Race and Mental Health Care Provision inside Prison

Abstract

Research Summary

This article uses a survey of nearly 15,000 prison inmates to examine patterns in mental healthcare provision. There is a significant treatment gap for all inmates. In addition, race and ethnicity is an important predictor of mental health care provision. Black, Hispanic and American Indian inmates were less likely to participate in important forms of mental health care including mental health counseling and substance abuse treatment.

Policy Implications

The United States disproportionately incarcerates black and Hispanic Americans. This paper suggests that disparate treatment continues in the form of differential mental health and substance abuse counseling. Lack of treatment inside prison may contribute to further negative interactions between black and Hispanic former inmates and law enforcement.

Treatment contexts matter for mental health care provision. Race, socioeconomic status, neighborhood conditions, and public versus private providers all impact the likelihood of receiving mental health treatment. One significant provider has been largely overlooked; America's jails and prisons. This is cause for concern, because jails and prisons hold 1.25 million of America's mentally ill. Given racial disparities in other healthcare settings along with disproportionate incarceration of racial minorities, it is important to know whether disparate treatment extends behind prison walls. This paper examines whether inmate race and ethnicity is a predictor of mental health treatment inside prison.

The paper proceeds as follows. First is a discussion of the deinstitutionalization of state mental health hospitals and the related expansion of state prisons as a mental healthcare provider. Next, some of the literature on racial disparities in mental healthcare provision is reviewed. Findings from a survey of nearly 15,000 state prison inmates ask whether race and ethnicity

plays a role in receiving mental health treatment. Finally, the implications of disparate mental health treatment inside jails and prisons is discussed.

Mental Healthcare- Hospitals and Prisons

There is a connection between the size of a country's prison population and the population kept in mental hospitals. Lionel Penrose[1] wrote that there are people in every society whose behavior is so undesirable that they require segregation from the rest of society. Generally, there are two ways to segregate the socially undesirable; either to place the person in a mental institution or to wait until the person commits a crime and then incarcerate that person. Penrose[1] noted the connection between these two institutions stating that "as a general rule, if the prison services are extensive, the asylum population is relatively small and the reserve also tends to be true". Since the 1950s, the United States has gone from an extensive population in state mental health hospitals and a relatively small prison population to a country with an extensive prison population and a relatively small population in state mental health hospitals.

In 1955, there were 560,000 resident patients in American state and county mental hospitals. These hospitals provided almost all inpatient mental healthcare in the United States.[2] Deinstitutionalization led to a dramatic decrease in the number and capacity of public mental health facilities. By 2005, 95 percent of the hospital beds available in 1955 were gone.[3] While private inpatient and outpatient facilities have absorbed some of the mentally ill who would have previously ended up in a state mental hospital, many of the mentally ill are now held by the criminal justice system. In fact, patients with serious mental illnesses are three times as likely to be held in a prison or jail rather than in a hospital.[4]

The Bureau of Justice Statistics reports that more than half of all prison and jail inmates have a mental health problem. In 2005, this included 705,600 inmates in state prisons, 78,800 in

federal facilities and 479,900 in local jails. This represents fifty-six percent of state prisoners, forty-five percent of Federal prisoners and sixty-four percent of jail inmates. There is a large treatment gap in receiving mental health services. Only one third of state prisoners, a fourth of federal prisoners and less than an eighth of local jail inmates with a mental illness were treated since admission.[5] Inmates also struggle with substance abuse problems. Sixty-six percent of state prison inmates and seventy-four percent of mentally ill state prison inmates had an issue with substance abuse or dependence. The need is so great, in fact, that only nineteen percent of state prison inmates do not have a substance abuse or mental health issue.[5]

In many ways, the most vulnerable of our citizens end up in prison or jail. The less educated, less wealthy, the mentally ill and substance abusers are incarcerated at disproportionate rates. Although only one to two percent of the American population is homeless, the homeless make up fifteen percent of the U.S. jail population. Severe mental illness and substance abuse are more prevalent among the homeless than among the general population. Homeless inmates are more likely to have previous involvement with the criminal justice system, to have a substance abuse and/or mental health issue, to be less educated and to be unemployed. Incarceration and homelessness appear to increase the risk of each other.[6]

People with mental health disorders and co-occurring substance-related problems are more likely to be incarcerated and to serve longer sentences.[7] In the past, many of these people would be sent to long term inpatient care at a state mental health hospital. In the state mental hospitals, people were institutionalized to the point of passivity and generally followed orders. When those patients were placed back into the community, they tended to remain there and to accept treatment. Today, most of the severely mentally ill have not spent large parts of their lives in hospitals and are not passive. The current generation of severely mentally ill people are more

likely to go off their medications and encounter the criminal justice system, leading to inappropriate incarceration.[8]

The closing of state mental hospitals and reductions in psychiatric beds is a significant factor for the placement of mentally ill people in jails and prisons rather than in the community or in hospitals. As socially disruptive people are excluded from psychiatric facilities, the criminal justice system has become the system that "can't say no".[9] Jails and prisons have become defacto mental health hospitals.[7,9] Unfortunately, jails and prisons lack the resources to treat every inmate with a mental illness. With an inability to treat every inmate, it is important to consider whether there are treatment patterns associated with inmate characteristics, especially with regards to race and ethnicity. Other areas of healthcare provision may suggest an answer. If race impacts healthcare provision outside prison, it is likely that race plays a role in healthcare provision inside prison.

Racialized Mental Health Care Provision

Evidence of racial and ethnic disparities in healthcare are remarkably consistent across a range of illnesses and services. The majority of studies have found racial and ethnic disparities even after adjustments were made for socioeconomic differences and other access related factors.[11] These disparities may be particularly pronounced in mental healthcare. A report by the Surgeon General found that more so than in other areas of health and medicine, mental health services are "plagued by disparities in the availability of and access to its services" and that "these disparities are viewed readily through the lenses of racial and cultural diversity, age and gender". The same report argues that these disparities place a greater disability burden on racial and ethnic minorities.[11]

Racial and ethnic minorities are less likely to participate in mental healthcare, across a wide variety of measures. Spanish-speaking Hispanic and black patients are significantly less likely to have had a physician or mental health visit. Minority race or ethnicity has been linked to a lower likelihood of having a regular source of care, fewer physician visits and lower total health care expenditures.[12] Poor Hispanics have lower access to outpatient mental healthcare than poor non-Hispanic whites. Blacks were less likely to receive outpatient mental healthcare than whites, even after controlling for demographic characteristics, insurance status and psychiatric morbidity.[13] Blacks have higher levels of psychological distress and lower levels of psychological well-being than whites. Racial differences persist even after controlling for socioeconomic status.[14] Black adults and adolescents were less likely to receive treatment for depression than whites. Hispanics were less likely to receive treatment for a substance abuse issue than whites.[15] Among those with need, whites were more likely than Hispanics or blacks to receive treatment for alcoholism, drug abuse or mental health issues.[16] In high poverty areas, whites are also more likely to be hospitalized for mental health issues.[17]

There are multiple reasons why whites may receive higher levels of mental healthcare than racial and ethnic minorities. Doctors have poorer communication with minority patients, providing less information and using a less-participatory decision-making style.[18] Doctors may intentionally or unintentionally communicate lower expectations for patients in disadvantaged social positions. Race and ethnicity help influence provider expectations. Providers may believe that a social or behavioral characteristic makes a patient more or less appropriate for a particular treatment. Group stereotypes inform doctors' treatment decisions about an individual's likelihood of success, leading to rationing of certain treatments.[19]

Alternatively, treatment differences may be caused by differences in prevalence amongst various racial and ethnic groups. The literature is divided on whether certain groups have higher rates of mental health issues than others. Some studies have found higher prevalence and severity of symptoms among blacks compared to whites, other studies have found the opposite and some studies have found no racial differences.[20] Vega and Rumbaut[21] found overall higher mental illness symptom levels for blacks and Hispanics than for non-Hispanic whites. Wells et al[16] also found that blacks had higher rates of probable mental disorders and higher perceived need for substance abuse treatment. Discrimination may lead to higher need for mental health treatment amongst minority groups. Experiences of discrimination are a source of stress that can adversely affect mental health. Reports of discrimination due to race or cultural background are positively related to psychological distress.[22] Race related stress may have a more adverse impact on the mental health of blacks than whites, in part due to higher levels of perceived discrimination among blacks.[14]

However, other studies have found equal or higher levels of self-esteem for blacks.[20, 23] James and Glaze[5] also estimate higher levels of mental illness for white inmates than black and Hispanic inmates. Treatment differences may be a reflection of variance in the prevalence of mental disorders among the inmate populations. I do not believe this is an issue for the current study. First, inmate populations are likely to be similar to each other, due to selection effects. Even if white inmates have a higher prevalence of mental health issues, there are a larger number of mentally ill black inmates, due to disproportionate incarceration patterns. Table 1 presents the prevalence and absolute numbers of mentally ill inmates by race for 2005, based on the Bureau of Justice Statistics estimates.

Table One- Prevalence and Absolute Numbers of Mentally Ill Inmates by Race (2005)

Race	Prevalence (%)	Total Number of Prisoners	Number of Inmates with a Mental Illness
White	62.2%	459,700	285,933
Black	54.7%	547,200	299,318
Hispanic	46.3%	279,000	129,177

American prisons and jails incarcerate large numbers of the mentally ill. Racial disparities exist in other areas of mental healthcare provision, and these disparities may extend to mental healthcare inside prisons. I will now turn to the quantitative analysis for this paper.

Data

The data come from the Bureau of Justice Statistics *Survey of Inmates in State and Federal Correctional Facilities, 2004* (2004 Survey). The 2004 Survey involved personal interviews in both state and federal prisons that provided information about the inmate's offense, criminal history, pre-incarceration life, participation in treatment programs and punishment inside prison. The 2004 Survey is a nationally representative sample of inmates, selected in a two-stage process. Prisons were selected in the first stage and inmates within the sampled prisons were selected in the second. In the first stage 290 State prisons were selected, including 225 male facilities and 65 female facilities. The 14 largest male prisons and 7 largest female prisons were selected with certainty. The remaining facilities were selected based on probability proportional to size. From the 290 state prisons, approximately 1 in every 85 males and 1 in every 24 females in were selected. There were 14,499 complete interviews for the State survey.

Given that inmates are clustered inside prisons, I analyzed data using conditional logit models. Conditional logit allows for fixed effects, which in this case were grouped by the facility code. Each model is therefore explaining **within** facility variation, after controlling for prison fixed effects. This should control for confounding factors, such as prisons with differential resources.

Dependent Variables

I focus on mental health and substance abuse treatment inside prison. I include two measures as dependent variables, labeled *Mental Health Counseling*, and *Substance Abuse Treatment*. *Mental Health Counseling* is a dichotomous variable for whether the inmate has participated in mental health counseling led by a professionally trained counselor since their admission to prison. *Substance Abuse Treatment* is a dichotomous variable for whether the inmate has participated in a substance abuse treatment program since their admission to prison.

Explanatory Variables

The 2004 Survey offers an opportunity to explore a nuanced examination of inmate characteristics. Nearly three thousand variables are included in the 2004 Survey, capturing many aspects of the inmate's pre-incarceral and incarceral life. The main explanatory variables of interest focus on the race of the inmate. Models also include measures of the inmate's pre-incareration life and criminal history.

Race, Gender and Age

I include six demographic variables. Four variables measure the inmate's race and ethnicity, *Black, Hispanic, Asian* and *American Indian*. All four variables are dichotomous dummy variables. White inmates are the reference category. It is hypothesized that all four groups will experience worse treatment outcomes than white inmates, but that the effects will be strongest for black inmates. Around forty-three percent of respondents identified as black, seventeen percent as Hispanic, five percent as American Indian and one percent as Asian. I also include measures of the inmate's age and gender. *Age* is the inmate's age, ranging from sixteen to eighty-four years old, with a mean age of thirty-five. *Female* is a dichotomous variable for

whether the inmate is a woman. I expect female inmates to participate at higher rates, as per previous Bureau of Justice Statistics findings. However, since I control for fixed effects at the facility level, it is not expected that gender will be statistically significant. Most prison facilities are segregated by gender.

Pre-Incarceral Life

I include four measures of the inmate's pre-incarceral life as control variables. *Drug User* is a dichotomous variable for whether the inmate used drugs before their arrest. *Drug User* includes all illegal drugs, including marijuana. Drug users are expected to participate more in substance abuse and mental health counseling, due to higher levels of need. *Highest Grade Attended* is a measure of the inmate's education level. The average surveyed inmate did not complete high school, and in fact stopped attending school in the tenth grade. The inmates surveyed ranged from the equivalent of no formal education to a master's degree. It is hypothesized that better educated inmates will be more likely to participate in mental health and substance abuse counseling. *Working Before Arrest* is a dichotomous variable for whether the inmate was employed at the time of their incarceration. An inmate who was capable of being employed may have life skills that improve their chances at success in rehabilitative programming. Finally *Ever Homeless* is a dichotomous variable for whether the inmate was ever homeless in their pre-incarceral life. Nearly ten percent of the inmates reported being homeless, offering another indication of the vulnerability of this population. It is expected that inmates reporting being homeless will participate more in rehabilitative programming, due to increased need.

Criminal History

The second set of controls measure the inmate's criminal history. Three variables are included, labeled *Violent Offender, Number of Arrests* and *Number of Incarcerations*. *Violent Offender* is a dichotomous variable for whether the inmate was convicted of a violent offense, such as assault or murder. *Number of Arrests* and *Number of Incarcerations* measure the number of times an inmate has been arrested and incarcerated, respectively. A higher number of arrests/incarcerations suggest a longer criminal history and a propensity towards trouble making, or at least a propensity towards getting caught. An inmate with a higher number of arrests/incarcerations is expected to have a negative social construction, participating less in rehabilitative services and being punished more

Table two presents descriptive statistics for the dependent and explanatory variables.

Table Two- Descriptive Statistics for Dependent and Explanatory Variables

Variable	Observations	Average	Standard Deviation	Minimum	Maximum
Substance Abuse Treatment	14499	0.077	0.266	0	1
Mental Health Counseling	14499	0.142	0.349	0	1
Female	14499	0.202	0.402	0	1
Age	14499	35.351	10.413	16	84
Hispanic Origin	14499	0.174	0.379	0	1
Black	14499	0.428	0.498	0	1
American Indian	14499	0.055	0.228	0	1
Asian	14499	0.010	0.097	0	1
Number of Arrests	13756	4.415	5.084	0	20
Number of Incarcerations	14288	1.393	2.109	0	10
Ever Homeless	13798	0.092	0.289	0	1
Highest Grade Attended	14327	10.829	2.347	0	18
Working Before Arrest	14073	0.704	0.457	0	1
Drug Use	14499	0.530	0.499	0	1

Table three presents model estimations for both the mental health counseling and substance abuse treatment dependent variables.

Table Three- Model Estimation for Mental Health Counseling and Substance Abuse Treatment

Explanatory Variables	Mental Health Counseling	Substance Abuse Treatment
Black	-0.206 ***	-0.246 ***
	(0.077)	(0.066)
Hispanic	-0.259 **	-0.221 **
	(0.112)	(0.092)
American Indian	-0.270 *	0.053
	(0.154)	(0.122)
Asian	-0.434	-0.109
	(0.442)	(0.331)
Female	-2.082	1.951
	(1.404)	(1.196)
Age	0.013 ***	0.005
	(0.004)	(0.003)
Drug User	0.846 ***	0.870 ***
	(0.077)	(0.065)
Highest Grade Attended	0.027 *	0.015
	(0.016)	(0.013)
Working Before Arrest	-0.046	-0.059
	(0.074)	(0.063)
Ever Homeless	0.171	0.230 **
	(0.107)	(0.092)
Violent Offender	-0.056	-0.312 ***
	(0.082)	(0.073)
Number of Arrests	0.015 ***	0.019 ***
	(0.004)	(0.003)
Number of Incarcerations	0.040 ***	0.050 ***
	(0.010)	(0.010)
Number of Observations	11507	12311
Pseudo R2	0.041	0.052
*p<.10, **p<.05, ***p<.01		

Findings

Two results stand out. First, there is a significant treatment gap for **all** inmates. Only 14.2 percent of inmates in the 2004 Survey participated in mental health counseling, despite estimates

that 56 percent of state prison inmates have a diagnosable mental disorder. Likewise, only 7.7 percent of inmates in the 2004 Survey participated in substance abuse treatment, while estimates suggest that 66 percent of state prison inmates have a substance abuse issue. Deinstitutionalization shifted many of the mentally ill and substance abusers from state mental health hospitals to the criminal justice system. Prisons do not seem to have enough resources to meet the need of their mentally ill inmates or their inmates with substance abuse issues.

Second, while there is a significant treatment gap for all inmates, the results are worse for minority inmates. Black and Hispanic inmates were less likely to participate in both mental health counseling and substance abuse treatment. American Indian inmates were less likely to participate in mental health counseling as well. Race and ethnicity seems to be a predictor of healthcare provision in prison, even when features of the inmate's criminal history and pre-incarceral life are accounted for.

Discussion

Previous research has found consistent racial disparities in mental healthcare. The majority of research has focused on non-institutionalized populations, thereby ignoring the 1.25 million mentally ill Americans who are held in prisons and jails. This paper examined treatment inside state prisons and found treatment disparities for black, Hispanic and American Indian inmates. Racial and ethnic minorities already receive disproportionate punishment in the American criminal justice system. Differential treatment inside prison may make it even more difficult for racial and ethnic minorities to successfully reintegrate into American society upon their release.

Treatment inside prison effects recidivism, future criminal activity, future wages and future political activity.[24, 25, 26, 27] Most inmates will eventually be released from prison, and treatment decisions, including the decision to provide mental health or substance abuse counseling, impact the life skills that inmates have upon release. To the extent that the purpose of prison is to punish inmates, this may not be a concern. However, if our goal is to rehabilitate and reform inmates, then current prison based mental healthcare seems insufficient.

Future research should examine the causal mechanisms that may explain these disparities. I have sought to identify and describe disparities that may exist, but this paper is agnostic as to the causal mechanisms at work. Future research should identify the gatekeepers to prison mental healthcare and the decision mechanisms that those gatekeepers use. Policy makers should also consider whether to expand prison mental health and substance abuse treatment, or whether there are more appropriate places for the detention of America's mentally ill criminals. The gap between need and treatment is substantial, and policy makers should identify ways to decrease that gap.

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