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Barriers and Facilitators to Effective Mental Health Care in Correctional Settings

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Abstract

It is estimated that one third to one half of the 2.3 million individuals inside U.S. jails and prisons have a mental illness in contrast to 18.3% of the general population. The implications of this on training mental health professionals to provide efficacious treatment inside correctional facilities, as well as planning for the rehabilitation and reintegration of incarcerated individuals, are significant and numerous. This article will present a brief history and overview of mental health services in the U.S. correctional system, as well as a discussion of the barriers to and potential facilitators of providing effective care in the future.

Keywords

correctional facilities, correctional mental health care, mental illness, assessment and diagnosis, medication and therapy

Introduction

Currently, there are approximately 2.3 million individuals in U.S. jails and prisons, rendering it the nation with the largest incarcerated population in the world (Kaeble & Glaze, 2016). Prevalence studies estimate one third to one half of those incarcerated have a mental illness (James & Glaze 2006; Lynch et al., 2014; Steadman, Osher, Robbins, Case, & Samuels, 2009), in contrast to 18.3% of the general population (National Institute of Mental Health, 2017). Given this concentration of mental illness, the availability and quality of mental health services inside such institutions is a crucial area of investigation. Of particular concern are the training of correctional staff, the availability of qualified mental health professionals (QMHPs), the ability to screen for and accurately diagnosis mental illness, and the pharmacological and psychological services that are received. The consequences for individuals who do not receive adequate support and services are profound. This issue is of great cost—socially, financially, and morally—making it of paramount concern to health professionals, policy makers, and the public.

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How Did We Get Here? A Brief History of Institutionalization

In the late 1800s and early 1900s, asylums began to emerge as a part of the Moral Movement with the "belief that humans could be perfected by manipulating their social and physical environment" (Morrissey & Goldman, 1986, p. 14). As individuals were admitted with increasing frequency during this period, small, treatment-oriented facilities morphed into overcrowded custodial institutions. This led to the rapid deterioration of conditions and services and in some cases unethical and dangerous treatments (Morrissey & Goldman, 1986). As the national asylum census reached its peak in the 1950s, the process of deinstitutionalization began, as concerns surrounding treatment efficacy and human rights violations rose to prominence.

Harcourt (2011) discussed three specific forces that led to deinstitutionalization: the development of psychiatric drugs that could subdue patients, the expansion of welfare programs providing states with financial incentive for community-based treatment, and a shift in the public's perception toward the mentally ill, with increased advocacy and acceptance. Deinstitutionalization had the well-intentioned goal of providing mentally ill individuals with more humane and effective treatment within the community. However, individuals were rapidly discharged from asylums during this era, with up to 30% of the total patient population released each year (Baumeister, Hawkins, Lee Pow, & Cohen, 2012), before sufficient community-based treatment programs were ever established (Harcourt, 2011).

As these former patients transitioned back into the community, there was a growing need to house and care for the many who struggled to navigate this change. This led to the movement of "transinstitutionalization," where many individuals with mental illness were swept up into the correctional system (Harcourt, 2011; Torrey, Kennard, Eslinger, Lamb, & Palve, 2010). Harcourt (2011) depicts how enormous this institutional movement was: In 1955, mental hospitals housed 830 per 100,000 adults and correctional institutions contained about 200 per 100,000 adults. In the year 2000, mental health hospitals contained 40 per 100,000 adults, whereas correctional institutions contained 840 per 100,000 adults.

Compounding this failure of deinstitutionalization were some significant financial and political changes. Most notably, there was an overall reduction in mental health spending, the establishment of stricter sentencing policies (e.g., three strikes law, get tough on crime movement), and an increasing number of barriers to mental health treatment (Abramsky & Fellner, 2003; Harcourt, 2011). Taken together, this left a large proportion of mentally ill individuals without adequate resources or treatment, which in turn rendered many homeless, vulnerable to substance use, and susceptible to other problematic situations that inevitably brought them into the legal system (Abramsky & Fellner, 2003; James & Glaze, 2006).

Challenges in Estimating Prevalence

The wide variability of current and lifetime prevalence estimates of mental illness within correctional institutions has been attributed to a number of factors (Prins, 2014). These factors will be reviewed and then considered in the context of existing prevalence studies. The first factor relates to how researchers operationally define mental illness, as some studies have examined all major diagnostic categories whereas others only report prevalence rates on specific disorders. A second factor is the method that researchers have used to assess for mental illness. The most common methods are reviewing case files, administering self-report measures, administering psychological assessments, and conducting clinical interviews (Prins, 2014). Each method comes with unique advantages and disadvantages. For instance, reviewing case files might be more time efficient and yield a larger sample size, but there is no direct contact with inmates. On the other hand, conducting psychological assessments or clinical interviews may produce more accurate diagnoses but is time

intensive, and the resources required typically constrain sample sizes and may not adequately represent certain conditions with lower base rates in the population. Further complicating matters, it has been reported that inmates in correctional institutions have myriad reasons to either overreport or underreport their symptoms (Martin, Hynes, Hatcher, & Colman, 2016). In short, the parameters and methodology used to assess mental illness in correctional populations introduce a certain level of variability in the prevalence estimates obtained.

Generally, prevalence rates for mental illness within U.S. correctional institutions fall somewhere between one third and one half of inmates (James & Glaze, 2006; Lynch et al., 2014; Steadman et al., 2009)—in contrast to 18.3% of the general adult population (National Institute of Mental Health, 2017). For example, the Bureau of Justice Statistics (James & Glaze, 2006) conducted the most widely cited prevalence study. It used inmate self-report methodology and defined mental illness broadly—inmates qualified as mentally ill if they reported a mental health problem in the past 12 months (based on *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition [DSM-IV], criteria) that required either diagnosis or intervention by a mental health professional. James and Glaze (2006) found that 64.2% of local jail inmates, 56.2% of state prison inmates, and 44.8% of federal prison inmates reported a mental health problem. Although on the higher end of estimates, this suggests rates of mental illness are more than 3 times higher in jails and state prisons than in the general population and more than twice as high in federal prisons. Although inmate self-report is not the most accurate method for assessment, it allowed for an enormous sample size and coverage of all diagnostic categories.

Lynch and colleagues (2014) conducted clinical interviews in women's jails to assess the 12-month and lifetime prevalence of specific psychiatric disorders. In assessing serious mental illness (SMI), which included major depressive disorder (MDD), bipolar disorders, and schizophrenia spectrum disorders, they found lifetime prevalence of 43% and current prevalence of 32%. They further reported rates of substance use disorder (SUD) to be 82% for lifetime and 53% for current prevalence, and post-traumatic stress disorder (PTSD) rates were 53% and 29%, respectively. Overall, rates were 1.4 to 5.0 times higher than are found in the general population. While their clinical interviews allowed for a more accurate assessment of psychological functioning as compared to self-report, the time-intensive nature of the methodology may have limited sample size and constrained their ability to explore other diagnostic categories.

Steadman and colleagues (2009) conducted a prevalence study for SMI in jails. They utilized the Structured Clinical Interview for DSM-IV with inmates who screened positive for mental illness during admission with a brief measure. They report that 14.5% of male and 31.0% of female inmates suffered from an SMI. Of the studies reviewed, this two-stage model is an ideal method for assessment within a correctional population. However, they failed to assess for many disorders that have severe impacts on functioning, such as PTSD, anxiety disorders, and personality disorders. Steadman and colleagues noted that had they included just PTSD as an SMI, their estimates would have increased to 17.1% for male and 34.3% for female inmates.

Mental Health Services in Jails and Prisons

QMHPs and Correctional Staff

Many correctional institutions have a shortage of QMHPs and lack of effective services (Abramsky & Fellner, 2003). There are multiple barriers to maintaining an adequate and consistent number of QMHP in a correctional setting. Among these, correctional institutions often lack sufficient mental health funding, which has not increased to keep pace with growing demands (Abramsky & Fellner, 2003). In general, QMHP in correctional institutions must cope with high caseloads and comparably

low pay. For example, Abramsky and Fellner (2003) report that psychologists may hold caseloads of 60 to 80 clients while being paid on average $20,000 less than a comparable job in the community.

Further, possible challenges come with delivering treatment in a punitive institution with individuals who are mandated to be there. Pope, Smith, Wisdom, Easter, and Pollock (2013) reported community-based providers' responses to working with clients who were mentally ill and had previously been incarcerated—many (44%) said that being mandated to treatment was a significant barrier, while some (20%) acknowledged fear and prejudice working with this population. Correctional settings also tend to have high turnover with all staff, which has adverse effects on any facility's services. As Abramsky and Fellner (2003) noted, "new staff are not as familiar with prisoners' mental health histories and behavior, and staff changes disrupts the development of the prisoner confidence and trust which is crucial to effective therapeutic relationships" (p. 97).

Given the lack of QMHP, it follows that mentally ill individuals are primarily managed by correctional staff. As QMHPs are busy conducting treatment, consultation, and training, clinical responsibilities such as screening for mental illness are left to correctional professionals (Hills, Siegfried, & Ickowitz, 2004). Despite the high prevalence of mental illness among inmates and the service-provider roles placed on correctional officers, adequate mental health training is absent from most institutions (Martin et al., 2016; Parker, 2009). A 2001 survey by the National Institute of Corrections reported that 40 states provided mental health training to correctional staff—however, only 7 states provided more than 4 hours of training (Abramsky & Fellner, 2003).

At the same time, there are institutions that offer quality training and the positive outcomes have been well-documented (Abramsky & Fellner, 2003). For example, correctional officers in an Indiana high-security unit received training on major diagnostic categories, the basic biological mechanisms behind mental illness, therapeutic and psychopharmacological interventions, and how to interact with individuals with mental illness (Parker, 2009). This training emphasized active learning with discussion, role-playing, and guest speakers. Parker (2009) found that in the 9 months after training, the number of total incidents, as well as those involving the use of force and battery by bodily waste, decreased significantly as compared to the 9 months prior to staff training.

The severity, frequency, and variety of mental health issues within a given institution, in conjunction with staff's inadequate training, leave them ill-equipped to deal with these inmates. At best, this can lead to a lack of understanding or recognition—a false negative screening at intake (Martin, Coleman, Simpson, & McKenzie, 2013) or being charged with a rule infraction for a behavior that is a direct result of mental illness (Fellner, 2006). At worst, this can lead to frustration, discrimination, and violence. "It is not surprising that some prison guards forced to work with such individuals in frightening and appalling conditions quickly lose patience and take out their frustrations on the prisoners" (Elsner, 2006, p. 88). The need for correctional staff who frequently encounter mentally ill inmates to receive adequate mental health training is absolutely essential.

Identifying Mental Illness: Screening, Assessment, and Diagnosis

The accurate identification of mental illness is necessary for effective mental health treatment in any setting. Screening for mental illness presents inherent challenges—for example, a level of reliance on self-report; differences in the expression of mental disorders by race, class, or culture; and the constant evolution of the diagnostic criteria or assessment tools. Even still, there are some unique and additive challenges in identifying mental illness within a correctional setting. Martin and colleagues (2016) highlight the interesting dialectic between under- and overdiagnosis in correctional institutions. Underdiagnosis has received the greatest attention, as the consequences are obvious: Mentally ill individuals are not identified and do not receive treatment. However, they also note the important and perhaps understudied consequences of overdiagnosis. Overdiagnosing individuals in a setting where qualified professionals and resources are limited brings about concern

that those who have the greatest need for services may not be receiving them (Martin et al., 2016). Even in community-based services where QMHP and treatment options are more plentiful, those with mild or moderate impairment are disproportionately more likely to receive services than those with SMI (Martin et al., 2016). This balance in diagnosis is crucial when considering the other challenges in identifying and treating mental illness in jails and prisons.

The task of screening for mental illness is often left to nonmental health professionals who frequently employ brief screening instruments (Hills et al., 2004; Martin et al., 2016). While valuable, this type of screening is not universally utilized in correctional settings, and there are myriad inmate, clinician, and systematic factors that contribute to diagnostic errors (Martin et al., 2016). Inmates frequently have reasons to overreport symptoms or malinger and also to deny or hide their symptoms depending on context or legal status (Hills et al., 2004). For example, some may overreport because they are desperate for support and services, while others may malinger wanting to be transferred out of a facility. For this reason, the fear of inmate malingering is common in correctional institutions, leaving some individuals with mental illness untreated because staff believe they are faking their symptoms (Abramsky & Fellner, 2003; Kupers, 2006). Inmates may also overreport because they are drug seeking, either for their own use or to sell to others (Abramsky & Fellner, 2003; Hills et al., 2004). An inmate may also be motivated to hide or deny symptoms due to fear of further stigmatization or victimization, not trusting the staff or institution, or not acknowledging their own illness (Hills et al., 2004; Wolff, Blitz, & Shi, 2007).

There are also clinician-related barriers to accurate diagnosis within correctional institutions. Clinicians often have very limited time when making diagnostic decisions and are only able to gather limited information. In addition, there are legal and practical barriers to obtaining collateral information from outside sources (Martin et al., 2016). Finally, system-level factors can lead to diagnostic errors and potential ethical dilemmas. For example, the nature of the relationship between the assessor and inmate is potentially confounded, such as in cases where the same individual screening for mental illness could also be delivering punitive interventions. Given the many demands of their job, it is unsurprising that correctional officers recognize the importance of training. Correctional officers report that it is challenging to switch roles between security enforcement and service provider (Martin et al., 2016). Martin and colleagues (2013) found that correctional officers felt a need for training on interviewing and rapport-building skills and reported difficulty in asking inmates about their current symptoms. Without a basis of rapport or trust, it is unlikely that an inmate would be willing to disclose personal information. This reflects back to the need to provide adequate training, as interviewing and rapport building are necessary fundamental skills.

A final and absolutely crucial system-level factor is accounting for the situational stress of being incarcerated during the screening process. It is most common for mental health screening to occur at the time of admission (Abramsky & Fellner, 2003). This is undoubtedly a time of high stress for any individual. Hassan, Rahman, King, Senior, and Shaw (2012) found that many inmates' symptoms of anxiety and depression decreased after their initial weeks in a facility. This suggests that screening at admission may lead to overdiagnosis, given the high level of stress attached to incarceration (Martin et al., 2016). While *not* screening at intake would help with overdiagnosis, it has the potential for more serious implications. For example, waiting a few weeks to assess for mental health concerns may provide a more accurate picture of psychological functioning, but risks leaving inmates with SMI untreated during a time of acute stress and risks leaving those who are suicidal at risk for death. For these reasons, some have suggested a two-tiered screening process (Hassanet et al., 2012; Martin et al., 2016). At admission (Stage 1), there would be universal screening for suicidality, homicidality, and psychosis with monitoring of psychiatric medications. At a later point (Stage 2), there would be comprehensive mental health screening and diagnosis to account for a full range of psychopathology. The time to implement Stage 2 of this process would need to be explored and studied based on inmates' adjustment to the routines of the institution in order for more common psychopathology to

be accurately assessed (Martin et al., 2016). This tiered system would not allow individuals with serious impairment to slip through the cracks and would also balance the overdiagnosis/underdiagnosis issue, allowing for more accurate screening once inmates begin to stabilize.

Treating Mental Illness in Correctional Settings

Ideally, the mental health services in jails and prisons would take an interdisciplinary approach with consideration for an inmate's life history, individualized needs, and specific diagnoses. However, as such comprehensive treatment is often lacking in community-based services, it is unsurprising that this is not standard practice in correctional settings. James and Glaze (2006) found that only 33.8% of inmates in state prisons, 24.0% in federal prisons, and 17.5% in jails with a mental health problem had received any form of mental health treatment since admission. Further, across all types of facilities, medication was more common than therapy. The provision of services in the community for these individuals is especially striking. When asked if they had received any mental health treatment in the year leading up to arrest, only 22.3% of state prison, 14.9% of federal prison, and 22.6% of jail inmates with a mental health problem reported that they had. This is critical to note. Less than 25% of the individuals who reported a mental health problem were receiving any treatment in the community in the year leading up to their arrest (James & Glaze, 2006). Some may be more likely to receive treatment while incarcerated than in the community.

It is common practice in correctional facilities to provide psychiatric medications as the sole form of treatment (Abramsky & Fellner, 2003; Elsner, 2006). QMHPs have limited resources and can often do little more than medication management for their large caseloads (Elsner, 2006), as it is far less time intensive than regular psychotherapy. However, even for SMI such as schizophrenia that relies heavily on pharmacological intervention, ample evidence supports the combined usage of psychosocial interventions for optimal outcomes (Allen, 2008). In addition, the issues with screening and diagnosis have the potential to leave inmates with incorrect diagnostic labels, leading to ineffective or harmful pharmacological interventions, or alternatively with no diagnosis leading to no pharmacological intervention. Faced with the task of treating such large numbers of individuals with mental illness, some facilities have turned to overmedication as a solution for implementing control (Elsner, 2006; Kupers, 2006). "For many who have the tough, day-to-day task of running these institutions, the best option is to heavily medicate them until they are released" (Elsner, 2006, p. 88). The use of sedative and other psychiatric drugs serves to control and pacify problem inmates and maintain a certain level of order within an institution.

Assuming an inmate has been accurately screened and diagnosed, the process of prescribing and delivering medications comes with its own challenges. It is often difficult to accurately assess the inmate's current functioning to determine the best medication regimen. For psychiatrists and other prescribers with high caseloads and limited time, "medication is prescribed without an adequate evaluation of the prisoner and the development of an individualized treatment plan" (Abramsky & Fellner, 2003, p. 115). Newer and more effective medications (e.g., atypical antipsychotics) may not be available to inmates because they are more expensive. Further, the correctional environment complicates the delivery of medication. Abramsky and Fellner (2003) report that inmates typically have to wait for medication in a single-file line in a common area, deterring some due to fear of being stigmatized or victimized. Another issue is medication discontinuity, which often occurs during times of staff turnover or transfer between facilities. The sudden removal of psychiatric medications can cause serious physiological reactions, as well as psychotic symptoms or suicidal ideation (Abramsky & Fellner, 2003; Kupers, 2006). Additional issues regarding psychopharmacological intervention in correctional facilities include the inadequate monitoring of medication side effects, inconsistent compliance, distributing prescribed medications to other inmates, and the

limited effectiveness of medication when the patient is confined to a cell (Abramsky & Fellner, 2003; Hills et al., 2004; Kupers, 2006).

There is comparably less literature regarding psychotherapeutic services delivered in jails and prisons and much of what was found discussed international facilities (e.g., Hassan et al., 2012, in England). Correctional facilities were not intended to be treatment-oriented, and thus establishing effective programs to address the wide variety of presentations is challenging at best (Meyer, Tangney, Stuewig, & Moore, 2014). The combined lack of QMHP and resources has led to suboptimal therapeutic services in most institutions. The most common mental health diagnoses in correctional institutions are MDD, bipolar I, schizophrenia, and PTSD (Allen, 2008). All of these disorders can be effectively treated with some form of psychotherapy alone or in conjunction with medication (Allen, 2008).

A further complication is the overwhelming prevalence of SUD in correctional settings with estimates ranging from 23% (James & Glaze, 2006) to 53% (Lynch et al., 2014). It is more common for SUD to be comorbid with another mental illness than to be a stand-alone diagnosis (Hassan et al., 2012; James & Glaze, 2006). For instance, Hassan and colleagues (2012) found that "a diagnosis of mental illness with a coexisting drug or alcohol misuse problem was the norm rather than the exception" (p. 1222) in their inmate sample. There are heightened challenges that come with treating a client who presents with comorbidities.

There are also barriers to the services that are available in correctional facilities. Meyer and colleagues (2014) looked at the reasons why individuals do not utilize mental health services if they are available. They found that 79.5% of jail inmates were in need of either mental health or substance use treatment, but of those in need, only 66.7% utilized any services offered. The most common reasons for nonparticipation were feeling they would not have enough time (average stay was 3.5 months), being put on a wait-list, and not believing that the intervention would be helpful. For jails in particular, there is a need for short-term interventions, whereas prisons have the opportunity for more long-term and specialized interventions. Several forms of psychotherapy have been effectively implemented in correctional institutions; these include cognitive–behavioral therapy for the treatment of MDD, psychosocial and psychoeducational treatment for schizophrenia (Allen, 2008), and various substance-use interventions (Hills et al., 2004). One of the most fundamental pieces for all treatments is building trust and a therapeutic alliance, as this universally bolsters positive outcomes. This is especially important to consider in jails and prisons as too often clinicians have limited opportunity to form a therapeutic relationship or provide psychoeducation regarding an inmate's diagnosis or medications (Kupers, 2006). The universal benefits of rapport and alliance building and the unique barriers in correctional settings make it an essential yet challenging component of treatment.

Release and Reintegration

Transition planning and prerelease services are essential components to community reintegration and lowered recidivism rates. Transition planning is broadly defined as "creating a continuum of care pertaining to mental health and substance abuse services as an inmate is released into the community" (Baillargeon, Hoge, & Penn, 2010, p. 369). Baillargeon and colleagues (2010) found that in the past decade, the number of correctional systems implementing such services has increased, with 44% providing an individualized discharge plan and 100% providing medication for those prescribed. While this demonstrates progress, it has already been acknowledged that a prescription does not constitute comprehensive treatment. Ideally, transition planning would begin at the start of treatment, but in practice, it does not begin until an inmate's release is approaching (Baillargeon et al., 2010). It would also be ideal to implement prerelease screening to get a current

picture of mental functioning, although such assessments are rarely administered as they are considered low priority.

The time of release is incredibly stressful, and the conditions of release are important. Inmates with mental illness are at greater risk for being denied parole, leading them to serve their maximum sentences and to be automatically released (Fellner, 2006). With an automatic release, there are typically no conditions to meet once back in the community and subsequently no services or supports provided. It is not a stretch to say that the typical inmate is set up for failure upon release. Travis (2005) developed the term *invisible punishment* to describe the lingering conditions imposed upon the individual after release. This can include being ineligible for employment, public assistance, driving privileges, public housing, and food stamps and even losing parental or voting rights (Travis, 2005). James and Glaze (2006) found those with mental illness were more than twice as likely to have been homeless before arrest. When an individual with mental illness is released, they must face these challenges *and* manage their illness, often without much support while living on the streets. While some mentally ill inmates are released with treatment plans and community-based services, many are released with only 2 or 3 weeks of medication (Elsner, 2006). The majority are released with no mental health services, as they were not receiving any while incarcerated.

Consequences: The Disproportionate Impact for Inmates With Mental Illness

The concentration of mentally ill individuals in U.S. jails and prisons is a primary issue of concern within our society. It is estimated that up to half of the 2.3 million individuals in our correctional facilities suffer from a mental illness (James & Glaze, 2006; Lynch et al., 2014). Correctional facilities were never intended and are not capable of providing appropriate services to such a diverse clinical population. Correctional facilities typically treat mentally ill inmates the same as other inmates with no special allowances (Fellner, 2006), which has led to several alarming consequences.

First, mentally ill inmates are disproportionately charged with rule infractions and sent to disciplinary courts across all types of institutions. Fellner (2006) notes that a majority of rule violations are either a direct result of an inmate's mental illness or the staff's lack of training. The more typical disciplinary court does not consider mental status and the outcome usually results in loss of privilege, monetary restitution, or solitary confinement in extreme cases. However, a growing number of disciplinary courts do consider mental health in determining punishment and will offer a rehabilitative alternative.

A second and more severe consequence is the disproportionate placement of the mentally ill in solitary confinement. It estimated that one third to one half of those in isolation are suffering from SMI (Abramsky & Fellner, 2003; Rodriguez, 2012). The conditions of solitary confinement make effective mental health treatment nearly impossible and services are significantly more limited for those who are segregated as compared to general population inmates (Abramsky & Fellner, 2003). While solitary confinement may exacerbate mental illness, some have argued that it also brings out mental illness in those who have no psychiatric history. Grassian (2006) found that the majority of the inmates he came in contact with in solitary confinement displayed psychiatric symptoms, although many had no prior psychiatric history. It has also been reported that those in solitary confinement have higher rates of self-mutilation and suicide attempts, as compared to the general correctional population (Grassian, 2006; Kupers, 2006).

A third consequence is the disproportionate rate of physical and sexual victimization that has been found both in correctional facilities and in the community. Those with mental illness are generally marginalized and stigmatized, making them easier targets for victimization. Being on high doses of psychiatric medication can also increase one's vulnerability (Kupers, 2006). James and Glaze (2006) found that inmates with mental illness are 2 to 3 times more likely to be injured in a

fight than those without mental illness. Wolff and colleagues (2007) found that both male and female inmates with mental illness were more likely to be sexually victimized than those without, although the difference was statistically significant only for males. James and Glaze (2006) also report that those with mental illness were 2 to 3 times more likely to have a history of sexual or physical abuse prior to admission.

The fourth consequence is the high rates of suicide within correctional facilities. It is well established that both being incarcerated and being mentally ill are risk factors for suicide (Abramsky & Fellner, 2003; Hills et al., 2004). The compounded level of risk for a mentally ill and incarcerated individual who is not receiving appropriate services is incredibly high. Suicide has been the leading cause of death in jails each year since 2000, with it accounting for 33.8% of total deaths in 2013. However, in state prisons, suicide has accounted for only about 6% of deaths since 2000 (Noonan, Rohloff, & Ginder, 2015). Although it is nearly impossible to study retrospectively, it is likely that many of those who complete suicide in correctional facilities either have an unidentified mental illness or are not receiving appropriate services.

Finally, it is thought that the recidivism rate is higher for mentally ill individuals as studies report repeated incarcerations (James & Glaze, 2006; Torrey et al., 2010). The term "frequent flyer" is used to describe the phenomenon of mentally ill individuals who cycle between homelessness and incarceration (Torrey et al., 2010).

Conclusions and Future Directions

The concentration of mentally ill individuals inside U.S. correctional institutions, the lack of resources, the immense challenges and barriers in implementing mental health care, and the alarming consequences have now been established. This is a deeply troubling and relatively unknown human rights issue. The fact that this population is segregated, silenced, and marginalized is what makes it an important issue but is also what keeps it from public view. In the future, there is hope for an increasing number of individuals to receive treatment in the community or to be diverted into psychiatric institutions, but while so many remain incarcerated, the services inside these institutions must improve.

It is essential for correctional staff within these institutions to receive sufficient mental health training, as the benefits of such investments have been documented (Parker, 2009). The staff who are charged with screening or clinical interviewing should receive specialized training and should not be tasked with delivering orders or punishments to the same population. It is unfair and unreasonable for staff to be expected to perform the duties of trained professionals without adequate support. These factors may allow for inmates to feel more comfortable in accurately reporting their symptoms.

The proposed two-tiered screening process (Martin et al., 2016) would allow for a more accurate assessment of mental illness while also decreasing the likelihood of overdiagnosis at the time of intake and preventing inmates with serious impairment from slipping through the cracks. With accurate assessment of mental illness, prevalence studies could then better identify which psychiatric disorders have the highest base rates in correctional populations, which would in turn inform the level of need for specific interventions. There is also great need for research into new or improved interventions through clinical trials to develop empirically supported treatments. Additionally, measuring the improvement of inmates' mental health through outcome studies would help evaluate the efficacy of currently utilized treatments. Group therapy is a cost-effective option that can be tailored to many types of treatment. Finally, establishing a comprehensive and attainable treatment plan for release is essential in order to break the cycle of repeated incarceration for those with mental illness.

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