A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems: Implications for Service Planning

Judith F. Cox, MA, CCHP
Pamela C. Morschauser, MSW, CSW
Steven Banks, PhD
James L. Stone, MSW, CSW

Abstract

This study investigates the relationship between recipients of mental health services and incarceration within local jails. The analyses showed that male and female recipients of mental health services are incarcerated in local jails at a higher rate than the general community but that most are not long-term incarcerations. The study further showed that the rate of incarceration for recipients of mental health services decreases with age but the relative risk of incarceration, when compared with the general population, actually increases with age. In addition, across all age groups female recipients of mental health services were found to be at greater risk of incarceration than male recipients.

Introduction

Mental health care providers are increasingly being held accountable for the care of persons who become incarcerated. As mental health service delivery systems change, and as the populations of correctional facilities expand, it becomes essential for mental health and criminal justice programs to collaborate in addressing the needs of adults and youths from their communities who will use both systems. This collaboration must be based on reliable information about the size and nature of this population. It must address the needs of persons with known mental health service histories as well as the needs of individuals who are diagnosed with a mental illness following their incarceration. This study addresses only the population of persons who are known recipients of mental health services in the community. It estimates the overlap between recipients of mental health services from 25 upstate New York counties and the jail population in the same counties.

The population of US jails and prisons has more than doubled in the last 12 years from 313 per 100,000 US residents in 1985 to 668 per 100,000 in 1998. In 1998 the estimated mid-year daily census

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Address correspondence to Judith F. Cox, MA, CCHP, Director of Case Management, New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229; e-mail: COFOJFC@OMH.STATE.NY.US.

Pamela C. Morschauser, MSW, CSW, is Local Projects Coordinator, New York State Office of Mental Health, Bureau of Forensic Services, Ulster County Department of Mental Health.

Steven Banks, PhD, is Associate Professor, Department of Psychiatry, University of Massachusetts Medical School.

James L. Stone is Commissioner of the New York State Office of Mental Health in Albany.

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in US jails was 592,000. Nationally, the jail population is predominantly male; however, there has been an increase in females from 9.2% of the jail population in 1990 to 10.6% of this population in 1998.[1] The mental health system in the United States also has experienced considerable changes moving from a primarily institutional service program to a community model of care and from a state and county provider system to one that is largely characterized by not-for-profit agencies and behavioral health care networks.

Existing research regarding the prevalence of mental illness in correctional populations has generally been accomplished utilizing one of three processes. The first is face-to-face clinical assessments of samples of individuals who are incarcerated.[2] The second is the application of self-reporting and aggregate-level reporting.[3,4,5] The final method is through a matching of incarceration records, with mental health program records to determine overlap.[6,7]

The largest study to date using face-to-face clinical assessments of incarcerated males was reported by Teplin.[2] Teplin found that 6.4% of inmates in Chicago jails had a diagnosis of schizophrenia, mania, or major depression, with 9.5% having a lifetime prevalence of serious mental illness. In Vermont, Powell and colleagues[8] found that 4% to 7% of the inmates had a schizophrenia diagnosis and that 15% to 25% had a major depression. Using a survey methodology, the US Department of Justice, Bureau of Justice Statistics (BJS),[4] indicated that 25% of jail inmates reported that they had been treated at some time for a mental or emotional problem. The BJS study also found that 10% of the males and 15% of the females reported having been admitted for at least one night to an inpatient mental health facility. In addition, the 1993 National Alliance for the Mentally Ill (NAMI) survey[5] of 1,392 local jails showed 7.25% of inmates were diagnosed with a serious mental illness.

Using a case match procedure, Wolff and colleagues[6] found that 17% of a sample of clients from an assertive community treatment program in Dane County, Wisconsin, were incarcerated during a 1-year period. Pandiani and colleagues,[7] using the same methodology as employed in this study, found that, on average, 7.7% of 3,000 persons served by community support programs in Vermont during 1993 were incarcerated in the state's combined jail and prison correctional system during 1994.

The current study was conducted in New York State and examines the overlap between recipients of mental health services and persons in local jails. In contrast to the Teplin[3] study, which based its findings on a stratified sample of 728 inmates admitted to one jail, this study based its findings on all the individuals incarcerated in 25 local jails. The study answers the question: How many individuals utilized the public mental health and were incarcerated in a local jail during a 5-year period (1991–1995)? In addition, it examines the differences in incarceration rates between individuals in the general community and recipients of mental health services for age- and gender-based subpopulations. A 5-year period for the study was selected. At the beginning of this study, data were available in all of the various components of the mental health system through 1995.

Method

Local correctional system

The local correctional system in New York State consists of 75 locally administered jails and penitentiaries. These facilities confine individuals age 16 and above who are arraigned and awaiting trial, convicted but not yet sentenced, sentenced to a term of 1 year or less, and awaiting transfer to a state prison. Variations in the information systems among the local jails in New York State and the fact that a different local government unit administered each jail limited the study to 25 jails in 25 different upstate counties. During the study period there were a total of 141,193 persons incarcerated within the 25 sample local jails. The 25 counties ranged in population from approximately 27,000 to 875,000.

It was necessary to request that each jail prepare a database in a format that could be used for analysis. The coordinating state-level agencies (the New York State Office of Mental Health and the New York State Commission of Correction) made a formal request to each jail for their cooperation

in this research effort. The New York State Division of Criminal Justice Services, the developer of a jail data management system used by approximately one half of the local jails, created an extract program that could be used by local staff to produce the needed database. Production of the database in those counties with a variety of other jail data management systems depended on local efforts to create the necessary extract programs to fit the systems. Technical assistance was provided to local jails by the research staff. The formal criterion for incarceration used in compiling these databases was that the study subjects had spent at least one night in the local jail during the 5-year study period.

Public mental health system

The New York Public Mental Health System, at the time of the study, included state-operated programs as well as state-certified and -funded locally operated programs. In 1996, the state-operated inpatient system included 18 adult facilities, 6 children facilities, 3 forensic facilities, and 2 research institutes; the locally operated inpatient programs included 135 general hospitals.[9] The mental health service history for the study was obtained using the databases for the state and locally operated psychiatric inpatient facilities and the New York State Medicaid database. These three databases are centrally maintained by the New York State Department of Health (NYSDOH) and/or the New York State Office of Mental Health (NYSOMH).

The state-operated inpatient facilities generally served persons with more chronic problems who required longer hospital stays. The locally administered general hospitals served persons with more acute problems. The Medicaid program helps support the inpatient and outpatient mental health costs for indigent persons. For medical reimbursement in state facilities, individuals must be younger than age 21 or older than age 65. In the general hospitals age is not a factor for Medicaid eligibility. During the 5-year study period within the 25 study counties there was a total of 73,128 persons who were enrolled in the Medicaid program and who used at least one mental health service, a total of 15,041 persons admitted at least once to the state hospitals, and a total of 58,326 persons admitted at least once to a general hospital with a psychiatric diagnosis at discharge.

Analytic method

The methodology used in this analysis required a county identifier as well as two subject identifiers: date of birth and gender. These data were obtained for all individuals admitted during 1991 through 1995 for both the mental health and local criminal justice systems. No additional information was extracted from the administrative databases.

This study involved the determination of rates of incarceration for people served in the public mental health sector. The methodology used in this part of the study was based on procedures routinely used to measure the outcomes of care of community programs in Vermont.[7] This procedure involves measurement of the overlap between the caseloads of mental health programs and the local jail population for specified time periods. The information used for this analysis consisted of anonymous database extracts obtained from the NYSOMH and the sample jails. Where a unique person identifier is shared across data sets, a simple matching of the data sets can provide the number of people in both data sets; rates of incarceration can be directly derived. When a unique person identifier is not available or concerns about personal privacy and the confidentiality of medical records limit the availability of personal identifiers, similar results can be derived using probabilistic population estimation.[10] Probabilistic population estimation is a statistical procedure that uses information on the number of dates of birth represented in a data set in conjunction with knowledge of the distribution of birth dates in the general population to determine the number of people represented in the data set.[11] A brief description of how this statistical technique was used in this study is provided below; a more detailed explanation of probabilistic population estimation, along with procedures to estimate the variability in the estimate, are provided elsewhere.[12]

As this study only received anonymous database extracts for a 5-year period, individuals may appear in a data set more than once. In order to derive the estimate of the number of unique people represented in a county data set that does not contain a unique client identifier, the county data set was broken into smaller data subsets in which all records have the same gender and year of birth (eg, all records for men born in 1965). The number of distinct birthdays that occurred in each data subset was counted. The number of people necessary to produce the observed number of birthdays was calculated using the following formula:

$$P_j(l) = \sum_{i=1}^{l} \frac{365}{365 - i}$$

where P_j is the population estimate for subset j, and l is the number of birthdays observed in the year.[13] Because this procedure uses the number of dates of birth represented in a data set, not the number of records in the data set, the data set may include multiple records for individual people (eg, event or episode records). The use of administrative data sets that include a complete enumeration of the outcome variable means no follow-up contact with subjects is required. Since outcome measures (eg, incarceration history) are available for all subjects the problems of loss of contact and non-response that have plagued longitudinal service system research are avoided.

The above calculation provides a method for estimating the number of unique persons who used the public mental health facility or the local jail within each county. In order to probabilistically determine the number of people shared across these two systems, the sizes of three populations are determined and the results are compared. The number of people in the incarceration data set and the number of people in a mental health data set provide the sizes of the first two populations. Combining both the mental health and incarceration data sets forms the third data set. The number of people represented in the combined data set was determined using probabilistic population estimation because no unique person identifier is shared by the two original data sets.

The number of people who are shared by the two data sets is the difference between the sum of the numbers of people represented in the two original data sets and the number of people represented in the combined data set. This result occurs because the sum of the number of people represented in the two original data sets will include a double count of every person who is represented in both data sets. The number of people represented in the combined data set does not include this duplication. The difference between these two numbers is the size of the duplication between the two original data sets, the size of the caseload overlap. In terms of mathematical set theory[14] the intersection of two sets ($A \cap B$) is the difference between the sum of the sizes of the two sets ($A + B$) and the union of the two sets ($A \cup B$).

$$(A \cap B) = A + B - (A \cup B)$$

The incarceration rates for each distinct component of the public mental health system (state psychiatric hospitals, local psychiatric hospitals, and Medicaid) as well as the total public mental health system can be calculated in each county using the techniques above. Dividing the number of individuals incarcerated in a county by the estimated census of the county in 1993 yielded the incarceration rate for the general population. Age groups were constructed by calculating the age of all individuals as of 1993, the midpoint in the 5-year study.

The elevated risk of incarceration for individuals who received services in the public mental health system as compared with the general population was determined by computing an odds ratio. The odds ratio measures how much more likely an individual who receives mental health services is to be incarcerated as an individual in the general population. To compute the odds ratio, the odds of being incarcerated for individuals who receive mental health services is divided by the odds of being incarcerated in the general population. Dividing the probability of being incarcerated by the probability of not being incarcerated yields the odds of being incarcerated.

Table 1

Persons served in New York State Public Mental Health System and incarcerated at least once between 1991 and 1995

	Age Group							
	20–39		40–64		65+		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
New York State psychiatric hospital	1,919 (38.4%)	215 (8.7%)	574 (19.5%)	128 (5.5%)	12 (1.4%)	9 (0.6%)	2,505 (28.5%)	352 (5.6%)
Medicaid	7,384 (37.3%)	2,419 (10.1%)	2,182 (21.0%)	631 (4.9%)	32 (1.9%)	14 (0.3%)	9,598 (30.1%)	3,064 (7.4%)
Local psychiatric hospital	3,607 (26.7)	1,260 (9.4%)	1,269 (16.4%)	393 (3.8%)	26 (0.6%)	17 (0.2%)	4,902 (19.2%)	1,670 (5.2%)
Public mental health* system	9,264 (32.3%)	3,061 (9.5%)	2,925 (17.5%)	837 (4.1%)	44 (0.7%)	24 (0.2%)	12,233 (23.7%)	3,922 (6.1%)
General population	94,322 (11.1%)	21,586 (2.6%)	20,418 (2.7%)	4,068 (0.5%)	684 (0.2%)	115 (0.0%)	115,424 (5.9%)	25,769 (1.0%)

*New York State psychiatric hospital + Medicaid + Article 28 local psychiatric hospital

Results

To investigate the relationship between the mental health and criminal justice systems, the incarceration rates for five different populations (four mental health populations and the general population of 25 counties) were determined. Table 1 presents the number of individuals within each of these populations who were incarcerated at least once between 1991 and 1995, for three different age groups (20–39 years old, 40–64 years old, and older than 65) and both genders. The percentages in the table for the four different populations of individuals who received a mental health service represent the incarceration rate for the recipients of each of these mental health programs. For the general population, the percentage represents the incarceration rate for persons in the general communities of the 25 study counties. The first major observation from Table 1 is that, irrespective of age and gender, persons who are recipients of mental health services are more likely than persons in the general population to spend at least one night in a local jail. As reported in a study by Cox et al,[15] most recipients were not convicted of offenses serious enough to warrant long-term prison incarceration. In fact, less than 3.5% of the persons in this study who spent at least one night in jail also were incarcerated in prison.

The second observation from Table 1 is that young adult males have the highest incarceration rate for all five populations. Approximately one in nine young adult males in the general population (11.1%) spent at least one night in jail during this 5-year period, whereas approximately one in three young adult male recipients of a mental health service (32.3%) were incarcerated during the same time period. For the general population and all four mental health populations, the incarceration rates were found to decrease as the population aged, but this decrease appeared to be slower for individuals who were recipients of mental health service. In addition, the gap between the incarceration rates for males and females appeared larger in the general population than it did in the populations of mental health service recipients. To examine this finding, the odd ratios were computed for the four populations of mental health service recipients and compared with the general population. Odds ratios greater than 1 indicate that a population is at an elevated risk of involvement with the criminal justice system.

Table 2

Odds ratio* for incarceration of mental health recipients as compared with the general population

	Age					
	20–39		40–64		65+	
	Male	Female	Male	Female	Male	Female
New York State psychiatric hospital	5.00	3.61	8.83	11.63	6.12	24.48
Medicaid	4.77	4.25	9.94	10.43	8.30	11.59
Local psychiatric hospital	2.92	3.91	7.18	7.97	2.47	7.50
Public mental health† system	3.82	4.00	7.72	8.61	2.94	6.94

*Odds ratio of greater than 1 equals an elevated risk of involvement with the criminal justice system.
†New York State psychiatric hospital + Medicaid + Article 28 local psychiatric hospital

The odd ratios presented in Table 2 detail the elevated risk of incarceration for recipients of mental health services. Consistent with what was seen in Table 1, the odds ratios are all greater than 1. For recipients of mental health services, the highest odds ratio of incarceration is for persons age 40 to 64; in many instances, the elevated risk of incarceration is higher for individuals over 65 years of age than for individuals between 20 and 39 years of age.

The final observation made from Table 2 is that female recipients of mental health services across all age groups have a greater elevated risk for incarceration (as compared with the general population) than the elevated risk for males who are recipients of mental health services. Female recipients in the public mental health system were incarcerated at a rate that ranged from 4 to 8.6 times higher than females in the general population of the 25 participating counties. The risk of incarceration for female recipients age 40 years and above was much higher for females who had been in the state hospital and Medicaid systems in contrast to those female recipients in the local hospital system. For example, females in the state hospital between age 40 and 64 were nearly 12 times (11.63) more likely to be incarcerated whereas females in general hospitals were approximately 8 times (7.97) more likely to be incarcerated when compared with the general population.

Discussion

The goal of this analysis was to determine the volume of persons during a 5-year period who were in the mental health system and spent at least one night in a local jail. However, in conducting the study it was necessary to collect and analyze data regarding the total number of individuals from each of the study counties that had spent at least one night in jail. Therefore, the study provides data regarding the general population as a whole and recipients of mental health services. In regard to the general population, the analysis showed that one in every nine young men in 25 rural and urban counties spent at least one night in jail during the 5-year study period. This large volume of young adults incarcerated, combined with the fact that the majority of these persons are local residents, is compelling data for state and local governments to take a proactive role in planning jail services and preventive strategies. The challenge for government is to identify and address the risk factors[16] associated with the incarceration of so many young adults while ensuring that those who do enter the jail are unharmed and provided appropriate services. In most states meeting this challenge will require a public health approach and an enhanced service relationship between the local jail and the community-based service system.

In regard to recipients, this study describes the overlap and the demographic characteristics of the population within the 25 sample counties who received services in both the mental health system and the local jail system.

Overlap between recipients and the local jail population

The finding that there is considerable overlap between persons who are incarcerated in local jails and persons who are served in the community mental health programs has been presented in the literature previously.[2,17] The previous studies used single jail samples and select components of a mental health system. This study, in contrast, confirms the same findings using data that represent a state's entire public mental health system and local jails from 25 counties. Of the 111,736 persons who use the public mental health system in this 25-county study, 16,155 (14.5%) also were incarcerated in the jail for at least one night during the study period. These data should remove any doubt that policy makers may have regarding the need to support resources for jail mental health services. However, it also should make policy makers and advocacy groups cautious in establishing mental health program outcome measures related to jail incarceration. Mental health programs are increasingly being pressured to develop these measures.[18] Some of this pressure is related to the fears of advocacy groups that the behavioral managed care movement of the 1990s will result in a dumping of persons with mental illness into the criminal justice system.[19,20] Without a baseline to establish prior incarceration rates, it will be difficult to measure the impact of this change on the incarceration of recipients of mental health services. These data suggest that behavioral health networks should not be held to standards that are based on a false assumption that the fee-for-service system is achieving a low rate of incarceration for recipients of mental health service. Instead, these data suggest that the mental health system needs to serve a subpopulation that already has a high rate of jail incarceration, and the mental health system must face the challenge of developing new services and fiscal packages and strategies to better engage and meet the unmet needs of this population.

The overlap between recipients and the local correctional facility population also was looked at for those recipients enrolled in the Medicaid program. Over 17% of persons from the general community receiving mental health services supported by the Medicaid program went to jail in the 5-year study period. This finding is upsetting in light of the fact that the federal Medicaid program discontinues support for medical care shortly after a person's jail admission[21]; therefore, jail mental health service costs rest largely with the state or locality. Disenrollment from Medicaid during incarceration, coupled with the lengthy Medicaid reinstatement process, prohibits timely access to critical medical and mental health services at release. The consequence is that persons during a period of high need (at release from the jail to the community) do not have access to critical mental health services.

Demographic characteristics of recipients in the local correctional system

In addition to the overlap between these populations this study analyzed the demographic characteristics of those recipients of mental health services who were incarcerated for at least one night during the 5-year study period. First, it showed that men aged 20 to 39 comprise the largest population of persons who are served in the mental health system and incarcerated in local jails. In this study 57% of the sample were men in this age group. This was not surprising given the fact that the majority of persons incarcerated in local jails also are men in this age group. However, it does suggest that the largest volume of mental health services should be developed to address the special needs of a young male population.

Second, studies in Europe[22,23] and America[4] also found that female recipients have an elevated risk for incarceration. Lindquist and Allebeck[22] and Hodgins[23] reported similar findings in studies using separate cohorts of patients from Swedish mental health programs. Hodgins found that the risk

of being registered for a criminal offense for female recipients was over twice that of male recipients. However, the elevated risk of incarceration among female recipients who use the state psychiatric hospitals and Medicaid program versus the local hospitals suggests that income status and chronicity are factors contributing to their criminal justice involvement. It is likely that many of these women, especially those who are older, do not have social supports, financial security, or legal advocacy.

It is not uncommon for correctional health and security staff to make anecdotal statements that men are much easier to care for than women. The data reported here suggest that these statements are true, but not because female inmates have more unfounded complaints than male inmates. It is because they have more health care needs. A recent BJS study[4] also found that female inmates receive more mental health treatment services while incarcerated than men.

The last finding was that risk of incarceration (when compared with the general population) increases as recipients of mental health services age. It suggests that appropriate community supports may not be available for this group. It also is likely that factors such as a lack of social supports and income status or poverty may be contributing to the risk of incarceration for the elderly. Without intervention it is likely that these phenomena will increase in the next 10 years as the presence of older persons in the general population increases. US Census Bureau projections in many states indicate large increases in the elderly population.[24] For example, projections by the US Census Bureau show that by the year 2010 over 3.3 million New Yorkers will be age 60 or older; of this group, 1.1 million will be 55 years and older, and more than 340,000 will be 85 and older. These numbers represent increases since 1990 of 5.5%, 11%, and 38%, respectively, in these age groups.[25]

There are some limitations associated with the methodology used to make the observations above. First, the data were analyzed on a county-by-county basis. If an individual only spent a night in a county jail other than the county where services were received, he or she would not be seen as being incarcerated. In this way, the incarceration rates reported above should be seen as a lower bound of the true rate of incarceration. Second, because individuals are not matched across the public mental health and criminal justice systems, the timing of an individual's involvement with the two systems cannot be determined. It is possible for an individual to have made contact with the criminal justice system before ever receiving services from the public mental health system, or to have received services before being incarcerated. Using the methodologies employed in this study, incarceration after receiving a community-based mental health service[7] was determined, but the focus of the current study was to examine the shared caseload between the public mental health and criminal justice systems irrespective of the order of contact.

Implications for Behavioral Health Services

The results of these analyses raise program and planning concerns for health, mental health, and corrections administrators. Among them are the pressing need to provide adequate care and treatment in local jails for persons with mental health problems, the importance of a continuous care model between communities and jails, the need to provide Medicaid support during incarceration, and the importance of applied research to demonstrate the impact of specific service packages on incarceration.

Adequate care during incarceration

The fact that such a large number of persons in the public mental health system enter the jail reinforces the need for communities and state and federal government to be accountable for ensuring adequate mental health care in local jails. It is clearly in the best interest of localities and state government to promulgate regulations and adopt national health care standards to ensure that services for persons with health care needs are available during local incarceration and that they are operated in accordance with community practices. For persons with mental illness incarcerated in local jails these

services should facilitate timely identification and appropriate clinical care, humane conditions in the correctional environment, and release linkages. Many local jails are still very negative environments. In fact, most jails do not have accredited health care services. Reportedly, in the over 3,000 jails in this nation, less than 7% have accredited health facilities through the National Commission of Correctional Health Care (238 facilities) (Judith F. Stanley, Director of Accreditation, National Commission of Correctional Health Care, personal communication, May 2000) and/or the American Correctional Association (99 facilities).[26] (There is overlap in these two numbers as some jails are dually accredited by the National Commission of Correctional Health Care and the American Correctional Association.) Without appropriate care and treatment, recipients of community mental health services who become incarcerated are likely to deteriorate, become victims of abuse by other inmates, and require more intense and costly services on release.

Coordinated planning

The delivery of adequate care in the jail setting requires collaboration between criminal justice and other human service leaders in the community (Diane Blemberg, Regional Manager, American Correctional Association, personal communication, May 2000). This collaboration should facilitate interagency planning and a continuous care model that integrates medical and mental health treatment in the community with security and health care in the jail. Examples of successful programs are in New York and Massachusetts. New York State recently passed legislation to require representatives of correctional facilities and local criminal justice agencies to be involved in the local governmental mental health planning process. In addition, New York's successful local correctional suicide prevention model[27] was developed through an integrative criminal justice and mental health planning process. Massachusetts, on the other hand, implemented a public mental health model in the Hampden County Correctional Center in Ludlow, Massachusetts.[28] This model promotes a continuous care approach to facilitate identification, continuity of care at admission to the jail, and appropriate service connections at release. Under this program, four community health centers contract with the correctional center to provide health and mental health care for inmates at the facility. The program emphasizes early detection, effective treatment, prevention, and continuity.

Medicaid

The large overlap between persons in the public mental health system and the local correctional system also reinforces the importance of continuing Medicaid during the incarceration period. Federal Medicaid support in most US communities is discontinued when a person on Medicaid is detained in local jails.[21] Torrey et al[19] described the termination of Medicaid eligibility for persons who are incarcerated as the disincentive that is probably the major underlying reason for the poor health care still characteristic of our nation's jails. States should advocate to extend the federal share of Medicaid (for persons enrolled in Medicaid) to cover medical care during the entire jail incarceration period.

In addition, states and localities should collaborate to ensure eligible persons are enrolled in Medicaid within a short period following release from jail and are provided with appropriate support during the enrollment period. For example, New York State recently implemented a model involving a centralized statewide pharmacy program. This program reimburses local pharmacies for the costs of medications provided to persons with mental illness released from jail, prison, or hospital awaiting Medicaid eligibility determination. As an immediate interim policy, local and state governments should cooperate to suspend enrollment during incarceration so that the reestablishment of Medicaid eligibility for persons who were on the Medicaid roster prior to incarceration will be accomplished immediately on release from jail. In addition, states can initiate interim incarceration policies to extend Medicaid eligibility.[21] For example, Oregon implemented a strategy that specifies that individuals cannot be disenrolled from the Oregon Health Plan in their first 14 days of incarceration.

Applied research

The results of these analyes support the need for a targeted research effort to understand and address the risk factors contributing to the incarceration of persons who receive mental health services and to determine the reasons for the higher risk of incarceration for female and older recipients. It cannot be determined from these analyses if there are certain characteristics or service needs that explain why some recipients are incarcerated and others are not. However, it is hypothesized that different service packages wrapped around these individuals will decrease involvement with the criminal justice system. Substance abuse treatment may be an effective service. Recent findings[29] show that substance abuse increases the risk of violence among persons with mental illness. Further, Clark et al[30] found that effective treatment of substance use among persons with mental illness appears to reduce incarcerations.

Furthermore, in 1997 the Substance Abuse Mental Health Service Administration (SAMHSA) initiated research[31] to study the effectiveness of jail diversion programs serving individuals with co-occurring disorders who come into contact with the criminal justice system. This research, which involves the study of programs within nine sites across the country, examines the impact of these programs on persons with mental illness and co-occurring substance abuse disorders.

In summary, many persons are both being served by the mental health system and incarcerated in local jails. Most have not committed serious crimes that warrant long-term prison incarceration and, on release, will be discharged from the jail to the community. Legally and morally it is in the best interest of state and local governments to be proactive in ensuring that health and mental health practices in local jails meet community standards.

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