Mental health courts.* Boston, MA: Harvard Health Publications.

Hills, H., Siegfried, C., & Ickowitz, A. (2004). *Effective prison mental health services: Guidelines to expand and improve treatment*. Washington, D.C.: U.S. Department of Justice, National Institute of Corrections.

Human Rights Watch. (2003). *Ill-Equipped: U.S. prisons and offenders with mental illness*. New York: Human Rights Watch.

James, D. J., & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates*. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

Krisberg, K. (2006). Serious mental health problems prevalent among U.S. inmates. *The Nation's Health, 36*(9), 1-24.

National GAINS Center. (1997). *The prevalence of co-occurring mental and substance abuse disorders in the criminal justice system.* Just the Facts Series. Delmar, N.Y.: National GAINS Center.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. Rockville, MD: Department of Health and Human Services Pub. No. SMA-03-3832. Retrieved on April 2, 2007, from http://www.mentalhealthcommission.gov./reports/reports.htm

Sniffen, M.J. (2006, September 6). Prisons lacking mental health treatment. *Washington Post.* Retrieved March 14, 2007, from http://www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601629.html

Teplin, L. (1990). Detecting disorder: The treatment of mental illness among jail detainees. *Journal of Consulting and Clinical Psychology, 58*(2), 233-236.

Teplin, L. (1994). Psychiatric and substance abuse disorder among male urban jail detainees. *American Journal of Public Health, 84*(2), 290-293.

Treatment Advocacy Center. (2007). *Fact sheet: Criminalization of Americans with severe mental illnesses*. Retrieved on April 5, 2007, from http://www.psychlaws.org/GeneralResources/fact3.pdf

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

White, T.W., & Gillespie, E. (2005). Mental health programs: Addressing the unfunded mandate. *Corrections Today, 67*(6), 108-115.