The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program

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Abstract: This paper presents the prevalence rates of schizophrenia and major affective disorders by age and race among a random sample of male jail detainees. Subjects were administered the National Institute of Mental Health Diagnostic Interview Schedule (NIMH-DIS). The jail prevalence rates were then compared with general population data from the five-city Epidemiologic Catchment Area program using difference of proportion tests and loglinear analysis. After controlling for demographic differences between the jail and five-city samples, the jail prevalence rates were still two to three times higher than those in the general population. These findings suggest several public policy modifications concerning the psychiatric management of our burgeoning jail population. (*Am J Public Health* 1990; 80:663–669.)

Introduction

Mental health professionals speculate that the jails have become a repository for the severely mentally ill. Often referred to as the criminalization hypothesis, this trend is thought to be the unintended consequence of policy modifications, e.g., deinstitutionalization and more stringent commitment criteria.[1–3] Of particular concern are minor offenders (e.g., shoplifters) who could be treated in the mental health system but are instead managed by the criminal justice system. Criminal processing of the mentally ill may be most common among the individuals of the underclass because they have less access to treatment, fewer treatment alternatives, and less social support than wealthier persons.[4]

Jails, rather than prisons, are the critical point to gather psychiatric epidemiological data. Jail populations include detainees awaiting trial and convicted offenders serving sentences of less than one year, while prisons contain only convicted criminals serving longer sentences. Prison samples are biased because inmates are often diverted to forensic psychiatric facilities prior to conviction or imprisonment; prevalence rates of severe disorders in prisons* appear to be lower than those in jails[2] and those in the general population.[5,6]

The Appendix displays the findings of previous prevalence studies of mental illness among jail populations.[7–24] Interestingly, the studies listed show no increase in prevalence rates over time, and little consistency across studies. The tremendous variation in prevalence rates may be explained, in part, by three major methodological limitations:

- *Sample Selection*—To date, only four studies have used random samples.[11–13,23] One study used volunteers,[20] resulting in a plethora of potential biases. The most common type of study includes only persons who are referred for a mental health evaluation, and is obviously biased.
- *Measurement*—The variability in prevalence rates may be a result of the unknown reliability of the instrumentation used in many investigations. Since many studies used unspecified diagnostic criteria and/or nonstandardized instruments,[11,14,16] the diagnostic process is probably inconsistent across samples.
- *Sample Size*—Psychotic disorders have an extremely low base rate, between 1–2 percent.[5,6] The low base rate requires a relatively large sample size to generate accurate prevalence statistics.[25] No study incorporating a random sampling strategy used a large enough sample size.

None of these studies compare the jail prevalence rates with those in the general population. Moreover, because jail detainees are disproportionately young and minority group members[26]—characteristics correlated with severe mental disorder[27]—any comparison with baseline data must control for the jail's demographic composition.

The dearth of reliable psychiatric epidemiological data is critical because of the correctional system's overwhelming growth: between 1978 and 1983, the jail census rose by 40 percent, and by 1987, it increased by another 28 percent.[28–30] Research and intervention at the jail level are particularly important because not only are many jail detainees in need of ameliorative treatment, they are captive and physically amenable to intervention.

This paper provides an accurate estimate of severe mental disorder among male jail detainees in Cook County, Illinois, and compares the prevalence rate to that of the general population.

Methods

Subjects

Jail subjects studied were a stratified random sample (approximately one-half misdemeanants, one-half felons) of male detainees who entered Cook County Department of Corrections in Chicago, Illinois, directly from pretrial arraignment between November 1983, and November 1984 (N = 728). Persons charged with both misdemeanors and felonies were categorized as felons. Data were subsequently weighted to reflect the actual composition of misdemeanants and felons. The jail receives approximately 60,000 admissions per year[31] and is demographically similar to other large urban jails on such variables as race and age.[32] The size of the facility ensured adequate subject availability.

By assuming a binomial distribution for the frequencies of occurrence or non-occurrence, this sample size allows us to reliably detect events which have a base rate in the general population of less than 1 percent.[33]

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*Collins JJ, Schlenger WE: The prevalence of psychiatric disorder among admissions to prison. Paper presented at annual meeting of the American Society of Criminology, Denver, CO, November 1983.

The age range of subjects was 16–68 years, mean and median age of 26.3 and 25.0 years, respectively; 57.4 percent were employed at the time of arrest. The racial composition was predominantly Black (80.8 percent); 6.5 percent of the sample were Hispanic, 12 percent were other Whites, and the remaining 0.8 percent were largely Asian or American Indian. Educational level ranged from two to 16 years of schooling, mean 10.6 years, median 11.0 years. The sample demographic characteristics (including the skewed racial/ethnic breakdown) reflect the demographic composition of the Cook County Jail.

Procedures

All detainees, excluding persons with gunshot wounds or other traumatic injuries, were part of the sampling pool. Personnel at the jail referred all persons targeted for participation in the project, regardless of their psychiatric morbidity, state of drug or alcohol intoxication, potential for violence, or fitness to stand trial. Subjects were selected via random numbers as they waited to be processed in the jail intake area. To ensure that the sample contained approximately equal numbers of misdemeanants and felons, the interviewers alternated between them in the sampling process.

Interviewers were clinical psychologists who had extensive training in interviewing techniques, psychopathology, and the data collection instrument. Interviewer consistency was scrupulously maintained after the initial three-month training period via mock interviews with live subjects, spot checks, and videotape training. Detainees who consented to be subjects were paid $5 which was mailed to an address of their choice. Of 767 subjects approached, 35 (4.6 percent) refused to participate. The low refusal rate was probably due to the detainees' viewing the research project as a way to avoid the crowded and dismal conditions of the regular intake area. Four other subjects were excluded: two "duplicate" subjects (they were re-arrested and randomly selected again) and two others who appeared to be confabulating their responses. Thus, the final N was 728.

Subjects were interviewed in a soundproof, private glass booth within the jail intake area using the National Institute of Mental Health Diagnostic Interview Schedule (NIMH-DIS).[34] Empirical tests have documented the reliability of the NIMH-DIS in both institutionalized samples and the general population[35–38] (in contrast, see the report by Anthony, *et al.*[39] The DIS systematically differentiates between disorders that were ever manifest, even if currently remitted (lifetime disorders), and disorders in which symptoms have been recently experienced (current disorders).

The NIMH-DIS provides diagnostic categories rather than global psychopathology scores. DSM-III diagnoses are scored from the interview data by a computer program written expressly for this purpose.[40] Because of subject variance over time and the rarity of many disorders, it is difficult to assess the reliability and validity of psychiatric assessment instruments such as the DIS.[41] Nevertheless, a reliability check of twenty pairs of interviews found 93 percent agreement across all diagnoses; 85 percent were given nearly identical profiles. The interview lasted between one and three hours, depending on the number of positive symptoms of the detainee.

The baseline (general population) data were obtained from the NIMH Epidemiologic Catchment Area program[42] which, also using the NIMH-DIS, calculated the prevalence rates of mental disorders in five cities: Baltimore (n = 3,481), New Haven (n = 5,034), Los Angeles (n = 3,131), Raleigh-Durham (n = 3,921), and St. Louis (n = 3,004).[5]

Because the jail sample was male, female subjects were eliminated from the comparison data. We also omitted all Hispanics (as well as other subjects who were neither Black nor White) from both data sets because there was an insufficient number of Hispanic jail detainees to include in the analysis (n = 47). Since the five-city sample excluded persons under the age of 18, we eliminated 53 subjects under that age from the jail sample in the comparison. Because almost all the jail sample were under age 60, we also excluded subjects over age 60 from the comparison. The final sample includes 627 jail detainees and 3,481 from the general population in the five cities: Baltimore, n = 825; New Haven, n = 748; Los Angeles, n = 431; Raleigh-Durham, n = 832; and St. Louis, n = 818. The complex sampling design of the five-city sample[43] required adjustment of the variances and standard errors presented in this paper using design effects estimated with Taylor Series Linearization provided by the National Institute of Mental Health.[44]

We calculated the prevalence rates of three disorders: major depressive episode, manic episode, and schizophrenia (including schizophreniform disorder). For each disorder, separate analyses were conducted to differentiate between "current" (defined as symptomatic within two weeks of the interview) and "lifetime" diagnoses. We conformed with the Epidemiologic Catchment Area study in that the disorders are not mutually exclusive: a subject could meet criteria for more than one disorder.[45]

In order to attain adequate statistical power for the jail-general population comparison, the data from the five cities needed to be combined. Before doing so, we compared the prevalence rates of each disorder across the five cities. This precautionary measure ensured that any observed differences between the jail and the general population data were not merely an artifact of the idiosyncratic characteristics of one or two of the cities. A loglinear analysis indicated that there were no significant or substantial dissimilarities in prevalence rates across the five cities (data available on request to author).

Results

Tables 1 and 2 show the prevalence rates with their standard errors, differences between the jail and the five-city sample, and the ratio of the differences in prevalence rates to the standard error of the difference (differences of proportions test[46]) for current and lifetime disorders, respectively. The uneven partitioning of age is dictated by the limited number of jail detainees over age 32 (n = 117). We did not simultaneously cross-classify by race and age because the resulting decrease in cell size would reduce power to an unacceptable level. The tables do not present data on socioeconomic status (SES) because the only SES indicators used in the five-city general population study (income and occupation) measure the individual's *achieved* status. These variables are inappropriate for this analysis because they have inconsistent bidirectional and temporal effects on the dependent variable. Low income and unemployment may either precede or result from severe mental illness.[47,48] Race is an indirect indicator of SES because of the strong correlation between these two factors.[49,50]

Tables 1 and 2 show that, overall, prevalence rates of current and lifetime major depression, mania, and schizophrenia, and "any severe disorder" (that is, any of the three

TABLE 1—Current Prevalence, Standard Errors, and Standard Errors of Differences for Major Depression, Mania, Schizophrenia and "Any Severe" Disorder for Jail and Five-City Samples

		Major Depression				Mania				Schizophrenia				Any Severe Disorder			
	N	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE
All	4,281	1.49	0.36			0.30	0.19			1.18	0.32			2.50	0.47		
Non-Jail	3,654	1.07	0.22			0.12	0.08			0.91	0.22			1.84	0.31		
Jail	627	3.94	0.78	2.87	4.61**	1.36	0.46	1.24	4.48**	2.74	0.65	1.83	3.03**	6.36	0.98	4.52	5.33**
By race																	
Black	1,541	1.62	0.53			0.51	0.31			1.60	0.55			3.15	0.75		
Non-Jail	994	0.80	0.37			0.14	0.17			1.03	0.46			1.73	0.57		
Jail	547	3.11	0.74	2.31	3.12**	1.18	0.46	1.04	2.52*	2.63	0.68	1.60	2.01*	5.74	1.00	4.01	3.75**
White	2,740	1.42	0.62			0.19	0.32			0.95	0.43			2.14	0.69		
Non-Jail	2,660	1.17	0.27			0.12	0.10			0.87	0.26			1.89	0.37		
Jail	80	9.60	3.31	8.43	5.08**	2.55	1.77	2.43	3.81**	3.52	2.07	2.65	1.74	10.57	3.46	8.68	3.95**
By age (years)																	
18–22	706	0.82	0.60			0.11	0.24			1.90	0.91			2.61	1.06		
Non-Jail	511	0.43	0.38			0.00	—			1.51	0.77			1.94	0.85		
Jail	195	1.85	0.97	1.42	1.67	0.40	0.45	—	—	2.91	1.21	1.40	0.97	4.36	1.47	2.42	1.47
23–27	838	2.17	0.92			0.09	0.22			1.00	0.63			2.92	1.07		
Non-Jail	639	1.12	0.54			0.00	—			0.74	0.48			1.65	0.70		
Jail	199	5.56	1.63	4.44	3.35**	0.39	0.44	—	—	1.82	0.95	1.08	1.07	6.99	1.81	5.34	3.31**
28–32	736	2.14	1.06			0.56	0.66			1.72	0.96			3.70	1.39		
Non-Jail	619	1.29	0.59			0.08	0.16			1.17	0.61			2.36	0.85		
Jail	117	6.62	2.31	5.33	3.17**	3.10	1.61	3.02	3.81**	4.61	1.95	3.44	2.09*	10.80	2.88	8.44	3.64**
33–60	2,002	1.20	0.44			0.36	0.40			0.81	0.42			1.86	0.60		
Non-Jail	1,885	1.15	0.32			0.21	0.15			0.73	0.28			1.72	0.42		
Jail	117	2.01	1.30	0.86	0.65	2.85	1.54	2.64	3.65**	2.18	1.36	1.45	1.24	4.18	1.86	2.46	1.42

*Significant at .05.
**Significant at .01.

disorders) are significantly higher in the jail sample than in the five-city sample. The overall prevalence rates for current disorders are 1.24 percent to 4.52 percent higher among jail detainees than in the five-city sample; for lifetime disorders, the rates are 2.01 percent to 5.07 percent higher in the jail sample. In general, the differences in both current and lifetime prevalence rates between the jail and five-city samples hold when controlling for race. Except for current schizophrenia among Whites, and lifetime schizophrenia among both Whites and Blacks, the differences between the jail and the five-city sample remain statistically significant for Blacks and Whites, ranging from 1.04 percent (current mania among Blacks) to 8.43 percent (current major depression among Whites). The differences between the jail and the five-city sample are somewhat less robust when controlling for age, but this may reflect the small sample sizes.

The difference of proportions test (Tables 1 and 2) is less powerful with low prevalence rates than other techniques, e.g., loglinear analysis.[51] Given the limitations of the difference of proportions test, we reanalyzed the data using hierarchical loglinear modeling[52] (Table 3). This technique enables us to test the differences between the jail and five-city samples while holding both age and race constant.

Table 3 reports the parameters, the ratio of parameters to their standard errors (roughly equivalent to the likelihood ratio chi-square test), and model statistics for the final loglinear models for each current and lifetime diagnosis. Empty cells were set to .05, rather than the less conservative technique of setting them to structural zeros and adjusting degrees of freedom.[53] Notice that for each of the eight models, the site (jail/five-city sample) by diagnosis (present/absent) effect is retained and is in the hypothesized direction. In other words, we can reject the hypothesis of homogeneity for all current and lifetime disorders. In all cases, the coefficient for a diagnosis by site interaction exceeds its standard error by at least 2.58, or with a probability of less than .01. The analysis thus strongly supports our hypothesis: the prevalence rates of major depression, mania, and schizophrenic disorders are significantly higher in the jail than in the five-city sample, and are not an artifact of race or age differences between the two samples.

Discussion

This study provides reliable data concerning the relative prevalence of severe mental disorder among urban jail detainees in Cook County, Illinois, and the five-city Epidemiologic Catchment Area sample of the general population: for all race-age subgroups, the observed jail rates of schizophrenia, major depression, and mania were two to three times higher than in the general population. Moreover, these prevalence rates likely underestimate the true prevalence of mentally ill persons who are processed through the criminal justice system; samples obtained at the jail level omit all persons who are arrested but not incarcerated because they are diverted to a mental health facility during their pretrial hearing.

Our results do not enable us to ascertain whether mental disorder is a causal determinant of a criminal career, or merely a frequent trait among these offenders. Comparison with similar studies is of little utility. As demonstrated in the Appendix, their methodological limitations do not permit us to infer with any certainty whether our prevalence rates are higher than those found in prior studies. Our data thus provide necessary, but not sufficient, evidence that the mentally ill may be diverted into the criminal justice process.

In their exhaustive review of the literature, Monahan and Steadman[27] concluded that the apparently greater prevalence

TABLE 2—Lifetime Prevalence, Standard Errors, and Standard Errors of Differences for Major Depression, Mania, Schizophrenia and "Any Severe" Disorder for Jail and Five-City Samples

		Major Depression				Mania				Schizophrenia				Any Severe Disorder			
	N	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE	Rate %	SE %	Diff. %	Diff./ SE
All	4,281	3.53	0.50			0.64	0.27			1.99	0.40			5.15	0.63		
Non-Jail	3,654	3.15	0.37			0.32	0.14			1.70	0.30			4.41	0.47		
Jail	627	5.75	0.93	2.60	2.65**	2.51	0.63	2.19	5.26**	3.71	0.76	2.01	2.52*	9.48	1.17	5.07	4.09**
By race																	
Black	1,541	2.94	0.71			0.91	0.41			2.64	0.70			5.29	0.96		
Non-Jail	994	1.86	0.56			0.19	0.20			2.05	0.64			3.31	0.79		
Jail	547	4.90	0.92	3.04	2.99**	2.22	0.63	2.03	3.76**	3.70	0.81	1.65	1.57	8.89	1.22	5.58	4.00**
White	2,740	3.87	0.77			0.49	0.43			1.62	0.49			5.07	0.87		
Non-Jail	2,660	3.64	0.47			0.37	0.17			1.56	0.34			4.82	0.58		
Jail	80	11.54	3.59	7.90	2.84**	4.50	2.33	4.13	3.89**	3.52	2.07	1.96	0.98	13.49	3.84	8.67	2.55*
By age (years)																	
18–22	706	1.54	0.79			0.22	0.34			2.46	1.02			3.76	1.25		
Non-Jail	511	1.11	0.60			0.00	—			2.29	0.94			3.23	1.09		
Jail	195	2.66	1.16	1.55	1.28	0.80	0.64	—	—	2.91	1.21	0.62	0.37	5.16	1.59	1.93	0.96
23–27	838	5.17	1.31			0.40	0.44			1.38	0.72			6.42	1.50		
Non-Jail	639	4.28	1.04			0.00	—			1.21	0.62			5.28	1.23		
Jail	199	8.02	1.93	3.74	1.74	1.67	0.91	—	—	1.92	0.98	0.71	0.58	10.09	2.14	4.81	1.92
28–32	736	5.74	1.49			1.35	0.89			3.01	1.20			7.67	1.81		
Non-Jail	619	5.12	1.15			0.77	0.51			2.38	0.87			6.36	1.36		
Jail	117	9.04	2.66	3.92	1.36	4.44	1.91	3.67	2.56**	6.37	2.27	3.99	1.79	14.57	3.28	8.21	2.38*
33–60	2,002	2.74	0.63			0.62	0.52			1.70	0.64			4.19	0.91		
Non-Jail	1,885	2.68	0.48			0.36	0.20			1.47	0.39			3.80	0.61		
Jail	117	3.77	1.77	1.09	0.55	4.85	1.99	4.49	4.77**	5.44	2.11	3.97	2.38*	10.54	2.85	6.74	2.64**

*Significant at .05.
**Significant at .01.

of mental disorder among offenders disappears when sociodemographic factors are taken into account. In this study, however, the differences between the jail and general population persisted even after controlling for race and age.

It is also interesting to note that the observed ratio of current jail rates to current population rates is substantially higher than the comparable ratio of lifetime rates. This finding lends further support to the criminalization hypothesis because we know the arrest occurred during a period of active illness. Mentally ill persons with co-occurring substance abuse and personality disorders may be the most vulnerable to arrest because few treatment alternatives are available.**,[4] Clearly, further research is needed to disentangle the relationship between mental disorder and criminality, as well as to ascertain if mentally ill persons who are more appropriately treated within the mental health system are being funneled into the criminal justice system.

The finding that over 6 percent of all incoming jail detainees were suffering from a "current" psychotic illness suggests several public policy implications.

First, since disorders such as schizophrenia, major depression, and mania require immediate attention, jails must routinely screen all incoming detainees for severe mental disorder.[54] Interestingly, although the courts mandate that jails conduct routine mental health evaluations,[55–57] many jails do not do so.[58] The relative paucity of routine evaluation programs in jails is probably due to insufficient fiscal and mental health resources, as well as a dearth of screening instruments that are appropriate for the jail setting. Recent developments in screening techniques designed to be used within correctional settings[59] are likely to aid in the detection of mental illness. Jail administrators should incorporate these or similar instruments into their routine intake process to ensure that severely ill detainees will be detected and treated.

Second, the prevalence of detainees who are actively psychotic suggests that jail administrators must negotiate programmatic relationships with mental health facilities. Unfortunately, although the courts have stipulated that mentally ill prisoners must receive treatment for mental disorders,[60–62] many jails, particularly those in rural areas, have no mental health liaison.[63] Detainees can either be treated "in house," or referred outside.[64] Whichever system is used, it must be designed to minimize bureaucratic impediments to treatment.

Third, in accordance with the American Bar Association Mental Health Criminal Justice Standards,[65] mentally ill detainees who have committed minor crimes, e.g., trespassing and disorderly conduct, should be diverted to the mental health system. Clearly, persons whose offenses are more symptomatic of mental illness than of criminality should be treated as disordered rather than disorderly.

In sum, our results cannot be interpreted as evidence that the mentally ill are increasingly subject to incarceration. Nevertheless, the data document that the prevalence rate of severe mental disorder is significantly higher in a typical urban jail than in the general population. Additional epidemiological work is needed to ascertain the extent to which this finding is generalizable to other geographical areas. In accordance with court rulings, and in view of the number of severely disturbed detainees in our jails, we must allocate sufficient resources and develop and implement innovative treatment programs so that the mentally ill in jail may be treated expeditiously and in the most humane manner possible.

**Abram KM, Teplin LA: Co-occurring disorders among mentally ill jail detainees: Prevalence, patterns and implications. Manuscript submitted.

TABLE 3—Loglinear Modeling of Major Depressive, Mania, and Schizophrenia, and "Any Severe" Disorder with Site, Age, and Race

	Major Depressive				Mania				Schizophrenia				Any Severe Disorder			
	Current		Lifetime		Current		Lifetime		Current		Lifetime		Current		Lifetime	
	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE	Coeff.	Coeff/SE
Site	0.64716	7.79429**	0.72082	9.59050**	0.36704	2.06367**	0.36565	2.90012**	0.69515	7.37876**	0.77727	9.78684**	0.66814	0.98984	0.73620	11.82454**
Age	−0.08916	−1.98927*	−0.49406	−3.41389**	−0.08916	−1.98927*	−0.68544	−1.82100	−0.08914	−1.98884*	−0.08914	−1.98884*	−0.08917	−1.98941*	−0.28710	−2.94520**
	0.03183	0.72611	0.22196	2.40217*	0.03183	0.72611	−0.21753	−0.76806	0.03183	0.72596	0.03183	0.72596	0.03185	0.72654	0.09918	1.27409
	−0.24995	−4.93573**	0.01302	0.13690	−0.24995	−4.93573**	0.24017	1.14957	−0.24995	−4.93586**	−0.24995	−4.93586**	−0.24995	−4.93585**	−0.07200	−0.90589
Race	0.23301	6.22200**	0.06238	0.89179	0.23301	6.22200**	0.23304	6.22283**	0.23302	6.22212**	0.23302	6.22212**	0.23298	6.22283**	0.14572	2.51508**
Diagnosis	1.93002	24.72801**	1.58786	23.86679**	2.74907	15.65617**	2.51726	15.29506**	2.06427	22.97210**	1.83130	24.68055**	1.66601	27.18680**	1.32669	26.86695**
Age by diagnosis			0.43504	3.02528**			0.60959	1.61575							0.22683	2.35182*
			−0.20492	−2.27764*			0.25908	0.91142							−0.07513	−0.99454
			−0.28878	−3.19583*			−0.50552	−2.40392*							−0.20997	−2.82254*
Race by diagnosis			0.18961	2.85341**											0.10255	1.95333
Site by age	−0.34099	−7.60792**	−0.34967	−7.76005**	−0.34099	−7.60792**	−0.35214	−7.80981**	−0.34101	−7.60835**	−0.34101	−7.60835**	−0.34098	−7.60778**	−0.35156	−7.79333**
	−0.23844	−5.43896**	−0.23417	−5.32806**	−0.23844	−5.43895**	−0.24658	−5.58891**	−0.23844	−5.43881**	−0.23844	−5.43881**	−0.23846	−5.43939**	−0.23556	−5.34996**
	0.01154	0.22779	0.01890	0.37175	0.01154	0.22779	0.02443	0.47626	0.01154	0.22791	0.01154	0.22791	0.01154	0.22791	0.02311	0.45316
Site by race	−0.72519	−19.36411**	−0.73429	−19.40516**	−0.72519	−19.36411**	−0.72522	−19.36494**	−0.72519	−19.36423**	−0.72519	−19.36423**	−0.72515	−19.36845**	−0.73223	−19.39179**
Site by diagnosis	0.33326	4.26988**	0.27160	3.66280**	0.60486	3.44474**	0.61423	4.97229**	0.27986	3.11444**	0.19861	2.67667**	0.32106	5.23927**	0.26795	4.48820**
Degree of freedom	20		16		20		17		20		20		16		16	
Model G^2	23.95568		10.54086		26.69138		14.87989		17.75185		20.09493		17.80153		11.33859	
Model Probabiilty	0.244		0.837		0.144		0.604		0.604		0.452		0.600		0.788	

*Significant at .05.
**Significant at .01.

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APPENDIX

The Prevalence of Mentally Disordered Persons in Jails: A Summary of the Most Recent Research

Study	Description of Sample	Findings
Bolton[7] 1976	N = 1,084 (gender unknown) from 5 county jails	6.7% psychotic
Petrich[8] 1976	N = 539 referred for evaluation; 80% male; 42% felons	49% psychotic 10% depression
Petrich[9] 1976	N = 122 referred for evaluation; 84% male; 80% felons	29% schizophrenia 12% depression 6% mania
Piotrowski, Losacco, & Guze[10] 1976	N = 50 selected from those referred for evaluation; 86% male	22% schizophrenia 10% bipolar
Swank & Winer[11] 1976	N = 445 referred for evaluation; gender unknown; 41% felons N = 100 randomly selected; gender unknown; 71% felons	26% psychosis 5% psychosis
Kal[12] 1977	N unknown; random sample	Any DSM-III diagnosis:50% females; 63% males
Schuckit, Herrman & Schuckit[13] 1977	N = 100 males randomly selected; no felony convictions; no current drug charge	3% affective 48% any diagnosis
Nielson[14] 1979	N unknown; sample referred	24% psychosis
Monahan & McDonough[15] 1980	N = 632 referred for evaluation; 82% male; 55.5% misdemeanants	32% schizophrenia
Whitmer[16] 1980	N = 500 (gender unknown) "in need of treatment"	Averaged 3 prior psychiatric hospitalizations
Morgan[17] 1981–2	N unknown; sheriff's perceptions of mental illness	Estimates from 4–50%
Lamb & Grant[18] 1982	N = 102 males; random sample from referrals for evaluation; drug/alcohol excluded; 53% felons	75% schizophrenia 22% affective disorder
Lamb & Grant[19] 1983	N = 101 females; random sample from referrals for evaluation; drug/alcohol excluded; 37% felons	59% schizophrenia 35% affective disorder
Ninzy[20] 1984	N = 50 volunteers; 74% males	26% psychosis
Virginia DMH[21] 1984	N = 171 "mentally ill" as identified by staff	40% schizophrenia 21% mania
Glaser[22] 1985	N = 50 referred for evaluation; Australians (gender unknown)	48% schizophrenia 16% affective disorders
Guy, Platt, Zwerling & Bullock[23] 1985	N = 486 males randomly selected; 96 given diagnostic interview	12% schizophrenia 4% affective disorder
Valdiserri, Carroll, & Hartl[24] 1986	N = 769 referred for evaluation; 86% male	17% psychotic 5.5% predicted morbidity rate: total jail