More Than a Quarter Million Inmates in U.S. Prisons and Jails Are Mentally Ill, Justice Department Report Finds

In its first comprehensive report on mental illness in the nation's correctional facilities, the Department of Justice estimated that in mid-1998 a total of 283,800 inmates in U.S. jails and prisons had a mental illness. An additional 547,800 offenders on probation in the community also were considered mentally ill.

The majority of the mentally ill offenders, 179,200, were in state prisons, while 96,700 were in local jails and 7,900 were in federal prisons, the report noted. Mentally ill offenders constituted 16 percent of inmates in state prisons and local jails and a similar percentage of community probationers. However, they made up only 7 percent of inmates in federal prisons.

The report, entitled *Mental Health and Treatment of Inmates and Probationers,* was released in July by the Justice Department's Bureau of Justice Statistics. It is based on surveys and personal interviews with nationally representative samples of offenders in local jails and state and federal prisons. Respondents were considered mentally ill if they reported a current mental or emotional condition; had ever received treatment for a mental or emotional problem other than drug or alcohol abuse; or had had an overnight stay in a mental hospital or treatment program at any time in the past.

Twenty-three percent of white inmates in state prisons and local jails were identified as being mentally ill, compared with 14 percent of blacks and 11 percent of Hispanics. Among community probationers, the rates were 20 percent for whites, 10 percent for blacks, and 9 percent for Hispanics.

Women had a higher prevalence of mental illness compared with men in all types of jail and prison settings and among community probationers. The rate was highest in state prisons, where 24 percent of the women inmates were identified as mentally ill compared with 16 percent of the men. White women in state prison had the highest rate of mental illness, 29 percent, compared with 22 percent for Hispanic women and 20 percent for black women.

Mental illness was most prevalent among offenders between the ages of 45 and 54. About 23 percent of jail inmates, 20 percent of state prison inmates, and 10 percent of federal prisoners in that age group were mentally ill, as were 21 percent of probationers. Rates of mental illness among mentally ill offenders age 24 or younger ranged from 7 percent in federal prisons to 14 percent in state prisons and among community probationers.

Compared with other offenders, mentally ill offenders were more likely to be currently incarcerated for a violent offense and to have previously served time for a violent offense. In state prisons 53 percent of the mentally ill inmates had a current sentence for a violent offense, compared with 46 percent of other inmates. Almost 61 percent of mentally ill inmates in state prisons who had committed a violent offense knew their victim; for 16 percent the victim was a relative and for 12 percent the victim was an intimate, such as a spouse, former spouse, or girlfriend.

Mentally ill inmates also reported longer criminal histories than other inmates. Fifty-four percent in local jails, 52 percent in state prisons, and 49 percent in federal prisons reported three or more previous sentences to probation or incarceration. Among other inmates, 42 percent in local jails and state prisons and 28 percent in federal prisons had three or more previous sentences.

Mentally ill inmates were more likely than other inmates to be under the influence of alcohol or drugs when committing their current offense. The highest rates of alcohol and drug use, 65 percent, were reported by mentally ill inmates of local jails, while 57 percent of other jail inmates reported alcohol or drug use at the time of the offense. A third of the mentally ill inmates and probationers were estimated to be alcohol dependent.

High rates of homelessness, unemployment, and physical and sexual abuse were reported by mentally ill offenders before their current incarceration. In the year preceding their arrest, 30 percent of mentally ill inmates in local jails and 20 percent of those in state or federal prison reported a period of homelessness, when they were living either on the street or in a shelter. Rates of homelessness among other inmates ranged from 3 percent in federal prisons to 17 percent in local jails.

Mentally ill offenders were less likely than others to report that they were

More Than Half the States Now Have Parity Laws

In July Louisiana became the 27th state to enact parity legislation requiring health insurance plans to provide coverage for mental illness that is more equal to coverage for physical illness. Hawaii and Nevada also passed parity legislation this past summer.

States that previously enacted parity laws are Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, and Virginia.

The National Alliance for the Mentally Ill closely tracks the status of state parity legislation and maintains a list of states that have enacted parity laws. The list, which includes the major features of the laws, is accessible on the Internet at http://www.nami.org/pressroom/statelaws.html.

working in the month before their arrest. About 38 percent of mentally ill state and federal prison inmates and 47 percent of mentally ill jail inmates were unemployed, compared with 30 percent of other state inmates, 28 percent of other federal inmates, and 33 percent of other jail inmates.

Rates of previous physical and sexual abuse reported by mentally ill female offenders were significantly higher than those for mentally ill male offenders and for other inmates. Rates of prior physical abuse were highest among mentally ill inmates of state prisons, where 68 percent of the women and 27 percent of the men reported such abuse. Local jails had the highest rates of prior sexual abuse among mentally ill inmates, reported by 63 percent of the women and 17 percent of the men.

Sentences of mentally ill inmates in state prisons were an average of 12 months longer than those of other inmates, 171 months compared with 159 months. Mentally ill inmates in local jails served an average of about two months less than other inmates, 8.7 months compared with 10.7 months.

An estimated 60 percent of mentally ill inmates in state and federal prisons said they received some form of mental health treatment during their current incarceration. Fifty percent said they had taken prescription medication, and 44 percent had received counseling or therapy. Forty-one percent of mentally ill jail inmates had received some form of mental health services since admission, while 56 percent of mentally ill probationers reported having received treatment while on probation.

Mental Health Treatment of Inmates and Probationers is available on the Internet at http://www.ojp.usdoj. gov/bjs.

Proposed Federal Rules Will Shift Oversight, Increase Acccessibility of Methadone Maintenance Treatment

In late July the U.S. Department of Health and Human Services proposed creating a new regulatory system for narcotic addiction treatment that will make methadone treatment more accessible. It will also increase clinicians' authority to exercise professional judgment in treating their patients.

The proposed rules will repeal an inspection system for methadone treatment programs that has been conducted by the Food and Drug Administration since 1972 and will shift oversight to the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration.

The new system incorporates recommendations for expanding access to methadone treatment made by several independent groups and by an expert panel convened in November 1997 by the National Institutes of Health (NIH) (see the January 1998 issue, pp. 120–121).

Under the new rules, methadone treatment programs will be accredited by independent organizations and states in accordance with best-practice guidelines established by CSAT. The standards emphasize improving the quality of treatment through individualized treatment planning, increased medical supervision, and assessment of patient outcomes.

One aim of the new approach is to move methadone treatment closer to the mainstream of the nation's health care system. Proponents hope that the approach will increase physicians' interest in office-based care of patients on methadone and that health maintenance organizations accustomed to meeting accreditation standards in other areas of medical practice will begin to expand or initiate narcotic addiction treatment services. It is estimated that no more than 170,000 of the nation's 810,000 heroin addicts currently receive methadone or LAAM (levo-alpha-acetylmethadol) as part of an addiction treatment program.

The new rules will give clinicians greater latitude in determining methadone dosages. The NIH panel raised concerns that the old regulations discouraged the higher dosages necessary for better retention of patients in treatment. The accreditation system will have a strong focus on outcomes, especially those pertaining to reduction in crime and drug use and engagement in productive employment.

The proposed rules provide for a 120-day period for public comment and a public hearing before final adoption. They are available on the Web at http://www.access.gpo.gov/su_docs by clicking on *Federal Register.*

Surgeon General's Call to Action on Suicide Stresses Strategies for Prevention

U.S. Surgeon General David Satcher, M.D., Ph.D., has issued a call to action to prevent suicide, which was responsible for 31,000 deaths among Americans in 1996, the most recent year for which statistics are available. Suicide ranks as the ninth leading cause of death in the U.S., well above homicide, which caused 20,000 deaths in 1996.

The federal focus on suicide follows up a national conference in Reno, Nevada, in October 1998, where a panel of experts and conference participants developed recommendations on suicide prevention based on a rigorous review of suicide and suicide prevention research. The recommendations were later refined and prioritized to serve as the first steps of an action agenda for suicide prevention.

The action paper presents 15 key recommendations in a framework called AIM: awareness, intervention, and methodology. The recommendations are designed to broaden public awareness of suicide and its risk factors, develop interventions that enhance population-based and clinical services and programs, and advance the science of suicide prevention through research and evaluation.

Statistics show that suicide rates for the U.S. general population declined between 1976 and 1996, from 12.1 per 100,000 persons to 10.8 per

100,000. However, in some age and ethnic groups, rates have increased substantially. Between 1980 and 1996, the rate of increase among persons age 15 to 19 was 14 percent; among African-American males in that age group, the increase was 105 percent. During that same period, suicide rates increased by 100 percent among children and adolescents age 10 to 14. Suicide is the third leading cause of death in the 15- to 24-year age group, exceeded only by unintentional injury and homicide, and is the fourth leading cause of death in the 10- to 14-year age group.

The recommendations aimed at increasing public awareness of suicide and its risk factors include using information technology to disseminate facts about the risk factors in suicide and about prevention approaches. They also call for developing strategies to reduce the stigma associated with seeking help for mental, emotional, and substance use disorders.

The action paper lists a number of risk factors for suicide, including a previous suicide attempt; mental disorders, particularly mood disorders such as depression and bipolar disorder; co-occurring mental and substance use disorders; a family history of suicide; hopelessness; impulsive or aggressive tendencies; and barriers to obtaining mental health treatment.

Other risk factors are loss of a close relationship or a social, work, or financial loss; personal isolation; physical illness; easy access to lethal methods, especially guns; and unwillingness to seek help because of stigma. Local epidemics of suicide and the influence of significant people, including family members, celebrities, and peers who have died by suicide, are also risk factors, as are cultural and religious beliefs that consider suicide a noble resolution of a personal dilemma.

Factors that protect against suicide include effective clinical care for mental, physical, and substance use disorders; easy access to a variety of clinical interventions; restricted access to highly lethal methods of suicide; family and community support; and support from ongoing medical and mental health relationships.

Eight recommendations focus on intervention. They include collaboration among public and private sectors to complete a national strategy for suicide prevention; improving the ability of primary providers to recognize and treat depression, substance abuse, and other major mental illness associated with suicide risk; and elimination of barriers in public and private insurance programs for provision of quality treatments of mental and substance use disorders and the creation of incentives to treat patients with coexisting disorders.

The action paper includes four recommendations related to methodology. The first focuses on enhancing research to understand the effects of risk factors and protective factors on suicide and suicidal behaviors. Other recommendations call for developing additional strategies for evaluating suicide prevention interventions and ensuring that all suicide prevention programs undergo evaluation; establishing improved monitoring systems for suicide and suicidal behaviors through federal, state, and local collaboration; and developing new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

The call to action is available on the Internet at http://www.surgeongeneral.gov/osg/calltoaction.htm.

NEWS BRIEFS

Text revision of *DSM-IV*: The board of trustees of the American Psychiatric Association has approved the development of a text revision of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, to be published next spring. All changes will be limited to the text sections; no changes will be made in the diagnostic criteria sets or the appendix categories. The text revision is being undertaken to correct factual errors in *DSM-IV*, to ensure that the text is up to date and reflects new information available since the *DSM-IV* literature reviews were completed in 1992, and to enhance the educational value of *DSM-IV*. The text revision is being done by APA's office of research under the supervision of the APA committee on psychiatric diagnosis and assessment.

Improving communication between patients and clinicians: In response to an international survey that found wide disagreement between psychiatrists, nurses, and patients about the prevalence of extrapyramidal symptoms among patients taking medication for schizophrenia and other psychotic disorders, Zeneca Pharmaceuticals has introduced its Approaches to Schizophrenia Communication Self-Report Questionnaire (ASC-SR) in the United States. The questionnaire, used by physicians in the United Kingdom, is intended to help doctors and patients talk more openly about side effects of medication and improve patients' compliance, which is critical to managing schizophrenia. The questionnaire includes a checklist of common side effects that the patient may experience and want to discuss with a doctor or nurse.